U.S. Department of Health and Human Services

FY 2004 Budget in Brief

200 Independence Avenue, SW
Washington, DC 20201
http://www.hhs.gov/

LETTER FROM SECRETARY THOMPSON

I am pleased to share with you the President's FY 2004 Budget for the United States Department of Health and Human Services (HHS). The proposed budget reflects the Administration's commitment to securing our Nation's safety needs, and the health and well-being of our citizens. The $539 billion proposed by the President will enable the Department to continue its important work with our partners in State and local governments and in the private and volunteer sectors to secure our commitment to protecting our Nation, expanding access to health care, and opening the doors of opportunity to all Americans.

It has been over a year since the tragic events of September 11th occurred, and we continue our vigorous commitment to protecting our Nation. Many of our programs at HHS provide the necessary services that contribute to the war on terrorism and protect us against biologic and other threats. In this area, we are focusing on preparedness at the local level, ensuring the safety of food products, and research and development on vaccines and other therapies to counter potential bioterrorist attacks. As we look to the future, we must continue to expand research, develop anti-bioterrorism strategies and encourage the use of new and emerging technologies. With the President's FY 2004 Budget, the Department of Health and Human Services will uphold its commitment to making our Nation safe.

While we prepare our Nation against today's threats, we must also prepare our programs to serve Americans even better in the future. This budget includes bold proposals to strengthen our largest programs. We need to modernize Medicare, preparing for the growth of the program and bringing its benefits up-to-date, including prescription drugs. In Medicaid, we need to build on the successful innovations of recent years, giving States more flexibility to serve more Americans in ways that meet today's needs. And, in welfare reform, we must take the next steps to ensure that opportunity and self-sufficiency are made available to all. This budget offers new approaches in each of these areas, as well as offering other steps to help ensure access to health care for the uninsured, provide critical support for America's children, and expand our support for treatment of substance abuse.

Consistent with the President's HealthierUS effort, HHS also proposes a coordinated, Department-wide effort to promote a healthier lifestyle emphasizing prevention of obesity, diabetes, asthma and youth risk behavior. In FY 2004 alone, the combined strength of all relevant HHS programs would prevent 75,000 to 100,000 Americans from developing diabetes, prevent 100,000 to 150,000 Americans from developing obesity, and prevent as many as 50,000 Americans from hospitalization due to asthma.

The President's FY 2004 Budget confronts external threats and domestic challenges. It offers a blueprint for improving the health, safety, and well-being of our Nation. It is innovative, responsive to the Nation’s needs, and responsible to our taxpayers. I look forward to working with the Congress to ensure that our programs continue to provide health and human services that are second to none.

Sincerely,

Tommy G. Thompson

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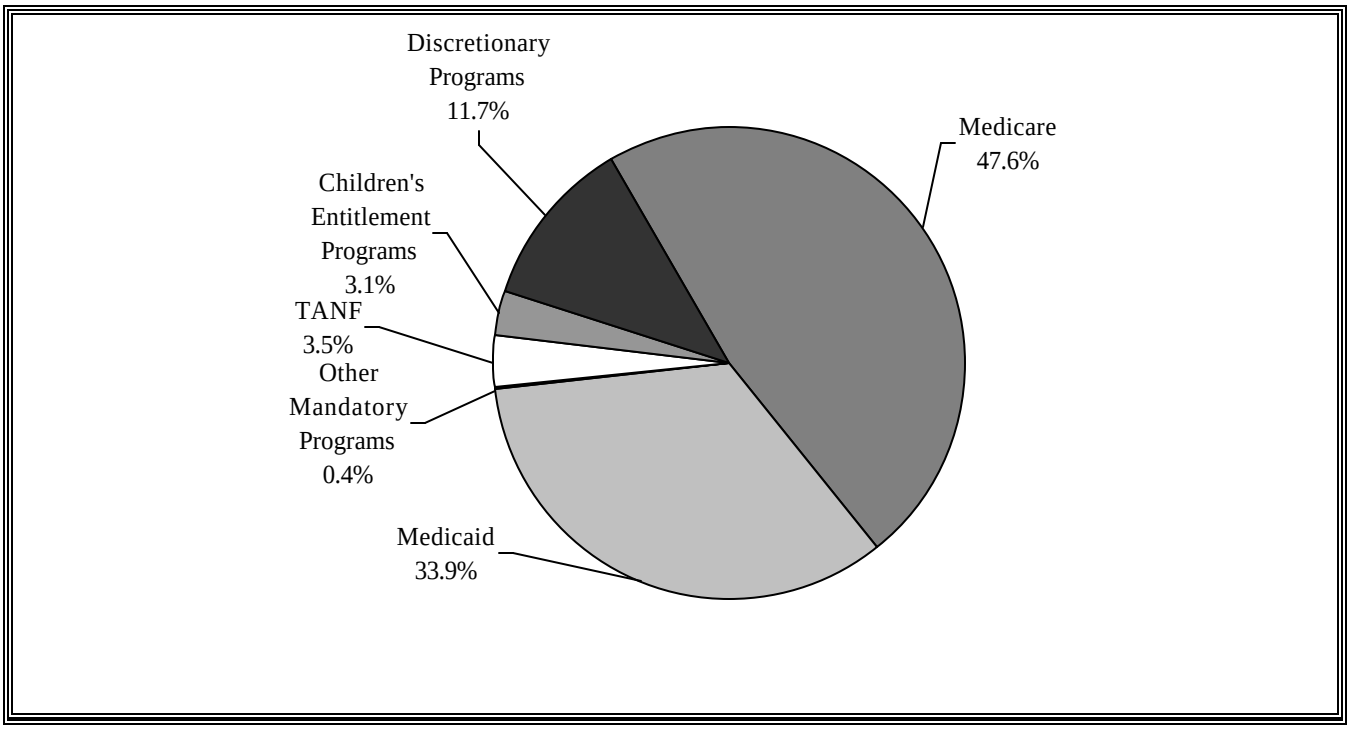
IMPROVING THE HEALTH AND SAFETY OF OUR NATION

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Budget Authority.....	$478,957	$507,835	$537,680	+$29,845
Outlays.....	$466,050	$502,156	$539,009	+$36,853
Full-Time Equivalents.....	63,506	65,508	65,525	+17
Commissioned Corps Detailed Outside HHS	*1,131*	*1,281*	*1,281*	*0*

President's Budget for HHS
FY 2004



IMPROVING THE HEALTH AND SAFETY OF OUR NATION

The fiscal year (FY) 2004 budget for the Department of Health and Human Services (HHS) builds on President Bush's commitment to protect the health and well being of our nation. The budget plan embraces the challenges of today by seeking new and innovative approaches for delivering services. The plan also recognizes the important role of our partners at State and local governments, community and faith-based organizations, and the newly created Department of Homeland Security in preserving the safety of our nation and health care for all Americans.

The HHS budget funds critical needs to modernize Medicare, Medicaid, State Children's Health Insurance Program (SCHIP) and welfare; prevent the spread of disease and illness; protect our homeland from biological attack; strengthen our health care systems; improve research; and provide for the economic and social well being of children, youth, families and the elderly. Our budget provides resources for:

MODERNIZING AND STRENGTHENING MEDICARE, MEDICAID, SCHIP AND WELFARE

The FY 2004 budget dedicates $400 billion over ten years for targeted improvements and modernization of Medicare, Medicaid, SCHIP, and Welfare programs.

Medicare Modernization: Medicare Improvements will expand beneficiaries' access to the same kind of health plan options and benefits that Federal employees and other Americans enjoy by:

- providing access to subsidized prescription drug coverage that would protect beneficiaries against high drug expenses and provide low income beneficiaries with additional assistance;
- linking Medicare +Choice plan payments to the rising cost of providing health care services;
- modernizing traditional fee-for-service coverage to protect beneficiaries against high out-of-pocket costs caused by serious illnesses;
- providing public information on the quality of care delivered in hospitals and nursing homes to help consumers make informed decisions about their health care needs.

Medicaid and SCHIP: The FY 2004 budget introduces a new Medicaid and SCHIP program option, under which States may take their Medicaid and SCHIP funding in a single Federal payment. This option provides States with great flexibility and the opportunity to design the most efficient and beneficial health coverage for their particular uninsured populations.

The budget also includes these proposals for States:

- A five year, $2.7 billion extension and simplification of Transitional Medical Assistance (TMA). Under this option, States may choose to continue Medicaid for welfare recipients returning to work for up to 12 months.
- An extension of FY 2000 SCHIP for an additional year, through FY 2004 at a cost of $565 million over 10 years.
- An improved and strengthened Medicaid drug rebate that will save the Federal government about $13.2 billion over the next ten years and save States a similar amount.

New Freedom Initiative: The President's Budget continues support of the New Freedom Initiative, an effort focused on promoting independence and reducing barriers to Americans with disabilities. Highlights include:

- Money Follows the Individual Demonstration – $1.75 billion over five years. Under this demo, the Federal government will pay the full cost of Medicaid services for individuals who transition from institutions to the community. After the first year, States pay their usual share.
- Three New Freedom Demonstrations from the FY 2003 budget will again be supported at $778 million over ten years. These projects will promote at-home care as an alternative to institutionalization; provide respite services to the care givers of disabled adults and severely disabled children; make home and community based services available to children residing in psychiatric residential treatment facilities; and address the shortage of community direct care workers.
- State option to continue Medicaid eligibility for spouses of disabled individuals returning to work – $238 million over ten years. This proposal would extend, to his or her spouse, the same Medicaid coverage offered to the disabled worker.

Advancing Welfare Reform: The budget again proposes to continue Temporary Assistance to Needy Families (TANF) at current levels while strengthening work requirements and support for healthy families. The budget includes an extensive package of proposals to strengthen the Child Support Enforcement program by passing on more of the child support collections to families and by toughening enforcement measures. The budget

also introduces a new program option for States to receive foster care funding in an annual payment in order to more flexibly design innovative services with a strong emphasis on prevention, safety, and family support.

FIGHTING BIOTERRORISM

The HHS budget provides funds to keep our Nation's citizens safe from the realities of terrorism. HHS's $3.6 billion bioterrorism budget substantially expands ongoing medical research, maintains State and local preparedness funding, and includes targeted investments to protect our food supply. While this total does not repeat FY 2003 one-time funding for security improvements, laboratory construction, and vaccine procurement, the budget includes considerable increases in bioterrorism spending.

The budget significantly expands the research funding needed to develop vaccines and medicines that will make these biologic agents much less effective as weapons. In addition to the substantial increase for this research, the Administration will propose legislation that enables the National Institutes of Health (NIH) to start and complete this work more quickly and efficiently. HHS will work closely with the new Department of Homeland Security to ensure that its pharmaceutical stockpiles include proper amounts of effective drugs, vaccines, and other biologics.

SUPPORTING THE PRESIDENT'S DISEASE PREVENTION INITIATIVE

The FY 2004 budget includes $125 million, with $100 million in new investments for Steps to a HealthierUS. This targeted disease prevention initiative combats diabetes, reduces rates of obesity, decreases asthma-related complications as well as promotes positive youth development. Steps to a HealthierUS is led by the Centers for Disease Control and Prevention (CDC) with full participation of the Health Resources and Services Administration (HRSA), the Administration for Children and Families (ACF), the Administration on Aging (AoA), and the Agency for Healthcare Research and Quality (AHRQ). The program would prevent 50,000 asthma-related hospitalizations, prevent over 75,000 Americans from developing diabetes, and prevent over 100,000 Americans from becoming obese in FY 2004.

IMPROVING THE NATION'S HEALTH

The FY 2004 budget takes the following steps to expand access and improve health.

Health Centers: The FY 2004 budget continues the President's initiative to expand access to critical health care services for the uninsured, especially in underserved rural and urban areas. With an increase of $169 million, HHS will be able to expand access to nearly 14 million individuals by 2004, and ensure that Health Centers' tort liability costs are covered.

National Health Service Corps: In connection with the Health Center initiative, the FY 2004 budget continues to support the National Health Service Corps (NHSC). HHS proposes to improve the placement of NHSC clinicians providing care to rural and underserved areas. Currently, 100 percent of NHSC clinicians provide services in underserved areas and nearly half work in Health Centers. Further, the FY 2004 budget proposes to retain 79 percent of the clinicians currently in the Corps.

Breast and Cervical Cancer Screening: The FY 2004 budget provides an increase of $10 million for the breast and cervical cancer program. The Centers for Disease Control and Prevention's breast and cervical cancer program supports screening services for low-income, underinsured, or uninsured women.

Ryan White ADAP: The FY 2004 budget proposes an increase of $100 million or 16 percent for the Ryan White AIDS Drug Assistance Program (ADAP). This highly successful program helps purchase drugs used in the treatment of those living with HIV/AIDS. The FY 2004 budget will increase the number of people receiving HIV/AIDS medications through the AIDS Drug Assistance Program.

Hospital Information Technology: The FY 2004 budget provides AHRQ with an increase of $24 million to help health networks implement and evaluate hospital-based information technology investments designed to enhance patient safety. In total, AHRQ will dedicate $50 million to this initiative in FY 2004, with an emphasis on small community and rural hospitals. In helping to create a business case for the adoption of proven technologies, AHRQ will use these demonstrations to disseminate broadly these types of technologies across the health care system.

Indian Health Service: The FY 2004 budget provides funding to the Indian Health Service (IHS) to improve the health status of American Indians and Alaska Natives by assuring access to high quality comprehensive personal and public health services. The FY 2004 budget will also increase funding to provide sanitation to over 22,000 American Indian homes, improve the health of those diagnosed with diabetes, and bring specialty health care, not available through IHS or tribal providers, to expand the number of outpatient services provided.

Generic and Over the Counter Drugs: The FY 2004 budget also provides the Food and Drug Administration (FDA) an increase of $13 million to improve consumers' access to generic and over the counter drugs. This investment will reduce medical costs by accelerating FDA's review of drug applications,

will fund research necessary to expand the types of drugs available in generic form, and will improve information available to consumers.

Childhood Immunization: The FY 2004 budget includes three major improvements in the financing of childhood vaccines. A total of $707 million will be used between FY 2003 and FY 2006 to develop stockpiles of childhood vaccines to help avert future shortages. Legislation will be proposed to improve access for many children already entitled to free vaccines from the Vaccines for Children (VFC) program, and restore tetanus and diphtheria vaccine to the VFC program. This legislation will increase vaccine purchases by $55 million in FY 2004.

Pandemic influenza: The budget also includes $100 million to improve our Nation's preparedness for an influenza pandemic. The funds will be used to spur the development of the manufacturing capacity that would be needed to make sufficient vaccine for the Nation quickly, regardless of the time of year the pandemic was detected.

Maintaining our Investment in Biomedical Research

Funding for NIH research will total $27.9 billion, an increase of $549 million. NIH will also redirect an additional $1.4 billion of base funding into research; these funds are allocated for facilities construction and anthrax vaccine procurement in FY 2003. As a result, the net increase in NIH's research budget totals $1.9 billion. This funding is critical to maintain scientific progress in areas such as biodefense, cancer, HIV/AIDS, Parkinson's, Alzheimer's, diabetes, and others.

Faith Based and Community Initiatives

In support of the President's Faith Based and Community Initiative, the HHS FY 2004 budget supports programs that promote positive relationships, including mentorships, through collaboration linking faith and community based organizations, State and local governments, and Federal partners to develop a shared picture for positive youth development.

Innovative Approaches to Drug Treatment and Recovery: The budget proposes to establish a new $200 million drug treatment program. For the first time, medical professionals in emergency rooms, health clinics, the criminal justice system, schools and private practice will be able to determine an individual's need for treatment and provide a voucher for those services at the same time.

Mentoring Children of Prisoners: The request doubles funding available, for a total of $50 million, to public and private organizations for programs that provide mentoring for children of incarcerated parents and those recently released from prison. Programs will provide supportive relationships to these children who are more likely to succumb to substance abuse, gangs, early childbearing and delinquency.

Additional programs that support the Faith Based Initiative at the grass roots level include: the Compassion Capital Fund which provides funds to public and private partnerships to support charitable organizations; promoting responsible fatherhood and marriage; and maternity group homes which provide an alternative to violent environments.

Supporting Children and Families

The FY 2004 budget provides funding to promote the economic and social well-being of children and families. The budget includes an investment in low-income children and their families through the Head Start program. The Head Start focus for FY 2004 will continue with the theme of school readiness and improved quality of Head Start programs.

The FY 2004 budget also funds programs that support the elderly. These programs encourage the ability of the elderly to stay active, healthy, and independent, with a particular focus on those living in rural, hard-to-reach areas. The FY 2004 budget transfers the Department of Agriculture's Nutrition Services Incentive Program to the HHS Administration on Aging.

Fighting the Transmission of Global AIDS

The FY 2004 budget contains funds to combat the spread of HIV/AIDS worldwide. The FY 2004 budget supports the President's Mother and Child HIV/AIDS prevention initiative that will target one million women and aims to reduce HIV/AIDS transmission to their children by 40 percent. CDC, in partnership with the United States. Agency for International Development (USAID), will use therapeutic interventions, such as replacing breast-feeding with infant formula, in 14 targeted countries. Together, in FY 2003 and FY 2004, HHS and USAID will meet the President's commitment of $500 million in support of this program.

Supporting the President's Management Agenda

The FY 2004 budget supports the President's Management Agenda and includes cost savings from consolidating administrative functions; organizational delayering to speed decision making processes; competitive sourcing; implementation of effective workforce planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations.

Our FY 2004 budget includes savings from ongoing information technolgoy (IT) consolidations and ensures that funds are invested in the highest priority IT projects.

CONCLUSION

The FY 2004 HHS budget supports progressive initiatives aimed at protecting the health and well–being of our Nation. It begins by modernizing Medicare, Medicaid, and Welfare. It also supports the President's Disease Prevention Initiative, and provides funding to improve our Nation's health. It increases support for the development of our Nation's children, especially those at risk. And, it maintains our goal of improving management and performance of HHS programs. The FY 2004 budget supports the President's goal of improving the health and safety of our Nation.

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Food & Drug Administration:				
Program Level	$1,551	$1,655	$1,713	+$58
Budget Authority	1,368	1,384	1,406	+22
Outlays	1,126	1,373	1,400	+27
Health Resources & Services Administration:				
Budget Authority	6,209	5,498	5,810	+312
Outlays	5,705	5,848	5,921	+73
Indian Health Service:				
Budget Authority	2,858	2,916	3,040	+124
Outlays	2,811	2,846	3,023	+177
Centers for Disease Control & Prevention:				
Budget Authority	4,450	4,264	4,231	-33
Outlays	3,672	4,214	4,210	-4
National Institutes of Health:				
Budget Authority	23,554	27,343	27,893	+550
Outlays	20,709	23,228	26,484	+3,256
Substance Abuse & Mental Health Services:				
Budget Authority	3,136	3,195	3,393	+198
Outlays	2,885	3,055	3,274	+219
Agency for Healthcare Research & Quality:				
Program Level	299	250	279	+29
Budget Authority	3	0	0	0
Outlays	-66	0	0	0
Centers for Medicare & Medicaid Services:				
Budget Authority	387,749	413,060	442,034	+28,974
Outlays	382,430	411,987	444,134	+32,147

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Administration for Children & Families:				
Budget Authority	47,292	47,394	46,990	-404
Outlays	45,649	47,207	47,740	+533
Administration on Aging:				
Budget Authority	1,349	1,341	1,344	+3
Outlays	1,255	1,438	1,341	-97
Departmental Management/Civil Rights/ *PHSSEF:				
Budget Authority	1,863	2,185	2,287	+102
Outlays	811	1,742	2,244	+502
Office of Inspector General:				
Budget Authority	35	39	39	0
Outlays	36	36	39	+3
Program Support Center:				
Budget Authority	386	393	424	+31
Outlays	322	359	410	+51
Proprietary Receipts:				
Budget Authority	-1,295	-1,177	-1,211	-34
Outlays	-1,295	-1,177	-1,211	-34
Total, Health & Human Services:				
Budget Authority	$478,957	$507,835	$537,680	+$29,845
Outlays	$466,050	$502,156	$539,009	+$36,853
Full-Time Equivalents	63,506	65,508	65,525	+17
Commissioned Corps Detailed Outside HHS	*1,131*	*1,281*	*1,281*	*0*

* Public Health and Social Services Emergency Fund

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Mandatory Programs (Outlays):				
Medicare	$228,720	$242,201	$256,336	+$14,135
Medicaid	147,512	162,541	182,543	+20,002
Temporary Assistance for Needy Families	18,749	19,209	18,713	-496
Foster Care & Adoption Assistance	5,885	6,297	6,718	+421
State Children's Health Insurance	3,682	4,751	2,657	-2,094
Child Support Enforcement	3,998	4,174	4,291	+117
Child Care	2,365	2,690	2,813	+123
Social Services Block Grant	1,780	1,792	1,790	-2
Other Mandatory Programs	1,035	1,074	1,203	+129
Proprietary Receipts	-1,295	-1,177	-1,211	-34
Subtotal, Mandatory (Outlays)	**$412,431**	**$443,552**	**$475,853**	**+$32,301**
Discretionary Programs (BA):				
Food & Drug Administration	$1,368	$1,384	$1,406	+$22
Health Resources & Services Administration	6,072	5,356	5,672	+316
Indian Health Service	2,758	2,816	2,890	+74
Centers for Disease Control and Prevention	4,450	4,264	4,231	-33
National Institutes of Health	23,454	27,243	27,743	+500
Substance Abuse & Mental Health Services	3,136	3,195	3,393	+198
Agency for Healthcare Research & Quality	3	0	0	0
AHRQ Program Level (Non-Add)	*299*	*250*	*279*	*+29*
Centers for Medicare & Medicaid Services	2,506	2,457	2,533	+76
Administration for Children & Families	13,057	13,080	13,449	+369
Administration on Aging	1,349	1,341	1,344	+3
Office of the Secretary	411	418	430	+12
PHSSEF	1,487	1,806	1,896	+90
Program Support Center/Commissioned Corps	0	0	13	+13
Subtotal, Discretionary (BA)	**$60,051**	**$63,360**	**$65,000**	**+$1,640**
Subtotal, Discretionary (Outlays)	**$53,619**	**$58,604**	**$63,156**	**+$4,552**
Total, HHS Outlays	**$466,050**	**$502,156**	**$539,009**	**+$36,853**

FDA

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Salaries and Expenses:				
Foods	$402	$409	$413	+4
Drugs	398	458	486	+28
Biologics	142	166	170	+4
Animal Drugs and Feeds	86	88	90	+2
Medical Devices	196	220	217	-3
National Center for Toxicological Research	43	41	40	-1
Other Activities	96	113	116	+3
Non-GSA Rent & Rent Related Activities	43	37	43	+6
GSA Rental Payments	105	108	120	+12
Subtotal, S&E	**$1,511**	**$1,640**	**$1,695**	**+$55**
Buildings and Facilities	34	8	12	+4
Export/Certification Fund	6	6	6	0
Total, Program Level	**$1,551**	**$1,654**	**$1,713**	**+$59**
Less User Fees:				
Prescription Drug User Fee Act (PDUFA)	$162	$223	$250	+$27
Medical Device User Fees (MDUFMA)	0	25	29	+4
Mammography Quality Standards Act (MQSA)	15	16	17	+1
Export/Certification Fund	6	6	6	0
Proposed Law, Animal Drugs User Fee Act (ADUFA)	0	0	5	+5
Subtotal, User Fees	**$183**	**$270**	**$307**	**+$37**
Total, Budget Authority	**$1,368**	**$1,384**	**$1,406**	**+$22**
Biodefense (non-add):				
Food Safety	*$98*	*$98*	*$116*	*+$19*
Vaccines/Drug Therapies/Diagnostics	*47*	*54*	*53*	*-1*
Security	*13*	*7*	*7*	*0*
Subtotal, Biodefense (non-add)	*$158*	*$159*	*$176*	*+$18*
FTE	10,042	10,479	10,841	+362

FOOD AND DRUG ADMINISTRATION

Mission: *The Food and Drug Administration's (FDA) mission is to promote and protect the public health by helping safe and effective products reach the market in a timely way, and monitoring products for continued safety after they are in use.*

The FY 2004 budget request for the FDA is $1.7 billion, a net program level increase of $59 million over the FY 2003 President's Budget. Within this total, there are program increases of $115 million, partially offset by $56 million in management savings. Of the funds requested, $307 million will be derived from industry-specific user fees. Program increases are focused on biodefense activities that ensure a safe food supply, accelerating the availability of generic and over-the-counter drugs; improving information on safety and efficacy of drugs for children; providing quick access to new, safe and effective drugs and medical technologies; and improving patient safety.

The budget seeks to enable the FDA to meet the challenges of food and drug regulation in the 21st century. FDA protects the public health by preventing injury or illness due to unsafe or ineffective products - foods, drugs, biologics, medical devices, etc., and by assuring consumer product information is truthful and clear. FDA actively identifies health problems associated with FDA-regulated products and assesses the origin and impact of these health problems. FDA is working to ensure its regulatory efforts are dynamic and responsive – preventing the public from being exposed to hazards, and monitoring the marketplace to ensure compliance with laws, regulations, and good manufacturing practices.

FOODS

FDA regulates over 60,000 U.S. food processors and warehouses and 6 million food imports in FY 2004. Products regulated by FDA account for about two-thirds of consumer spending on food, with an annual retail value of about $430 billion. The budget includes $413 million for foods, a net increase of $3 million. Within the amount requested, an additional $20.5 million over the FY 2003 President's Budget will be directed towards activities that implement the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (PHSBPRA) and other biodefense activities needed to ensure the nation's food security.

The request directs $5 million toward improving laboratory preparedness. These funds will enable FDA to expand federal, State and local involvement in the Electronic Laboratory Exchange Network (eLEXNET) that enables State and federal laboratories to exchange information on pathogens in food. These food laboratory improvements will be closely coordinated with CDC's investments in public health laboratories participating in the Laboratory Response Network.

FDA will improve the quality of food monitoring and inspections through State contracts and grants, as required by Section 311 of PHSBPRA. The budget directs $5 million to be used for this. FDA requests $10.5 million to implement a registration system for domestic and foreign food production, handling and storing facilities, as well as a prior notice system for imported food shipments.

FDA is also actively implementing other components of the PHSBPRA. Regulations are being developed that govern the detention of food if evidence is found indicating a serious threat to humans or animals; and to establish the collection and maintenance of records for tracking the immediate source and recipient of foods.

HUMAN DRUGS AND BIOLOGICS

FDA evaluates all new drugs for safety and efficacy before entering the market and monitors more than 10,000 drugs already on the market to be sure they continue to meet the highest standards of safety and efficacy. FDA is also responsible for ensuring that biological products, including whole blood and blood products; vaccines; and therapeutic products, including cells, gene therapies, and tissues, are safe and effective. FDA also works closely with other Federal agencies and industry to promote the development and availability of biodefense countermeasures. To carry out this work, FDA seeks a total of $656 million, an increase of $32 million. Of this amount, $227 million is in industry-specific user fees.

Generic Drugs: The budget includes an increase of $13 million for reviewing and ensuring the safety of generic drugs. Rapid review of these applications is essential to maximize the availability of high quality, lower cost prescription drugs. With this increase, FDA will complete its review, on average, about two months faster. FDA will also initiate targeted research that is necessary to establish more standards of bioequivalence, and broaden the types of drugs for which generics are available. This investment will be complemented by regulatory reforms under which FDA will limit

Last year, the average brand name drug cost more than $72 per prescription. The average price for generic drugs, which are just as safe and effective as the brand name drugs, was less than $17 per prescription. Generic drugs make America's health care far more affordable.

President Bush

the number of automatic delays in the review process related to patent filings and make sure approved generic drugs are used safely.

Over-the-Counter (OTC) Drugs: OTC drugs provide an effective means to reduce consumer prescription costs for specified ailments. The increase of $1 million for OTC drugs will be used to provide consumers faster access to safe and effective products that may have been previously marketed by prescription or available OTC in other nations.

Best Pharmaceuticals for Children Act (BPCA): The budget expands the joint FDA and NIH effort, begun in 2003, to ensure that medicines have been properly evaluated for use in pediatric populations and improve the information physicians have to use when prescribing medicines to children. An additional $30 million is requested – $5 million in FDA and $25 million in NIH – to dedicate towards this work. FDA will use a portion of the funds to expand its work with industry to develop pediatric specific information for on-patent drugs. FDA will also work with NIH to determine the specific research that is needed for frequently used off-patent drugs, and NIH will carry out the research. Total funding for BPCA efforts will be up to $61.5 million in FY 2004, including $11.5 million in FDA and up to $50 million in NIH.

Patient Safety: FDA will expand its efforts to reduce drug-related adverse events. FDA will also improve its analysis and follow-up of adverse event reports. Over 300,000 confidential adverse event reports are received each year. Reviews are conducted to detect potential patterns that may warrant follow-up investigations. The most common outcome is improved information for medical providers on the safe use of regulated products. This information is also used to determine when unanticipated side effects or usage errors are sufficiently severe for a product to be removed from the market.

User Fees: The budget includes $249 million from the Prescription Drug User Fee Act (PDUFA) fees, of which $220 million is available for the Human Drugs and Biologics programs and the remaining $29 million for rent and other costs related to the management and operations of the program. The PDUFA program has been highly successful in reducing the time needed to review applications for new drugs and biologics, while maintaining the safety standards essential to the public's health. These fees have also enabled the provision of substantially more technical assistance, advice, and rapid responses to special inquiries during the drug development and testing period. As a result, industry has been able to significantly shorten the time needed for drug development and testing. Similarly, the new MDUFMA fees are expected to accelerate the availability of tissue-based medical devices overseen by the Biologics program.

MEDICAL DEVICES

New and increasingly complex medical devices are making exciting medical advances possible, in both diagnosis and treatment. These advances are reflected in the increase in the number of domestic and international medical device firms from 9,061 in FY 1997 to approximately 14,250 in FY 2002. To meet this challenge, FDA requests $217 million. Of this amount, $32 million is derived from industry-specific user fees related to medical devices and mammography quality standards.

FY 2004 will be the first full year of implementation of the Medical Device User Fee and Modernization Act of 2002 (MDUFMA). These new fees will enable FDA to make the information technology and human resource investments needed to both accelerate reviews and improve their quality. The budget includes $29 million from MDUFMA fees. $16 million of this total is requested in the Medical Devices budget activity, with $7 million supporting tissue-based device review in the Biologics program, and $6 million paying legal support, space costs for new staff, and central management oversight.

The Medical Devices program will continue implementing the Medical Device Product Surveillance Network (MeDSuN) that is essential to meeting FDA's patient safety goals. This network will provide FDA with statistically reliable information on adverse events, and partnerships that will facilitate efforts to improve patient safety. Having active surveillance information will improve FDA's ability to target adverse event follow-up and reduction efforts. The number of participating hospitals and other providers will increase from 180 in FY 2003 to 240 by the end of FY 2004.

ANIMAL DRUGS

The Animal Drugs and Feeds Program protects the health and safety of all food producing, companion or other non-food animals; and, assures that food from animals is safe for human consumption. FDA is proposing a new animal drug pre-market review user fee in FY 2004. FDA's budget includes $5 million from the fees to be paid

by animal drug applicants, sponsors, and manufacturers. These funds will allow FDA to provide quality pre-market reviews in a cost-efficient and timely manner. FDA also conducts post-market inspections, investigations, and sample collections and analyses.

FACILITIES

The request includes $12 million for buildings and facilities, and $43 million for rent and rent-related costs. This includes $4 million increase to complete the Arkansas Regional Laboratory and $6 million for telecommunications cabling and related costs for the new Center for Drug Evaluation and Research facility that the General Services Administration is constructing at White Oak, in suburban Maryland.

PRESIDENT'S MANAGEMENT AGENDA

FDA's FY 2004 budget request supports the President's Management Agenda and includes cost savings from consolidating administrative functions such as personnel, and implementing a new Shared Services approach for internal administrative support functions. This will include customer advocated, service level agreements, governance boards, etc., to ensure the quality as well as the cost-effectiveness of these services. FDA will also continue its efforts to achieve savings through competitive outsourcing of additional services such as graphics, property management, etc. These efforts will achieve $26 million in savings throughout the Agency. A second example of these management improvements is the decision to consolidate review of drugs and drug-like products. Review of products used like drugs for therapeutic purposes, currently overseen by the Center for Biologics Evaluation and Research, will be consolidated into the Center for Drug Evaluation and Research.

FDA is expanding its efforts to consolidate information technology systems. FDA worked closely with industry to develop improvements in the agency's electronic interchange with those it regulates. FDA is also consolidating information technology activities outside the user-fee-funded areas and anticipates $30 million savings from these efforts.

HRSA

(dollars in millions)

	2002	2003	2004	2004 +/-2003
Community Health Centers	$1,343	$1,458	$1,627	+$169
Health Centers Tort Claims Fund (non-add)	*15*	*25*	*45*	*+20*
National Health Service Corps	145	189	213	+24
Ryan White HIV/AIDS Activities	1,910	1,911	2,010	+99
AIDS Drug Assistance Program (non-add)	*639*	*639*	*739*	*+100*
Bioterrorism Hospital Preparedness	135	518	518	0
Bioterrorism Medical School Curriculum	0	60	60	0
Poison Control/EMS for Children	40	40	40	0
Hospital Emergency Relief	140	0	0	0
Nurse Training Programs	93	98	98	0
Health Professions Training Programs	295	11	11	0
Children's Hospitals Graduate Medical Education	285	200	199	-1
Rural Health	127	75	80	+5
Denali Commission	20	0	0	0
Maternal and Child Health Block Grant	731	732	751	+19
Healthy Start	99	99	99	0
Abstinence Education	90	123	123	0
Organ Transplantation	20	25	25	0
Family Planning	265	265	265	0
Bone Marrow/Black Lung/Hansen's Disease/TBI	56	56	55	-1
Radiation Exposure Compensation	4	4	4	0
Telehealth	37	6	6	0
Health Care Facilities	315	0	0	0
Community Access Program/State Planning Grants	120	0	0	0
Universal Newborn Hearing Screening/Trauma	14	0	0	0
Program Management	156	154	157	+3
National Practitioner Databank (User Fees)	16	17	17	0
Health Integrity & Protection Databank (User Fees)	5	5	4	-1
Total, HRSA Program Level	**$6,461**	**$6,045**	**$6,361**	**+$316**
Less Funds Allocated From Other Sources:				
Mandatory Abstinence Education Grants to States	$50	$50	$50	$0
Items Financed from PHSSEF (Bioterrorism/Recovery)	319	618	618	0
User Fees	21	22	21	-1
Subtotal, Funds From Other Sources	$390	$690	$689	-$1
Total, HRSA Discretionary B. A.	**$6,071**	**$5,355**	**$5,672**	**+$317**
FTE	1,844	1,937	1,912	-25

HEALTH RESOURCES AND SERVICES ADMINISTRATION

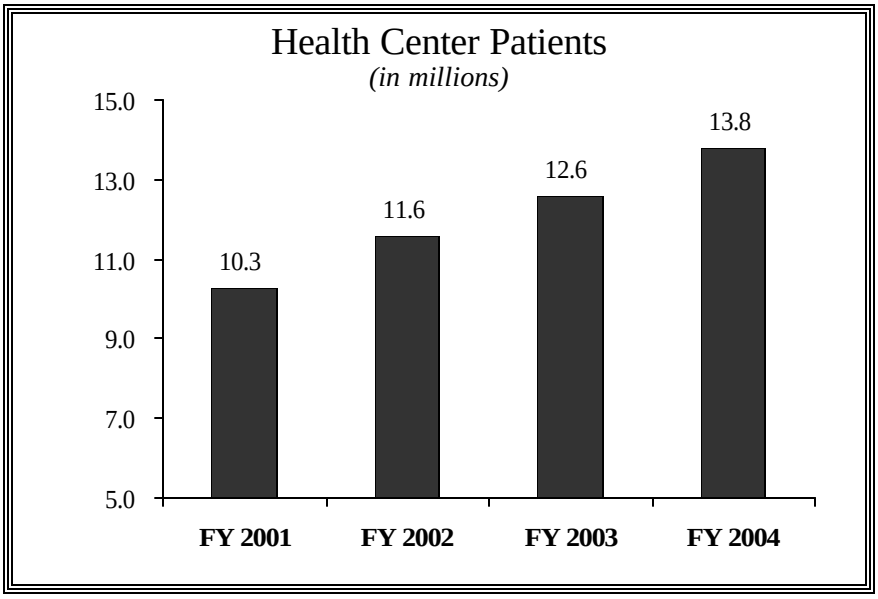
Mission: *The Health Resources and Services Administration's (HRSA) mission is to improve and expand access to quality health care for all.*

The FY 2004 budget requests $6.4 billion for HRSA, a net increase of $316 million above the FY 2003 President's Budget. FY 2004 continues the President's multi-year initiative to increase access to health care for the uninsured and underserved by enhancing and strengthening the Health Centers program. The National Health Service Corps will provide additional health professionals to underserved and minority communities, especially in Health Centers. HRSA will expand services for people living with HIV/AIDS. The Agency will maintain its significant investment in preparing our nation's hospitals and health professions workforce for a bioterrorism event. In order to address the national nursing shortage through enhanced recruitment and retention, HRSA will direct more resources towards basic nurse education, loan repayments, and scholarships. The budget increases funding for rural health programs, to help meet the unique challenges facing rural America, and for important maternal and child health programs.

PROVIDING QUALITY HEALTH CARE IN UNDERSERVED AREAS

Today there are an estimated 41 million uninsured people. Many of our Nation's uninsured live in rural communities where there are few or no physicians or health care services. Rates of uninsured are higher among minority populations. The uninsured are hospitalized at least 50 percent more often than the insured for "avoidable hospital conditions." Through the continued expansion of the health center network and investment in programs that direct health professionals to underserved areas, the Department will help meet the challenge of providing high quality health care for all Americans.

Health Centers: The FY 2004 budget provides funding for the third year of the Health Centers Presidential initiative. A net increase of $169 million, for a total of $1.6 billion, for the Health Center program is requested, to expand services to an additional 1.2 million individuals in approximately 120 new sites and 110 expanded existing sites.



This initiative is intended to create 1,200 new or expanded health center sites and serve an additional 6 million people by 2006. By FY 2004, this Presidential initiative will have increased the total number of health center sites to over 3,650 and will provide nearly 14 million Americans with quality health care, an increase of over 3 million in three years.

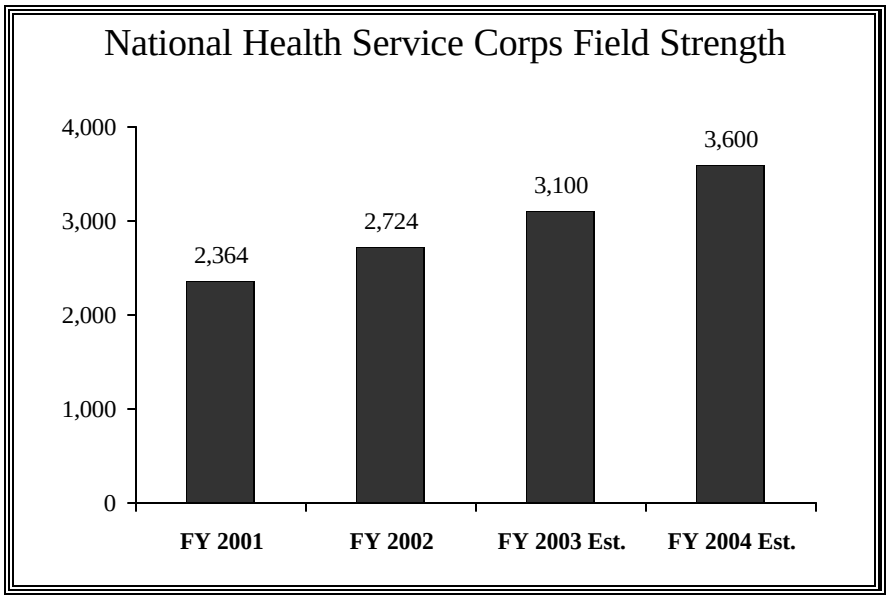
These centers deliver comprehensive preventive and primary care services to low income and uninsured populations. Nearly 40 percent of the patients treated at health centers have no insurance coverage, and many others have inadequate coverage.

Through "Health Disparities Collaboratives", health centers focus on preventing specific diseases by developing interdisciplinary teams that have changed practices and improved health outcomes for patients living with diabetes, cardiovascular disease, asthma, and depression. Nationally, approximately 400 health centers have participated in these successful collaboratives. The Health Center program also participates in the joint effort called the Initiative to End Chronic Homelessness, administered by the Departments of Housing and Urban Development, Veterans Affairs and Health and Human Services.

Health centers employ approximately 4,000 full time physicians and 22,500 other health care clinicians including nurse practitioners, nurse midwives, and dentists. In 2004, these providers will serve nearly 14 million patients through as many as 50 million encounters. The FY 2004 budget request also includes $45 million, an increase of $20 million, for the Health Centers Federal Tort Claims Program, which provides medical malpractice

coverage for the increasing number of health center employees.

National Health Service Corps: Geographic maldistribution of health professionals remains a major problem for many inner city and isolated rural communities. Over the National Health Service Corps' (NHSC) 30 year history, more than 22,000 health professionals have committed to service in underserved areas across the country. The FY 2004 budget continues the expansion of the NHSC with a net increase of $24 million, for a total of $213 million. Within this total, $168 million will be used to recruit clinicians by offering loan repayments and scholarships and $45 million will be used for NHSC field costs. The NHSC will prioritize the recruitment of clinicians from disadvantaged backgrounds, including under-represented minorities, by providing loan repayments and scholarships to health care providers who agree to serve in the neediest communities across the country. By increasing efforts to target providers to the neediest communities, the program will better serve minority and other disadvantaged populations. This increase funding total will support an estimated 2,300 loan repayments and scholarships, and a total field strength of 3,600 clinicians. The NHSC will continue to work with Health Centers to help meet their provider needs, since half of NHSC clinicians serve in Health Centers.



EXPANDING SERVICES FOR PEOPLE LIVING WITH HIV/AIDS

The FY 2004 budget includes $2 billion for the Ryan White HIV/AIDS program, a net increase of $99 million over the FY 2003 President's Budget. The Ryan White program will continue to improve services to an estimated 530,000 individuals living with HIV/AIDS.

The $100 million increase for the AIDS Drug Assistance Program (ADAP) will support purchasing medications for over 9,000 additional persons living with HIV/AIDS, for a total of 159,000 individuals over the course of a year. Funding will also allow States to expand on the recent improvements that have been made in providing medications to underserved populations. These improvements include increasing the number of States with 26 or more drugs on their formulary from 17 to 23; increasing the number of States that required only an HIV positive diagnosis for eligibility from 41 to 46; and increasing the number of States that set the financial eligibility above the 200 percent Federal Poverty Level from 18 to 23.

Funds will continue to provide a full spectrum of outpatient medical care through 51 Eligible Metropolitan Areas. Through the Early Intervention Services program, 337 community based grantees will provide comprehensive primary care services to 158,000 clients. The request will also sustain primary health care and social support services to over 40,000 women, infants, children and youth living with HIV/AIDS.

HRSA also assists international AIDS efforts in the development of training programs and materials for health care professionals, which through a partnership with CDC, are shared with foreign countries significantly impacted by the virus.

PREPARING FOR BIOTERRORISM

As part of the Department's efforts to prepare our Nation's health system to provide medical and public health services in the event of a bioterrorist attack or other public health emergency, HRSA will continue to improve the capacity of local hospitals and front line health care professionals to better respond during an emergency.

Hospital Preparedness: The Hospital Preparedness program was initiated in the past year to help States, territories, and municipalities develop and implement biological and chemical preparedness plans focused on hospitals. Funds are being used to set up hospital preparedness offices with bioterrorism coordinators and medical advisors, complete needs assessments, develop and implement regional hospital plans to manage a large scale epidemic, and to focus on four first priority areas: medication and vaccine distribution, isolation and decontamination, communication, and biological disaster drills. Through coordinated efforts on both

the State and Federal levels, the hospital preparedness plans have been linked with State and local public health preparedness planning funded by CDC, and, where applicable, the Metropolitan Medical Response Systems.

The FY 2003 budget and authorizing legislation expanded the program to further upgrade the capacity of hospitals, outpatient facilities, emergency medical services systems and poison control centers to care for victims of bioterrorism and other public health emergencies. The new authorization allowed States to use funds for infrastructure improvements and expansions so that hospitals have adequate laboratory capacity; improved capabilities to control infection; to purchase personal protective equipment, infection control facilities and other equipment; and to forward high-risk specimens to higher level laboratories. In FY 2004, the Department will maintain this increased investment, at a total of $518 million.

Bioterrorism Health Professional Schools Curriculum Development and Training: This Nation's health professions workforce must be prepared to recognize indications of a terrorist event in their patients, treat patients in a safe and appropriate manner, and rapidly and effectively alert the public health system. This budget includes $60 million to maintain the Educational Incentives for Curriculum Development and Training Program, for which funds were first requested in FY 2003. This program provides incentives for curricular reform in health professions schools, to ensure future health care providers are adequately trained, as well as funds for continuing education for community and hospital based healthcare professionals already in practice.

Hospital Preparedness State Activities

Tennessee: Based on patient flow patterns to medical centers, Tennessee developed six Hospital Bioterrorism Planning Regions and is developing regional hospital plans based on these regions. Tabletop exercises that will test the capability of hospitals in each region to respond to a bioterrorism scenario and accommodate a surge of 500 patients, will be conducted by late 2003.

Pennsylvania: All of the over 200 hospitals that received Pennsylvania's Hospital Emergency Preparedness Needs Assessment, participated in the assessment. Initial review shows that most hospitals currently have in place emergency plans for the delivery of essential goods and services, but only 40% have plans that address the reconfiguration of hospital space for quarantine of communicable diseases and treatment of infectious disease epidemics. Pennsylvania will distribute funds to each eligible hospital by providing a base funding level and an additional amount based on the volume of emergency department visits in the previous year.

California: The State of California and the County of Los Angeles both received Hospital Preparedness funding. California developed, conducted, and is analyzing the results of its Statewide Hospital and Clinic Bioterrorism Preparedness Survey, completed by 72% of acute care hospitals and 54% of licensed community care clinics. Working with the Universities of California at Berkeley, and at Los Angeles, the State expects to create a multi-media modular training package and will offer standardized curriculum training to all hospital-based employees as well as community-based health workers.

Poison Control Centers: The budget also provides $21 million for Poison Control Centers, the same as the FY 2003 President's Budget. The Centers are an integral part of the health system and part of the continuum of necessary emergency services. The majority of these funds directly support Poison Control Centers, which provide expert advice to the public 24 hours a day, seven days a week, regarding exposure or potential exposure to poisons. Stabilization and enhancement grants are awarded to approximately 80 Centers each year. Funding is also provided for a national toll-free number which is accessible throughout the United States.

Emergency Medical Services for Children: The budget includes $19 million for Emergency Medical Services for Children, the same as the FY 2003 President's Budget. EMS providers are some of the first to come into contact with children in need of emergency health care. Each year over 31 million children and adolescents are seen in emergency departments, however, many States do not have pediatric guidelines to assure that children get to the right hospital in a timely manner. This program will provide 44 grant awards to assist States and territories in improving care and making systems enhancements, and 44 additional awards to academic health centers, to ensure that health care professionals are prepared to meet the unique needs of children in the event of a bioterrorism attack.

ADDRESSING THE NATIONAL NURSING SHORTAGE

The Nation continues to face a nursing shortage. In 2000, the estimated national demand for registered nurses was over 100,000, or 6 percent, more than the supply. Demand for nurses is rapidly increasing as a result of a growing and aging population that needs more health care, as well as continued medical advances that heighten the

need for nurses. The nursing supply is not keeping pace with demand due to a decline in nursing school graduates and an aging of the workforce.

The budget provides $98 million for HRSA nursing programs, including $7 million to implement a newly authorized scholarship program that will reduce the financial barrier to nursing education for all levels of professional nursing students, thus increasing the number of students in the pipeline. Scholarship recipients must fulfill a service commitment of providing nursing care for a minimum of two years in a facility with a critical shortage of nurses. With this $7 million, an estimated 140 additional nursing students will be supported with scholarships averaging up to $25,000 per year for two years.

Based on recommendations from an independent expert panel, nursing program funds are also being redistributed among existing nursing programs. The expert panel identified factors considered important to nursing workforce development and funding distribution (e.g. trends in supply/demand, demographics, science and technology, etc). Priority in FY 2004 is being placed on supporting basic education and retention and workforce diversity activities. In FY 2004, the budget allocates $72 million for basic workforce development and $26 million for advanced nursing education.

To ensure a continuing source of scholarships focused on increasing diversity in the health professions and nursing workforce, the budget maintains a $10 million investment in the Scholarships for Disadvantaged Students program. The FY 2004 budget continues the policy of not funding more general training efforts – primary care, interdisciplinary community projects, training for diversity, and public health. The budget requests $199 million to support health professions training in free-standing children's hospitals through the Children's Hospitals Graduate Medical Education program.

Ensuring Access to Health Care in Rural America

There are 65 million Americans who live in rural areas. Rural residents are less likely to have health insurance and more likely to be poor. In general, rural areas have a higher proportion of elderly residents. Geography and transportation play important roles in limiting rural residents access to health care. The Department will continue, and expand, efforts to meet the unique challenges facing rural America and ensure access to quality health care.

Rural Health Programs: The FY 2004 budget includes $80 million for rural health programs, an increase of $5 million over the FY 2003 President's Budget. Additional funds will expand the Rural Hospital Flexibility Grant program, for a total of $30 million, to provide grants to implement new hospital technologies in isolated rural areas. The budget also maintains support for Rural Health Outreach and Network Development grants, which enable community partnerships to implement creative strategies to meet their unique health needs; State Offices of Rural Health; policy research studies and dissemination of information on rural health issues; and access to life-saving emergency devices.

The Department will also continue to help rural communities experiencing a shortage of health care providers by serving as the interested government agency that reviews J-1 Visa waiver applications. The waivers allow foreign doctors who trained in the U.S. to remain in the country and serve in rural, underserved communities. Each year, approximately 1,000 physicians are serving rural communities through J-1 Visa waivers. The FY 2004 budget also includes $2.5 million to support the administration and increased oversight of this program, and to ensure that these physicians are able to continue serving rural communities.

Improving Maternal and Child Health

The Department works towards improved health outcomes for all American women and children. The FY 2004 budget continues support for the programs that contribute to recently observed positive health trends, such as reduced infant mortality, increases in breastfeeding, and higher rates of abstinence.

Maternal and Child Health Block Grant: The FY 2004 budget request includes a net increase of $19 million, a total of $751 million, for the Maternal and Child Health (MCH) Block Grant. The Block Grant supports Federal and State partnerships that provide critical services to 27 million women and children. These services include direct health care services for children with special health care needs, the promotion of health and safety in child care settings, and enabling services such as home visiting and nutrition counseling. The MCH Block Grant also provides support for newborn screening, trauma care, lead poisoning, and injury prevention. The Block Grant continues to play a valuable, complementary role to SCHIP and Medicaid programs by reaching out and enrolling eligible women and children in these and other programs. HRSA regularly collects timely performance data for this program, using a model approach, and uses this information to review each State's performance and assess their progress in comparison with other States.

Healthy Start: The budget proposes $99 million for the Healthy Start program, maintaining the current level. Healthy Start funding supports community-driven programs to reduce the incidence of risk factors that contribute to infant mortality in

targeted high risk communities. While low birth weight (LBW) has been steadily increasing at the national level, Healthy Start projects reduced LBW in their high risk communities from an average of 12.1 percent in 1998 to 10.5 percent in 2000. At this funding level, 114 communities will receive Healthy Start funds in FY 2004, increasing the total number of communities that have been supported by this program to 118.

Abstinence Education: The budget maintains a substantial investment in abstinence education, a total of $123 million in HRSA, the same as the FY 2003 President's Budget. The Community-Based Abstinence Education program, funded at $73 million, provides support to public and private entities for the development and implementation of abstinence-only education programs for adolescents, ages 12 through 18, in communities across the country. This program, which began in FY 2001, is unique in that funded projects focus entirely on educating young people and creating a positive environment within communities that supports teen decisions to postpone sexual activity until marriage. Within three years, 112 communities have received funding, and up to 80 more will be funded in FY 2004.

The budget proposes to continue the $50 million in mandatory funding for Abstinence Education Grants to States. This program provides grants to 59 States and territories to provide mentoring, counseling, and adult supervision to promote abstinence with a focus on those groups which are most likely to bear children out-of-wedlock.

In addition to the HRSA activities, the Adolescent Family Life Program's budget includes $13 million for abstinence activities. Combined with the HRSA activities, the FY 2004 budget maintains the President's goal of supporting abstinence education at $136 million.

ENCOURAGING ORGAN DONATION

Nearly 80,000 people are on the national organ transplantation waiting list. During 2001, nearly 24,000 human organs were transplanted, assisting less than one-third of the people waiting for a transplant. The Secretary's Gift of Life Donation Initiative, a collaboration with companies and employee groups to make information on organ, tissue, marrow and blood donation available, has grown to include over 3,000 members, representing roughly 60 million employees.

Since 1999, HRSA has awarded grants to evaluate strategies for increasing consent to donation and intent to donate coupled with family notification. HRSA also continues to refine methods for identifying those patients with the greatest medical need for transplantation. The FY 2004 budget includes $25 million, the same as the FY 2003 President's Budget, to continue support for these programs, as well as the network that manages the distribution of organs throughout the United States.

FAMILY PLANNING

The Family Planning program supports a network of more than 4,500 clinics nationwide serving 4.8 million people. These clinics provide access to a wide array of reproductive health care and preventive services. Of the patients served, approximately 90 percent have incomes below 200 percent of Federal poverty level, and approximately two thirds are over age 20. Funds are also used to support 15 demonstration projects focused on developing and implementing approaches for delivering family planning services to men. Counseling and education regarding abstinence are required for all adolescent clients through this program. The FY 2004 budget request includes $265 million, maintaining the FY 2003 President's Budget's level.

OTHER HRSA PROGRAMS

The budget proposes $65 million for the remaining HRSA programs including Telehealth, Bone Marrow, Hansen's Disease, Black Lung, Radiation Exposure Compensation, and Traumatic Brain Injury, essentially maintaining FY 2003 President's Budget levels.

PROGRAM MANAGEMENT

The budget requests $157 million for HRSA's program management, a net increase of $3 million over the FY 2003 President's Budget. This includes $2.5 million to oversee the J-1 Visa program. HRSA will be able to fund Federal pay cost increases as well as the HHS Unified Financial Management System within this funding level.

ACCOMPLISHING THE PRESIDENT'S MANAGEMENT AGENDA

In order to accomplish the President's Management Agenda, HRSA will reduce FTE by eliminating redundant positions, and will achieve additional administrative cost reductions by consolidating contractual services. These efforts will result in a total decrease of $5 million. HRSA will also achieve cost reductions by targeting projects deemed by Information Technology experts to be poorly performing or obsolete, such as systems developed to provide interim solutions to Y2K problems. In addition, savings will result from HRSA's participation in Departmental consolidation of information technology infrastructure services. A total reduction of $5 million will be achieved within HRSA's information technology systems.

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Indian Health Service:				
Clinical Services	$2,421	$2,501	$2,550	+$49
Contract Health Services (Non-Add)	*461*	*468*	*493*	*+25*
Preventive Health	100	103	108	+5
Contract Support Costs	268	271	271	0
Tribal Management/Self-Governance	12	12	12	0
Urban Health	31	32	32	0
Indian Health Professions	31	35	35	0
Direct Operations	55	55	56	+1
Diabetes Grants	100	100	150	+50
Subtotal, Services Program Level	**$3,018**	**$3,109**	**$3,214**	**+$105**
Indian Health Facilities:				
Health Care Facilities Construction	$86	$72	$70	-$2
Sanitation Construction	94	94	114	+20
Facilities & Environmental Health Support	127	133	140	+7
Maintenance & Improvement	52	53	53	0
Medical Equipment	16	16	16	0
Subtotal, Facilities Program Level	**$375**	**$368**	**$393**	**+$25**
Total, Program Level	**$3,393**	**$3,477**	**$3,607**	**+$130**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	-$529	-$554	-$561	-$7
Rental of Staff Quarters	-6	-6	-6	0
Diabetes Grants	-100	-100	-150	-50
Total, Budget Authority	**$2,758**	**$2,817**	**$2,890**	**+$73**
FTE	14,899	14,961	15,021	+60

INDIAN HEALTH SERVICE

Mission: *The Indian Health Service (IHS) is responsible for raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level in partnership with the population served.*

The IHS FY 2004 budget request is $3.6 billion, a net increase of $130 million over the FY 2003 President's Budget. Additional funds will be used to invest in disease prevention for diabetes and the provision of safe water and sewage disposal to Indian communities and to ensure continued access to health care by eligible Indian people. The IHS will receive an estimated $561 million in health insurance reimbursements in FY 2004, primarily from Medicare and Medicaid.

AGENCY DESCRIPTION

The IHS provides care to approximately 1.6 million American Indians and Alaska Natives who are members of more than 560 Federally recognized tribes. Inpatient and outpatient care is provided directly in 49 hospitals and over 500 outpatient clinics and smaller facilities located primarily in Alaska, along the Pacific Coast, the Southwest, Oklahoma, and the Northern Plains. The IHS also purchases medical care from private sector hospitals and health professionals. In addition to medical care, the IHS engages in substantial health promotion and disease prevention activities including construction of water and waste disposal systems to serve Indian homes, diabetes prevention and treatment, injury prevention and health education. The IHS also provides mental health and alcohol/substance abuse treatment and funds 34 urban Indian programs.

PREVENTIVE HEALTH INVESTMENTS

To raise the health status of Indian people to the highest possible level, the IHS has long invested a substantial portion of its budget in preventive health activities. The budget request makes significant preventive health investments in sanitation construction and diabetes prevention and treatment.

Sanitation Construction: The budget includes $114 million for sanitation construction, an increase of $20 million over the FY 2003 President's Budget. This 21 percent increase would be the largest increase provided for sanitation construction in more than a decade. The budget supports provision of safe water and waste disposal to an estimated 22,000 homes, an increase of 2,600 over the number of homes served in 2003.

The IHS credits its sanitation construction program with playing a key role in the long term reductions it has achieved in infant mortality and deaths from gastrointestinal disease. Over the last thirty years, the percent of Indian homes with a safe in–home water supply has grown from 58 percent to 92 percent. During this same period, the infant mortality rate has fallen by 60 percent and the mortality rate for gastrointestinal disease has fallen by 69 percent. With this additional funding, we expect continued improvement.

Currently, about eight percent of Indian homes lack a safe indoor water supply compared to one percent of all U.S. homes. The percentage of Indian homes lacking safe indoor water is much higher in certain areas (e.g., 35 percent in Alaska and 17 percent on the Navajo reservation).

Diabetes: The budget includes $150 million for diabetes prevention/treatment grants, an increase of $50 million over FY 2003. These funds were made available by P.L. 107–360. The IHS awards grants to 318 tribes and Indian organizations. Grantees will use these additional funds to: improve their diabetes wellness centers, provide better physical activity facilities and purchase newer medications which are effective in preventing Type II diabetes. Diabetes rates are significantly higher among American Indians and Alaska Natives (AI/ANs) than in the general population as is the incidence of diabetes related blindness, amputations, and End Stage Renal Disease.

The IHS has improved the blood sugar control of its patients with diabetes. Since 1994, there has been a 58 percent improvement in attaining the target goal for blood sugar control. The efficacy of such improvement has been demonstrated by large clinical trials. This investment will lead to significant reductions in kidney failure, amputations, heart attacks, strokes and diabetes related deaths.

CONTINUED ACCESS TO HEALTH SERVICES

The number of people eligible for IHS services is estimated to be 1.6 million, and continues to increase annually. Like any health care provider, the IHS experiences increases in the cost of providing services.

Contract Health Services (CHS): The budget includes $493 million, an additional $25 million or 5 percent increase, for CHS. The IHS supplements the care provided in its own facilities by purchasing medical care from other hospitals and health providers. CHS funds pay for specialty care, including most types of surgery, and are used to purchase all medical care for Tribes that do not have an IHS facility nearby. The budget supports the purchase of 511,000 outpatient visits, an increase of 18,000 compared to the FY 2003 President's Budget.

Opening New Facilities: An additional $25 million is included to add staff at two new hospitals, serving the Navajo Tribe in Arizona and the Winnebago and Omaha Tribes in Nebraska, and at the Pawnee Outpatient Center, serving seven tribes in Oklahoma. While existing IHS facilities serve these tribes, the opening of these modern health facilities will significantly improve both the quality and quantity of health care provided. When these three facilities are fully operational, they will increase the number of visits to health professionals that can be accommodated annually by 23 percent at these sites, and make new medical services available (e.g., the new Pawnee Outpatient Facility will provide ultra sound and physical therapy for the first time).

Contract Support Costs (CSC): The budget includes $271 million, the same as the FY 2003 President's Budget, to support tribal efforts to develop the administrative infrastructure critical to their ability to successfully operate IHS programs. In FY 2002, the IHS entered into self-determination contracts for the managements of two hospitals and six outpatient facilities serving nearly 60,000 Indian people on the Navajo reservation (Arizona and Utah) and the Eastern Cherokee reservation (North Carolina).

Health Facility Construction: The budget includes a total of $70 million for construction of new health facilities allowing IHS to replace its priority health care facility needs with modern health facilities and to significantly expand capacity at its most overcrowded sites. The request will complete outpatient facilities at Pinon (Navajo Reservation, Arizona) and Metlakatla (Annette Island, Alaska); continue construction of the Red Mesa Outpatient Facility (Navajo Reservation, Arizona) and begin construction of a new outpatient facility to replace the Sisseton hospital (Sisseton–Wahpeton Sioux Tribe, South Dakota). When the Sisseton hospital is closed, IHS will purchase inpatient and emergency care from non–IHS facilities such as the nearby Coteau Des Prairies hospital.

Pay Costs: The budget includes an additional $35 million to cover increased pay costs for IHS's 15,021 FTEs and to allow tribally run health programs to provide comparable pay raises to their own staffs.

Increasing IHS Health Insurance Reimbursements: In FY 2004, IHS will receive an estimated $561 million in health insurance reimbursements–primarily from Medicare and Medicaid. The 2003 IHS Medicare and Medicaid rates will be published shortly in the Federal Register and are expected to increase reimbursement in FY 2003 and FY 2004. IHS and the Centers for Medicare and Medicaid Services have worked cooperatively to develop a cost-based reimbursement methodology to better reflect the full cost of providing services. This methodology, together with better efforts to enroll eligible Indian people and legislative changes expanding the scope of covered services, has led to an increase in health insurance reimbursements of 176 percent since FY 1995.

Supporting Indian Self-Determination

The Department continues to provide Tribes with input into policy changes that affect them. In November 2002, the Secretary reactivated the Intradepartmental Council on Native American Affairs to provide greater access and quality services for American Indians, Alaska Natives and Native Americans and to promote the Tribal/Federal government–to–government relationship.

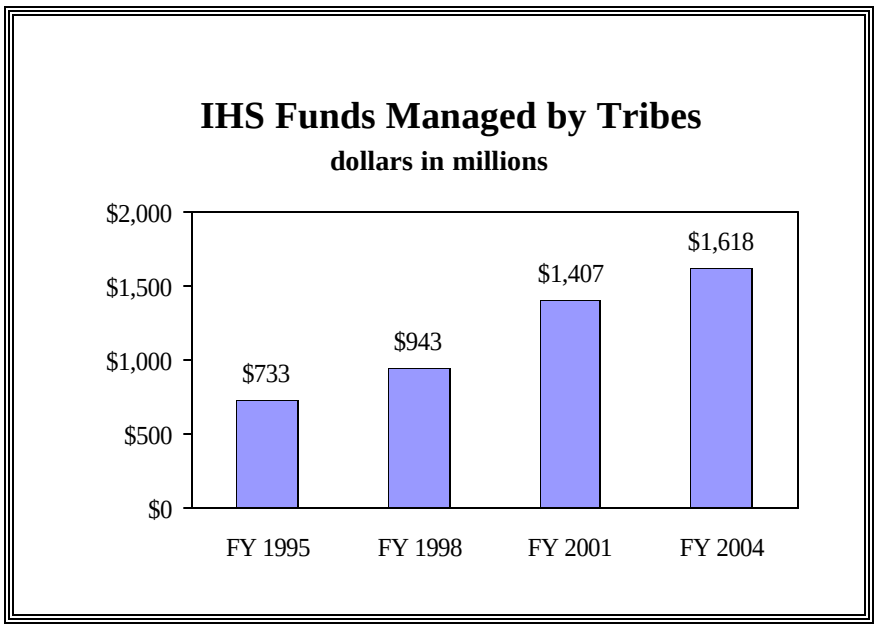
The number of tribally managed IHS programs continues to increase, both in dollar terms and as a percentage of the whole IHS budget. Tribes will control an estimated $1.6 billion of IHS programs in FY 2004, representing 53 percent of the IHS's total budget request.

Highlights of the IHS Diabetes Grantees

- ***Oklahoma Tribes:*** Added certified diabetes educators, dieticians, and exercise specialists to teach diabetes self–management practices. Grantees provided additional eye, tooth and foot care, including previously unavailable dentures which are critical for proper nutrition.
- ***Tanana Chiefs Conference (Central Alaska):*** Established a walking for fitness program, based on the 1,049 mile Iditarod Sled dog race. To encourage participation, progress records are kept, prizes are awarded, and each participant's progress is widely reported.
- ***Indian Health Board of Billings (Montana):*** Tripled the number of diabetics receiving regular care by adding specific diabetes care hours at the wellness center, bringing a dietician on–site, and purchasing additional diabetes care supplies (e.g., home glucose monitors, testing strips, syringes).
- ***Chapa-De Indian Health Program (California):*** Improved patient's blood sugar control by teaching diabetics–and their families–the importance of controlling blood sugar levels including the role that healthy lifestyles play, and providing blood sugar testing supplies and newer diabetes, hypertension and cholesterol medications.

MANAGEMENT SAVINGS

The budget includes savings of $31 million from administrative reductions and better management of information technology. The IHS will achieve these savings primarily by reducing the use of Federal staff. IHS will also reduce costs associated with administrative travel, overtime, copying and the purchase of administrative equipment and supplies. In particular, efficiencies will be achieved in the development, modernization and enhancement of IHS information systems. Tribes, and urban health programs, will be responsible for achieving savings in the programs which they administer.



(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Chronic Disease Prevention & Health Promotion:				
Steps To A Healthier US Initiative	0	$25	$125	+$100
Youth Media Campaign	$68	0	5	+5
Breast and Cervical Cancer	192	201	211	+10
Other Chronic	487	484	493	+9
Subtotal	$747	$710	$834	+$124
Environmental Health	153	152	150	-2
HIV/AIDS, STDs & TB Prevention	1,157	1,235	1,281	+46
Global AIDS program (non-add)	*169*	*244*	*294*	*+50*
Immunization				
Vaccines For Children-Current Law	$990	$1,056	$980	-$76
Proposed Law Changes	0	0	165	+165
Subtotal, VFC	$990	$1,056	$1,145	+$89
Section 317 Program, Current Law	627	628	621	-7
Effect of VFC Proposed Law Changes	0	0	-110	-110
Subtotal, Section 317 Program	$627	$628	$511	-$117
Subtotal, Immunization	$1,617	$1,684	$1,656	-$28
Office of the Director	49	51	60	+9
Buildings & Facilities	296	184	114	-70
Bioterrorism (other than facilities)				
State and Local Capacity	940	940	940	0
CDC Capacity/Research	161	176	176	0
Subtotal	$1,101	$1,116	$1,116	0
Health Statistics	127	126	125	-1
Birth Defects, Disability & Health	90	89	87	-2
Epidemic Services & Response	80	78	76	-2
Preventive Health Block Grant	135	135	135	0
Injury Prevention & Control	150	145	145	0
Public Health Improvement	148	117	114	-3
Infectious Disease Control	348	335	332	-3
Occupational Safety & Health	276	247	246	-1
ATSDR (VA/HUD Appropriation)	78	77	73	-4
Emergency Recovery	12	0	0	0
User Fees	2	2	2	0
Subtotal, Program Level (current law)	**$6,566**	**$6,485**	**$6,491**	**+$6**
Subtotal, Program Level (proposed law)	**$6,566**	**$6,485**	**$6,546**	**+$61**
Less Funds Allocated from Other Sources:				
Vaccines for Children Current Law (mandatory)	$990	$1,056	$980	-$77
Proposed Law Changes	0	0	165	165
Public Health and Social Service Emergency Fund	1,101	1,116	1,116	0
PHS Evaluation (Health Statistics)	23	47	52	+5
User Fees	2	2	2	0
Total, Current Law Budget Authority	**$4,450**	**$4,264**	**$4,341**	**+$77**
Total, Proposed Law Budget Authority	**$4,450**	**$4,264**	**$4,231**	**-$33**
FTE	8,663	8,668	8,671	+3

CENTERS FOR DISEASE CONTROL AND PREVENTION

Mission: *The mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury and disability.*

The FY 2004 budget requests a total program level of $6.5 billion for the Centers for Disease Control and Prevention (CDC), a net increase of $61 million above the FY 2003 President's Budget. This net change reflects $240 million in program expansions, FY 2003 initialization of childhood immunization improvements, completion of some new facilities in FY 2003, and administrative streamlining. The FY 2004 budget for CDC includes $1.1 billion in mandatory immunization funding, and $52 million from the Public Health Service evaluation interagency transfer funds for activities related to Health Statistics.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

CDC supports numerous ongoing activities designed to prevent chronic diseases including cardiovascular disease, diabetes, arthritis and cancer. CDC also addresses the risk factors that are among the most prominent contributors to death in the U.S. including tobacco, poor diet, and lack of exercise. Chronic disease programs provide a wide array of support to prevent the occurrence and progression of chronic diseases. For example, the CDC funded State Diabetes Control program in Minnesota has reduced participants' risk for diabetes-related heart problems by 40 percent and their risk for eye and kidney disease by 25 percent. Efforts to date have focused on reducing complications of diabetes; the next step is to prevent its onset.

The budget includes $834 million for Chronic Disease Prevention and Health Promotion, a net increase of $124 million, or 17 percent, above the FY 2003 President's Budget.

Steps To A Healthier U.S. Initiative: The FY 2004 budget includes $125 million, including $100 million in new investments to pursue a prevention initiative to reduce the burden of diabetes, obesity and asthma-related complications in the population.

The centerpiece of this initiative will be a single Steps to a Healthier US cooperative agreement program. This program will make awards to States and communities to implement effective public health strategies through community interventions to achieve healthier lifestyles. States and communities will also address related risk factors, including a specific emphasis on promoting healthy choices by youth.

The Steps initiative supports President Bush's HealthierUS program. With a strong emphasis on proven interventions and existing science, Steps will promote: State leadership and programs to motivate and support responsible health choices, and to reduce the burden of disease; Community initiatives to promote and enable healthy choices, with a special focus on youth and the elderly; Health care and insurance systems that put prevention first—reducing risk factors and reducing complications of chronic disease; and, State and federal policies that invest in the promise of prevention for all Americans.

The initiative's goals are to:

- Prevent 75,000 to 100,000 Americans from developing diabetes,
- Prevent 100,000 to 150,000 Americans from developing obesity, and
- Prevent 50,000 Americans from being hospitalized for asthma.

Common reporting requirements on performance measures as well as a coordinated evaluation process to measure performance progress will be instituted as part of this initiative. CDC will lead the effort, with full participation from HRSA, Administration for Children and Families, Administration on Aging, and Agency for Healthcare Research and Quality. This initiative will expand upon the Healthy Communities initiative originally proposed in HRSA, in FY 2003.

Breast and Cervical Cancer Screening: The budget includes $211 million for the National Breast and Cervical Cancer Early Screening Detection Program (NBCCEDP), an increase of $10 million. This increase will expand screening, diagnostic, and case management services to at-risk women, especially minority women, providing an additional 32,000 screenings. Since its inception in 1991, over 3 million screening tests have been provided by the NBCCEDP, with over 12,000 cases of breast cancer and over 800 cases of invasive cervical cancer diagnosed. CDC also supports education and outreach activities, case management services, and research to increase screening rates.

Youth Media Campaign: The budget includes $5 million for the Youth Media Campaign. These funds will enable CDC to maintain a library of proven media messages for distribution by the Ad Council.

Other Chronic: In addition, the budget provides net increases totaling $9 million to improve heart disease and stroke public health communications, add more States to school health programs, and expand Comprehensive Cancer Control programs.

ENVIRONMENTAL HEALTH

The budget includes $150 million to maintain ongoing environmental disease prevention programs. In FY 2004, CDC will continue its focus on studying the relationship between exposure to toxic substances and human health effect, and providing emergency response and coordination capacity for natural disasters, and chemical, technological and radiological emergencies. CDC will also continue its environmental health tracking efforts, the goal of which is to develop a surveillance system that can integrate environmental hazards data with human exposure and health effects data that have possible links to the environment.

HIV/AIDS, STDS AND TB

Over the last two decades, HIV/AIDS prevention and treatment have advanced dramatically. The number of deaths among persons with AIDS in this country has declined markedly since 1996. However, new domestic HIV infections still number an estimated 40,000 each year. Worldwide, 42 million people are living with HIV/AIDS and five million of them became infected with HIV in 2002. More than 800,000 children under 15 years of age, predominantly in African countries, contracted HIV during 2002; more than 90 percent were infected in the womb, during childbirth or through breastfeeding. The budget includes $1.28 billion, a net increase of $46 million over the FY 2003 President's Budget, for prevention and control of HIV/AIDS, sexually transmitted diseases and tuberculosis.

Domestic HIV efforts are focusing on the overarching goal of helping States reduce the number of new infections 50 percent by 2005. A total of $690 million supports HIV/AIDS prevention programs in every State and territory to prevent new infections, link people who are infected to medical care and translate scientific research into actual program capacity-building assistance to more than 700 community-based organizations.

The Global AIDS Program (GAP) will be funded at $294 million, a programmatic increase of $50 million over the FY 2003 President's Budget. GAP funds are implementing programs to reduce HIV transmission while improving care and treatment of HIV/AIDS patients in resource poor areas of the world. CDC works to prevent HIV infection and to provide care and treatment for HIV/AIDS patients around the world. Average life expectancy in four countries in Africa is less than 40 years old because of the devastation caused by AIDS. Sub-Saharan Africa is home to 29.4 million people living with AIDS; approximately 3.5 million new infections occurred there in 2002. CDC has established country programs in 25 countries—17 in Africa, 5 in Asia, 2 in Latin America and 1 in the Caribbean and works jointly with USAID in many of these nations.

Preventing Mother-to-Child Transmission: Within the overall global HIV/AIDS request is $150 million for prevention of mother-to-child transmission, an increase of $50 million over the FY 2003 President's Budget for the President's Mother and Child HIV Prevention Initiative. The combination of these funds, the FY 2003 request for CDC, and equal amounts requested in USAID meets the President's commitment to provide a total of $500 million for this effort through FY 2004. HIV infected pregnant women give birth to an estimated two million children each year; without intervention between 25 and 35 percent of these children will become infected with the disease. Approximately 2000 children are infected each day through their mothers. GAP has a defined strategy for implementing programs to prevent mother-to-child transmission. The strategy includes short-course antiretroviral drug therapy for HIV-infected pregnant women, counseling on safe infant feeding after delivery and postpartum AIDS care and treatment for HIV infected women and their families. Together, CDC and USAID will target one million women and aim to reduce HIV/AIDS transmission to their children by 40 percent.

CHILDHOOD IMMUNIZATION

Delivery of safe and effective vaccines is one of the most cost-effective methods of preventing illness. The goal for the year 2004 is to ensure that at least 90 percent of all two-year-olds receive the full series of vaccines and that a vaccination system is built that will sustain and further improve high coverage levels. The budget request of $1.6 billion includes two streams of funding to improve vaccination rates. The mandatory Vaccines for Children (VFC) program provides free vaccine to Medicaid recipients, the uninsured, American Indians and Native Alaskans, and children with limited health coverage that does not cover specific immunizations. The discretionary Section 317 program provides funds for State immunization operational costs and many of the vaccines used in public health clinics.

The budget includes three important immunization initiatives. First, under current law, work will be initiated in VFC to build a six-month, vendor-managed stockpile of all routinely recommended childhood vaccines. A total of $707 million in VFC funds will be used between FY 2003 and FY 2006 for development of these stockpiles. This includes added investments of $143 million in FY 2003 and $94 million in FY 2004. HHS will develop an overall strategic plan to guard against future vaccine shortages.

Second, legislation will be proposed to improve access to VFC vaccines

for children already entitled to them. The proposed legislation will expand the number of access points for underinsured children—those whose private insurance does not cover the immunizations—by allowing them to receive their VFC vaccines at State and local public health clinics. This change will both increase immunization rates for new vaccines and reduce needs for discretionary funding.

Third, proposed legislation will also restore tetanus and diptheria vaccines to the VFC program. The VFC statute caps prices for the three vaccines that were in use prior to 1993, but the price caps are so low that tetanus booster was removed from the VFC program in 1998 when no vendor would bid on the contract. The change will also enable development of a VFC stockpile for tetanus booster.

With these legislative changes, an additional $165 million will be added annually to the VFC budget to cover the additional children that will be covered under this program and fund tetanus vaccines. Fewer children will need to be covered through the discretionary immunization program, leading to a $110 million savings in the Section 317 discretionary program

While the budget includes these major policy initiatives, total 317 and VFC obligations are projected to decline $28 million between FY 2003 and FY 2004. This reflects the aggressive vaccine stockpile investments planned for immediate implementation in FY 2003; the $55 million increase resulting from the legislative proposal; a $28 million reduction in the underlying VFC program as States "catch-up" in FY 2003 with new vaccines and immunizations deferred during the shortages; and $7 million in management savings in CDC's intramural program.

The immunization budget will continue to provide $135 million for global immunization activities, including polio eradication. While worldwide polio cases were reduced by an estimated 95 percent between 1988 and 2002, a major international effort continues to reach the World Health Organization's goal to certify global polio eradication by 2005.

Improvements in Childhood Immunization in FY 2004

1. Create 6 month stockpile of all routinely recommended childhood vaccines
2. Expand access for VFC-eligible children (proposed law)
3. Restore tetanus to the VFC program by lifting price caps (proposed law)

BIOTERRORISM

The President's budget includes $1.1 billion for bioterrorism preparedness, the same level as the FY 2003 President's budget. CDC will direct $940 million of this amount to improving State and local preparedness, $158 million to improve CDC's internal preparedness and response functions. $18 million will continue to be directed to applied anthrax research. The total funding level reflects the creation of the new Department of Homeland Security, which is now responsible for financing vaccine and pharmaceutical purchases for the Strategic National Stockpile.

Upgrading State and Local Capacity: The budget includes $940 million for the State and local program, which emphasizes improved laboratory capacity, enhanced epidemiological expertise in the identification and control of diseases caused by terrorism, better electronic communication and distance learning, and cooperative training between public health agencies and local hospitals. In FY 2002, funding for bioterrorism was awarded under a new approach that ensures coordination across public health and medical systems, expects accountability, and recognizes performance. This process coordinated funding from CDC and HRSA hospital preparedness grants. This coordination will be expanded in FY 2003 and FY 2004 to include efforts at FDA to increase the number of State food labs in the Laboratory Response Network, a system which currently has 120 public health labs specifically trained in identifying pathogens that could be used for bioterrorism.

CDC will continue to support linkages between public health departments and health care providers by maintaining rapid communications capacity and access to training via distance-learning mechanisms. The 24 university-based Centers for Public Health Preparedness (CPHP) will continue to ensure that frontline public health workers have the competencies to respond to current and emerging health threats. The CPHPs provide ongoing education through teleconferences and training programs in disaster management, implement and test reliable communications systems, and offer other hands-on experiences such as tabletop training exercises. In addition, resources will be available to support disease detection and outbreak control, including epidemiological and medical response.

Upgrading CDC Capacity: Funds totaling $158 million will be used to upgrade scientific response capacity at CDC. Funds will sustain equipment and personnel, including the Rapid Response and Advanced Technology (RRAT) Lab at the National Center for Infectious Diseases. The RRAT lab specializes

in the triage and analysis of biological specimens suspected as potential agents of terrorism. Work will continue on the rapid toxic screen, technology that can quickly identify up to 150 chemical threats.

Funds will also be used to support around-the-clock terrorism surveillance and response operations at CDC's Emergency Operations Center. The request will continue support for ten disaster response teams and for approximately 64 Epidemic Intelligence Service (EIS) Officers for assignment to States. Work will also continue in conjunction with the Department of Agriculture, in accordance with an emerging rule, to ensure that all entities that possess, use, or transfer certain toxins have registered with the Select Agent program. CDC inspected 105 laboratories in FY 2002 and, through the new regulation, will be working toward the goal of inspecting all eligible facilities.

Modern, Secure Laboratories and Facilities

The work conducted in laboratories at CDC is relied upon worldwide to help control disease outbreaks, respond to emergencies and prevent illness and injury. For example, analysis at CDC labs has been instrumental in interpreting exposure of firefighters to 110 different chemicals as a result of their response to the terrorist attacks on the World Trade Center. The FY 2004 budget includes a total request of $114 million to continue CDC's long-term master facilities plan to construct, repair and secure facilities of the CDC.

Funding provided in FY 2003 will enable the completion of an environmental health laboratory and one infectious disease laboratory. A priority focus in FY 2004 is the construction of a new Headquarters/ Emergency Operations Center which will provide a permanent, secure, and consolidated command and control center for CDC's response to terrorist events, outbreaks and other natural disasters. The request will also enable continued construction of critically needed campus-wide infrastructure and physical security upgrades.

Office of the Director

The budget includes $60 million for the Office of the Director, a net increase of $9 million above the FY 2003 President's Budget. CDC will continue to concentrate management attention on achieving results in accordance with the President's Management Agenda including the implementation of the Unified Financial Management System to promote the consolidation of accounting operations and reduce the cost of providing accounting services throughout HHS.

Public Health Information Network: The budget includes an increase of $10 million for the development of the Public Health Information Network (PHIN). PHIN will build upon and integrate existing public health communication systems, and will include public health data standards necessary for interoperability between the health-care sector and local, State, and Federal public health authorities. This work is being coordinated closely with activities elsewhere in the Department focused on improving information technology in the health care sector.

Birth Defects, Developmental Disabilities, Disability and Health

The FY 2004 budget includes $87 million to support States in the prevention of birth defects and developmental disabilities (such as spina bifida) where proven strategies have been developed. Surveillance activities are designed to help find causes for others, such as autism. Other activities include tracking infants who test positive for hearing loss to ensure that proper diagnostic follow-up and prevention services are provided, and a pilot project for attention-deficit hyperactivity disorder.

Epidemic Services and Response

CDC 's epidemiologists are the "disease detectives" that determine the cause of outbreaks and develop the countermeasures that stem the spread of illness. For example, in FY 2002, Epidemic Intelligence Service (EIS) officers, trained by the CDC to detect and control disease outbreaks, were sent to more than 69 outbreaks. The FY 2004 budget includes $76 million for the Epidemic Services and Response Program. Funds will support efforts to provide epidemiological and technological assistance and consultation to international, State and local health agencies, to fund urban research centers to assess and improve the health of urban communities, and to monitor and track infectious diseases in this country.

Health Statistics

The FY 2004 budget includes $125 million for health statistics conducted by the National Center for Health Statistics (NCHS). NCHS will continue to support surveys that provide a wealth of valuable information to support decision-making and research on health. NCHS supports the National Health Interview Survey, the National Health and Nutrition Examination Survey, the National Vital Statistics System, and the National Health Care Survey. These surveys, along with NCHS research and analytic programs, provide critical information such as tracking health insurance coverage, teen birth and out-of-wedlock data, environmental exposure tracking, and early development of children data. The budget will support technical updates to reengineer the vital statistics system and a sample redesign for the National Health Interview Survey.

Preventive Health Block Grant

The FY 2004 budget includes $135 million for the Preventive Health and Health Services Block Grant (PHHSBG). The PHHSBG provides its 61 grantees, including all States, two American Indian Tribes and 11 territories the autonomy and flexibility to fit prevention and health promotion programs to their unique needs. States are encouraged to use their PHHSBG funding to augment their efforts as part of the Prevention Initiative—"Steps"—that addresses prevention of diabetes, obesity and asthma.

Injury Prevention

Injuries are the number one killer of children and young adults in the United States. The FY 2004 budget includes a total of $145 million for encouraging the use of programs and policies that are successful in reducing injuries and deaths across the country. Examples of CDC activities include support for State rape crisis programs, research to prevent domestic violence, gathering data for the National Violent Death Reporting System, and helping States develop systems to collect surveillance data on child maltreatment and related injuries.

Public Health Improvement

The budget includes $114 million for Public Health Improvement. Funding is included for the Racial and Ethnic Approaches to Community Health (REACH 2010) demonstration projects, which seek to eliminate racial disparities in health in areas including chronic and infectious diseases. Other activities funded within this amount includes the National Electronic Disease Surveillance System (NEDSS) standards, initially developed for tracking laboratory results, serves as the foundation for many States' bioterrorism information systems. Funds also support a single point of contact for State-wide public health issues, and provides training and performance measurement of public health activities at the State, local, and national level.

Infectious Diseases

Infectious diseases are the leading cause of death globally. More than 35 newly emerging infectious diseases were identified in the world between 1973 and 2002. In addition, foodborne diseases are estimated to cause 5,000 deaths and 76 million illnesses in the U.S. each year. The budget includes $332 million in Infectious Diseases for work to prevent and detect these diseases.

Strategies to combat infectious diseases are developed by focusing on surveillance, improving State laboratory ability to detect selected pathogens and trace outbreaks, slowing the development of antibiotic resistant microbes, and reducing the number and severity of infections acquired in hospitals. The Infectious Disease activity also provides laboratory support for the HIV/AIDS, tuberculosis and immunization programs.

Occupational Safety and Health

Each day, an average of 9,000 U.S. workers sustain disabling injuries on the job, 16 workers die from an injury sustained at work, and 137 workers die from job-related diseases. The National Institute for Occupational Safety and Health (NIOSH) establishes and disseminates scientific and public health information necessary to ensure safe and healthful working conditions for millions of American men and women. Research will continue to address solutions to occupational disease and workplace safety concerns in those fields where the dangers are the greatest.

The budget includes a total of $246 million, $1 million below the FY 2003 President's Budget. In addition to its ongoing activities, NIOSH assists in the implementation of the Energy Employees Occupational Illness Compensation Act of 2000. Funds for this activity are provided by the Department of Labor.

Agency for Toxic Substances and Disease Registry (ATSDR)

ATSDR is managed as part of CDC and is the lead public health agency responsible for public health activities related to Superfund sites. ATSDR develops profiles of the health effects of hazardous substances, assesses health hazards at specific Superfund sites, and provides consultations to prevent or reduce exposure and related illnesses.

The budget includes $73 million for ATSDR. Funding for ATSDR is provided through the Veterans Affairs, Housing and Urban Development Appropriations Subcommittee.

Administrative and Information Technology Savings

Across CDC, the budget includes $17 million for pay raises, and $55 million in savings related to the President's Management Agenda as a result of consolidating administrative functions and information technology, organizational delayering to speed decision making processes, competitive outsourcing, implementation of effective workforce planning and human capital management strategies, and adoption of other economies and efficiencies in administrative operations.

CDC is focusing on reducing the costs of the information technology infrastructure, such as providing e-mail messaging services, helpdesk, and remote access. CDC is also looking to retire some systems that will be replaced by a more comprehensive and integrated solution.

NIH OVERVIEW BY INSTITUTE

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Institutes:				
National Cancer Institute	$4,113	$4,609	$4,771	+$162
National Heart, Lung, & Blood Institute	2,554	2,762	2,868	+106
National Institute of Dental & Craniofacial Research	342	369	382	+13
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,563	1,703	1,820	+117
National Institute of Neurological Disorders & Stroke	1,309	1,416	1,469	+53
National Institute of Allergy & Infectious Diseases	2,526	3,981	4,335	+354
National Institute of General Medical Sciences	1,698	1,849	1,923	+74
Natl Inst. of Child Health and Human Development	1,109	1,195	1,245	+50
National Eye Institute	580	625	648	+23
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	563	609	631	+22
VA/HUD Appropriation	81	76	79	+3
National Institute on Aging	891	958	994	+37
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	447	485	503	+17
Natl Inst. on Deafness & Communication Disorders	341	366	380	+15
National Institute of Mental Health	1,234	1,333	1,382	+50
National Institute on Drug Abuse	885	960	996	+36
National Institute on Alcohol Abuse & Alcoholism	383	415	430	+15
National Institute for Nursing Research	120	130	135	+5
National Human Genome Research Institute	428	458	478	+20
Natl Inst. for Biomedical Imaging & Bioengineering	262	270	282	+12
National Center for Research Resources	985	1,065	1,054	-11
Natl Center for Complementary & Alternative Med	104	112	116	+4
Natl Center for Minority Health & Health Disparities	157	186	193	+7
Fogarty International Center	56	62	64	+2
National Library of Medicine	274	306	316	+10
Office of the Director	253	274	318	+44
Buildings & Facilities	296	769	80	-689
ONDCP Drug Forfeiture Fund Transfer (NIDA)	7	0	0	0
Total, Program Level	**$23,561**	**$27,343**	**$27,893**	**+$549**
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-$7	$0	$0	$0
Type 1 Diabetes Research 1/	-100	-100	-150	-50
Total, Budget Authority	**$23,454**	**$27,243**	**$27,743**	**+$499**
Labor/HHS Appropriation	**$23,373**	**$27,168**	**$27,664**	**+$496**
VA/HUD Appropriation	**$81**	**$76**	**$79**	**+$3**
FTE	17,250	17,693	17,526	-167

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

NATIONAL INSTITUTES OF HEALTH

Mission: *The mission of the National Institutes of Health (NIH) is to uncover new knowledge that will lead to better health for everyone.*

This Administration continues its strong commitment to biomedical research. In FY 2003, the President's Budget completed the five-year doubling of the NIH budget. As a result of the doubling, NIH will be funding nearly 10,000 more research grants than it did before the doubling began—10,000 more ideas that could lead to vaccines, cures, and treatments, as well as fundamental scientific breakthroughs, that could open up even more new opportunities for improving human health. NIH can also now support the training of over 1,500 more scientists each year than it could in FY 1998. This investment will help ensure there are enough trained professionals ready to turn today's research advances into tomorrow's medical success stories.

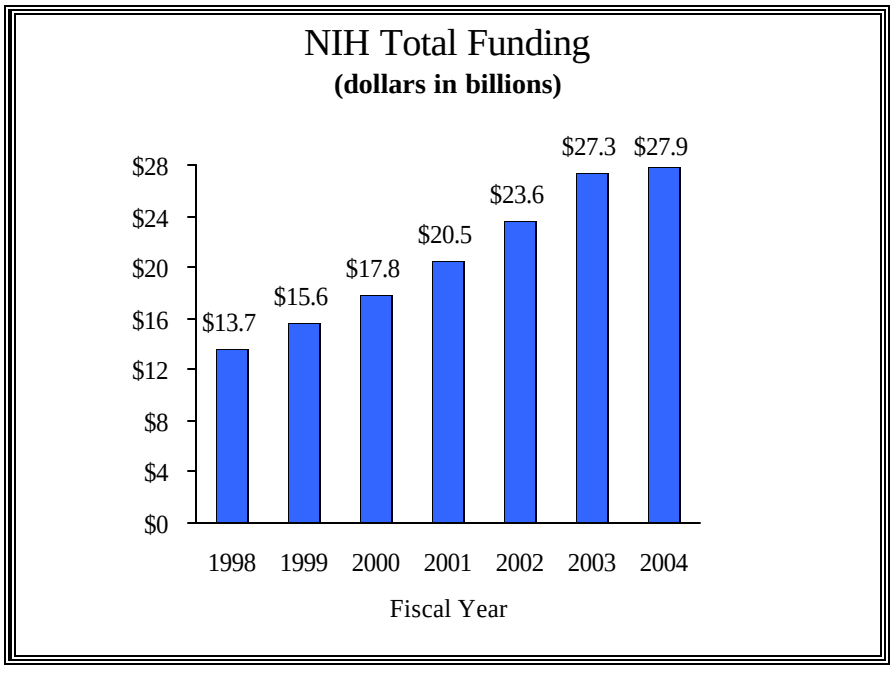
Building on the research momentum generated over the past five years, the FY 2004 budget provides $27.9 billion for NIH. This is a net increase of $549 million, or 2.0 percent, over the FY 2003 President's Budget. However, as a result of converting approximately $1.4 billion from one-time non-recurring costs in FY 2003 for facilities construction and anthrax vaccine procurement, NIH research programs and support will have a robust increase of over $1.9 billion, or 7.5 percent.

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 2004, over 80 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 50,000 researchers affiliated with about 1,700 university, hospital, and other research facilities. About 9-10 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 program, which includes the NIH Clinical Center, gives our nation the unparalleled ability to respond immediately to health challenges nationally and worldwide. Another 3 percent will provide for research management and support.

RESEARCH PRIORITIES IN FY 2004

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The FY 2004 budget request will allow NIH to address imperative requirements in biodefense; continue progress in promising arenas of science related to specific diseases such as cancer, HIV/AIDS, diabetes, Parkinson's disease, Alzheimer's disease; and pursue whole new avenues of post-genomics research.

Biodefense Research: Our Nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. In FY 2004, the number one priority for the program increases requested in the NIH budget is supporting research needed for the war against terrorism. To guide this research, NIH last year developed a *Strategic Plan for Biodefense Research* and a *Biodefense Research Agenda for CDC Category A Agents*, with short-, intermediate-, and long-term goals. These plans stress two overarching, complementary, and urgent components: a) basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response to infection and defense mechanisms; and b) applied research with predetermined milestones for the development of new or improved diagnostics, vaccines, and therapeutics. NIH will continue to consult with the new Department of Homeland Security, the HHS Assistant Secretary for Public Health Emergency Preparedness, and the

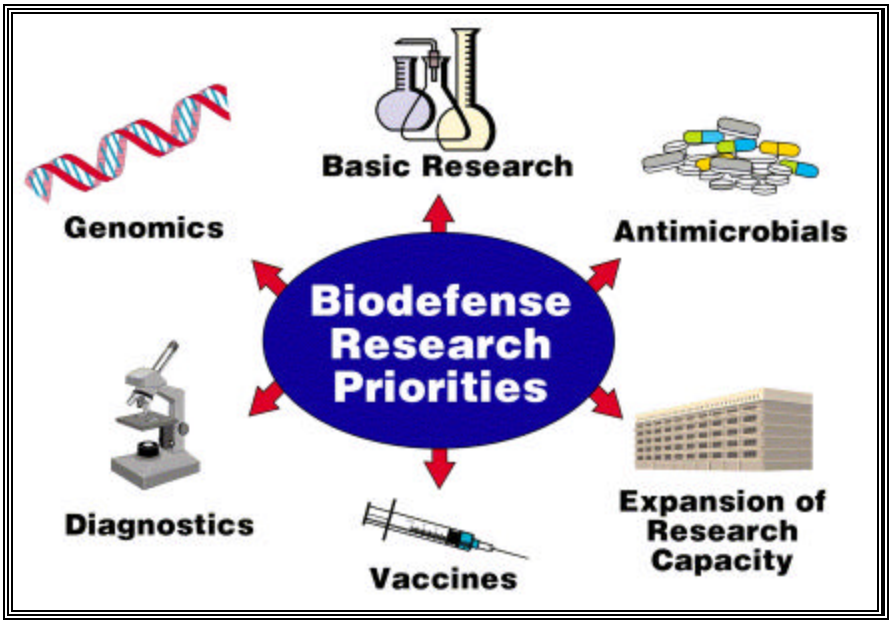


Department of Defense to ensure full coordination with other Federal agencies in the war against terrorism.

On January 7th, the President submitted a budget amendment to reallocate $225 million within the $1.7 billion FY 2003 biodefense budget request for NIH in order to accelerate construction of specialized biosafety laboratories at universities and research institutions across the country that must be built first in order to carry out priority biodefense and infectious disease research. This budget amendment increases the FY 2003 request for extramural biodefense laboratory construction from $150 million to a total of $375 million. The first six or seven of these biosafety level (BSL) 3 or 4 research facilities would be financed with FY 2003 funds, instead of the three or four originally proposed.

For FY 2004, the President's budget proposes a total of $1.6 billion for NIH biodefense efforts. While this is a net overall decrease of $121 million, it is the result of significant one-time, non-recurring biodefense expenses in FY 2003, including $746 million in intramural and extramural laboratory construction and $250 million for anthrax vaccine procurement costs. By retaining these prior-year one-time expenditures in the research program, NIH's biodefense research activity will effectively expand by $875 million in FY 2004. Examples of planned research initiatives for FY 2004 include developing novel therapeutic strategies for blocking the effects of botulism toxin; establishing animal models and standardized reagents, microarray panels, and other materials for the study of priority pathogens; expanding research to discover how the two main cell types of the immune system, B and Y lymphocytes, help regulate immune responses to dangerous microbes; and further accelerating the testing of new biodefense therapeutics, vaccines, and diagnostic tools. NIH is currently testing a range of candidate vaccines in clinical and pre-clinical studies, including third-generation vaccines against smallpox; a second-generation vaccine to prevent anthrax; a DNA vaccine to prevent Ebola virus; and a new vaccine for plague.

NIH will continue to provide support for advanced research and early-phase clinical trials needed to develop new biodefense vaccines and other countermeasures. However, the NIH budget for FY 2004 does not include resources for vaccine procurement. Once a determination is made that these NIH-developed countermeasures are licensable and industrial-scale production is feasible, subsequent procurement contracts would be financed from a new mandatory account in the Department of Homeland Security. Legislation is also being proposed to give NIH more flexible management tools to further accelerate its biodefense research.



HIV/AIDS Research: The FY 2004 budget includes a total of $2.9 billion for HIV/AIDS-related research. This is an increase of $110 million, or 4.0 percent over the FY 2003 level. The FY 2004 NIH HIV/AIDS research agenda continues the following overarching themes: HIV prevention research, including development of vaccines, microbicides, behavioral interventions, and strategies to prevent perinatal transmissions; therapeutics research to develop simpler, less toxic, and cheaper drugs and regimens to treat HIV infection and its associated illnesses, malignancies, and other complications; international research, particularly to address the critical research and training needs in developing countries; and research targeting the disproportionate impact of the AIDS epidemic on racial and ethnic minority populations in the United States. All of these efforts require a strong foundation in basic science. The overall budget request for NIH also includes $100 million in NIAID to continue HHS contributions initiated in FY 2002 to the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis.

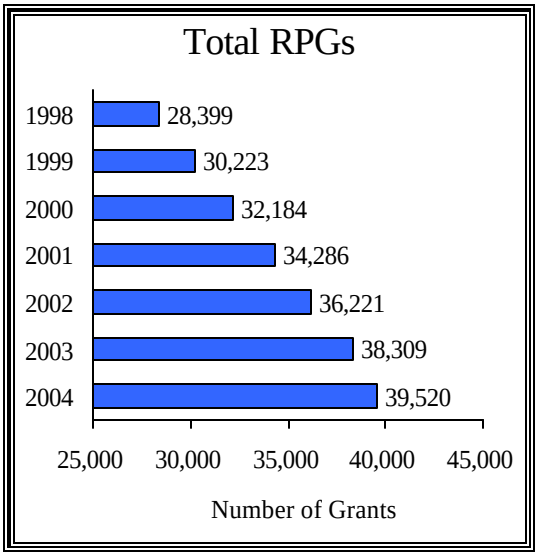
Institutional Development Awards (IDeA) Program: For FY 2004, the budget proposes $210 million for the Institutional Development Awards (IDeA) program, an increase of $25 million or 14 percent, over FY 2003. These funds are included within the request for the National Center for Research Resources (NCRR). This increase supports NIH's continuing efforts to develop a critical mass of competitive biomedical researchers in States that have

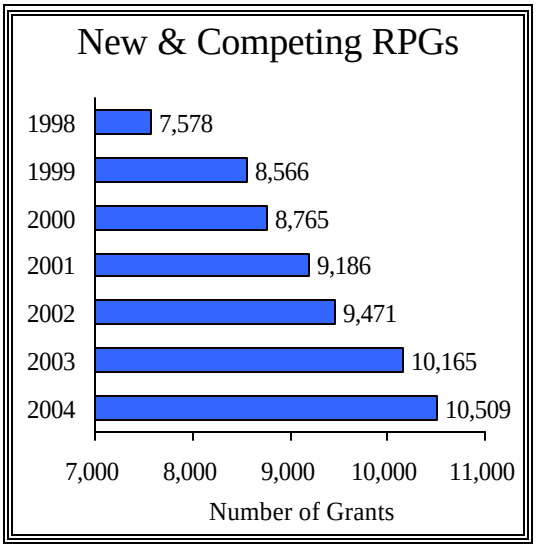
not fully participated in NIH research funding in the past.

Best Pharmaceuticals for Children Act: The request for NIH includes an additional $25 million, for a total of up to $50 million, to continue implementing the Best Pharmaceuticals for Children Act (BPCA). Under the Act, NIH is responsible for contracting for studies cited by FDA as needed to provide dosage, safety, and effectiveness data in children to permit labeling of off-patent drugs for pediatric use when manufacturers decline to perform the studies. NIH, working cooperatively with FDA and other outside experts, has recently published a list that identified the 12 highest priority drugs needing pediatric review. NIH and FDA have also been working to identify the specific pediatric testing that needs to be done; issue requests for manufacturers to perform the studies; and, if they decline to do the testing, issue requests for proposals from NIH to have these studies conducted under contract. NIH has announced that the first two requests for proposals will cover the drugs sodium nitroprusside, for the controlled reduction of blood pressure; and lorazepam, for the treatment of status epilepticus and for sedation in the pediatric intensive care unit. NIH will also request proposals to establish a BPCA Coordinating Center which will help those conducting pediatric clinical trials funded under this authority.

Diabetes and Obesity: The epidemic of obesity threatens the Nation's health by sharply increasing the incidence of Type 2 diabetes, fatty liver disease, kidney failure, and cardiovascular and other diseases. However, dramatic advances in our understanding of regulation of appetite and weight offer new opportunities to develop methods to treat obesity and to prevent Type 2 diabetes and other obesity-related diseases. The FY 2004 budget includes an increase of $14 million for expanded trans-NIH research programs in obesity and diabetes. Total NIH diabetes spending in FY 2004 is estimated to be $946 million. This includes $150 million, an increase of $50 million over FY 2003, specifically for research on the prevention and cure of type 1 diabetes. These special diabetes funds were reauthorized in December of 2002, with annual funding increasing to $150 million through FY 2008.

"Roadmap" Funding: As an additional effort to accelerate fundamental discovery and translation of that new knowledge into preventive and therapeutic strategies, the FY 2004 budget request for the Office of the Director includes an increase of $35 million for strategic "roadmap" initiatives. These funds will be allocated by the NIH Director to the Institutes and Centers to address critical roadblocks and knowledge gaps that currently constrain rapid progress in biomedical research. Three broad initiatives will be stimulated with these funds: 1) new pathways to discovery, which includes a comprehensive understanding of the building blocks of the body's cells and tissues and how complex biological systems operate, regenerative medicine, structural biology, molecular libraries, nanotechnology, computational biology and bioinformatics, and molecular imaging; 2) multidisciplinary research teams of the future; and 3) re-engineering the clinical research enterprise. These efforts will allow the NIH to rethink the technical and human infrastructure required to translate findings from genetics and proteomics into front-line treatments and prevention strategies.





Research Project Grants

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 55 percent of NIH's total budget request for FY 2004.

In FY 2004, the NIH budget provides $15.2 billion, a 6.3 percent increase over FY 2003, to fund 39,520 total projects, the highest level in the agency's history. This is 1,211 more grants in total than are expected to be funded in FY 2003.

Competing RPGs: Within this total, NIH estimates it will support 10,509 competing RPGs in FY 2004, an increase of 344 over FY 2003 and itself a record high. Of these, 322 will be fully funded in the first year they are awarded, for $179 million in FY 2004. This includes programs such as

Academic Research Enhancement Awards, Shannon Awards, and challenge grant programs, all of which were initially designed with multi-year funding as an intrinsic part of the program. NIH will undertake a study this year to determine the types of grants that can be fully funded from both the point of financial stewardship and scientific accountability. Following this study, other categories of grants may also be considered for multi-year funding. The average cost of research project grants will increase in the aggregate by 2.7 percent.

Extramural Research Facilities Construction

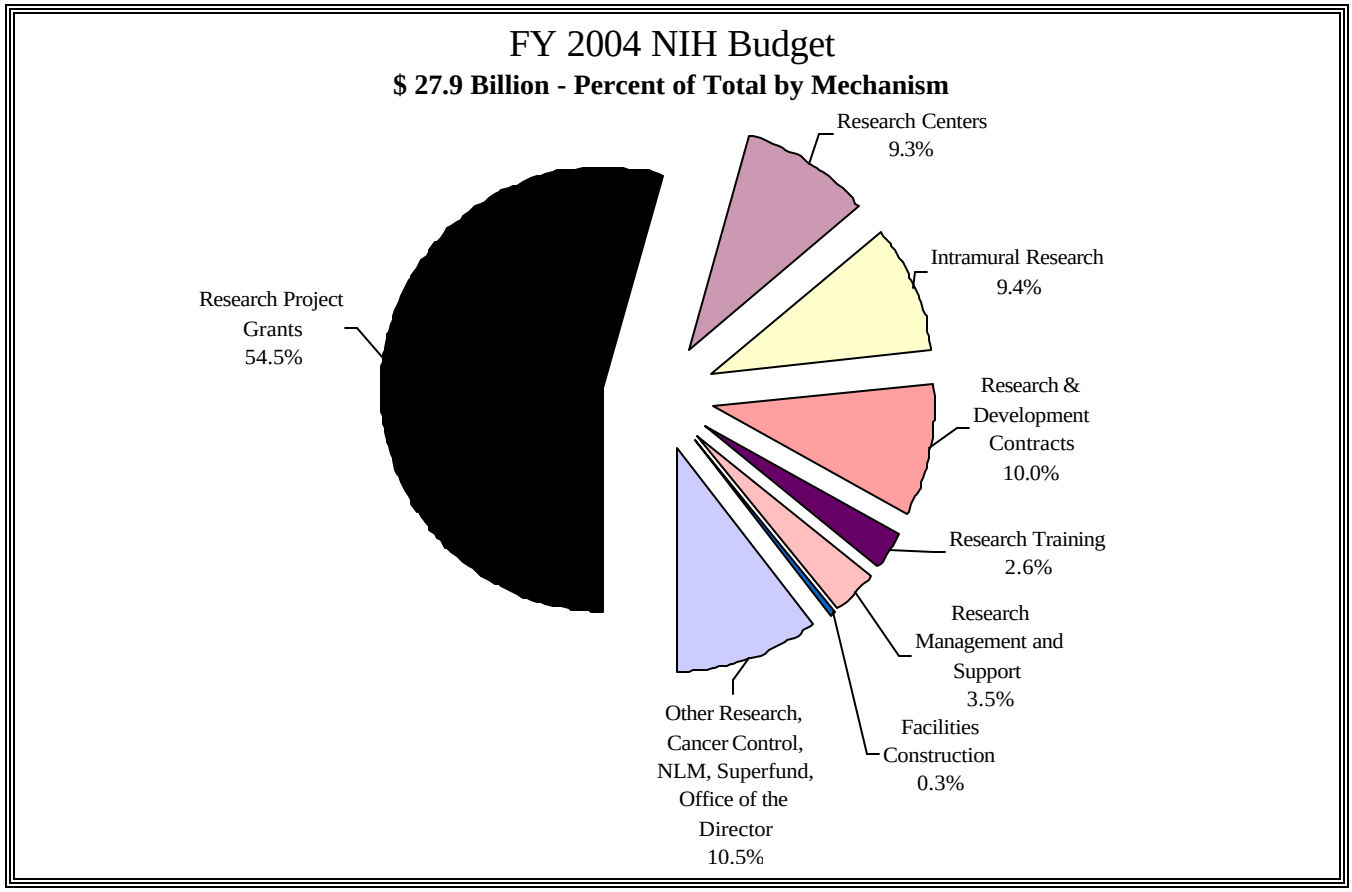
For FY 2004, no new funds are requested for extramural research facilities construction grants, a reduction of $457 million from FY 2003. Of this reduction, $375 million is from the non-recurring expenditures for extramural biodefense laboratory construction requested for FY 2003, and $82 million is from non-biodefense research facilities construction. Over the past 10 years, nearly $500 million has been appropriated for non-biodefense extramural construction projects. In FY 2004, NIH's budget places a higher priority on the support of additional research project grants.

Intramural Buildings and Facilities

A total of $80 million is requested for NIH intramural buildings and facilities (B&F) in FY 2004, a reduction of $689 million from FY 2003. Of this reduction, $371 million is due to one-time construction of biodefense research laboratories and physical security improvements on NIH's intramural campuses, and $318 million is from other non-biodefense intramural facilities projects. The $80 million requested for FY 2004 will be used for general repairs and improvements across NIH's nearly 200 total buildings. Over the past eight years, through the FY 2003 request, Congress will have appropriated over $800 million for major new, non-biodefense construction projects on the NIH campus, including the Louis Stokes Consolidated Laboratory Facility; the Mark O. Hatfield Clinical Research Center; the Dale and Betty Bumpers Vaccine Laboratory Center; and the John E. Porter National Neurosciences Research Center. On January 7th, the President submitted a budget amendment to reallocate $136 million within NIH's non-biodefense research request in order to fully fund construction of the second phase of the Porter Neuroscience Center in FY 2003.

Management Savings

Across NIH, the budget includes savings of $151 million from better management of administrative and information technology functions. In support of the President's Management Agenda, NIH plans to save $42 million from consolidating administrative functions, organizational delayering; competitive sourcing, implementation of effective workforce planning and human



capital management strategies, and adoption of other economies and efficiencies in administrative operations. Overall, NIH's FTEs for FY 2004 decrease by a net 167, which includes -292 FTE in administrative reductions and increases of +125 FTE for biodefense research and research support. In addition, NIH plans to reduce information technology expenditures to achieve $109 million in savings in FY 2004 primarily through consolidating information technology infrastructure services such as e-mail, help desk, wireless networking, and wide-area networking services across NIH; reducing costs associated with overlapping areas of support for Institute research systems, such as in reporting and tracking of research grant applications; and accelerating the pace of subsuming local administrative systems into NIH and HHS enterprise systems expected to be coming on-line in FY 2004 in areas such as funds status monitoring and budget forecasting and reporting.

NIH OVERVIEW BY MECHANISM

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Mechanism:				
Research Project Grants	$13,016	$14,298	$15,204	+$906
[# of Non-Competing Grants]	*[24,856]*	*[26,195]*	*[26,958]*	*[+763]*
[# of New/Competing Grants]	*[9,471]*	*[10,165]*	*[10,509]*	*[+344]*
[# of Small Business Grants]	*[1,894]*	*[1,949]*	*[2,053]*	*[+104]*
[Total # of Grants]	*[36,221]*	*[38,309]*	*[39,520]*	*[1,211]*
Research Centers	2,117	2,422	2,589	+167
Research Training	653	693	715	+22
Research & Development Contracts	1,793	2,430	2,779	+349
Intramural Research	2,234	2,549	2,630	+81
Other Research	1,933	2,149	2,214	+65
Extramural Research Facilities Construction	118	457	0	-457
Research Management and Support	786	920	969	+49
National Library of Medicine	274	306	316	+10
Office of the Director	253	274	318	+44
Buildings and Facilities	296	769	80	-689
NIEHS VA/HUD Appropriation (Superfund)	81	76	79	+3
ONDCP Drug Forfeiture Fund Transfer (NIDA)	7	0	0	0
Total, Program Level	**$23,561**	**$27,343**	**$27,893**	**+$549**
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-$7	$0	$0	$0
Type 1 Diabetes Research 1/	-100	-100	-150	-50
Total, Budget Authority	**$23,454**	**$27,243**	**$27,743**	**+$499**
Labor/HHS Appropriation	**$23,373**	**$27,168**	**$27,664**	**+$496**
VA/HUD Appropriation	**$81**	**$76**	**$79**	**+$3**
FTE	17,250	17,693	17,526	-167

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

(dollars in millions)

	2002	2003	2004	2004 +/-2003
Substance Abuse:				
Substance Abuse Block Grant	$1,725	$1,785	$1,785	$0
Programs of Regional and National Significance:				
Treatment	291	358	557	+199
Prevention	197	153	148	-5
Subtotal, Substance Abuse	**$2,213**	**$2,296**	**$2,490**	**+$194**
Mental Health:				
Mental Health Block Grant	$433	$433	$433	$0
Path Homeless Formula Grant	40	47	50	+3
Programs of Regional and National Significance	230	213	212	-1
Children's Mental Health Services	97	97	107	+10
Protection and Advocacy	32	32	32	0
Subtotal, Mental Health	**$832**	**$822**	**$834**	**+$12**
Program Management	$91	$77	$85	+$8
Recovery/Bioterrorism	10	10	0	-10
Total, Program Level	**$3,146**	**$3,205**	**$3,409**	**+$204**
Less Funds Allocated from Other Sources:				
PHSSEF	-$10	-$10	$0	$10
PHS Evaluation Funds	0	0	-16	-16
Total, Discretionary BA	**$3,136**	**$3,195**	**$3,393**	**+$198**
FTE	582	588	572	-16

SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION

Mission: *The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to improve the quality and availability of prevention, early intervention, treatment and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness.*

The FY 2004 budget for SAMHSA is $3.4 billion, a net increase of $204 million or 6 percent, over the FY 2003 President's Budget. The request continues the President's commitment to reduce current illicit drug use through the creation of a new treatment services voucher program. The budget provides for increases in mental health services targeted towards some of our most vulnerable individuals—children and homeless. Resources are also provided to enhance our Federal and State level drug and mental health data collection activities.

SUBSTANCE ABUSE

The request includes $2.5 billion, a net increase of $194 million, or 9 percent, for substance abuse treatment and prevention activities. The FY 2004 budget represents the third year of the President's commitment to expand drug treatment services over five years. The Administration's goal is to reduce current use of illicit drugs by 10 percent in two years and 25 percent in five years.

Meeting the treatment needs of people who are currently substance dependent is a major priority in this budget, and a new $200 million State voucher program is proposed. Over one million individuals receive treatment for drug use each year, and it is estimated that as many as 100,000 of those seeking treatment are unable to access the appropriate services. This new State voucher program will increase substance abuse treatment capacity, consumer choice and access to a comprehensive continuum of treatment options, including faith and community based organizations. Approximately 100,000 people would receive services through this effort. Awards will be through competitive grants and will provide States with maximum flexibility in customizing a voucher program to fit a State's unique needs.

To target those who currently use but are not dependent on drugs, the budget continues the $50 million State Targeted Capacity Expansion program launched in FY 2003. This program will allow States to expand screening and brief intervention services available in communities. The goal is to increase treatment capacity by expanding the continuum of care available in communities through increased access to clinically appropriate treatment matched to the person's stage of illness and problem severity. States will demonstrate, commit to, and report performance targets for reducing overall drug use and the number of people needing drug treatment. A greater emphasis has been placed on marijuana and non-dependent users. Preliminary findings have shown that brief

Substance Abuse Facts

- The percentage of the populations age 12 and older using illicit drugs increased from 6.3% in 1999 and 2000 to 7.1% in 2001.
- SAMHSA's 2001 National Household Survey estimates that 16 million Americans used an illicit drug in the past month.
- 10.8% of youth aged 12-17 reported using an illicit drug in the past month, an increase from the 2000 rate of 9.7%.
- Marijuana is used by 76% of all illicit drug users and it is the exclusive drug of choice for 56% of users.
- Adult dependence on illicit drugs was more likely among individuals who first used marijuana at age 14 or younger than among those who first used marijuana after age 14.
- Marijuana was the primary substance of abuse for 47% of youth treatment admissions compared with 7% for all other ages.
- Among youth 12-17 who participated in a group fight, 35% used an illicit drug in the past year.
- In 2001, an estimated 28 million persons aged 12 or older used an illicit drug during the past year.
- 7 to 10 million individuals in the United States suffer from co-occurring disorders (have at least one mental disorder as well as an alcohol or drug use disorder)

Sources: National Household Survey on Drug Abuse, Drug and Alcohol Services Information System Report and Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders

interventions for marijuana and non-dependent drug users resulted in significantly larger reductions in substance abuse problems for these individuals.

A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant provides support for over 10,500 community-based treatment and prevention organizations.

MENTAL HEALTH

The budget includes $834 million for mental health services, a net increase of $12 million over the FY 2003 President's Budget. The request emphasizes increasing access to mental health services to some of our most vulnerable citizens.

Children's Mental Health Services: Studies show that at least one in five children and adolescents may have a mental health problem, yet an estimated two-thirds are not expected to receive the mental health services they need. The budget proposes $107 million for Children's Mental Health Services, an increase of $10 million, or 10 percent. This level will support mental health services to nearly 17,000 children and adolescents with serious emotional disorders and their families.

Homeless Services: Recent studies have found that 20 percent of individuals experiencing chronic homelessness also have a serious mental illness. The budget includes $50 million for the Projects for Assistance in Transition from Homelessness (PATH), a $3 million increase over FY 2003. These funds will allow SAMHSA to reach out to 147,000 homeless individuals in an effort to get them off the streets and into mental health and substance abuse treatment services, as well as adequate housing. In addition to PATH, SAMHSA will be a major contributor to the joint effort called the Initiative to End Chronic Homelessness, administered by the Departments of Housing and Urban Development, Veterans Affairs and Health and Human Services. This initiative will improve the provision of permanent housing and support services to chronically homeless individuals and families. The budget also includes an increase for homeless policy academies, which bring State policy makers together to improve service coordination for homeless persons at the State and local level.

Other Mental Health: The President's budget also includes funding for New Freedom demonstration projects with the Centers for Medicare and Medicaid for home and community based waivers; grants to assists States in developing programs for individuals with co-occurring mental health and substance abuse disorders; grants to States to ensure Statewide implementation of evidence-based practices to phase in non-use of seclusion and restraints in mental health facilities.

A total of $433 million is requested for the Community Mental Health Services Block Grant to States that will support comprehensive community services to 222,500 adults with a serious mental illness and children with serious emotional disturbances.

PROGRAM MANAGEMENT

The FY 2004 budget includes $85 million, a net $8.5 million increase over the FY 2003 President's Budget to support 516 FTE and increased contribution to the agency SAMHSA-wide national surveys. The request includes savings of $2 million and 16 FTE associated with the President's Management Agenda. The reduction reflects anticipated savings from future competitive sourcing of commercial activities, as well as savings in other administrative areas.

INFORMATION TECHNOLOGY

The request for SAMHSA, as a whole, reflects a reduction of $6 million in information technology resources, both direct and supported through program contracts and other mechanisms. Savings will be achieved through the consolidation of information technology services across the Department, in addition to other efficiencies.

Children's Mental Health Services Program Results

- The rate of school suspensions declined dramatically from 41.4% at intake, to 35.9% at six months, to 30.4% at 12 months, and to 28.7% at 18 months.
- The percentage of children with a "D" grade average or below declined from 43.7% at intake to 32.2% at 18 months.
- The rate of arrests decreased from 12% at intake, to 9.3% at six months, to 7.4% at 12 months, and to 6.5% at 18 months.
- 92.5% of the children improved or remained stable in their problem behaviors and emotions after six months.

(dollars in millions)

	2002	2003	2004	2004 +/-2003
Health Costs, Quality and Outcomes Research.....	$248	$184	$211	+$27
Patient Safety Research (non-add).....	*55*	*60*	*84*	*+24*
Other Quality, Cost-Effectiveness and Intramural Research (non-add).....	*193*	*124*	*127*	*+3*
Medical Expenditures Panel Surveys.....	49	53	55	+2
Current Population Survey.....	0	10	10	0
Program Support.....	3	3	3	0
Subtotal, Program Level.....	**$299**	**$250**	**$279**	**+$29**
Less Transfers: PHS Evaluation Funds.....	$296	$250	$279	+$29
Total, Budget Authority.....	**$3**	**$0**	**$0**	**$0**
FTE.....	278	294	294	0

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Mission: *The mission of the Agency for Healthcare Research and Quality (AHRQ) is to support, conduct, and disseminate research that improves the outcomes and quality of health care, reduces costs, improves patient safety, and broadens access to services.*

The FY 2004 request for AHRQ provides a total program level of $279 million, an increase of $29 million, or 11.6 percent, from FY 2003 President's Budget. This request reflects the Department's priority on improving patient safety and reducing the number of medical errors through the implementation of information technology in hospitals.

AHRQ conducts and sponsors health services research to inform decision-making and improve clinical care and the organization and financing of health care. AHRQ supports the translation of research into measurable improvements in the care Americans receive. This work contributes not only to improved clinical care, but also to more cost-effective care. AHRQ accomplishes its mission through partnerships with other Federal agencies, academic institutions, medical societies, managed care organizations, and health care payers.

The Agency supports research project grants and research contracts at colleges and universities to capitalize on the expertise of academic institutions. In addition, AHRQ has forged cooperative relationships with major health care organizations to ensure that research funded by the Agency is implemented by the major players in the health system. In FY 2004, AHRQ will be fully funded through inter-agency transfers of evaluation funds.

HEALTH COSTS, QUALITY, AND OUTCOMES

The President's Budget will continue to support improvements through research on the cost effectiveness and quality of health care by providing a total of $211 million. Within this total funding, spending on patient safety efforts will increase from $60 million to $84 million.

Patient Safety: A total of $84 million is dedicated to patient safety activities in FY 2004.

Of this total, $50 million will be made available for hospital-based information technology investments designed to enhance patient safety, with an emphasis on small community and rural hospitals. These investments will facilitate uptake of technologies such as computerized physician order entry, computer monitoring for potential adverse drug events, automated medication dispensing, computerized reminder systems to improve compliance with guidelines, handheld devices for prescription information, computerized patient records, and patient-centered computerized support groups. An important aspect of diffusion of effective use of information technology requires the development of a business case for these tools. Working with public and private partners, AHRQ will help use the data from these hospital information technology investment demonstrations to effectively push proven technology through the healthcare system.

> *A study of the impact of simple computerized decision support showed a 55% reduction in the rate of serious medication errors.*
>
> *--David Bates, M.D. JAMA, 1998*

$10 million will be used toward promoting and accelerating the development, adoption and diffusion of information technology in health care. A consensus has emerged that a major obstacle to the development and use of health information systems to support quality improvements and patient safety is the lack of clinical terminology and messaging standards that support interoperability. Progress is occurring as a result of several efforts, including the recommendations of the National Committee on Vital and Health Statistics, federal interagency efforts such as the Consolidated Healthcare Informatics initiative, and the activities of voluntary industry standards development organizations, but significant advances on a broad scale require dedicated Federal resources, leadership and coordination.

These priority projects will identify barriers and practical solutions for the widespread adoption and use of information standards and technology to support patient safety in the U.S., develop a common vision for health information technology and standards across the health care spectrum, and promote and accelerate efforts needed to make that vision a reality in the U.S.

The remaining $24 million in the patient safety budget supports a variety of activities. AHRQ, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services continue to work collaboratively to develop a common Web interface for medical providers that will both enhance the usefulness of adverse event information and reduce reporting burden for their partners in the health care community. Funded at $3 million in FY 2004, this streamlined reporting

system will integrate data from such systems as the National Healthcare Safety Network operated by CDC as well as the reporting systems for drugs, biologics, vaccines, and medical devices operated by FDA. In addition, AHRQ will continue a $3 million series of challenge grants begun in FY 2003 designed to test new error-reducing interventions and a $2 million program to train safety experts to assist States and local healthcare organizations in developing a safety focus. Finally, AHRQ continues a number of grants and contracts related to impact of technologies, workforce, and organizational structure on patient safety.

Other Quality, Cost-Effectiveness and Intramural Research: An increase of $3 million will support those programs that provide ready access to a wide breadth of national and State level data to accurately reflect the status of the healthcare system and expenditures for providing care in the system. An increase of $2 million in Healthcare Cost and Utilization Project (HCUP) will help to improve to improve availability of the outpatient data, make HCUP data and quality indicators, such as benchmarks, more usable, and facilitate effective use of these improvements through outreach. A $1 million increase in the Consumer Assessment of Health Plans (CAHPS) program will improve technical assistance and enable the assessment of the impact of the program from the perspective of a variety of audiences: consumers, health care providers, and purchasers.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

The FY 2004 budget for MEPS includes a request for $2 million over the FY 2003 level for a total of $55 million. MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of visit-level information on medical expenditures. This requested increase will be used to improve the usability and timeliness of MEPS data through several activities. It will help sustain prior year enhancements to the sample size and content of the surveys that collect information from medical providers, insurers, and households. Enhancements in MEPS will lead to a better understanding of the quality of care the typical patient receives, and of disparities in the care delivered. MEPS data are critical for tracking the impact of Federal and State programs, including the State Children's Health Insurance Program (SCHIP), Medicare and Medicaid.

National Reports on Quality and Disparities in Health Care: MEPS supports two forthcoming reports required by AHRQ's 1999 reauthorization, to be released at the end of FY 2003. The National Healthcare Quality Report--the first-ever annual report on the quality of health care in the United States--will include information on patient assessment of health care quality, clinical quality measures of common health care services, and performance measures related to outcomes of acute and chronic disease. The second report--the National Healthcare Disparities Report–highlights populations that are at high risk for disparities in care. These populations include the elderly, people in inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs. The NHDR is being developed in partnership with other HHS agencies to ensure synergy with existing efforts, including Healthy People 2010.

CURRENT POPULATION SURVEY

To support State efforts, HHS is interested in improving the reliability of State-level estimates of the uninsured obtained through the Census Bureau's Current Population Survey (CPS). Of the five existing government surveys, only one, the CPS, currently produces annual estimates of the uninsured at the State level. $10 million will go toward the expansion and enhancement of information collected in the CPS. This will provide more comprehensive information for States and the Federal government to use in the development of plans to expand coverage of the uninsured.

CENTERS FOR MEDICARE & MEDICAID SERVICES

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Current Law:				
Medicare /1	$257,219	$273,015	$284,013	+$10,998
Medicaid	147,512	162,366	176,754	+14,388
SCHIP	3,682	4,751	5,090	+339
State Grants and Demonstrations	10	37	65	+28
Total Outlays, Current Law	**$408,423**	**$440,169**	**$465,922**	**+$25,753**
Premiums	-25,951	-28,269	-30,998	-2,729
Other Offsetting Collections (net)	-42	-8	0	+8
Total Net Outlays, Current Law	**$382,430**	**$411,892**	**$434,924**	**$23,032**
Proposed Law:				
Medicare Administration	$0	-$130	-$201	-$71
Medicare Modernization (Allowance)	0	0	6,000	$6,000
Medicaid/ SCHIP	0	225	3,411	3,186
Total Proposed Law	**$0**	**$95**	**$9,210**	**$9,115**
Total Net Outlays, Proposed Law /2	**$382,430**	**$411,987**	**$444,134**	**+$32,147**

/1 Includes benefits and administration.

/2 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Mission: *The Centers for Medicare & Medicaid Services' mission is to assure health care security for beneficiaries.*

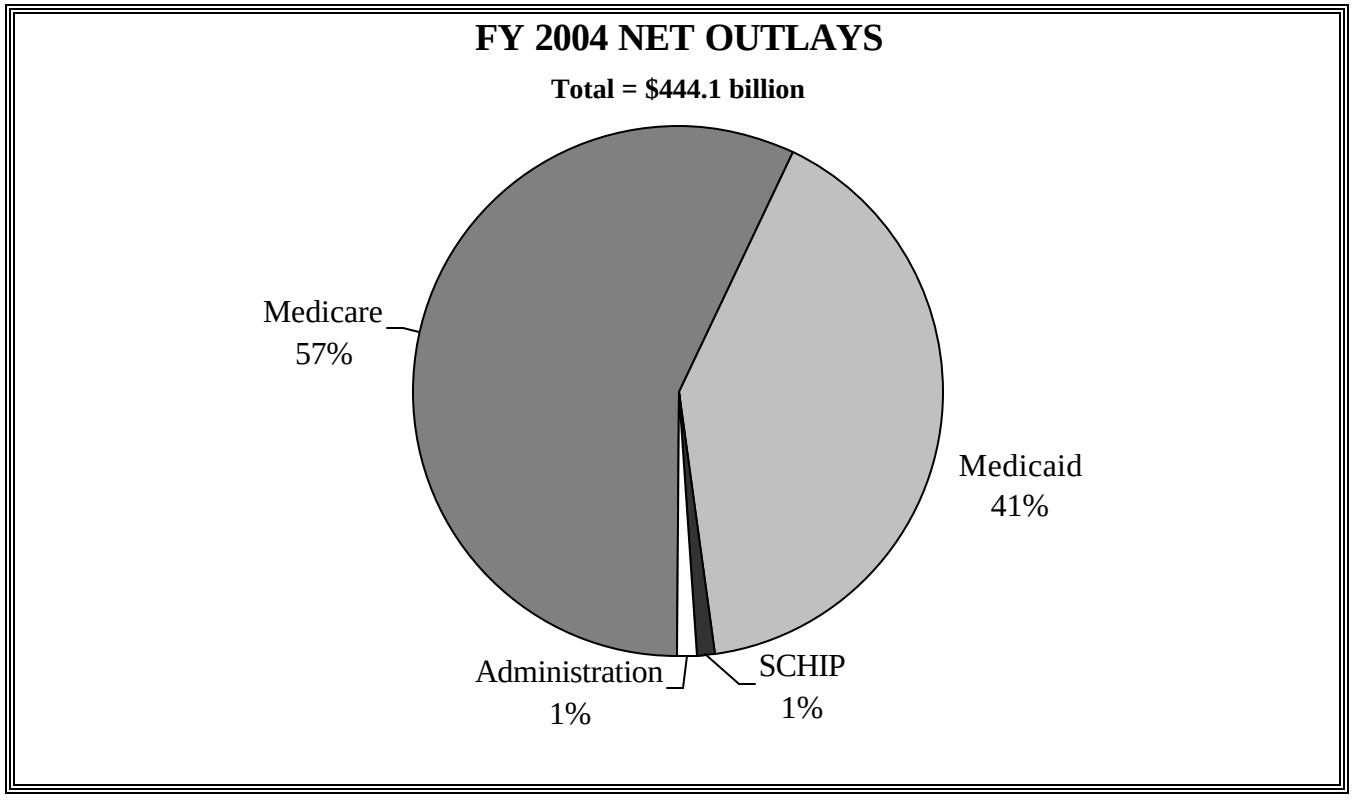
The FY 2004 budget request for the Centers for Medicare & Medicaid Services (CMS) is $444.1 billion in net outlays. The request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and CMS' operating costs. This budget reflects an increase of $32.1 billion over FY 2003.

The FY 2004 President's Budget includes important proposals for modernizing Medicare, a program that represents the Nation's commitment to our seniors and disabled. It dedicates $400 billion over ten years (2004- 2013) to support the President's framework for targeted improvements, including: providing access to subsidize prescription drug coverage for beneficiaries; enhancing Medicare+Choice; modernizing Fee-for-Service and changing the appeal system. The President proposes to provide access to prescription drug coverage that will protect beneficiaries from high drug expenses and provide low-income beneficiaries with additional assistance. The budget enhances Medicare+Choice by linking payments to the rising cost of providing health care services. It modernizes Fee-for-Service by adding a provision to protect beneficiaries against high out-of-pocket costs caused by serious illness. Lastly, the FY 2004 budget proposes to provide consumers with information to help make informed decisions regarding the quality of care provided in hospitals and nursing homes.

The President's Budget also proposes fundamental changes to the Medicaid and SCHIP programs. Building upon the Health Insurance Flexibility and Accountability and Pharmacy Plus waiver templates, the Administration is proposing a bold new Medicaid modernization plan to introduce more State flexibility and fiscal stability into the program. The centerpiece of this reform is the creation of State HealthCare Partnership Allotments which would replace the current entitlement funding structure with two allocations that will enhance State flexibility and promote innovation.

The budget also includes significant new efforts to help the disabled under the New Freedom Initiative and the extension of assistance to vulnerable populations through the Transitional Medical Assistance and QI-1 programs. The budget includes a proposal to extend the availability of expiring SCHIP funds until FY 2004.

Lastly, the budget includes $65 million in funding for CMS' Revitalization Plan. This Plan will allow CMS to make use of recent advances in technology and improve the way it processes and analyzes claims data.



MEDICARE

Medicare is the Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 2004, the program will serve more than 41 million eligible individuals. Medicare consists of three parts:

Part A –Hospital Insurance (HI) is an entitlement for all qualified beneficiaries. Part A pays for inpatient hospital care, some skilled nursing facility care, home health care related to a hospital stay, and hospice care. The HI program is funded through the HI Trust Fund, which receives most of its income from the HI payroll tax (2.9 percent of payroll, split evenly between employers and employees). The Medicare Trustees recently reported that the HI Trust Fund's depletion date has improved slightly, from 2029 to 2030, but HI spending will begin to exceed tax receipts by 2016.

Part B –Supplementary Medical Insurance (SMI) coverage is optional. However, 94 percent of those enrolled in Part A enroll in Part B. Part B pays for medically necessary physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, home health care, and certain other medical services and supplies. Enrollees pay 25 percent of Part B costs (or $58.70 per month in 2003), with remaining costs covered by general revenue.

Part C –The Medicare+Choice program offers beneficiaries a variety of coverage options, including a traditional HMO, a preferred provider organization (PPO), or a private fee-for-service plan. Currently, 4.6 million, or 11 percent of beneficiaries, are enrolled in a Medicare+Choice plan. These figures are lower compared to last year, when 5.6 million beneficiaries, or 14 percent of all beneficiaries, were enrolled. This drop in enrollment reflects the large number of plans, about 407, that have left the Medicare+Choice program or reduced their service areas in the last five years.

Medicare Spending Growth: Under current law, Medicare gross benefit outlays are projected to increase from $279 billion in FY 2004 to $480 billion in FY 2013. The program is expected to grow at 6.0 percent per year during this period. Part A benefit outlays are projected to grow from $159 billion in FY 2004 to $258 billion in FY 2013, at an average annual growth rate of 5.4 percent. Part B benefit outlays are expected to grow from $119 billion in FY 2004 to $223 billion in FY 2013. The Part B average annual growth rate during the projection period is 6.8 percent.

Health Care Fraud and Abuse Control Program (HCFAC): Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the HCFAC Program. The program combats health care fraud, waste, and abuse. Included within this overarching program is the Medicare Integrity Program (MIP), which is run by CMS, Federal Bureau of Investigation (FBI) health care investigation funding, and the Fraud and Abuse Control account which is administered by a number of agencies including the Administration on Aging, the Office of the Inspector General, the Office of the General Counsel, and the Department of Justice.

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

In FY 2004, HIPAA authorizes $720 million for MIP, the same amount as FY 2003, as mandated by law. Within this level, CMS will fund activities that will stop unnecessary payments before they leave the Trust Funds through pre-payment review and provider education. These actions help lower the payment error rate cited in recent Chief Financial Officer's reports.

Also under MIP, CMS is developing contractor-specific error rates that will gauge the progress the agency is making in correcting payment errors by providers. This effort began in Summer 2000 and initial results have shown that this new methodology will provide CMS with the targeted information it needs to further reduce error rates in the future.

HIPAA also created the Fraud and Abuse Control account. This account funds much of the health care investigational and prosecutorial activities of the HHS Office of Inspector General (OIG) and the Department of Justice. The Fraud and Abuse Control account is funded at $241 million. In FY 2003, CMS expects to receive $4.5 million from this account to work with States that wish to develop Medicaid payment error rates, $3.7 million to begin work on SCHIP financial management, and an additional $10 million for Medicaid financial management. In FY 2004, the Secretary will work with the Attorney General to increase Fraud and Abuse Control account

spending for Medicaid financial management to $20 million.

The Administration's health care fraud, waste, and abuse control efforts have helped protect the Medicare Trust Funds. These efforts, in addition to improved provider compliance, have cut the Medicare overpayment error rate in half from FY 1996 through FY 2002, from 14 percent to 6.3 percent. We have set a goal of further reducing the error rate to 4 percent by FY 2008. Recent Medicare Trustee's reports have cited our health care fraud, waste, and abuse control efforts as a contributing factor in the slower Medicare spending growth experienced over the last several years. We hope to bring similar success to the state-administered Medicaid and SCHIP programs as well.

Quality Improvement Organizations (formerly known as Peer Review Organizations): These organizations were established by Title XI, Section 1151 of the Social Security Act, Part B, to serve the following functions:

- Improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and,
- Protect beneficiaries by addressing individual beneficiary's complaints, and hospital issued notices of noncoverage and Emergency Medical Treatment and Labor Act (EMTALA) "dumping" violations.

QIOs are a central player in this Administration's efforts to improve the quality of care provided to Medicare's beneficiaries. Under their current three year funding plan, QIOs are part of groundbreaking efforts underway in Medicare to promote public awareness and use of information about the quality of care delivered in nursing homes, hospitals, and home health agencies, and assist providers seeking to improve quality of care outcomes. These efforts are essential to Administration goals to modernize and strengthen the Medicare program.

In November 2002, HHS and CMS launched the national Nursing Home Quality Initiative (NHQI). The initiative provides new comparative information to consumers and new resources to facilities all aimed at improving nursing home quality of care. Not only will consumers be better informed about the performance of individual nursing homes, but nursing homes themselves will be able to identify what they must do in order to improve quality. In 2003, HHS plans to report similar information on home health agencies.

As of January 1, 2003, nursing homes across America are required to publicly post the number of nursing staff they have on duty to care for patients on each daily shift. Posting this information was required by Congress in recent legislation. Providing this information to consumers is consistent with the NHQI's goal of arming families with information about the quality of nursing homes in their area.

Last December, HHS joined with national hospital leadership, consumers, and the National Quality Forum to initiate voluntary public reporting of 10 quality outcome measures for hospitals. This agreement with the hospital industry also includes a three-State pilot project and a standardized patient experience survey instrument.

On January 15, 2003, a CMS study was published in the Journal of the American Medical Association. It shows that we are making important progress on the quality of health care. The study shows that from 1998 to 2000, there has been across-the-board improvement in a series of health care quality measures tracked by QIOs. For instance, the study shows that the percentage of diabetic patients screened for cholesterol problems rose from 56 percent to 74 percent, and that the percentage of patients receiving beta-blockers at hospital discharge, which reduce complications in patients who have had a heart attack, rose from 72 percent to 79 percent. Despite these improvements, the study reports that more than a quarter of Medicare beneficiaries still do not receive services that could protect them from disease or prolong life.

MEDICARE MODERNIZATION

This budget builds upon the President's framework for Medicare modernization, including a access to subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. This budget allocates $6 billion in FY 2004, $130 billion over five years and $400 billion over 10 years to modernize Medicare.

Providing Access to Prescription Drugs: While drugs were not a standard part of health insurance coverage when Medicare was created, they are an integral part of modern medicine today. However, with few exceptions, Medicare does not cover outpatient prescription drugs. The drug benefit would protect beneficiaries against high drug expenditures and would provide additional assistance to low-income beneficiaries. It would offer beneficiaries a choice of plans, and would support the continuation of the coverage that many beneficiaries already receive through employer-sponsored and private health insurance plans.

More Choice through Health Plan Competition: The absence of prescription drug coverage is not the only serious gap in the Medicare benefit package: beneficiaries are increasingly unable to obtain coverage through Medicare+Choice plans. Although Medicare+Choice

The President's Principles for Medicare Modernization

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illnesses.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened to improve care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

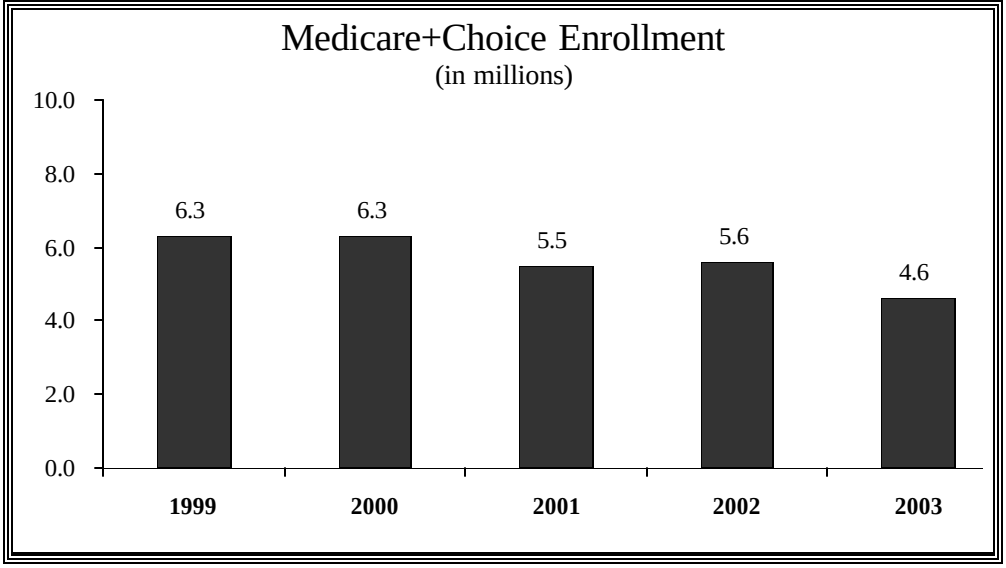
was established to offer beneficiaries a private plan option for their health coverage, few new types of plans have entered the program, and many have withdrawn because Federal payments to Medicare+Choice plans have not kept pace with rising health care costs.

In the short term, this Administration believes that Medicare+Choice payments must be linked to the costs of providing health care services, including prescription drugs. Beneficiaries should have access to the same kind of reliable health care options available to most Americans. Those health care options should be provided through a market-based system in which private plans compete to provide coverage for beneficiaries. Those beneficiaries who select less costly options should be able to keep most of the savings.

Preventive Benefits: When the Medicare program began, preventive benefits were not included in the benefits package. Recognizing the value of preventive services in preventing illness and saving lives, several services were added over the years. However, this coverage is insufficient and beneficiaries face hundreds of dollars each year in deductibles and copayments. The cost may prevent many beneficiaries from actually seeking out the services to which they are entitled.

Modernized Fee-For-Service (FFS): The Medicare benefits package needs to be updated to meet the needs of beneficiaries in the twenty-first century and come into better alignment with the insurance packages offered by the private sector. Catastrophic coverage and a more rationalized system of cost-sharing should be considered to protect the beneficiaries against high out-of-pocket expenditures.

Provider Payments: Payments to physicians have decreased over the past two years and are expected to decrease further over the next several years. These decreases are the result of a payment formula defined in statute. This budget proposes to adjust the formula to use actual data instead of estimates in current and previous updates. This would result in higher updates for the next several years. Also, we will work with Congress to monitor payments to other providers, as many sources have found that some providers are being overpaid, and these overpayments could be used to modernize the Medicare program.



Additional Medicare Improvements: This budget includes two other proposals that support efforts to modernize and improve the Medicare program:

- The Administration will pursue legislation to ensure that Medicare more accurately reimburses for covered outpatient drugs, including the cost of administering them.

♦ Medicare and the Federal employees Health Benefits Program jointly finance health insurance for about 2.1 million Federal retirees and their dependents. The Administration will work with stakeholders to better coordinate these two programs and look to the practices of the private sector to ensure high quality, cost-conscious choices for retirees.

A Full View of Medicare's Financial Health: Medicare is not financially secure for the retirement of the baby boom generation. The 2002 Medicare Trustees Report estimates the Hospital Insurance Trust Fund will go insolvent in 2030. Currently, there is no comprehensive measure of Medicare's solvency that accounts for both Part A and Part B Trust Fund financing. This underestimates the magnitude of Medicare's financial difficulties. The Medicare Trustees acknowledge this disconnect in their 2001 Trustees report by stating that, "Although this report focuses on the financial status of the Hospital Insurance (HI) Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions."

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	2002	2003	2004	+/-
Aged	34.6	34.8	35.0	+0.2
Disabled	5.9	6.1	6.3	+0.2
Total Beneficiaries	40.5	40.9	41.3	+0.4

MEDICARE OUTLAYS

(outlays in millions)

	2002 Actual	2003 Enacted	2004 Request	Request +/-Enacted
Current Law:				
HI Benefits	145,307	150,000	159,418	+9,418
SMI Benefits	106,901	117,627	119,214	+1,587
Subtotal, Medicare Benefits	**$252,208**	**$267,627**	**$278,632**	**+$11,005**
Administration /1	3,582	3,840	3,936	+96
HCFAC /2	963	1,075	1,075	0
Quality Improvement Organizations	354	346	370	+24
Transfers to Medicaid	112	127	0	-127
Total Outlays, Current Law	**$257,219**	**$273,015**	**$284,013**	**+$10,998**
Premiums	-25,951	-28,269	-30,998	-2,729
Other Offsetting Collections	-42	-8	0	+8
Total Net Outlays, Current Law	**$231,226**	**$244,738**	**$253,015**	**+$8,277**
Proposed Legislation:				
Premium Interaction with Medicaid policies	0	50	55	+5
Proposed User Fees	0	-130	-201	-71
Medicare Modernization (Allowance)	0	0	6,000	+6,000
Total Medicare Proposed Legislation	**$0**	**-$80**	**$5,854**	**+$5,934**
Total Net Outlays, Proposed Law	**$231,226**	**$244,658**	**$258,869**	**+$14,211**

1/ Includes Administrative payments to the SSA and other non-CMS agencies.
2/ Health Care Fraud and Abuse Control, including FBI and OIG.

MEDICAID

Medicaid is a jointly-funded, Federal-State program that provides medical assistance to certain low-income groups. In FY 2004, approximately 42.4 million individuals will be covered by Medicaid. These individuals include children, the aged, blind, and/or disabled, people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program, and individuals who receive Medicaid benefits through waivers and amended State plans that have higher income limits. Under current law, the Federal share of Medicaid outlays is expected to be about $176.8 billion in FY 2004. This is a $14.4 billion (8.9 percent) increase over projected FY 2003 spending.

BACKGROUND

Under Medicaid, State expenditures for medical assistance are matched by the Federal government using a formula based on per capita income in each State relative to the national average per capita income. Federal matching rates for FY 2004 will range from 50 to 77 percent for medical assistance payments. The average Federal matching rate is approximately 57 percent. In addition to medical assistance payments, the Medicaid appropriation funds the Vaccines for Children program and the Federal share of Medicaid State and local administration.

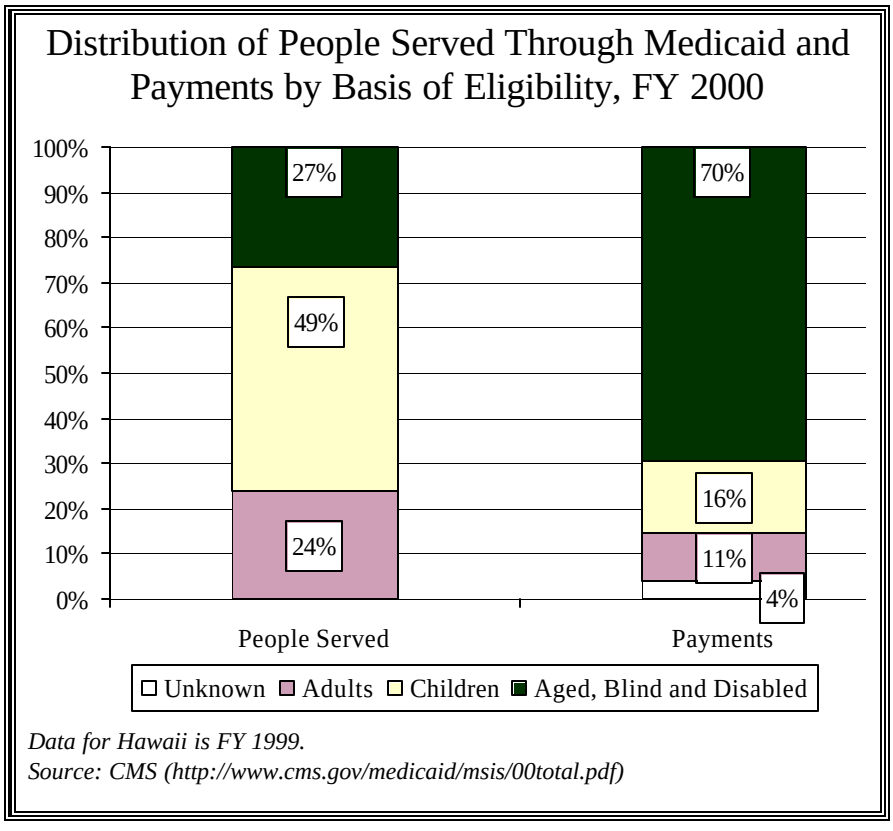
Historically, eligibility for Medicaid has been based on receipt of cash assistance under AFDC or Supplemental Security Income (SSI). With the creation of the Temporary Assistance for Needy Families (TANF) program in 1996 (which replaced AFDC) eligibility for Medicaid and cash assistance was de-linked.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

Medicaid covers pregnant women and infants whose family income does not exceed 185 percent of the Federal poverty level. As of September 30, 2002, all children under the age of 19 living below the poverty level are eligible for Medicaid.

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

PROGRAM DEVELOPMENTS

Medicaid Growth: Outlays are estimated to grow by 10.1 percent from FY 2002 to FY 2003. Prescription drug spending, nursing homes, community-based long-term care costs, and payments to health plans are expected to be significant contributors to this expenditure growth and are expected to continue



Data for Hawaii is FY 1999.
Source: CMS (http://www.cms.gov/medicaid/msis/00total.pdf)

to contribute to program growth in future years. State programs providing "enhanced payments" to institutional providers have also played a significant role in driving up Medicaid costs at an accelerated rate. Although recently issued regulations will eventually curtail much of the impact of these payments, enhanced payments will contribute to higher spending growth for a number of years during the transition period.

According to State estimates, the fastest growing service category in the Medicaid program is prescription drugs. States expect the prescription drug category, which includes drug rebate offsets, to grow by $2.2 billion, or 14.1 percent, between FY 2003 and FY 2004. The State estimated increase for prescription drugs accounts for 14.9 percent of the total FY 2004 benefit growth.

Waivers: Under Section 1115 of the Social Security Act, States have sought demonstration waivers to expand health care coverage to low-income, uninsured populations, and to test innovative approaches in health care service delivery. Many of the demonstrations include the Temporary Assistance for Needy Families (TANF) and related populations, and some include the elderly and the disabled. Although demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care for the Medicaid population.

Currently, CMS has approved 27 Statewide comprehensive health care reform demonstrations in 23 States. CMS has also approved two sub-state health reform demonstrations and 10 demonstrations specifically related to family planning.

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

The main goals of the HIFA initiative are to encourage innovation in the Medicaid and SCHIP programs, give States the programmatic flexibility to increase health insurance, simplify the waiver process, and increase the accountability of both the States and the Federal government in ensuring SCHIP and Medicaid funds are spent appropriately.

To date, the Administration has approved seven HIFA demonstration waivers (six of which also affect the SCHIP program), in Arizona, California, Colorado, Illinois, Maine, New Mexico and Oregon. These Medicaid and SCHIP demonstration waivers focus on vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adults with incomes less than twice the Federal Poverty Level.

Pharmacy Plus: The Administration developed Pharmacy Plus waivers under Section 1115 to help low-income seniors and people with disabilities who need assistance with prescription drug purchases. Pharmacy Plus is directed to Medicare beneficiaries with low-incomes and people with disabilities with incomes of 200 percent or less of the Federal poverty level (FPL) who are not eligible for full Medicaid benefits. Four States have approved Pharmacy Plus waivers (Florida, Illinois, South Carolina, and Wisconsin) and Maryland has revised its statewide 1115 demonstration to add a pharmacy benefit. Eight other States have applications pending.

MEDICAID AND SCHIP REFORM

To increase State flexibility and promote State innovation in health care, the Administration is introducing new options. States now have the option to accept their Federal Medicaid and SCHIP funding in two lump-sum allotments - one for acute care and one for long-term care - with an additional provision that States may transfer 10 percent of their funding between each allotment. The size of each participating State's allotment will be

Principles for Medicaid and SCHIP Modernization

- Provide States the flexibility to design innovative programs without waivers, including increased use of consumer-directed services and home and community-based care.
- Create new opportunities for States to coordinate with the private sector to deliver services.
- Rein in the growth of State and Federal program costs.
- Simplify the payment policies and rules for SCHIP and Medicaid.
- Minimize State incentives to refinance State-funded programs with Medicaid and SCHIP matching funds.
- Increase State accountability by ensuring that Medicaid and SCHIP dollars are being used to address the health care needs of low-income, uninsured Americans.
- Promote more efficient coordination of care for beneficiaries who are dually eligible for Medicare and Medicaid.

determined by FY 2002 expenditure levels increased annually using a specified trend rate. The State will also be expected to contribute maintenance of effort (MOE) funds based on FY 2002 State expenditures. MOE will also be inflated annually by a trend rate, but one lower than that for Federal allotments.

States will be given significant flexibility within the allotment to design health insurance options for their uninsured populations. Building upon the HIFA initiative, States will also be encouraged to seek private sector solutions to insuring their Medicaid population, including premium assistance programs, and coordination with any federally enacted health tax credit. The program is budget neutral over 10 years.

MEDICAID LEGISLATIVE PROPOSALS

Please note that FY 2004 budget estimates assume program operation in the absence of Medicaid/SCHIP reform. Final estimates for most Medicaid/SCHIP proposals depend on State participation in the State Health Care Partnership Allotment option.

Extension of Transitional Medical Assistance: Transitional Medical Assistance (TMA) provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare benefits due to earnings from work. This provision was enacted along with welfare reform and was scheduled to sunset in September 2002. Congress has extended this program, through continuing resolutions, into 2003. The budget proposal would extend TMA through FY 2008, costing $175 million in FY 2003, $400 million in FY 2004 and $2.4 billion over five years.

Simplification of Transitional Medical Assistance: The 2004 President's Budget proposes to simplify eligibility for Transitional Medical Assistance benefits to the low-income working poor. There are four provisions to the proposal.

- States will be given the option to offer 12 months of continuous care to eligible participants.
- States may waive income reporting requirement for beneficiaries.
- States that have Medicaid eligibili ty for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements.
- States have the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits.

This plan is estimated to cost $20 million in 2004 and $290 million over five years.

Drug Rebates Based on Average Manufacturer's Price: Over the past year, it has become evident that the best price component of the rebate can be confusing, as it is not always clear which prices a manufacturer must include when calculating and reporting to CMS its best price. In addition, best price may serve to limit the discounts that private-sector purchasers are able to negotiate with pharmaceutical manufacturers. The Administration is interested in exploring with Congressional Committees of jurisdiction policy options in this area that would improve the Medicaid drug pricing and reimbursement system and generate program savings. The current methodology sets rebates equal to the difference between a drug's average manufacturer's price (AMP) and the manufacturer's best price for that medication.

New Freedom Initiative Demonstrations: The administration reproposes three demonstration projects under the New Freedom Initiative. Each promotes at-home care as an alternative to institutionalization. The demonstrations are:

- respite services for caregivers of disabled adults.
- respite services for caregivers of severely disabled children.
- home and community based services for children currently residing in psychiatric residential treatment facilities.

These three demonstrations will cost $8 million in FY 2004 and $778 million over ten years. They will be funded out of mandatory Medicaid funds.

In addition, HHS is proposing to fund a fourth demonstration project to address shortages of community direct care workers. This last project would be funded out of the CMS Research, Demonstrations, and Evaluation budget.

"Money Follows the Individual" Rebalancing Demonstration: The Administration is committed to promoting the use of at home care as an alternative to nursing homes for elderly and disabled Americans. Under the "Money Follows the Individual" demonstration, at-home care combines cost effective benefits with increased independence and quality of life for the beneficiary.

In this five-year demonstration project, the Federal government will fully reimburse States for one year of Medicaid services for individuals who move from institutions into at-home care. After this initial year, States will be responsible for matching the Federal government at their respective FMAP rates. This demonstration will cost $350 million in FY 2004 and $1.75 billion over five years.

Paying Nursing Facilities for Residents that Elect Hospice: Current law requires States to pay room and board to the agency

providing hospice services if clients are receiving hospice and are residing in a nursing facility. In turn, the agency providing hospice services pays the nursing facility. This system is burdensome and unnecessarily inefficient. This proposal will eliminate the requirement that State agencies make room and board payments to hospice for Medicaid and dually entitled beneficiaries residing in a nursing facility who are also receiving hospice services. Through this proposal the Federal government will require the State to make these room and board payments directly to the nursing facilities. This proposal is technical and has no costs associated with it.

Partnership for Long Term Care: This proposal would eliminate the legislative prohibition of developing more Partnership programs. The Partnership for Long Term Care (LTC) was formulated to explore alternatives to current long-term care financing by blending public and private insurance. Four States currently have these partnerships whereby private insurance is used to cover the initial cost of LTC. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria. This proposal has no costs associated with it.

Extension of Premium Benefits to Certain Qualified Individuals (QI-1s): Under the QI-1 program, which expired in FY 2002, Medicaid pays Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent of poverty. Currently Part B premiums cost approximately $700 a year. The Administration recognizes the burden these premiums place on low-income beneficiaries and proposes to extend the QI-1 benefit for five more years. States will continue to be fully reimbursed for the cost of the program. This extension is estimated to cost $50 million in FY 2003, $115 million in 2004, and $645 million over five years.

Spousal Exemption: This proposal extends eligibility for Medicaid benefits to the spouses of disabled individuals entering the workforce. The lack of spousal coverage is a significant impediment to employment for many low-income disabled individuals and this exemption smooths the road to independence. The Federal government will invest $16 million in this program for FY 2004 and $238 million over 10 years.

Extending the Availability of Expiring SCHIP Funds: According to current estimates, about $830 million in SCHIP funds will return to the Treasury at the end of FY 2003. This budget proposal would extend the availability of the expiring funds to States through FY 2004. This would save the Medicaid program $230 million from FY 2004 to FY 2013. See the SCHIP Section of the Budget in Brief for more detail.

Child Support Enforcement Proposal: This proposal requires States to review child support cases every three years, thereby increasing the number of State medical child support reviews for TANF recipients. A higher rate of reviews would result in more children receiving private health insurance and consequently decrease the number of children who receive their health care through the Medicaid program. This proposal has no fiscal effect on Medicaid in FY 2004 but will save the program $103 million over 10 years.

Disability Determination Proposal: The Social Security Administration has proposed a management improvement that has a Medicaid impact. The proposal requires that 50 percent of all favorable adult disability benefit decisions be reviewed to verify eligibility. The program will save money in the Medicaid program by insuring that only legally disabled individuals receive Medicaid services due to their SSI status. The proposal saves the Medicaid program $1 million in FY 2004 and $599 million over 10 years.

Additional Funding for the Vaccines for Children (VFC) Program: VFC is a CDC administered, Medicaid-funded program that administers free vaccines to children. The Administration is proposing two legislative changes to the program. First, the Administration proposes to lift the price cap on the tetanus-diphtheria booster, thereby increasing access for VFC eligible children. Second, the Administration would allow under-insured children to receive VFC administered inoculations at State and local health departments in addition to Federally Qualified Health Centers and Rural Health Centers. These proposals will cost an additional $165 million in FY 2004 and $1.6 billion over ten years.

Advanced Purchase of Durable Medical Equipment: CMS will issue guidance to States clarifying States' ability to purchase allowable DME or assistive devices up to 60 days prior to patient discharge from a nursing home. This will allow Medicaid beneficiaries to transition into the community easier by allowing time for them to learn how to use the equipment and make adjustments as needed. This proposal has no fiscal impact on the Medicaid program.

Presumptive Eligibility for Community-Based Services: This proposal will establish a State Medicaid option allowing presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community. This will increase the number of Medicaid beneficiaries who receive home and community-based services. This proposal will have no effect on the Medicaid budget.

Special Enrollment Period in Group Market for Medicaid/SCHIP Eligibles: This legislative proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance, by making eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season. This proposal will help States implement premium assistance programs in Medicaid and SCHIP.

MEDICAID ENROLLMENT

(average number of enrollees in millions)

	2002	2003	2004
Aged 65 and Over	4.2	4.3	4.3
Blind and Disabled	7.5	7.8	7.9
Needy Adults	9.8	10.3	10.6
Needy Children	18.4	19.1	19.6
Total /1	**39.9**	**41.4**	**42.4**

/1 Numbers may not add due to rounding.

MEDICAID OUTLAYS

(outlays in millions)

Current Law:	2002 Actual	2003 Enacted	2004 Request	Request +/- Enacted
Benefits /1	$140,239	$153,464	$167,686	+$14,222
State Administration	7,273	8,902	9,067	+$165
Total Net Outlays, Current Law	**$147,512**	**$162,366**	**$176,754**	**+$14,388**

/1 Includes Vaccines for Children Outlays.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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

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

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

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

- expanding Medicaid,
- creating a new, non-Medicaid Title XXI separate State program, or,
- a combination of both approaches.

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

IMPLEMENTATION AND ENROLLMENT

By September 1999, SCHIP plans were approved for all 50 States, the District of Columbia, and five Territories. As of January 2003, States have received approval for 21 Medicaid expansion programs, 19 separate programs, 16 combination programs, and 146 State plan amendments.

Today, 39 States cover children in families with incomes up to 200 percent of the FPL. Of these States, 13 cover children above that level. Six of the States cover children up to 300 percent of the FPL, and one State covers children up to 350 percent of the FPL.

During FY 2002, an estimated 4.2 million children were enrolled in SCHIP.

SCHIP REPORTS AND EVALUATIONS

Congress required several SCHIP evaluations in statute. Title XXI required States to assess the operation of their SCHIP State plans and report to the Secretary by January 1 of each fiscal year. The statute also directed each State to submit to the Secretary State evaluation reports by March 31, 2000. These reports are available on the CMS website. As required by the statute, the Secretary submitted a report on the States' evaluations, which was made available to Congress and the public in December 2002. In addition to this report to Congress, CMS has planned future evaluations to examine the SCHIP program in greater detail.

The Balanced Budget Refinement Act of 1999 (BBRA) also required HHS to conduct an independent evaluation of 10 States. The interim evaluation report is scheduled to be submitted to Congress early this year. A final report is due to Congress in 2004.

BBRA also directed the Secretary, through the Inspector General, to evaluate SCHIP every three years. The OIG is instructed to evaluate: 1) State compliance with the requirement that Medicaid-eligible children are not enrolled in SCHIP, and, 2) State progress made in reducing the number of uninsured children. The OIG released two reports in February 2001 which fulfill these requirements. In order to satisfy the requirement to submit these evaluations every three years, the OIG plans to work on a new series of evaluations this year. The OIG will expand the scope of the follow-up studies to more comprehensively assess the SCHIP program by analyzing a broader array of States.

As directed by BBRA, the Comptroller General submitted a report to Congress monitoring these OIG audits. The Comptroller General's report suggests that the OIG expand the study to include a more diverse sample of States.

SCHIP WAIVERS

The requirements of Federal law and regulations can be waived by the Department of Health and Human Services (HHS) in order to give States the programmatic flexibility to increase health insurance coverage and encourage innovation in their SCHIP programs. These waivers can enable States to more effectively tailor their programs to meet local needs, and they allow States to experiment with new approaches to providing health care services to SCHIP recipients.

Section 1115 waivers allow States to waive certain provisions of Federal law and demonstrate innovative methods for improving coverage and the quality of services for children. As of December 2002, SCHIP waivers were approved for Maryland, Minnesota, New Jersey, New Mexico (2), Ohio, Rhode Island, and Wisconsin. These Section 1115 waivers provide health insurance to uninsured children, their parents, and pregnant women.

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) DEMONSTRATION INITIATIVE

In August 2001, the Administration invited States to participate in the HIFA demonstration initiative. This new Section 1115 approach encourages States to develop comprehensive insurance coverage for individuals at twice the Federal poverty level and below using SCHIP and Medicaid funds. It gives States the flexibility to increase health insurance coverage through support of private group health coverage, and simplifies the waiver application process.

The main goals of the HIFA initiative are to encourage innovation in the Medicaid and SCHIP programs, give States the programmatic flexibility to increase health insurance, simplify the waiver process, and increase the accountability of both the States and the Federal government in ensuring SCHIP and Medicaid funds are spent appropriately.

Since December 2001, the Administration has approved six HIFA demonstration waivers that affect SCHIP--in Arizona, California, Colorado, Illinois, New Mexico and Oregon. These demonstration waivers target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adults with incomes less than twice the Federal Poverty Level.

LEGISLATIVE PROPOSALS

Extending the Availability of Expiring SCHIP Funds: The Balanced Budget Act of 1997 (BBA) authorized SCHIP grants to the States for each fiscal year between 1998 and 2007. States are given three years in which to spend each year's allotment. If States have not spent their entire allotment by the end of the third year, BBA requires these unspent funds to be redistributed to States that have used all of their funds. These redistributed funds would remain available for one year, after which time any of the unspent redistributed funds revert to the Treasury at the end of the fiscal year. At the end of FY 2002, approximately $1.2 billion reverted back to the Treasury.

According to current estimates, approximately $830 million in SCHIP funds will return to the Treasury at the end of FY 2003. The budget proposal would extend the availability of FY 2000 funds for one year, through FY 2004. This proposal costs $35 million in 2004, and $565 million over 10 years.

This extension of availability will allow States to maintain their current coverage levels, as well as provide additional health coverage to more uninsured Americans under HIFA.

Medicaid and SCHIP Reform: Building on the success of HIFA in increasing flexibility and reducing the administrative burden on States, the Administration proposes the State Health Care Partnership Allotments. The proposal would help reduce the complexity of the current Medicaid and SCHIP programs. These optional allotments combine SCHIP and Medicaid funding to provide States with two individual allotments: long-term care and acute care. The increased flexibility of these allotments will allow each State to innovatively tailor their provision of health benefit packages for its low-income, uninsured citizens (refer to the Medicaid section of the Budget-in-Brief for further details).

SCHIP ENROLLMENT

(average number of enrollees in millions)

	2002	2003	2004
Children, Total /1.....	4.2	4.8	4.8

/1 This figure does not include children covered with regular Medicaid match after SCHIP allotment is exhausted.

SCHIP OUTLAYS

(outlays in millions)

	2002 Actual	2003 Projected	2004 Projected	2003 +/- 2004
Current Law				
Total Outlays.....	$3,682	$4,751	$5,090	+$339

MEDICAID AND SCHIP PROPOSALS

(dollars in millions)

	2004	2004-2008	2004-2013
MEDICAID PROPOSALS			
State Health Care Partnership Allotments	$3,258	$8,944	-$66
Paying Nursing Facilities for Residents that Elect Hospice	$0	$0	$0
Partnership for Long-Term Care	$0	$0	$0
"Money Follows the Individual" Rebalancing Demonstration	$350	$1,750	$1,750
Simplify Transitional Medical Assistnace	$20	$290	$290
Five-year Extension of Transitional Medicaid	$400	$2,400	$2,400
Five-year Extension of Premium Assistance for QI-1's	$115	$645	$645
Spousal Exemptions	$16	$95	$238
Additional Funding for VFC Program	$165	$810	$1,610
Presumptive Eligibility for Community Based Services	$0	$0	$0
Medicaid AMP Based Drug Rebate Program	-$800	-$5,000	-$13,200
Reproposal of FY 2003 New Freedom Demonstration Projects	$8	$217	$778
Medicaid Savings from Extension of SCHIP Funding	-$160	-$220	-$230
TOTAL MEDICAID	**$3,372**	**$9,931**	**-$5,785**
SCHIP PROPOSALS			
Extension of SCHIP Funding	$195	$690	$795
TOTAL SCHIP	**$195**	**$690**	**$795**
OTHER PROPOSALS WITH IMPACT ON MEDICAID/SCHIP			
Mandatory Rev. and Adjustment of Child Support Orders (non-add)	$0	-$40	-$210
SSA Disability Determinations (non-add)	-$3	-$215	-$1,227
TOTAL OTHER PROPOSALS	**-$3**	**-$255**	**-$1,437**
INTERACTION EFFECT OF REFORM PROPOSAL	**-$153**	**-$703**	**$3,265**
TOTAL MEDICAID AND SCHIP	**$3,411**	**$9,663**	**-$3,162**

STATE GRANTS AND DEMONSTRATIONS

(outlays in millions)

	2002 Actual	2003 Estimate	2004 Request	Request +/- Enacted
Budget Authority				
Ticket to Work grant programs/1.....	$67	$72	$77	+$5
Qualified High-Risk Pools grant programs...		$60	$40	-$20
Total Budget Authority.....	**$67**	**$132**	**$117**	**$15**
Outlays				
Ticket to Work grant programs.....	$10	$30	$50	+$20
Qualified High-Risk Pools grant programs...		$7	$15	+$8
Total Outlays.....	**$10**	**$37**	**$65**	**$28**

/1 The Ticket to Work and Work Incentives Improvement Act was signed into law on December 17, 1999. The legislation established appropriations for the grant programs starting in FY 2001.
/2 Legislation which established the qualified high-risk pool grant programs was passed on August 6, 2002. The legislation established appropriations for the grant programs starting in FY 2003.

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

The TWWIIA authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. Section 203 of the Act provides an appropriation each year from FY 2001 to FY 2011 for Medicaid Infrastructure Grants. These grants provide funding to States to build Medicaid infrastructure and supports, conduct outreach activities, explore new service options, and form partnerships to improve the employment environment for people with disabilities. Section 204 provides for an appropriation of $42 million for each of the fiscal years from 2001 to 2004, and $41 million for both FY 2005 and FY 2006 for Demonstration to Maintain Independence projects. The demonstration program will evaluate the potential benefits of providing Medicaid services to workers with physical or mental impairments that, without medical intervention, are likely to result in disability.

In FY 2004, the budget authority provided by statute for the two grant programs totals $77 million. Medicaid Infrastructure Grants are authorized and appropriated for $35 million of non-matched Federal funding. Demonstration to Maintain Independence and Employment is authorized and appropriated for $42 million. States must match Federal funding for this demonstration program at the normal Federal matching rate.

As of December 31, 2002, 41 entities (40 States and the District of Columbia) were approved for funding from the Infrastructure Grant Program since its inception. For fiscal year 2003, 36 entities (35 States and the District of Columbia) will receive funding through the Medicaid Infrastructure Grant program. With this funding, States plan to make systemic changes to the Medicaid program that will help individuals with disabilities gain employment and retain their health care coverage. These changes are designed to increase and improve Medicaid buy in programs, enhance State personal assistance service programs, and explore other employment support options.

Three States (Rhode Island, Texas, and Mississippi) and the District of Columbia were awarded Demonstration to Maintain Independence and Employment grant funding since the program was started. States implementing demonstration grant programs will provide Medicaid equivalent services to targeted populations of working individuals with disabilities. The demonstration projects will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability. The State demonstration projects approved so far will cover the HIV/AIDS, Multiple Sclerosis, and Bi-Polar/Schizophrenia populations.

QUALIFIED HIGH-RISK POOLS

The Trade Adjustment Assistance Reform Act of 2002 (TAA) establishes two grant programs for States to provide health insurance coverage through qualified high-risk pools. The first program makes available a total of $20 million to States that, as of the day of enactment of the TAA, do not already operate qualified high-risk pools. These funds will be used for the creation and initial

operation of pools. The second program makes available $40 million in both 2003 and 2004 for grants to States with existing qualified high-risk pools to be used for the operation of their pools.

States that do not have existing qualified high-risk pools and will be eligible to apply for funds to create and initially operate a qualified high-risk pool. The TAA legislation makes available $20 million in FY 2003 for these "seed grants." This money will be available until the end of FY 2004. In November 2002, the Secretary sent letters and instructions to the governors and State insurance commissioners to announce the availability of the seed grants and invite them to apply for funding. Applications must be received before March 31, 2004 to be considered for the grants.

The legislation also makes available $40 million in both FY 2003 and FY 2004 for the States that already operate qualified pools that meet the requirements of the statute. The FY 2003 funds will be available until the end of FY 2004 and the FY 2004 funds will be available until the end of FY 2005. A letter and grant application will be sent to the governors and State insurance commissioners of these States in early 2003. The deadlines for the States to apply for these grants will be included in the grant instructions.

PROGRAM MANAGEMENT

(dollars in millions)

	2002 Actual	2003 Enacted	2004 Request	2004 +/-2003
Medicare Operations /1	$1,605	$1,748	1,777	+$29
Survey and Certification	253	248	248	0
Federal Administration	530	562	581	+18
Research	117	28	63	+35
Revitalization Plan	0	0	65	+65
CMS Budget Authority Subtotal /2	**$2,506**	**$2,587**	**$2,734**	**+147**
CLIA/HMO and Data Spending	$45	$45	$45	$0
National Medicare Education Program	17	16	14	-2
Reimbursable Spending Subtotal	**$62**	**$61**	**$59**	**$2**
CLIA/Sale of Data/HMO User Fees	-45	-45	-45	0
National Medicare Education Program	-17	-16	-14	+2
User Fee Subtotal	**-$62**	**-$61**	**-$59**	**+$2**
Proposed Discretionary User Fees	$0	-$130	-$201	-$71
Proposed Budget Authority	**$2,506**	**$2,457**	**$2,533**	**+$76**
Proposed Outlays	$2,506	$2,457	$2,533	+$76
FTE	4,497	4,661	4,486	-175

/1 The FY 2002 and FY 2003 columns include a $73 million comparability adjustment for the costs of processing Medicare appeals under the Benefits Improvement and Protection Act (BIPA) of 2000.
/2 Numbers may not add due to rounding.

PROGRAM MANAGEMENT

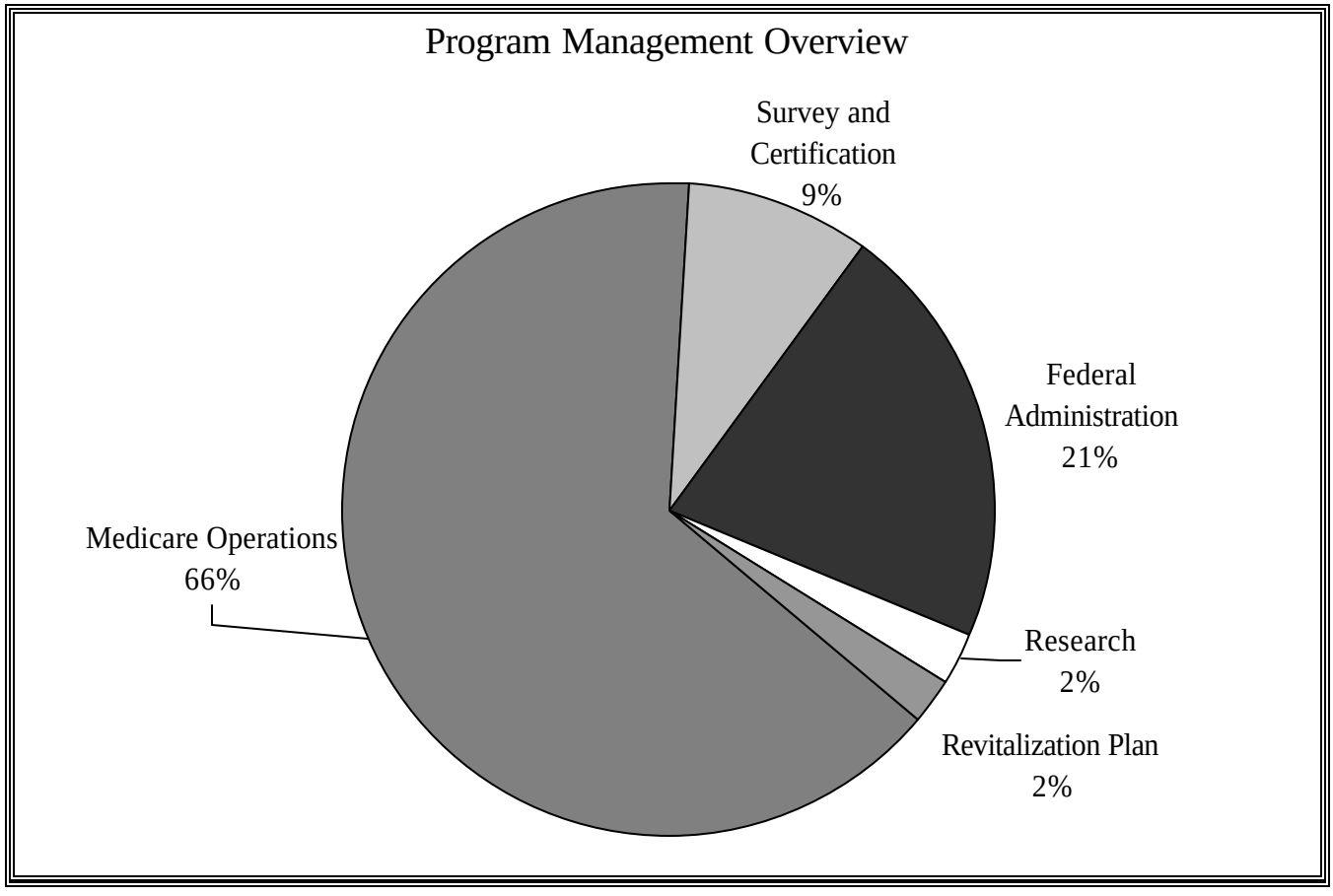
CMS' FY 2004 Program Management budget request is $2.7 billion in budget authority, a $147 million or 5.7 percent increase over the FY 2003 President's Budget. The total program level request is $2.8 billion. This level assumes $201 million in proposed user fees in addition to the $59 million in current offsetting collections from Medicare+Choice plans for the National *Medicare & You* Education Program (NMEP), the user fees for the Clinical Laboratory Improvement Amendments program, and for the sale of data.

The two proposed fees for duplicate claims and Medicare appeals filing total $201.0 million. As proposed, the appropriation would be reduced by the amount of the fees upon enactment of user fee legislation. Assuming these fees are enacted, CMS' proposed law budget authority request is $2.5 billion.

CMS is making a major commitment to modernize its infrastructure and operations through a $65 million Revitalization Plan. Over the next few years, the initial investment in this plan will help CMS take advantage of advances in technology and improve information systems that allow the agency to process claims and analyze claims data.

CMS' FY 2004 budget is driven by ever increasing workloads, such as processing 1.1 billion claims, answering 45 million inquiries, handling nearly 8 million appeals, responding to over 9 million calls to the 1-800-MEDICARE toll-free line, and conducting over 71,000 health care facility inspection and complaint investigations. CMS' budget is also affected by legislative provisions it must implement as a result of the Health Insurance Portability and Accountability Act (HIPAA), the Balanced Budget Act (BBA), the Balanced Budget Refinement Act (BBRA), TWWIIA, the Benefits Improvement and Protection Act (BIPA), and TAA. Finally, CMS has devoted significant resources over the past few years to comply with financial management laws governing all Federal agencies, such as the Federal Financial Management Improvement Act (FFMIA), the Government Information Security Reform Act (GISRA), and the Government Performance and Results Act (GPRA).

CMS' budget also reflects top budget, legislative, and management priorities of the Administration, including: reforming the Medicare appeals process; educating beneficiaries about their health plan and benefit choices; reducing burden on our partners; improving financial management performance through ongoing implementation of the healthcare general ledger accounting



system (HIGLAS); and strategic management of its human resources

MEDICARE OPERATIONS

The Medicare Operations budget supports a broad array of activities. The budget is $1.8 billion, an increase of $29 million, or 1.6 percent, over the FY 2003 President's Budget level comparably adjusted for the services that will be transferred to CMS but are now performed by the Social Security Administration.

By law, the Medicare program is administered by private insurance companies, or contractors. Contractor responsibilities include: processing claims and making benefit payments; responding to the needs and inquiries of Medicare beneficiaries and health care providers and suppliers; and developing and implementing management changes to improve program operations. In addition, Medicare Operations funds a variety of mission critical information technology systems. For example, it funds managed care systems, standard processing systems, and maintenance on current contractor systems.

CMS' Medicare Operations includes:

Ongoing Activities: carriers' and fiscal intermediaries' regular activities, such as processing claims, conducting hearings and appeals, answering inquiries, and educating providers and beneficiaries.

Systems Maintenance: activities to keep shared claims processing systems current.

Operations: Common Working File (CWF), funding for termination costs of contractors leaving the program, and moving all contractors to three standard claims processing systems.

Enterprise-Wide Activities: funding for the CMS Data Center (contractor-operated), the Medicare data communications network, and hardware and software maintenance.

Legislative Mandates: funding for implementing new legislation such as HIPAA, BBA, BBRA, BIPA, CFO, and FFMIA.

Program Improvements: funding contractor oversight, reducing regulatory burden on health care providers, and the Medicare training network.

In FY 2004, CMS will process 1.1 billion claims and answer an estimated 45 million inquiries. We expect a slight decrease in the unit cost to process a claim from FY 2003 estimates. In FY 2004, the unit cost to process a Part A claim will be $0.87, slightly below the estimated President's Budget FY 2003 unit cost projections of $0.89 for a Part A claim. Part B unit costs are estimated to dip from $0.67 in the FY 2003 President's Budget to $0.65 in FY 2004.

Approximately 67 percent of the FY 2004 Medicare Operations program level request will be spent on mission critical contractor workloads, including claims processing, on-going appeals (as distinguished from the new appeals process), inquiries, and provider assistance. CMS will spend $1,184 million in FY 2004, a 5 percent increase over the FY 2003 President's Budget level. Medicare contractors have been experiencing a dramatic rise in Part B claims workload and expect to see an 11 percent increase in total claims over the FY 2003 President's Budget estimate.

Legislative mandates comprise 20 percent of the Medicare Operations budget and are funded at $354 million in FY 2004, a 0.4 percent increase over the comparable FY 2003. The bulk of this substantial increase reflects CMS' implementation of BIPA Section 521 appeals reform.

Systems maintenance spending will be $72.1 million in FY 2004, a $12.9 million, or 15 percent, decrease below FY 2003.

CMS Operations spending will be $82.6 million in FY 2004, a decrease of $20.3 million, or 20 percent, below FY 2003.

Funding decreases also occur in the Program Improvements and Enterprise activities within Medicare Operations. Program Improvements will be funded at $17.3 million in FY 2004, a $1.7 million, or a 9 percent decrease, below FY 2003 levels. Meanwhile, Enterprise activities will be funded at $53.1 million, a decrease of $6.2 million, or 11 percent.

Finally, CMS will provide $14.0 million towards the Department-wide Information Technology (IT) Enterprise Infrastructure Fund ($11.0 million) and Unified Financial Management System ($3.0 million).

FEDERAL ADMINISTRATION

For FY 2004, the President's Budget requests $580.6 million for CMS' Federal administrative costs. This is an increase of $18.1 million over the FY 2003 President's Budget level. The additional $18.1 million will allow CMS to: cover pay increases, support the Nursing Home Oversight Improvement Program (NHOIP) activities, begin to implement BIPA section 522, and fund the New Freedom Initiative. It includes savings achieved through consolidation of Information Technology infrastructure services.

The FY 2004 President's Budget proposes a total of 4,586 FTE for CMS. Funding for FTE is in Federal Administration, Medicare Operations, and the Health Care Fraud and Abuse Control account. The requested level includes FTE for continuing operations, Health Insurance Portability and Accountability Act (HIPAA) enforcement, and Medicaid oversight activities.

The Healthy Start, Grow Smart program will publish and disseminate a series of 13 informational brochures in English and Spanish to

new Medicaid mothers. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build the skills these children need to be successful in school. In addition to these educational suggestions, each Healthy Start pamphlet includes vital health and safety information for new parents. Content for each brochure is tied to the developmental states of the child at the time it is sent.

The FY 2004 budget includes $13.0 million to run Healthy Start, Grow Smart for the coming year. These funds will be used primarily for printing costs, and postage. This initiative will be fully funded by the Federal government, but will be operated solely by the States.

This budget also continues support for the Healthcare Integrated General Ledger and Accounting System (HIGLAS) project which is part of the Department-wide Unified Financial Management System (UFMS).

RESEARCH, DEMONSTRATIONS AND EVALUATION

The FY 2004 budget requests $63.4 million for the Research, Demonstrations and Evaluation program, $35 million more than the FY 2003 request. This increase supports two Administration priorities, Real Choice Systems Change Grants and the President's New Freedom Initiative.

The budget proposes $40 million to continue funding for Real Choice System Change Grants. These grants will allow States to improve community based support systems to enable people with disabilities and long-term illnesses to live and participate in their communities. These changes will allow children and adults with disabilities or long-term illnesses to (1) live in the most integrated community setting possible, (2) exercise choices about their living environment, and (3) obtain quality services in a manner as consistent as possible with community living preferences and priorities. In FY 2002, 25 new and 5 supplemental Real Choice System Change Grants were awarded.

The budget requests $3 million for New Freedom Initiative demonstrations. The demonstrations test the extent to which workforce shortages and instabilities might be addressed through better coordination with the Temporary Assistance for Needy Families (TANF) program. This includes making vouchers for worker health insurance or for tuition or day care credits available to qualifying individuals. Participating states would be expected to develop options for workers to purchase affordable group health coverage through the state health insurance system or similar organized insurance group.

At the $63.4 million request level, a small number of high-priority research projects will be funded. These projects include the Medicare Current Beneficiary Survey, evaluating CMS programs and developing alternatives, and implementing a scaled back number of projects mandated by the BBA, BBRA, and BIPA.

SURVEY AND CERTIFICATION

CMS' FY 2004 budget request is $247.6 million, the same as the FY 2003 President's Budget request. Ensuring the safety of beneficiaries and the quality of care provided in health facilities are two of CMS' most critical responsibilities. CMS contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and to ensure compliance with Federal health, safety, and program standards.

Included in this total is $35.2 million to continue implementing activities associated with the Nursing Home Oversight Improvement Program (NHOIP), such as: imposing immediate sanctions on nursing homes found guilty of a second offense that causes actual harm to residents; conducting more frequent inspections of nursing homes with repeat violations; and conducting more focused reviews of a nursing home's efforts to prevent bed sores, dehydration, and malnutrition. CMS will also continue to invest money to expedite investigation of resident complaints within a ten-day time frame.

Of the total request, $203.9 million will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies, as well as maintain the FY 2003 recertification levels for ESRD facilities, non-accredited hospitals, hospices, rural health clinics, ambulatory surgical centers, outpatient physical therapy, and outpatient rehabilitation facilities. CMS expects to complete a total of 23,400 initial or recertification inspections. In addition, CMS estimates conducting 47,900 visits in response to beneficiary or family complaints.

The remaining $8.5 million will fund base support contract activities. These activities include maintenance and enhancements to the Online Survey Certification and Reporting (OSCAR) data system, which contains information on nursing home survey results and outcomes; support services for surveying psychiatric hospitals; and curricula development for surveyor training.

The Nursing Home Oversight Improvement Program: The President's Budget for CMS commits $92.5 million in mandatory and discretionary funds to the NHOIP in FY 2004, an increase of $6.5 million over CMS' FY 2003 amount. CMS is committed to working with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive quality care and protection.

In conjunction with States, CMS successfully imposes immediate sanctions against nursing homes that have caused harm to a resident in consecutive survey cycles; focuses on preventing bed sores, malnutrition, and abuse as part of the annual nursing home survey; investigates complaints alleging actual harm to residents within 10 days; and staggers surveys and conducts visits on weekends, early mornings and evenings, when quality, safety and staffing problems may be more likely to occur. CMS also conducts more frequent inspections of nursing homes with repeated serious violations.

REVITALIZATION PLAN

The FY 2004 budget request includes $65 million in two-year money to fund the first year of a multi-year Revitalization Plan. The Medicare program has relied on a number of antiquated legacy systems that have been characterized by the General Accounting Office (GAO) and the Department's OIG as inflexible, insecure, and obsolete.

The Revitalization Plan will begin the process of improving CMS' systems security ($34 million), modernizing the agency's Medicare fee-for-service claims processing systems ($17.8 million), modernizing CMS' information technology data structure ($11.2 million), and revamping the agency's internal infrastructure ($2 million).

The Revitalization Plan will provide the flexibility and security needed to take on the growing workload and health care options and provide future beneficiaries with the information that they need to make informed choices.

NATIONAL *MEDICARE &YOU* EDUCATION PROGRAM

In FY 2004, the *National Medicare & You* Education Program (NMEP) will continue to fund the following activities: mailings to beneficiaries with general information about Medicare, plus specific information on plans available in their areas; a toll-free telephone service staffed by customer service representatives able to provide information on available plans; www.medicare.gov, the user-friendly Internet site that provides comparative information on plans by zip code; community-based outreach activities such as those provided by the State Health Insurance Assistance Programs (SHIPs); and a national advertising campaign that educates beneficiaries about available services in Medicare.

In FY 2004, CMS will also continue to provide the enhanced service levels it began in FY 2002. These include 24-hour-a-day, seven-day-a-week access to customer service representatives at 1-800-MEDICARE and the implementation of a web-based decision tool, the Medicare Personal Plan Finder, on http://www.medicare.gov.

The President's Budget provides approximately $149.5 million to finance NMEP activities. NMEP is funded through a variety of sources, including $122 million from Program Management, as well as an estimated $13.5 million in the QIO/PRO account, and $14 million in Medicare+Choice user fees.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS:

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

The CLIA program is fully operational, with 177,300 laboratories registered with CMS, 21.8 percent of which are subject to routine inspection (every 2 years) under the program. Workloads for each inspection period includes a 5 percent sample review of the 16,200 accredited laboratories, surveys of 20,980 non-accredited laboratories, State validation surveys of 810 accredited laboratories, and approximately 1,570 follow-up survey and complaint investigations.

PROGRAM MANAGEMENT PRIORITIES

Appeals Reform: CMS' FY 2004 budget includes $129 million to implement Medicare appeals reform as required by BIPA, and for the transfer of the Medicare hearing function currently performed by Administrative Law Judges in the Social Security Administration. In addition, the Administration proposes several changes to the Medicare appeals process to give CMS additional flexibility to reform the appeals system. These changes will enable CMS to respond to beneficiary appeals in a more timely and effective manner.

Beneficiary Education: One of CMS' top priorities is making sure that beneficiaries and their caregivers are active and informed participants in their health care decisions. Last year, CMS implemented new and expanded services to help beneficiaries better understand their health care options and where they can obtain information about them. CMS plans to continue these enhanced and expanded services in FY 2004:

- Expanded call center services. Beginning in October 2001, customer service representatives at 1-800-MEDICARE were available 24 hours a day, seven days a week.

- Development of a web-based decision tool. The Medicare Personal Plan Finder, which became available in October 2001, enhances the databases currently available on http://www.medicare.gov by allowing beneficiaries to narrow down the

health plan choices available in their zip codes based on the features that are most important to them.

♦ Beneficiary education campaign. CMS continued its $25 million media campaign to help beneficiaries make informed decisions about their health plan options. The campaign, which coincided with the 2003 open enrollment period, encouraged beneficiaries to call 1-800-MEDICARE and visit http://www.medicare.gov with their Medicare questions. The campaign also advertised the new nursing home quality information available on http://www.medicare.gov. CMS will continue to ensure that the toll-free line is able to accommodate increased call volume in FY 2004.

HIGLAS: In FY 2004, CMS plans to spend $57 million for both the contractor and internal accounting systems. HIGLAS is an important component of CMS' Medicare contractor oversight. We are requesting two-year appropriations authority for these funds.

HIGLAS represents a coordinated approach to improving the accounting and financial management processes used by CMS' Medicare contractors to administer the Medicare Parts A and B programs, and the agency's central administrative accounting and financial management processes. The goals of HIGLAS are to deploy an integrated, enterprise-wide financial management solution to support administrative and program financial management needs. The project will focus on the contractors' accounts receivable, accounts payable, general ledger, and reporting processes and replace CMS' legacy accounting system and systems that currently support its procurement, travel management, grants management, and asset management.

HIGLAS will ensure that CMS can meet all of these objectives by creating a state-of-the-art uniform agency-wide accounting system. HIGLAS information will feed into the Department-wide system to allow the Department to produce automated audited reports.

One of the Secretary's top priorities is to centralize the Department's financial accounting process through a Unified Financial Management System (UFMS). A major segment of UFMS is HIGLAS.

HIPAA Enforcement: In October 2002, CMS was tasked with the responsibility for enforcing the HIPAA Administrative Simplification security, transactions, identifiers and code sets standards. The FY 2004 request includes $10 million to begin activities related to the start-up and implementation of the enforcement program.

In order to enforce the HIPAA standards, CMS will assemble an enforcement staff, write an enforcement regulation that outlines the enforcement program, implement the enforcement system, and begin to accept complaints. CMS intends to provide education and technical assistance to covered entities to help them achieve compliance, rather than seeking out non-compliant entities and imposing fines on them. If a covered entity is found to be non-compliant, CMS will work with them to achieve compliance and will only impose civil monetary penalties if these efforts fail.

President's Management Agenda: CMS is currently implementing the President's Management Agenda. Successes in the current activities are the basis for initiatives within the 2004 budget. President's Management Agenda highlights within each section include:

Human Capital: through strategic placement of resources, CMS was able to transfer 93 FTE from administrative areas to direct mission support.

Competitive Sourcing: CMS has already transferred 122 positions to the Department as a result of the Department's consolidated Human Resource Initiative. In addition, CMS has submitted a plan identifying 17 functions (210 FTEs) that will be subject to a competitive sourcing study in 2004.

Financial Management: Improving financial management is a top priority for CMS. CMS is in the process of revamping its fragmented and incomplete account reporting system with the development of HIGLAS. HIGLAS will be an integrated, enterprise-wide financial management solution to support administrative and program financial management needs. CMS has also been in the forefront of measuring payment error and developing corrective action plans to lower its payment error rate. CMS has lowered the Medicare payment error rate from 14 percent in FY 1996 to 6.3 percent in FY 2002. CMS is currently in the process of developing methodologies to measure payment error in both the Medicaid and SCHIP programs through the HCFAC program.

Expanding E-Gov: CMS is continuing work with expanded 1-800 Medicare call center services and enhanced general web services. In addition, CMS is taking a lead role in the Consolidated Health Informatics (CHI) initiative which will adopt a single set of government wide health data inter-operability standards for Federal agencies. This will allow agencies to share health data regardless of the system that collects the data.

Budget and Performance Integration: The FY 2004 agency budgets will continue the focus on results-oriented government guided by performance as part of the President's Management Agenda. In 2002, two of CMS' programs, the MIP and SCHIP were assessed using the President's Performance Assessment Rating Tool (PART), and were found to be successful. As a result of the MIP PART, two new program integrity goals were introduced for FY 2004.

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The FY 2004 President's Budget includes two user fee proposals totalling $201 million that, if enacted, could improve the efficiency and lower the cost of processing Medicare claims in the future. The budget also includes proposals for Medicare appeals and contractor reform.

Duplicate Claim Penalty: Allows the Secretary to assess a fee for each duplicate or unprocessable claim submitted by providers. Duplicate or unprocessable claims are a drain on a system that must process over a billion claims over the course of a year ($195 million).

Appeals Filing Fee: This allows the Secretary to assess a $50 fee for providers who wish to elevate a fee-for-service appeal to the Qualified Independent Contractor level of adjudication. This fee will finance a case control system, which will allow CMS to log and track appeals that advance to the QIC level of adjudication and beyond ($6 million).

Appeals Reform: The budget assumes that BIPA Section 521 will be modified to allow CMS 16 months to implement reforms once funding is received. This will allow CMS time to begin the process of contracting with the QICs. The budget also assumes a reduction in the number of QICs and an increase in decision-making timeframes to allow for adequate record development from one level of review to the next.

Contracting Reform: We will again pursue contracting reform to bring the Medicare contracting system closer to the Federal Acquisition Regulations that govern virtually all other contractor procurement. During the past legislative session, language similar to the Administration's was included in many of the Medicare packages proposed by Congress.

CMS PERFORMANCE HIGHLIGHTS

CMS' primary mission is to assure health care security for its beneficiaries. CMS' Annual Performance Plan and Report (APP) emphasizes this focus by helping CMS expand its resources in ways that enhance service to the public, encourage accountable stewardship of Agency resources, and ensure that its programs are monitored and evaluated for their effectiveness. The APP is designed to reflect goals that are representative of CMS' vast responsibilities. CMS has had many challenges and demands and, overall, is reporting positive results for FY 2002. Although results for several of the 35 FY 2002 goals are still pending, approximately 77 percent of the goals have been reported, with 74 percent of those goals reaching their targets. Further, over 51 percent of the total FY 2004 goals support the President's Management Agenda. CMS also included two new program integrity goals, developed during the Program Assessment Rating Tool (PART) process, in the FY 2004 plan. Following are some of CMS' performance achievements and advancements that support important Administration priorities:

Program Integrity: CMS' program integrity efforts ensure the Medicare program pays the right amount to a legitimate provider for covered, reasonable and necessary services that are provided to an eligible beneficiary. CMS is also committed to assisting interested States in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates.

- CMS cut the Medicare fee-for-service error rate virtually in half over the past few years, from 14 percent in FY 1996 to 6.3 percent in FY 2002. The FY 2004 target is 4.8 percent.

- The MIP will be further strengthened by the implementation of two new FY 2004 goals, developed during the PART process, which measure the provider compliance rate and the contractor error rate.

- The Medicaid Payment Accuracy Measurement (PAM) model began with two States in FY 2001 and has expanded to 12 States as of FY 2003. By FY 2004, the model will enable CMS to produce both State specific and national level estimates and ultimately reduce Medicaid payment error rates.

Quality Improvement: Improving the quality of care for Medicare beneficiaries is one of CMS' primary objectives. Several of the QIOs' national quality priorities are reflected in performance goals and represent health conditions that affect a large number of beneficiaries and impose a significant burden on the health care system. A sampling of these conditions are highlighted below:

- One of the QIO goals is to protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime pneumococcal vaccination. For FY 2001, 67.4 percent (target 72 percent) received an influenza vaccination and 63.3 percent (target 63 percent) received a pneumococcal vaccination. Shortages of vaccination were among the reasons for not reaching this target.

- A key performance goal is to increase the percentage of female Medicare beneficiaries age 65 and older who receive a biennial mammogram. CMS surpassed its FY 2001 target of 51 percent by reaching 51.6 percent.

- Given the growing prevalence of diabetes nationally, CMS plans to increase special eye exams for its diabetic beneficiaries, reflecting its commitment to improve diabetes care. CMS surpassed its FY 2001 goal to increase the rate of biennial

diabetic eye exams to 68.3 percent by achieving a rate of 68.9 percent. CMS anticipates future success with this goal based on the progress seen thus far.

Children's Health Care: The implementation of SCHIP has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The energy invested by States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children.

♦ CMS and States exceeded the FY 2002 goal to enroll an additional million children in SCHIP or Medicaid over the previous year's level. In fact, CMS and the States enrolled 1.2 million children over the FY 2001 level. According to the Statistical Enrollment Data System (SEDS), approximately 5.3 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2002, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

♦ CMS is also developing a performance goal for immunization of two-year olds on Medicaid. In FY 2002, CMS continued to work with States on its project to increase the percentage of Medicaid two-year old children who are fully immunized.

♦ CMS is developing a goal to establish formal Federal-State collaborations for improving health care delivery and quality for Medicaid and SCHIP populations using performance measures. In FY 2002, CMS met with States to explore a strategy to effectively use performance measures to quantify and stimulate measurable improvement in delivering quality health care.

Beneficiary Education: In order for Medicare beneficiaries to have greater knowledge of Medicare and its benefits, CMS is focusing on a number of educational programs. These programs not only provide information about Medicare but also gauge the beneficiaries' awareness of Medicare benefits.

♦ One performance measure is to improve the effectiveness of disseminating Medicare information to beneficiaries. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time." In FY 2002, CMS continued to track beneficiary education efforts toward the ultimate five-year target of beneficiary accessibility and understanding of educational efforts in the area of the Medicare+Choice program.

♦ To promote beneficiary and public understanding of CMS and its programs, CMS developed a goal to improve and measure beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and, (2) CMS sources from which additional information can be obtained. In FY 2002, CMS developed baselines and future targets.

ACF: DISCRETIONARY SPENDING

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Strengthening Families:				
Compassion Capital Fund	$30	$100	$100	$0
Mentoring Children of Prisoners	0	25	50	+25
Promoting Responsible Fatherhood/Healthy Marriage	0	20	20	0
Maternity Group Homes	0	10	10	0
Center for Faith-Based and Community Initiatives	0	1	1	0
Head Start 1/	$6,537	$6,668	$6,816	+$148
LIHEAP:				
Regular Appropriation	$1,700	$1,400	$1,700	+$300
Emergency Contingency Fund	300	300	300	0
Subtotal, LIHEAP	$2,000	$1,700	$2,000	+$300
Child Care & Development Block Grant (CCDBG):				
Child Care & Development Block Grant	$2,090	$2,090	$2,090	$0
Research and Evaluation Fund	10	10	10	0
Subtotal, Child Care	$2,100	$2,100	$2,100	$0
Community Services:				
Community Services Block Grant	$650	$570	$495	-$75
Individual Development Accounts	25	25	25	0
Community Services Discretionary Programs	64	45	32	-13
Subtotal, Community Services	$739	$640	$552	-$88
Promoting Safe and Stable Families (PSSF):				
Discretionary	$70	$200	$200	$0
Mandatory (non-add)	*305*	*305*	*305*	*0*
Subtotal, PSSF Program Level (non-add)	*$375*	*$505*	*$505*	$0
Independent Living:				
Discretionary	$0	$60	$60	$0
Mandatory (non-add)	*140*	*140*	*140*	*0*
Subtotal, Independent Living Program Level (non-add)	*$140*	*$200*	*$200*	$0
Refugee and Entrant Assistance	$460	$453	$428	-$25
Victims of Torture (non-add)	*10*	*10*	*10*	*0*
Unaccompanied Alien Children (Transfer form INS)	0	33	34	+1
Subtotal, Refugees	$460	$486	$462	-$24
Native Americans	46	45	45	0
Developmental Disabilities	140	140	140	0
Child Abuse/Welfare	421	421	421	0
Federal Administration	172	172	180	+8
Social Services Research & Demonstration	31	6	6	0
Early Learning Fund	25	0	0	0
Runaway and Homeless Youth	103	103	103	0
Adoption Incentives/Awareness	56	56	56	0
Violence Against Women	127	127	127	0
Total, ACF Discretionary Budget Authority	**$13,057**	**$13,080**	**$13,449**	**+$369**
FTE	1,465	1,512	1,472	-40

/1 FY 2002, FY 2003 and FY 2004 funding levels included $1.4 billion advanced appropriation for subsequent year.

ADMINISTRATION FOR CHILDREN AND FAMILIES

Mission: *The Administration for Children and Families (ACF) provides national leadership through programs that assist low-income, disadvantaged families and individuals to lead economically and socially productive lives, for children to develop into healthy adults, and for communities to become more prosperous and supportive of their members.*

The FY 2004 budget request for ACF totals $47.0 billion, a net decrease of $405 million, or 1 percent below the FY 2003 President's Budget. Of these funds, $13.4 billion is the discretionary program level and $20.4 billion is the entitlement budget authority.

Discretionary Spending

The FY 2004 discretionary budget totals $13.4 billion, a net increase of $369 million or 2.8 percent over the FY 2003 President's Budget.

STRENGTHENING FAMILIES/SUPPORTING COMMUNITIES

The President's Budget reinforces a commitment to fund faith- and community-based organizations that can provide innovative services at the grass-roots level.

Successful outcomes for those in need can come from many sources, not just the Government. In every instance where this Administration sees a responsibility to help people, it will look to faith-based organizations, charities, and community groups that have shown the ability to change lives. These groups will not replace Government, but rather partner with it to make life better for those in need.

Compassion Capital Fund: The budget provides a total of $100 million for the Compassion Capital Fund. In FY 2002, HHS awarded the first round of grants to 21 intermediary organizations which will provide technical assistance to help faith- and community-based organizations access funding sources, operate and manage their programs, develop and train staff, expand the reach of programs into the community and replicate promising programs. Funds were also awarded for research into best practices and to develop a national resource center and information clearinghouse. At the level requested in FY 2004, an estimated 80 intermediary organizations will be funded, the third year of the fund.

Mentoring Children of Prisoners: The request doubles the FY 2003 President's Budget for Mentoring Children of Prisoners for a total of $50 million to expand the number of grantees to 20 in FY 2004. Recently authorized, this program will award grants of up to $5 million each to enable public and private organizations to establish or expand projects that provide mentoring for children of incarcerated parents and those recently released from prison. The arrest and incarceration of a parent often results in traumatic separations for children, followed frequently by erratic shifts from one caregiver to another. As a group, these children are less likely than their peers to succeed in school and more likely to succumb to substance abuse, gangs, early childbearing, and delinquency. This program will help children through the time parents are imprisoned, including efforts to keep children connected to a parent in prison, and increase the chances that the family can come together successfully when the parent is released.

Promoting Responsible Fatherhood and Healthy Marriages: The Administration is committed to helping the over 25 million children who live in homes without fathers.

Compassion Capital Fund

The first round of grants for the Compassion Capital Fund were awarded in FY 2002. Examples include,

- The University of Nebraska leads a broad coalition of organizations, in a project conducted in at least 55 municipalities to assist community and faith based organizations to increase their capacity to implement a broad range of behavioral health services throughout the state of Nebraska. Activities will include, direct technical assistance, workshops around the State, grant sub-awards for start-up and expansion of behavioral health services, developing a consensus for a statewide plan for the integration of behavioral health care, and performing an outcome evaluation.
- The Southeast Asia Resource Action Center (SEARAC), will seek to build capacity and knowledge among faith-based organizations (FBO's) and local mutual assistance associations (MAA's) serving poor and low-income Southeast Asian families. SEARAC and its partners will: provide leadership training and one-to-one technical assistance; disseminate information on best practices and help organizations conduct needs assessments; assist in the development of websites and email digests; develop mentoring relationships between grant makers and FBOs and MAAs; and develop collaborative efforts to meet targeed unmet needs.

To assist non-custodial fathers to become more involved in the lives of these children, the budget provides $20 million in competitive grants to faith- and community-based organizations, along with Indian tribes and tribal organizations, to encourage and help fathers to support their families, avoid welfare, improve fathers' ability to manage family business affairs, and support healthy marriages and married fatherhood.

Maternity Group Homes: The President's Budget includes $10 million to provide pregnant and parenting youth access to transitional living opportunities, an alternative to the environments of violence and despair which many young pregnant mothers face, to secure brighter futures for their children. These funds will support adult-supervised community-based group homes for mothers who cannot live safely with their own families, and a range of coordinated services including childcare, job training, and counseling.

The Center for Faith-Based and Community Initiatives: Since its inception in 2001, the Center for Faith-Based and Community Initiatives (CFBCI) has continued to work with agencies across the department to eliminate barriers in regulations, rules, internal guidance, policies and procedures, and practices to the participation of faith-based and other community organizations; to propose the development of innovative pilot and demonstration programs; and to promote and ensure compliance with current Charitable Choice provisions. Outreach activities include numerous workshops and presentations to HHS program areas, other government agencies, special interest groups and faith- and community-based groups.

HEAD START

The budget request includes $6.8 billion for Head Start, a net increase of $148 million over the FY 2003 President's Budget. In FY 2004, almost 923,000 children will receive Head Start services including 62,000 children in Early Head Start. This increase, coupled with a reallocation of resources through legislative changes proposed as part of the Head Start reauthorization, will be used to maintain current service levels and increase enrollment by up to 10,500 children.

The Administration's Good Start, Grow Smart initiative has made significant progress in improving Head Start, by sharpening the focus on school readiness, improving teacher training and mandating a system to determine the success of Head Start programs in preparing children for school. The FY 2004 Head Start reauthorization offers the unique opportunity to encourage what works in Head Start and initiate new efforts to promote school readiness and State and local coordination.

The Head Start program has a long tradition of delivering comprehensive and high-quality services designed to foster healthy development for low-income children. In addition, the entire range of Head Start services is responsive and appropriate to each child's and family's developmental, ethnic, cultural, and linguistic heritage and experience.

CHILD CARE

The Child Care and Development Block Grant (CCDBG) program provides funds to States, territories, and tribes to assist low-income families, including families receiving temporary public assistance and those transitioning from public assistance, in obtaining child care so they can work, attend training, or pursue educational opportunities.

In FY 2004, funding for child care will provide assistance to an estimated 1.8 million children each month, with a total budget of $4.8 billion including $2.1 billion in discretionary funds and $2.7 billion in mandatory funds. In addition, when added to other Federal and related State funds available for child care, nearly 2.5 million children will be served in an average month in FY 2004.

Our most recent data suggest that Federal and related State funds provide child care services to 28 percent of children eligible for the Child Care Development Fund under State rules. Further, for children in families with incomes below poverty for a family of three, the proportion served increases to 45 percent.

Subsidized child care services are available to eligible families through certificates or contracts with providers. Parents may select any legally operating child care provider. Child care providers serving children must meet basic health and safety requirements set by States and tribes. These requirements must address prevention and control of infectious diseases, including immunizations; building and physical premises safety; and minimum health and safety training.

COMMUNITY SERVICES PROGRAMS

Community services programs fund a range of programs and activities providing housing and employment assistance, education and training services, nutrition, energy assistance, health and substance abuse treatment, as well as economic development opportunities.

The budget proposes a total of $552 million in support of the Community Services Block Grant (CSBG), Individual Development Accounts and other community services programs which have demonstrated performance. This is $88 million less than the FY 2003 President's Budget. The budget targets funds to programs which have proven track records of success and reduces funding for programs where similar services are provided by other Federal grant programs.

As part of the CSBG reauthorization, the Administration intends to work to develop a set of performance measures to be consistently applied by all States and Community Action Agencies (CAAs) to ensure program outcomes and accountability. Once established, CAAs will be held accountable to performance targets. Non-performing CAAs may lose their historical designation and be subject to a State-run award competition, open to other area community-based organizations.

Low Income Home Energy Assistance Program (LIHEAP)

The FY 2004 budget provides a total of $2.0 billion for LIHEAP, including $1.7 billion for formula block grants to States and $300 million for contingency funding. The contingency funds are available for release in a heating or cooling emergency such as extreme temperature or high fuel prices, or to meet energy needs related to a natural disaster.

LIHEAP provides heating and cooling benefits to approximately 4.6 million households each year. Of the households receiving heating assistance, almost forty percent include an elderly member, one-third include a person with a disability, over forty percent include a child under age 18, and one-third do not receive any other public assistance.

Refugee and Entrant Assistance

The budget requests $428 million in FY 2004 for refugees, asylees, Cubans/Haitians, and victims of torture and trafficking. The funding level reduction below the FY 2003 President's Budget reflects the impact of a lower than initially estimated number of arrivals entering the country in FY 2002 and FY 2003. The FY 2004 request is sufficient to support a full eight months of cash and medical assistance and access to social service programs such as English language training, case management, employment preparation, and job placement and retention services. In addition, the budget continues support for services, including rehabilitation, social and legal services for those who have experienced torture as well as access to benefits to the same extent as refugees for victims of trafficking.

Recognizing the Office of Refugee Resettlement's expertise in assisting refugee children, in March, 2003 the Unaccompanied Alien Children program will be transferred from the Immigration and Naturalization Service (INS) to ACF. With an estimated budget of $34 million in FY 2004, ACF will be able to provide for the care and safety of more than 5,000 alien children each year. The FY 2003 President's Budget includes $33 million for this activity, reflecting an initial estimate of the resources which will be transferred from INS to HHS.

Developmental Disabilities

Today, there are nearly four million Americans with developmental disabilities. Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely.

In FY 2004, the budget request includes $140 million, the same level as the FY 2003 President's Budget, for programs that support partnerships with State governments, local communities, and the private sector to assist people with developmental disabilities to reach their maximum potential through increased independence, productivity, and community integration.

HHS Office on Disability: In 2002, HHS announced the creation of the Office on Disability to oversee the coordination, development and implementation of programs and special initiatives within HHS that impact people with disabilities. The office will build on the President's New Freedom Initiative and centralize many of the recommended strategies outlined in the report to President Bush, *Delivering on the Promise*, which explored solutions to reducing barriers in all areas of society for people with disabilities.

Native American Programs

The budget request includes a total of $45 million for the programs of the Administration for Native Americans. Through direct grants, contracts, and interagency agreements, Native American programs provide financial assistance for social and economic development and governance, training and technical assistance, and research, demonstration and evaluation. The programs foster a balanced developmental approach at the community level across three major goals: self-governance, economic development, and social development.

Other ACF

In FY 2004, the President's Budget includes $421 million through the Child Abuse/Welfare programs to support States and localities in their efforts to protect children by strengthening families and preventing abuse and neglect. These funds will help to provide services to prevent child abuse and neglect and to intervene in cases in which child maltreatment has been reported. In addition, the budget includes $56 million for the Adoption Incentives and Adoption Awareness programs to support efforts to encourage adoptions. Funds are available to States to enhance their overall adoption program as well as competitive grants to train health care professionals and continue a national media campaign, informing the public about the adoption of children with special needs. The budget also maintains funds for programs that offer safe havens and access to services for victims of domestic violence ($127 million) and runaway and homeless youths ($103 million).

Central to the ACF mission is sound research to help guide State and local efforts to help low-income families become and remain economically self-sufficient and to strengthen families. The FY 2004 budget maintains the FY 2003 level for the Social Services Research and Demonstration program.

The budget does not support the Early Learning Fund, which was funded at $25 million in FY 2002. The Administration supports similar activities which promote early literacy in the Department of Education and the Head Start program.

FEDERAL ADMINISTRATION

The Federal Administration request is $180 million in FY 2004, including an estimated 1,472 FTE. The budget includes an additional $2 million to support the increasing demands of ACF's child and family services reviews. The reviews are designed to ensure that State child welfare agency practice is in conformity with Federal child welfare requirements and to assist States to enhance their capacity to help children and families achieve positive outcomes. In addition, the budget includes $5 million to develop and implement measures to reduce the incidence of erroneous payments in TANF, Foster Care, and Head Start.

The budget level includes savings totaling $7.9 million resulting from the President's Management Agenda and the consolidation and elimination of duplicative information technology projects across ACF programs. Workforce cost savings will be achieved through consolidating administrative functions, implementation of effective workforce planning and human capital management strategies, and adoption of other economies and efficiencies in administrative operations.

ACF: ENTITLEMENT SPENDING

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
TANF/1	$17,009	$19,009	$17,609	-$1,400
Child Care Entitlement	2,758	2,717	2,717	$0
Child Support Enforcement & Family Support (net BA)	3,846	4,037	4,346	+$309
Foster Care/Adoption Assistance /2	6,622	6,496	6,814	+$318
Children's Research & Technical Assist (net BA) /3	37	50	50	$0
Promoting Safe and Stable Families /4	305	305	305	$0
Social Service Block Grant	1,700	1,700	1,700	$0
Total, Budget Authority	**$32,277**	**$34,314**	**$33,541**	**-$773**

/1 FY 2002 figure does not include the Contingency Fund or the High Performance Bonus; budget authority for these funding sources was made available in prior years. FY 2003 figure includes $2 billion for the Contigency Fund for FYs 03-07. FY 2004 includes $500,000,000 for high performance bonus for FYs 04-08 and $200,000,000 for family formation demonstrations, research, and TA for FY 2004.

/2 In FY 2003 and FY 2004 the Foster Care/Adoption Assistance has an additional $60 million in discretionary funds for education vouchers in the Independent Living Program.

/3 In FY 2002, Congress rescinded $21 million in budget authority from this account. The FY 2003 and FY 2004 request

Entitlement Spending

The Department's FY 2004 ACF budget includes $33.541 billion in budget authority for entitlement programs. The ACF entitlement programs serve some of the nation's most vulnerable populations through programs such as Temporary Assistance to Needy Families (TANF), Child Support Enforcement, the Child Care, Foster Care, and Adoption Assistance. This year's request anticipates the reauthorization of TANF and the Child Care Entitlement, modifications in the Child Support Enforcement program, and an option for States to receive their foster care funds as a fixed allotment.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 dramatically changed the nation's approach to income support of low-income families. PRWORA replaced individual entitlements to welfare with time-limited assistance accompanied by work requirements through the new TANF program. PRWORA also created a new partnership between States and the Federal government, giving States considerable flexibility to design their own TANF programs.

Welfare reform is widely regarded as a success. According to State reports, work effort among current welfare participants in FY 2001 was three times its 1996 levels. As of June 2002, caseloads had declined to 54 percent of 1996 levels. According to the most recent data available from HHS studies, 75 percent of former welfare recipients worked at some point during the year after leaving welfare. Former recipients generally earn between $7.00-8.00 per hour and their earnings rise, on average, over the course of their first year off of welfare.

TANF is a capped pre-appropriated annual amount of approximately $16.7 billion to States, Territories and eligible Tribal programs to help families transition from welfare to self-sufficiency TANF expired at the end of FY 2002. To date, Continuing Resolutions have provided funding for TANF State Family Assistance Grants and other TANF components. The TANF bonus to reward high-performing States is authorized through FY 2003. The 2002 Economic Recovery Act and Continuing Resolution provided funds for the Supplemental Grants and Contingency Fund through March 31, 2003.

States have tremendous flexibility in determining how to use their TANF dollars. States now spend less on cash payments than during initial years of TANF implementation and more on helping families achieve self-sufficiency. States may transfer up to a combined 30 percent of their TANF funding to either the Child Care and Development Block Grant or the Social Services Block Grant (SSBG) with not more than 4.25 percent transferable to SSBG (FY 2002 Appropriations language modified current law allowing for 10 percent transfer to SSBG).

TANF LEGISLATIVE PROPOSALS

The FY 2004 budget reproposes the President's FY 2003 plan to build on the considerable successes of welfare reform and to reauthorize Temporary

Assistance for Needy Families program. The proposal includes five years of funding for Family Assistance Grants to States and Territories at current levels; Supplemental Grants at the FY 2001 level of $319 million; restoring the allowable SSBG transfer to 10 percent as well as renewal of the $2 billion Contingency Fund with modified Maintenance of Effort (MOE) and reconciliation requirements to make it more accessible for States.

The central focus of the President's proposal is to strengthen work requirements while allowing States greater flexibility in determining what should count as work. The plan would require recipients to participate 40 hours per week through a combination of a job and activities to promote self-sufficiency. In addition, the plan also strives to strengthen families. It includes a matching grant program for initiatives to promote healthy marriages. The proposal would replace the bonus to reduce out-of-wedlock births with a new initiative to fund research, demonstrations, and technical assistance activities, primarily targeted towards family formation and promoting healthy marriages. The proposal also modifies the reward for high performing States by directing a portion of the bonus funds to a matching grant program geared towards effective family formation.

CHILD CARE ENTITLEMENT TO STATES

The current Child Care and Development Fund consists of the discretionary CCDBG and the Child Care Entitlement funds preappropriated under TANF and made subject to the rules of the CCDBG. The Child Care Entitlement is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for Indian Tribes and Tribal organizations. The Child Care Entitlement relates in part to the TANF program. States are mandated to spend at least 70 percent of the Child Care Entitlement on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of four percent of the all child care funds - mandatory, matching, and discretionary - to improve the quality and availability of healthy and safe child care for all families. Additional amounts of the discretionary funds are also set aside for quality improvements and research and referral activities.

For FY 2004, HHS is requesting funding the Child Care Entitlement of $2.7 billion. This is equal to the funding level provided under the President's FY 2003 reauthorization request. States are allowed flexibility in developing child care programs. These funds, combined with the requested $2.1 billion in discretionary child care funding, will continue to provide valuable support for working families and help move families from welfare to work.

CHILD SUPPORT ENFORCEMENT

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to ensure financial and emotional support for children from both parents by locating noncustodial parents, establishing paternity, and establishing and enforcing child support orders. Child support services are available for all families with a noncustodial parent, regardless of whether or not the custodial parent receives welfare. Child support collections play an important role for families transitioning from welfare to self-sufficiency, particularly in light of time limits on receipt of cash assistance.

The CSE program continues to make impressive gains. Child support collections hit a record $20 billion in FY 2002, serving an estimated 17.1 million child support cases. In FY 2001, the program set a new record amount of $1.6 billion collected in overdue child support from Federal income tax refunds, which benefitted more than 2.2 million families. Last year, the Federal Parent Locator Services (FPLS) helped locate more than four million non-custodial parents. In addition, paternity was established for almost 1.6 million children in FY 2001.

The Federal government shares in the financing of this program by providing a 66 percent match rate for general State administrative costs and an enhanced match rate for paternity testing. In addition, States receive incentive payments based on their performance on five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. In FY 2004, the Federal government will spend an estimated $4.5 billion for these administrative costs. The CSE program also includes a capped entitlement of $10 million annually for grants to States to facilitate noncustodial parents' access to and visitation of their children.

The CSE program assists families in obtaining the support they are owed from noncustodial parents. Families in which a custodial parent has never received cash assistance receive all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients are shared between the State and Federal governments. A portion of the collections are shared with these families as well.

CHILD SUPPORT LEGISLATIVE PROPOSALS

The Budget anticipates the enactment of the child support provisions in the President's 2003 welfare reform proposal, including proposals that give States incentives to pass through additional child support to families currently on welfare and to simplify

distribution rules for the benefit of families who formerly received cash assistance. Beginning in FY 2006, the Budget proposes that the Federal government will share in the costs of State efforts to expand policies for passing through and disregarding child support for TANF families.

The provisions also require States to review and adjust child support orders for families receiving TANF at least every three years beginning in FY 2005; reduce the threshold for denying passports to noncustodial parents owing overdue child support from $5,000 to $2,500; and give States the ability to collect past-due child support by withholding a limited amount of OASDI payments from beneficiaries in appropriate cases. Finally, States will be required to charge a $25 annual fee to families who have never received AFDC or TANF assistance and receive child support collections through the IV-D program.

The President's 2004 Budget provides additional proposals to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. These proposals require a total 10 year Federal investment of $218 million. In return these proposals offer an impressive $7.5 billion in increased child support payments for families over 10 years. The Budget identifies a source of untapped income for recovery of overdue child support -- gambling proceeds. Proposals are also included for access to insurance claims and settlements databases; direct Tribal access FPLS and Tax Offset data; and Federal seizure of accounts in multi-state financial institutions, which will enable families in interstate situations to benefit from this data match that has been so effective in identifying assets to secure past due child support.

Lastly, the President's Budget proposes to increase funding for access and visitation grants in support of the Administration's commitment to strengthening fatherhood and parenting skills and increasing family stability. Studies show that non-custodial parents who are involved in their children's lives are more likely to pay child support. The proposal would allow, for the first time, funds to be used by Tribal organizations operating their own child support enforcement programs under title IV-D of the Act.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE (CRTA)

The FY 2004 President's Budget includes $49.7 million in funds for welfare research and technical assistance for States. Of this amount, $34.7 million is devoted to two child support set-asides: one for training and technical assistance ($11.6 million) and the other to assist in operating the Federal Parent Locator Service (FPLS) ($23.1 million). The funds appropriated for these activities are equal to one and two percent respectively of the amount paid to the Federal government for its share of child support collections during the preceding fiscal year.

The President's Budget proposal anticipates reauthorization of $15 million annually in preappropriated mandatory funds for welfare research through 2008. These funds will support research on the effects of welfare reform and on ways to improve the welfare system.

FOSTER CARE, ADOPTION ASSISTANCE, AND INDEPENDENT LIVING PROGRAMS

The FY 2004 budget request for the Foster Care, Adoption Assistance, and the Independent Living programs is $6.9 billion. These programs provide essential services to vulnerable children by supporting safe living environments and preparing for independence older foster youth who are likely to age out of the system.

Of the total request, $5.0 billion will support the Foster Care program. This is a $238 million increase from last year's request and includes the cost of the legislative proposal described in the following section. The funds will be used for maintenance payments and administrative costs for approximately 240,600 children each month. In addition, States may use the funds for training and for the operation and development of the Statewide Automated Child Welfare Information Systems (SACWIS), a computer-based data and information collection system.

The budget includes $1.7 billion for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $80 million over the FY 2003 request. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training professionals and adoptive parents. The proposed level of funding will support approximately 348,700 children each month.

The budget also contains $200 million for the Independent Living Program (ILP). This includes $140 million in mandatory funds, the same as the FY 2003 request, for a variety of services to ease the transition from foster care for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21. The total request also includes $60 million in discretionary funds for an education and training voucher program for the approximately 16,000 youths who age out of foster care each year.

FOSTER CARE PROPOSAL

The FY 2004 President's Budget includes a legislative proposal which would allow States to move to an alternative system for foster care to better meet the needs of their child welfare populations. States choosing to participate will receive funds in the form of flexible grants, which will serve as an incentive to create innovative child welfare plans with a strong emphasis on prevention and family support. Participating States will also face fewer administrative burdens. Under the flexible funding plan, States will be required to continue to uphold the child safety protections outlined in the Adoption and Safe Families Act, agree to maintain existing levels of State investment in child welfare programs, and continue to participate in the Child and Family Services Reviews. The proposal provides access to the TANF Contingency Fund from which States may receive additional funding under certain circumstances if a severe foster care crisis were to arise. A $30 million set-aside will be available for Indian Tribes, and a one-third of one percent set-aside will be available for monitoring and technical assistance of State foster care programs.

PROMOTING SAFE AND STABLE FAMILIES

The Promoting Safe and Stable Families (PSSF) program is a capped entitlement program designed to assist States in coordinating services related to child abuse prevention and family preservation. These services include community-based family support, family preservation, time-limited reunification services, and adoption promotion and support services. States generally must spend at least 20 percent of their funds on each of the above four categories. The Adoption and Safe Family Act of 1997 (AFSA) established that a child's health and safety must be of paramount concern in any efforts made by a State to preserve or reunify a child's family. The FY 2004 request for PSSF is $555 million, which includes $305 million in mandatory funds and $250 million in discretionary. This is equal to the FY 2003 request. Tribes are allotted one percent of the mandatory funds and two percent of the discretionary funds. The FY 2004 discretionary budget request for PSSF includes $50 million for competitive grants to community-based groups, charitable and faith-based organizations, and State and local governments to expand or establish programs that provide mentors to children of prisoners.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG), a capped entitlement, provides funds to assist States in delivering social services and allows States substantial discretion in allocating funds in order to best suit their specific needs. SSBG is funded at $1.7 billion for FY 2004. This is the same level as FY 2003. Programs or services that are frequently supported by SSBG funds include child care, child welfare (foster care, adoption and protective services), home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for the disabled.

PERFORMANCE HIGHLIGHTS

HHS programs demonstrate, through their aggressive performance goals and annual achievement, the Department's commitment to its strategic goals and priorities. The programs highlighted below show the commitment of HHS to improving the economic and social well-being of individuals, families and communities, and improving the stability and development of our nation's youth.

The Temporary Assistance to Needy Families (TANF) program achieved remarkable success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2001, all States met the work requirement for all families and 88 percent of States with two-parent family programs met the rigorous two-parent family work participation rate. As of FY 2000, the program exceeded its target for the percentage of adult TANF recipients who became newly employed. Also, in FY 2000, of the adult TANF recipients or former recipients who became employed, 65 percent retained their jobs over at least two quarters and 25 percent attained higher earnings over two quarters.

The Child Care and Development Fund is designed to help families achieve and maintain self-sufficiency and improve the overall quality of child care. The Child Care Bureau collaborates with the Head Start Bureau, Department of Education, and the Health Resources and Services Administration to achieve these goals. HHS estimates that in FY 2003 and 2004, CCDF funds will provide subsidies to even more than the 1.74 million served by CCDF subsidies on an average monthly basis in FY 2000. Services are provided by over 9,000 child care centers and homes which are accredited by a nationally recognized early childhood development professional organization. CCDF is developing and implementing new and improved performance measures to better meet HHS performance goals in the future.

Child Support Enforcement (CSE), which aims to assure that assistance in obtaining support is available to children, consistently performs well. In FY 2002 the CSE program collected $20 billion for child support. Also, the program is continuously improving on other aspects of performance. In FY 2001 CSE exceeded its targets for all five of its

objectives. For example, CSE increased the percentage of paying cases among IV-D arrearage cases to 60 percent. Also, CSE achieved a cost-effectiveness ratio of $4.10 (dollars collected per $1 of expenditures).

The Foster Care, Adoption Assistance and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children. In CY 2000, the programs surpassed the targets for the performance measure on safety. The programs also performed well on permanency measures.

In FY 2001, 68 percent of children who exited the foster care system exited through reunification within one year of placement. Also, the percentage of children who exit care through adoption within two years of placement increased to 23 percent in FY 2001 from 20 percent in FY 2000. The programs also improved on the family and child well-being measure by increasing the percentage of children who had been in care less than 12 months that had no more than two placement settings in FY 2001.

CHILD SUPPORT ENFORCEMENT: COLLECTIONS & COSTS

(dollars in millions)

	2002 Actual	2003 Estimate	2004 Estimate	2004 +/- 2003
Total Collections Distributed:				
All Families	$17,879	$19,350	$20,875	+$1,525
TANF program	2,080	2,035	2,078	+43
Federal Share	1,151	1,127	1,151	+24
State Share	929	908	927	+19
Foster Care program	49	52	54	+2
Federal Share	28	29	30	+1
State Share	21	23	24	+1
Total	**$20,008**	**$21,437**	**$23,007**	**+$1,570**
Administrative Costs:				
Federal Share	$3,481	$3,711	$4,035	+$324
State Share	1,751	1,875	2,021	+146
Total	**$5,232**	**$5,586**	**$6,056**	**+$470**
Incentive Payment to States	**$450**	**$461**	**$454**	**-$7**
Program Costs (Costs minus Distributed Collections):				
Federal Costs	$2,752	$3,016	$3,308	+292
State Costs	351	483	616	+133
Net Costs to Taxpayers	**$3,103**	**$3,499**	**$3,924**	**+425**

NOTE: Program Costs equal the Administrative Costs minus the portion of collections distributed to TANF and Foster Care Programs

ACF PROPOSED ENTITLEMENT LEGISLATION

(dollars in millions)

	FY 2004	FY 04-08	FY 04-13
TANF (BA in millions]			
State and Territory Family Assitance Grants	$16,567	$82,835	$165,670
Matching Grants to Territories	15	75	150
Supplemental Grants	319	1,595	3,190
High Performance Bonus	500	500	1,000
Family Formation, Research, Demonstration, and Techincal Assitance Activities	200	1,000	2,000
Tribal Work Program	8	40	80
Contingecy Fund [Non-add]	[2,000]	2,000	4,000
TANF Subtotal	$17,609	$88,045	$176,090
Child Support Enforcement /1			
Federal Seizure of Accounts in Multi-State Financial Institutions	-$1	-$41	-$117
Require Intercept of Gaming Proceeds	-1	-21	-77
Provide for Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	-1	-9	-19
FPLS Access to Insurance Settlement Databases	0	-8	-28
Increased Funding for Access and Visitation	2	32	81
Direct Access for Indian Tribes to the Federal Income Tax Refund Offset Program and the Federal FPLS	0	0	0
Contractor and Tribal Access to Tax Data	0	0	0
Optional Pass Through and disregard above Current Effort /2	0	74	212
Optional Simplified Distribution /2	0	468	1,478
Review and Adjustment of Child Support Orders /3	0	-40	-160
Reduce Threshold for Passport Denial to $2500	-1	-10	-20
$25 Annual Fee for Never -TANF Cases with Collections	-53	-291	-661
OASDI Benefit Match	-6	-38	-78
Child Suport Enforcement Subtotal	-$61	$116	$611
Child Welfare (BA in millions)			
Child Welfare Program Option	$35	$0	$0
Contingency Fund /4	0	0	0
Child Welfare Subtotal	$35	$0	$0

/1 All of the child support proposals, with the exception of the user fee and a portion of the impact of mandatory review and adjustment, increase or decrease gross budget authority across the Federal government due to offsetting collections received by the Tresasury.

/2 These numbers do not reflect savings to Food Stamps.

/3 These numbers do not reflect savings to Medicaid.

/4 The Child Welfare Program Option will provide States access to the TANF Contingency Fund. While there is no additional BA for the contingency fund part of the proposal, outlays are projected at $35 million from FY 2004 - FY 2008 and $40 million from FY 2004 - FY 2013.

(dollars in millions)

	2002	2003	2004	2004 +/-2003
National Family Caregiver Support.....	$142	$142	$142	$0
Supportive Services and Centers.....	357	357	357	0
Nutrition Services:				
Home-Delivered Meals.....	$176	$178	$178	$0
Congregate Meals.....	390	390	390	0
Nutrition Services Incentive Program.....	150	150	150	0
Subtotal, Nutrition Programs	**$716**	**$718**	**$718**	**$0**
Program Innovations.....	$40	$31	$31	0
Senior Medicare Patrols.....	*12*	*13*	*13*	*0*
Aging Network Support Activities.....	2	2	2	0
Preventive Health Services.....	21	21	21	0
Grants for Native Americans.....	26	26	26	0
Protection of Vulnerable Older Americans....	18	18	18	0
Alzheimer's Disease.....	11	11	11	0
Program Administration.....	18	18	18	0
White House Conference on Aging.....	0	0	3	+3
Total, Program Level.....	**$1,351**	**$1,344**	**$1,347**	**+$3**
Less Funds Allocated From Other Sources:				
Senior Medicare Patrols (HCFAC).....	-$2	-$3	-$3	**$0**
Total, Budget Authority.....	**$1,349**	**$1,341**	**$1,344**	**+$3**
FTE.....	120	120	120	0

ADMINISTRATION ON AGING

Mission: *The Administration on Aging's (AoA's) mission is to serve as the Federal focal point for older persons, providing funding for home and community-based programs across the country to help America's rapidly growing older population remain healthy, actively engaged and able to live independently in their own homes and communities.*

The FY 2004 budget request for AoA is $1.3 billion. This amount maintains funding for AoA core services, consistent with the FY 2003 President's Budget; in addition, it includes $2.8 million for start-up costs for a White House Conference on Aging. Finally, the budget transfers the Nutrition Services Incentive Program from the Department of Agriculture to AoA.

Under the Older Americans Act, funds are distributed primarily by formula. Services are provided through a nationwide network of State, tribal and area agencies on aging to over 29,000 local service providers. AoA will continue to build partnerships with other Federal agencies that improve coordination of existing services and systems, including:

- Working with the Centers for Medicare and Medicaid Services (CMS) and others on efforts to help States redirect and integrate their systems of care to respond to older people's preference for care in the community;
- Working with the Centers for Disease Control (CDC) on the Aging States Project to establish new statewide public health and aging network partnerships; and,
- Working with the Federal Transit Administration to increase coordination of transportation services for older adults, which are a key to helping older people remain independent.

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

The FY 2004 budget includes $142 million to maintain funding for the National Family Caregiver Support Program. Family caregivers provide an invaluable resource to their loved ones as well as to America. AoA is leading the Department's efforts to assist caregivers and provide them with resources in their communities. The National Family Caregiver Support Program, for a minimal cost, provides information, counseling, respite and supplemental services that support the efforts of America's caregivers. Research indicates that informal caregiving supports can have a significant impact on the status of caregivers, delay the need for institutional services, and significantly reduce costs to Medicare, Medicaid and private payers.

HOME AND COMMUNITY-BASED SUPPORTIVE SERVICES AND CENTERS

Home and Community-based Supportive Services are the gateway to independence for America's seniors. This program provides three categories of services—access, in-home, and community services—which improve the quality of life for elderly Americans. The budget for these services totals $357 million.

National Family Caregiver Support Program

States are using the funding provided through the National Family Caregiver Support Program to develop innovative approaches to meeting the needs of caregivers and their families. For example:

- Colorado has successfully reached 20,731 primary caregivers of frail, older adults (including caregivers of persons 18 or younger with mental retardation and related developmental disabilities) and senior caregivers of children ages 18 and younger. Colorado supports family caregivers by providing information services; assistance in helping families access services; counseling, support groups and trainings; respite services; and a wide range of supplemental services — minor home modifications, assistive technologies, emergency response systems, equipment, and transportation services.
- The Alabama Cares program is currently supporting 39,748 primary caregivers of frail, older adults and senior caregivers of children ages 18 and younger. Through the National Family Caregiver Support Program, Alabama has been able to offer respite services to provide a brief period of relief for caregivers in adult day care and in-home settings (personal care, homemaker, skilled and unskilled care).
- In North Carolina approximately 8,636 older adults and senior caregivers of children ages 18 and younger are receiving information, assistance, training and respite services though the National Family Caregiver Support Program. North Carolina has developed a statewide steering team to increase awareness in the business, faith, education and health and human service community about the diverse needs of caregivers and how to be responsive to the needs of caregivers in the workplace and in the community at large.

Services—including transportation, information and referral, chore, homemaker and personal care services, and adult day care—make a difference in the lives of seniors and help to ensure that they can remain independent and in their own homes and communities. For example, transportation is vital, particularly in areas which are typically underserved by public transportation and where more than 70 percent of older Americans live. In FY 2004, AoA estimates that the aging network will provide 51 million rides, providing older Americans with the means to visit health professionals, pharmacies and grocery stores. These services are provided through senior centers and other community-based resources.

NUTRITION PROGRAMS

The budget requests a total of $718 million for Nutrition Programs. These funds will continue to provide home delivered meals to the most frail and at-risk elderly—more than 300 million meals in FY 2004. Nutrition Programs also offer nutrition screening, education and counseling, services which are all necessary to maintain the health and independence of older adults. Last year marked the 30th anniversary of the Nutrition Programs, which have provided almost 6 billion meals to at-risk older persons since their inception.

Research indicates that for many older Americans, the availability of a home-delivered meal is crucial to their ability to function independently at home—according to this research, meal preparation is difficult or impossible for 41 percent of home delivered meal recipients.

The FY 2004 budget proposes transferring intact the Nutrition Services Incentive Program (NSIP) from the Department of Agriculture (USDA) to AoA. Funds will continue to be distributed by the current USDA formula, which is based on the number of meals served in the prior year. AoA will work with USDA to ensure that States that wish to receive commodities in lieu of cash may continue to do so.

OTHER PROGRAMS

White House Conference on Aging: The FY 2004 Budget requests $2.8 million to provide startup funds for a White House Conference on Aging, to take place by December 2005, as called for in the Older Americans Act. The Conference is intended to provide a national forum on aging issues and serve as a catalyst for the development of aging policy.

Grants for Native Americans: The FY 2004 request includes $26 million for grants for Native Americans. The 2000 Census identified nearly 213,000 American Indians and Alaskan Natives over the age of 60. AoA programs supply nutritional and supportive services to older American Indians, Alaskan Natives, and Native Hawaiians, helping them to remain healthy and independent.

Prevention, Protection, and Network Support: The FY 2004 request includes $41 million to fund activities which: teach older Americans to adopt healthier lifestyles in order to delay or prevent the onset of chronic disease; protect vulnerable older Americans from abuse/neglect and give them greater control over their living situations; and identify local resources available for older Americans and their families.

Alzheimer's: The FY 2004 budget also includes $11 million for the Alzheimer's Disease Demonstration Grant program. These grants improve the quality of services provided to those suffering from Alzheimer's Disease by moving findings and approaches from theory to practice. Each year, approximately 5,500 families receive direct home and community-based services, and an additional 125,000 Alzheimer's families receive support services. Many grantees are developing culturally competent services for minority populations with limited English proficiency. A total of 42 states have participated in demonstration grants since the program's inception.

Program Innovations: A total of $31 million is included to continue innovative programs that initiate, develop, and test best practices in serving the elderly. Projects also assist States, Area Agencies, and community providers with information, assistance, and services, involving specific aging related issues and the needs of vulnerable subgroups of the elderly, including minority populations. Funding for these programs is held at the FY 2003 President's Budget level.

Program Administration: A total of $18 million and 120 FTE is requested to support AoA activities. Within the overall request are savings of $732,000, which are attributed to achieving the goals of the President's Management Agenda and efficiencies in information technology infrastructure support.

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
General Departmental Management:				
Adolescent Family Life	$29	$31	$31	$0
Physical Fitness & Sports	1	1	1	0
Office of Minority Health	50	46	47	+1
Office on Women's Health	27	29	29	0
Office for Human Research Protections	7	8	8	0
CCRF/ Reserve Affairs	1	1	1	0
Transformation of Commissioned Corps	0	0	5	+5
Minority HIV/AIDS	50	50	50	0
Office of Global Health Affairs	4	4	9	+5
IT Security and Innovation Fund	22	20	18	-2
Other General Departmental Management	143	153	155	+2
Evaluation Activities	22	22	22	0
Health Care Fraud and Abuse Control	4	5	5	0
Total, GDM Program Level	**$360**	**$370**	**$381**	**+$11**
Policy Research:				
Broad-Based Research	$18	$18	$21	+$3
State Innovation Fund	2	2	2	0
Total, PR Program Level	**$20**	**$20**	**$23**	**+$3**
Total, GDM and PR Program Level	**$380**	**$390**	**$404**	**+$14**
Public Health and Social Services Emergency Fund:				
PHSSEF	$1,487	$1,806	$1,896	+$90
Total, PHSSEF Program Level	**$1,487**	**$1,806**	**$1,896**	**+$90**
Total, DM Program Level	**$1,867**	**$2,196**	**$2,300**	**+$104**
Less funds from other sources:				
Evaluation Activities	$40	$40	$43	+$3
Health Care Fraud and Abuse Control	4	5	5	0
Total, DM Budget Authority	**$1,823**	**$2,151**	**$2,252**	**+$101**
FTE	1,414	1,536	1,532	-4

DEPARTMENTAL MANAGEMENT

Mission: *The mission of Departmental Management (DM) is to support the Secretary in his role as chief policy officer and general manager of the Department.*

Departmental Management (DM) includes funding for three appropriation accounts in the Office of the Secretary: General Departmental Management (GDM), Policy Research, and the Public Health and Social Services Emergency Fund (PHSSEF).

The FY 2004 budget request for GDM and Policy Research provides a total program level of $404 million, including appropriations of $356 million, interagency transfers of $43 million in evaluation funds, and $5 million in health care fraud and abuse funds. Included within the GDM request are savings of $6 million, resulting from savings of $4 million attributed to achieving the goals of the President's Management Agenda and savings of $2 million attributed to information technology consolidation efforts and spending reductions. The FY 2004 budget request for the PHSSEF account is $1.9 billion

GENERAL DEPARTMENTAL MANAGEMENT

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs and activities of the Department. These activities are carried out through thirteen Staff Divisions (STAFFDIVs). The GDM budget request for FY 2004 totals $381 million, an increase of $11 million or 3 percent above the comparable FY 2003 level.

The GDM request also provides funding for program-related activities, including the following:

Office of Population Affairs (OPA): The request of $31 million will continue to provide support for the Adolescent Family Life (AFL) demonstration and research program authorized under Title XX of the Public Health Service (PHS) Act. Through the grants awarded under this program, AFL provides funding in three areas: care demonstration projects, prevention projects, and research projects. This request also continues to provide for abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193). Further, OPA also administers the Family Planning program under Title X of the PHS Act, which is funded through the Health Resources and Services Administration.

Office of Minority Health (OMH): The OMH request of $47 million, a $1 million increase from FY 2003, will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts that focus on health concerns that cause the high rate of death in racial and ethnic minority communities.

The request reflects the continuation of support for the Department's Initiative to Eliminate Racial and Ethnic Disparities in Health.

Office on Women's Health (OWH): The OWH request of $29 million will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education–both throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups.

Office of Human Research Protections (OHRP): The OHRP request of $8 million will be used to accomplish the following: ensure implementation of Departmental regulations for the protection of human subjects; negotiate formal written assurances of compliance with institutions engaged in research covered by OHRP; investigate and oversee institutional compliance; and fund professional and public education.

Commissioned Corps Readiness Force (CCRF): The CCRF request of $1 million will continue to support a cadre of approximately 1,100 active duty US Public Health Service officers, qualified with special training and skills and ready to rapidly deploy in emergency situations.

Transformation of the Commissioned Corps/Reserve Affairs: The FY 2004 request includes $5 million to increase the size and skills of a fully deployable active duty Commissioned Corps.

HIV/AIDS in Minority Communities: The FY 2004 request includes $50 million to address the high-priority HIV prevention and treatment needs of minority communities heavily impacted by HIV/AIDS. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Office of Global Health Affairs (OGHA): The OGHA request of $9 million, an increase of $5 million from FY 2003, will support this newly-created STAFFDIV formed from the Office of International and Refugee Health, the US-Mexico Border Health Commission, and the Office of International Affairs. The increase of $5 million will support an HHS health care initiative in Afghanistan.

In keeping with the vision that Secretary Thompson laid out following his visit to Afghanistan, HHS has begun to develop a program of cooperation in maternal and child health with the Afghan Ministry of Health to achieve the following objectives:

- Demonstrate the ongoing commitment of the United States to Afghanistan's reconstruction and to the Karzai Government;
- Bolster the ability of the Karzai Government to fulfill its promise to provide essential services;
- Address dire healthcare needs in the Afghan population through the creation of five maternal and child health teaching clinics throughout the country;
- Provide opportunities for the training of local Afghan health care workers in modern medicine; and
- Provide a vehicle for expatriate Afghan health workers to return to Afghanistan.

Information Technology Security and Innovation Fund: The FY 2004 budget request includes $18 million to continue funding for the IT Security and Innovation Fund. Projects funded through the IT Security and Innovation Fund focus on HHS enterprise-wide investments, notably: enterprise architecture; key E-Government projects; HHS common IT infrastructure services; and on security and infrastructure to enable HHS common administrative systems.

POLICY RESEARCH

The Policy Research account examines broad issues that cut across agency and subject lines, as well as new policy approaches developed outside the context of existing programs. The FY 2004 request for Policy Research includes $2.5 million to continue the State Innovation Fund and $21 million to continue evaluation activities.

State Innovation Fund: The FY 2004 budget provides $2.5 million to continue a program to provide competitive grants to States to design, demonstrate, and evaluate new models for delivering health and/or human services at the community level to low-income adults, children, and families. The grants are of two types: planning grants and demonstration grants. FY 2004 will be the third year of funding for planning and demonstration grants from this Fund. Measurable indicators of performance to facilitate evaluation of the outcomes of the demonstrations are a key ingredient of the program. States are encouraged to integrate separate but related services funded by different programs and/or provided by different agencies.

Broad-Based Research: The FY 2004 Policy Research budget also includes $21 million, a $3 million increase from FY 2003, to support research on issues that cut across agency and subject lines, as well as new approaches developed outside the context of an existing program. Priority issues that will be examined are those related to: the well-being of children and youth; the outcomes of welfare reform and the status of low-income families; reform of major public-sector programs, especially Medicare and access for those who lack health insurance; promoting and expanding consumer-directed home and community-based services; nursing home quality; managed care and disability; post-acute care; employment and disability; active aging; and science policy.

Twenty percent of Afghanistan's children die before their fifth birthday, and 40 percent of fatalities among women occur because of complications during and after childbirth.

The increase of $3 million will support the National Electronic Health Information Initiative, to focus on national electronic health information systems. This initiative will accelerate the development and adoption of the technology and national standards necessary for Electronic Health Record Information Systems and their use by the health care and public health systems, as well as related support for the National Health Information Infrastructure.

It is proposed that in FY 2004 the entire $21 million request again be derived through interagency transfers of evaluation funds.

HHS agencies will conduct significant health services and policy research in FY 2004. This body of research covers a wide range of subjects, from assessing the quality of health care provided to the nation's elderly, to evaluating the effectiveness of programs aimed at reducing health risk behaviors among teens and other high-risk populations. The HHS Research Coordination Council (RCC), chaired by the Assistant Secretary for Planning and Evaluation, works to ensure that agencies collaborate in the conduct of health services research in order to ensure the most efficient and effective use of research resources in support of HHS's primary mission and objectives.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND (PHSSEF)

The PHSSEF provides $1.9 billion, a net $90 million increase above FY 2003. This includes $1.8 billion for bioterrorism and $100 million for a new effort to ensure the nation would have an adequate supply of influenza vaccine in the event of a pandemic. The PHSSEF includes

half of the overall HHS bioterrorism budget of $3.6 million.

Pandemic Influenza: The budget includes $100 million to begin efforts to ensure the nation has an adequate supply of vaccine in the event of an influenza pandemic. The influenza strains circulating usually change somewhat from year to year. Periodically, there is a major change in the virus's genetic structure resulting from a strain that can cause widespread disease and death. Three such global epidemics—called pandemics—occurred in the 20th century. Such a pandemic could cause an additional 90,000 to 300,000+ deaths in the U.S—especially if adequate vaccine were not available quickly. Once a pandemic begins, it would be too late to accomplish the many key activities required to minimize this toll. Therefore, planning and implementation of preparatory activities must start well in advance.

Because influenza vaccines must be tailored to the viruses in circulation and since a pandemic would be caused by an influenza virus significantly different from today's viruses, vaccine cannot be prepared in advanced and stockpiled. As a result, these funds will be used to work with industry to develop year round domestic influenza vaccine production capacity and production techniques that could be scaled up rapidly — provide surge capacity — in the event of a pandemic. Currently, the Nation uses about 90 million doses of influenza vaccine annually. Preparing for a severe pandemic could require 280 - 575 million doses of vaccine, with no more than four or five months lead time available for manufacturing. The added resources will be used to develop a targeted and responsive strategy to resolve this significant National deficiency.

Bioterrorism: The HHS FY 2004 budget includes $3.6 billion for bioterrorism. While this level is nominally $233 million below the FY 2003 President's Budget, this change reflects the decision to have the Department of Homeland Security finance the anthrax vaccine procurement NIH will begin in FY 2003, and the completion of a number of one-time expenditures for research laboratories in CDC, NIH, and the extramural science community. The entire $3.6 billion FY 2004 request will fund ongoing preparedness and research efforts, an increase of $883 million above FY 2003 for comparable activities.

State and Local Preparedness: The Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) directs and coordinates the efforts of CDC, HRSA and FDA to help States develop the personnel, procedures and systems needed to detect and respond to a potential bioterrorist attack. CDC supports State surveillance and epidemiology capacity, laboratory capacity, communications and information technology infrastructure, education and training, and health information dissemination. HRSA's funding readies hospitals for medication and vaccine distribution, quarantine and decontamination, communication, and biological disaster drills. OASPHEP is involved with the planning, review and evaluation processes for these activities.

Centers for Disease Control and Prevention: The FY 2004 request for the PHSSEF includes $1.1 billion for CDC, the same as FY 2003. The majority of these funds ($940 million) will support CDC's ongoing State and local preparedness program. In addition, this request provides support for State and local activities, upgrading capacity at CDC, expanding national planning efforts, oversight of inter-laboratory transfers of dangerous pathogens and toxins, laboratory safety inspections, and anthrax research. Included in this total is funding to support CDC's expanded role in regulating transfer of select biological agents.

Health Resources and Services Administration: The FY 2004 request for the PHSSEF includes $618 million for HRSA, the same as the FY 2003 level. The majority of these funds ($518 million) will support the third year of HRSA's hospital preparedness program. In addition to continued support for regional and local hospital preparedness and poison information centers, HRSA's request again provides funding for a new program focused on medical curricula for instruction on the detection and treatment of diseases that can be caused by bioterrorism. Funds also will be used to address the unique needs of children during and following a terrorist attack.

Office of the Secretary: The FY 2004 request for the PHSSEF includes $62 million for the Office of the Secretary, the same as FY 2003.

Office of the Assistant Secretary for Public Health and Emergency Preparedness (ASPHEP): Funding is maintained at $42 million in FY 2004. The role of ASPHEP is to direct and coordinate the implementation of the Department's bioterrorism programs and support the Department of Homeland Security by providing health and medical leadership. The $42 million includes funding for the ongoing operations of ASPHEP at headquarters and in the field; supports the Secretary's Emergency Response Team and the Department's International Early Warning Surveillance efforts; provides funding for bioterrorism preparedness, planning and evaluation studies and a advance research program to promote a national bioscience research and development effort related to civilian biodefense; and to continue the development of an effective risk communication and information strategy for the public.

Medical Reserve Corps: Funding is maintained at $10 million in FY 2004 for the Medical Reserve Corps, the Citizen Corps component that organizes local volunteers to assist regular medical response professionals and facilities during a large-scale local emergency, such as an influenza epidemic or a hazardous materials spill. Program oversight is the responsibility of the Office of the Surgeon General. It is estimated that approximately 200 grants to small cities, rural counties and large metropolitan areas will be awarded in FY 2004.

CyberSecurity: The FY 2004 request for the PHSSEF includes $10 million to protect the Department's information technology infrastructure from cyber-terrorist attacks. These funds will provide continuous security monitoring for all HHS systems, assets, and services.

Bioterrorism Other than PHSSEF: Funds totaling $1.8 billion are included for bioterrorism activities in the following agency requests: This finances the work of NIH and FDA. The FY 2004 request for NIH includes $1.6 billion, a net decrease of $120 million, from FY 2003. This decrease reflects one-time FY 2003 expenses of laboratory construction and anthrax vaccine procurement costs. This request will support two complementary components: basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response to infection and defense mechanisms; and applied research for the development of new or improved diagnostics, vaccines, and therapies. Legislation is being proposed that will give NIH more flexibility in accelerating biodefense research by providing funding for procurement of countermeasures once such countermeasures are considered licensable.

FDA's budget includes $176 million for bioterrorism activities. Within FDA's request, $20.5 million will be directed to specific food safety activities that implement the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (PHSBPRA), and related activities needed to protect the food supply. These include improved communication with State food laboratories, working with States to upgrade their food safety efforts, and the new registration system for domestic and foreign food facilities. FDA will continue to work closely with other Federal agencies and industry to promote the development and availability of defense countermeasures. FDA's request also reflects anticipated efficiencies from management and information technology initiatives.

Cooperation with the Department of Homeland Security (DHS): The DHS has been assigned responsibility to finance the procurement of biodefense medical countermeasures; as a result, funding for the National Pharmaceutical Stockpile and smallpox vaccine which had previously been budgeted for in HHS are now in the DHS request. HHS will continue to provide the scientific leadership needed to determine what countermeasures are needed, and will also procure and manage these pharmaceuticals for DHS. The FY 2004 DHS request includes a new mandatory funding authority that will ensure that adequate funding is available to procure needed new countermeasures once sufficient research has been done to conclude that the products will ultimately be proven safe and effective. The Office of Emergency Response Headquarters and Regional Emergency Coordination staff have also been transferred to DHS, along with the Metropolitan Medical Response System, the National Disaster Medical System, and the Mobile Training Center.

BIOTERRORISM

(dollars in millions)

	2002	2003	2004	2004 +/-2003
Public Health and Social Services Emergency Fund				
Bioterrorism:				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity	$940	$940	$940	$0
Upgrading CDC Capacity	142	158	158	0
Anthrax Vaccine Research	18	18	18	0
Independent Studies	2	0	0	0
Subtotal, CDC	$1,102	$1,116	$1,116	$0
Health Resources and Services Administration:				
Hospital Preparedness and Infrastructure	$135	$518	$518	$0
Education Incentives for Medical Curriculum	0	60	60	0
Trauma/EMS	3	0	0	0
EMS for Children	19	19	19	0
Poison Control	21	21	21	0
Subtotal, HRSA	$179	$618	$618	$0
Office of the Secretary:				
OASPHEP:				
Operations 1/	$13	$13	$13	$0
Advanced Research	5	5	5	0
International Security Early Warning Surveillance 1/	10	10	10	0
Emergency Response Team	3	3	3	0
Preparedness, Planning and Evaluation	6	7	7	0
Command, Control and Communication	13	0	0	0
Media/Public Information Campaign	0	5	5	0
Subtotal, OASPHEP	49	42	42	0
CyberSecurity	5	10	10	0
Medical Reserve Corps	3	10	10	0
Subtotal, Office of the Secretary	$57	$62	$62	$0
Substance Abuse and Mental Health Services Administration	0	$10	0	-$10
Subtotal, PHSSEF Bioterrorism	**1,337**	**1,806**	**1,796**	**-10**
Pandemic Influenza	0	0	100	+100
Recovery Activities	150	0	0	0
Total, PHSSEF	**$1,487**	**$1,806**	**$1,896**	**+$90**

BIOTERRORISM CONTINUED

(dollars in millions)

Bioterrorism and Recovery Activities in Agency Budgets				
Food and Drug Administration:				
Food Safety	$98	$98	$116	+$19
Vaccines/Drugs/Diagnostics	46	54	53	-1
Physical Security	13	7	7	0
Subtotal FDA	$157	$158	$176	+$18
National Institutes of Health:				
Research 2/	$198	$750	$1,625	+$875
Anthrax Vaccine Procurement	0	250	0	-250
Extramural Physical Security & Facilities	0	375	0	-375
Intramural Physical Security & Facilities	92	371	0	-371
Subtotal NIH	$290	$1,746	$1,625	-$121
CDC Physical Security & Facilities 3/	$46	$120	$0	-$120
Recovery Activities	$23	$0	$0	$0
Subtotal, Bioterrorism/Recovery Activities in Agency Budgets	$515	$2,024	$1,801	-$223
Total Bioterrorism Funding	**$1,830**	**$3,830**	**$3,597**	**-$233**
Bioterrorism Funding by Function:				
Facilities Construction/Security (non-add)	*$138*	*$866*	*0*	*-$866*
NIH Vaccine Procurements (non-add)	*0*	*250*	*0*	*-250*
Ongoing Research/Preparedness (non-add)	*1,693*	*2,714*	*3,597*	*+883*
Total Bioterrorism Funding (non-add)	*$1,830*	*$3,830*	*$3,597*	*-$233*

Transfers to Department of Homeland Security				
Centers for Disease Control and Prevention				
National Pharmaceutical Stockpile (CDC)	$645	$300	-	-
Smallpox Vaccine (CDC)	512	100	-	-
Subtotal, CDC	$1,157	$400	-	-
Office of Emergency Response				
Headquarters and Regional Staff and Noble Training Center	$17	$18	-	-
Metropolitan Medical Response System	22	50	-	-
Disaster Med. Asst. Team/Natl. Med. Resp. Team	33	34	-	-
Subtotal, OER	$72	$101	-	-
Transfer of Overhead from HHS to DHS 4/	$3	$3	-	-
Total, Transfers to Homeland Security	**$1,232**	**$504**	**-**	**-**

1/ Reflects FY 2002 recission of a total of $1.396 in the PHSSEF.

2/ Displayed on a comparable basis -- appropriated $88.5 millon in the PHSSEF in FY 2002.

3/ Displayed on a comparable basis -- appropriated in the PHSSEF in FY 2002.

4/ Displayed on a comparable basis. Includes $1.0 M from OASPHEP, $.584 M from CDC, $.583 M each from NIH and FDA, and $.25 M from OIG.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Program Level.....	$31	$33	$34	+$1
FTE.....	242	267	267	0

Mission: *The Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and correction of unlawful discrimination and protection of the privacy of medical information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.*

The FY 2004 budget request for OCR is $34 million, an increase of $1 million over the FY 2003 level. OCR is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes prohibit discrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion.

Among the most significant issues that OCR addresses are: implementation of the Supreme Court's 1999 decision in the *Olmstead* case concerning the provision of services in the most integrated setting to persons with disabilities; implementation and enforcement of medical privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA); the effects of discrimination on racial disparities in health care; nondiscriminatory implementation of the Temporary Assistance to Needy Families (TANF) program and welfare-to-work programs; assessment of the effects of managed care on services to minority and disability communities; and removal of discriminatory barriers to access for immigrant populations, including language barriers affecting individuals with limited English proficiency.

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

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

HIPAA Medical Privacy

From FY 2001 through FY 2003, OCR has been preparing for implementation of a new compliance, policy development, public education, outreach, and technical assistance responsibility for protecting the privacy of medical information under HIPAA. OCR is developing policy guidance, public education, and technical assistance materials for health providers, health plans, and clearing houses that maintain individuals' medical information. The HIPAA privacy rule takes effect April 14, 2003. Through the rest of FY 2003 and in FY 2004, OCR's resources will also support the investigative, legal, and related administrative expenses associated with implementing compliance with and enforcement of the HIPAA privacy rule.

New Freedom Initiative and *Olmstead*

A primary focus of OCR's requested FY 2004 budget increase is for continued and expanded work related to the *Olmstead* decision. OCR supports the President's New Freedom Initiative by providing expert consultant technical assistance to States as they continue to develop comprehensive plans consistent with the requirements of the Supreme Court's *Olmstead* decision. The decision found that unnecessary institutionalization of individuals is a violation of the Americans with

Disabilities Act, and that under appropriate circumstances individuals have a right to receive care in the "most integrated" setting that is appropriate for them. OCR is using a more intense technical assistance approach that supplements its normal complaint investigation procedures to assist States in developing system-wide plans for moving people from costly institutional settings into community-based care.

In addition to this, to support a June 2001 Presidential Executive Order directing HHS to, whenever possible, use alternative dispute resolution to resolve complaints, in FY 2003 and FY 2004 OCR will enter into a memorandum of understanding with the Department of Justice (DOJ) to use alternative dispute resolution and mediation techniques for *Olmstead* complaints. OCR will also work with DOJ and others to review, identify, and disseminate best practices in "most integrated setting" cases in which alternative dispute resolution has been used successfully.

OTHER FY 2004 PRIORITIES

In FY 2004, OCR will continue to focus on traditional civil rights priorities, such as quality access improvements designed to eliminate racial disparities and improve the quality of health care for racial and ethnic minorities. OCR also will focus on improving access to the Medicaid and SCHIP programs by removing possible discriminatory barriers.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2002	2003	2004	2004 +/- 2003
Program Level \1.....	$180	$200	$200	$0
FTE	1,569	1,640	1,559	-81

1/ The FY 2004 level assumes $160 million for Medicare and Medicaid related fraud and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control program.

Mission: *Under the authority of the Inspector General Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the Public.*

For FY 2004, the Office of Inspector General (OIG) requests a discretionary appropriation of $39 million, level funding from the FY 2003 discretionary level. OIG will also receive between $150 and $160 million in FY 2004 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare and Medicaid related fraud and abuse activities. In the FY 2003-FY 2004 period, OIG will use its discretionary funding to continue its work across the non- Medicare and non-Medicaid areas of HHS, which are public health, children and families, aging, and Department-wide activities.

CHILD SUPPORT ENFORCEMENT PROGRAM

OIG will continue its coverage of all 50 States by 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. These task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, U.S. Marshals Service personnel, the Federal Bureau of Investigation, State and county child support personnel, and all other interested parties. From 1998 to December 15, 2002, OIG has opened 1,859 child support cases nationwide resulting in 624 Federal convictions and court-ordered restitution of $30.1 million. The Child Support Task Forces have resulted in an additional 280 convictions at the State level and $10.9 million in restitution.

OVERSIGHT OF GRANTS

OIG plans to review Departmental grant programs to determine whether they are appropriately monitored and managed throughout the grant life cycle. We will assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are used only for authorized purposes. Our work will include review of performance measures used to determine the nature and value of the product of the grants, as well as the methods used to evaluate the individual grants and grant programs as a whole. Our reviews will cover internal controls, accounting controls, performance measurements, and program evaluation. Examples of upcoming work include: recipient capability audits of new organizations having little or no experience managing Federal funds; grants management and oversight at the National Institutes of Health; oversight of HIV/AIDS grants at the Centers for Disease Control and Prevention; and oversight and monitoring of grants to Community Health Centers, to name a few.

HEALTH CARE FRAUD AND ABUSE

Through the Health Insurance Portability and Accountability Act (HIPAA), OIG receives mandatory funding for its activities that focus on fraud, abuse, and efficiency improvements in the Medicare and Medicaid programs. The Act provides for minimum and maximum amounts of funding that are decided each year by the Secretary of HHS and the Attorney General. OIG works with the Centers for Medicare & Medicaid Services (CMS), other HHS agencies, and the Department of Justice to ensure that funds due to the Medicare Trust Fund or CMS are recovered through audits and investigations, and provides recommendations for statutory, regulatory, and program changes that could strengthen program integrity.

PROGRAM SUPPORT CENTER

(dollars in millions)

	2002	2003	2004	Request +/-Enacted
Expenses.....	$414	$449	$459	+$10
FTE.....	1,151	1,151	1,151	0

Mission: *The Program Support Center's (PSC) mission is to provide customer-focused administrative services and products for the Department of Health and Human Services. The PSC's guiding principles in accomplishing its mission are customer focus, workforce excellence, cost management, best business practices, and communication.*

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

HUMAN RESOURCES SERVICE

The FY 2004 estimated expenses for the Human Resources Service (HRS) are $52 million, representing level funding from the FY 2003 level. HRS provides a full range of human resources services, including automated personnel and payroll systems support, personnel and payroll processing, staffing and classification, and employee and labor relations.

COMMISSIONED PERSONNEL SERVICE

The FY 2004 estimated expenses are $19 million, which is at the same level as FY 2003 estimated expenses, with minor adjustments for pay and inflationary increases. The Commissioned Personnel Service integrates the development, implementation, and evaluation of a comprehensive program for personnel management, medical support systems, and pay administration for the U.S. Public Health Service (PHS) Commissioned Corps. CPS provides a full range of personnel services and activities to the Department of Health and Human Services and non-HHS agencies that employ the PHS Commissioned Corps officers and to the active-duty, inactive, and retired officers' populations.

FINANCIAL MANAGEMENT SERVICE

The FY 2004 estimated expenses for the Financial Management Service (FMS) are $56 million, an decrease of $1 million below the FY 2003 level. The decrease includes Information Technology (IT) reductions for the PSC's accounting (-$.6 million), grants payment (-$.5 million), and other administrative cost reductions ($.7 million), as well as increases for the FY 2004 pay raise and other costs (+$.9 million). FMS supports the financial operations of HHS and other departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates. The FMS also provides specialized ADP systems development in the area of workforce management.

ADMINISTRATIVE OPERATIONS SERVICE

The FY 2004 estimated expenses for the Administrative Operations Service (AOS) are $194 million, an increase of $2 million above the FY 2003 level. This increase is for pay and other costs (+$2 million), replenishment of the pharmaceutical supply inventory at the Supply Service Center (+$8 million), and IT reductions for telecommunications improvement (-$4 million), regions (-$2 million), reprographics (-$1 million), and other administrative cost reductions (-$1 million). AOS provides a wide array of administrative management services within the Department, both in

headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are property and materiel management, acquisitions management, and support services ranging from commercial graphics to mail distribution and telecommunications services. The Telecommunications Improvement Project consolidated telephone services under one contract with substantial savings in telephone bills to HHS agencies located in Maryland.

FEDERAL OCCUPATIONAL HEALTH

The FY 2004 estimated expenses for the Federal Occupational Health (FOH) are $138 million, an increase of $9 million above the FY 2003 level. This increase is comprised of $9 million in anticipated increased reimbursements from other Federal agencies. The FOH provides occupational health services, including health, wellness, employee assistance, work/life, safety, environmental and industrial hygiene-related services to more than 160 Federal components across the country. The FOH services are provided through interagency agreements as authorized under the Government Management Reform Act and the Economy Act.

RETIREMENT PAY & MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2002	2003	2004	Request +/-Enacted
Retirement Payments.....	$204	$219	$234	+$15
Survivor's Benefits.....	13	14	15	+$1
Medical Care.....	56	52	54	+$2
Total, Budget Authority.....	**$273**	**$285**	**$303**	**$18**

/1 The FY 2004 Budget proposes extension of accrual financing to non-Medicare eligible uniformed services retirees. Current law provides for accrual of health costs

This appropriation provides for annuities of retired Public Health Service (PHS) Commissioned Officers, payment to survivors of deceased retired officers, and medical care to active duty PHS commissioned officers, retirees, and dependents of members and retirees of the PHS Commissioned Corps.

Beginning in FY 2003, the accrued costs of medical benefits for those aged 65 and over are paid by HHS agencies to the DoD's Uniformed Services Retiree Health Care Fund under P.L. 107- 107. Contributions for these medical care benefits are reflected in OPDIV budget presentations. Monthly contributions to the Uniformed Services Retiree Health Care Fund are based upon the number of active duty Commissioned Officers, as applied to the DoD's actuarially determined cost of medical benefits for those officers and beneficiaries at the age of 65 and above.

New legislation is being proposed to allow for the adjustment of accrual amounts that uniformed services currently pay into the Department of Defense Uniformed Services Retiree Health Care Fund for Medicare-eligible beneficiaries. The adjustment would allow accrual rates to reflect more accurately the all-officer composition of the Public Health Service Commissioned Corps. The FY 2004 budget includes $13 million for the difference between the rate under existing law and the rate that would result from the proposal.

The FY 2004 request of $303,392,000 is a net increase of $17,906,000 over the FY 2003 level. This amount reflects increased retirement payments of $15 million, increased survivor benefits of $.9 million, and increased medical benefits costs of $2 million.