Department of Health and Human Services
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This document also available at http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf.

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

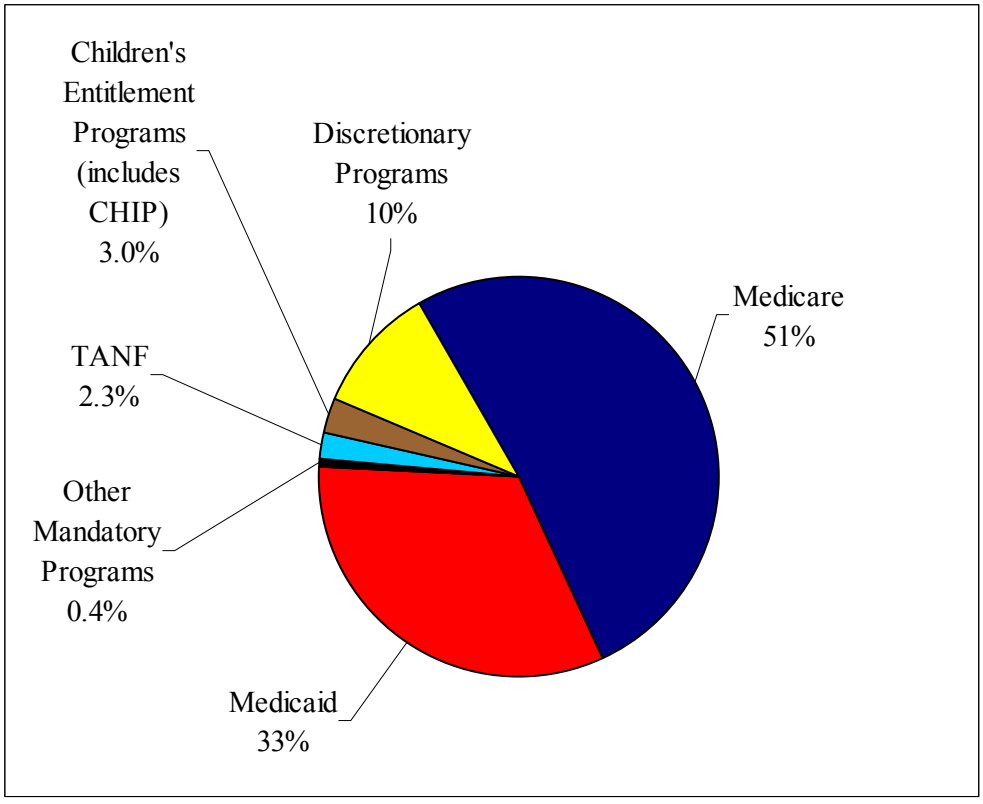
FY 2011 President's Budget for HHS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Budget Authority (excluding Recovery Act)	779,419	800,271	880,861	+80,591
Recovery Act Budget Authority	55,087	45,162	21,066	-24,096
Total Budget Authority	**834,506**	**845,432**	**901,927**	**+56,495**
Total Outlays	**794,234**	**859,763**	**910,679**	**+50,916**
Full-Time Equivalents	67,875	70,028	72,923	+2,895

Composition of the FY 2011 Budget

$911 Billion in Outlays



General Notes

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

Budget data in this book are presented "comparably" with the FY 2011 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2011. This is consistent with past practice, and allows increases and decreases in this book to reflect true funding changes.

In addition – consistent with past practice – the FY 2010 figures herein reflect final enacted levels.

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) Budget, consistent with the President's goals, invests in health care, disease prevention, social services, and scientific research. These investments will enable HHS to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves.

The President's FY 2011 Budget totals $911 billion in outlays, an increase of $51 billion over FY 2010. The Budget proposes $81 billion in discretionary budget authority, an increase of $2.3 billion over FY 2010 on a comparable basis.

HHS's portion of the American Recovery and Reinvestment Act of 2009 (Recovery Act) addresses and responds to critical challenges in our health care and human services systems through investments that immediately impact the lives of Americans. To fulfill the President's health care vision, the Budget builds on Recovery Act investments and continues on the path to health insurance reform in key HHS priority areas.

REDUCING HEALTH FRAUD

Enhancing Medicare and Medicaid Program Integrity: Reducing fraud, waste, and abuse in government spending is a top priority for the President. The Budget includes $561 million in discretionary resources, an increase of $250 million, to strengthen Medicare and Medicaid program integrity activities, with a particular emphasis on fighting health care fraud in the field, increasing Medicaid audits, and strengthening program oversight while reducing costs.

This investment, as part of a multi-year effort, will augment existing resources for combating health care fraud and abuse and save $9.9 billion over ten years. The additional funding will better equip the Federal government to minimize inappropriate payments, pinpoint potential weaknesses in program integrity oversight, target emerging fraud schemes by provider and type of service, and establish safeguards to correct programmatic vulnerabilities.

The Budget also includes a set of new program integrity proposals that will give HHS the necessary tools to fight fraud by enhancing provider enrollment scrutiny, increasing claims oversight, improving Medicare's data analysis capabilities, and reducing overutilization of Medicaid prescription drugs. These proposals will save approximately $14.7 billion over 10 years.

IMPROVING QUALITY OF AND ACCESS TO HEALTH CARE

Health Insurance Reform: Congress is focused on health insurance reform to provide security and stability for Americans with health insurance and expand coverage to those Americans who do not have insurance. These reforms will improve the quality of care, lower costs for families and businesses, and help reduce the Nation's deficit.

Strengthening the Centers for Medicare & Medicaid Services (CMS): The Budget includes $3.6 billion, an increase of $186 million. The request is necessary to meet current administrative workload demands from recent legislative requirements and continuous beneficiary growth. The request provides targeted investments to revamp information technology (IT) systems and optimize staffing levels so that CMS can meet the future challenges of the Medicare and Medicaid programs and can be an active purchaser of high quality and efficient care.

Specifically, $110 million of CMS' increase is for a new, comprehensive Health Care Data Improvement Initiative to transform CMS's data environment from one focused primarily on claims processing to one also focused on state-of-the art data analysis and information sharing. These changes are vital to modernizing the Medicare and Medicaid programs by making CMS a leader in value-based purchasing, improving systems security, and increasing analytic capabilities and data sharing with key stakeholders.

Increasing Child Health Care Access: Additional resources distributed to States and Territories after the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 resulted in 38 percent of States expanding or improving child health coverage in FY 2009. Forty-seven States now cover children in families with incomes at or above 200 percent of the Federal

poverty guidelines. In September of 2009, CMS awarded $40 million in grants to assist in enrolling the over 5 million children who are uninsured but eligible for either Medicaid or the Children's Health Insurance Program.

Strengthening the Health Professions Workforce:
The Budget includes $995 million, an increase of $33 million, to address the shortage of health care providers in underserved areas. This funding will expand loan repayment programs for physicians, nurses, and dentists who agree to practice in medically underserved areas. This funding will also enable nursing schools to expand their nursing student capacity, and it will provide for workforce development grants that will enable States to increase access to oral health care.

Expanding Health Centers:
The Administration remains committed to building on Recovery Act investments and ensuring quality access to health centers. The Budget includes an increase of $290 million for further expansions of health center services, including the creation of 25 new access points in communities without access to a health center, and will facilitate the integration of behavioral health into the existing health centers' primary care system. With this increased funding, health centers will be able to serve a total of more than 20 million patients in FY 2011.

Improving Health Outcomes of American Indian and Alaska Natives: The President is committed to improving health outcomes for American Indian and Alaska Native communities and supporting the provision of health care for American Indians and Alaska Natives. The Budget includes nearly $5.4 billion, an increase of $354 million, that will enable the Indian Health Service (IHS) to focus on reducing health disparities, supporting Tribal efforts to deliver quality care, ensuring that IHS services can be supplemented by care purchased outside the Indian health system where necessary, and funding health facility and medical equipment upgrades. These investments will ensure continued improvement to support the Administration's goal of significantly reducing health disparities for American Indians and Alaska Natives.

Enhancing Health Information Technology (Health IT):
The Budget includes $78 million, an increase of $17 million, for the Office of the National Coordinator for Health Information Technology (ONC) to advance the President's health IT initiative by accelerating health IT adoption and electronic health records (EHRs) utilization as essential tools to modernizing the health care system. The increase will enable ONC to lead and coordinate Federal health IT efforts while implementing and evaluating Recovery Act health IT programs.

The Recovery Act also established Medicare and Medicaid health IT incentive programs to provide an estimated $20.6 billion over 10 years for the adoption and meaningful use of EHRs. In FY 2011, these programs begin providing incentive payments to eligible providers. The use of EHRs will improve the reporting of clinical quality measures and will promote health care quality, efficiency, and patient safety.

Protecting Access to Medicaid for Low-Income Families: To continue to fulfill the President's commitment to ensuring access to health care for millions of Americans, the Budget includes a proposal to extend by an additional six months, through June 2011, the temporary Federal Medical Assistance Percentage (FMAP) increase provided by the Recovery Act. The extension will result in an additional $25.5 billion to States for maintaining support for children and families helped by Medicaid.

Advancing Patient-Centered Health Research: The Budget includes an additional $261 million, including program support costs, in the Agency for Healthcare Research and Quality (AHRQ) to support new research projects. This funding will support the generation, translation, and dissemination of research that will improve health care quality and efficiency by providing patients and clinicians with evidence-based information to enhance medical decision-making. The Budget also continues to support Patient-Centered Health Research within NIH. HHS continues to invest the $1.1 billion for this research provided in FY 2009 to AHRQ, NIH, and the Office of the Secretary by the Recovery Act.

PROMOTING PUBLIC HEALTH

Transforming Food Safety:
The President is committed to securing our Nation's food supply by transforming and improving our food safety system. The Budget includes $1.4 billion, an increase of $327 million or 30 percent, for food safety efforts that will strengthen the ability of the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) to prioritize prevention, strengthen surveillance and enforcement, and improve response and recovery – key priorities of the Food Safety Working Group the President established in March 2009. CDC will improve the speed and accuracy of foodborne disease

outbreak detection and investigation. FDA will increase inspections to improve the security of the supply chain and invest in the analytical tools needed to make data-driven decisions about how to best deploy food safety resources to prevent foodborne illnesses.

Reducing Tobacco Use: In June 2009, the President signed the Family Smoking Prevention and Control Act, providing FDA with new authorities and responsibilities for regulating tobacco use and establishing the FDA Center for Tobacco Products. The Budget includes $450 million from user fees to reduce tobacco use in minors by regulating marketing and distribution of tobacco products, promote public health understanding of harmful constituents of tobacco products, and reduce the toll of tobacco-related disease, disability, and mortality. In addition, $504 million in funding from CDC, the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA), will further help reduce smoking among teens and adults and will support research on preventing tobacco use, understanding the basic science of the consequences of tobacco use, and improving treatments for tobacco-related illnesses.

Preventing and Treating HIV/AIDS: The Budget includes more than $3 billion, an increase of $70 million, for CDC and the Health Resources and Services Administration (HRSA) to enhance HIV/AIDS prevention, care, and treatment. This increase includes $31 million for CDC to integrate surveillance and monitoring systems, address high-risk populations, and support HIV/AIDS coordination and service integration with other infectious diseases. This increase also includes $40 million for HRSA's Ryan White program to expand access to care for underserved populations, provide life-saving drugs, and improve the quality of life for people living with HIV/AIDS.

Prevention: Reducing the burden of chronic disease, collecting and using health data to inform decision-making and research, and building an interdisciplinary public health workforce are critical components to successful prevention efforts. The Budget includes $20 million for a CDC initiative to reduce the rates of morbidity and disability due to chronic disease in up to ten of the largest U.S. cities. These cities will be able to incorporate the lessons learned from implementing evidence-based prevention and wellness strategies of the Recovery Act's Communities Putting Prevention to Work Initiative.

The Budget also includes $10 million at CDC for a new Health Prevention Corps, which will recruit, train, and assign a cadre of public health professionals in State and local health departments. This program will target disciplines with known shortages such as epidemiology, environmental health, and laboratory science.

The Budget also includes $162 million for Health Statistics, an increase of $23 million, to improve CDC's ability to collect data on the health of the Nation for use by policy-makers and Federal, State, and local leaders. This increase will ensure data availability on key national health indicators by supporting electronic birth and death records in States and enhancing national surveys.

Addressing Autism Spectrum Disorders: The Budget includes $222 million, an increase of $16 million, for Autism Spectrum Disorders (ASD). NIH research will pursue comprehensive and innovative approaches to defining the genetic and environmental factors that contribute to ASD, investigate epigenomic changes in the brain, and accelerate clinical trials of novel pharmacological and behavioral interventions. CDC will expand autism monitoring and surveillance and support an autism awareness campaign. HRSA will increase resources to support children and families affected by ASD through screening programs and evidence-based interventions.

Preventing Teen Pregnancy: The Budget includes $183 million within the Office of Public Health and Science for teen pregnancy prevention programs. These programs will support State, Tribal, Territory, and community-based efforts to reduce teen pregnancy using evidence-based models and promising programs needing further evaluation. The Budget also includes $22 million, an increase of $7 million, for CDC teen pregnancy activities to reduce the number of unintended pregnancies through science-based prevention approaches.

Investing in Drug Demand Reduction: The Budget invests in innovative approaches to prevent and treat substance abuse. These efforts include $23 million to implement evidence-based community prevention programs for young people throughout their at-risk years, $14 million to design and test a community-level early warning system to detect emerging drug threats, and an additional $13 million to expand the treatment capacity of drug courts.

Global Health: The Budget includes $352 million, an increase of $16 million, for CDC Global

Health Programs to build global public health capacity by strengthening the global public health workforce; integrating maternal, newborn, and child health programs; and improving global access to clean water, sanitation, and hygiene. Additionally, the Budget includes $6.4 million in the Office of Global Health Affairs (OGHA) to support global health policy leadership and coordination.

FDA Medical Product Safety Initiative: The Budget includes $1.4 billion, an increase of $101 million, for medical product safety. This increase will enable FDA to invest in tools that will enhance the safety of increasingly complex drugs, medical devices, and biological products. With these additional resources, FDA also will increase inspections to improve the security of the supply chain and reduce the potential for harm.

PROTECTING AMERICANS FROM PUBLIC HEALTH THREATS AND TERRORISM

Supporting Advanced Development: The Budget includes $476 million, an increase of $136 million, for the Biomedical Advanced Research and Development Authority (BARDA). This funding will sustain the support of next generation countermeasure development in high priority areas including anthrax and acute radiation syndrome by allowing the BioShield Special Reserve Fund to support both procurement activities and advanced research and development. The increased flexibility will enable BARDA to use Project BioShield to target resources to the most promising countermeasure candidates, whether through advanced development or acquisition.

Protecting Against Pandemic Influenza: Reassortment of avian, swine, and human influenza viruses has led to the emergence of a new strain of H1N1 influenza A virus, 2009 H1N1 flu, that is transmissible among humans. According to the World Health Organization, more than 208 countries and overseas territories have reported cases of 2009 H1N1 infection. CDC estimates that through December 12, 2009, there were approximately 55 million cases of 2009 H1N1 in the United States, resulting in about 246,000 related hospitalizations and about 11,160 related deaths. On June 24, 2009, Congress appropriated $7.65 billion to HHS for pandemic influenza preparedness and response to 2009 H1N1 flu. HHS has been able to use these resources to support H1N1 preparedness and response in States and hospitals ($1.44 billion), invest in the H1N1 vaccine production ($1.6 billion), and conduct domestic and international response activities ($75 million).

The Budget includes $302 million for ongoing pandemic influenza preparedness activities at the CDC, NIH, FDA, and the Office of the Secretary for international activities, virus detection, communications, and research. In addition, the use of balances from the June 2009 funds, including approximately $330 million in FY 2011, will enable HHS to continue advanced development of cell-based and recombinant vaccines, antivirals, respirators, and other activities that will help ensure the Nation's preparedness for future pandemics. Previous pandemic influenza investments enabled the 2009 H1N1 response, including investments that increased the level of domestic vaccine manufacturing capacity, supported the development and procurement of adjuvants and antivirals, provided a new antiviral drug for critically ill patients, and provided experience in vaccine and antiviral stockpiling.

IMPROVING THE WELLBEING OF CHILDREN, SENIORS, AND HOUSEHOLDS

Enhancing Quality Early Care and Education and the Zero to Five Plan: The Budget provides critical support for the President's Zero to Five Plan to enhance quality early care and education for our Nation's children.

The Budget lays the groundwork for a reauthorization of the Child Care and Development Block Grant and entitlement funding for child care. The Budget includes a total of $6.6 billion for the Child Care and Development Fund (discretionary and entitlement child care assistance), an increase of $1.6 billion. These resources will enable 1.6 million children to receive child care assistance in FY 2011 – approximately 235,000 more than could be served in the absence of these additional funds. The Budget will help more low-income families access critical services during this continued time of economic hardship.
The Administration's principles for reform of the Child Care and Development Fund include establishing a high standard of quality across child care settings, expanding professional development opportunities for the child care workforce, and promoting coordination across the spectrum of early childhood education programs. The Administration looks forward to working with Congress to begin crafting a reauthorization proposal that will make needed reforms to ensure that children receive high quality care that meets the diverse needs of families and fosters healthy child development.

Also in support of the President's Zero to Five Plan, the Budget includes $8.2 billion, an increase of $989 million, for Head Start to serve an estimated 971,000 children, an increase of approximately 66,500 children over FY 2008. Early Head Start will serve approximately 116,000 infants and toddlers in FY 2011, nearly twice as many as were served in FY 2008. The Budget also includes $118 million for quality enhancements. Since FY 2008, the Administration has invested almost $500 million in improving the quality of Head Start programs. Additionally, the Administration plans to implement key provisions of the 2007 Head Start Act that will improve the quality of Head Start programs.

Protecting Access to Foster Care and Adoption Assistance for Vulnerable Children and Youth: To continue to fulfill the President's commitment to improving the development, safety, well-being, and permanency of children and youth in foster care, adoption assistance, and guardianship assistance, the Budget includes a proposal to extend by an additional six months, through June 2011, the temporary FMAP increase for foster care and adoption assistance provided by the Recovery Act. This extension will result in an additional $237 million over five years to States for maintaining critical services to vulnerable children and youth.

Administration on Aging (AoA) Caregiver Initiative: To enable families to better care for their aging relatives and support seniors trying to remain independent in their communities, the Budget provides $102.5 million for a new Caregiver Initiative at AoA. This funding includes $50 million for caregiver services, such as counseling, training, and respite care for the families of elderly individuals; $50 million for transportation, homemaker assistance, adult day care, and personal care assistance for elderly individuals and their families; and $2.5 million for respite care for family members of people of all ages with special needs. This funding will support 755,000 caregivers with 12 million hours of respite care and more than 186,000 caregivers with counseling, peer support groups, and training.

Supporting Low-Income Families: The Budget includes an extension of the Temporary Assistance for Needy Families (TANF) block grant and related programs, including the Contingency Fund and Supplemental Grants, through FY 2011. The Budget also includes $500 million for a new Fatherhood, Marriage, and Families Innovation Fund. The fund will provide competitive grants to States to conduct and rigorously evaluate comprehensive responsible fatherhood programs and demonstrations geared towards improving child outcomes by improving outcomes for custodial parents with serious barriers to self-sufficiency. The Budget also includes an increase of $2.5 billion for the TANF Emergency Fund and makes several program changes focused on strengthening States' efforts to enhance employment-related assistance to low-income families. The Budget includes a one-year, $669 million extension of the Federal match to States' reinvestment of incentive payments into Child Support Enforcement programs. Without this critical extension of resources, it is estimated that States would reduce program expenditures by 10 percent. The Budget also includes two proposals focused on increasing child support collections and a proposal to expand resources for non-custodial parents' access to and visitation with their children.

Low Income Home Energy Assistance (LIHEAP): The Budget proposes a new way to fund LIHEAP to help low-income households heat and cool their homes. It provides $3.3 billion in discretionary funding and an estimated $2 billion in mandatory funding. Under this proposal, mandatory funds will be released almost immediately in response to changes in energy prices or the number of people living in poverty. The $2 billion estimate is based on current projections of Supplemental Nutrition Assistance usage and energy prices.

INVESTING IN SCIENTIFIC RESEARCH AND DEVELOPMENT

Exploring Scientific Opportunities in Biomedical Research: The Budget includes $32.2 billion for NIH, an increase of $1 billion, to support innovative projects from basic to clinical research. This effort will be guided by NIH's five areas of exceptional research opportunities: supporting genomics and other high-throughput technologies; translating basic science into new and better treatments; reinvigorating the biomedical research community; using science to enable health care reform; and focusing on global health. The Administration interest for the high-priority areas of cancer and autism fits well into these five NIH theme areas. In FY 2011, NIH estimates it will support a total of 37,001 research project grants, including 9,052 new and competing awards.

The additional $1 billion will enable NIH to capitalize upon

recent successful investments in biomedical research, such as the Human Genome Project, that have provided a powerful foundation for a deeper level of understanding human biology and have opened another window into the causes of disease. New partnerships between academia and industry are working to revitalize the drug development pipeline. An era of personalized medicine is emerging where prevention, diagnosis, and treatment of disease can be tailored to an individual rather than using the one-size-fits-all approach that all too often falls short, wasting health care resources and potentially subjecting patients to unnecessary and dangerous medical treatments and diagnostic procedures.

Investing in FDA's Scientific Infrastructure: The Budget includes $25 million for advancing regulatory science at FDA. This initiative builds on the President's commitment to harness the power of science for America's benefit and includes $15 million for nanotechnology related research, which holds great promise for advances in medical products and cosmetics. The additional resources will also enable FDA to update review standards and provide regulatory pathways for new technologies, such as biosimilars.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2009	2010	2011	2011 +/- 2010
Food & Drug Administration:				
Program Level	2,751	3,287	4,033	746
Budget Authority	2,062	2,365	2,510	145
Outlays	1,843	2,349	2,429	80
Health Resources and Services Administration:				
Budget Authority (excl. Recovery Act) /3	7,328	7,587	7,635	48
Recovery Act Budget Authority /1	2,500	-	-	-
Outlays	7,267	8,488	8,532	44
Indian Health Service:				
Budget Authority (excl. Recovery Act)	3,731	4,202	4,556	354
Recovery Act Budget Authority /1	500	-	-	-
Outlays	3,644	4,505	4,612	107
Centers for Disease Control and Prevention:				
Budget Authority (excl. Recovery Act) /5	6,370	6,477	6,342	-135
Recovery Act Budget Authority /1	300	-	-	-
Outlays	6,247	6,581	6,491	-90
National Institutes of Health:				
Budget Authority (excl. Recovery Act)	30,096	31,255	32,255	1,000
Recovery Act Budget Authority /1	10,400		-	-
Outlays	29,847	31,807	37,189	5,382
Substance Abuse and Mental Health Services:				
Budget Authority	3,335	3,432	3,541	110
Outlays	3,369	3,349	3,457	108
Agency for Healthcare Research and Quality:				
Program Level /6	372	397	611	214
Budget Authority (excl. Recovery Act)	3	-	-	-
Recovery Act Budget Authority /2	700	-	-	-
Outlays	-80	141	317	176
Centers for Medicare & Medicaid Services:				
Budget Authority (excl. Recovery Act) /5	657,147	696,077	763,290	67,213
Recovery Act Budget Authority /1,7	31,887	39,865	20,138	-19,727
Outlays	686,791	733,457	781,713	48,256
Administration for Children and Families:				
Budget Authority (excl. Recovery Act)	56,564	46,337	57,897	11,560
Recovery Act Budget Authority	5,933	5,284	913	-4,371
Outlays	52,211	61,281	58,472	-2,809
Administration on Aging:				
Budget Authority (excl. Recovery Act)	1,488	1,513	1,625	112
Recovery Act Budget Authority /1	100	-	-	-
Outlays	1,453	1,596	1,583	-13
Office of the National Coordinator:				
Budget Authority (excl. Recovery Act)	44	42	78	36
Recovery Act Budget Authority /4	2,000	-	-	-
Outlays	21	639	851	212

1/ FY 2009 Recovery Act appropriations were provided to fund programmatic costs in multiple fiscal years.

2/ The Recovery Act appropriated $1.1 billion for research that compares the effectiveness of medical options and transferred $400 million of this amount to NIH. Of the remaining $700 million, $400 million is for allocation at the discretion of the Secretary.

3/ Does not include C/J/S vaccines.

4/ Total includes $20 million transfer to NIST.

5/ Levels are comparably adjusted to show transfer of OGHA activities to CDC.

6/ The AHRQ program level includes $3 million in mandatory BA from the Medicare Improvements for Patients and Providers Act of 2008 (MPIPPA)

7/ Budget Authority for CMS defined as program outlays.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2009	2010	2011	2011 +/- 2010
Medicare Hearings and Appeals:				
Budget Authority	65	71	78	7
Outlays	67	71	78	7
Office for Civil Rights				
Budget Authority	40	43	45	2
Outlays	32	38	42	4
Departmental Management:				
Budget Authority (excl. Recovery Act) /5	384	490	594	104
Recovery Act Budget Authority /1	-	-	-	-
Outlays	355	443	543	100
Prevention and Wellness				
Recovery Act Budget Authority /1	700			
Outlays		158	314	156
Public Health Social Service Emergency Fund:				
Budget Authority (excl. Recovery Act)	10,611	738	735	-3
Recovery Act Budget Authority /1	50	-	-	-
Outlays	1,868	5,179	4,325	-854
Office of Inspector General:				
Budget Authority (excl. Recovery Act)	126	62	37	-26
Recovery Act Budget Authority /1	17	13	16	3
Outlays	56	99	90	-9
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds):				
Budget Authority	553	594	637	43
Outlays	466	590	633	43
Offsetting Collections:				
Budget Authority	-1,223	-1,008	-992	16
Outlays	-1,223	-1,008	-992	16
Budget Authority (excl. Recovery Act)	**779,419**	**800,271**	**880,861**	**+80,591**
Total Recovery Act Budget Authority	**55,087**	**45,162**	**21,066**	**-24,096**
Total Budget Authority	**834,506**	**845,432**	**901,927**	**+56,495**
Outlays	**794,234**	**859,763**	**910,679**	**+50,916**
Full-Time Equivalents	67,875	70,028	72,923	+2,895

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Discretionary Programs (Budget Authority)					
Food and Drug Administration /1	2,055	--	2,362	2,508	+146
FDA Program Level /4	*2,691*	--	*3,284*	*4,032*	+748
Health Resources and Services Administration	7,243	2,500	7,483	7,511	+28
HRSA Program Level	*7,296*	*2,500*	*7,531*	*7,561*	+29
Indian Health Service	3,581	500	4,052	4,406	+354
IHS Program Level	*4,551*	*500*	*5,037*	*5,392*	+354
Centers for Disease Control and Prevention	6,568	300	6,475	6,342	-133
CDC Program Level	*10,339*	*300*	*10,521*	*10,622*	+101
National Institutes of Health	30,396	10,400	31,089	32,089	+1,000
NIH Program Level	*30,554*	*10,400*	*31,247*	*32,247*	+1,000
Substance Abuse and Mental Health Services	3,335	--	3,432	3,541	+110
SAMHSA Program Level	*3,466*	--	*3,563*	*3,674*	+110
Agency for Healthcare Research and Quality	--	*700*	--	--	--
AHRQ Program Level	*372*	700	*397*	*611*	+214
Centers for Medicare & Medicaid Services	3,230	--	3,415	3,601	+186
CMS Program Level (Excluding HCFAC)	*3,843*	--	*4,084*	*4,211*	+126
Administration for Children and Families Services	17,307	5,150	17,336	17,480	+144
ACF Program Level	*17,355*	*5,150*	*17,342*	*17,486*	+144
Administration on Aging	1,494	100	1,516	1,625	+108
AoA Program Level	*1,515*	*100*	*1,519*	*1,628*	+109
General Departmental Management	382	--	490	544	+54
OS Program Level	*434*	--	*562*	*618*	+56
Office for Civil Rights	40	--	41	44	+3
Office of the National Coordinator	44	2,000	42	78	+36
ONC Program Level	*61*	*2,000*	*61*	*78*	--
Medicare Hearings and Appeals	65	--	71	78	+7
Office of Inspector General	45	17	50	52	+1
OIG Program Level	*301*	*17*	*292*	*334*	+42
Health Care Fraud and Abuse Control (Discretionary)	*198*	--	311	561	+250
HCFAC Program Level	*1,459*	--	*1,584*	*1,809*	+225
Public Health and Social Services Emergency Fund /2	10,611	50	738	734	-3
PHSSEF Program Level	*10,611*	*50*	*1,347*	*1,541*	+194
Prevention and Wellness (OS)	--	700	--	--	--
Medicare Eligible Healthcare Accruals (Com. Corps)	35	--	36	37	+1
Aligning Head Start to Budget Year	*1,389*	--	--	--	0
Rescissions of Prior Year Balances	-22	--	--	--	0
Offset for PHS Evaluation Funds (Prog. Level)	-943	--	*-1,004*	*-1,193*	*-189*
HCFAC Funds in Agency Prog. Levels or DOJ /3	*-456*	--	*-455*	*-556*	*-101*
Total, Discretionary Budget Authority /5	**87,995**	**22,417**	**78,940**	**81,233**	**+2,293**
Subtotal, Discretionary Program Level	***94,957***	***22,417***	***87,064***	***90,252***	***+3,189***
Discretionary Outlays	**75,603**	**--**	**90,703**	**92,903**	**+2,200**

*American Recovery and Reinvestment Act of 2009 (ARRA).

1/ FY 2009 budget authority level reflected in the Budget Appendix differ due to the timing and availability of user fee collections.

2/ Reflects Bioshield funding in the year appropriated not in the year funds were transferred from DHS to HHS.

3/ In addition to HCFAC amounts in Agency program levels, $25 million is shown in OIG for Medicaid Integrity (FY 2009, 2010, and 2011); $25 million in OIG for Medicaid Fraud in FY 2009; and the following amounts transferred to the Department of Justice (DOJ): $201 million in FY 2009, $211 million in FY 2010, $272 million in FY 2011.

4/ FY 2009 Program Level includes $23.5 million in tobacco fees which are categorized as mandatory only in FY 2009.

5/ As footnote 2 indicates, Bioshield funds transferred from DHS are included on a comparable basis so that changes in the location of funds do not distort the year-to-year comparisions. In addition, some of the OMB-published tables include an additional $19 million in the FY 2009 accounting adjustments. As a result, on a purely accounting basis, the FY 2009 total would be $1,744 million lower ($86,250 million); the FY 2010 number $3,033 million higher ($81,972 million), and the change from FY 2010 to FY 2011 would be $3,033 million lower (-$739 million).

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Mandatory Programs (Outlays) /1:				
Medicare	424,747	444,003	468,601	+24,598
Medicaid	250,924	275,383	296,841	+21,458
Temporary Assistance for Needy Families	18,933	22,083	21,001	-1,082
Foster Care & Adoption Assistance	6,859	7,403	7,442	+39
Children's Health Insurance Program /2	7,547	9,103	10,485	+1,382
Child Support Enforcement	4,352	4,710	4,324	-386
Child Care	2,952	2,925	3,417	+492
Social Services Block Grant	1,854	2,118	1,832	-286
Other Mandatory Programs	1,686	2,340	4,825	+2,485
Offsetting Collections	-1,223	-1,008	-992	+16
Subtotal, Mandatory Outlays	718,631	769,060	817,776	+48,716
Total, HHS Outlays	**794,234**	**859,763**	**910,679**	**+50,916**

1/ FY 2009 and FY 2010 Recovery Act funding included in this table. See details on Mandatory Recovery Act table.

2/ Includes outlays for the Child Enrollment Contingency Fund in FY 2010 & FY 2011.

HEALTH REFORM

The Administration is committed to reforming the health care system to assure affordable, quality, health coverage for all Americans.

A HISTORIC STEP FORWARD

Health care costs are consuming an ever-increasing amount of our Nation's resources, straining family, business, and government budgets. Rising premiums hurt the competitiveness of American businesses and erode workers' take-home pay. Health care costs take up a growing share of Federal and State budgets and are the greatest threat to the government's long-term fiscal outlook.

The President laid out principles in the FY 2010 Budget to reform health care without increasing the deficit and has worked closely with Congress to bring about this much-needed change.

Health Reform is necessary to provide security and stability for Americans, who are paying more and more for less and less high quality health care. It starts by making insurance coverage stronger for Americans who have insurance ending many of the worst insurance industry practices. Reform will also expand coverage to millions of Americans who do not have insurance; improving the quality of care, lowering costs for families and businesses and helping to both reduce the Nation's deficit and improve the bottom-line budget of America's families. The goal is to ensure that from now on, Americans who change or lose their job will always be able to find affordable health insurance coverage, regardless of their health status.

PROGRESS TOWARD HEALTH INSURANCE REFORM

As Congress has worked toward health reform, major strides have already been made in improving care and cutting costs at the Department of Health and Human Services through key iniatives like the Recovery Act , the Genetic Information and Non Discrimination Act and the Children's Health Insurance Program (CHIP) reauthorization:

- *CHIP*: Covering millions more uninsured children and providing new tools to increase outreach and enrollment;
- *COBRA*: Temporarily lowering the cost of COBRA coverage by 65 percent for laid-off workers and their families;
- *Ending Insurance Discrimination:* CMS issued rules that protect Americans' genetic information from discrimination by insurers and employers.
- *Health Centers*: Investing $2 billion to support needed capital improvements and expanded services, including new sites and extended hours; and
- *Workforce*: Investing $500 million to address workforce shortages through the National Health Service Corps and other health professions activities.
- *Health IT*: Embarking on an effort to improve health care quality and efficiency by computerizing health records;
- *Prevention*: Investing $1 billion in prevention and wellness;
- *Patient-Centered Health Research*: Devoting $1.1 billion to patient-centered health research.

RECOVERY ACT

The American Recovery and Reinvestment Act was signed into law on February 17, 2009. The Recovery Act provides funding for health IT, research that compares the effectiveness of different medical options, prevention and wellness, scientific research, social and health care services, and Medicaid relief to the States.

The American Recovery and Reinvestment Act (the Recovery Act) provides HHS programs an estimated $141 billion for Fiscal Years 2009 – 2019. While most provisions in HHS programs involve rapid investments, the Recovery Act also includes longer term investments in health information technology (primarily through Medicare and Medicaid). As a result, HHS plans to have outlays totaling $87 billion through FY 2010.

Since the Recovery Act was passed in February 2009, HHS has made great strides in improving access to health and social services, stimulating job creation, and investing in the future of health care reform through advances in health information technology, prevention and scientific research.

PROGRAM PERFORMANCE

HHS Recovery Act funds have had an immediate impact on the lives of individuals and communities across the country affected by the economic crisis and the loss of jobs. As of September 30, 2009,

- The $31.5 billion in Federal Payments to States helped maintain State Medicaid services to a growing number of beneficiaries and provided fiscal relief to States.
- The National Institutes of Health awarded $5 billion for biomedical research in over 12,000 grants.
- Area agencies on aging provided more than 350,000 seniors with over 6 million meals delivered at home and in community settings.
- Health Centers provided primary health care services to over 1 million new patients.

These programs and activities will continue in FY 2010, and more will come on line. For example,

- 64,000 additional children and their families will participate in a Head Start or Early Head Start experience.
- Approximately 30,000 American Indian and Alaska Natives' homes will have safe drinking water and adequate waste disposal facilities.
- HHS will be assisting States and communities to develop capacity, technical assistance and a trained workforce to support the rapid adoption of health IT (information technology) by hospitals and clinicians.
- The Centers for Disease Control and Prevention will support community efforts to reduce the incidence of obesity and tobacco use.
- New research grants will be awarded to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers about what interventions are most effective for patients under specific circumstances.

TRANSPARENCY AND ACCOUNTABILITY

Transparency: HHS Recovery Act funds are being managed with greater transparency and accountability than ever before. In October 2009, HHS collected the first round of quarterly recipient reports as required by the Recovery Act. About 18,000 HHS reports were submitted for discretionary grant programs and contracts. Although HHS managed more reports than any other Federal agency, over 98 percent of HHS recipients entered required data into FederalReporting.gov. This data can now be found on Recovery.gov.

***Accountability*:** HHS has placed a strong emphasis on ensuring that risks for fraud, waste and abuse are minimized. The Department has evaluated all Recovery Act-funded programs to ensure that funds are awarded and distributed promptly, fairly and in a responsible manner for authorized purposes. HHS will also review projects for unnecessary delays or cost overruns and make sure program outcomes are achieved.

HHS RECOVERY ACT PROGRAMS

HHS Recovery Act activities touch the lives of Americans in numerous areas.

IMPROVING AND PRESERVING HEALTH CARE

Medicaid FMAP Increase: The Recovery Act temporarily increases the Federal share of Medicaid expenditures by an estimated $84.5 billion through a 6.2 percent increase in the Federal Medical Assistance Percentage (FMAP) for all States, with additional relief tied to rates of unemployment. Territories also

benefit from increased Medicaid funding. These funds are available for obligation until the end of 2010.

Temporary Increase in DSH Allotments: The Recovery Act provides an estimated $595 million in increased State Disproportionate Share Hospital (DSH) payments through a 2.5 percent increase in FY 2009 and FY 2010 allotments. These payments assist hospitals that serve a disproportionate share of low-income or uninsured patients.

Transitional Medical Assistance: Beginning in July 2009, the Recovery Act provides an estimated $915 million in additional Medicaid expenditures by extending Transitional Medical Assistance (TMA) through December 31, 2010. This extension allows States to provide assistance for longer periods and waive some requirements for families seeking assistance.

Qualified Individuals Program: The Recovery Act provides approximately $563 million to extend premium assistance for Medicare beneficiaries who are Qualified Individuals (incomes of 120-135 percent of the poverty line) through December 31, 2010.

Medicaid and CHIP Provisions to Benefit American Indians and Alaska Natives: The Recovery Act provides protections for Indians under Medicaid and the Children's Health Insurance Program (CHIP), including requirements for managed care organizations, limits on cost-sharing, and exclusion of certain property for purposes of determining eligibility for Medicaid and CHIP.

Health Professions: The Recovery Act includes $200 million for HRSA's health workforce training programs to strengthen the health workforce in key areas through direct student support, loan repayment, and support for the purchase of equipment.

ACCELERATING THE ADOPTION OF HEALTH IT

The Recovery Act includes both additional resources and a new authorization to guide the Federal government's health IT activities. Medicare and Medicaid estimates for health IT reflect revised estimates of the enacted legislation based on newly proposed regulations.

Incentives for Electronic Health Records: The Recovery Act provides an estimated $20.6 billion in incentives, from FY 2009 to FY 2019, through Medicare and Medicaid to encourage providers and hospitals to adopt certified electronic health record (EHR) technology. On December 30, 2009, the Centers for Medicare & Medicaid Services (CMS) published a proposed regulation and the Office of the National Coordinator (ONC) published an interim final regulation (IFR). These actions lay a foundation for improving quality, efficiency, and safety through meaningful use of electronic health record (EHR) technology. In the proposed regulation, CMS outlines provisions governing the incentive program, including defining the central concept of "meaningful use" of EHR technology. The IFR, issued by ONC, sets initial standards, implementation specifications, and certification criteria for EHRs.

Medicare Incentives ($10.9 billion): For each qualified physician, incentive payments to encourage EHR adoption would be a maximum of $18,000 in 2011, decreasing to zero by 2015. Physicians not adopting EHRs will see their fee schedule payments reduced by one percent in 2015, growing to three percent in 2017 and between three to five percent thereafter. For hospitals, incentive payments will vary based on Medicare inpatient days, hospital discharges, and charity care. Hospitals not adopting EHRs by 2014 will receive a reduced market basket update beginning in 2015.

Medicaid Incentives ($9.7 billion): The Recovery Act also provides 100 percent Federal match of State expenditures for incentive payments to eligible Medicaid providers for adoption and meaningful use of certified EHR technology and 90 percent Federal match for related State administrative expenses. Physician payments are subject to provider dollar limits, and hospital payments are based on a formula prescribed in statute and are available to providers over a six-year period.

Office of the National Coordinator for Health IT: The Recovery Act authorizes Federal health IT efforts through the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and provides $2 billion for those efforts. Of this amount, $693 million will support the HIT Extension Program, $564 million is for the State Health Information Cooperative Agreement Program, $235 million will support Beacon Communities to demonstrate the vision of the future where providers and patients are meaningful users of health IT, $118 million will support workforce development, and the remainder will focus on privacy

and security, standards and interoperability, public health, research and evaluation, technical assistance and funding for the National Institute of Standards and Technology.

The HITECH Act also enhances privacy protections by expanding the Health Insurance Portability and Accountability Act (HIPAA) to include Medicare Part D, applying HIPAA security standards and privacy rules to business associates, and increasing enforcement and penalties for violations.

Strengthening Community Health Care Services

HRSA Health Centers and National Health Service Corps: The Recovery Act provides $1.5 billion to modernize, renovate and repair health centers. These funds will also be used for the acquisition of health IT systems. An additional $500 million supports the establishment of 127 new health center sites and service areas, and increased services at over 1,100 existing sites.

The Recovery Act also provides $300 million to increase the ranks of the National Health Service Corps by placing clinicians in health professional shortage areas. As of December 31, 2009, the Recovery Act has added more than 1,600 primary care providers, for a total of 4,000 primary care providers that have already begun providing needed health services in health profession shortage areas.

IHS Facilities: The Recovery Act provides $415 million for the construction of priority health care facilities, building maintenance and improvement, water and wastewater sanitation projects, and the purchase of medical equipment.

In addition, $85 million is provided for health IT activities including EHR, telehealth, and infrastructure developments.

Strengthening Scientific Research and Facilities

NIH: NIH's two-year infusion of $10 billion in Recovery Act funds will empower the Nation's best biomedical scientists to discover new cures, advance technology, and solve some of our greatest health challenges. Within the total, the Recovery Act provides $8.2 billion for general biomedical research. These funds support cutting edge research into treating and preventing such diseases as cancer, heart disease and HIV/AIDS. The funds will allow NIH to expand the Cancer Genome Atlas, collecting more that 20,000 tissue samples to sequence the DNA of more than 20 types of cancer and provide the potential to better understand and treat this extraordinarily destructive disease.

Of the remaining funds, $1.3 billion is for extramural research infrastructure, including laboratories and shared equipment; and $500 million is for facility construction, repairs, and renovations at NIH.

Improving Services for Children and Communities

Child Support Enforcement: An estimated $1.8 billion is made available to the States through FY 2010 to match Federal incentive payments that are reinvested into State programs. The funding will improve and strengthen child support enforcement efforts in a challenging economic climate.

Foster Care and Permanency: The Recovery Act provides an estimated $929 million through a 6.2 percentage point FMAP increase through December 2010 for maintenance payments to the States and Puerto Rico for foster care, adoption assistance, and kinship guardianship assistance programs.

Temporary Assistance for Needy Families (TANF): The Recovery Act provides $5 billion to States, Territories, and Tribes through a new Emergency Contingency Fund to assist low-income families during the economic downturn.

States can request Emergency Funds if they have increased TANF caseloads and related basic assistance spending; increased spending on non-recurrent short-term benefits; or increased spending on subsidized employment. As of December 31, 2009, States have expended $614 million in TANF Recovery Act funds.

The Recovery Act also includes $319 million to extend TANF Supplemental grants through FY 2010. These grants provide additional assistance to 17 States with historically high population growth or increased poverty since the mid 1990s.

Child Care and Development Block Grant: The Recovery Act provides $2 billion for supplementing State funds for child care assistance to low-income families. A portion of the funds are also reserved for quality improvement activities. As of the end of FY 2009, States reported spending $247 million in Recovery Act funds on direct child care services for low-income families, allowing States

to: shorten, eliminate or avoid waiting lists for services; increase periods of eligibility for job search in recognition of high unemployment; and lower co-payments for families who are under economic stress.

Head Start and Early Head Start: The Recovery Act provides $2.1 billion for Head Start, including $1.1 billion for Early Head Start. This significant increase will expand Head Start and Early Head Start services to approximately 64,000 additional children, 50,000 of whom are children, from birth up to age three. Additionally, the Recovery Act enabled all grantees to receive a full Head Start staff cost of living increase for FY 2009 and provides funds to improve the quality of Head Start and Early Head Start programs.

Community Services Block Grant: The Recovery Act provides $1 billion to States to distribute to community action agencies to reduce poverty and assist low-income residents in becoming self-sufficient. Eligible entities can serve individuals with incomes up to 200 percent of the poverty line – an increase above the previous limit of 125 percent of the poverty line.

Strengthening Communities Fund: The Recovery Act provides $50 million to build the capacity of non-profit organizations, including faith and community-based organizations, and government entities to address the needs of low-income and disadvantaged populations. The Administration for Children and Families has made 35 awards to community non-profit organizations, local foundations, universities, and 49 awards to State, local and Tribal governments.

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Nutrition Programs for Seniors: The Recovery Act includes $100 million for nutrition programs for seniors. The funds are bolstering assistance provided through Congregate Nutrition Services, Home-Delivered Nutrition Services, and Native American Nutrition Services. By the end of FY 2010, programs are expected to serve nearly 14 million meals.

SUPPORTING PATIENT-CENTERED HEALTH RESEARCH

The Recovery Act provides $1.1 billion in total for research that compares the effectiveness of different medical treatments including $300 million for AHRQ, $400 million for NIH, and $400 million allocated by the Secretary. The Recovery Act also established the Federal Coordinating Council for Comparative Effectiveness Research, which has developed definitions, criteria for prioritization and a strategic framework for investments which categorize current activity, identified gaps, and high-priority recommendations. At the framework's core is responsiveness to expressed needs for comparative effectiveness research to inform health care decision-making by patients, clinicians, and the clinical and public health communities.

PROMOTING PREVENTION AND WELLNESS

A total of $1 billion is provided for prevention and wellness activities. Within this amount, $650 million is for the new Communities Putting Prevention to Work Initiative, which will expand the use of evidence-based strategies and programs, mobilize local resources at the community-level, and strengthen the capacity of States to reduce obesity and tobacco use, as well as better manage chronic disease for the Nation's elderly. The initiative has a strong emphasis on policy and environmental change at both the State and local levels to: increase levels of physical activity; improve nutrition; decrease obesity rates; and decrease smoking prevalence, teen smoking initiation, and exposure to second-hand smoke.

Of the remaining funds, $300 million is for the CDC Section 317 Immunization Program; over 1.5 million childhood vaccines doses will be available in FY 2010. Additionally, $50 million is for States to implement strategies for reducing health care-associated infections.

IMPROVING ACCOUNTABILITY AND IT SECURITY

IT Security: The Recovery Act provides $50 million to improve the security of the HHS IT infrastructure. The Recovery Act funding will support agency-wide investments and accelerate efforts by HHS to improve security architecture. Funds will also support security tools to protect sensitive information and strengthen computer defense mechanisms against attacks.

Accountability: The Recovery Act provides $48 million to the Office of Inspector General for oversight and review of HHS Recovery Act spending and the Medicaid Program and to enhance accountability and enforcement activities to prevent fraud, waste and abuse.

RECOVERY ACT

(dollars in millions)

Discretionary Programs

	Total Resources Available	Obligations FY 2009	FY 2010	FY 2011
Health Resources and Services Administration				
Health Centers Modernization, Renovation, and Repair	1,500	889	611	--
Health Center Services	500	497	3	--
National Health Service Corps	300	66	159	75
Health Professions	200	67	133	--
Subtotal, Health Resources and Services Administration	**2,500**	**1,519**	**906**	**75**
Indian Health Service				
Buildings and Facilities /1	415	254	161	--
Health Information Technology	85	40	45	--
Subtotal, Indian Health Service	**500**	**294**	**206**	--
National Institutes of Health				
Scientific Research	8,200	4,607	3,593	--
Extramural Lab Construction and Renovation	1,000	52	948	--
Buildings and Facilities	500	50	450	--
Shared Instrumentation grants/contracts	300	53	247	--
Subtotal, National Institutes of Health	**10,000**	**4,762**	**5,238**	**--**
Administration for Children and Families				
Child Care and Development Block Grant (CCDBG)	2,000	1,997	3	--
Early Head Start	1,100	8	1,092	--
Head Start	1,000	569	431	--
Community Services Block Grant (CSBG)	1,000	992	8	--
Strengthening Communities Fund	50	48	2	--
Subtotal, Administration for Children and Families	**5,150**	**3,614**	**1,536**	--
Administration on Aging				
Congregate Nutrition Services	65	65	--	--
Home-Delivered Nutrition Services	32	32	--	--
Native American Nutrition Services	3	3	--	--
Subtotal, Administration on Aging	**100**	**100**	**--**	**--**
Office of the Inspector General	**17**	**3**	**5**	**5**
HHS Information Technology Security	**50**	**6**	**44**	**--**
Health Information Technology (ONC) /2	**2,000**	**1**	**1,919**	**35**
Prevention and Wellness				
Section 317 Immunization Program (CDC)	300	155	145	--
Healthy Communities Initiative (CDC, AoA, OS)	650	--	650	--
Healthcare Associated Infections (CDC, CMS)	50	41	9	--
Subtotal, Prevention and Wellness	**1,000**	**196**	**804**	**--**
Patient-Centered Health Research/Comparative Effectiveness				
AHRQ	300	5	295	--
NIH	400	192	208	--
Department-wide	400	2	398	--
Subtotal, Patient-Centered Health Research	**1,100**	**198**	**902**	**--**
Total, HHS Recovery Act Discretionary Obligations	**22,417**	**10,692**	**11,560**	**115**
Total, HHS Recovery Act Discretionary Outlays	**22,417**	**682**	**8,437**	**10,100**

1/ This does not include $90 million in Sanitation funds from EPA.
2/ These funds remain available until expended.

RECOVERY ACT

(dollars in millions)

Mandatory Programs

	FY 2009-FY 2019	FY 2009	FY 2010	FY 2011
Centers for Medicare & Medicaid Services (CMS)				
Medicaid				
Temporary Increase in Medicaid FMAP	84,511	31,511	38,100	14,900
Temporary Increase in Disproportionate Share Hospital Payments	595	75	520	--
Transitional Medical Assistance (TMA) Extension/1	915	30	480	395
Qualified Individuals (QI) Extension	563	--	413	150
Protections for Indians under Medicaid and CHIP/1	150	5	10	10
Interaction of FMAP Increase with other Medicaid Provisions/1	115	5	90	20
Subtotal, Medicaid	**86,849**	**31,626**	**39,613**	**15,475**
Medicare & Medicaid Health Information Technology Incentives				
Medicare Incentives to Providers	10,850	--	--	2,410
Medicaid Incentives to Providers	9,729	--	--	1,828
Medicaid HIT Efficiency Savings	-100	--	--	-3
State Administrative Costs for Medicaid HIT Implementation	2,308	--	152	283
Subtotal, Medicare & Medicaid HIT Incentive Payments	**22,787**	**--**	**152**	**4,518**
CMS Administration				
Medicare HIT Implementation	745	1	62	102
Medicaid HIT Implementation	300	--	37	43
Subtotal, CMS Administration of HIT Incentive Payments	**1,045**	**1**	**99**	**145**
Total, CMS HIT Funding (non-add)	*23,832*	*1*	*251*	*4,663*
Medicare				
Moratorium on Medicare Regulations (Hospice, IME Reduction)/2	200	300	**	**
Medicare Moratoria CMS Administration	2	2	--	--
Subtotal, Medicare	**202**	**302**	**--**	**--**
Administration for Children and Families				
TANF Emergency Fund/3	5,000	251	3,229	452
TANF Supplemental Grants	319	--	255	64
Child Support Enforcement	1,817	274	1,300	243
FMAP Increase for Foster Care and Adoption Assistance	929	258	500	154
Subtotal, Administration for Children and Families	**8,065**	**783**	**5,284**	**913**
Medicaid and Foster Care FMAP Increase Implementation	**5**	**1**	**4**	****
Office of the Inspector General	**31**	**--**	**13**	**16**
Total, HHS Recovery Act Mandatory Outlays	**118,984**	**32,713**	**45,164**	**21,066**
Total, HHS Recovery Act Discretionary Outlays	**22,417**	**682**	**8,437**	**10,100**
Total, HHS Recovery Act Outlays	**141,401**	**33,395**	**53,601**	**31,166**

** Numbers round to zero.

1/ Outlays reflect actuarial estimates of spending because actual outlays associated with these provisions are not tracked separately.

2/ Policies had costs of $300 million in FY 2009, and small savings in each year thereafter (FY 2010-FY 2019), resulting in a net ten-year cost of $200 million.

3/ Reflects current law baseline estimates. Total FY 2009-2019 number represents budget authority for the TANF Emergency Fund.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Program				
Foods	644	784	1,042	+258
Human Drugs	774	880	1,000	+120
Biologics	270	305	329	+23
Animal Drugs and Feeds	133	156	175	+19
Medical Devices	328	368	385	+16
National Center for Toxicological Research	52	59	61	+3
Center for Tobacco Products	27	217	421	+205
Headquarters and Office of the Commissioner	159	200	256	+56
FDA Consolidation at White Oak	41	41	42	--
GSA Rental Payments	159	172	194	+22
Other Rent and Rent Related Activities	79	76	103	+27
Export/Color Certification Fund	10	10	10	--
Subtotal, Salaries and Expenses	2,675	3,268	4,019	+751
Buildings and Facilities	12	12	12	--
National Center for Natural Products Research	3	3	--	-3
Total, Program Level	**2,691**	**3,284**	**4,032**	**+748**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA)	511	578	667	+89
Medical Device (MDUFMA)	53	57	62	+5
Animal Drug (ADUFA)	15	17	19	+2
Animal Generic Drug	5	5	5	--
Mammography Quality Standards Act (MQSA)	19	19	19	--
Family Smoking Prevention and Tobacco Control Act	24	235	450	+215
Export/Color Certification Fund	10	10	10	--
Subtotal, Current Law User Fees	636	922	1,233	+311
Proposed Law				
Food Inspection and Food Facility Registration	--	--	220	+220
Human Generic Drug	--	--	38	+38
Reinspection	--	--	27	+27
Export Certification Fund (Foods and Feeds)	--	--	4	+4
Subtotal, Proposed Law User Fees	--	--	289	+289
Total, User Fees	**636**	**922**	**1,523**	**+601**
Total, Budget Authority /1	**2,055**	**2,362**	**2,508**	**+146**
Initiative				
FDA Food Safety (non-add)	876	1,049	1,368	+318
FTE	11,413	12,335	13,677	+1,342

1/ The FY 2009 Budget Authority level reflected in the Budget Appendix differs due to the timing and availability of user fee collections.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is responsible for protecting 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 Food and Drug Administration is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get accurate, science-based information they need to use medicines and food to improve their health.

The FY 2011 Budget requests more than $4 billion for the Food and Drug Administration (FDA), a net program level increase of $748 million, or 23 percent, over FY 2010. The FDA budget includes increased investments to improve the safety of the Nation's food supply, drugs, and other medical products, advance the agency's scientific infrastructure, and further develop and implement public health strategies to prevent youth from using tobacco and help adults to quit tobacco use. Given the need to enhance FDA's ability to protect the public health and recognizing the importance of shared responsibility, the Budget proposes new user fees to help finance these increased demands.

TRANSFORMING FOOD SAFETY

FDA plays a critical role in helping to ensure that the food we eat is safe and does not cause harm. In March 2009, President Obama established the Food Safety Working Group to develop solutions to the problems that our Nation's food safety system has experienced. To achieve the President's vision of a new food safety system to protect the American public, FDA will focus greater efforts and resources on the science-based prevention of foodborne illness, strengthening surveillance and enforcement through more frequent and targeted inspections, and improving response and recovery from outbreaks of food-related illnesses.

With an increase in food safety resources of $318 million in FY 2011, FDA will work with States to set standards for State inspection programs and build the infrastructure needed to integrate Federal and State food safety activities. FDA will invest in analytical tools needed to make data-driven decisions about how to best deploy its safety strategies and resources to prevent and respond to foodborne illness. FDA will also invest in the modernized laboratory capacity and test methods needed to more rapidly detect harmful food contaminants, which are essential for preventing, containing, and recovering from illness outbreaks. The FY 2011 Budget will allow for an additional 159 foreign inspections and 1,978 domestic inspections as new staff is fully trained and deployed.

PROTECTING PATIENTS

FDA is the global leader for regulating medical products, and FDA regulatory activities assure that Americans have access to thousands of drugs and devices that are safe and effective for treating everything from seasonal allergies to aggressive cancers. The FY 2011 Budget request will provide an investment of $1.4 billion for medical product safety, which is an increase of $101 million above FY 2010. This increase will allow FDA to invest in tools to assure the safety of increasingly complex drugs, medical devices and biological products. Specifically, this initiative focuses additional funding on three critical areas: import safety, high-risk products, and partnerships for patient safety. The FY 2011 investments are vital to FDA's ability to understand and respond to the growing challenge of globalization and to act as a public health agency committed to safety. Within the increase of $101 million for FY 2011, FDA will devote an additional $40 million to the generic drugs program, at least $10 million for postmarket drug safety, and $4 million to establish a medical device registry. The FY 2011 President's Budget increases inspections to improve the security of the supply chain and reduce the potential for harm to patients.

Investing in a New Food Safety System

Recent food outbreaks have left thousands of Americans ill, and associated recalls have devastated industries. FDA is working to transform our Nation's food safety system to protect the public and reduce undue harm to affected industries. The FY 2011 Budget adds an additional $318 million towards this effort to help:

- Prioritize prevention by developing an integrated national food safety system and setting new standards for food safety.
- Strengthen surveillance and enforcement by improving risk analysis and research for food safety.
- Improve response and recovery by working to integrate Federal, State, and local government roles and responsibilities to an outbreak.

ADVANCING REGULATORY SCIENCE FOR PUBLIC HEALTH

The FY 2011 Budget proposes a $25 million increase for advancing regulatory science at FDA. With this initiative, the Budget includes $15 million for nanotechnology related research, which holds great promise for advances in medical products and cosmetics. The nanotechnology investment will help assure that FDA's regulatory research offers Americans both the protection they deserve and the assurance that approved nanotechnology products are indeed safe. The increased resources will also allow FDA to update review standards and provide regulatory pathways for new technologies such as biosimilars. Given the tremendous potential for biotechnology to improve health and reduce illness, FDA will use these resources to define regulatory pathways for animal biotechnology products and provide product guidance to industry.

REDUCING TOBACCO USE

On June 22, 2009, the President signed the Family Smoking Prevention and Tobacco Control Act, which provides FDA important new responsibilities for regulating the manufacture, marketing and distribution of tobacco products, protecting public health and reducing tobacco use by minors. Accordingly, the Center for Tobacco Products was established within FDA, a user fee program was created, and a center director and key staff were hired. In FY 2011, the center will take steps to reduce the appeal of and access to tobacco products by young people, work with retailers to ensure compliance with all advertising and marketing requirements, and coordinate with State, local, and Tribal governments to prevent the sale of tobacco products to children. In total, the Budget includes $450 million in user fees for FDA to implement the new tobacco control law.

USER FEES

The Budget re-proposes four new user fees and increases in existing user fees, which will provide critical resources to FDA to perform its public health mission. The food registration and inspection user fee will aid FDA with resources to ensure the safety and security of America's food supply. With these resources, FDA will increase its capacity to establish an integrated national food safety system and further strengthen food safety inspection, response, and import review. The generic drug user fee will give Americans greater access to safer and more affordable generic drugs. The reinspection user fee requires manufacturers to pay the full costs of reinspections and associated follow-up work due to their failure to meet FDA health and safety standards during an inspection, thus rewarding firms that do comply. The export certification for food and animal feeds user fee will expand the current drug, animal drug, and medical device export certification user fee program by $4 million to also include export certificates for food and animal feed. Export certificates issued by FDA enhance the global competitiveness of American food and animal feed producers by ensuring that the products meet regulatory requirements. The Budget also includes an additional $311 million increase for current law user fees.

SUPPORTING FDA FACILITIES

The Budget requests $39 million in budget authority for headquarters consolidation at the new FDA campus in White Oak, Maryland. These resources will enable FDA to continue to transition to the newly consolidated facility under construction by the General Services Administration (GSA). The White Oak complex will replace and centralize existing geographically disparate facilities with new, state-of-the-art laboratories, office buildings and support facilities into one location. The Budget also requests an increase of $50 million for GSA rental payments and other rent and rent related costs. In FY 2011, the Budget provides $12 million to pay for necessary repair and maintenance of FDA-owned facilities nationwide.

Performance Highlight

FDA scientists designed and trained a new method to increase the ease and accuracy of interpreting complex magnetic resonance spectroscopy scans that are expected to detect early-stage cancers. In FY 2008, the experiment was expanded to include more than 130 brain scans which provided confirmation that the approach can provide enough information to classify and grade tumors at an accuracy rate of about 85 percent. In 2009, a major breakthrough was made when FDA scientists reanalyzed the data and in the process discovered patentable spectral processing that improved the analytical models to an accuracy rate of over 96 percent for nine different types of brain tissue lesions and are now capable of grading tumors, far exceeding the original goals.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Primary Care					
Health Centers:					
Health Centers	2,146	2,000	2,146	2,436	+290
Health Centers Tort Claims	44	--	44	44	--
Subtotal, Health Centers	2,190	2,000	2,190	2,480	+290
Free Clinics Medical Malpractice	.04	--	.04	.04	--
Hansen's Disease Programs	18	--	18	18	--
Subtotal, Primary Care	2,208	2,000	2,208	2,498	+290
Clinician Recruitment and Service					
National Health Service Corps:					
National Health Service Corps Field	40	60	41	46	+5
National Health Service Corps Recruitment	95	240	101	123	+22
Subtotal, National Health Service Corps	135	300	142	169	+27
Nurse Loan Repayment and Scholarship Program	37	27	94	94	--
Loan Repayment / Faculty Fellowships	1	1	1	1	--
Subtotal, Clinician Recruitment and Service	173	328	237	264	+27
Health Professions					
Health Professions Training for Diversity:					
Centers of Excellence	21	5	25	25	--
Scholarships for Disadvantaged Students	46	40	49	49	--
Health Careers Opportunity Program	19	3	22	22	--
Subtotal, Training for Diversity	86	47	96	96	--
Training in Primary Care Medicine and Dentistry	48	48	54	54	--
Health Workforce Information and Analysis	--	--	3	9	+6
Interdisciplinary, Community-Based Linkages:					
Area Health Education Centers	33	--	33	33	--
Geriatric Programs	31	--	34	34	--
Allied Health and Other Disciplines	14	--	22	22	--
Subtotal, Interdisciplinary, Community-Based Linkages	77	--	89	89	--
Public Health Workforce Development:	9	11	10	10	--
Nursing Workforce Development:					
Advance Nursing Education	64	--	64	64	--
Nursing Workforce Diversity	16	3	16	16	--
Nurse Education, Practice and Retention	37	--	40	40	--
Nurse Faculty Loan Program	12	12	25	25	--
Nurse Managed Care				--	--
Comprehensive Geriatric Education	5	--	5	5	--
Subtotal, Nursing Workforce Development	134	15	150	150	--
Patient Navigator	4	--	5	5	--
Equipment	--	52	--	--	--
Children's Hospital Graduate Medical Education Program	310	--	318	318	--
Subtotal, Health Professions	668	172	725	731	+6
Maternal and Child Health					
Maternal and Child Health Block Grant	662	--	662	673	+11
Heritable Disorders	10	--	10	10	--
Congenital Disabilities	1	--	1	1	--
Autism and Other Developmental Disorders	42	--	48	55	+7
Traumatic Brain Injury	10	--	10	10	--
Sickle Cell Service Demonstrations	4	--	5	5	--
Universal Newborn Hearing Screening	19	--	19	19	--
Emergency Medical Services for Children	20	--	22	22	--
Healthy Start	102	--	105	110	+5
Family-to-Family Health Information Centers (mandatory)	5	--	--	--	--
Subtotal, Maternal and Child Health	876	--	881	904	+23

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
HIV/AIDS					
Emergency Relief - Part A	663	--	679	679	--
Comprehensive Care - Part B	1,224	--	1,254	1,284	+30
AIDS Drug Assistance Program (non add)	*815*	--	*835*	*855*	*+20*
Early Intervention - Part C	202	--	207	212	+5
Children, Youth, Women, and Families - Part D	77	--	78	78	--
Education and Training Centers - Part F	34	--	35	37	+3
Dental Services - Part F	13	--	14	15	+2
Subtotal, HIV/AIDS	2,213	--	2,266	2,305	+40
Public Health Services (PHS) Evaluation Funding	25	--	25	25	--
Subtotal, HIV/AIDS	2,238	--	2,291	2,330	+40
Health Care Systems					
Organ Transplantation	24	--	26	26	--
Cord Blood Stem Cell Bank	12	--	12	14	+2
C.W. Bill Young Cell Transplantation Program	24	--	24	27	+3
Office of Pharmacy Affairs, 340B Program	1	--	2	5	+3
Poison Control Centers	28	--	29	29	--
State Health Access Grants	75	--	75	75	--
Countermeasures Injury Compensation Program	--	--	--	3	+3
Subtotal, Health Care Systems	164	--	168	179	+10
Rural Health					
Rural Health Policy Development	10	--	10	10	--
Rural Health Outreach Grants	54	--	56	57	+1
Rural and Community Access to Emergency Devices	2	--	3	3	--
Rural Hospital Flexibility Grants	39	--	41	41	--
State Offices of Rural Health	9	--	10	10	--
Delta Health Initiative	26	--	35	--	-35
Denali Project	20	--	10	--	-10
Radiogenic Diseases	2	--	2	2	--
Black Lung Clinics	7	--	7	7	--
Telehealth	8	--	12	12	--
Subtotal, Rural Health	176	--	186	142	-44
Facilities and Other Projects	310	--	338	--	-338
Family Planning	307	--	317	327	+10
Program Management	142	--	147	154	+7
Vaccine Injury Compensation Program	5	--	7	7	--
HEAL Direct Operations 1/	3	--	3	--	-3
National Practitioner Data Bank (User Fees)	20	--	20	21	+1
Healthcare Integrity and Protection Data Bank (User Fees)	4	--	4	4	--
Total, Program Level	**7,296**	**2,500**	**7,531**	**7,561**	**+29**
Less Funds From Other Sources					
User Fees	-24	--	-24	-25	-1
PHS Evaluation Funds (HIV/AIDS)	-25	--	-25	-25	--
Family-to-Family Health Information Centers (mandatory)	-5	--	--	--	--
Total, Budget Authority	**7,243**	**2,500**	**7,483**	**7,511**	**+28**
FTE	1,492	102	1,518	1,518	--

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

1/ In FY 2011 President's Budget proposes a transfer to Department of Education

HEALTH RESOURCES AND SERVICES ADMINISTRATION

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

The FY 2011 Budget requests $7.6 billion for the Health Resources and Services Administration, a net increase of $29 million above FY 2010. When excluding one-time Congressional projects, the Budget provides an increase of $412 million, or six percent, to improve access to health care in underserved areas and enhance the capacity of the health care workforce.

IMPROVING ACCESS TO HEALTH CARE IN UNDERSERVED AREAS

Health Centers: The Budget includes $2.5 billion, an increase of $290 million, for health centers to expand service capacity beyond the Recovery Act and make investments in behavioral health services. Health centers provide access to comprehensive primary and preventive services to people in need, many of whom are uninsured. Currently, 70 percent of health center patients live in poverty and 39 percent are uninsured. The Budget will provide funding for the expansion of health centers to communities that currently do not have a health center and can support one. In FY 2011 health centers will provide services to more than 20 million patients. The budget will expand services for behavioral health, directing funding towards the integration of behavioral services into primary care health systems in health centers.

HEALTH WORKFORCE: BUILDING A WORKFORCE FOR THE 21ST CENTURY

As the Nation expands access to health services through reform of the health care system, it is critical to simultaneously make investments to increase the supply of well trained health professionals. The Budget includes $995 million, an increase of $33 million, to support health care workforce programs that will increase the number of providers practicing in underserved areas.

Within this total, the Budget includes $169 million, an increase of $27 million above FY 2010, for the National Health Service Corps to recruit and retain clinicians, including primary care, dental, and behavioral health professionals, in communities of greatest need. Nearly 80 percent of these clinicians stay in an underserved area after fulfilling their service commitment and more than half make a career of caring for underserved people. The Budget will support 400 new loan repayments and 49 new scholarship awards.

Nurse Workforce: The Budget includes $228 million for investments to increase the capacity of the nurse workforce. As the population continues to grow and age, the need for nurses continues to increase. The Budget will support the recruitment, education, and retention of 20,000 nursing students and registered nurses and support over 1,370 loan repayments and scholarship awards.

Health Professions Diversity: Minority and disadvantaged health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic groups and to practice in or near designated health care shortage areas. The Budget includes $113 million for maintaining our national capacity to train underrepresented minorities and financially disadvantaged students in health professions. These funds will provide disadvantaged and underrepresented minority students and faculty with opportunities to enhance their academic skills and obtain the support needed to graduate from health professions schools or faculty development programs.

The Budget provides $33 million to support State efforts to improve and address

Investing in Primary Care Providers

In FY 2009, the National Health Service Corps (NHSC) placed 4,664 primary care providers in health centers and other community-based systems of care to improve the quality of care provided. In FY 2011, the Budget will provide funding for a total of 8,561 providers.

oral health workforce needs and $34 million to provide training and education to individuals who provide care for the aging population.

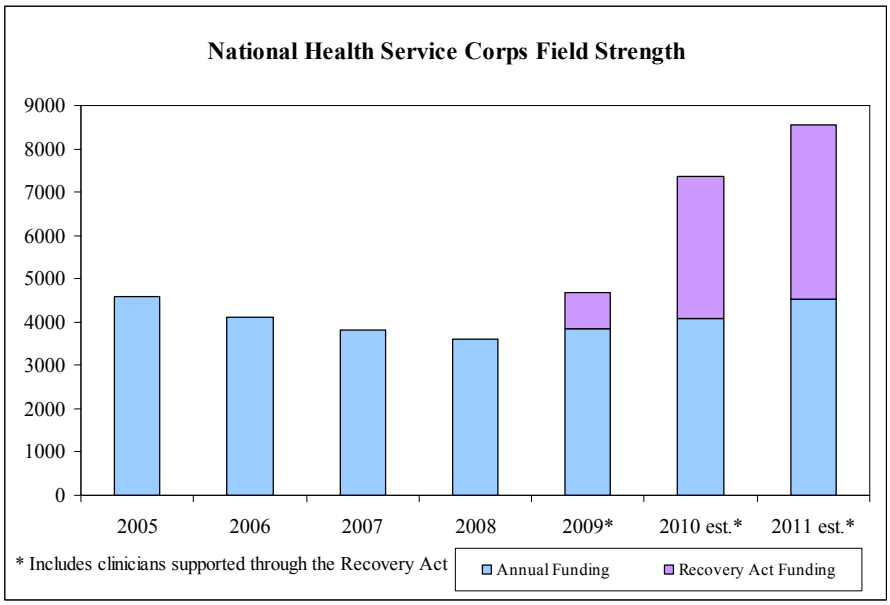
The Budget also includes $318 million for the Children's Hospitals Graduate Medical Education Payment Program that provides payments to children's hospitals for the training of future physicians who work to improve the quality of care to children.

In addition, $101 million will fund a range of other health professions programs to support the collection of core data on the health workforce and to strengthen and improve the pipeline of clinicians for future years.

Improving Rural Health: There are nearly 50 million people living in 2,052 rural counties throughout America who experience ongoing challenges in accessing health care. The Budget includes $142 million to improve access to quality health care in rural areas. Within this total, $62 million is included to work with Critical Access Hospitals, conduct research on rural health issues and support community access to emergency devices. As part of the President's initiative to improve rural health care, HRSA will develop stronger links between telehealth activities and other investments in rural health.

PROTECTING AT-RISK POPULATIONS

HIV/AIDS: The request includes $2.3 billion, a $40 million increase, for HIV/AIDS treatment activities authorized by the Ryan White CARE Act of 2009. This funding supports a comprehensive approach to address the health needs of persons living with HIV/AIDS, including medical treatment, life saving medications, and access to care. The program addresses the unmet health needs of persons living with HIV by funding primary health care and vital health-related support services that enhance access to and retention in care. The program reaches over half a million individuals each year, making it the Federal government's largest program specifically for people living with HIV/AIDS.



Making Prescription Drugs Affordable: The FY 2011 request includes $5 million to improve access to potentially lifesaving drugs as authorized by section 340B of the Public Health Service Act, allowing Federally funded grantees and other health safety net providers to purchase medications at significantly discounted prices.

SUPPORTING HEALTHY FAMILIES

The Budget provides $1.2 billion, an increase of $34 million for Maternal and Child Health and Family Planning activities that provide quality health care and support to families and communities.

Autism and Other Developmental Disorders: The Budget requests $55 million, an increase of $7 million, as part of the President's Initiative to support children with autism spectrum disorders and their families. This funding will continue to expand Federal and State programs authorized in the Combating Autism Act to research, and support screening and evidence-based interventions when a diagnosis is confirmed.

Family Planning: The FY 2011 Budget includes $327 million, an increase of $10 million, to expand family planning services to low-income individuals by improving access to family planning centers and preventive services. This funding will provide services to nearly 5 million low-income women and men at more than 4,500 clinics each year, at least 90 percent of whom are at or

below 200 percent of the Federal poverty level.

Maternal and Child Health Programs: The Budget provides $673 million, an increase of $11 million, for the Maternal and Child Health Block Grant to provide funding to States to improve the health of mothers, children, and their families through greater access to coordinated comprehensive care. The block grant will support services for over 40 million women, children, and their families.

Healthy Start: The request includes $110 million, an increase of $5 million, to provide services that reduce the incidence of risk factors that contribute to infant mortality in high risk communities and provide services to mothers in geographically, racially, ethnically, and linguistically diverse communities. The Budget will support a total of 107 Healthy Start projects. The Budget will also continue to provide critical support that includes peer mentoring, technical assistance, and sharing of best practices among projects.

Recovery Act

HRSA has awarded $2 billion to expand health care services to 2 million low-income and uninsured individuals through its Health Centers program. This includes $500 million for expanded services to over 7,500 service delivery sites and $1.5 billion for needed capital improvements to over 1,500 existing health centers. On December 9, 2009, HRSA awarded $509 million for major construction and renovation to health centers to build new facilities.

Crusader Community Health Center in Rockford, Illinois received $5 million to construct a new facility to accommodate four medical providers-a family practice physician, a pediatrician, a mid-level medical provider, a dentist and specialty clinics including OB/GYN, podiatry, and pain management.

OTHER ACTIVITIES AND PROGRAM MANAGEMENT

Countermeasures Injury Compensation Program: The Budget includes $3 million to support the administrative and claim costs associated with Public Readiness and Emergency Preparedness Act (PREP) declarations. These declarations limit liability for the use of countermeasures such as vaccines and medical devices during public health emergencies.

National Vaccine Injury Compensation Program: The Budget requests $7 million for the Vaccine Injury Compensation Program to prepare for projected increases in claims and continue reviews of over 5,100 claims from autism proceedings.

Supporting Transplantation: The Budget includes $66 million to support organ, bone marrow, and cord blood stem cell transplantation. Within this total, $26 million supports a national system to develop policies to ensure the fair allocation and distribution of organs. The Budget also requests $26 million for potentially life-saving efforts to support individuals who need marrow or cord blood transplants, and $14 million for the National Cord Blood Inventory program to collect and purchase approximately 9,100 new cord blood units.

Program Management: The Budget requests $154 million to fund rent, salaries, information technology, utilities, and agency oversight of its programs. The Budget transfers the Health Education Assistance Loan program to the Department of Education which has expertise managing a number of other loan guarantee programs.

INDIAN HEALTH SERVICE

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Services					
Clinical Services:	3,439	85	3,782	4,029	+247
Contract Health Services (non add)	*634*	--	*779*	*864*	*+84*
Health Information Technology (non add)	*115*	*85*	*131*	*135*	*+4*
Preventive Health	135	--	144	151	+7
Contract Support Costs	282	--	398	444	+46
Tribal Management/Self-Governance	9	--	9	9	+0
Urban Health	36	--	43	46	+2
Indian Health Professions	38	--	41	42	+1
Direct Operations	65	--	69	70	+1
Diabetes Grants	150	--	150	150	--
Subtotal, Services Program Level	4,155	85	4,636	4,940	+304
Facilities					
Health Care Facilities Construction	40	227	29	66	+37
Sanitation Facilities Construction	96	68	96	98	+2
Facilities & Environmental Health Support	178	--	193	202	+9
Maintenance & Improvement	60	100	60	62	+2
Medical Equipment	22	20	23	24	+1
Subtotal, Facilities Program Level	396	415	401	452	+50
Total, Program Level	**4,551**	**500**	**5,037**	**5,392**	**+354**
Less Funds From Other Sources					
Health Insurance Collections /1	-814	--	-829	-829	--
Rental of Staff Quarters	-6	--	-6	-6	--
Diabetes Grants /2	-150	--	-150	-150	--
Total, Budget Authority	**3,581**	**500**	**4,052**	**4,406**	**+354**
FTE	15,461	--	15,634	15,649	+15

1/ Represents estimates of collections from public and private insurers for current and future fiscal years. Estimates are based on actual FY 2008 collections and current reimbursement rates. These estimates may change as a result of actual FY 2009 collections.

2/ These mandatory funds were pre-appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008.

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

INDIAN HEALTH SERVICE

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

The FY 2011 Budget requests $5.4 billion for the Indian Health Service (IHS), an increase of $354 million, or nine percent, over FY 2010. The Budget continues the Administration's policy from the FY 2010 Budget of strengthening the Indian health system to improve the quality of health services to American Indians and Alaska Natives. The funding will reduce the disparities experienced by American Indians and Alaska Natives and provide funds to improve the Indian health system. IHS, in partnership with Tribes, provides primary care, behavioral and community health, and sanitation services for a growing population of eligible American Indians and Alaska Natives.

FULFILLING THE UNIQUE ROLE OF THE INDIAN HEALTH SERVICE

IHS provides comprehensive health services to members of more than 560 Federally recognized Tribes through direct services in 45 hospitals, 288 health centers, and 313 health stations, school health centers, and Alaska village clinics. As part of the unique relationship between Tribes and the Federal Government, IHS provides American Indians and Alaska Natives with preventive health care and direct medical care, and contracts with hospitals and health care providers outside the IHS system to purchase care it cannot provide through its own network. IHS works with Tribes to ensure their maximum participation in administering the programs that impact their communities. In addition to the provision of health care services, IHS activities include building sanitation systems to provide water and waste disposal for Indian homes; supporting Tribal self-governance through contract funding; and providing scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, to serve in areas with high provider vacancies.

STRENGTHENING THE INDIAN HEALTH SYSTEM

The Budget includes significant increases to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives. The Budget also makes key investments that build on the resources provided in the Recovery Act.

Population Growth and the Cost of Providing Care: The Budget reflects a sustained investment in providing care to a growing population of American Indians and Alaska Natives. The Indian population is growing at a faster rate than the U.S. population as a whole, and the IHS service population is expected to increase by 1.5 percent in FY 2011. These increases are coupled with the rising cost of health care and salaries for Federal and Tribal employees who provide needed health services in often remote areas. The Budget includes an additional $176 million to cover pay increases, population growth, and inflation. The Budget includes $44 million for the Indian Health Care Improvement Fund, a significant investment aimed at creating parity in funding among service sites. Providing additional funds to service sites with the greatest resource deficiencies will help ensure that all eligible American Indians and Alaska Natives have access to quality health care.

Contract Health Services: IHS purchases health care from outside the IHS system in cases where no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet. The Budget includes $864 million, an increase of $84 million, for the purchase of medical care, including essential services such as inpatient and outpatient care, routine and emergency care, and medical

Initiative: Ensuring Access to Care

The FY 2011 Budget provides $864 million, an increase of $84 million, to cover the cost of care purchased outside the IHS system, as part of the commitment to strengthen the Indian health system with sustained investments that improve health outcomes and expand access to care for American Indians and Alaska Natives.

In FY 2008, there were 35,953 Contract Health Services (CHS) cases that could not be funded, often causing patients to delay or defer needed medical treatment or cover costly procedures out of pocket. The FY 2011 budget will cover additional CHS cases to address the need for medical treatment outside the IHS system.

Recovery Act

IHS received $227 million in Recovery Act funds for health care facilities construction. IHS is using these funds to complete construction of a hospital in Nome, Alaska and a health facility in Eagle Butte, South Dakota. The sites will serve a combined total of 19,300 users.

support services, such as diagnostic imaging, physical therapy, and laboratory services. These funds are crucial to covering the cost of care for injuries, heart disease, digestive diseases, and cancer, some of the leading causes of death among American Indians and Alaska Natives.

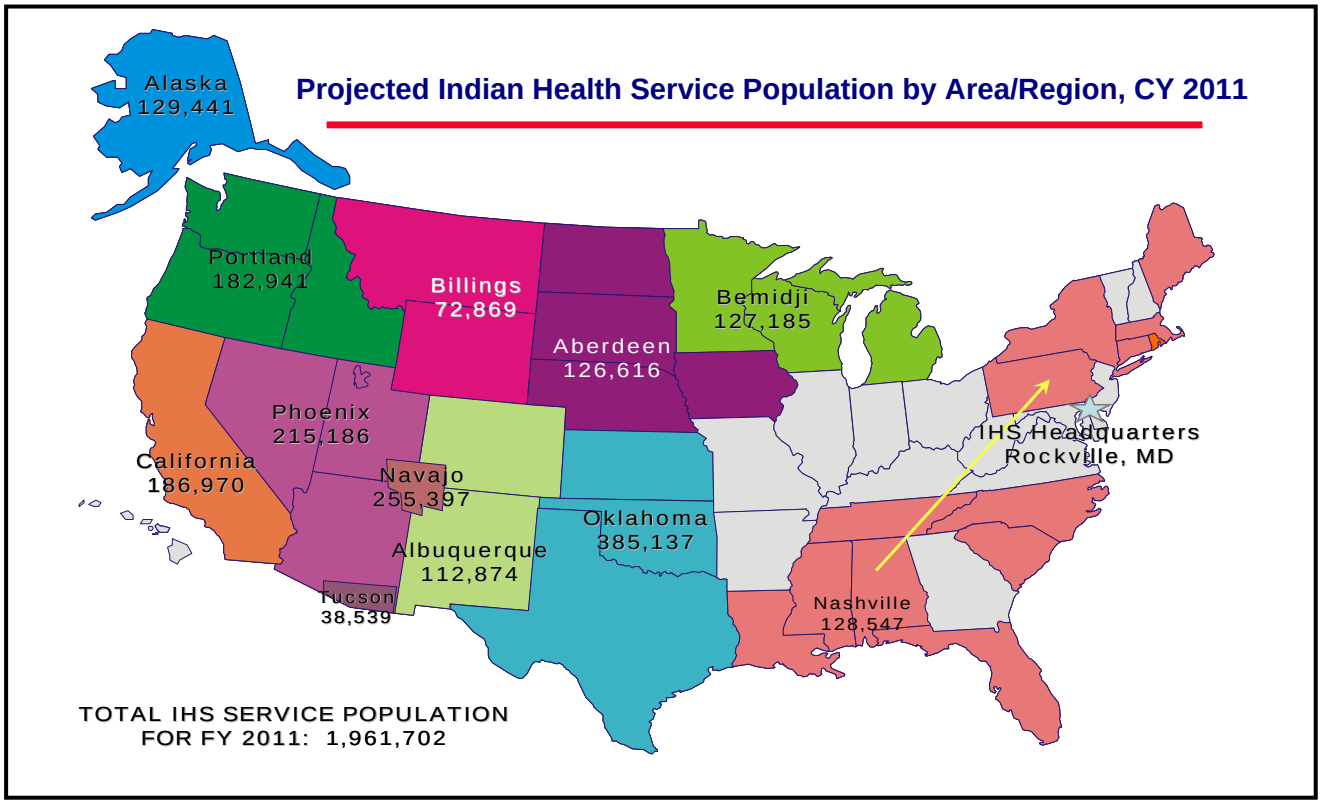
Health Information Technology: IHS has been a recognized leader in health information technology and continues to develop and deploy innovative health IT tools that improve the lives of individual patients, populations and communities. The Budget includes an increase of $4 million to support secure data exchange.

Construction: The Budget includes $66 million for Health Care Facilities Construction to continue construction of a hospital in Barrow, Alaska and two outpatient facilities in San Carlos and Kayenta, Arizona. Once completed, these facilities will serve a combined projected annual user population of 38,380 patients.

Staffing New and Renovated Health Facilities: Construction and renovation funds for IHS health facilities have been targeted to expand services at sites experiencing overcrowding. These expansions require new staff and operating support. An additional $39 million is included in the Budget to support staffing and operating costs for new or expanded facilities to be completed in FY 2011. These facilities include a Hospital in Ada, Okalahoma as well as health centers elsewhere. Some of the facilities are joint venture projects, where IHS partners with a Tribal entity to provide funds for staffing, equipping, and operating a facility, and participating Tribes cover the costs of design and construction. When these facilities are fully operational, they will be able to meet the increasing demand for services at their sites, where the existing capacity is overextended.

Alcohol and Substance Abuse: A new competitive grant program will expand access to and improve the quality of treatment for substance abuse treatment services. The program will target sites with the greatest need for substance abuse services. The program will enable service sites to hire additional staff to provide evidence-based and practice-based culturally competent treatment services.

Health Insurance Reimbursements: IHS relies on the collection of third party resources for as much as 50 percent of the operating budgets for some facilities. In FY 2011, IHS



Performance Highlight

Depression is often a factor contributing to suicide, domestic and intimate partner violence, and alcohol and substance abuse. Early identification allows providers to plan interventions and treatment to reduce the impact of depression, including the reduction of suicide rates, which are disproportionately high in Indian communities. In order to improve the mental health and well-being of American Indians and Alaska Natives, IHS increased the proportion of patients aged 18 and older who are screened for depression from 24 percent in FY 2007, to 35 percent in FY 2008, and to 44 percent in FY 2009.

estimates it will receive approximately $829 million in health insurance reimbursements for the provision of care to people covered by Medicare, Medicaid, and private insurers. These funds are essential for covering the costs of hiring additional medical staff, purchasing equipment, making necessary building improvements, and maintaining accreditation standards.

SUPPORTING INDIAN SELF-DETERMINATION

IHS recognizes that Tribes and Tribal organizations are the most knowledgeable about the type of services needed in their own communities, and that the planning and delivery of health services at the local level ensures effective, quality health care. More than 57 percent of the IHS budget is administered by Tribes through the authority provided to them under the Indian Self-Determination and Education Assistance Act of 1975. The Act allows Tribes to assume the administration of programs that were previously carried out by the Federal Government.

Contract Support Costs: The Budget includes $444 million for contract support costs, an increase of $46 million. Contract support costs are defined as reasonable costs for activities that enable Tribes to develop the infrastructure needed to administer Federal programs. These funds provide Tribes with additional support in the operation of their own health programs. This investment will allow IHS to increase funding significantly to Tribes with existing self-determination agreements and for new or expanded contracts in order to ensure Tribes have the resources they need to successfully manage programs at the local level.

Consultation: One of the key components of the government to government relationship with Tribes is consultation, in which Tribal governments and organizations play an integral role in the agency's budget and policy decision-making processes. In addition to extensive solicitation of Tribal input used to determine the way IHS operates at the local, area, and national level, HHS holds an annual department-wide budget consultation. This process gives Tribal leaders the opportunity to express their budget priorities, and continues to affirm the unique political and legal partnership between Tribes and the Federal Government.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Infectious Diseases					
Immunization and Respiratory Disease	916	300	718	736	+17
Section 317 Discretionary Program (non-add)	*560*	*300*	*562*	*579*	*+17*
Pandemic Influenza (non-add)	*356*	--	*156*	*156*	--
Balances from P.L. 111-32 Pandemic Flu (non-add)	--	--	--	*156*	*+156*
Vaccines For Children	3,383	--	3,636	3,651	+15
HIV/AIDS, Viral Hepatitis, STDs and TB Prevention	1,006	--	1,045	1,083	+38
Zoonotic, Vector-Borne, and Enteric Diseases	68	--	77	58	-19
Preparedness, Detection, and Control of Infectious Diseases	157	--	169	192	+23
Subtotal, Infectious Diseases	5,531	300	5,645	5,721	+75
Health Promotion					
Chronic Disease Prevention and Health Promotion	882	--	931	937	+6
Birth Defects, Disability and Health	138	--	143	144	--
Subtotal, Health Promotion	1,020	--	1,075	1,081	+6
Health Information and Service					
Health Statistics	125	--	139	162	+23
Informatics and Health Marketing	155	--	150	145	-5
Subtotal, Health Information and Service	279	--	289	307	+18
Environmental Health and Injury					
Environmental Health	185	--	187	182	-5
Injury Prevention and Control	145	--	149	148	-1
Subtotal, Environmental Health and Injury	331	--	336	330	-6
Occupational Safety & Health	415	--	429	511	+83
Energy Employee Occupational Illness Compensation Program (non-add)	*55*	--	*55*	*55*	--
World Trade Center Treatment and Screening (non-add)	*70*	--	*71*	*150*	*+79*
Global Health /1	319	--	336	352	+16
Public Health Research	31	--	31	31	--
Public Health Improvement and Leadership	209	--	211	193	-19
Preventive Health and Health Services Block Grant	102	--	102	102	--
Buildings and Facilities	152	--	69	--	-69
Business Services Support	360	--	370	382	+12
Terrorism Preparedness and Emergency Response					
State and Local Preparedness and Response Capability	747	--	761	758	-3
CDC Preparedness and Response Capability	198	--	193	183	-9
Strategic National Stockpile	570	--	596	592	-4
Balances from P.L. 111-32 Pandemic Flu (non-add)	--	--	--	*69*	*+69*
Subtotal, Terrorism Preparedness and Emergency Response	1,515	--	1,549	1,533	-16
Agency for Toxic Substances and Disease Registry	74	--	77	76	--
User Fees	2	--	2	2	--
Subtotal, Program Level	**10,339**	**300**	**10,521**	**10,622**	**+101**
Less Funds Allocated from Other Sources					
Vaccines for Children (mandatory) /2	-3,383	--	-3,636	-3,651	-15
Energy Employee Occupational Injury Compensation Program (mandatory)	-55	--	-55	-55	--
PHS Evaluation Transfers	-331	--	-352	-346	+7
Balances from P.L. 111-32 Pandemic Flu	--	--	--	-225	-225
User Fees	-2	--	-2	-2	--
Total, Discretionary Budget Authority	**6,568**	**300**	**6,475**	**6,342**	**-133**
Total, Discretionary Program Level	**6,901**	**300**	**6,830**	**6,915**	**+86**
FTE	9,635		9,735	9,835	+100

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

1/ Adjusts FY 2009 and FY 2010 levels comparable with FY 2011.

2/ The estimates for the Vaccines for Children Program reflect the anticipated transfer from Medicaid and do not reflect FY 2009 carry-forward funds available for obligation. VFC is funded through the Medicaid appropriation is reflected in the Medicaid baseline.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The mission of the Centers for Disease Control and Prevention (CDC) is to collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

The FY 2011 Budget request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $10.6 billion, an increase of $101 million above FY 2010. Due to the availability of unobligated balances from the FY 2009 pandemic influenza supplemental, less resources are requested, as reflected by a reduction of $133 million in budget authority below FY 2010.

The Budget request increases support for prevention of infectious diseases, such as vaccine preventable diseases and HIV/AIDS; for improved data collection and establishment of State electronic birth and death records; for efforts to build global public health capacity; and for treatment and monitoring services for those affected by the September 11, 2001, World Trade Center attacks. The Budget request funds new programs, such as a community health program that engages large cities to prevent chronic disease, and for development of the Health Prevention Corps to build an interdisciplinary public health workforce. In addition, the Budget request includes both programmatic and administrative savings. Specifically, the Budget includes targeted programmatic savings for completed, duplicative, and one-time activities funded in FY 2010. The Budget achieves a total of $100 million in administrative savings, by decreasing travel and reducing advisory and assistance service contracts, through an agency-wide effort to reduce inefficiencies and improve overall management of program activities. These savings will allow CDC to achieve efficiencies without impacting CDC program activities. The Budget finances pandemic flu and a portion of Strategic National Stockpile activities with $225 million in unobligated balances from the FY 2009 pandemic influenza supplemental.

Global Health

The FY 2011 Budget increases global public health capacity by $19 million to monitor, prevent, and control and to improve life expectancy and the quality of life for the developing world, especially for mothers and children. CDC's Global Public Health Capacity Building program provides technical assistance to help Ministries of Health build capacity in a range of areas, including epidemiology, outbreak investigation, health surveillance systems, applied economics, communications, and resource management. In 2008, the Field Epidemiology and Laboratory Training program had 276 active trainees. The trainees and graduates conducted over 300 outbreak investigations. Data indicate that the vast majority of graduates move into leadership positions within the Ministries of Health in their own country, which is critical to sustain public health capacity in these countries.

PROTECTING THE NATION AGAINST INFECTIOUS AGENTS

The Budget includes a total of $1.9 billion in discretionary funding for Infectious Diseases and $3.7 billion in mandatory funding for the Vaccines for Children (VFC) program .

HIV/AIDS, Viral Hepatitis, STD and TB Prevention: The FY 2011 Budget provides $1.1 billion, an increase of $38 million above FY 2010, to develop, implement, and evaluate effective domestic prevention programs for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STD), and Tuberculosis (TB). These programs support prevention, control services, surveillance, and research.

Of the increased funds, $10 million supports comprehensive and integrated surveillance and monitoring system demonstrations, and $10 million supports program coordination and service integration grants across HIV/AIDS, Viral Hepatitis, STD, and TB Prevention activities. The request also includes increased funds to support key components of a National HIV/AIDS Strategy under development. CDC will address high-risk populations and use new medical approaches to communicate culturally appropriate and effective messages about HIV risk reduction behavior. The increased funds in FY 2011 will help CDC work towards decreasing annual HIV incidence, the HIV transmission rate, and the prevalence of risk behaviors among

persons at risk for acquiring HIV; and increasing the proportion of HIV-infected people who know they are infected.

Immunization and Respiratory Diseases: Children can now be protected from more vaccine preventable diseases than ever before due to advances in biotechnology. In 1985, vaccines for seven diseases were available and recommended for routine use in children in the United States. Now, vaccines for 17 diseases are available and routinely recommended for children and adolescents.

CDC's $4 billion immunization program has two components: the mandatory VFC program and the discretionary Section 317 program. These two programs combined provide nearly 50 percent of the pediatric vaccines and thirty percent of the adolescent vaccines distributed in the United States each year. The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2011 Budget includes $579 million, an increase of $17 million, for the Section 317 program to build on gains made with FY 2009 Recovery Act funds to increase vaccination coverage and to support States in obtaining reimbursement of immunization services provided to children with private health insurance.

The FY 2011 Budget includes $58 million, a decrease of $19 million, for Zoonotic, Vector-Borne, and Enteric Diseases, which is the net result of programmatic increases, the elimination of dedicated funding for West Nile Virus activities, and administrative savings. Within this request, the budget includes $35 million, $8 million above FY 2010, to reduce the public health burden of foodborne illness. CDC will expand the network of OutbreakNet Sentinel Sites, which are used to assess multi-State foodborne outbreaks to improve State and local capacity to identify and stop outbreaks, and will improve the speed and accuracy of foodborne disease outbreak detection and investigation.

The FY 2011 Budget includes $192 million, $23 million above FY 2010, for the Prevention, Detection, and Control of Infectious Diseases. Within the total, $27 million is included for prevention of healthcare-associated infections to expand the National Healthcare Safety Network to approximately 2,500 new hospitals. This expansion builds on progress CDC has made with FY 2009 Recovery Act funds to leverage the National Health Care Safety Network and support the dissemination of HHS evidence-based practices within hospitals to reduce these infections and save lives. CDC will also use increased funds in FY 2011 to build the workforce capacity, laboratory facilities, and skills sets within State and local health departments to enhance the ability to detect and control emerging infectious diseases.

PROMOTING HEALTH AND PREVENTING CHRONIC DISEASE

The Budget includes $1.1 billion, $6 million above FY 2010, for Health Promotion. Within this total, $937 million, $6 million above FY 2010, is for Chronic Disease Prevention, Health Promotion, and Genomics and $144 million is for Birth Defects, Developmental Disabilities, Disability and Health. These increases are the net result of increased programmatic investments, targeted programmatic reductions to eliminate duplicative and less effective activities, and administrative savings.

Recovery Act

The Recovery Act provided HHS $650 million to implement evidenced-based prevention and wellness strategies through the Communities Putting Prevention to Work Initiative. As part of this initiative, CDC will mobilize local resources at the community-level and strengthen the capacity of States to implement strategies that improve physical activity and nutrition, address obesity, and decreases smoking prevalence and exposure to second-hand smoke. In FY 2011, CDC will continue to provide programmatic support to communities and States participating in this initiative.

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. The increased FY 2011 investments in Health Promotion include $20 million for the CDC Big Cities Initiative to reduce the rates of morbidity and disability due to chronic disease in up to ten of the largest U.S. cities. This focused investment is an efficient way to reach large populations with high population densities. Funded cities can incorporate lessons learned from the Recovery Act Communities Putting Prevention to Work Initiative, which is focused on the implementation of evidence-based prevention and wellness strategies. In addition to increased funds for the Big Cities Initiative,

the Budget's increased investments in Health Promotion continue the initiative to expand support for children, families, and communities affected by autism spectrum disorders. In FY 2011, CDC will expand autism monitoring and surveillance and support an autism awareness campaign. The increased investments in Health Promotion also support adolescent and school health and the prevention of teen pregnancies. Additionally, the Budget provides new funds to address the risk factors associated with the most prevalent birth defects and blood disorders. Finally, the Budget increases State flexibility to address the leading causes of death and improve overall health outcomes.

USING HEALTH INFORMATION AND SERVICE FOR PUBLIC HEALTH

The Budget includes $307 million, $18 million above FY 2010, for Health Statistics, Health Marketing, and Public Health Informatics. The FY 2011 Budget for Health Statistics includes $162 million, $23 million above FY 2010, to obtain and use statistics to understand health problems, recognize emerging trends, identify risk factors, and guide programs and policy. Funds will also support electronic birth and death records in States. In addition, CDC will maintain its FY 2010 enhancements to national survey systems to ensure data availability on key national health indicators such as diet and nutrition, blood pressure, and mental health. Policy-makers, researchers, and the public rely on data from these surveys to support decision making and research on health.

Public health informatics uses information systems and information technology to prevent diseases, disability, and other public health threats. The Public Health Informatics Budget request includes $67 million, a decrease of $3 million for contract and travel savings, to design information systems and technology tools that foster the exchange of, and access to, data to improve public health.

The Budget includes $78 million, a decrease of $2 million, for contract and travel savings, for Health Marketing activities. Within the request, $5 million is included for the Guide to Community Preventive Services.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION AND CONTROL

The Budget includes $330 million for Environmental Health and Injury Prevention and Control. CDC's Environmental Health programs protect human health by preventing disability, disease, and death from environmental causes. The FY 2011 Budget provides $182 million, a decrease of $5 million, which is the net result of programmatic increases, targeted programmatic savings for completed and duplicative activities, and administrative savings. Within the programmatic increases, $4 million will support Safe Routes to School programs to encourage healthy community design.

The CDC Injury Prevention and Control program supports efforts to reduce premature deaths, disability, and the medical costs associated with injuries and violence, such as motor vehicle safety, intimate partner and sexual violence prevention, and child abuse and neglect. The Budget includes $148 million for Injury Prevention and Control, a decrease of $1 million below FY 2010, for the National Violent Death Reporting System to expand to six additional States, for a total of 24 States, and link with State vital statistics to enhance the timeliness of data.

IMPROVING PREPAREDNESS AND RESPONSE TO TERRORISM

The Budget includes $1.5 billion, a net decrease of $16 million resulting from improved efficiencies in travel and contracting for CDC's terrorism preparedness and emergency response activities. The bioterrorism budget supports the Strategic National Stockpile (SNS), State and local preparedness and response capabilities, as well as CDC-wide preparedness and response capabilities.

Strategic National Stockpile: The Budget focuses on ensuring a sufficient supply of countermeasures and other medical supplies to protect and care for victims of a bioterrorism attack or other public health emergency. The Budget includes a program level of $592 million for the SNS to finance the procurement 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.

State and Local Response Capability: In FY 2011, $715 million is requested for the Public Health and Emergency Preparedness Program, the same as FY 2010, bringing the total investment to over $8.2 billion since September 11, 2001. The Budget request also includes $30 million for the Centers for Public Health Preparedness, which is a network of 27 universities working with States and collaborating with one another to develop and support the public health emergency preparedness-

related knowledge and skills of first responders and other public health professionals.

CDC Preparedness and Response Capability: The FY 2011 Budget request includes $183 million for improving CDC's preparedness and response efforts. These funds continue support of the Laboratory Response Network, the Select Agent Program, and research and surveillance on potential emergency situations such as biothreat agent releases. In addition, these programs ensure the ongoing evaluation and improvements of surveillance, laboratory science, research, and support throughout CDC and its grantees while continuing to advance public health preparedness and response capabilities through technical assistance, resource allocation, planning tools, education and training.

Advancing Occupational Safety and Health

The FY 2011 Budget provides $511 million for Occupational Safety and Health programs, $83 million above FY 2010. The National Institute for Occupational Safety and Health is the primary Federal entity responsible for conducting research, making recommendations, and translating knowledge for the prevention of work-related illness and injury. Within the request, $150 million, an increase of $79 million, is included to support treatment and monitoring services for responders of the World Trade Center (WTC) attacks and for non-responders in the community directly affected by the attacks. CDC currently funds support six clinical centers and two data and coordination centers throughout the New York City metropolitan area as well as the WTC Health Registry, which assesses the extent of WTC-related health conditions for the exposed population.

Within the total for Occupational Safety and Health, $17 million supports the elimination and mitigation of the hazards associated with nanomaterial development, and $55 million in mandatory funding is included for CDC's role in the Energy Employees Occupational Illness Compensation Program.

Global Health

The FY 2011 Budget includes $352 million, $16 million above FY 2010, for Global Health programs to protect the U.S. and world populations from emerging global health threats. The increased investments will build global public health capacity by strengthening the global public health workforce; integrating maternal, newborn, and child health programs; and improving global access to clean water, sanitation, and hygiene. For instance, CDC will develop at least three new Field Epidemiology and Laboratory Training Programs and expand capacity at four existing programs; and will initiate safe water programs in three to four countries and expand programs in four to five countries. The health impact of the investment in maternal, newborn, and child health will allow CDC to decrease the number of preventable child deaths in countries with high infant and under-five mortality rates by over 50 percent.

Within the total for Global Health, $6 million supports the Afghanistan Health Initiative and $2 million supports the Health Diplomacy Initiative. The FY 2011 Budget maintains support for other CDC global health programs, including the Global AIDS Program, which plays a vital role in implementation of the CDC responsibilities under the President's Emergency Plan for AIDS Relief.

Supporting Public Health Research

Public Health Research provides evidence to support specific programs, practices, and policies that affect health decisions made by the American public and those responsible for health policies and programs. With funding of $31 million for health protection research, the same as FY 2010, CDC is building a cadre of health protection researchers, research training programs, and centers of excellence that enable multidisciplinary approaches to public health practice.

Performance Highlight

HIV testing is a valuable tool to decrease HIV transmission and to improve the health of those aware of their infections. CDC initiated a 3-year project to investigate the feasibility and acceptability of conducting voluntary opt-out HIV testing in the emergency room (ER) setting. Preliminary results indicate that opt-out HIV testing in ERs is not only possible, but also well-received and highly valuable for identifying new infections. At the two project sites in Colorado and California, the number of HIV tests increased by over 600 percent, from 4,353 to 27,859. The number of confirmed positive diagnoses also increased over nine-fold, from 16 diagnoses to 152 diagnoses. In a survey of 204 ER staff involved with the HIV testing project, 90 percent rated the testing program as excellent or very good. Similarly, results from a survey of 207 patients indicated that 97 percent were satisfied with the HIV testing process.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

The FY 2011 Budget provides $102 million, the same as FY 2010, for the Preventive Health and Health Services Block Grant. These funds will support primary prevention activities and health services in States and local communities.

MANAGING CDC INFRASTRUCTURE AND HUMAN CAPITAL

The Budget includes $575 million in administrative and infrastructure activities to support CDC mission-critical efforts.

Business Services Support: CDC has improved and achieved efficiencies in its business and management operations and will continue to find ways to achieve higher performance at lower costs. The Budget includes $382 million, $12 million above FY 2010, for agency-wide operating costs, such as rent, utilities, and security.

Public Health Improvement and Leadership: The Budget includes $193 million, $19 million below FY 2010, for Public Health Improvement and Leadership to support cross-cutting areas in CDC that seek to ensure the effectiveness of public health programs and science. This decrease is the net result of programmatic increases, the elimination of one-time Congressional projects included in FY 2010, and administrative savings. Within the request, $10 million is included for a new Health Prevention Corps, which will recruit, train, and assign a cadre of public health professionals in State and local health departments. This program will target disciplines with known shortages such as epidemiology, environmental health, and laboratory. CDC will use FY 2011 funds to establish the program framework, which includes the program design, a plan to phase-in and pilot test programmatic tracks, and the development of curriculum for members. CDC will also conduct outreach to States and will train and place members in State and local health departments.

Buildings and Facilities: CDC has made remarkable progress on its 10-year Master Plan through its investments to build and upgrade facilities and laboratories. The FY 2011 Budget does not request funds for Buildings and Facilities. CDC will fund repairs and improvements with unobligated balances from FY 2010.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

The Budget request for ATSDR is $76 million, $0.5 million below FY 2010, for contract and travel savings. Managed as part of CDC, ATSDR is the lead agency responsible for public health activities related to toxic substance exposures. The Agency's mission is to use the best science, take responsive action, and provide trustworthy health information to prevent and mitigate harmful exposures and related disease. Within the funds requested, $2 million continues the epidemiologic studies of health conditions caused by non-occupational exposures to uranium released from past mining and milling operations on the Navajo Nation. Created in 1980 by the Comprehensive Environmental Response, Compensation and Liability Act, ATSDR leads Federal public health efforts at Superfund and other sites with known or potential toxic exposures.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Institutes					
National Cancer Institute	4,969	1,257	5,102	5,265	+163
National Heart, Lung and Blood Institute	3,016	763	3,096	3,188	+92
National Institute of Dental and Craniofacial Research	403	102	413	424	+10
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,911	445	1,957	2,008	+50
National Institute of Neurological Disorders and Stroke	1,593	403	1,636	1,681	+46
National Institute of Allergy and Infectious Diseases	4,703	1,113	4,817	4,977	+160
National Institute of General Medical Sciences	1,998	505	2,051	2,125	+74
Eunice K. Shriver Natl Inst. of Child Hlth & Human Dev	1,295	327	1,329	1,369	+40
National Eye Institute	688	174	707	724	+18
National Institute of Environmental Health Sciences:					
Labor/HHS Appropriation	663	168	690	707	+18
Interior Appropriation	78	19	79	82	+3
National Institute on Aging	1,081	273	1,110	1,142	+33
Natl Inst. of Arthritis & Musculoskeletal & Skin Diseases	525	133	539	556	+17
Natl Inst. on Deafness and Communication Disorders	407	103	419	429	+10
National Institute of Mental Health	1,451	367	1,490	1,540	+51
National Institute on Drug Abuse	1,033	261	1,059	1,094	+35
National Institute on Alcohol Abuse and Alcoholism	450	114	462	475	+12
National Institute of Nursing Research	142	36	146	150	+5
National Human Genome Research Institute	502	127	516	534	+18
Natl Inst. of Biomedical Imaging and Bioengineering	308	78	316	326	+9
National Center for Research Resources	1,226	1,610	1,269	1,309	+40
Natl Center for Complementary and Alternative Medicine	125	32	129	132	+3
Natl Center on Minority Health and Health Disparities	206	52	212	219	+8
Fogarty International Center	69	17	70	73	+3
National Library of Medicine	339	84	359	373	+14
Office of the Director	1,247	1,337	1,177	1,220	+43
Buildings and Facilities	126	500	100	126	+26
Total, Program Level	**30,554**	**10,400**	**31,247**	**32,247**	**+1,000**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	--	-8	-8	--
Type 1 Diabetes Research (NIDDK) /1	-150	--	-150	-150	--
Total, Budget Authority	**30,396**	**10,400**	**31,089**	**32,089**	**+1,000**
Labor/HHS Appropriation	**30,318**	**10,381**	**31,010**	**32,007**	**+997**
Interior Appropriation	**78**	**19**	**79**	**82**	+3
FTE	17,926	--	17,890	18,784	+894

1/ These mandatory funds were pre-appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008.

*American Recovery and Reinvestment Act of 2009 (Recovery Act), including $400 million transfer from the Agency for Healthcare Research and Quality for patient-centered health research.

NATIONAL INSTITUTES OF HEALTH

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

The FY 2011 Budget requests $32.2 billion for the National Institutes of Health (NIH), an increase of $1.0 billion, or 3.2 percent, over the FY 2010 enacted level.

The success of the Human Genome Project and several other major projects that have followed quickly afterward have provided a powerful foundation for a new level of understanding human biology, and have opened a new window into the causes of disease. This includes the revelation of hundreds of previously unknown risk factors for cancer, diabetes, heart disease, hypertension, and a long list of other common illnesses that have previously been unapproachable. In the area of cancer, for example, a new ability to comprehensively understand the mechanisms responsible for malignancy has already provided insights into diagnostics and pointed to a whole new array of drug targets. New partnerships between academia and industry are working to revitalize the flagging drug development pipeline. An era of personalized medicine is appearing, where prevention, diagnosis, and treatment of disease can be individualized, instead of using the one-size-fits-all approach that all too often falls short, wasting health care resources and potentially subjecting patients to unnecessary and dangerous medical treatments and diagnostic procedures. Vigorous support of biomedical research in all of these areas promises to save lives, reduce the burden of chronic diseases, stimulate the economy, empower new and more effective prevention strategies, and reduce health care costs.

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 2011, about 83 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 300,000 scientists and research personnel affiliated with over 3,100 organizations, including universities, medical schools, hospitals, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to national and global health challenges. Another 6 percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2011

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. In FY 2011, NIH will utilize the $32.2 billion Budget to support innovative research across the spectrum from basic to clinical, guided by the NIH Director's five areas of exceptional research opportunities that includes: 1) supporting genomics and other high-throughput technologies; 2) translating basic science into new and better treatments; 3) reinvigorating the biomedical research community; 4) using science to enable health care reform; and 5) focusing on global health.

Genomics: Science-driven increases in genomics and other high-throughput technologies in FY 2011 will support a range of

Cancer and Autism Research Initiatives

NIH believes that exceptional scientific opportunities will exist in FY 2011 for combating cancer and autism. Consequently, the President's Budget will support a range of bold and innovative cancer efforts, including the initiation of 30 new drug trials in FY 2011, and a doubling of the number of novel compounds in Phase 1-3 clinical trials by 2016. In addition, FY 2011 will support the completion of a comprehensive catalog of cancer mutations for the 20 most common malignancies, setting the stage for complete genomic characterization of every cancer as part of medical care within 10 years. Critical research to improve the effectiveness of smoking cessation interventions and reduce the use of smokeless tobacco will also be supported, as will 10 clinical trials of potential smoking cessation medications. For autism, NIH will pursue comprehensive and innovative approaches to defining the genetic and environmental factors that contribute to autism spectrum disorders; investigate epigenomic changes in the brain; and accelerate clinical trials of novel pharmacological and behavioral interventions by 2016.

Recovery Act

NIH provided support to about 12,800 research projects in FY 2009 with Recovery Act funds. In one such project, NIH awarded $751,060 to the University of Vermont for Dr. David Krag to continue operations of large, randomized surgical trial for 5,000 breast cancer patients. This project is testing whether an individually tailored approach to breast cancer treatment using a radiotracer technique to identify which lymph nodes are cancerous can reduce potential side effects for the patient and avoid unnecessary treatment. This technique would enable non-cancerous lymph nodes to be left in place to perform their normal function of managing fluid balance and providing immune defense.

bold and innovative efforts against cancer and autism. With this support in FY 2011, and building on a major kick start from Recovery Act funds, The Cancer Genome Atlas will be able to complete a comprehensive catalog of all the reasons why normal cells become malignant for twenty of the most common malignancies, including prostate, breast and pancreatic cancer. This research will enable precise diagnosis of cancer subtypes with different prognoses, as well as identify at least 10 new drug targets based on the detailed understanding of what pathways within the cell have gone awry. These activities will set the stage for complete genomic characterization of every cancer as part of medical care within 10 years.

In FY 2011, for autism spectrum disorders, again building on significant Recovery Act investments, NIH will undertake complete genome sequencing and comprehensive DNA analyses of 300 autism spectrum disorder cases, and will launch the first epigenomic studies of brain samples from individuals with and without autism. NIH will also use a network of health maintenance organizations to identify patterns of environmental exposure during pregnancy and perinatal life that may contribute to autism.

By increasing its nanotechnology research portfolio by $30 million, for a total of $359 million, NIH will support the National Nanotechnology Initiative and nanotechnology-related environmental, health, and safety research for efforts such as expanding nanomaterial characterization, broadening data dissemination, and optimizing scalable designs of nanosystems.

Translational Research: As examples of projects that translate basic science into new and better treatments, NIH plans to double support for its Therapeutic Rare and Neglected Diseases Initiative in FY 2011 to a total of $50 million. These funds will support more rapid drug development through a truly integrated partnership between NIH and the private sector. The Clinical and Translational Science Award (CTSA) program, begun in FY 2006, will also receive increased support to stimulate research institutions to foster more productive collaborations among investigators in different fields, encouraging creative organizational models and training programs, and producing new approaches to complex medical mysteries. NIH plans to add another $20 million in new and reallocated funds within the National Center for Research Resources for a total CTSA program level of $500 million in FY 2011.

To shorten the timeline for development of new cancer drugs and move promising new treatments into human clinical trials as quickly as possible, NIH will initiate 30 new trials in FY 2011 to rapidly test the effectiveness of molecularly-targeted cancer therapies, and expects to double the number of novel compounds in Phase 1-3 clinical trials by FY 2016. In FY 2011, NIH will also accelerate Phase 3 clinical trials of a promising mGluR5 antagonist, begin a clinical trial of the drug rapamycin, and create a translational pipeline for advancing additional small molecule drugs for autism.

With the issuance of the President's Executive Order 13505 on March 9, 2009, that established the conditions for Federal funding of responsible research involving human embryonic stem cells, followed by formal NIH approval of 40 new stem cell lines in December 2009, the field of stem cell research is being invigorated. Along with the development of induced pluripotent stem cells, human embryonic stem cells will provide an unprecedented opportunity in FYs 2010 and 2011 to understand the earliest stages of human development, and to explore powerful new therapeutic approaches to Parkinson's disease, type 1 diabetes, spinal cord injury, and a long list of rare genetic diseases.

Launched with Recovery Act support in FY 2010, the NIH Basic Behavioral and Social Sciences Opportunity Network (OppNet) is a new NIH-wide initiative to accelerate and expand basic behavioral and social sciences research. The mission of OppNet is to pursue opportunities for

Performance Highlight

Goal: By 2012, increase the probability that predoctoral and postdoctoral scientists newly-trained through the Ruth L. Kirschstein National Research Service Award program remain involved in NIH-funded research in the 10 years following their training.

Performance: NIH has routinely met the targets for this training program measure. In 2009, NIH postdoctoral fellows were 14 percent more likely to remain active in biomedical research than non-NIH fellows, exceeding the annual target of 12 percent. NIH predoctoral trainees and fellows were also 13 percent more likely to remain active than non-NIH trainees and fellows, exceeding the annual target of 12 percent. Over time, NIH postdoctoral and predoctoral fellows have consistently been about 13 percent more likely to remain active in biomedical research than non-NIH fellows.

strengthening basic behavioral and social sciences research at the NIH while innovating beyond existing investments. Twenty-four NIH Institutes and Centers and four program offices in the NIH Office of the Director will collaborate on new research initiatives supported through shared OppNet-specific funds over an initial five-year period. A total of $20 million is provided for this program in FY 2011.

NIH estimates it will devote nearly $3.2 billion for research on HIV/AIDS in FY 2011. Controlling and ultimately eliminating HIV/AIDS will require safe, effective vaccines and other preventive measures. Developing such vaccines remains a priority and one of NIH's greatest challenges. This effort will require significant advances in basic research to both better understand the virus and the disease and to develop new vaccine strategies.

In addition to these funds, the budget for the National Institute of Allergy and Infectious Diseases includes $300 million, the same level as in FY 2010, as part of the United States Government's $1 billion contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis in FY 2011.

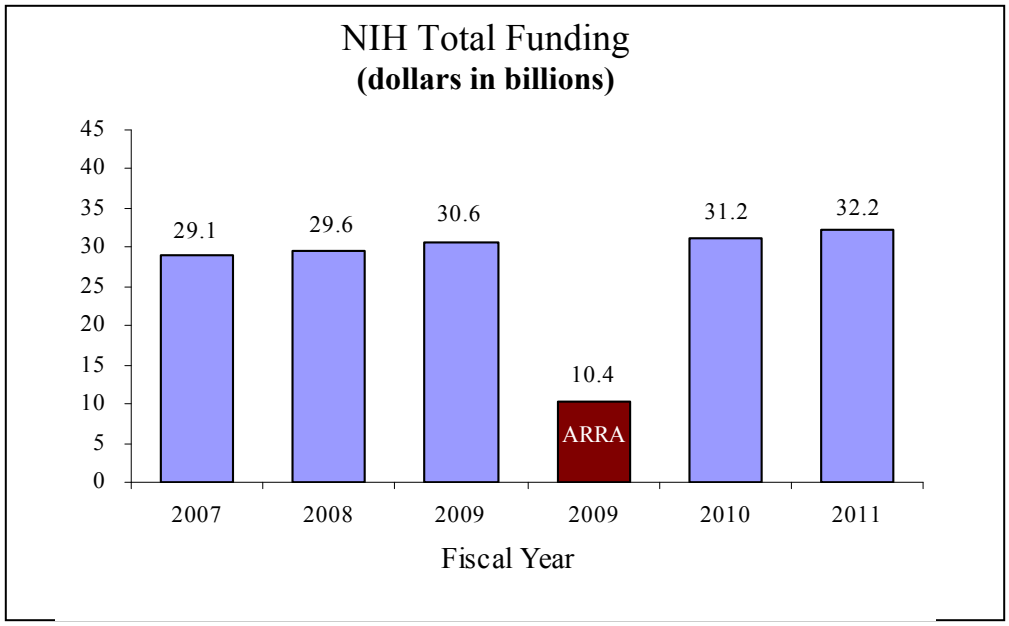
Reinvigorating Biomedical Research: To reinvigorate the biomedical research community, the FY 2011 budget request provides for a two percent increase to help cover inflationary increases and thus preserve purchasing power for both new and competing and non-competing continuation awards for research project grants (RPGs). The average cost of a new and competing RPG in FY 2011 will be about $443,000. The $17.1 billion provided by NIH in total for these peer-reviewed and investigator-initiated RPGs represent 53 percent of the total NIH budget request in FY 2011.

The backbone of biomedical research has been and will continue to be the creativity of investigator-initiated research. However, increasingly, investigators are working in interdisciplinary teams, utilizing newly accessible tools, databases, and technologies, which has raised the need to carefully balance the biomedical enterprise between individual investigator-initiated projects and large-scale community resource research programs. Many of the opportunities that will advance the NIH Director's scientific themes may best be accomplished through other research mechanisms, such as research and development contracts for comparative effectiveness studies, or research centers for genomic and other high-throughput technologies. Consequently, NIH estimates that it will support 9,052 new and competing RPGs in FY 2011, a decrease of 199 below the estimated level for FY 2010, excluding Recovery Act funds. The total number of RPGs to be funded in FY 2011 is expected to be 37,001, an increase of 195 above FY 2010 non-Recovery Act levels.

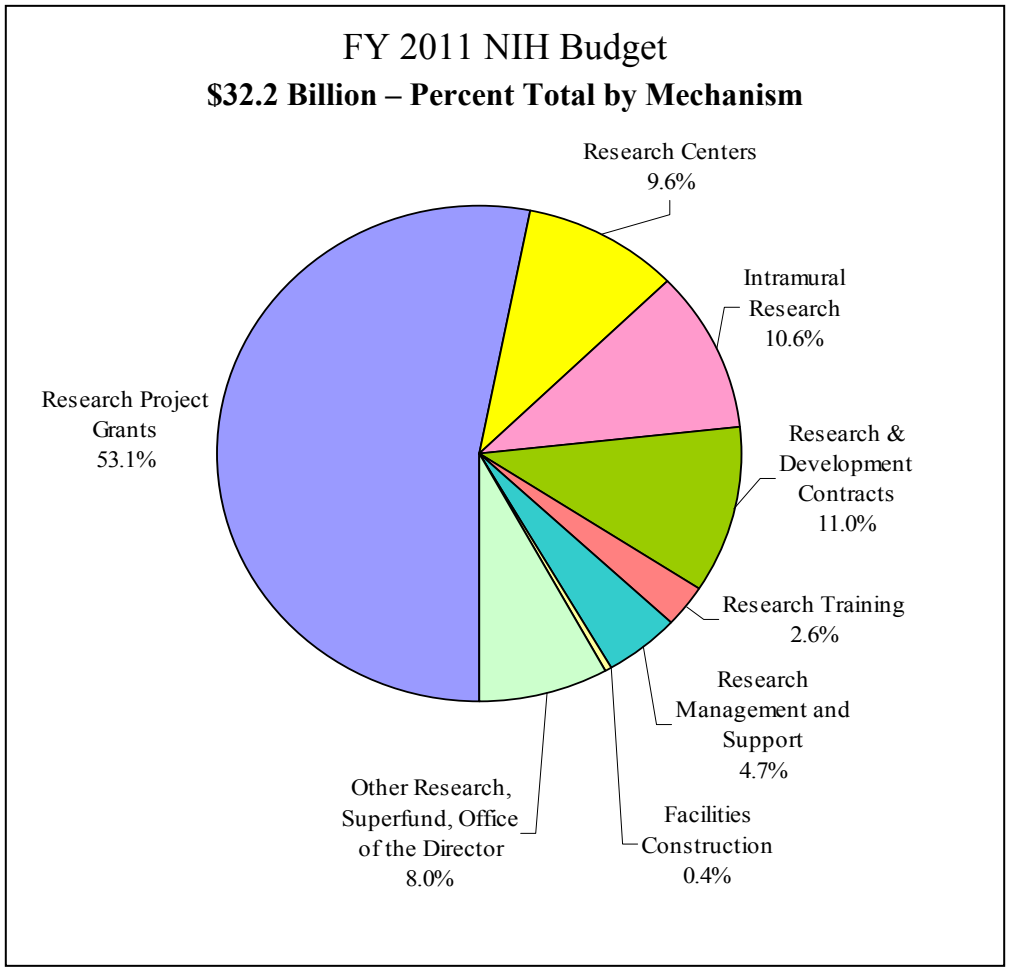
As part of the President's initiative in FY 2011 to emphasize support for science, technology, engineering, and mathematics (STEM) education programs, the budget proposes a six percent stipend increase for predoctoral and postdoctoral research trainees supported by NIH's Ruth L. Kirschstein National Research Service Awards program. This $42 million increase in stipends will allow NIH to continue to attract high-quality research trainees that will be available to address the Nation's future biomedical, behavioral, and clinical research needs.

Intramural Buildings and Facilities

A total of $133 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2011, an increase of $26 million above FY 2010, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2011, NIH will focus on upgrades to ensure essential safety and regulatory compliance, as well as on facility repairs and improvements to address the most critical utility systems, fire safety, and environmental deficiencies. Within the B&F mechanism total, $8 million is appropriated to the National Cancer Institute for facilities projects at its Frederick, Maryland campus.



ARRA (American Recovery and Reinvestment Act) funds are available for obligation in both FY 2009 and FY 2010.



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

Mechanism	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Research Project Grants (dollars)	16,106	6,615	16,598	17,132	+533
[# of Non-Competing Grants]	*[26,217]*	*[n/a]]*	*[25,779]*	*[26,150]*	*[+371]*
[# of New/Competing Grants]	*[9,111]*	*[n/a]]*	*[9,251]*	*[9,052]*	*[-199]*
[# of Small Business Grants]	*[1,740]*	*[n/a] [*	*[1,776]*	*[1,799]*	*[+23]*
[Total # of Grants]	*[37,068]*	*[n/a]]*	*[36,806]*	*[37,001]*	*[+195]*
Research Centers	3,019	666	3,034	3,090	+56
Other Research	1,773	528	1,807	1,854	+47
Research Training	776	33	783	824	+42
Research and Development Contracts	3,387	715	3,459	3,546	+86
Intramural Research	3,238	73	3,294	3,402	+109
Research Management and Support	1,426	268	1,452	1,525	+73
Extramural Research Facilities Construction	--	1,000	--	--	--
Office of the Director	617	**	633	659	+26
[NIH Common Fund (non-add)]	*[541]*	**	*[544]*	*[562]*	*[+18]*
Buildings and Facilities	134	500	108	133	+26
NIEHS Interior Appropriation (Superfund)	78	**	79	82	+3
Total, Program Level	**30,554**	**10,400**	**31,247**	**32,247**	**+1,000**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	--	-8	-8	--
Type 1 Diabetes Research (NIDDK) /1	-150	--	-150	-150	--
Total, Budget Authority	**30,396**	**10,400**	**31,089**	**32,089**	**+1,000**
Labor/HHS Appropriation	**30,318**	**10,381**	**31,010**	**32,007**	**+997**
Interior Appropriation	**78**	**19**	**79**	**82**	**+3**
FTE	17,926	--	17,890	18,784	+894

1/ These mandatory funds were pre-appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008.

*American Recovery and Reinvestment Act of 2009 (Recovery Act), including $400 million transfer from the Agency for Healthcare Research and Quality for patient-centered health research.

** Funds are rolled up into the above mechanisms.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Substance Abuse:				
Substance Abuse Block Grant	1,779	1,799	1,799	--
PHS Evaluation Funds (non-add)	*79*	*79*	*79*	--
Programs of Regional and National Significance:				
Treatment	412	453	487	+34
PHS Evaluation Funds (non-add)	*9*	*9*	*9*	--
Prevention	201	202	223	+21
Prescription Drug Monitoring	2	2	2	--
Subtotal, Substance Abuse	2,394	2,455	2,510	+55
Mental Health:				
Mental Health Block Grant	421	421	421	--
PHS Evaluation Funds (non-add)	*21*	*21*	*21*	--
PATH Homeless Formula Grant	60	65	70	+5
Programs of Regional and National Significance	344	362	374	+13
Children's Mental Health Services	108	121	126	+5
Protection and Advocacy	36	36	36	--
Subtotal, Mental Health	969	1,005	1,028	+23
Program Management/Data Collection	100	102	136	+34
PHS Evaluation Funds (non-add)	*23*	*23*	*23*	+1
St. Elizabeths Hospital	1	1	--	-1
Data Evaluation	3	--	--	--
Program Level Total	**3,466**	**3,563**	**3,674**	**+110**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-132	-132	-132	-1
Budget Authority Total	**3,335**	**3,432**	**3,541**	**+110**
FTE	528	549	553	+4

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 2011 Budget requests $3.7 billion for the Substance Abuse and Mental Health Services Administration, a net increase of $110 million over FY 2010. The Budget includes funding increases to expand community prevention and wellness efforts, the treatment capacity of drug courts, screening and brief intervention, children's mental health services, and support for those suffering from mental illness and facing homelessness.

SUBSTANCE ABUSE

An estimated 23 million Americans struggle with a serious substance abuse problem that requires treatment. Substance abuse affects not only the individuals suffering from it, but families, schools, workplaces, and communities. Recognizing the devastating impacts of substance abuse, the FY 2011 Budget includes $2.5 billion, an increase of $55 million, for substance abuse prevention and treatment.

Promoting Wellness Among Children and Adolescents: The Budget includes $37 million for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), an increase of $12 million for new grants that will enable communities to conduct evidence-based prevention and wellness interventions focused on children. This funding will prevent substance abuse and mental illness concurrently by targeting the common set of risk factors that lead to these disorders.

Expanding the Treatment Capacity of Drug Courts: The Budget includes $56 million to expand the treatment capacity of drug courts, an increase of $13 million. Drug courts use close supervision, drug testing, sanctions, and incentives to ensure adherence to treatment plans to help break the cycle of drug abuse. States and localities increasingly use drug courts to effectively facilitate recovery and reduce recidivism.

Promoting Behavioral Health

The Michigan State Department of Community Health was recently awarded a grant to improve comprehensive wellness for young children and their families using a public health approach expanding and enhancing early childhood systems of care, including the integration of behavioral health into primary care.

Building on this approach to integrated and comprehensive prevention through an expansion of Project LAUNCH in FY 2011, approximately 20 additional communities will receive Federal support to assist them in developing and implementing effective mental illness and substance abuse prevention practices for children. This funding will support communities in their development of comprehensive prevention and health promotion systems of care.

Providing Screening and Brief Intervention: Early identification and interventions can decrease total health care costs by impeding progression to addiction. The Budget provides $37 million, an increase of $8 million, for substance abuse and mental health screening and interventions within general medical and primary care settings. This funding level supports a pilot project to better equip primary health care physicians and other healthcare providers to screen for, diagnose, and treat a broad range of substance abuse disorders.

Supporting Treatment and Prevention: Substance Abuse Block Grant funds support approximately 2 million client admissions annually, and are the cornerstone of States' and Territories' substance abuse-related programs. The Budget includes $1.8 billion for the Substance Abuse and Treatment Block Grant. Block grant funds are used by 60 jurisdictions to plan, implement, and evaluate substance abuse prevention and treatment services.

Providing Access to Recovery: The Budget includes $109 million, an increase of $10 million over FY 2010, to support States and Tribes in providing a choice of treatment opportunities for individuals with substance use disorders. The additional funding will support up to 4 new grants. More than 80 percent of clients

Performance Highlight

A national evaluation found that children receiving services through systems of care developed through the Children's Mental Health Services program demonstrated improved mental health and substance abuse outcomes, better school performance, and fewer disciplinary and law enforcement encounters. These comprehensive results are achieved by integrating the efforts of previously fragmented child-serving systems into a single system of care. For example, within such a system, the teacher, coach, physician, and prevention/promotion specialist for a given student work in a coordinated fashion to reinforce positive behavior and ensure the proper supports are available.

receiving services through this program abstained from substance use in FY 2009.

Reducing the Burden of HIV/AIDS Among Minority Populations: The Budget includes $117 million to reduce health disparities in minority communities by delivering high quality substance abuse, mental health, and HIV prevention and treatment services.

Establishing Prevention Prepared Communities: The Budget includes $23 million for a new initiative to implement comprehensive, evidence-based community prevention programs that serve young people during their at-risk years. This new program also funds grants to States for community prevention specialists to assist in implementation.

Linking Funding to Performance: In order to encourage treatment providers to enhance the overall quality of substance abuse treatment, the Budget invests $6 million to provide supplemental grants to providers who achieve specific performance targets.

Preventing Addiction to Prescription Drugs: While prescription medications are beneficial treatments for many health conditions, they can lead to adverse health effects and addiction when abused. The Budget provides $2 million, the same level as FY 2010, for State-administered controlled substance monitoring programs, as authorized by the National All Schedules Prescription Electronic Reporting Act of 2005. These programs ensure that health care providers can access accurate and timely prescription information, facilitating early identification of patients at risk of addiction.

MENTAL HEALTH

Untreated serious mental illness can make it difficult to hold a job, go to school, relate to others, and cope with day-to-day life demands. The Budget includes $1 billion, an increase of $23 million, for the prevention and treatment of mental illness.

Improving Children's Mental Health: Fifty percent of children with serious emotional disturbances drop out of high school. The Budget provides $126 million, an increase of $5 million, for grants to States and localities to support the development of comprehensive, community-based, age appropriate systems of care for children and adolescents with serious emotional disturbances.

Assisting in the Transition from Homelessness: Approximately one-fifth of homeless individuals also have serious mental illness. The Budget dedicates a total of $159 million, an increase of $17 million, for services to support individuals suffering from mental illness and facing homelessness. Included within this funding is a new $16 million Homelessness Initiative to provide behavioral health and other support services to homeless individuals and families with the aim of preventing and reducing homelessness. This funding also includes $70 million, an increase of $5 million, for Projects for Assistance in Transition from Homelessness to increase State formula grant allotments for expanding services.

Supporting Community Mental Health Services: The Budget provides $421 million for the Community Mental Health Block Grant. States and Territories have significant flexibility to target services supported through this funding stream to their unique needs, including infrastructure, service delivery, planning, and evaluation to develop comprehensive community-based mental health service delivery systems.

Preventing Youth Violence: SAMHSA collaborates with the Departments of Education and Justice through local partnerships to implement best practices for education, justice, law enforcement and mental health services through the Safe Schools/Healthy Students

program. The Budget includes $95 million, the same as FY 2010, for the prevention of youth violence. SAMHSA-supported interventions foster early childhood development of mental and physical health, reduce or delay the onset of emotional and behavioral problems, and treat children with serious emotional disturbances.

Preventing Suicide: The Budget dedicates $54 million, an increase of $6 million, to prevent suicide. The Budget continues to invest in activities authorized by the Garrett Lee Smith Memorial Act that support intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations. The Budget increases the capacity of the national hotline that routes calls across the country to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources.

Protecting Individuals With Mental Illness: Individuals with mental illness and serious emotional disturbances who reside in treatment facilities are vulnerable to neglect and abuse. The Budget provides $36 million, the same level as FY 2010, to support State protection and advocacy systems to monitor residential treatment facilities. More than 80 percent of the substantiated complaints handled through these systems result in positive changes for their clients.

Fostering Community Resilience: Many Americans continue to experience heightened levels of stress and anxiety associated with financial and job insecurity. The Budget invests $5 million to continue to promote stress reduction and behavioral health.

In addition to these targeted resources, broader investments made by SAMHSA in the prevention and treatment of mental health and substance abuse disorders will continue to play a key role in facilitating resilience and recovery.

Program Management and Data Collection: The Budget includes $136 million, an increase of $34 million, for the administration of SAMHSA programs and the support of national data collection efforts. The majority of this increase will support data collection and analysis, including increased costs associated with ongoing efforts as well as enhancing data collection on drug related emergency room visits and deaths. Analyses conducted through SAMHSA's national surveys are used by Federal, State, and local authorities, as well as health care providers, to inform policy regarding substance use and mental disorders, the impact and treatment of these disorders, and the recovery process. Additionally, it will fund a new initiative to design and test a community-level early warning system to detect the emergence of new drug threats and assist in identifying the public health and safety consequences of drug abuse. These investments will enable policymakers and practitioners to stay ahead of emerging substance abuse trends.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Health Costs, Quality and Outcomes Research					
Patient Safety Research:					
Health Information Technology	45	--	28	32	+4
General Patient Safety Research	49	--	91	65	-26
Subtotal, Patient Safety	94	--	118	96	-22
Patient-Centered Health Research	50	700	21	273 **	+252
Crosscutting Activities	97		112	90	-21
Value	4		4	4	--
Prevention/Care Management	7	--	16	16	--
Total, Health Costs, Quality and Outcomes	252	700	271	479	+208
Medical Expenditure Panel Surveys	55	--	59	59	+1
Program Support	65	--	68	73	+5
Total, Program Level	**372**	**700**	**397**	**611**	**+214**
Less Funds From Other Sources					
PHS Evaluation Funds	-372	--	-397	611	+214
Total, Budget Authority	**--**	**700***	**--**	**--**	**--**
FTE	289	38	338	315	-23

*American Recovery and Reinvestment Act of 2009 (Recovery Act) appropriated $1.1 billion to AHRQ of which $400 was for transfer to NIH. Of the $700 remaining million, $400 million is for allocation across the Department at the discretion of the Secretary.

** In addition, $13 million within Program Support is for Patient-Centered Health Research activities, for a total of $286 million in FY 2011.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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

The FY 2011 Budget request for the Agency for Healthcare Research and Quality (AHRQ) is $611 million, an increase of $214 million above FY 2010. The FY 2011 Budget request, includes a significant investment in Patient-Centered Health Research. The Budget request also continues to support efforts to improve research in patient safety and prevention and care management research, as well as investing in improving the capacity of data collection through the Medical Expenditure Panel Surveys (MEPS) and the Healthcare Cost and Utilization Project (HCUP).

AHRQ conducts and sponsors health services research within the agency and across many other settings including leading academic institutions, hospitals, and health care systems to inform decision-making and improve health care clinical care, organization, and financing. 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 efficient and safer care. The agency's research agenda is broad and spans from medical informatics to health care system redesign, and from research that compares the effectiveness of medical treatment to patient safety research.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2011 Budget request provides a total of $479 million, an increase of $208 million over FY 2010, to support research on health care cost, quality, effectiveness and efficiency within six research priorities including prevention and care management, improving patient safety, achieving greater health care value, improving health care through health IT, conducting patient-centered health research, and crosscutting research on health cost, quality and outcomes.

Patient-Centered Health Research: The Recovery Act appropriated $1.1 billion to AHRQ for research to compare the effectiveness of different health treatments and medical options, of which the Act specified $400 million for transfer to the National Institutes of Health and $400 million for allocation at the discretion of the Secretary. The remaining $300 million were provided to expand and broaden these efforts within AHRQ. Specifically, AHRQ funds will build on its Effective Health Care Program to increase national output of research data, build research infrastructure and capacity, and address existing research gaps. Recovery Act funds for allocation by the Secretary similarly invest in high priority issues while strengthening and sustaining the foundation for this research in the long-term.

The FY 2011 Budget request provides a total of $286 million (including $273 million for research and $13 million for related program support), which, including program support, is a total increase of $261 million above FY 2010, for Patient-Centered Health Research. This investment will continue to provide a broad range of stakeholders, ranging from consumers to clinicians and policymakers, with timely and usable state-of-the-science information for informed decision-making related to health care. This program supports the generation of new scientific information through research on the outcomes of health care services and therapies.

In FY 2011, these funds will continue to build on previous investments to support the following activities: identifying new and emerging issues; synthesizing current, existing evidence; identifying evidence gap areas; generating new evidence; translating and disseminating knowledge generated; training and career development; and, comprehensively engaging stakeholders. A total of $116 million, an increase of $104 million over FY 2010, will fund 138 research grants, of which 105 are new and competing in FY 2011.

AHRQ will continue to support the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Network, which generates new knowledge through the conduct of studies on outcomes, comparative clinical effectiveness, safety, and appropriateness of health care items and services. To date, the DEcIDE network has produced 14 Effective Health Care research reports in addition to a series of methodological tools for researchers which are available on the AHRQ Effective Health Care website, www.effectivehealthcare.ahrq.gov.

AHRQ will also continue to support the John M. Eisenberg Clinical Decisions and Communications Science Center to make patient-centered health research findings and products available to consumers, clinicians, and policy makers, through translation and dissemination efforts. From FY 2008 to FY 2009, the Eisenberg Center produced a total of 30 summary guides which translated complex scientific research from the Effective Health Care Program into concise and usable products for the health care community. In FY 2011, AHRQ will build on expansions made possible through the Recovery Act investments to develop and implement innovative approaches to integrate findings into clinical practice and inform health care decision making. Funds will also continue to support innovative approaches for translation and dissemination activities.

Finally, AHRQ will strengthen the patient-centered health research infrastructure and capacity by investing in the development of knowledgeable researchers through training and career development. FY 2011 funds will support career development of clinicians and research doctorates focusing on this type of research, including research synthesis, generation, and translation of new scientific evidence.

Investing in Health IT: The FY 2011 Budget includes $32 million, $4 million above the FY 2010 level, for health IT research to develop and disseminate evidence and evidence-based tools to inform stakeholders about how health IT can improve the quality, safety, and efficiency of health care. The AHRQ health IT program both translates and conducts innovative research and continues to serve as a valuable science partner for HHS agencies as well as entities across the Federal government. The health IT program will also continue to fund research in strategic focus areas that are aligned with "meaningful use", in collaboration with the Office of the National Coordinator for Health Information Technology. The FY 2011 Budget level for health IT will fund 44 research and training grants to improve the quality and safety of care by demonstrating best approaches to broader diffusion, implementation, and effective use of health IT, and contracts to support the National Resource Center for Health IT as well as projects to develop and disseminate evidence and evidence-based tools on the use of health IT.

Supporting Other Patient Safety Activities: The FY 2011 Budget request includes $65 million for the AHRQ patient safety program comprised of two research components: Patient Safety Threats and Medical Errors, and Patient Safety Organizations that support efforts to identify the most significant causes of threats to patient safety, identify best practices to address these threats, and widely disseminate lessons learned. The FY 2011 budget does not continue funding for one-time medical liability reform demonstration projects, funded at $25 million in FY 2010.

In FY 2011, AHRQ will invest $34 million to reduce and prevent healthcare-associated infections (HAIs). Of this total, $9 million will specifically be used to focus on the Methicillin-Resistant Staphylococcus Aureus Collaborative Research Initiative. AHRQ funding has targeted the reduction of HAIs with projects such as a patient safety program to reduce blood steam infections in hospital intensive care units by implementing a safety compliance checklist and providing staff with evidence-based practices. This project was expanded to all States, Puerto Rico and the District of Columbia, and has increased the number of intensive care units in hospitals implementing the program throughout the country. In FY 2011 AHRQ will continue to work closely with partners, including CDC and CMS, to identify and design appropriate projects to reduce the incidence of HAIs.

Recovery Act

The Recovery Act provided $1.1 billion, of which $400 million was directed to be transferred to NIH, and $400 million is was allocated at the discretion of the Secretary, for research that compares the effectiveness of health care services. The Department's overall goal for these Recovery Act investments is to build a sustainable foundation for promoting high quality health care through broad availability of information for patients and clinicians that will match the best science to individual needs and preferences. One example of a research project grant funded by the Recovery Act will build new clinical infrastructure and improve practices for collecting clinical information from electronic databases. Studies will enhance the Nation's capacity and ability to systemically collect data to inform this research, particularly in populations with limited access to health care or that are typically under-represented in clinical trials.

Performance Highlight

AHRQ is focusing on best practices for healthcare-associated infection (HAI) prevention through disseminating proven techniques for reducing central-line associated blood stream infections in hospital intensive care units in all 50 States, the District of Columbia, and Puerto Rico. AHRQ will also initiate testing of similar techniques for other infection sites, including catheter-associated urinary tract infections and surgical site infections.

Each year, an estimated 250,000 cases of central line-associated bloodstream infections occur in hospitals in the United States, leading to at least 30,000 deaths, according to the Centers for Disease Control and Prevention. The average additional hospital cost for each infection is over $36,000, which totals over $9 billion in excess costs annually.

Results from this project will improve care, save lives, and lead to substantial cost savings for participating hospitals and the health care system.

Supporting Other Research and Dissemination Activities: The FY 2011 Budget invests $16 million for research and dissemination activities in prevention and care management, $4 million for activities aimed at increasing the value of health are, and $90 million for research and dissemination of activities on crosscutting topics aimed at improving healthcare quality, safety and efficiency. AHRQ will improve primary care and clinical outcomes by supporting activities such as health care redesign, clinical-community linkages, care coordination, and integration of health IT. Within the crosscutting portfolio, which would be funded at $90 million, AHRQ will increase funding for the Healthcare Cost and Utilization Project (HCUP), by nearly $2 million, which provides encounter-level data in the U.S. At this level, AHRQ will support all continuation grants in FY 2011.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

The FY 2011 Budget request for MEPS is $59 million, an increase of nearly 1 million over FY 2010, to support a sample size for MEPS that ensures full analytical capacity and precision. MEPS is the only national source on how Americans use and pay for health care. The survey collects detailed information from individuals and families on medical utilization and expenditure. Data produced by MEPS has enabled the projection of regional and national estimates on the impact of changes in financing, coverage and reimbursement policy.

PROGRAM SUPPORT

In addition, the FY 2011 Budget will provide $73 million, an increase of $5 million, for program support across the agency. Of this total, $13 million will support patient-centered health research.

CENTERS FOR MEDICARE & MEDICAID SERVICES

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law:				
Medicare /1	430,066	450,476	475,915	+25,439
Medicaid /2	250,924	275,368	271,446	-3,922
CHIP /3	7,547	9,103	10,485	+1,382
State Grants and Demonstrations	498	980	1,036	+56
Recovery Act Provisions (non-add)	*31,887*	*39,828*	*20,095*	--
Total Net Outlays, Current Law	**689,035**	**735,927**	**758,882**	**+22,955**
Proposed Law:				
Medicare	--	--	11	+11
Medicaid	--	15	25,395	+25,380
Total, Proposed Law	**--**	**15**	**25,406**	**+25,391**
Total Net Outlays, Proposed Law /4	**689,035**	**735,942**	**784,288**	**+48,346**

1/ Current law Medicare outlays net of offsetting receipts.

2/ Net outlays net of Qualified Individuals.

3/ Includes the Child Enrollment Contingency Fund.

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

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

The FY 2011 Budget request for the Centers for Medicare & Medicaid Services (CMS) is $784.3 billion in mandatory and discretionary outlays, a net increase of $48.3 billion over the FY 2010 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), program integrity efforts, and operating costs.

CMS is the largest purchaser of health care in the United States, serving almost 102 million Medicare, Medicaid, and CHIP beneficiaries, almost one in three Americans.

RECENT LEGISLATION

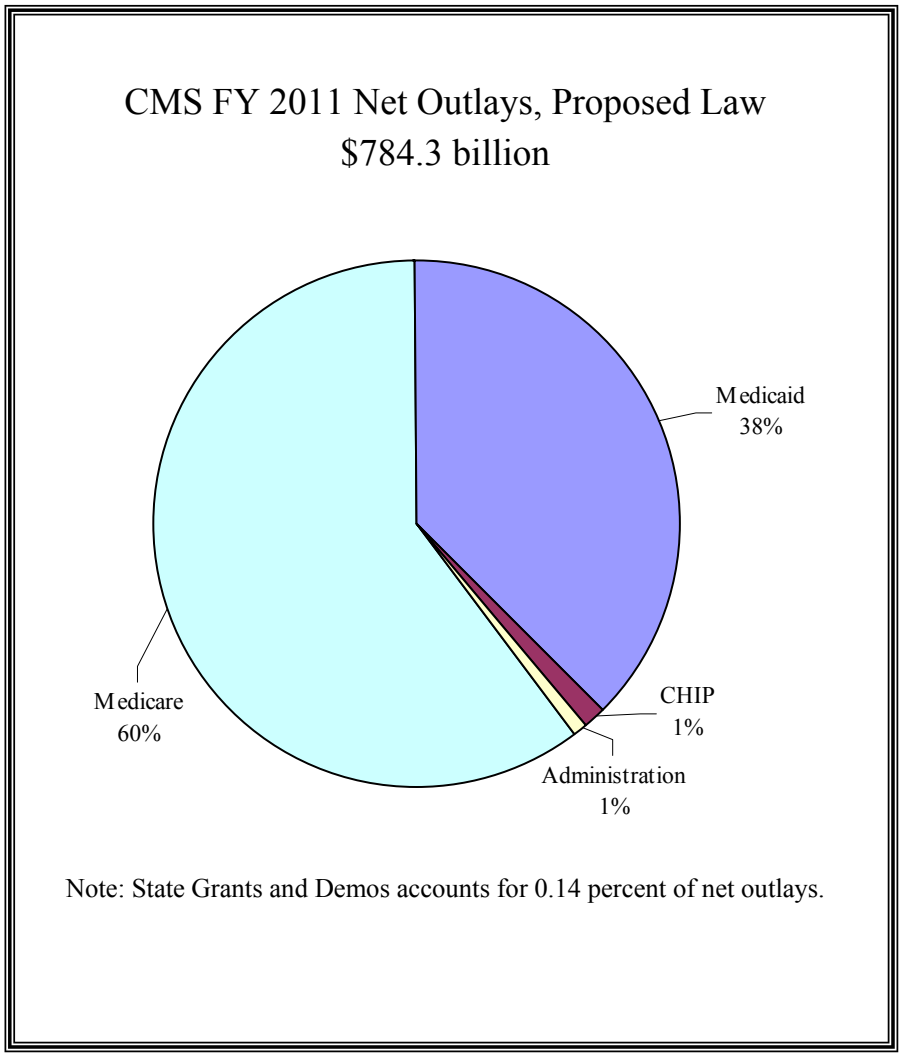
The recent reauthorization of CHIP fulfills the President's commitment to expand health insurance coverage to millions of uninsured children who qualify for Medicaid or CHIP. It increased funding for State CHIP allotments and created several new initiatives to increase innovation and enrollment in the Medicaid and CHIP programs.

The Recovery Act has allowed States to protect health care coverage for millions of Americans during the recession by temporarily increasing Federal Medicaid funding to help States facing budget shortfalls maintain their current programs.

The Recovery Act also includes an estimated $20 billion over 10 years in funding to accelerate the adoption of electronic health records through incentives to Medicare and Medicaid providers starting in FY 2011.

BUDGETARY REQUEST

Program Integrity: The FY 2011 Budget makes fighting health care fraud a top priority by safeguarding public funds and sending a clear message that fraud and waste in our health programs will not be tolerated. The Budget invests $250 million in new fraud-fighting resources to allow HHS and its partners to take ground breaking new steps to detect, prevent, and prosecute health care fraud. The Budget also proposes a package of new authorities that will strengthen existing program integrity oversight. These investments will show real, measurable results and return money to the Medicare Trust Funds.



Note: State Grants and Demos accounts for 0.14 percent of net outlays.

Medicaid: The Budget includes $25.5 billion for a 6 month extension through June 2011 of the Recovery Act's temporary increase in Medicaid Federal medical assistance percentage (FMAP) rates to maintain support for children and families helped by Medicaid.

Discretionary Program Management: The Budget makes a robust investment in CMS program management. It invests $110 million for a Health Care Data Improvement Initiative to begin needed investments to aging information systems, transforming CMS's health care data environment so that the Agency can meet current needs and be prepared for future growth. The Budget also includes an increase of $28 million to support increased CMS staffing levels to handle expanding program workloads. Transforming CMS's information systems and investing in human capital are infrastructure investments that will ensure that the Agency can meet existing workload demands.

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law:				
Outlays				
Benefits Spending (gross) /1	491,133	515,803	549,825	+34,022
Less: Premiums Paid Directly to Part D Plans /2	-3,654	-4,282	-4,773	-491
Subtotal, Benefits Net of Direct Part D Premium Payments	**487,479**	**511,521**	**545,052**	**+33,531**
Related-benefit Expenses/3	9,885	10,189	10,066	-123
Administration /4	6,579	8,076	8,062	-14
Recovery Act Provisions (non-Add)	*301*	*475*	*2,662*	*+2,187*
Total Outlays, Current Law (CL)	**503,943**	**529,786**	**563,180**	**+33,394**
Offsetting Receipts				
Premiums and Offsetting Receipts /5	-73,877	-79,310	-87,265	-7,955
Current Law Outlays, Net of Offsetting Receipts	**430,066**	**450,476**	**475,915**	**+25,439**
Proposed Law:				
Offsetting Receipts (from Program Integrity Package)	--	--	11	+11
Total Medicare Proposals	**0**	**0**	**11**	**+11**
Total Net Outlays, Proposed Law/6	**430,066**	**450,476**	**475,926**	**+25,450**
Current Policy:				
Adjustment to Physician Payments	--	6,638	22,146	+15,508
Net Current Policy Outlays	**430,066**	**457,114**	**498,072**	**+40,947**

1/ Represents all spending on Medicare benefits by either the Federal government or beneficiaries.
2/ In Part D only, some beneficiary premiums are paid directly to plans and are netted out here because those payments are not paid out of the Trust Funds.
3/ Includes related benefit payments, including refundable payments made to providers and plans, transfers to Medicaid, and additional Medicare Advantage benefits.
4/ Includes Program Management, non-CMS administration, HCFAC, Recovery Act Administration and QIOs. Of this total in FY 2011, $6.6 billion represents discretionary and non-HHS spending.
5/ Includes beneficiary premiums, State contributions to Part D, and other offsets.
6/ FY 2011 does not include $733 million in non-PAYGO scorecard savings from program integrity efforts.

In FY 2011, gross current law spending on Medicare benefits will total $549.8 billion. Medicare will provide health insurance to 48.1 million individuals who are either 65 or older, disabled, or have end–stage renal disease (ESRD).

THE FOUR PARTS OF MEDICARE

Part A ($193 billion in 2011): Medicare Part A, or Hospital Insurance (HI), pays for inpatient hospital, skilled nursing facility, home health (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, but most services require a beneficiary co-payment or coinsurance. In 2010, beneficiaries pay a $1,100 deductible for a hospital stay of 1-60 days, and $137.50 daily coinsurance for days 21-100 in a skilled nursing facility.

Medicare Enrollment
(enrollees in millions)

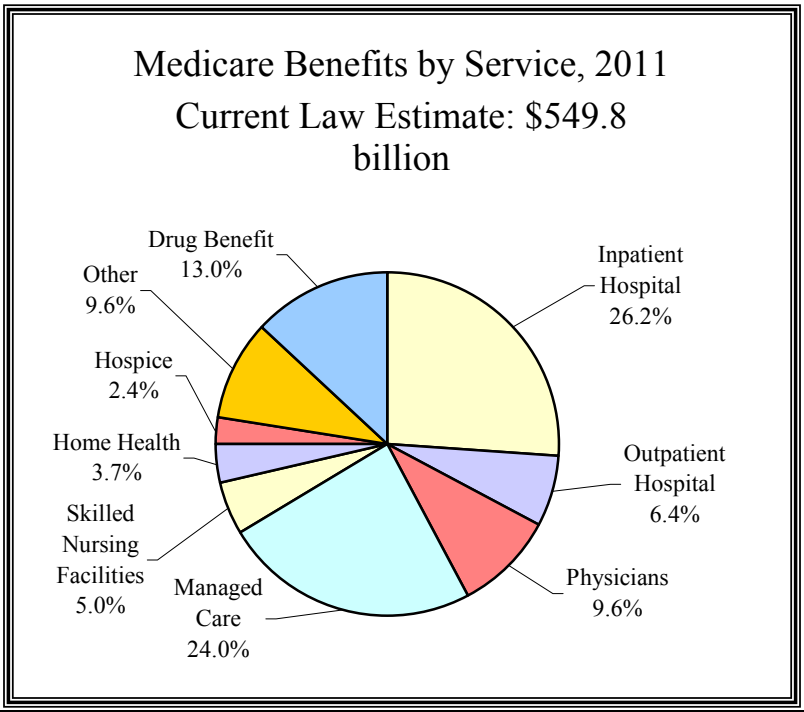
	2009	2010	2011	2011 +/- 2010
Aged	38.5	39.0	39.8	+0.8
Disabled	7.6	8.0	8.3	+0.3
Total Beneficiaries	**46.1**	**47.0**	**48.1**	**+1.1**

Part B ($154 billion gross spending in 2011): Medicare Part B, or Supplementary Medical Insurance (SMI), pays for physician, outpatient hospital, ESRD, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 93 percent of Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

Part B premiums are based on income. The standard monthly premium is $110.50 in 2010. However, most beneficiaries will continue to pay a $96.40 monthly premium, the same level as 2009, because current law protects them from a reduction in Social Security benefits as a result of Medicare premium increases. In 2010, the Social Security cost-of-living adjustment did not increase. Some beneficiaries pay a higher premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married couple) will pay from $154.70 to $353.60 per month.

Part C ($132 billion in 2011): Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including health maintenance organizations, preferred provider organizations, special needs plans, and private fee-for-service plans. MA enrollment will total more than 11 million in 2010.

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 a variety of 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.

Part D ($72 billion gross spending in 2011): Medicare Part D offers a standard prescription drug benefit with a 2010 deductible of $310 and an average monthly premium of about $30. 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 $4,550, Medicare covers 95 percent or more of drug costs. For people who are low-income, varying degrees of cost sharing are available with co-payments ranging from $0 to $6.30 in 2010 and low or no monthly premiums.

As of December 2009, there were about 27.3 million beneficiaries in Medicare Part D, including over 10 million low-income subsidy (LIS) beneficiaries. About 65 percent of those with Part D coverage are enrolled in a stand-alone Part D prescription drug plans and 35 percent are enrolled in a Medicare Advantage Prescription Drug Plan (MA-PD). Overall, approximately 90 percent of all Medicare beneficiaries receive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage.

Recovery Act
Electronic Health Records

The Recovery Act invests approximately $20 billion over ten years for Medicare and Medicaid incentive payments to encourage provider adoption of electronic health records.

PHYSICIAN PAYMENTS

To promote more honest and transparent budgeting, the Budget includes an adjustment totaling $371 billion over ten years (FY 2011–FY 2020) to reflect the Administration's best estimate of future Congressional action based on what the Congress has done in recent years for physician payments. However, this adjustment does not signal a specific Administration policy.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

Between 2008 and 2011, approximately $1.1 billion will be provided to Quality Improvement Organizations (QIOs) under the current (9th) contract cycle. This contracting cycle includes significant reforms to the management of the program and increases the expected performance of the QIOs. The major goals of the 9th contracting cycle include preventing illness, increasing the safety of care provided, reducing health care disparities, and promoting the use of efficient and high quality care. The 9th contracting cycle aims to measurably reduce illness, injury, and re-hospitalization.

Clinical Quality Efforts: Under the 9th contracting cycle, clinical care efforts will focus on preventing disease, improving the coordination of care to avoid unnecessary re-hospitalizations, identifying and intervening in the area of health care disparities, and increasing patient safety. In addition to the clinical quality efforts, QIOs will continue to protect beneficiaries by responding to quality of care complaints and making information available to support public reporting.

Medicare Prescription Drug Benefit
Beneficiary Cost Sharing in 2010

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Out-of-Pocket Spending For Total Drug Expenditures:	
			≤ $6,440	> $6,440
≥150% FPL (standard benefit)	$310	$30 (avg)	25% from $310-2,830; 100% from $2,830-6,440	Greater of 5% or $2.50-6.30 copay
135-150% FPL*	$63	25-75% of $30 (avg)**	15% from $63-6,440	Copayment of $2.50 generic $6.30 brand
100-135% FPL*	$0	$0**	Copayment of: $2.50 generic $6.30 brand name	$0
≤100% FPL*	$0	$0**	Copayment of: $1.10 generic $3.30 brand name	$0

FPL=Federal Poverty Level / LIS=Low-Income Subsidy

*At these income levels, beneficiaries must also meet an asset test.

**Monthly prescription drug premium will be the amount shown in the table if the beneficiary enrolls in a basic Part D plan with a premium that is below the LIS premium amount.

New Performance Management Strategy: The 9th contracting cycle includes several innovations in QIO contract management, including ongoing performance management reviews, mid-contract performance assessments, and financial consequences if contractors do not maintain pre-specified performance levels.

Estimated Quality Improvement Organization Funding by Major Task – 9th Contract Cycle (2008-2011)
(dollars in millions)

	Funds
Clinical Quality Improvement	**409**
Prevention	*126*
Care Transitions	*41*
Patient Safety	*227*
Provider Performance	*15*
Data Processing, Theme Implementation, and Collaboration	**262**
Other Support Contracts	**220**
Protecting Beneficiaries and the Trust Funds	**208**
Total, QIO Ninth Cycle of Contracts	**1,099**

PROGRAM INTEGRITY INITIATIVE

(dollars in millions)

	2011	2011-2015	2011-2020
Program Integrity Legislative Proposals:			
Medicare:			
Modify Certain Medical Review Limitations	--	-28	-73
Establish a CMS-IRS Data Match to Identify Fraudulent Providers	3	-227	-1,211
Extrapolate MA Plan Sample Error Rate to Entire Plan Payment in Risk Adjustment Audits	8	-2,266	-7,594
Subtotal, Medicare	11	-2,521	-8,878
Medicaid:			
Track Drug Utilizers and Prescribers to Reduce Over-utilization	-120	-1,590	-4,200
Subtotal, Medicaid	-120	-1,590	-4,200
Total, Program Integrity Legislative Proposals	**-109**	**-4,111**	**-13,078**
Medicare Program Integrity Administrative Policies:			
Consolidate Medical Review	-40	-550	-1,530
Consolidate Medicare Provider Enrollment Activities	--	-40	-140
Expand Medicare Revocations for Abuse of Billing Privileges	--	--	--
Total, Program Integrity Administrative Policies	**-40**	**-590**	**-1,670**
Total, Program Integrity Budget Proposals and Policies	**-149**	**-4,701**	**-14,748**
Savings from Discretionary HCFAC Investment:			
Return-on-Investment /1	-740	-4,470	-9,870
Total, Savings from Discretionary HCFAC Investment	**-740**	**-4,470**	**-9,870**
Total, Program Integrity Initiative Savings	**-889**	**-9,171**	**-24,618**

1/ These additional savings are beyond what would be scored under PAYGO rules.

PROGRAM INTEGRITY INITIATIVE

The FY 2011 Budget makes fighting health care fraud a priority by investing an additional $250 million in new resources and supporting a package of legislative and administrative changes that will give HHS new tools that enhance program integrity oversight and generate $14.7 billion in program savings over ten years.

HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC) FUNDING

The FY 2011 Budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2011 HCFAC program level is over $1.7 billion, $250 million more than in FY 2010. Of this total program level, approximately $1.2 billion is mandatory and $561 million is requested in discretionary funding.

HCFAC Mandatory Funds:
The $1.2 billion in mandatory funds for FY 2011 are financed from the Medicare Part A Trust Fund. This funding is allocated into three major parts: 1) the Medicare Integrity Program (MIP); 2) the Federal Bureau of Investigation (FBI); and 3) the HCFAC Account, which is divided annually among the HHS Office of the Inspector General (OIG), other HHS agencies, and law enforcement partners at the Department of Justice (DOJ). These dollars fund efforts to combat health care fraud, waste, and abuse, including prevention activities, provider education, data analysis, audits, investigations, and enforcement.

Mandatory HCFAC funding has a proven record of returning money to the Medicare Trust Fund for each dollar spent. For MIP, the actual return on investment (ROI) averages 14 to 1, and for the HCFAC Account, the ROI averages 6 to 1. From 1997 to 2008, HCFAC activities (excluding MIP) have returned over $13 billion to the Trust Fund. MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade. In FY 2008 alone, more than $1.9 billion in recoveries were returned to the Trust Fund and approximately $344 million in Medicaid recoveries were returned to the Treasury as a result of program integrity efforts.

Health Care Fraud and Abuse Control (HCFAC)
(dollars in millions)

	2010 Base	2011	2012	2013	2014	2015	2011-2015
Mandatory Base Funding	1,172	1,172	1,172	1,172	1,172	1,172	5,860
Discretionary Funding	311	561	589	619	649	682	3,100
Total Program Level	**1,483**	**1,733**	**1,761**	**1,791**	**1,821**	**1,854**	**8,960**
Savings from Discretionary Investment:	**-485**	**-740**	**-860**	**-910**	**-960**	**-1,000**	**-4,470**

HCFAC Discretionary Funds:
As part of a government-wide proposal to fund successful program integrity activities through an adjustment to discretionary spending totals, the FY 2011 Budget requests $561 million in discretionary HCFAC funding, an increase of $250 million over FY 2010. This total will be allocated as follows:

- Medicare: $328.4 million
- Medicaid: $47.7 million
- DOJ: $90.0 million
- OIG: $94.8 million

The additional funding will better equip HHS and its DOJ partners to prevent improper payments, increase data sharing, strengthen our field presence, and ensure greater value for program expenditures.

This investment supports initiatives of the newly established joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) task force by adding up to 13 new Strike Force cities to combat fraud and abuse on the front lines, which would bring the total number of Strike Force cities to 20. The HEAT task force is a joint effort between HHS and DOJ that has made fighting health care fraud a Cabinet level priority. It brings together the best minds and resources from two Departments to share best practices, prosecute criminals, and recover billions in taxpayer dollars.

Strike Forces have a proven record of success in combating Medicare and Medicaid fraud. Since March 2007, Strike Force cases that included HHS agents have obtained 200 convictions, 500 indictments, and an estimated $235 million in expected recoveries. The FY 2011 Budget builds on this effective Strike Force model.

The additional $250 million in discretionary funding will also expand data sharing and coordination between HHS and DOJ. This increased data sharing will not only help stop fraudulent schemes and practices before they take root, but will also expose

Combating Health Care Fraud

The Budget fulfills the President's commitment to strengthen efforts to combat health care fraud and abuse with a $250 million discretionary HCFAC increase, the largest one-year increase in HCFAC since its inception in 1997.

The entire program integrity initiative in the Budget will generate nearly $25 billion in Medicare and Medicaid savings over ten years, including $15 billion in savings from seven proposals to strengthen program integrity oversight and $10 billion from estimated return-on-investment savings resulting from the discretionary investment.

The increased discretionary funding supports efforts of the newly launched HHS-DOJ HEAT Task Force. Specifically, it can finance up to 13 new Strike Force cities, bringing the total number of cities to 20.

systemic vulnerabilities that have been exploited by fraudulent health care providers. Investment in cutting-edge technology and data mining technologies will allow for the analysis of potential fraud with unprecedented speed and efficiency, such as receiving snapshots of fraudulent claims activity in real-time and completing analyses that previously took months or years in a matter of days.

Finally, the increased funding will cover the implementation costs of new authorities that will provide CMS with better tools to carry out its program integrity activities.

Based on the proven success of the mandatory HCFAC program, it is expected that this additional discretionary investment will also aid in the reduction of improper payments and recoup many times its initial investment.

CMS actuaries currently estimate that for every new dollar spent by HHS to combat health care fraud, $1.55 is saved or averted. Based on these projections, the $561 million in HCFAC discretionary funding will yield Medicare and Medicaid savings of $4.5 billion over five years and $9.9 billion over ten years.

NEW PROGRAM INTEGRITY PROPOSALS

The Budget includes seven new legislative and administrative proposals to fight Medicare and Medicaid fraud and abuse, saving almost $14.7 billion over ten years, $13 billion through proposed legislation and $1.7 billion through administrative policies.

Legislative Proposals

Modify Medical Review Limitations: Modify existing statutory provisions that currently limit random medical review and place statutory limitations on the application of Medicare prepayment review. [Effective CY 2011]

Establish a CMS-Internal Revenue Service (IRS) Data Match to Identify Fraudulent Providers: Authorize CMS to work collaboratively with the IRS to determine which providers have not filed Federal tax returns to help identify potentially fraudulent providers sooner. The data match will primarily target certain high-risk provider types in high-vulnerability areas. This proposal also ensures that both IRS and Medicare recoup any monies owed to the Federal government through this program. [Effective CY 2013]

Extrapolate Medicare Advantage Plan Sample Error Rate to Entire Plan Payment in Risk Adjustment Audits: Clarify in statute that CMS can extrapolate the error rate found in the risk adjustment validation (RADV) audits to the entire MA plan payment for a given year when recouping overpayments. [Effective CY 2011]

Track Drug Utilizers and Prescribers to Reduce Over-utilization under Medicaid: Require States to monitor and remediate high-risk billing activity, not just claims limited to high volume, to improve Medicaid integrity and beneficiary quality of care. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes of care where possible. [Effective FY 2011]

Administrative Proposals

Consolidate Medical Review: Consolidate medical review activities into fewer Medicare Administrative Contractors (MACs) to promote efficiency and encourage consistency in reviewing and paying for Medicare claims.

Consolidate Medicare Provider Enrollment Activities: Create a limited number of MACs to carry out provider enrollment. Each contractor would enroll providers for designated regions of the country, standardizing the process and creating efficiencies.

Expand Medicare Revocations for Abuse of Billing Privileges: Allow CMS to revoke Medicare billing privileges in response to abusive billing practices, such as instances where the provider claims to have provided a service or supply, but the beneficiary and/or physician attest that they did not receive and/or prescribe the service.

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law:				
Benefits /1	240,575	264,298	257,878	-6,420
State Administration	10,349	11,070	13,567	+2,497
Recovery Act Impact (non-add) /2	*31,586*	*39,353*	*17,433*	
Total Net Outlays, Current Law	**250,924**	**275,368**	**271,446**	**-3,922**
Proposed Law:				
Legislative Proposals	--	15	25,395	+25,380
Total Net Outlays, Proposed Law	**250,924**	**275,383**	**296,841**	**+21,458**

1/ Includes Vaccines for Children outlays.

2/ Represents the impact of the American Recovery and Reinvestment Act of 2009 on the level of Benefits and State Administration in the Medicaid program. For more information please see the Recovery Act Chapter.

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans and is a central component of our Nation's medical safety net, providing health coverage to millions who would otherwise be unable to obtain health insurance. In FY 2011, an estimated 56 million people will receive health coverage through Medicaid.

Although the Federal government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal Government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP) which can be no lower than 50 percent. For FY 2009, FY 2010, and part of FY 2011, State FMAP rates are adjusted to reflect temporary increases enacted by the Recovery Act.

Medicaid beneficiaries include children, the aged, blind, and/or disabled, and people who meet certain minimum income eligibility criteria. States also have the flexibility to extend coverage to higher income groups through waivers and amended State plans to provide benefits to larger groups of beneficiaries. In FY 2011, the Federal share of current law Medicaid outlays is expected to be $271 billion. This is a $4 billion (1.4 percent) decrease below projected FY 2010 spending, mainly due to the end of the Recovery Act's increased match rate.

Medicaid Enrollment
(enrollees in millions)

	2009	2010	2011
Aged 65 and Over	4.8	4.9	5.1
Blind and Disabled	9.0	9.3	9.5
Children	25.4	27.0	27.8
Adults	11.5	12.4	12.8
Territories	1.0	1.0	1.0
Total	**51.7**	**54.6**	**56.1**

Source: CMS Office of the Actuary estimates

Six-month Extension of the Recovery Act Temporary Increase in Medicaid FMAP

The Recovery Act provides a temporary increase in the Federal medical assistance percentage (FMAP) through December 31, 2010. The FY 2011 President's Budget proposes to provide this increased match rate to States through June 2011, providing an additional $25.5 billion in Federal support to States.

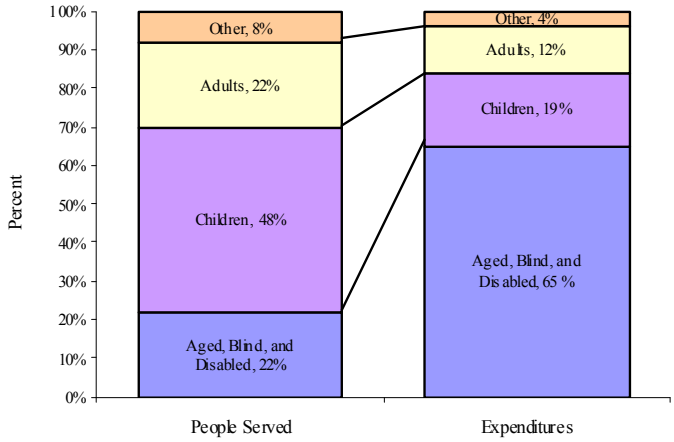
HOW MEDICAID WORKS

States are required to cover individuals who meet certain minimum categorical and financial eligibility levels, including individuals who qualified under the former Aid to Families with Dependent Children program, most Supplemental Security Income (SSI) recipients, pregnant women and children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL), and children ages 6 through 18 whose family income is below the FPL, all of whom are commonly referred to as the "categorically eligible." States may also cover medically needy individuals. These individuals meet the categorical eligibility criteria, but have too much income or resources to meet the financial criteria. These individuals include pregnant women, children under age 18, newborns, and certain blind individuals, among others. For more information, see http://aspe.hhs.gov/poverty/09poverty.shtml.

Recovery Act: Medicaid Health IT Incentive Payments

The Recovery Act provides an estimated $10 billion over ten years for incentive payments to eligible Medicaid providers for efforts to adopt, implement, upgrade, and meaningfully use certified EHRs. These incentive payments will help improve health care quality, efficiency, and safety for Medicaid beneficiaries.

FY 2008 – Percent of Medicaid Beneficiaries vs. Payments (by beneficiary group)



Source: Medicaid Statistical Information System, FY 2008, CMS.
Note: FY 2007 data used for AZ, HI, MI, ND, PA, TX, UT, VT and WI.

FY 2011 LEGISLATIVE PROPOSALS

Six-month Temporary FMAP Increase: To protect Medicaid access for low-income families and provide additional fiscal relief to States and support their Medicaid programs, the FY 2011 President's Budget includes a proposal to extend by six months the temporary increased FMAP that was first provided by the Recovery Act. The increased FMAP rate would be provided to States through June 30, 2011.

Program Integrity: Track Drug Utilizers and Prescribers to Reduce Over-utilization: This proposal improves Medicaid integrity and beneficiary quality of care by requiring States to track and monitor prescription drug billing, prescribing, and utilization patterns that could be indicative of abuse or over-utilization. For more information on this proposal and other program integrity initiatives, see the chapter on Program Integrity.

Performance Highlight

Improve Health Care Quality across Medicaid and CHIP through Implementation of CHIPRA Quality Initiatives:

As required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), HHS published a core set of child health quality measures in December 2009. CMS has developed a new performance goal to measure State adoption of these measures. Beginning in FY 2011, States will report on at least one core child health quality measure to CMS, with the target of at least 90 percent of States reporting.

- FY 2012 target: At least 90 percent of States report on 5 core measures to CMS.
- FY 2013 target: At least 90 percent of States report on 10 core measures to CMS.

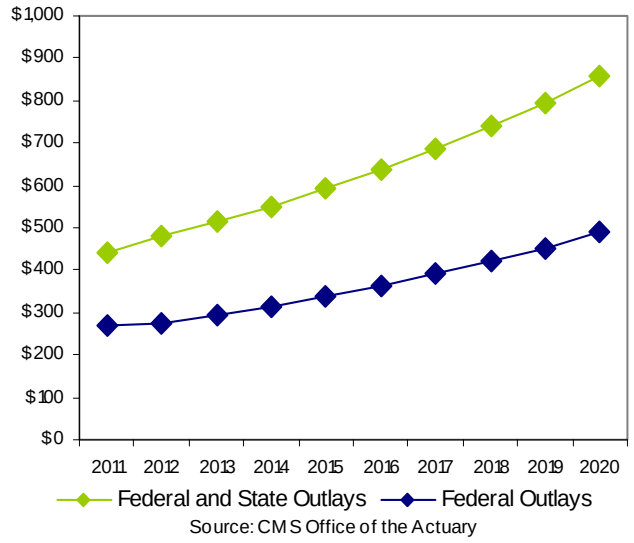
RECENT PROGRAM DEVELOPMENTS

American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

Temporary Increase in Medicaid FMAP: The Recovery Act provides a temporary increase in each State's FMAP rate from October 1, 2008 to December 31, 2010. In FY 2009, CMS awarded over $34 billion to States to protect people whose Medicaid eligibility might otherwise have been at risk if State budget shortfalls resulted in Medicaid cutbacks, and to generate State economic activity.

Incentives for Adoption of Health Information Technology: The Recovery Act provides a 100 percent Federal match for incentive payments to Medicaid providers for the adoption and meaningful use of certified electronic health records (EHRs) and a 90 percent Federal match for State administrative expenditures. The Recovery Act also provides implementation funding for CMS. Several States have already begun planning activities for implementation of the Medicaid incentive payments. Incentive payments will likely begin in 2011.

Estimated State and Federal Medicaid Outlays
FY 2011-2020
(dollars in billions)



Source: CMS Office of the Actuary

Family Smoking Prevention and Tobacco Control Act of 2009 (P.L. 111-31)

This landmark legislation allows the Food and Drug Administration (FDA) to limit the amount of nicotine in cigarettes and place limits on certain marketing and labeling practices. The reduced negative health outcomes associated with a decrease in smoking as a result of this new law are estimated to lower Medicaid spending by almost $100 million by 2020.

Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) - Medicaid Provisions

Numerous provisions in the Children's Health Insurance Program Reauthorization Act of 2009 apply to both Medicaid and CHIP. Please refer to the CHIP chapter for updates on the implementation of these provisions.

MEDICAID PROPOSALS

(dollars in millions)

	2011	2011 -2015	2011 -2020
Medicaid Proposals			
Extend the Recovery Act Increased FMAP for 6 Months.....	+25,500	+25,500	+25,500
Track High Prescription Drug Utilizers and Prescribers.....	-120	-1,590	-4,200
Total, Medicaid Proposals	**25,380**	**+23,910**	**+21,300**
Medicaid Interactions			
Exclude refundable tax credits from means-tested programs /1.....	+15	+75	+150
Veterans Affairs Reduced Pension Extension /2.....	--	+1,330	+1,697
Total, Medicaid Interactions	**+15**	**+1,405**	**+1,847**

1/ This proposal is a multi-agency proposal with costs to Medicaid.
2/ This proposal is included in the Department of Veteran's Affairs FY 2011 Budget Request. The proposal results in Federal savings overall but is a cost to Medicaid.

CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law:				
Children's Health Insurance Program.....	7,547	8,903	10,285	+1,382
Child Enrollment Contingency Fund.....	--	200	200	--
Total Outlays	**7,547**	**9,103**	**10,485**	**+1,382**

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. The BBA appropriated almost $40 billion in mandatory funding to the program over 10 years (FY 1998 through FY 2007). The program was extended by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) through March 2009 with supplemental appropriations for States experiencing shortfalls in FY 2009 funding.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized the CHIP program through FY 2013, providing an additional $44 billion in funding over five years and creating several new initiatives to increase innovation and enrollment in the program.

HOW CHIP WORKS

CHIP is a partnership between Federal and State Governments that helps provide low-income 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. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

States with an approved CHIP plan are eligible to receive an enhanced Federal matching rate, which ranges from 65 to 85 percent of total costs for child health care services and program administration, drawn from a capped allotment. Since September 1999, every State, the District of Columbia, and all five Territories have had approved CHIP plans.

States have a high degree of flexibility in designing their programs. They can implement CHIP by expanding Medicaid, creating a separate title XXI program, or a combination of both approaches. As of December 2009, there were 12 Medicaid expansion programs, 18 separate programs, and 26 combination programs among the States and Territories.

In FY 2009, an estimated 8.3 million individuals were enrolled in CHIP at some point during the year. This represents an increase of 7.8 percent over FY 2008 enrollment.

RECENT PROGRAM DEVELOPMENTS

Children's Health Insurance Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3): In addition to providing access to health care coverage for a greater number of uninsured children, additional resources in CHIPRA also supports the goals of improving the quality of child health care, increasing enrollment and retention of difficult to reach populations, and expanding the range of services available to children enrolled in CHIP.

Financing CHIP: The funding for CHIP allotments to States increased under CHIPRA by $44 billion in FY 2009 through FY 2013 for a five-year total of $69 billion. This expansion allowed for better funding predictability at the State

Performance Bonus Payments

In December 2009 CMS awarded more than $72 million to States that made significant improvement in enrolling children in Medicaid and title XIX CHIP programs in FY 2009.

- To qualify for a bonus payment, States must perform five of eight specific enrollment and retention activities set out in CHIPRA.
- Performance bonus payments were awarded to States that exceeded a target enrollment figure. Alaska, Alabama, Illinois, Louisiana, Michigan, New Jersey, New Mexico, Oregon, and Washington received performance bonus payments for FY 2009.

level. A Child Enrollment Contingency Fund was established for States that predict a funding shortfall based on higher than expected enrollment. The contingency fund received an initial appropriation of $2.1 billion in FY 2009 and is invested in interest bearing securities of the United States.

Increasing Enrollment and Improving Retention: CHIPRA provided $100 million in funding for grants to States, community-based organizations, Indian health care providers, and other local entities to perform outreach and enrollment work. Through this funding CMS will assist States to provide health care coverage to low-income children eligible for CHIP or Medicaid, but not yet enrolled. (See the State Grants and Demonstrations section for details.) CHIPRA included new State plan options for facilitating enrollment and retention of children into CHIP and the Medicaid program, such as Express Lane Eligibility (ELE). Under ELE, findings of income and other criteria are obtained from tax records or public services agencies to streamline enrollment in

Medicaid and CHIP. CMS has been working closely with States to develop this option and identify opportunities for data sharing with other agencies.

States are also able to take advantage of new opportunities to provide premium assistance to families with access to employer-sponsored insurance for their children that would be unaffordable if not for the subsidies.

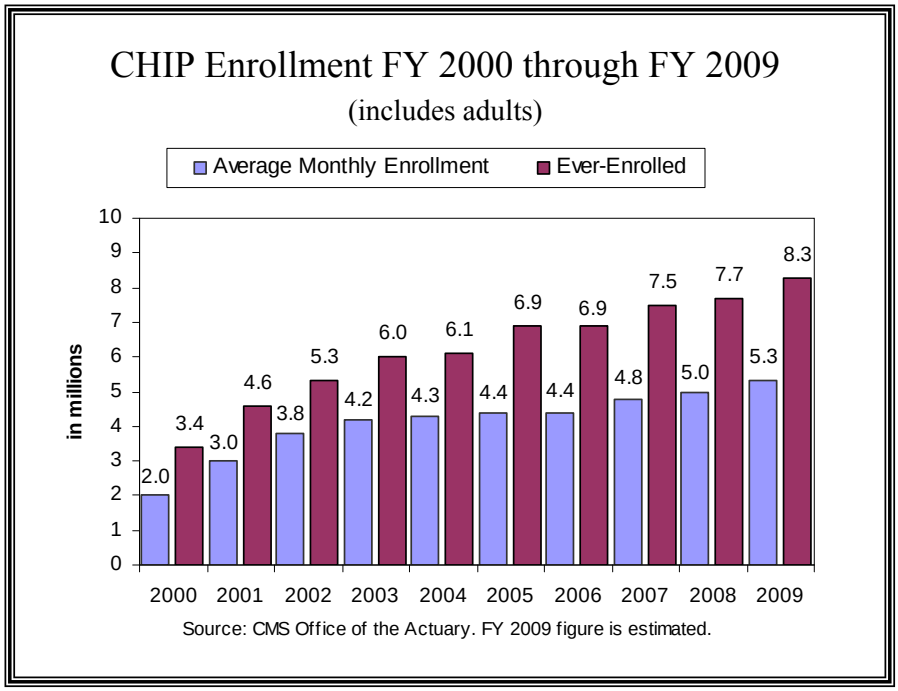
Improving Quality: Under the authority and funding provided by CHIPRA, CMS is undertaking new activities to improve the quality of child health care provided by CHIP and Medicaid. In 2009, an expert panel consisting of State and Federal stakeholder groups identified a core set of existing child health measures to be applied to CHIP and Medicaid programs (see inset on Performance Highlight in Medicaid section).

Partnerships with the Agency for Healthcare Research and Quality (AHRQ) will result in development of new child health quality measures, a model electronic health record for children, and technical assistance to States in developing quality improvement programs. In FY 2010, up to ten States and child health providers will receive grant funding to conduct demonstrations for improving quality of children's health care under CHIP and Medicaid.

Expanding Services: CHIPRA created a State option to provide coverage under Medicaid and CHIP for otherwise eligible pregnant women and children who are lawfully residing in the United States, without application of a five-year waiting period. To date, 24 States have submitted proposals to elect this option in Medicaid and/or CHIP.

To ensure children in CHIP receive a full spectrum of health services, CHIPRA added provisions to title XXI to guarantee that States provide mental health and substance abuse services on par with medical and surgical services through their CHIP State plans, and that all CHIP enrollees are provided coverage of dental benefits.

Additional information regarding implementation of these provisions can be located here: http://www.cms.hhs.gov/CHIPRA/05_Guidance.asp.



Performance Highlight

Decrease the Number of Uninsured Children by Working with States to Enroll Children in CHIP: In FY 2008, CMS reported an 11 percent increase in enrollment over the FY 2006 baseline, substantially exceeding the target of a two percent increase. This measure was rebased for FY 2009 with the following targets for children ever-enrolled during the year:

- **FY 2009**: + 1% over FY 2008
- **FY 2010**: + 5% over FY 2008
- **FY 2011**: + 7% over FY 2008

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law Budget Authority:				
CHIP Outreach and Enrollment Grants	100	--	--	--
CHIP Grants for Prospective Payment System Transition	5	--	--	--
Medicaid Integrity Program	75	75	75	--
Psychiatric Residential Treatment Demo. and Evaluation	49	53	57	+4
Money Follows the Person (MFP):				
MFP Demonstration	349	399	449	+50
MFP Evaluation	1	1	1	--
Expansion of State Long-Term Care Partnership Program	3	3	--	-3
Ticket to Work Grant Programs	46	47	47	--
Rescission of Section 204 funding	-22	--	--	--
Drug Surveys and Reports	5	5	--	-5
Total, Current Law B.A.	**612**	**583**	**629**	**46**
Current Law Outlays:				
CHIP Outreach and Enrollment Grants	2	25	32	+7
CHIP Grants for Prospective Payment System Transition	--	2	3	+1
Medicaid Integrity Program	53	133	75	-58
Psychiatric Residential Treatment Demo. and Evaluation	4	30	29	-1
Money Follows the Person (MFP):				
MFP Demonstration	64	425	681	+256
MFP Evaluations and Technical Support	2	2	2	--
Expansion of State Long-Term Care Partnership Program	1	3	3	--
Ticket to Work Grant Programs	73	136	100	-36
Drug Surveys and Reports	-- *	-- *	--	--
Medicaid Transformation Grants /1	39	51	26	-25
Emergency Services for Undocumented Aliens /1	181	111	70	-41
High Risk Pools /2 /3	3	1	-- *	--
Katrina Hurricane Relief /4	60	36	-- *	-36
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants /5	2	--	--	--
PACE Funds for Outlier Costs /6	--	2	4	+2
Alternate Non-Emergency Network Providers /4	14	23	11	-12
Total, Current Law Outlays	**498**	**980**	**1,036**	**56**

1/ FY 2009 through FY 2011 outlays are from FY 2008 budget authority.

2/ FY 2009 and 2010 outlays are from FY 2006 budget authority.

3/ The Consolidated Appropriations Act, 2010 (P.L. 111-117) appropriated $55 million for State High Risk Pools for FY 2010, which are administered in the Program Management budget.

4/ FY 2009 through 2011 outlays are from FY 2006 budget authority.

5/ FY 2009 outlays from FY 2006 budget authority.

6/ FY 2010 and FY 2011 outlays from FY 2007 budget authority.

* Outlays are less than $500,000

STATE GRANTS AND DEMONSTRATIONS

The State Grants and Demonstrations budget funds a diverse group of program activities. The Children's Health Insurance Program Reauthorization Act of 2009; the Deficit Reduction Act of 2005; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and the Ticket to Work and Work Incentives Improvement Act of 1999 added many activities to this account.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009 (P.L. 111-3)

Outreach and Enrollment Grants: Section 201 of CHIPRA provided funding for Outreach and Enrollment Grants in the Children's Health Insurance Program (CHIP). The Act appropriates $100 million for FY 2009 available through FY 2013 for these grants, of which $90 million is allocated for competitive grants to States, community-based organizations, Indian Tribes, providers, schools, and other groups. Of this amount, $10 million is set aside specifically to increase enrollment of Indian children in Medicaid and CHIP. Another $10 million is dedicated to a national enrollment campaign to improve enrollment of eligible children in Medicaid and CHIP. (See highlight in this section for more details.)

Grants for Transitioning to a Prospective Payment System: Section 503 of CHIPRA provided $5 million for grants to States to help Federally Qualified Health Centers and Rural Health Clinics transition to a prospective payment system for CHIP. CMS anticipates awarding these grants in FY 2010.

DEFICIT REDUCTION ACT (DRA) OF 2005 (P.L. 109-171)

Medicaid Integrity Program: The Medicaid Integrity Program (MIP) was established by Section 6034 of the DRA and was implemented in FY 2006. Congress appropriated resources to the MIP as follows: $5 million in FY 2006, $50 million in each of FY 2007 and FY 2008, and $75 million in FY 2009 and for each year thereafter. States have the primary responsibility for combating fraud and abuse in the Medicaid system. HHS supports State efforts through contracting with eligible entities to carry out activities including reviews, audits, identification of overpayments, education, and technical support to States.

In collaboration with the Department of Justice, CMS also established the Medicaid Integrity Institute to provide State employees with a comprehensive program of course work encompassing all aspects of Medicaid program integrity. These initiatives are highlighted in annual reports found at: http://www.cms.hhs.gov/DeficitReductionAct/021_repcongress.asp. (See Program Integrity section for more information on HHS efforts to improve program integrity).

Alternatives to Psychiatric Residential Treatment Facilities for Children: This five-year demonstration (FY 2007-FY 2011) authorized by Section 6063 of the DRA provides up to 10 States with funds totaling no more than $217 million to provide home and community-based services as alternatives to psychiatric residential treatment facilities for individuals under the age of 21. In addition, $1 million is available for evaluation of the program.

Promoting Outreach and Enrollment in CHIP

- On September 30, 2009, CMS announced that 69 grantees in 41 States and the District of Columbia were awarded amounts totaling $40 million to perform outreach and enrollment activities through September 2011. Awardees will report on achievements in enrollment and retention of children in Medicaid and CHIP to facilitate dissemination of best practices.
- In April 2010, CMS will award $10 million in grants to improve outreach and enrollment of Native American and Alaskan Native children in Medicaid and CHIP.
- In November 2009, CMS kicked-off a national enrollment campaign with a National Children's Health Insurance Summit that brought together grantees, States, advocates, and members of the policy community. The campaign has also produced outreach and enrollment toolkits and revamped the www.insurekidsnow.gov website in support of State and local outreach efforts.

Money Follows the Person Demonstration: Section 6071 of the DRA established this demonstration that allows States to work toward sustaining their

Medicaid programs while helping individuals achieve independence. States are awarded competitive grants along with an increased Medicaid matching rate for transitioning individuals from an institutional setting to a qualified home or community-based setting.

The DRA appropriated $1.75 billion over five years (FY 2007 – FY 2011) for this demonstration, with grants committed to 31 States totaling $1.4 billion in FY 2007.

Expansion of State Long-Term Care Partnership Program: The expansion of the State Long-Term Care (LTC) Partnership Program, enacted under Section 6021 of the DRA, established authority for all States to implement LTC partnership plans that provide a dollar for dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual.

Medicaid Transformation Grants: Established by Section 6081 of the DRA, this program provides grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Performance Highlight

Medicaid Integrity Program, Percentage Return on Investment: To evaluate implementation and success of the Medicaid Integrity Program (MIP), CMS has developed a measure to demonstrate the program's return on investment (ROI). Through the program, CMS has Medicaid Integrity Contractors who review and audit provider claims to identify potential fraud, abuse, and overpayments. Overpayments identified and recouped are compared to the total Federal funding for the Medicaid Integrity Contractors to establish ROI. In FY 2009, these efforts yielded a 175 percent ROI which was well above the target of greater than 100 percent. The targets for FY 2009 and FY 2010 are greater than 100 percent ROI, and the FY 2011 target is greater than 200 percent ROI.

Further information on projects funded through the DRA can be found here: http://www.cms.hhs.gov/DeficitReductionAct/01_Overview.asp.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT (MMA) OF 2003 (P.L. 108-173)

Federal Reimbursement of Emergency Health Services Furnished To Undocumented Aliens: Section 1011 of the MMA appropriated $250 million per year in FY 2005 through FY 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified non-citizens who are not eligible for Medicaid and other public programs.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) OF 1999 (P.L. 106-170)

TWWIIA of 1999 authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. The authority to provide payments for the Demonstration to Maintain Independence & Employment in Section 204 expired September 30, 2009. The Medicaid Infrastructure Grants, established in Section 203, continues through FY 2011. More information about the grants can be found here: http://www.cms.hhs.gov/TWWIIA/01_Overview.asp

PROGRAM MANAGEMENT

(dollars in millions)

	2009	2009 ARRA	2010	2011	2011 +/-2010
Discretionary Administration					
Medicare Operations	2,266	--	2,336	2,357	21
Federal Administration	641	--	697	725	28
Survey and Certification	293	--	347	362	15
Research	30	--	36	47	12
Health Care Data Improvement Initiative	--	--	--	110	110
State High-Risk Pools /1	--	--	--	--	--
Total, Discretionary	**3,230**	**--**	**3,415**	**3,601**	**186**
Mandatory Administration					
Medicare Improvement Patient and Provider Act	183	--	35	38	3
Children's Health Insurance Program Reauthorization Act	5	--	--	--	--
State High Risk Pools	75	--	55	--	-55
American Recovery and Reinvestment Act	142	142	140	140	--
Total, Mandatory	**405**	**142**	**230**	**178**	**-52**
Reimbursable Administration (non-add) /2	*209*	*--*	*430*	*429*	*-1*
Subtotal, Discretionary and Mandatory	**3,635**	**142**	**3,645**	**3,779**	**134**
FTE /3	4,407	--	4,717	4,869	152

1/ State High Risk Pools recategorized as mandatory Program Management in 2009 and 2010.

2/ Includes Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program information campaign, and recovery audit contracts.

3/ FTE totals include FTE from other funding sources, including HCFAC, State Grants, reimbursable, and the Recovery Act. CMS will fund the following FTEs from these other sources: FY 2009 - 285 FTEs; FY 2010 - 441 FTEs; FY 2011 - 543 FTEs.

The FY 2011 discretionary budget request for CMS Program Management is $3.6 billion, an increase of $186 million over FY 2010. This request will allow CMS to continue to effectively administer Medicare, Medicaid and the Children's Health Insurance Program (CHIP). With the funding requested for FY 2011, CMS will achieve its priority goals: make targeted investments and increase security in information technology (IT); achieve optimal staffing levels; increase survey frequencies; administer new legislation; augment its research agenda; and administer basic operations.

HEALTH CARE DATA INITIATIVE

The Budget requests an initial investment of $110 million for the new Health Care Data Improvement Initiative. This initiative will transform the focus of CMS's data environment from claims processing to state-of-the art data analysis and information sharing. It will allow CMS to become a leader in value-based purchasing, improve systems security, and increase analytic capabilities and data sharing with key stakeholders, giving CMS the tools necessary to manage the Medicare and Medicaid programs of the future. The key objectives of this investment include:

- *Data Improvement:* Enhance the quality and timeliness of data so that CMS can conduct more robust data analysis to identify aberrant billing patterns using up-to-date, authoritative claims information.

Health Care Date Improvement Initiative (HCDII)

(dollars in millions)

Data Improvement	45
Medicare Transformation	16
Encounter Data for Medicare Advantage Plan Analysis	6
Modernize IT Infrastructure	34
Systems Security	5
Systems Sustainability for Medicare	5
Total	**110**

- *Medicare Transformation Initiative:* Transform payment systems to improve payment accuracy and provide the infrastructure for value-based purchasing and comparative effectiveness research.
- *Encounter Data for Medicare Advantage (MA) Plans:* Begin collecting, editing, and storing new data for 10 million MA beneficiaries, allowing CMS to more accurately risk adjust MA plan payments.
- *Modernize IT Infrastructure:* Improve the ability to track and store data so that CMS can respond more quickly to data requests from Congress and other partners, better address disaster recovery needs, and strengthen the security of sensitive beneficiary data being used internally and externally.
- *Systems Security:* Create an updated inventory and monitoring process which better detects, prevents, and responds to cyber-attacks.
- *Systems Sustainability for Medicare:* Sustain existing systems so that current operations can continue as CMS's data infrastructure is modernized over time.

OTHER BUDGET ACCOUNT SUMMARIES

Medicare Operations: The Medicare Operations request is $2.4 billion, an increase of $21 million above FY 2010. The Medicare Operations account funds mission-critical contractor and IT activities necessary to administer the Medicare program and implement activities required by legislation. Top priority activities for FY 2011 include:

- ***MIPPA Implementation:*** The Budget requests $89 million to continue implementing the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). This funding will supplement the mandatory appropriation provided in the law for implementation. The complexity and volume of provisions in MIPPA require additional administrative investment. Specifically, the request will allow CMS to continue implementing end-stage renal disease (ESRD) pay-for-performance.

- *Ongoing Contractor Operations and Support:* A little over 42 percent, or $998 million, of the FY 2011 Medicare Operations request supports ongoing contractor operations, 3.5 percent below the FY 2010 level. These savings have been achieved due to a multiyear commitment to radically reform Medicare's contracting system. Despite numerous bid protests slowing down the reform process, CMS plans to complete the conversion to 15 Part A/B Medicare Administrative Contractors (MACs) and four durable medical equipment Medicare Administrative Contractors (DME MACs) by the end of FY 2011. Contracting reform will generate $3.1 billion in Trust Fund savings over the next five years (FY 2010 – FY 2014) through more accurate payment of claims.

- *Beneficiary Education and Outreach:* The Budget includes $363 million for mandated and other beneficiary education and outreach activities through the National Medicare & You Education Program (described in a later section).

- *Healthcare Integrated General Ledger and Accounting System (HIGLAS):* The Budget requests $156 million to implement HIGLAS, a state-of-the-art accounting system for CMS. Of this total, $118 million supports ongoing HIGLAS operations at 25 contractors (MACs and the remaining legacy contractors) that will be operating HIGLAS by the end of FY 2010, and $37.7 million will be used to transition additional MACs to HIGLAS. HIGLAS yields significant savings and efficiencies through more rapid recovery collections, resulting in $387 million in projected earned interest through FY 2011. Apart from the budget request above, an additional $9 million will be used to perform financial statement audits.

- *IT Systems and Other Supporting Activities:* The Budget includes $732 million for IT systems and other support, such as: systems to manage and administer Medicare Advantage and the Part D benefit; CMS's data center and telecommunications infrastructure; and funding for HIPAA, qualified independent contractor appeals, Part B drug competitive bidding, operations support, claims processing investments, and the final stages of contracting reform.

This amount also includes $60.million to continue converting to ICD-10, a classification system of diseases, injuries, and medical conditions developed by the World Health Organization. The amount consists of $40 million for systems costs, code policy analysis, training, and planning requirements, as well as $20 million for the development of a new ICD-10 compliant transaction format for billing. The ICD-10 code set, currently used by much of the industrialized world, will make it easier to determine if a claim was appropriately billed, provide more specific data necessary for value-based purchasing, and help protect against fraud and abuse. Regulations promulgated January 2009 require CMS and other insurers to convert to ICD-10 by October 1, 2013.

Performance Highlight

CMS has a goal to reduce the use of physical restraints in nursing homes, an indicator of low quality of care in nursing homes. The use of restraints has declined dramatically from the 1996 baseline of 17.2 percent of residents. CMS exceeded its FY 2008 target, achieving an historic low level of 4 percent. This recent success can be attributed to CMS's major quality initiatives including CMS annual surveys, efforts of the Quality Improvement Organizations, and the national campaign entitled *Advancing Excellence in Nursing Homes*. The FY 2010 target is 3.8 percent, and the FY 2011 target is 3.7 percent.

Federal Administration: For FY 2011, the President's Budget requests $725 million for CMS Federal administrative costs, a $28 million increase over FY 2010.

Of this total, $592 million will support a Full Time Equivalent (FTE) complement of 4,326, an increase of 50 FTE over FY 2010. This staffing increase will enable CMS to administer increasing responsibilities resulting from legislation passed in recent years, such as the Recovery Act and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In addition, this staffing level will allow CMS to begin transformation of its data environment and position the agency to effectively manage the modernization of Medicare and Medicaid into the future.

Survey and Certification: The FY 2011 Survey and Certification request is $362 million, a $15 million increase over FY 2010. At this funding level, CMS will maintain the more frequent surveys of health facilities achieved in FY 2010. Prior to FY 2010, survey frequencies had steadily declined, potentially compromising the safety

and quality of care provided to beneficiaries.

All facilities participating in the Medicare and Medicaid programs must undergo an inspection when entering the program, and on a regular basis thereafter, to ensure compliance with Federal health, safety, and program standards. CMS contracts with State agencies to conduct these inspections. Between FY 2003 and FY 2011, the number of Medicare-certified facilities increased by 20 percent. CMS expects States to complete 25,500 certifications and over 55,000 complaint visits in FY 2011.

States will inspect long-term care facilities and home health agencies at their statutorily mandated frequencies. Survey frequencies for all other facility types will be maintained at no less than once every six years (see table this page). The funding in the Budget request is essential to ensure adequate oversight and improve the quality of care for Medicare-participating providers.

Research, Demonstrations, and Evaluation: The FY 2011 Research, Demonstrations and Evaluation request is $47 million, a $12 million increase over FY 2010.

Of this total, $30 million will be dedicated to expanding the Medicare and Medicaid research agenda. In addition to continuing existing research, CMS will develop new demonstration and pilot projects that will focus on payment reforms, such as better aligning provider payments with costs, providing higher quality care at a lower cost, and improving beneficiary education. Research projects conducted with this funding will advance efforts to change incentives in CMS payment systems to promote better outcomes and quality of care.

Survey and Certification Frequencies

Type of Facility	2009	2010	2011
Long-Term Care Facilities /1	Every Year	Every Year	Every Year
Home Health Agencies /1	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1% Per Year	2% Per Year	3.3% Per Year
Non-Accredited Hospitals	Every 5 Years	Every 3 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 3 Years	Every 2.6 Years
ESRD Facilities	Every 4.6 Years	Every 3 Years	Every 3 Years
Ambulatory Surgical Centers /2	Every 11.5 Years	Every 6 Years	Every 4 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Rays, Rural Health Clinics, and Ambulatory Surgical Centers	Every 11.5 Years	Every 6 Years	Every 6 Years

/1 Legislatively Mandated

/2 Does not reflect increased survey frequency of every 3 years in 2010 due to Recovery Act funding.

Additionally, the Medicare Current Beneficiary Survey (MCBS) is fully funded at $15 million within the request. The MCBS, a continuous, multi-purpose survey that represents the Medicare population, aids CMS in monitoring and evaluating the Medicare program.

The request also includes $2.5 million to fund Real Choice Systems Change grants. The grants will assist States in designing and implementing improvements to community-based support systems that enable people with disabilities and long-term illnesses to live and participate in the community.

National Medicare & You Education Program (NMEP): The total FY 2011 program level for NMEP is $436 million, an increase of approximately $39 million from the FY 2010 level. The NMEP program level includes funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and QIOs. Beneficiary education remains a top priority for CMS, as recent enhancements and changes to the Medicare program will give beneficiaries more responsibility for making their own health care decisions.

Of the total, $287 million, or 66 percent, supports the 1-800-MEDICARE call center, which provides customer service in English and Spanish. The request is $42 million higher than the FY 2010 level to support 30 million calls (an increase of 1.9 million over FY 2010), as well as salary increases for call center employees. CMS anticipates increased call volume mainly because of a projected increase in Medicare eligible beneficiaries, but continues to improve call center efficiencies.

The remaining NMEP funding supports other important beneficiary education activities. $53 million will be used to distribute about 45 million

Medicare & You handbooks, 1 million more than in FY 2010. Another $32 million will support 421 million page views at www.medicare.gov, 6 million more than FY 2010. Since one-on-one counseling is an important method to help beneficiaries navigate their health plan options, the Budget allocates $53 million for community-based outreach, including $50 million for State Health Insurance Assistance Program (SHIP) grants. The SHIP request will fund more than 12,000 counselors in more than 1,300 community based organizations that will provide one-on-one assistance to beneficiaries on complex Medicare related topics. Finally, NMEP includes $11 million for program support services and a multi-media Medicare education program to inform beneficiaries about their benefits and plan choices.

National *Medicare & You* Education Program

(dollars in millions)

Activity	2010	2011
Beneficiary Materials (e.g. Handbook).....	51.0	52.7
1-800-MEDICARE Toll Free Line /1.....	244.8	287.0
Internet/2.....	34.1	31.8
Community-Based Outreach /3.....	47.4	52.9
Program Support Services /2/4.....	18.9	11.3
Total, NMEP Program Level /5.....	**$396.3**	**$435.7**

/1 Includes funding previously allotted to Medicare contractors for claims-related inquiries

/2 FY 2011 QIO funding amounts are not included, as the 10th scope of work (SOW) has yet to be approved. This impacts the FY 2011 funding levels of the Internet and Program Support Services

/3 Includes State Health Insurance and Assistance Program (SHIP) grants

/4 Includes multi-media campaign and consumer research

/5 Includes funding from Program Management, user fees and QIOs.

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

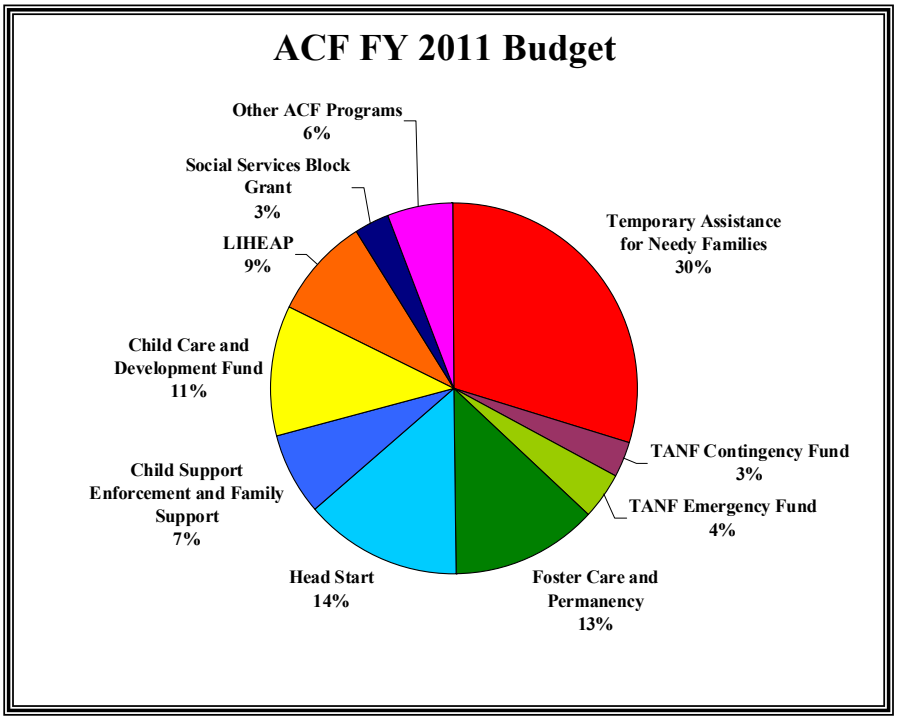
	2009	2010	2011	2011 +/- 2010
Discretionary /1				
Program Level	22,505	17,342	17,486	+144
Budget Authority	22,457	17,336	17,480	+144
Entitlement /2				
Budget Authority	38,652	34,284	41,329	+7,045
Total, ACF Budget Authority	**61,109**	**51,620**	**58,809**	**+7,189**
Total, ACF Budget Authority, Excluding Recovery Act	**50,144**	**49,490**	**58,809**	**+9,319**

1/ Includes Recovery Act funding of $5.1 billion in FY 2009.

2/ Includes Recovery Act funding of $5.8 billion in FY 2009 and $2.1 billion in FY 2010.

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

The FY 2011 Budget request for the Administration for Children and Families (ACF) is $58.8 billion, a net increase of $9.3 billion above FY 2010, excluding Recovery Act funding. ACF administers over 60 programs to fulfill its mission of serving America's children and families. The discretionary Budget includes additional funding for Head Start, Child Care, Refugee programs, and a new child welfare initiative. The mandatory Budget includes $17.4 billion for Temporary Assistance for Needy Families, $7.5 billion for Foster Care and related programs, $4.3 billion for Child Support Enforcement and Family Support, and $3.7 for Child Care Entitlement to States.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

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

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Head Start	7,113	2,100	7,235	8,224	989
Child Care and Development Block Grant (disc.)	2,127	2,000	2,127	2,927	800
Child Care Entitlement (non add)	*2,917*	--	*2,917*	*3,717*	*800*
Refugee Programs					
Transitional and Medical Services (TAMS)	282	--	353	417	64
Unaccompanied Alien Children (UAC)	205	--	149	207	58
Social Services and other Refugee Programs	228	--	228	253	25
Subtotal, Refugee Programs	715	--	731	878	147
Child Abuse Programs	110	--	97	107	10
Family Violence Prevention	131	--	133	145	11
Child Welfare/Adoption Assistance Programs	340	--	360	360	--
Adoption Opportunities (non add)	*26*	--	*26*	*39*	*13*
Children's Health Act Programs (non add)	*13*	--	*13*	--	*-13*
Adoption Incentives	37	--	40	42	3
LIHEAP 1/					
Formula Grants	4,510	--	4,510	2,510	-2,000
Contingency Fund	590	--	590	790	200
Subtotal, LIHEAP Discretionary Budget Authority	5,100	--	5,100	3,300	-1,800
Subtotal, Including Legislative Proposal (non add)	*5,100*	--	*5,100*	*5,300*	*200*
Promoting Safe and Stable Families (disc)	63	--	63	63	--
Runaway and Homeless Youth Programs	115	--	116	116	--
Mentoring Children of Prisoners	49	--	49	49	--
Chafee Education & Training Vouchers	45	--	45	45	--
Abstinence Education, discretionary	95	--	--	--	--
PHS Evaluation Funds	4	--	--	--	--
Abstinence Education, mandatory	38	--	--	--	--
Subtotal, Abstinence Education Program Level	137		--	--	--
Disaster Human Services Case Management	--	--	2	2	--
Community Services Block Grant	700	1,000	700	700	--
Other Community Services Programs	75	--	73	60	-13
Rural Community Facilities (non add)	*10*	--	*10*	--	*-10*
Job Opportunities for Low Income Individuals (non add)	*5*	--	*3*	--	*-3*
Subtotal, Community Service Programs	775	1,000	773	760	-13
Native Americans	47	--	49	49	--
Developmental Disabilities	184	--	187	187	--
Compassion Capital Fund (CCF)	48	--	--	--	--
Strengthening Communities Fund	--	50	--	--	--
Center for Faith Based and Community Initiatives	1	--	1	1	--
Social Services Research & Demonstration	14	--	20	3	-17
PHS Evaluation Funds	6	--	6	6	--
Subtotal, Social Services R&D	20	--	25	9	-17
Federal Administration	197	--	208	222	14
Total, Program Level	**17,355**	**5,150**	**17,342**	**17,486**	**144**
Less Funds From Other Sources:					
PHS Evaluation Funding	-10	--	-6	-6	--
Mandatory Abstinence Education	-38	--	--	--	--
Total, Budget Authority	**17,307**	**5,150**	**17,336**	**17,480**	**144**
FTE (including those financed with mandatory funds)	*1,246*		*1,422*	*1,471*	*+49*

*American Recovery and Reinvestment Act 2009

1/ The Budget includes a legislative proposal to provide an additional $2 billion based on the Administration's projections for energy prices and the number of people in poverty.

ADMINISTRATION FOR CHILDREN AND FAMILIES

The FY 2011 discretionary Budget request for ACF is $17.5 billion, a net increase of $144 million over FY 2010. Within this total, annual funding for early childhood programs is increased by $1.8 billion, including increases of $989 million for Head Start and $800 million for Child Care. The discretionary budget request for the Low-Income Home Energy Assistance Program (LIHEAP) is $3.3 billion, a $1.8 billion reduction from FY 2010, but the Budget includes a legislative proposal to provide an additional $2 billion in mandatory funds not reflected in the ACF discretionary total in response to higher energy prices and increases in the proportion of people in poverty.

Zero to Five Plan: As part of the President's Zero to Five Plan, the Budget provides significant increases to improve access to high quality, affordable child care and continue the major investments in Head Start expansion and quality made by the Recovery Act.

Head Start: The FY 2011 Budget request for Head Start is $8.2 billion, an increase of $989 million over FY 2010. Head Start will serve an estimated 971,000 children from birth to age five in FY 2011, approximately 66,500 more children than FY 2008. This number includes approximately 116,000 infants and toddlers in Early Head Start, nearly twice the number served in FY 2008. The FY 2011 funding increase will maintain services to children currently supported by the Recovery Act and provide a cost of living increase for grantees. The Budget also dedicates $118 million to improve Head Start program quality. Including requested FY 2011 funding, this Administration has invested nearly $500 million in improving the quality of Head Start programs.

Child Care: The Budget prepares for a reauthorization of the Child Care and Development Block Grant (CCDBG) and the Child Care Entitlement. The FY 2011 request for CCDBG is $2.9 billion, an increase of $800 million over the FY 2010 enacted level. The request also includes an $800 million increase to the Child Care Entitlement. Total funding for the Child Care and Development Fund is $6.6 billion in FY 2011, an increase of $1.6 billion over FY 2010. The proposal calls for mandatory child care funding to be adjusted for inflation in the years after FY 2011, representing a firm commitment to maintaining child care funding at these levels in the future and ensuring that these funds do not erode with inflation. The FY 2011 request serves 1.6 million children, approximately 235,000 more than would have otherwise been served. The Administration supports reforms in CCDBG that would establish a high standard of quality across child care settings, expand professional development opportunities for the child care workforce, and promote coordination across the spectrum of early childhood education programs.

PROMOTING THE WELL BEING OF CHILDREN AND FAMILIES:

Refugees: ACF provides services to newly arrived refugees and other entrants, unaccompanied alien children, and victims of trafficking and torture. New arrivals receive time-limited cash and medical assistance, English instruction, and job-training to help them achieve economic self-sufficiency as quickly as possible. ACF also has legal custody of unaccompanied alien children apprehended in the United States by the Department of Homeland Security or other law enforcement. Shelter is provided until these children's immigration relief claims are resolved or they can be released to relatives or sponsors.

The Budget includes $878 million for these activities, an increase of $147 million. This increase includes an additional $64 million for transitional cash and medical assistance for new arrivals and an additional $25 million for refugee social services – homelessness assistance and case management. These additional funds are requested because refugees are having more difficulty achieving self-sufficiency and making ends

Recovery Act

The Recovery Act provided $2.1 billion for Head Start, $1.1 billion of which was specifically for Early Head Start expansion. This historic investment is providing quality early childhood experiences to approximately 64,000 additional children, including 50,000 infants and toddlers. The Head Start program helps low-income children arrive at school ready to learn by enhancing their social and cognitive development through the provision of educational health, nutritional, social and other services. The program has served more than 25 million children since it began in 1965.

meet in the current economy. The overall increase also includes an additional $58 million to provide shelter to additional children, implement provisions of the Trafficking Victims Protection reauthorization, and locate additional shelter capacity closer to the border with Mexico where most children served by this program are apprehended. Since the annual costs of refugee cash and medical assistance are difficult to estimate, the Budget includes a new $25 million contingency fund which will remain available until expended.

Child Abuse Prevention: The Budget request includes $107 million for Child Abuse Prevention programs, an increase of $10 million. This funding prevents child abuse and neglect by improving investigations of abuse, training child protection workers, and enhancing the capacity of the program to prevent and treat child abuse and neglect. The additional $10 million will be used for a new competitive grant program to encourage States to use evidence-based practices for preventing child abuse and neglect.

Family Violence Prevention: The Budget includes $145 million for family violence prevention programs, an $11 million increase over FY 2010, which is the primary Federal-funding stream dedicated to the support of domestic violence shelters and services for victims of domestic violence and their dependents. The additional funding will be used to expand shelter capacity and support services, provide services to children who witness domestic violence, and support increased call volume to the Domestic Violence Hotline.

Child Welfare/Adoption Assistance: The Budget requests $360 million to promote the safety, permanency, and well being of children. Within this total, $13 million is redirected from two adoption programs authorized by the Children's Health Act to the Adoption Opportunities program. Funding is redirected because the Adoption Opportunities program can fund the Children's Health Act programs, but it has broader authority to help eliminate barriers to adoption, particularly for children with special needs.

Adoption Incentives: To increase the adoption of children, ACF provides bonuses to States if they increase the number of children adopted from their public foster care systems. Additional bonuses are provided for adoption of children nine and older, and for adoption of younger children with special needs. To fully cover anticipated State bonuses, the Budget includes $42 million, an increase of $3 million over FY 2010.

Performance Highlight

The percentage of Head Start and Early Head Start teachers with an Associates degree or higher, or a relevant credential, increased from 69 percent in FY 2005 to 77 percent in FY 2009, exceeding the FY 2009 target of 75 percent.

Low Income Home Energy Assistance: The Budget proposes a new way to fund the LIHEAP program to help low income households heat and cool their homes. The proposal will adjust annual funding levels according to changes in the need for assistance.

The Budget includes $5.3 billion in LIHEAP funding, $3.3 billion in discretionary funding and $2.0 billion in mandatory funds triggered by increases in energy prices and the percent of the population living in poverty (as measured by those receiving supplemental nutrition assistance).

A legislative proposal would provide this mandatory funding in FY 2011. Under this proposal, mandatory funds would be released almost immediately in response to changes in actual energy prices and the anticipated number of people receiving supplemental nutrition assistance.

Other Programs for Children and Youth: The Budget maintains funding for Promoting Safe and Stable Families to continue support for States' efforts related to child abuse prevention services and promote family preservation. It also includes $116 million for Runaway and Homeless Youth programs, the same as FY 2010, to make grants to public and private organizations that establish and operate shelters for youth, offer supportive services, like Transitional Living Programs, including Maternity Group Homes. The Budget maintains funding at $49 million for the Mentoring Children of Prisoners program to provide grants to eligible entities that support one on one mentoring for children of incarcerated parents and those recently released from prison. ACF will continue to enhance the quality of these mentorships by working with grantees to implement evidence-based models. To continue to provide post secondary educational assistance to foster care youth ages 16 to 21, the Budget includes $45 million for Chafee Education and Training Vouchers (Independent Living) providing up to $5,000 per participant for expenses like tuition, books, and other fees.

COMMUNITY AND OTHER ACF PROGRAMS

Disaster Human Services Case Management: The Budget requests $2 million to continue preparations to assist individuals affected by disasters regain self-sufficiency. This funding will be used to identify and pre-screen volunteers that will be ready to provide case management services in the event of a national disaster.

Community Services Programs: The FY 2011 Budget includes $760 million for Community Services Programs, a reduction of $13 million from FY 2010. The Budget maintains funding for the Community Services Block Grant, while discontinuing funding for two discretionary grant programs that finance projects that could be supported by other Federal funding streams.

The Budget maintains $36 million for Community Economic Development, including $20 million for community development corporations to develop projects specifically targeted toward improving access to grocery stores, farmers markets, and other venues for fresh groceries.

Native Americans: The Budget includes $49 million to assist Tribes and tribal communities in developing and supporting their local economies through business expansion, job creation, and improved provision of social services. In addition to these economic benefits, this funding also preserves Native American languages, builds the capacity of tribal governments, and improves tribal control of local natural resources.

Developmental Disabilities: The Budget includes $187 million to ensure that individuals with developmental disabilities have access to consumer-centered support services and have opportunities to participate in community life. This funding is also used to protect the legal and human rights of individuals with disabilities and to increase voter participation.

Research: There is a continuing need for research to help low-income families become economically self-sufficient, promote the social and cognitive development of young children, and assist at-risk youth in making a successful transition to adulthood. The Budget includes $9 million to support research and evaluation projects in these critical areas, including $3 million for an evaluation related to early childhood care and education.

Federal Administration: The Budget includes $222 million for the administration of ACF programs, an increase of $14 million that will enable ACF to meet new program responsibilities resulting from recently enacted legislation. This includes re-competition for certain Head Start grants under Head Start Reauthorization and the significant expansion of Head Start and Early Head Start programs since FY 2008.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

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

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law B.A.:				
Temporary Assistance for Needy Families (TANF) /1	17,059	17,059	16,740	-319
Supplemental Grants (non-add) /2	*319*	*319*	--	*-319*
TANF Contingency Fund /3	--	--	1,855	+1,855
TANF Emergency Fund /4	5,000	--	--	--
Child Care Entitlement to States	2,917	2,917	2,917	--
Child and Development Block Grant (non-add)	*4,127*	*2,127*	*2,127*	--
Child Care and Development Fund (non-add)	*7,044*	*5,044*	*5,044*	--
Child Support Enforcement and Family Support	4,282	4,789	3,583	-1,206
Recovery Act Child Support Enforcement (non-add)	*429*	*1,388*	--	*-1,388*
Foster Care and Permanency	7,218	7,381	7,219	-162
Recovery Act Foster Care and Permanency (non-add) /5	*389*	*425*	*118*	*-307*
Children's Research and Technical Asst.	58	58	52	-6
Promoting Safe and Stable Families (mandatory only)	380	380	360	-20
Social Services Block Grant	1,700	1,700	1,700	--
Abstinence Education	38	--	--	--
Total, Current Law B.A.	**38,971**	**34,284**	**34,426**	**+142**
Proposed Law B.A.:				
TANF	17,059	17,059	17,409	+350
Supplemental Grants (non-add) /2	*319*	*319*	*319*	--
Healthy Marriage Responsible Fatherhood (non-add) /6	*150*	*150*	--	*-150*
Fatherhood, Marriage, and Families Innovation Fund (non-add)	--	--	500	+500
TANF Contingency Fund	--	--	1,855	+1,855
TANF Emergency Fund /4	5,000	--	2,500	+2,500
Child Care Entitlement to States	2,917	2,917	3,717	+800
Child Care and Development Block Grant (non-add)	*4,127*	*2,127*	*2,927*	*+800*
Child Care and Development Fund (non-add)	*7,044*	*5,044*	*6,644*	*+1,600*
Child Support Enforcement and Family Support /7	4,282	4,789	4,256	-533
Recovery Act Child Support Enforcement (non-add)	*429*	*1,388*	--	*-1,388*
Foster Care and Permanency /8	7,218	7,381	7,455	+74
Recovery Act Foster Care and Permanency (non-add)	*389*	*425*	*118*	*-307*
Children's Research and Technical Assistance	58	58	58	--
Promoting Safe and Stable Families (mandatory only) /9	380	380	380	--
Social Services Block Grant	1,700	1,700	1,700	--
Abstinence Education /10	38	--	--	--
LIHEAP /11	--	--	2,000	+2,000
Total, Proposed Law B.A.	**38,652**	**34,284**	**41,329**	**+7,045**
Total, Proposed Law B.A. Excluding Recovery Act	**32,834**	**32,152**	**41,211**	**+9,059**

1/ TANF programs include family assistance grants to States and Territories, Matching Grants to Territories, TANF Supplemental Grants for Population Increases, Healthy Marriage and Responsible Fatherhood Grants, and Tribal Work Programs.
2/ The Recovery Act extended the TANF Supplemental Grants through FY 2010. The Budget extends the grants for one year.
3/ The Deficit Reduction Act of 2005 (DRA) extended the availability of unobligated Contingency Fund balances through FY 2010. The FY 2011 baseline assumes the fund is reauthorized at $1.855 billion, the same level available at the time DRA was enacted.
4/ The Recovery Act established a $5 billion TANF Emergency Fund for FY 2009 and FY 2010 to address rising costs related to basic assistance and other employment related services. The Budget proposes a new TANF Emergency Fund in FY 2011.
5/ The Recovery Act provision increasing the FMAP rate is effective FY 2009 through the first quarter of FY 2011.
6/ The Budget proposes to redirect funding for the Healthy Marriage and Responsible Fatherhood grants to the Fatherhood, Marriage, and Families Innovation Fund.
7/ The Budget includes $669 million for a proposal to extend for one year a provision in the Recovery Act that allows States to receive a Federal match for incentive payments reinvested in their child support programs.
8/ The Budget includes $214 million for a proposal to extend for six months a provision in the Recovery Act that increases the FMAP rate.
9/ The Budget includes a proposal to reauthorize the State Court Improvement Program.
10/ The Budget includes $183 million in the Office of Public Health and Science for teen pregnancy prevention programs that could include abstinence education.
11/ See ACF Discretionary Programs Section for further explanation.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

The FY 2011 Budget request for ACF Entitlements is $41.2 billion, a net increase of $9.1 billion over FY 2010, excluding Recovery Act funding. ACF serves the Nation's most vulnerable populations through entitlement programs such as Temporary Assistance for Needy Families, Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

The Budget proposes to extend several provisions originally enacted in the Recovery Act including a one-year extension of the TANF Supplemental Grants; a one-year resumption of State child support enforcement programs' ability to draw a Federal match by reinvesting incentive payments; and extending for six months the additional increase in the match for Foster Care, Adoption Assistance, and Guardianship Assistance. Other major increases are attributed to the modification and additional funding for the TANF Emergency Fund, the creation of a new LIHEAP mandatory funding trigger, additional funds for child care assistance, and creation of a Fatherhood, Marriage, and Families Innovation Fund.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

TANF provides approximately $17.1 billion annually to States, Territories, and eligible Tribes to support low income working families. The Deficit Reduction Act of 2005 (DRA) (P.L. 109-171) reauthorized TANF through FY 2010.

States have enormous flexibility under TANF to determine their own eligibility criteria, benefit levels, and types of services and benefits available to TANF recipients. In addition, States may transfer up to a combined 30 percent of their TANF funding to the Child Care and Development Fund (CCDF) and Social Services Block Grant (SSBG), with not more than 10 percent transferred to SSBG.

Since welfare reform was enacted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), States are spending less on cash assistance 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, compared to 33 percent in FY 2008.

The economic crisis has put enormous pressure on low-income families and TANF. The Recovery Act made several temporary changes to the TANF program to help States facing rising expenditures for TANF and other low-income families. In 2009, the Recovery Act's $5 billion Emergency Fund provided assistance to 37 States and 12 Tribes facing higher cash assistance caseloads and related spending, and increased spending on subsidized employment and non-recurrent short-term benefits for low-income families. The Recovery Act also extended the TANF Supplemental Grants through FY 2010, temporarily allowed certain adjustments to the caseload reduction credit, and permanently expanded use of TANF carry-over funds.

TANF LEGISLATIVE PROPOSALS

The Budget extends the TANF block grant and related programs,

Fatherhood, Marriage, and Families Innovation Fund

The Budget includes a legislative proposal for a new mandatory fund that would provide competitive grants to States for program innovations in two areas focused on helping hard-to-reach populations.

Strengthening families by investing in comprehensive responsible fatherhood initiatives. Programs might include expanding service provided through child support enforcement offices, funding comprehensive responsible fatherhood programs, eliminating barriers to employment, providing enhanced training, and employment opportunities. States will partner with non-profits and community organizations with these programs.

Improving child outcomes by improving outcomes for custodial parents facing serious barriers to self-sufficiency. Funded activities would focus on barriers to employment and could include interventions like home visitation, subsidized employment, transitional jobs, and mental health and substance abuse treatment.

General specifications for the fund include: Three-year grants to States on a competitive basis; States proposing activities supported by strong evidence will be prioritized; States that receive funding will be expected to rigorously evaluate programs; and, funds may be for statewide or community-specific initiatives.

including the Contingency Fund and Supplemental Grants, through FY 2011. It also creates a new Fatherhood, Marriage, and Families Innovation Fund that will provide competitive grants to States to conduct and evaluate comprehensive responsible fatherhood programs that rely on strong partnerships with community-based organizations as well as demonstrations geared toward improving child outcomes by improving outcomes for custodial parents experiencing serious barriers to self-sufficiency. The Budget assumes a cap on Contingency Fund obligations in FY 2011 to reflect its one-year extension. The Budget includes a legislative proposal that provides $2.5 billion for the TANF Emergency Fund. This proposal expands the allowable uses for the Emergency Fund made available by the Recovery Act and helps pay for increased expenditures on cash assistance, employment-related services (including subsidized jobs), and other related services in the States, Territories, and Tribes.

CHILD CARE ENTITLEMENT (CCE)

The Budget prepares for a reauthorization of the Child Care and Development Block Grant and the Child Care Entitlement. The FY 2011 request for CCES is $3.7 billion, an increase of $800 million over the FY 2010 enacted level. The request also includes an $800 million increase to the Child Care and Development Block Grant. Total child care funding for the Child Care and Development Fund is $6.6 billion in FY 2011, an increase of $1.6 billion over FY 2010. The proposal calls for mandatory child care funding to be adjusted for inflation in the years after FY 2011, representing a firm commitment to maintaining child care funding at these levels in the future and ensuring that these funds do not erode with inflation. In FY 2011, the request would enable 1.6 million children to receive child care assistance – approximately 235,000 more than could be served in the absence of these additional funds.

Child Care Performance: ACF continues its efforts to improve the quality of child care providers. In CY 2007, CCDF successfully encouraged 32 States to implement early learning guidelines linked to the education and training of caregivers, preschool teachers, and administrators. This performance exceeds the CY 2007 target of 28 States.

CHILD SUPPORT ENFORCEMENT (CSE) AND FAMILY SUPPORT PROGRAMS

CSE is a joint Federal, State, Tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. Title IV-D of the Social Security Act establishes child support services that are available for all families regardless of welfare status. The FY 2011 President's Budget request is $4.3 billion in net budget authority for CSE and Family Support Programs.

Custodial families that have never received TANF get all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some arrearage collections on behalf of former TANF recipients are shared between the State and Federal governments as reimbursement for providing TANF or Foster Care benefits. Beginning in FY 2009, the Federal government shares in the cost when States opt to distribute more collections directly to current and 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 by funding incentive payments.

The Recovery Act temporarily allowed States to use Federal incentive payments as their State share of expenditures eligible for Federal match in FY 2009 and FY 2010. States receive Federal incentive payments based on their performance in paternity establishment, support order establishment, collection of current support and arrearages,

Recovery Act

- To date, 37 States and 12 Tribes have accessed the $5 billion Emergency Fund available to provide assistance to States, Tribes, and Territories facing higher cash assistance caseloads and related spending, and increased spending on subsidized employment and non-recurrent short-term benefits for low-income families. These funds are available through FY 2010.
- Provides an estimated $929 million to States for a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) rate used to determine the Federal match for maintenance payments for Foster Care, Adoption Assistance, and Kinship Guardianship through December 2010.
- Temporarily restored States' ability to use Federal child support incentive payments as their State share of expenditures eligible for Federal match, bringing an estimated $1.8 billion to support State efforts.

and cost-effectiveness.

The CSE program also provides $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation with their children.

Other family support programs funded in this account include Payments to Territories and Repatriation. Payments to Territories funds approximately $33 million in State maintenance assistance programs for eligible aged, blind, and disabled residents of Guam, Puerto Rico, and the Virgin Islands, per Title XVI of the Social Security Act.

The Repatriation program, authorized by section 1113 of the Social Security Act and the Act of July 5, 1960, provides assistance to United States citizens and their dependents who are returning from foreign countries and are deemed to be destitute, mentally ill, or in need of emergency evacuation due to threatened armed conflict, civil strife, or natural disasters. The cap for this program is $1 million annually, although it has been necessary to raise or lift the cap in the past. In the aftermath of the earthquake that devastated Haiti, Congress, the Administration, and the States have recently focused on the program.

CSE Legislative Proposals

The Budget includes four legislative proposals for this program. The request includes a one-year extension of States' ability to draw a match when they reinvest incentive payments in their respective programs provided by the Recovery Act. This will allow States to maintain program efforts. The Budget also includes two child support proposals aimed at increasing collections. Together these two proposals will increase child support collections by $271 million over five years.

Performance Highlight

The Child Support Enforcement (CSE) program continues to make strong gains in child support collections as well as support order and paternity establishment. In FY 2008:

- Child support collections reached $26.6 billion, a seven percent increase from the previous year.
- 1.8 million paternities were established and acknowledged, a 3.1 percent increase from the previous year.
- CSE achieved a 96 percent paternity establishment rate, exceeding its target of 95 percent in 2008.
- CSE surpassed its target for establishing child support orders, generating support orders for 79 percent of all child support cases, which is four percentage points above the target of 75 percent for 2008.
- For every dollar invested in the program, CSE collected $4.80 in child support, exceeding the target of $4.63. CSE aims to increase the cost effectiveness ratio to $4.84 by FY 2011.

Recognizing that healthy families need more than financial support alone, the fourth FY 2011 proposal would increase resources for Access and Visitation Programs by $2 million to support and facilitate non-custodial parents' access to and visitation with their children. In FY 2011, these four proposals will cost $672 million in new budget resources with an expected $558 million to be spent in FY 2011.

Children's Research and Technical Assistance

The Budget request includes $58 million for activities in three areas: child support enforcement training and technical assistance; operation of the Federal Parent Locator Service (FPLS) which assists States in locating absent parents; and research on welfare and child well-being. Of the total, $12 million will fund child support enforcement training and technical assistance, and $25 million will support FPLS operations. The remaining $21 million will fund a proposal for a one-year extension of funds for welfare research ($15 million) and for the National Survey of Child and Adolescent Well-Being ($6 million), a longitudinal study on the well-being of children who come into contact with the child welfare system.

Foster Care and Permanency

The Budget request for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs is $7.5 billion in budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence.

Of the total request, $4.6 billion in budget authority will support the Foster Care program, including maintenance payments to children. This is a $36 million decrease from the FY 2010 level. The proposed level of funding will support approximately 168,200 children each month, about 6,500 fewer children than in FY 2010. This is partially due to placement of more children in permanent settings. It is also due to a reduction in the foster care children funded under the Federal program because the income eligibility criteria required by statute is tied to the old Aid to Families with Dependent Children (AFDC) which has resulted in the payment's value eroding over time due to inflation.

The Budget also includes $2.5 billion in budget authority for the Adoption Assistance program, an increase of $84 million above the FY 2010 enacted level. This increase reflects a rise in the number of children participating in the Adoption Assistance program, as well as the legislative proposal to extend the enhanced Federal Medical Assistance Percentage (FMAP) match rates for maintenance payments for an additional two quarters through June 30, 2011. An estimated average of 453,900 children per month, an increase of 19,600 over FY 2010, will have payments made on their behalf.

In FY 2011, the Budget includes $78 million for the Guardianship Assistance program, an increase of $27 million above FY 2010 reflecting an increase in the number of children participating in the Guardianship Assistance program, as well as the impact of the legislative proposal to extend the enhanced FMAP match rate for maintenance payments for an additional two quarters through June 30, 2011. An estimated average of 14,300 children per month, an increase of 5,800 over FY 2010, will have payments made on their behalf in FY 2011.

The Budget also contains $140 million in budget authority for the Independent Living Program, the same as the FY 2010 level. This program funds services for youth who will likely remain in foster care until they turn 18 and for former foster children between the ages of 18 and 21.

The Federal government uses the FMAP to match State maintenance payments for Foster Care, Adoption Assistance, and Guardianship Assistance under Title IV-E of the Social Security Act. The Recovery Act temporarily increased the FMAP rate for these Title IV-E entitlement programs by 6.2 percentage points. It is estimated that States will receive an additional $929 million between October 1, 2008 and December 31, 2010 due to this provision.

FOSTER CARE AND PERMANANCY LEGISLATIVE PROPOSAL

The Budget includes a legislative proposal to extend the increased FMAP under the Recovery Act for six additional months. This proposal adds $237 million for States in their Federal match rate for maintenance payments for Title IV-E foster care, adoption assistance, and guardianship assistance. The increased match rate will help provide fiscal relief to States.

Foster Care and Permanency Performance: The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2008, the latest year for which complete performance data are available. Working with the States, these programs supported 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. In FY 2008, almost 84 percent of children who had been in care less than 12 months had no more than two placement settings, exceeding the target of 80 percent.

The programs also supported 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 was not possible. In FY 2008, almost 42 percent of children exited Foster Care (within two years of placement) either through guardianship or adoption, exceeding the target of 36 percent.

Promoting Safe And Stable Families (PSSF): The Budget maintains funding for PSSF to ensure continued support for a variety of important State child welfare activities, including post-adoptive services. This program has two distinct funding streams, one discretionary and one mandatory. The total FY 2011 Budget request for PSSF is $423 million. The mandatory portion of this Budget request provides funding for this capped entitlement at $360 million.

The Budget includes a proposal for a five-year reauthorization of $20 million in funds for two elements within the State Court Improvement program, improved data collection and training and collaboration between courts and child welfare agencies.

Promoting Safe and Stable Families Performance: In FY 2008 the percentage of children in Foster Care without a case plan goal was reduced to 3.4 percent, exceeding the goal of 5.9 percent. By increasing the proportion of cases with a case plan goal developed in a timely manner, ACF is helping to ensure that there is a focus on moving children from Foster Care to a permanent home.

SOCIAL SERVICES BLOCK GRANT (SSBG)

SSBG is a capped entitlement which provides flexible grants to States for the provision of social services ranging from child care to residential treatment. SSBG is funded at $1.7 billion for FY 2011, which is the same as the FY 2010 funding level. States have broad discretion over the use of these funds. SSBG funds are allocated to States according to population size.

ACF ENTITLEMENT- CURRENT LAW OUTLAYS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Current Law Outlays:				
Temporary Assistance for Needy Families (TANF) /1	17,861	17,753	17,462	-291
Recovery Act Supplemental Grants (non-add) /2	--	*255*	*64*	*-185*
TANF Contingency Fund /3	820	592	1,597	+1,005
TANF Emergency Fund /4	251	3,229	452	-2,777
Child Care Entitlement	2,952	2,925	2,915	-10
Child and Development Block Grant (non-add)	*2,353*	*3,393*	*2,670*	*-723*
Child Care and Development Fund (non-add)	*5,305*	*6,318*	*5,585*	*-733*
Child Support Enforcement and Family Support	4,352	4,710	3,766	-944
Recovery Act Child Support Enforcement (non-add)	*274*	*1,300*	*243*	*-1,057*
Foster Care and Permanency	6,859	7,403	7,228	-175
Recovery Act Foster Care and Permanency (non-add) /5	*258*	*500*	*154*	*-346*
Children's Research and Technical Assistance	63	63	62	-1
Promoting Safe and Stable Families (mandatory only)	387	349	373	+24
Social Services Block Grant	1,854	2,118	1,832	-286
Abstinence Education	20	22	10	-12
Total, Current Law Outlays	**35,419**	**39,164**	**35,697**	**-3,467**
Total, Current Law Outlays Excluding Recovery Act	**34,636**	**33,880**	**34,784**	**+898**

1/ TANF programs include family assistance grants to States and Territories, Matching Grants to Territories, TANF Supplemental Grants for Population Increases, Healthy Marriage Promotion and Responsible Fatherhood Grants, and Tribal Work Programs.
2/ The Recovery Act extended the TANF Supplemental Grants through FY 2010.
3/ In FY 2006, the Deficit Reduction Act of 2005 extended the availability of unobligated Contingency Fund balances through FY 2010. The FY 2010 beginning balance of $212 million was completely obligated by December 2009.
4/ The Recovery Act established a $5 billion TANF Emergency Fund to address rising costs related to basic assistance and other related services.
5/ The Recovery Act provision increasing the FMAP rate is effective FY 2009 through the first quarter of FY 2011.

ACF ENTITLEMENT LEGISLATIVE PROPOSALS

(outlays in millions)

	2010	2011	2011 - 2015	2011 - 2020
Temporary Assistance for Needy Families (TANF)				
TANF Contingency Fund /1	--	-1,240	--	--
TANF Emergency Fund /2	+508	+2,597	+3,500	+3,500
Extend Supplemental Grants for Population Increases	--	+255	+319	+319
Fatherhood, Marriage, and Families Innovation Fund /3	--	--	+500	+500
Healthy Marriage and Responsible Fatherhood Grants	--	-118	-150	-150
Subtotal	**+508**	**+1,494**	**+4,169**	**+4,169**
Child Care Entitlement /4	**--**	**+502**	**+4,436**	**+11,015**
Child Support Enforcement and Family Support Programs				
Federal Match for Incentive Payments	--	+555	+669	+669
Federal Seizure of Accounts in Multi-State Financial Institutions	--	+1	-2	-7
Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	--	--	-4	-9
Increase Access and Visitation Funding	--	+2	+2	+2
Subtotal	**--**	**+558**	**+665**	**+655**
Children's Research and Technical Asst. - Child Welfare Study	--	**+3**	**+6**	**+6**
Promoting Safe and Stable Families - State Court Improvement Program	--	**+1**	**+59**	**+100**
Increased Foster Care and Permanency FMAP Rate	--	**+214**	**+237**	**+237**
Create LIHEAP Mandatory Funding Trigger /5	--	**+1,460**	**+5,113**	**+6,406**
Total, ACF Proposals	**+508**	**+4,232**	**+14,685**	**+22,588**

1/ Under current law the Contingency Fund baseline assumes the fund will be reauthorized for five years at $1.855 billion in FY 2011 and FY 2016, and completely outlayed in FY 2011. Negative outlays in FY 2011 reflect the legislative proposal to limit FY 2011 obligations to 20 percent of total budget authority.

2/ The Budget assumes a legislative proposal that expands the allowable uses of funds under the Recovery Act's TANF Emergency Fund in FY 2010 and provides funding for a new TANF Emergency Fund in FY 2011.

3/ Due to their competitive nature, these grants are assumed to be awarded late September 2011; outlays would start in FY 2012.

4/ The Budget includes an additional $800 million in FY 2011 for the Child Care and Development Block Grant, the discretionary component of the Child Care and Development Fund.

5/ See ACF Discretionary Programs Section for further explanation.

ADMINISTRATION ON AGING

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Health and Independence					
Home and Community-Based Supportive Services	361	--	368	416	+48
Congregate Nutrition Services	434	65	441	446	+5
Home-Delivered Nutrition Services	214	32	218	221	+3
Native American Nutrition and Supportive Services	27	3	28	30	+2
Nutrition Services Incentive Program	161	--	161	161	--
Preventive Health Services	21	--	21	21	--
Subtotal, Health and Independence	1,219	100	1,237	1,295	+58
Caregiver Services					
Family Caregiver Support Services	154	--	154	202	+48
Native American Caregiver Support Services	6	--	6	8	+2
Alzheimer's Disease Supportive Services Program	11	--	11	11	--
Lifespan Respite Care	3	--	3	5	+3
Subtotal, Caregiver Services	175	--	175	227	+53
Protection of Vulnerable Older Americans					
Long-Term Care Ombudsman Program	16	--	17	18	+1
Prevention of Elder Abuse and Neglect	5	--	5	6	+0.5
Subtotal, Vulnerable Older Americans	21	--	22	23	+1
Network Support and Demonstrations					
Health and Long-Term Care Programs	28	--	31	30	-0.1
Program Innovations	18	--	19	13	-6
Aging Network Support Activities	14	--	14	14	--
Subtotal, Network Support and Demonstrations	60	--	63	57	-6
Health Care Fraud and Abuse Control**	3	--	3	3	+0.1
Chronic Disease Self-Management Programs	--	--	--	--	--
Medicare Enrollment Assistance**	18	--	--	--	--
Program Administration	19	--	20	23	+3
Total, Program Level	**1,515**	**100**	**+1,519**	**+1,628**	**+109**
Less Funds from Other Sources					
Health Care Fraud and Abuse Control **	-3	--	-3	-3	-0.1
Chronic Disease Self-Management Programs	--	--	--	--	--
Medicare Enrollment Assistance	-18	--	--	--	--
Total, Budget Authority	**1,494**	**100**	**+1,516**	**+1,625**	**+108**
FTE	**103**	**--**	**108**	**112**	**+4**

* American Reinvestment and Recovery Act of 2009 (Recovery Act)

**Funding from Medicare Trust Funds

ADMINISTRATION ON AGING

The mission of the Administration on Aging (AoA) is to help elderly individuals maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long-term care, and livable communities across the U.S.

The FY 2011 Budget requests $1.6 billion for the Administration on Aging (AoA), an increase of $109 million above FY 2010. Of this increase, $102.5 million will fund AoA's new Caregiver Initiative, of which $50 million will support caregiver services, such as counseling, training, and respite care; $50 million will support services to enable those elderly individuals with disabilities with routine daily activities such as transportation, homemaker assistance, adult day care; and $2.5 million will support respite for family members of any individual with special needs.

The request also provides continued support to demonstrate and evaluate evidence-based disease prevention programs, Aging and Disability Resource Centers, and other ongoing activities of national significance.

SUPPORTING FAMILY CAREGIVERS

Families are the Nation's primary provider of long-term care, but societal changes such as increasing geographic separation of families and smaller family sizes are placing great pressure on caregivers. Caregivers often experience conflicts between work and care-giving, with 25 percent reporting that they have had to make adjustments such as changing or reducing work hours.

As part the Caregiver Initiative, the FY 2011 Budget requests an additional $50 million to continue funding for programs that support caregivers. It also doubles funding, to $5 million, for the Lifespan Respite Care program which improves respite care for those caring to family members with special needs. Combined, these programs supporting caregiving provide information, assistance, counseling, training, respite, and other services which enable elderly individuals to remain independent and at home longer and less expensively. The Budget will support 755,000 caregivers with 12 million hours of respite care or temporary relief from their caregiving responsibilities. It will also provide more than 186,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving. Family caregivers value these services and 81 percent report that services enable them to care for their loved ones longer than otherwise would have been possible.

MAINTAINING HEALTH AND INDEPENDENCE

In order to serve a growing senior population, AoA's vision is to ensure the continuation of a vibrant aging services network at State, Territory, local and Tribal levels, through funding of lower-cost, non-medical services and supports that provide the means by which more seniors can maintain their health and independence. The Budget includes an additional $50 million to fund services including transportation assistance, case management, and information and referrals; in-home services such as personal care, chore, and help eating, dressing, and bathing; and community services such as adult day care and physical fitness programs to support seniors to remain independent in their communities. The Budget will support 28.5 million rides

Helping Middle Class Families Care for Aging Relatives

Caregiving responsibilities demand time and money from families who too often are already strapped for both. The Budget includes an additional $102.5 million to enable families to better care for their aging relatives and to support seniors trying to remain independent in their communities. The initiative builds on the successful network of agencies in local communities across the country that already provide critical help to seniors and their caregivers. More specifically, this initiative includes:

- An increase of $50 million for caregiver services, such as counseling, training, and respite care for the families of elderly individuals including Native Americans;
- An increase of $50 million for services such as transportation, homemaker assistance, adult day care, personal care assistance to elderly individuals and their families, including Native Americans; and,
- An increase of $2.5 million for respite for family members of people of all ages with special needs.

Recovery Act

In FY 2010, AoA will distribute $32 million in Recovery Act funds to improve seniors' ability to manage chronic diseases by following evidence-based chronic disease self-management programs that have been proven effective through randomized control trials.

AoA expects 50,000 individuals will complete a program to improve their management of chronic diseases. Data will also be collected to assess the impact on participant health behaviors, health status, health care utilization and health care costs.

for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; 33 million hours of assistance to seniors unable to perform daily activities; and over 9 million hours of care for adult day care, enabling working families to remain on the job. It will also provide one million rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

The Budget also requests $828 million, an increase of $8 million, for Nutrition services to ensure that millions of older adults have access to the nutritious food needed to stay healthy and decrease their risk of disability. The Budget will support 214 million home-delivered and congregate meals to over 2.3 million elderly individuals in a variety of community settings as well as 4.7 million meals to 66,000 Native American seniors.

The Budget maintains funding for activities that educate older adults about the importance of healthy lifestyles and that promote healthy behaviors that can prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions.

PROTECTING VUNERABLE OLDER AMERICANS

Up to 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone they depended on for care or protection. The Budget includes $6 million to enable States to develop and carry out comprehensive statewide systems of elder justice and elder rights protections. These programs address public education and outreach, coordination of services with adult protective services programs, law enforcement, protection and advocacy programs, licensure and certifications programs, and victim assistance programs. In addition, the Budget includes $18 million for Long-Term Care Ombudsmen services. The ombudsmen supported with this funding are advocates for residents of nursing homes and other adult residential care facilities. As part of this program, more than 12,000 individuals regularly visit long-term care facilities, monitor conditions and care, resolve problems of individual residents and provide a voice for those unable to speak for themselves.

SUPPORTING THE NATIONAL AGING NETWORK SERVICES

AoA identifies, evaluates, and replicates the best models and practices nationwide as part of its overall strategy for strengthening its core programs and the national aging services network. The Budget includes $30 million for Aging and Disability Resource Centers and Evidence-Based Disease Prevention programs, two examples of state-of-the-art approaches that AoA is continuing to evaluate and replicate in support of the core programs. In addition to these programs, the Budget also requests $27 million for ongoing activities of national significance and for investment in other innovative approaches to further strengthen the core programs.

PROGRAM ADMINISTRATION

A total of $23 million is requested in the Budget for program management and support activities, including costs associated with AoA's headquarters lease renewal and increases for purchase of external services, and to more effectively and efficiently address the needs of the growing aging population.

OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Teen Pregnancy Prevention…….....		110	179	+69
Other General Departmental Management.....	382	380	415	+35
Evaluation Activities.....	47	65	65	--
Health Care Fraud and Abuse Control.....	6	9	9	--
Subtotal, GDM Program Level	435	564	668	+104
Less funds from other sources:				
Evaluation Activities.....	47	65	65	--
Health Care Fraud and Abuse Control.....	6	9	9	--
Teen Pregnancy Prevention (mandatory funding for States).....	--	--	50	+50
Total, GDM Budget Authority	**382**	**490**	**544**	**+54**
FTE	1,358	1,417	1,417	--

General Departmental Management supports the Secretary in her role as chief policy officer and general manager of the Department.

The FY 2011 Budget request for General Departmental Management (GDM) is $668 million, a net increase of $104 million. This request supports some grant programs as well as 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 12 Staff Divisions and Offices in GDM.

The FY 2011 Budget request provides increased funding for a variety of critical activities.

Teen Pregnancy Prevention: The FY 2011 Budget request to support community-based efforts to reduce teen pregnancy totals $179 million, an increase of $69 million over FY 2010. These efforts will be managed through the newly established Office of Adolescent Health (OAH), in the Office of Public Health and Science, which will coordinate with the Centers for Disease Control and Prevention (CDC) and other HHS Operating Divisions in implementing teenage pregnancy prevention programs. Funding of $125 million will be used for: replicating programs that have proven effective through rigorous evaluation to reduce teenage pregnancy; research and demonstration grants to develop, replicate, refine and test additional models and innovative strategies; and training, technical assistance and outreach. The Budget also requests $50 million in mandatory funds for new formula grants to support teen pregnancy prevention efforts in States, Tribes and Territories. Also provided in the request is $4 million to carry out longitudinal evaluations of teenage pregnancy prevention approaches. In addition to the $179 million, $4 million is also provided in PHS evaluation funds for this activitiy. Also, the FY 2011 Adolescent Family Life (AFL*)* Budget includes a total of $17 million to provide support for AFL Care demonstration grants and research programs. In an effort to ameliorate the negative effects of childbearing on teen parents, their infants and their families, care grant community-based projects develop, test and evaluate interventions with pregnant and parenting teens, and focus on ways to build and strengthen families.

Office of Minority Health (OMH): The FY 2011 Budget request for OMH is $58 million,

an increase of $2 million. This funding will enable OMH to enhance disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities in racial and ethnic minority populations across the country. The increase will also support activities related to minority health and disparities in the U.S.

***Minority HIV/AIDS*:** The Budget includes $54 million to support innovative approaches to HIV/AIDS prevention and treatment in minority communities disproportionately impacted by this disease. These funds will 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.

Office on Women's Health (OWH): The Budget request of $34 million will allow OWH to continue support for the advancement of women's health programs through the promotion and coordination of research, service delivery and education throughout the agencies and offices of HHS, with other government organizations, and with consumer and health professional groups.

Commissioned Corps: The FY 2011 Budget request includes $14 million for the continued support of the Public Health Service's Commissioned Corps. Activities will focus on modernizing the force and management of the Commissioned Corps. FY 2011 funding will be used to train and equip officers to respond to emerging public health threats and to improve response operations.

Office of Global Health Affairs (OGHA): The FY 2011 Budget includes $6 million which will enable OGHA to support global health policy leadership and coordination. This does not include funding formerly located in OGHA for the Health Diplomacy and Afghanistan Health Initiatives, which will be transferred in FY 2011 to the CDC.

Acquisition Reform: An additional $7 million is included for the HHS portion of a government-wide initiative in contract and acquisition reform. Funding will be used to increase the capacity and capabilities of the Department's acquisition workforce.

Other General Departmental Management: The FY 2011 Budget request includes $226 million for the remainder of GDM, an increase of $4 million. This funds activities within offices which provide leadership, policy, legal, and administrative guidance to HHS components, and also includes funding to continue ongoing programmatic activities.

PHS Evaluation Funds: The FY 2011 Budget request also includes $65 million in PHS Evaluation Funds, as authorized by section 241 of the Public Health Service Act. In addition to investments in Healthcare Reform activities, these funds will support evaluation activities related to Teen Pregnancy Prevention, policy research and evaluation activities in the Office of the Assistant Secretary for Planning and Evaluation, and evaluation activities in the Office of Public Health and Science and the Office of the Assistant Secretary for Financial Resources.

OFFICE OF THE SECRETARY
OFFICE OF MEDICARE HEARINGS & APPEALS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Total, Program Level.....	65	71	78	+7
FTE.....	357	378	422	+44

The Office of Medicare Hearings and Appeals provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. This mission is carried out by a cadre of knowledgeable Administrative Law Judges (ALJs) exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional legal and administrative staff.

The FY 2011 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $78 million, a net increase of $7 million over FY 2010. Funds are requested from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, to hear cases under Title XVIII of the Social Security Act and related provisions in Title XI of the Act.

OMHA was established by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA transferred the responsibility for hearing Medicare appeals at the ALJ level – the third level of Medicare claims appeals – from the Social Security Administration to the HHS Office of the Secretary. In addition, the Medicare Benefits Improvement and Protection Act of 2000 (BIPA) mandated that such ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant for a hearing.

OMHA administers appeals in four field offices: Southern (Miami, Florida), Midwestern (Cleveland, Ohio), Western (Irvine, California), and Atlantic (Arlington, Virginia). OMHA extensively utilizes hearings held via video-teleconference (VTC) and telephone, in order to provide appellants with hearings which are timely, close to their homes, and with a broad array of access points. VTC technology, which is commonly used throughout the country in courtrooms and for tele-medicine, plays a critical role in OMHA's ability to both meet the BIPA timeframes and provide expanded access for appellants to ALJ hearings.

OMHA began processing cases on July 1, 2005; since then, it has received more than 650,000 claims from across the United States for Medicare Parts A, B, C, and D appeals, as well as Medicare entitlement and eligibility appeals. Beginning in FY 2010, OMHA will also receive additional claims resulting from the permanent expansion to all 50 States of the Recovery Audit Contractor (RAC) program, administered by the Centers for Medicare & Medicaid Services (the demonstration phase of the RAC program in FY 2008 and FY 2009 included only five States). During FY 2009, OMHA received a total of 215,847 claims, an increase of 16 percent over FY 2008. OMHA projects that its caseload will continue increasing, to approximately 297,000 total claims in FY 2010 (a 38 percent increase over FY 2009) and 336,000 total claims in FY 2011 (a 13 percent increase over FY 2010).

With the requested funding level of $78 million, OMHA will continue to process its ALJ appeals workload within the BIPA-mandated timeframes. To accomplish this while also maintaining the quality and accuracy of its decisions, OMHA will continue to utilize state-of-the-art technology and to offer appellants access to multiple hearing venues and services.

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

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Budget Authority	44	2,000	42	78	+36
PHS Evaluation Funds	18	--	19	--	-19
Total, Program Level	**61**	**2,000****	**61**	**78**	**+17**
FTE	31	--	75	120	+45

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

**The Recovery Act appropriation to ONC includes $20 million to be transferred to NIST.

The FY 2011 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $78 million, $17 million above FY 2010. The FY 2011 President's Budget includes resources for ONC to serve as the Federal health IT leader and coordinator and to continue implementing Recovery Act programs. These roles are vital to achieving the goals of the President's health IT initiative and health reform. The FY 2011 Budget request, in conjunction with the $2 billion appropriated to ONC under the Recovery Act, will enable HHS to continue implementing the Health Information Technology for Economic and Clinical Health (HITECH) Act, accelerating the adoption of health IT and helping physicians achieve meaningful use of electronic health records (EHR). ONC and the Centers for Medicare & Medicaid Services (CMS) have worked closely to develop rules defining the "meaningful use" of EHRs and setting initial standards, implementation specifications, and certification criteria for EHR technology. In FY 2011 ONC and CMS will update these rules as needed. CMS, with Recovery Act funding, will provide financial incentives to help Medicare and Medicaid providers adopt and meaningfully use EHRs. Incentive payments to eligible hospitals may begin as soon as October 2010. Incentive payments to eligible professionals may begin in January 2011.

In addition to funds requested for ONC, the FY 2011 Budget request for other HHS divisions includes funds to advance the Administration's health IT agenda. The Budget request includes $32 million in the Agency for Healthcare Research and Quality (AHRQ) to advance the use of health IT to enhance patient safety, $1.6 million in the Office of Civil Rights (OCR) for regional privacy advisors, and $1 million in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) for independent evaluations of EHR adoption and economic factors influencing health IT, in coordination with ONC. In addition, the Budget request for CMS includes resources to conduct the third year of a demonstration project to encourage small physician practices to adopt EHRs.

Electronic Health Records Standards and Certification

As required by HITECH, ONC has issued an interim final rule (IFR) describing the standards that certified EHR technology must meet to exchange healthcare information among providers and between providers and patients. These standards will support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

RECOVERY ACT IMPLEMENTATION

The Recovery Act provided $2 billion for health IT and includes the authorization of ONC; two new Federal Advisory Committees to guide standards and policy development processes; new grant and loan programs; and increased privacy and security protections. ONC's plans for the $2 billion Recovery Act investment in health IT include:

- $693 million to establish the Health IT Extension Program to disseminate best practices for health IT implementation, adoption, and use, and provide technical assistance supporting the adoption and meaningful use of health IT;
- $564 million for a Health Information Exchange State Grant Program to support sub-national and regional efforts toward health information exchange, nationwide interoperability, and statewide planning;
- $118 million to develop the health IT workforce;
- $235 million for a Beacon Communities Program to demonstrate the potential of health IT and convey evidence to providers and other communities that the widespread adoption of health IT and exchange of health information is feasible and improves care delivery and health outcomes;
- $24 million to carry out the Department's statutory responsibilities under the HITECH Act to draft regulations, guidance, and reports, and to conduct studies and audits to strengthen privacy protections and security safeguards;
- $20 million for the National Institute of Standards and Technology to develop health IT standards testing and evaluation infrastructure; and
- $345 million for a variety of activities designed to complement and advance the goal of supporting the care of all Americans with EHRs by 2014.

In FY 2011, ONC will continue implementing Recovery Act programs, evaluate Recovery Act funded programs, and update rules and regulations as needed. ONC will also involve stakeholders and fulfill the unprecedented transparency and accountability reporting requirements for recipients of Recovery Act funding.

Recovery Act Programs

The Recovery Act encourages accelerating the adoption of health information technology and utilization of electronic health records. Building on this unprecedented investment, the Administration will continue efforts to further the adoption and implementation of health information technology – an essential tool in modernizing the health care system.

INTEROPERABILITY

The interoperability of EHRs is a critical element of the national health IT agenda and a necessary building block for achieving the President's health IT goals. The FY 2011 budget request includes $23 million to support the development of health data standards necessary to enable the interoperability of EHRs, and to ensure that standards are available for both private sector and Federal use. This funding will support the ongoing standards harmonization process, which is required for IT systems to exchange data across different health care settings. ONC will also continue implementing the new processes outlined in the HITECH Act for standards development, which include recommendations from the Health IT Policy Committee and a Health IT Standards Committee. The Health IT Policy Committee also provides policy recommendations related to the implementation of a nationwide health information technology infrastructure. The Health IT Standards Committee recommends standards, implementation specifications, and certification criteria for the electronic exchange and use of health information.

Realizing the full benefits of reliable and secure health information exchange across organizations and jurisdictions requires a health information exchange network of common technical, privacy, and security standards and policies. The FY 2011 Budget request includes support for expanding health information exchange network capabilities. In FY 2011 ONC will also continue supporting Recovery Act activities that will further develop the nationwide health information network (NHIN) and support expanding health information exchange capabilities.

In addition to supporting the implementation of Recovery Act activities, ONC will also promote the adoption of health IT through working with mental health and substance abuse

providers to integrate substance abuse and mental health prevention and treatment into the larger primary care delivery system health IT framework and with Medicaid and other safety net services. ONC will work closely with the Substance Abuse and Mental Health Services Administration in developing this new $4 million effort.

PRIVACY AND SECURITY

The FY 2011 Budget includes $7 million to support the continued development of appropriate Federal privacy and security protections of electronic health information, and State consensus efforts to address patient protections. Ensuring adequate Federal protections and facilitating multi-State collaboration is essential to building public confidence and trust in nationwide health information exchange. ONC will also work with other Federal agencies to protect and secure the transmission of health information over computer networks through a health IT cybersecurity program.

In FY 2011, ONC will continue working with partners, such as OCR, CMS, States, and other stakeholders to protect patients' health information. ONC will also continue to support the implementation and development of HITECH Act privacy and security regulations and guidance, and to update these regulations and guidance as necessary.

ADOPTION

Increasing the adoption of health IT and reducing barriers to achieving the meaningful use of EHRs are essential to achieving the President's health IT initiative. The FY 2011 budget includes $4 million for ONC to identify consumer perspectives on consumer e-health tools and the development of patient decision aids, anticipate and mitigate unintended consequences of the electronic exchange of health information, and support State governments as they implement their HITECH grants.

RESEARCH, EVALUATIONS, AND OPERATIONS

The FY 2011 budget includes $7 million to conduct economic analysis and develop models describing the factors driving the adoption, meaningful use, and interoperability of EHRs, and to evaluate and measure the success of programs funded under the Recovery Act and other ONC efforts to further the adoption and meaningful use of health IT. ONC will use $38 million to increase Federal staff and reduce contractor support to continue efficiently implementing Recovery Act programs and to continue a communications and outreach program begun in CY 2009.

MEASURING SUCCESS

In FY 2011, ONC will continue to define measures of success and report on these measures as appropriate. ONC will use existing performance measures as well as the milestones and objectives of the Federal Health IT Strategic Plan (as will be reflected in the CY 2010 revision), and the Recovery Act operating plans in developing these measures. ONC will also measure its success by continuing to fund surveys on the adoption rates of EHRs among physicians and hospitals.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Total, Program Level.....	40	41	44	+3
FTE.....	227	270	280	+10

The Office for Civil Rights (OCR) ensures that people have equal access to and the opportunity to participate in and receive services from all HHS programs without facing unlawful discrimination and that the privacy and security of their health information is protected while ensuring access to care. By enforcing our Nation's civil rights laws in health and human services settings and protecting the privacy and security of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all Americans affected by its many programs.

The FY 2011 Budget request is $44 million for the Office for Civil Rights (OCR). 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, pursuant to Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1964; Title II of the Americans with Disabilisites Act of 1990; Titles VI and XVI of the Public Health Services Act (Hill-Burton Act); the Multi-Ethnic Placement (MEPA); the Age Discrmination Act of 1975; and Title IX of the Education Amendments of 1972.

In addition, the budget supports OCR's significantly expanded compliance responsibilities that protect individuals' personal health information under the Privacy and Security Rules issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA), and supports the creation of ten regional office privacy advisors as mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.
OCR assesses compliance with nondiscrimination and Privacy and Security Rule requirements through:

- Complaint investigation, violation findings, resolution agreements, enforcement actions, and monitoring;
- Public education;
- Technical assistance; and
- Compliance reviews, including civil rights reviews of new Medicare provider applicants.

In July 2009, the Secretary delegated to OCR the authority to administer and enforce the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Security Rule). Combining the authority for both administering and enforcing Federal standards for health information privacy and security under HIPAA will improve HHS' ability to protect individuals' health information.

As the Department's civil rights and health privacy law enforcement agency, OCR's key priorities in FY 2010 and FY 2011 are: ensuring understanding of and compliance with the HIPAA Privacy and Security Rules; implementing statutory privacy protections for genetic information; promoting adequate privacy protections in the use of health information technology; enforcing the confidentiality protections afforded to patient safety information; enforcing Federal civil rights laws to increase non-discriminatory access to health care and human services, including adoption, foster care, and TANF; promoting best practices for effective communication in hospital settings with persons who are deaf or hard of hearing and persons of limited English proficiency; strategically disseminating an OCR-developed Federal civil rights curriculum for medical schools to help narrow disparities in health care quality, access and patient safety; supporting appropriate services in the most integrated setting for

persons with disabilities; and promoting non-discrimination and privacy protections in emergency preparedness and response activities.

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 free from discrimination on the basis of race, color, national origin, disability, age, religion and sex. OCR's efforts also promote public trust and confidence that the health care system will maintain the privacy of protected health information while ensuring access to care.

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

Enforcing HIPAA: OCR investigates and resolves approximately 8,000 complaints of alleged HIPAA violations annually. A noteworthy example of OCR enforcement action was a 2009 resolution agreement for $2.25 million with CVS for improper disposal of personal health information. Under this resolution agreement, CVS agreed to implement a robust corrective action plan that requires Privacy Rule-compliant policies and procedures for safeguarding patient information during disposal, employee training and employee sanctions for noncompliance.

Privacy Provisions of the Genetic Information Non-discrimination Act of 2008 (GINA): GINA protects individuals against discrimination by employers and health plans based on an individual's genetic information. OCR will enforce amendments to the HIPAA Privacy Rule, as required by GINA, to prohibit health plans from using or disclosing an individual's genetic information for underwriting purposes.

Privacy and Security Provisions of the HITECH Act: HITECH Act provisions include extending security and privacy rule liability to business associates, new limitations on marketing and fundraising communications, a prohibition on the sale of protected health information, stronger individuals' rights to electronic access and to request restrictions, a requirement to notify individuals of breaches of their protected health information and to report breaches of protected health information to the Secretary, and enhanced enforcement authority, including increasing the civil monetary penalties up to $50,000 per violation with an annual cap of $1.5 million. The Act also mandates the development and maintenance of a multi-faceted national public education campaign, to be conducted in a variety of languages, which will enhance public transparency regarding the uses of protected health information and the rights of individuals with respect to those uses.

In September 2009, the interim final rule implementing the breach notification provisions of HITECH went into effect. In the first quarter of FY 2010, OCR received 23 notifications involving breaches affecting 500 or more individuals. OCR is in the process of verifying the breach reports and will investigate these cases, to determine the underlying causes of the breaches and ensure that appropriate corrective action is taken by the covered entities.

Enforcing Compliance with Civil Rights Laws: OCR investigates and resolves nearly 3,000 administrative discrimination complaints annually. For example, in 2009, following OCR's investigation of a complaint filed on behalf of a Spanish-speaking member, Medco, the nation's largest pharmacy benefit manager, took steps to implement a multi-faceted plan to improve services to individuals with limited English proficiency. Medco will expand its pool of bilingual customer service representatives who speak Spanish and redesign its referral system to more quickly link Spanish-speaking members to bilingual staff. Medco will continue to use a telephonic interpreter service available for more than 150 languages to improve communication with limited English proficient individuals.

In FY 2010 and FY 2011, OCR will strengthen efforts to improve statewide compliance with civil rights laws and ensure that civil rights enforcement outcomes impact the lives of those who have suffered discrimination. For example, in FY 2008, OCR entered into a statewide agreement with Georgia to remedy Olmstead violations, reduce institutional bias, and ensure that 2,500 individuals now in public psychiatric hospitals and facilities for the developmentally disabled will have the opportunity to live in the community. Such statewide agreements provide a cost effective way to ensure that the states are in compliance with the law with respect to how they administer HHS-funded programs impacting the lives of tens of millions of citizens.

OFFICE OF THE SECRETARY
Service and Supply Fund

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Non-PSC	52	70	56	-14
PSC	807	957	1,009	+52
Revenues	859	1,027	1,065	38
Non-PSC	128	141	142	1
PSC	1,207	1,253	1,312	59
FTE	1,335	1,394	1,454	60

The Service and Supply Fund Provides consolidated financing and accounting for business-type operations which involve the provisions of common services to customers at HHS and other government departments and agencies.

The Service and Supply Fund (SSF) governed by a Board of Directors, consisting of representatives from each of the Department's ten Operating Divisions (OPDIVs) and the Office of the Secretary Staff Divisions (STAFFDIVs). A representative from the Office of Inspector General (OIG) serves as a non-voting member. The SSF does not have its own appropriation, and is funded entirely through charges to its customers (HHS OPDIVs and STAFFDIVs, plus other Federal agencies) for their usage of goods and services. Each activity financed through the SSF is billed to the Fund's customers, based on either fee-for-service billing determined by actual usage of service or an allocated methodology.

Many of the Fund's activities and business lines are based at the Program Support Center (PSC), and they represent the largest portion of the SSF budget. The non-PSC activities, many of which facilitate compliance with public laws, regulations, or other Federal management guidelines, make up the remainder of SSF activities.

PSC products and services are provided in broad business areas described below.

Administrative Operations Services (AOS): AOS provides a wide range of administrative and information technical services within the Department, both at headquarters and in the regions, and to customers throughout the Federal government. Services include: HHS payroll processing, building management and operations, safety, security services, lease management, alterations and maintenance, parking management, locator services and supply and inventory management. AOS also provides shipping and labor services, real property surpluses, mail and messenger services, conference room facilities support services, graphic design, printing, and copier maintenance throughout HHS.

Federal Occupational Health Service: The Federal Occupational Health Service (FOHS) provides occupational health services for Federal employees, including health and wellness programs, employee assistance, work/life, and environmental health and safety services. Over 1.5 million Federal employees in 45 Federal departments and agencies are serviced by FOHS.

Financial Management Service (FMS): FMS supports HHS financial operations through the provision of fund accounting, disbursement, financial reporting, financial statement preparation, payroll accounting, and debt management and collection services. It supports Federal grantor and contracting agencies efforts to negotiate and approve indirect costs, fringe benefits and other specialty rates used by not-for-profit organizations receiving Federal awards. Lastly, grant disbursement, cash management, and grant accounting support services are also provided.

Information and Systems Management Service (ISMS): ISMS provides high-quality information technology and

technical services including: human resource systems; Freedom of Information Act (FOIA) on implementation and records management; Web content and publications management; IT infrastructure operations and consulting services; overseeing the PSC information systems security program; maintenance of the Unified Financial Management System (UFMS) and the HHS Consolidated Acquisition System.

Strategic Acquisition Service (SAS): The SAS is responsible for providing leadership, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides acquisition services, strategic sourcing services, including a Strategic Sourcing Center of Excellence; and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies.

Human Resources (HR) Centers and HHS University (HHSU): The HR Centers represent a consolidation of human resources services within the Department, with sites located in Maryland, Atlanta, and Georgia. HHSU provides training and development opportunities, including both online and classroom training.

Below are descriptions of non-PSC activities, many of which facilitate compliance with public laws, regulations, or other Federal management guidelines.

Acquisition Integration and Modernization (AIM): AIM creates a seamless integration of HHS-wide acquisition process standardization, internal controls and oversight, and performance measurement inputs to serve employees, customers and vendors. AIM is used to improve a number of acquisitions-related processes related to purchase cards, acquisition plans, interagency contracting, and emergency contracting procedures.

Audit Resolution: Audit Resolution, as mandated by P.L. 96-304 and P.L. 98-502, resolves grantee audit findings within a statutorily mandated six month period.

Claims: Claims does mission critical work that is required by the Federal Tort Claims Act (FTCA). This act requires claimants to file administrative claims with the responsible agency before filing suit against the United States in Federal court.

Commissioned Corps Force Management (CCFM): CCFM provides personnel support to active-duty, inactive reserve and retired PHS Commissioned Officers as well as force management activities for the Corps as a whole.

Office of Small and Disadvantaged Business Utilization: The Small Business Office provides leadership, guidance and recommendations to insure that small businesses are given an equitable opportunity to participate in the provision of goods and services to HHS.

Grants and Contracts Data: Several activities focus on the provision of competitive sourcing, procurement, and grants databases. The Tracking Accountability in Government Grants System is HHS' central repository of grant award data. The publicly searchable database houses HHS discretionary and mandatory grant funding data awarded from 1995 to the present. The Departmental Contracts Information System serves as the central repository for Department-wide procurement data, and is the primary system used by HHS to fulfill procurement reporting requirements under the Federal Procurement Data System Next Generation/OMB, which is mandated by Public Law 93-400. This system compiles contract information to produce geographically-based reports to OMB and Congress. High Performing Organizations and Commercial Services Management maintains a database to gather Federal Activities Inventory Reform Act inventory data at all levels of the Department.

Web Communications and New Media Division (WCD): The WCD is responsible for HHS Department Web sites. The Web Policy Testers enhances Section 508 Compliance efforts and improves web page maintenance efforts.

Homeland Security Presidential Directive 12 (HSPD-12): The HSPD-12 activity is managed by the Office of Security and Strategic Information and addresses control of "physical access" to buildings.

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

	2009	2010	2011	2011 +/- 2010
Retirement Payments	333	356	386	+30
Survivor's Benefits	24	25	28	+3
Medical Care for Retirees and Survivors	92	94	104	+10
Accrued Medical Benefits for over-65 /1	35	36	37	+1
Total, Budget Authority	**485**	**510**	**555**	**+45**

1/ The FY 2010 amount has been adjusted to reflect an anticipated increase in average force *Appendix, Budget of the United States Government, Fiscal Year 2011* includes $37 million, the amount adjusted to reflect the revised on-board projections for FY 2010.

The FY 2011 Budget of $555 million is a net increase of $45 million over FY 2010. This Budget request provides for annuities retirement payments of retired Public Health Service (PHS) Commissioned Corps Officers and payments 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 Budget also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, and dependents of deceased members. This account includes payments to the Department of Defense Medicare-eligible Retiree Healthcare Funds for the accrued costs of health care for beneficiaries over the age of 65.

The Budget reflects increased costs in medical benefits, an annualization of amounts paid to retirees and survivors, and a net increase in the number of retirees and survivors during FY 2011.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2009	2009 ARRA*	2010	2011	2011 +/- 2010
Discretionary Appropriation.....	45	17	50	52	+2
Discretionary HCFAC.....	19	--	30	95	+65
Mandatory HCFAC.....	177	--	177	177	--
Medicaid Integrity Program DRA...	25		25	–	-25
Medicaid Oversight**.....	25	31	–	–	--
Total Funding, All Sources	**291**	**48**	**282**	**324**	+42
FTE.....	1,512		1,566	1,776	

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

**The Supplemental Approriations Act of 2008 (P.L. 110-252) provides $25 million for Medicaid oversight in FY 2009.

The Office of Inspector General mission is to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; providing industry guidance; and holding accountable those who do not meet program requirements or who violate Federal laws.

The FY 2011 Budget request for the Office of Inspector General (OIG) is $324 million in mandatory and discretionary budget authority, a net increase of $42 million over FY 2010; of which $40 million is for the joint DOJ-HHS Health Care Fraud Prevention and Enforcement Action Team initiative.

The request will enable OIG to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws.

Ativities in FY 2011 will be determined by its annual work planning process and the assessment of the top management and performance challenges facing HHS. The mission is accomplished by conducting audits, investigations, evaluations and inspections; recommending corrective action for vulnerabilities identified during these inquiries; referring suspected criminal action for prosecution, imposing administrative sanctions such as exclusions from Federal health programs and civil monetary penalties, and providing industry guidance to HHS program participants.

The HHS top management challenges identified by OIG for the most recent year fall into three broad categories:

- Integrity of Medicare, Medicaid, and the Children's Health Insurance Program;
- Integrity of the Department's public health and human services programs; and
- Cross-cutting issues that span the Department.

INTEGRITY OF MEDICARE, MEDICAID, AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

In FY 2011, OIG efforts to combat waste, fraud and abuse in the Medicare, Medicaid, and CHIP programs will be guided by five principles. These principles offer a framework for implementing programs, as well as designing and implementing integrity safeguards.

- Enrollment: Scrutinize individuals and entities that seek to participate as providers and suppliers prior to their enrollment in health care programs.
- Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
- Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.
- Oversight: Vigilantly monitor programs for fraud, waste, and abuse.
- Response: Respond swiftly to detected fraud, impose appropriate punishment to deter others, and promptly remedy program vulnerabilities.

INTEGRITY OF THE DEPARTMENT'S PUBLIC HEALTH AND HUMAN SERVICES PROGRAMS

Emergency Preparedness and Response: Events like Hurricanes Katrina and Rita, and more recently the outbreak of the H1N1 virus, highlight the importance of a comprehensive national public health infrastructure that is prepared to respond rapidly to public health emergencies. Since 2002, HHS has provided over $10 billion to States and localities through various programs to enhance their emergency preparedness activities and to better enable them to respond to large-scale, natural or man-made public health emergencies, such as acts of bioterrorism or infectious disease outbreaks. In FY 2011 OIG will continue its work in monitoring the public and private sectors' preparedness for and response to public health emergencies.

Oversight of Food, Drug and Medical Device Safety: OIG will continue to focus on public health agencies, such as FDA and NIH, responsible for food, drug and medical device safety. These agencies are required to have policies and programs in place that create safeguards to ensure the integrity of medical research endeavors, protect human research subjects, and provide for pre-approval and post-approval monitoring of regulated medical products and treatments.

Grants Oversight: HHS receives and distributes more grant money than all other Federal agencies combined. OIG will continue providing oversight to ensure that HHS grants are appropriately monitored and managed throughout the grant life-cycle. In FY 2011 OIG will assess the mechanisms in place to ensure that proper procedures are used to award and fund grants, account for expenditures, and verify that grant dollars are only used for authorized purposes.

Child Support Enforcement Program: OIG will continue to provide coverage of all 50 States and the District of Columbia through its multi-agency task forces that identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. OIG task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, United States Marshals Service, and State and county child support personnel, to identify and resolve egregious cases of nonsupport.

CROSS-CUTTING ISSUES THAT SPAN THE DEPARTMENT

Ethics Program Oversight and Enforcement: OIG has long been involved in oversight and enforcement related to the Department's ethics program. Prior OIG work identified vulnerabilities in HHS oversight of outside activities and potential conflicts of interest. In FY 2011 OIG will continue to ensure the effectiveness of the HHS ethics program.

Health Information Technology: HHS has a significant role in advancing the development and implementation of a national health information network. OIG will continue its oversight efforts of HHS health information technology programs and objectives by monitoring HHS implementation efforts andexamining HHS grantees' compliance with applicable requirements.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2009	2009 ARRA	2010	2011*	2011 +/- 2010
Pandemic Influenza					
Agency Budgets	430	--	231	237	+6
PHSSEF	8,026	--	341	396	+55
Subtotal, Pandemic Influenza Program Level	8,456	--	572	632	+61
Terrorism Preparedness					
Agency Budgets	3,594	--	3,651	3,693	+41
PHSSEF	822	50	936	1,110	+182
Subtotal, Terrorism Preparedness	4,415	50	4,588	4,803	+223
Total, Emergency Preparedness	**12,871**	**50**	**5,159**	**5,435**	**+284**
Transfer of Funds					
Transfer of Project BioShield SRF from DHS to HHS	--	--	2,424	--	-2,424

* FY 2011 PHSSEF funding includes $330 million in balances from the FY 2009 pandemic influenza supplemental.

To protect our Nation from the threat of pandemic influenza, the FY 2011 Budget request includes $632 million in HHS-wide funding. The FY 2011 Budget request also includes approximately $4.8 billion for bioterrorism and emergency preparedness activities across the Department. Funding for these activities is appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agencies.

PANDEMIC INFLUENZA

The FY 2011 Budget request for pandemic influenza preparedness includes $302 million in annual funding to continue pandemic influenza activities at CDC, FDA, NIH, and the Office of the Secretary (OS), including international activities, communications, and research. In addition, approximately $330 million in balances from the FY 2009 supplemental will be used in FY 2011 to continue the advanced development of antiviral drugs and influenza vaccines, and to ensure that the U.S. has sufficient vaccine manufacturing capacity in the event of a pandemic. A transfer from FY 2009 supplemental funding will also support pandemic influenza activities at CDC.

Reassortment of avian, swine and human influenza viruses has led to the emergence of a new strain of H1N1 influenza A virus (2009-H1N1 influenza) that is transmissible among humans. During the fall H1N1 peak, there was widespread influenza activity in 48 States. Visits to doctors for influenza-like illness as well as flu-related hospitalizations and deaths among children and young adults were also higher than expected for that time of year. In response to the H1N1 pandemic threat, HHS characterized the virus, identified candidate strains, supported pandemic vaccine manufacturing, performed clinical trials, and licensed five 2009 H1N1 influenza vaccines with unprecedented speed. The efficiency of H1N1 vaccine development and manufacturing was possible due to investments over the past four years in influenza vaccine advanced research and development, and manufacturing infrastructure building.

Prior pandemic preparedness investments resulted in the development of medical countermeasures that are currently being used in the present H1N1 pandemic response. Those investments increased the level of domestic vaccine manufacturing capacity, supported the development and procurement of adjuvants and antivirals, provided a new antiviral drug for critically ill patients with H1N1 influenza under Emergency Usage Authorization,

and provided experience in vaccine and antiviral stockpiling.

On June 24, 2009, Congress appropriated $7.65 billion to HHS for pandemic influenza preparedness and response to respond to the 2009 H1N1 influenza, including $1.85 billion in direct appropriations and $5.8 billion in contingent appropriations. HHS has submitted plans for $6.1 billion of the $7.65 billion FY 2009 supplemental appropriation. HHS has been obligating these funds for H1N1 response activities, including vaccine production, distribution, and administration; antiviral drugs; domestic and international surveillance; communications and community mitigation; and laboratory support for virus detection. Just over $2 billion has been obligated to purchase bulk and finished vaccine and adjuvant products and ancillary supplies for administration of the vaccine. In addition, $1.44 billion was provided to States and hospitals for preparedness activities, and for vaccination campaign planning and implementation.

The original plan for the FY 2009 supplemental appropriation included $3 billion for the purchase of H1N1 vaccine, enough to purchase 600 million doses of the vaccine, or two doses for every American. However, due to the strong immunogenic response produced by the vaccine, we now know that adults and children ten years and older only require one dose of the vaccine. As a result, funding previously set aside for H1N1 vaccine can be directed to other pandemic influenza activities.

H1N1 Response

The Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) provided $1.44 billion to States and hospitals to support H1N1 planning, preparation, and implementation efforts. Through the Hospital Preparedness Program, ASPR provided $90 million for improving healthcare workforce protection and optimizing health care during a pandemic. CDC provided $1.36 billion to States and local governments through the Public Health Emergency Response grants to enhance pandemic preparedness, response, and surveillance, as well as for the implementation of an H1N1 vaccination campaign. An additional $500 million has also been made available to States in need of additional support for their H1N1 vaccination efforts. As of January 7, 2010, more than 115 million doses of H1N1 vaccine have been ordered by States and private partners.

Remaining FY 2009 supplemental funding, including an estimated $330 million in FY 2011, and the FY 2010 appropriation will be used to advance the Nation's pandemic preparedness through investments in development of next generation recombinant and molecular vaccine technologies; further expanding domestic vaccine manufacturing capacity; continuing development of antigen-sparing adjuvant technology; continuing development of new and better influenza antiviral drugs; and continuing advanced development in technologies that help us identify influenza. These continued efforts will enhance the Nation's preparedness in the event of another influenza pandemic. Additionally, HHS will continue to evaluate priorities for pandemic influenza funding, including FY 2009 supplemental balances, and will notify Congress of any changes to current plans.

A total of $302 million is requested in the FY 2011 budgets of the CDC, FDA, NIH, and the OS, including a transfer from the FY 2009 supplemental to CDC, to finance ongoing preparedness activities including:

- Expanding international and domestic surveillance and detection capabilities, including identification of vaccine virus strains and identify emerging viruses with pandemic potential;
- Accelerating research and development of rapid diagnostic tests;
- Improving pandemic preparedness and response capabilities on the National, State, and local levels;
- Improving our Nation's ability to contain a potential pandemic influenza outbreak; and
- Supporting international efforts designed to strengthen the public health and vaccine manufacturing infrastructure, expand surveillance systems, and improve pandemic influenza preparedness and response capabilities.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2009	2010	2011	2011 +/- 2010
Pandemic Influenza:				
PHSSEF				
Vaccine:				
Achieve capacity and/or buy courses from egg-based manufacturers..	279	--	--	--
Pandemic vaccine potency reagents library.....	--	5	--	-5
Cell based and recombinant vaccine development.....	--	50	--	-50
Advanced development of antigen sparing technologies.....	65	--	--	--
Cell based vaccine production facility.....	--	63	--	-63
Vaccine fill/finish mfg warm base.....	--	40	--	-40
Subtotal, Vaccine	344	158	--	-158
Antivirals:				
Antiviral drug advanced development.....	123	53	--	-53
Subtotal, Antivirals	123	53	--	-53
Ventilators:				
Next Generation Ventilators:.....	--	65	--	-65
Subtotal, Ventilators	--	65	--	-65
Shared Responsibility:				
Countermeasures and PPE for HHS clinical and patient populations..	40	--	--	--
Subtotal, Shared Responsibility	40	--	--	--
Pandemic Influenza Emergency Supplemental:				
Preparedness and response, inlcuding H1N1 response.....	7,450	--	--	--
Subtotal, Pandemic Influenza Emergency Supplemental Funding	7,450	--	--	--
Subtotal, No-Year Funding BA	7,957	276	--	-276
Program Level:				
2009 Supplemental Balances.....	--	--	330	+330
Subtotal, No-Year Funding Program Level	7,957	276	330	+54
Office of the Secretary:				
Annual Request.....	69	65	66	+1
Subtotal, PHSSEF	8,026	341	396	+55
Agency Budgets				
CDC.....	356	156	156	--
FDA.....	39	39	45	+6
NIH.....	35	35	35	--
Subtotal, Agency Budgets	430	231	237	+6
Total, Program Level	**8,456**	**572**	**632**	**+61**

EMERGENCY PREPAREDNESS

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2011 Budget requests $4.8 billion for HHS bioterrorism and emergency response, an increase of $169 million over FY 2010. These funds, appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agency budgets, are to protect Americans from a possible bioterrorist attack or other public health emergency.

PHSSEF ACTIVITIES

The FY 2011 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $1.1 billion, a net increase of $182 million over FY 2010. The PHSSEF Budget request will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to, and recover from the adverse health effects of public health emergencies and disasters.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) is the lead for the Federal Government for public health and medical services response efforts under the National Response Framework, Emergency Support Function (ESF) #8. ASPR coordinates the bioterrorism and emergency preparedness activities of HHS agencies, develops and coordinates national policies and plans, provides program oversight, and serves as the Secretary's public health emergency representative to other Federal, State and local agencies.

The Budget requests $1.1 billion for ASPR, an increase of $162 million. In December, 2009, Secretary Sebelius announced a review of the public health countermeasures enterprise with the goal of improving our ability to prepare for, respond to, and recover from public health threats. Improving this system is an iterative process and represents a long-term commitment to preparedness.

There are steps that can be taken now to make progress in critical areas. The Budget includes $476 million, to be made available from current BioShield Special Reserve Fund (SRF) balances, for the Biomedical Advanced Research and Development Authority (BARDA), which will continue support for the development of existing and new promising next-generation medical countermeasures. This represents an increase of $136 million over FY 2010. BARDA is responsible for coordinating and administering Federal efforts to develop and procure vaccines and countermeasures to mitigate the medical consequences of potential chemical, biological, radiological, and nuclear threat events. Funding in FY 2011 will be targeted to countermeasure development in the high priority areas of anthrax, enhanced biothreats, and acute radiation syndrome. BARDA also manages pandemic influenza and Project BioShield, and the request consolidates the associated management costs.

Additionally, the Budget will permit the Secretary to make additional BioShield funds available for advanced research and development activities after notification of Congress. This flexibility would enable BARDA to target resources to the most promising countermeasure candidates whether through advanced development or through acquisition using Project BioShield. ASPR works with Federal, State, local, and Tribal partners to ensure coordinated planning and response to bioterrorism and other public health and medical emergencies.

The ASPR budget request includes $44 million for Preparedness and Emergency Operations, an increase of $11 million over FY 2010. This funding will support improved regional coordination; increased interagency coordination for ESF #8; improved Federal response capabilities; and address the special needs of at-risk populations. Also included within this budget request is $15 million, available until expended, to prepare for and respond to National Special Security Events and other planned and unplanned events.

The Budget also includes $57 million for the National Disaster Medical System (NDMS) to implement emergency readiness response improvements. The request will support training, exercises, medical equipment and other deployable assets for over 100 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and other NDMS Teams to improve our Nation's capacity to respond to a terrorist attack or other public health emergency.

In the FY 2011 Budget, $10 million is included to continue the HHS medical countermeasure dispensing

demonstration project with the United States Postal Service (USPS), of which up to $8 million may be transferred to the USPS. The USPS is a unique Federal entity because it reaches the homes of every American, and will be a significant asset in the distribution of medical countermeasures to the public in the event of a public health emergency. ASPR will work with the USPS to expand the number of cities in the demonstration project from the four planned in FY 2010 to eight in FY 2011.

In FY 2011, $426 million is requested for Hospital Preparedness, which provides cooperative agreements to States, cities, and territories to strengthen the capability of hospitals and healthcare systems to plan for, respond to and recover from all-hazards events. The Budget also requests $41 million to support ASPR strategic oversight and operational coordination for preparedness and response activities. This includes $10 million to co-locate the majority of ASPR staff in a single facility, instead of the current five sites. These activities are key to improving ASPR's ability to properly advise the Secretary, HHS, and the White House while preparing for and responding to public health emergencies, as well as implementing the National Health Security Strategy, which was released in December 2009.

Cybersecurity: The Budget request provides $37 million for cybersecurity, an increase of $10 million, to protect the Department's information technology infrastructure from cyber attacks by providing continuous security monitoring for all HHS systems, assets, and services. This funding will build off of the $50 million provided in the Recovery Act, and will support a Department-wide collaboration to identify and address security vulnerabilities. Additionally, this will enhance Department-wide computer systems intrusion detection capabilities, security information event management systems, and network forensics capabilities.

Medical Reserve Corps: Comprised of medical and public health volunteers, the Medical Reserve Corps contributes its expertise to local public health initiatives on an ongoing basis. The Budget request includes $13 million for the Medical Reserve Corps in FY 2011 to enhance the leverage of these efforts during a national catastrophic emergency.

Office of Security and Strategic Information: The Budget includes $6.5 million for the Office of Security and Strategic Information (OSSI), an increase of $1.6 million over FY 2010, to increase the efficiency of processing HHS security clearances, improve physical security across the Department, and create a new liaison position with the National Counter Terrorism Center. OSSI is responsible for the development, maintenance, and operation of policy and programming in areas of physical security, personnel security, communications security and strategic information. OSSI is also the point of contact for all of HHS in working with the Director of National Intelligence.

Medical Countermeasure Review

Medical countermeasures are a critical element for achieving the objectives of HHS and ASPR – to ensure that our communities are prepared for, can respond, and can quickly recover from events with public health consequences. The successes of the Nation's Pandemic Influenza strategy translate well to all aspects of all-hazards preparedness. However, challenges remain as we prepare for a range of threats – an anthrax attack, a dirty bomb, or exposure to smallpox. Therefore in December, 2009, Secretary Sebelius announced a review of the public health countermeasure enterprise. The goal is a modernized countermeasure production process with more promising discoveries, more advanced development, more robust manufacturing, better stockpiling, and more advanced distribution practices. The review is being led by ASPR and is expected to be completed in spring 2010.

HIGHLIGHTED BIOTERRORISM PREPAREDNESS ACTIVITIES

In addition to ASPR, many of the agencies and offices across HHS play important roles in ensuring that the country is prepared for and able to respond to a bioterrorist attack or significant public health emergency. In addition to funding in the PHSSEF, another $3.7 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for CDC, FDA, NIH, ACF, HRSA, and the Office of the Secretary.

The CDC has a lead role for the detection and containment of bio-threats, as well as for ensuring that the country has the right medical countermeasures and the ability to use them in the event of an attack. Quarantine stations improve CDC capacity to respond to natural and intentional communicable disease emergencies of public health significance by catching disease at

the border and preventing it from spreading to the American public. The FY 2011 Budget provides $27 million to continue support of the 20 quarantine stations located at airports across the country. This effort will also support more robust partnerships with Federal agencies operating at the ports of entry, including Customs and Border Patrol. The request also provides $34 million for BioSense, to improve open collaboration and communication across State and local jurisdictions and begin integration with the National Health Information Network.

The Budget includes a program level of $592 million for the CDC Strategic National Stockpile (SNS), a Federally-owned repository of countermeasures. These funds will help support the replacement of expiring products and increasing warehousing costs as the volume of the Stockpile increases, and additional products are added through Project BioShield.

The Preparedness Countermeasures Injury Compensation Fund is authorized to provide compensation to individuals suffering from any unintended side effects of a covered countermeasure administered during a disaster. Within HRSA, $2.5 million is included for this program. As of January 2010, there have been 13 declarations for pandemic influenza, anthrax, botulism, smallpox, and acute radiation syndrome.

In order to ensure that the public is able to use the countermeasures distributed from the Stockpile and that local communities are able to respond effectively during a public health emergency, HHS helps States, local public health departments and hospitals prepare for public health emergencies and acts of bioterrorism. In FY 2011, $715 million is requested in CDC, which complements the $426 million requested in ASPR. The Upgrading State and Local Capacity Grants Program at CDC and the Hospital Preparedness Cooperative Agreement Grants Program at ASPR prepare States and local public health departments and hospitals for public health emergencies and acts of terrorism. HHS has invested of over $12 billion since September 11, 2001 on these efforts.

In addition to the grant programs, HHS has several efforts to help the public respond during a public health emergency. The FY 2011 budget request provides $13 million to support the Commissioned Corps response to public health challenges and health care crises that can result from natural disasters, technological catastrophes, terrorist attacks, and other extraordinary needs.
The budget request also includes $2 million for the Disaster Human Services Case Management planning and coordination effort in ACF. This program is a collaboration between ACF, ASPR, and the Federal Emergency Management Agency consistent with the command structure and reporting requirements in the National Incident Management Plan and the National Response Framework.

Our bioterrorism readiness relies on quickly protecting Americans that have been exposed to a biological, chemical, or radiological threat agent and treating those who have become sick following an exposure. Our Nation's ability to counter bioterrorism ultimately depends on advancing biomedical science to develop next generation countermeasures. HHS activities in NIH and FDA, in addition to those in ASPR, are vital to ensuring that next generation medical countermeasures move from concept to licensed product.

The Budget request for NIH biodefense activities is $1.8 billion,

Performance Highlight

Within days of the devastating earthquake hitting Haiti on January 12, 2010, HHS launched a medical response. As of January 26, 2010, HHS has:

- Approximately 275 medical personnel on the ground in Haiti as part of the international medical response, led by the United Nations.
- Supported missions that include hospital augmentation, care at the embassy, assessment to assist the Haitian government with fatality management, and technical assistance in public health.
- Seen more than 15,500 patients; the most common medical conditions being treated are traumatic injuries and exacerbations of chronic disease. In some cases treatment has required surgery by our medical personnel.
- Provided a surgical cache of medical equipment and supplies to USAID that will be distributed to medical facilities in Haiti. Four planeloads of the medicine, medical equipment and medical supplies have arrived in Haiti for use by HHS medical teams.
- Provided, through its State partners, a range of temporary assistance including cash, travel, immediate medical care, hotel/lodging, and food for over 15,000 U.S. citizens who have returned from Haiti.

which includes $100 million for radiological/nuclear and chemical countermeasures research. These funds will support basic and applied research on agents with bioterrorism potential which will ultimately lead to the availability of new or improved vaccines and therapies to protect or treat persons exposed to threat agents. In addition, the budget for FDA includes $68 million to review and approve vaccines, drugs, and diagnostic equipment that will be part of the next generation of medical countermeasures.

Protecting our Nation's food supply from intentional contamination is an important responsibility of the FDA food defense program. To protect our Nation's food supply, $217 million is included in the budget request, to support key food defense activities, including support for the Food Emergency Response Network. This funding builds on the $1.3 billion in food safety funding in FDA, which will increase and improve inspections, domestic surveillance, laboratory capacity, and domestic response to prevent and control foodborne illnesses.

EMERGENCY PREPAREDNESS

(dollars in millions)

CDC Preparedness and Response Capability	198	--	193	183	-9
Strategic National Stockpile	570	--	596	592	-4
Subtotal, CDC	1,515	--	1,549	1,533	-16
National Institutes of Health:					
Biodefense Research	1,681	--	1,696	1,749	+53
Radiological/Nuclear Countermeasures Research	48	--	48	51	+3
Chemical Countermeasures Research	49	--	49	49	-0
Subtotal, NIH	1,777	--	1,793	1,849	+56
Food and Drug Administration:					
Food Defense	213	--	217	217	--
Vaccines/Drugs/Diagnostics	67	--	68	68	--
Physical Security	7	--	7	7	--
Subtotal, FDA	287	--	292	292	--
Adminstration for Children and Families:					
Disaster Human Services Case Management Initiative	--	--	2	2	--
Health Resources Services Administration:					
Covered Countermeasures Fund	--	--	--	3	+3
Office of the Secretary:					
Revitalization of Commissioned Corps	15	--	15	14	-1
Subtotal, Direct Appropriations	3,594	--	3,651	3,693	+41
Office of the Secretary, PHSSEF					
Assistant Secretary for Preparedness and Response (ASPR):					
Operations	13	--	13	12	-1
Preparedness and Emergency Operations	22	--	33	45	+12
National Disaster Medical System (NDMS)	50	--	56	57	+1
Hospital Preparedness	394	--	426	426	--
BARDA**	306	--	341	476	+136
Medical Countermeasure Dispensing	--	--	10	10	--
Medicine Science and Public Health	9	--	9	10	+1
Policy, Strategic Planning, and Communications	4	--	4	8	+4
Policy, Strategic Planning, and Communications	--	--	--	10	+10
Subtotal, ASPR	797	--	892	1,054	+162
Other Office of the Secretary:					
Office of Security and Strategic Information (OSSI)	3	--	5	6	+2
CyberSecurity	9	50	27	37	+10
Medical Reserve Corps	12	--	13	13	+0.1
Subtotal, Other Office of the Secretary	25	50	45	56	+20
Subtotal, PHSSEF	822	50	936	1,110	+182
Total Program Level	**4,415**	**50**	**4,588**	**4,803**	**+172**
Less Funds from Other Sources					
BioShield Funds available for Advanced Development	--		--	-476	-476
Transfer from P.L. 111-32 Pandemic Flu	--		--	-69	-69
Total Budget Authority	**4,415**		**4,588**	**4,258**	**-372**
Transfer of Funds					
Transfer of Project BioShield SRF from DHS to HHS	--	--	2,424	--	-2,424

**FY 2011 Funds are from existing BioShield SRF funds by making those funds available for advanced development in addition to procurement contracts.

ABBREVATIONS AND ACRONYMS

A

ACF	Administrations for Children and Families
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
ADUFA	Animal Drug User Fee Act
ADRC	Aging and Disability Resource Centers
AFDC	Aid to Families with Dependent Children
AFL	Adolescent and Family Life
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Administration on Aging
ARRA	American Recovery and Reinvestment Act
ASD	Autism Spectrum Disorder
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry

B

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

C

CBRN	Chemical, Biological, Radiological and Nuclear
CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCES	Child Care Entitlement to States
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidate Omnibus Budget Reconcillation Act
CSBG	Community Services Block Grant
CSE	Child Support Enforcement
CTSA	Clinical and Translational Science Award
CY	Calendar Year

D

DEcIDE	Developing Evidence to Inform Decisions about Effectiveness
DME	Durable Medical Equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospitals

E

EEOICPA	Energy Employees Occupational Illness Compensation Program Act
EHR	Electronic Health Record
ESRD	End Stage Renal Disease

F

FBI	Federal Bureau of Investigation
FCC	Federal Coordinating Council for Comparative Effectiveness Research
FDA	Food and Drug Administration
FFS	Fee-For-Service
FHA	Federal Health Architecture
FMAP	Federal Medical Assistance Percentage
FMS	Financial Management Services
FOHS	Federal Occupational Health Service
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FTE	Full Time Equivalent
FY	Fiscal Year

G

GDM	General Departmental Management
GINA	Genetic Information Non-Discrimination Act
GME	Graduate Medical Education
GSA	General Services Administration

H

HAI	Healthcare Associated Infections
HCFAC	Health Care Fraud and Abuse Control
HCUP	Health Care Cost and Utilization Project
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health and Human Services
HI	Federal Hospital Insurance
HI	Hospital Insurance (Trust Fund)
HIE	Health Information Exchange
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRSA	Health Resources and Services Administration

I

IHS	Indian Health Service
IME	Indirect Medical Education

ABBREVATIONS AND ACRONYMS

IRS	Internal Revenue Service
IT	Information Technology

L

LIHEAP	Low Income Home Energy Assistance Program
LTC	Long-Term Care

M

MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCH	Maternal and Child Health
MDUFA	Medical Device User Fee Act
MEPS	Medical Expenditure Panel Surveys
MIP	Medicaid Integrity Program
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MQSA	Mammography Quality Standards Act

N

NCRR	National Center for Research Resources
NDMS	National Disaster Medical System
NHIN	Nationwide Health Information Network
NHSC	National Health Service Corps
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NMEP	National Medicare & You Education Program

O

OCR	Office for Civil Rights
OGHA	Office of Global Health Affairs
OIG	Office of Inspector General
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPDIV	Operating Division
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
OSSI	Office of Security and Strategic Information
OWH	Office on Women's Health

P

PAHPA	Pandemic and All-Hazards Preparedness Act
PDP	Prescription Drug Plan
PDUFA	Prescription Drug User Fee Act
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PQRI	Physician Quality Reporting Initiative
PREP Act	Public Readiness and Emergency Preparedness Act
PSC	Program Support Center
PSSF	Promoting Safe and Stable Families

Q

QIO	Quality Improvement Organization

R

ROI	Return on Investment
RPG	Research Project Grant

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Strategic Acquisition Service
SHIP	State Health Insurance Assistance Program
SNS	Strategic National Stockpile
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSF	Service and Supply Fund
SSI	Supplemental Security Income
STAFFDIV	Staff Division
STD	Sexually Transmitted Diseases
STEM	Science, Technology, Engineering, and Mathematics Education Programs

T

TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TMA	Transitional Medical Assistance
TRNDI	Theraputic Rare and Neglected Disease Iniatives
TWIIA	Ticket to Work and Work Incentives Improvement Act of 1999

U

UAC	Unaccompanied Alien Children

V

VFC	Vaccines for Children
VTC	Video Teleconference