Fiscal Year 2013

Budget in Brief

Strengthening Health and Opportunity for All Americans

U.S. Department of Health & Human Services

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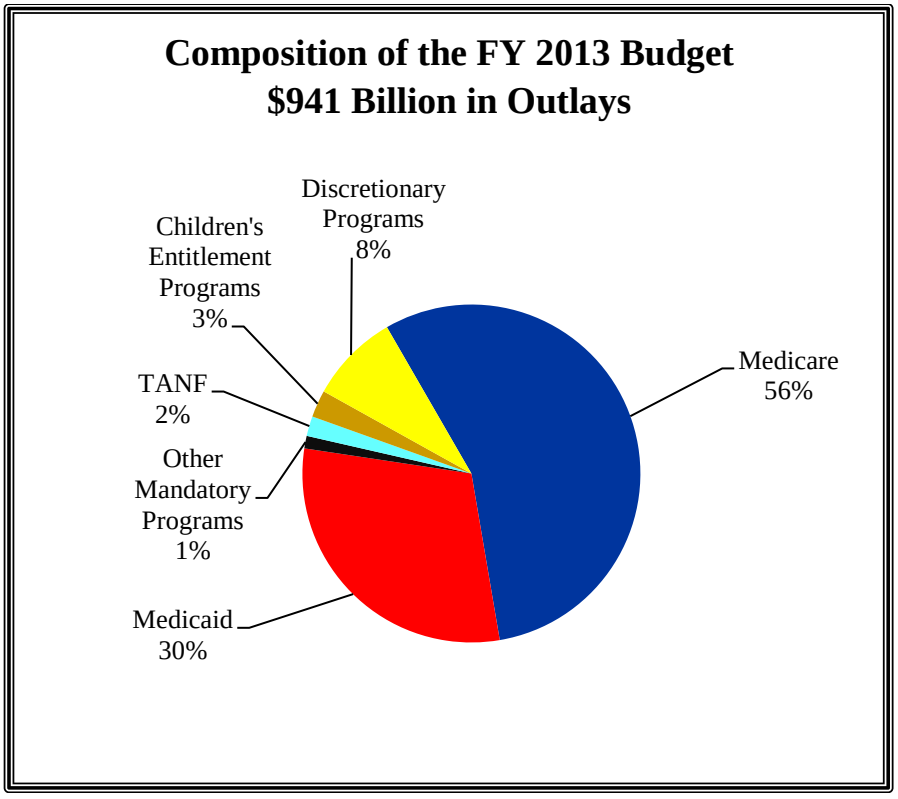
ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR NATION

FY 2013 President's Budget for HHS

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Budget Authority	**882,993**	**866,017**	**932,234**	**+66,217**
Total Outlays	**891,323**	**871,924**	**940,927**	**+69,003**
Full-Time Equivalents (FTE)	73,704	74,948	76,341	+1,393



General Notes

Detail in this document may not add to the totals due to rounding. Budget data in this book are presented "comparably" to the FY 2013 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2013. This approach allows increases and decreases in this book to reflect true funding changes.

The FY 2011 figures herein reflect final enacted levels. The FY 2012 discretionary figures reflect the full-year appropriation as adjusted by rescissions and discretionary transfers. The FY 2012 and FY 2013 mandatory figures reflect current law and mandatory proposals reflected in the Budget.

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

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

The Budget for the Department of Health and Human Services (HHS) invests in health care, disease prevention, social services, and scientific research. HHS makes investments where they will have the greatest impact, build on the efforts of our partners, and lead to meaningful gains in health and opportunity for the American people.

The President's fiscal year (FY) 2013 Budget for HHS includes a reduction in discretionary funding for ongoing activities, and legislative proposals that would save an estimated $350.2 billion over 10 years. The Budget totals $940.9 billion in outlays and proposes $76.7 billion in discretionary budget authority. This funding will enable HHS to: Strengthen Health Care; Support American Families; Advance Scientific Knowledge and Innovation; Strengthen the Nation's Health and Human Service Infrastructure and Workforce; Increase Efficiency, Transparency, and Accountability of HHS Programs; and Complete the Implementation of the Recovery Act.

STRENGTHEN HEALTH CARE

Delivering benefits of the Affordable Care Act to the American People: The Affordable Care Act expands access to affordable health coverage to millions of Americans, increases consumer protections to ensure individuals have coverage when they need it most, and slows increases in health costs. Effective implementation of the Affordable Care Act is central to the improved fiscal outlook and well-being of the Nation. The Centers for Medicare & Medicaid Services (CMS) is requesting an additional $1 billion in discretionary funding to continue implementing the Affordable Care Act, including Exchanges, and to help keep up with the growth in the Medicare population.

Expand Health Insurance Coverage: Beginning in 2014, Affordable Insurance Exchanges will provide improved access to insurance coverage for more than 20 million Americans. Exchanges will make purchasing private health insurance easier by providing eligible consumers and small businesses with one-stop-shopping where they can cross compare plans. New premium tax credits and reductions in cost will help ensure that eligible individuals can afford to pay for the cost of private coverage through Exchanges. FY 2013 will be a critical year for building the infrastructure and initiating the many business operations critical to enabling Exchanges to begin operation on January 1, 2014. The expansion of health insurance coverage for millions of low-income individuals who were previously not eligible for coverage through Medicaid also begins in 2014. CMS has worked closely with states to ensure they are prepared to meet the 2014 deadline and will continue this outreach in FY 2013.

Many important private market reforms have already gone into effect, providing new rights and benefits to consumers to put them in charge of their own health care. The Affordable Care Act's Patient's Bill of Rights allows young adults to stay on their parents' plans until age 26 and ensures that consumers receive the care they need when they get sick and need it most by prohibiting rescissions and lifetime dollar limits on care. The Patient's Bill of Rights also guarantees independent reviews of coverage disputes. Temporary programs, like the Pre-Existing Condition Insurance Plan program, support affordable coverage for individuals who often face difficulties obtaining private insurance in the current marketplace.

Additionally, enforcement of rate review and medical loss ratio (MLR) provisions ensure that health care premiums are kept reasonable and affordable year after year. The already operational rate review provision gives states additional resources to determine if a proposed health care premium increase is unreasonable and, in many cases, empowers state authorities to deny an unreasonable rate increase. HHS will review large proposed increases in states that do not have effective rate review programs. The MLR provisions guarantee that, starting in 2011, insurance companies use at least 80 percent or 85 percent, depending on the market, of premium revenue to provide or

improve health care for their customers or give them a rebate.

Strengthen the Delivery System: The Affordable Care Act established a Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center is tasked with developing, testing, and—for those that prove successful—expanding innovative models to improve quality of care and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program. The Innovation Center began operations in 2011 and has undertaken an ambitious research agenda encompassing patient safety, coordination of care among multiple providers, and enhanced primary care. These projects can serve as crucial stepping stones towards a higher quality, more efficient health care system. The Innovation Center is developing multiple, new, and evidence-based models to test in coming years.

HHS is also working to ensure that the most vulnerable in our Nation have full access to seamless, high-quality health care. The Affordable Care Act established a new office to more effectively integrate benefits and improve coordination between states and the Federal Government for those who are dually eligible for both Medicare and Medicaid. Medicare-Medicaid beneficiaries make up a relatively small portion of enrollment in the two programs but represent a significant portion of expenditures. HHS is currently supporting 15 states as they design models of care that better integrate Medicare and Medicaid services, and is designing additional demonstrations to continue to improve care.

CMS is currently offering three initiatives that will help spur the development of Accountable Care Organizations (ACOs) for Medicare beneficiaries. ACOs are groups of health providers who join together to give high-quality care to the patients they serve. If an ACO meets quality standards, it will be eligible to share in the savings it achieves for the Medicare program, offering a powerful incentive to restructure care to better serve patients.

Ensuring Access to Quality, Culturally Competent Care for Vulnerable Populations: Health Centers are a key component of the Nation's health care safety net. The President's Budget includes a total of $3 billion, including an increase of $300 million from mandatory funds under the Affordable Care Act, to the Health Centers program. This investment will provide Americans in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services. This funding will create 25 new health center sites in areas of the country where they do not currently exist and provide access to quality care for 21 million people, an increase of 300,000 additional patients over FY 2012. The Budget also promotes a policy of steady and sustainable health center growth by distributing Affordable Care Act resources over the long-term. This policy safeguards resources for new and existing health centers to continue services and ensures a smooth transition as health centers increase their capacity to provide care as access to insurance coverage expands.

Improving Healthcare Quality and Patient Safety: The Affordable Care Act directed HHS to develop a national strategy to improve health care services delivery, patient health outcomes, and population health. In FY 2011, HHS released the National Strategy for Quality Improvement in Health Care, which highlights three broad aims: Better Care, Healthy People and Communities, and Affordable Care. Since publishing the Strategy, HHS has focused on raising awareness about this effort and providing private partners with the opportunity to give their input. HHS will enhance the Strategy by incorporating input from stakeholders and developing metrics to measure progress toward achieving the Strategy's aims and priorities.

CMS will continue funding for the Partnership for Patients, a new initiative that sets aggressive targets for reducing hospital-acquired conditions and unnecessary hospital readmissions and gives hospitals the tools to meet these targets. In addition to improving patient safety and quality of care, successfully meeting these targets could save the health care system, including Medicare and Medicaid, billions of dollars over the next several years.

Investing in Innovation: HHS is committed to advancing the use of health information technology (health IT). The Budget includes $66 million, an increase of $5 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate the adoption of health IT and promote electronic health records (EHRs) as tools to improve both the health of individuals and the health care system as a whole. The increase will allow ONC to give more help to health care providers to become meaningful users of health IT. Furthermore, through

the HITECH provisions of the American Recovery and Reinvestment Act, CMS is providing hospitals and medical professionals who participate in Medicare and Medicaid with substantial incentive payments to encourage the adoption and meaningful use of EHRs. As of the end of 2011, CMS had made incentive payments to over 15,800 providers who have demonstrated meaningful use in the Medicare EHR Incentive Program and over 15,100 providers who have either adopted or met meaningful use in the Medicaid EHR Incentive Program. By encouraging providers to modernize their systems, this investment will improve the quality of care and protect patient safety.

SUPPORT AMERICAN FAMILIES

Healthy Development of Children and Families: HHS oversees many programs that support children and families, including Head Start, Child Care, Child Support, and Temporary Assistance for Needy Families (TANF). The FY 2013 Budget request invests in early education, recognizing the role high-quality early education programs can play in preparing children for school success. The request also supports TANF and proposes to restore funding for the Supplemental Grants without increasing overall TANF funding.

Investing in Education by Supporting an Early Learning Reform Agenda: The FY 2013 Budget supports critical reforms in Head Start and a Child Care quality initiative that, when taken together with the Race to the Top – Early Learning Challenge, are key elements of the Administration's broader education reform agenda designed to improve our Nation's competitiveness by helping every child enter school ready for success.

On November 8, 2011 the President announced important new steps to improve the quality of services and accountability at Head Start centers across the country. The Budget requests over $8 billion for Head Start programs, an increase of $85 million over FY 2012, to maintain services for the 962,000 children currently participating in the program. This investment will also provide resources to effectively implement new regulations that require grantees that do not meet high-quality benchmarks to compete for continued funding, introducing an unprecedented level of accountability into the Head Start program. By directing taxpayer dollars to programs that offer high-quality Head Start services, this robust, open competition for Head Start funding will help to ensure that Head Start programs provide the best available early education services to children.

The Budget provides $6 billion for Child Care, an increase of $825 million over FY 2012. This funding level will provide child care assistance to 70,000 more children than could receive services without this increased investment, and 1.5 million children in total. In addition to providing direct assistance to more children, the Budget includes $300 million for a new child care quality initiative that states would use to invest directly in programs and teachers so that individual child care programs can do a better job of meeting the early learning and care needs of children and families. States and tribes that demonstrate a strong commitment to making significant strides in their ability to measure the quality of individual child care programs through a rating system or another system of quality indicators and to clearly communicate program-specific information to parents so they can make informed choices for their families will be eligible for additional competitively awarded funding. These investments are consistent with the broader reauthorization principles outlined in the Budget, which encompass a reform agenda that would help transform the Nation's child care system to one that is focused on continuous quality improvement and provides more low-income children access to high-quality early education settings that support children's learning, development, and success in school.

Improve the Foster Care System: The Budget includes an additional $2.8 billion in mandatory funds over ten years both to provide incentives to states to align performance with improved outcomes for children in foster care and those who are receiving in-home services from the child welfare system, and also to require that child support payments made on behalf of children in foster care be used in the best interest of the child. Additionally, the Budget creates a new teen pregnancy prevention program specifically targeted to youth in foster care.

Child Support and Fatherhood Initiative: The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to TANF families. Recognizing that healthy families need more than financial support alone, the proposal

would also require states to include parenting time provisions in initial child support orders and increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and implement domestic violence safeguards. The Budget request also includes new enforcement mechanisms that will enhance child support collection efforts.

Strengthen TANF: The Budget continues the TANF program and permanently funds the Supplemental Grants for Population Increases. When Congress takes up reauthorization, the Administration will work with lawmakers to strengthen the program's effectiveness in accomplishing its goals. This effort should include using performance indicators to drive program improvement and ensuring that states have the flexibility to engage recipients in the most effective activities to promote success in the workforce – including families with serious barriers to employment. The Administration will also work with Congress to revise the Contingency Fund to make it more effective during economic downturns.

Continue the Administration's Commitment to American Indians and Alaska Natives: At the Tribal Nations Conference in December 2011, the President reiterated his commitment to make government work better to fulfill our trust management responsibilities to tribes. The President is committed to continuing progress in Indian Country by making quality health care accessible to more Native Americans and by reducing health disparities. The Indian Health Service (IHS) discretionary budget has increased 32 percent since FY 2008. The FY 2013 Budget funds IHS at $5.5 billion, an increase of $116 million over FY 2012. The Budget prioritizes funding for health care services purchased, where needed, outside the IHS system by providing an additional 848 inpatient visits, 31,705 outpatient visits, and 1,166 ambulance trips. The Budget also prioritizes hiring 402 additional health care providers in 6 newly opened facilities.

Keeping America Healthy: The President's Budget includes resources necessary to enhance clinical and community prevention, support research, develop the public health workforce, control infectious diseases, and invest in prevention and management of chronic diseases and conditions.

Tobacco Prevention Activities: Tobacco use kills an estimated 443,000 people in the United States each year. Despite progress in reducing tobacco use, 1 in 5 high school students and adults continue to smoke, costing our Nation $96 billion in medical costs and $97 billion in lost productivity each year. To combat the most preventable cause of disease, disability, and death, the Budget includes $505 million for the Food and Drug Administration (FDA) to establish tobacco product standards to reduce or eliminate harmful ingredients found in tobacco products and to implement public education campaigns to ensure that the public is informed about the harms and addictiveness of tobacco product use. In addition, $586 million in funding from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) will further help reduce smoking among teens and adults and will support research on preventing tobacco use, understanding the basic science of the consequences of tobacco use, and improving treatments for tobacco-related illnesses. HHS is striving to reduce adults' annual cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita by 2013.

Million Hearts Initiative: The Million Hearts Initiative is a national public-private initiative intended to prevent 1 million heart attacks and strokes over 5 years, from 2012 to 2017, by reducing the number of people who need treatment and improving the quality of treatment for those who need it, by focusing on increasing the number of Americans who have their high blood pressure and high cholesterol under control, reducing the number of people who smoke, reducing the average sodium intake, and reducing the average trans fat intake. To achieve this overall goal, the Initiative will promote medication management and support a network of EHR registries to track blood pressure and cholesterol control, along with many other public-private collaborations. In FY 2013, the Budget requests $5 million for CDC under the initiative to achieve measurable outcomes in these areas.

Preventing Teen Pregnancy: The Budget includes $105 million for the Office of the Assistant Secretary for Health for teen pregnancy prevention programs. These programs will support community-based efforts to reduce teen pregnancy using evidence-based models and promising programs needing further evaluation. The Budget also includes $15 million in funding for CDC teen pregnancy prevention activities to reduce the number of

unintended pregnancies through science-based prevention approaches.

Protect Vulnerable Populations: HHS is committed to ensuring that vulnerable populations continue to receive critical services during this period of economic uncertainty.

Preventing and Treating HIV/AIDS: The FY 2013 Budget includes $3.3 billion for domestic HIV/AIDS activities to increase the availability of treatment to people living with HIV/AIDS in the United States, improve adherence to medications, and support prevention programs in states and communities. This total investment includes $1 billion, an increase of $67 million, to increase access to life-saving treatments through the AIDS Drug Assistance Program, and $236 million, an increase of $20 million, to support care provided by HIV clinics across the country.

This total also includes $826 million for CDC's domestic HIV/AIDS prevention activities, an increase of $40 million above FY 2012, to support grants to health departments to reduce new HIV infections, identify previously unrecognized HIV infections, and improve health outcomes. In addition, funds will support research, surveillance, evaluation, and implementation of high-impact prevention programs among HIV-affected populations. In FY 2013, CDC will award grants to 69 state and local health departments to implement HIV/AIDS prevention programs according to a revised funding algorithm instituted in FY 2012, which better aligns the distribution of prevention resources with the disease burden rather than with historical AIDS data. CDC will also support up to 36 jurisdictions for an expanded testing initiative to focus on groups at highest risk for acquiring HIV such as men who have sex with men, African Americans, and injection drug users.

Refugee Transitional and Medical Services: The Budget requests $805 million to provide time-limited cash and medical assistance to newly arrived refugees, helping them become self-sufficient as quickly as possible, and to provide shelter for unaccompanied alien children until they can be placed with relatives or other sponsors, repatriated to their home countries, or receive relief under U.S. immigration law. Additional funding will primarily cover rising medical costs—many refugees have spent their lives in camps where medical care is limited or non-existent—and to serve the growing number of unaccompanied refugee children made eligible for benefits under the Trafficking Victims Protection Reauthorization Act of 2008.

Elder Justice: The Budget includes $43 million for the Administration on Aging (AoA) to address the growing problem of elder abuse, neglect, and exploitation which affects more than 5 million seniors annually. Research indicates that older victims of even modest forms of abuse have dramatically higher morbidity and mortality rates than non-abused older people. To combat this abuse, the Budget provides $8 million for newly-authorized Adult Protective Services Demonstration grants, along with $9 million in ongoing funding for state grants to raise awareness of elder abuse and neglect and for resource centers and related activities that support nationwide elder rights activities. The Budget also includes $17 million for the Long-term Care Ombudsman Program to improve the quality of care for the residents of long-term care facilities by resolving complaints on behalf of residents.

Keeping People in Communities: Part of HHS' strategic plan includes enabling seniors to remain in their own homes with a high-quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers. Some seniors, if unable to remain independent in the community, will be forced to move into a nursing home at a significant potential cost to Medicaid. The Budget includes $1.4 billion in AoA to help seniors stay in their homes through Home and Community-Based Supportive Services, Senior Nutrition Programs, and Caregiver Support programs. Such investments can have significant opportunity for savings across the healthcare system.

Reduce Foodborne Illness: The Budget reflects the Administration's commitment to transforming our Nation's food safety system into one that is stronger and that reduces foodborne illness. To reach this goal, the Budget includes $1.5 billion, an increase of $271 million over FY 2012, for FDA and CDC food safety activities. HHS will continue to modernize and implement a prevention-focused domestic and import safety system. Collaboratively, FDA and CDC are working to decrease the rate of Salmonella Enteritidis illness in the population from 2.6 cases per 100,000 to 2.1 cases per 100,000 by December 2013. In FY 2013, CDC will enhance surveillance systems and designate five Integrated Food Safety Centers of Excellence at state health departments. In addition to working with manufacturers to

implement preventive controls, the Budget proposes an FDA food inspection and food facility registration user fee that will aid in providing resources to FDA to ensure the safety and security of the Nation's food supply.

ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

Biomedical and Behavioral Research: The FY 2013 Budget maintains funding for the NIH at the FY 2012 level of $30.9 billion, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that spurs economic growth while advancing medical science to improve health. NIH is generating discoveries that are opening new avenues for disease treatment and prevention and revolutionizing patient care. In FY 2013, NIH will seek to take advantage of such discoveries by investing in basic research on the fundamental causes and mechanisms of disease, accelerating discovery through new technologies, advancing translational sciences, and encouraging new investigators and new ideas.

National Center for Advancing Translational Sciences: In FY 2013, NIH will continue to implement the new National Center for Advancing Translational Sciences (NCATS), established in FY 2012, in order to re-engineer the process of translating scientific discoveries into new medical products. Working closely with partners in the regulatory, academic, nonprofit, and private sectors while not duplicating work going on in the private sector, NCATS will strive to identify innovative solutions to overcome hurdles that slow the development of effective treatments and cures. A total of $639 million is proposed for NCATS in FY 2013, including $50 million for the Cures Acceleration Network.

Medical Countermeasure Development: The HHS Medical Countermeasure Enterprise includes initiatives across the Department covering the spectrum of medical countermeasure development, from early biological research to stockpiling of approved products. The FY 2013 Budget includes $547 million for the Biomedical Advanced Research and Development Authority, an increase of $132 million over FY 2012, to develop and improve next-generation medical countermeasures (MCM) in response to potential chemical, biological, radiological, and nuclear threats. The Budget also provides $50 million to establish a strategic investment corporation that would function as a public-private venture capital fund providing companies developing MCMs with the necessary financial capital and business acumen to improve the chances of successful development of new MCM technologies and products. Together, these investments will provide HHS with new tools to enhance the success of medical countermeasure development.

Enhancing Health Care Decision-Making: The HHS Budget includes $599 million for research that compares the risk, benefits, and effectiveness of different medical treatments and strategies, including health care delivery, medical devices, and drugs, including $78 million from the Patient-Centered Outcomes Research Trust Fund established by the Affordable Care Act. Evidence generated through this research is intended to help patients make informed health care decisions that best meet their needs. This level of funding will primarily support research conducted by NIH, core research activities within the Agency for Healthcare Research and Quality, and data capacity activities within the Office of the Secretary. Resources from the Trust Fund will support comparative clinical effectiveness research dissemination, improved research infrastructure, and training of patient-centered outcomes researchers. HHS core research will be coordinated to complement projects supported through the Trust Fund and through the independent Patient-Centered Outcomes Research Institute.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORK FORCE

Investing in Infrastructure: A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes $677 million, an increase of $49 million over FY 2012, within the Health Resources and Services Administration to expand the capacity and improve the training and distribution of primary care, dental, and pediatric health providers. The Budget will support the placement of more than 7,100 primary care providers in underserved areas and begin investments that expand the capacity of institutions to train 2,800 additional primary care providers over five years.

The FY 2013 Budget also supports state and local capacity for core public health functions. Within the Prevention Fund allocation, CDC will invest

$20 million in new activities to coordinate with public health laboratories to improve efficiency through proven models, such as regionalizing testing in multi-state laboratories. To ensure an effective public health workforce, the Budget requests $61 million, of which $25 million is through the Prevention Fund, for the CDC public health workforce to increase the number of trained public health professionals in the field. CDC's experiential fellowships and training programs create a prepared and sustainable health workforce to meet emerging public health challenges. In addition, the Budget requests $40 million in the Prevention Fund to maintain support for CDC's Public Health Infrastructure Program. This program will assist health departments in meeting national public health standards and will increase the capacity and ability of health departments in areas such as information technology and data systems, workforce training, and regulation and policy development.

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILIY OF HHS PROGRAMS

Living Within our Means: HHS is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. The FY 2013 discretionary request demonstrates this commitment by maintaining ongoing investments in areas most central to advancing the HHS mission while making reductions to lower priority areas, reducing duplication, and increasing administrative efficiencies. Overall, the FY 2013 request includes over $2.1 billion in terminations and reductions to fund initiatives and provide net deficit reduction. Many of these reductions, such as the $452 million cut to the Low Income Home Energy Assistance Program, the $177 million cut to the Children's Hospital Graduate Medical Education Payment Program, and the $327 million cut to Community Services Block Grants, are necessitated by the current fiscal environment.

In September 2011, the Administration detailed a plan for economic growth and deficit reduction. The FY 2013 Budget follows this blueprint in its legislative proposals for Medicare and Medicaid, presenting a package of proposals that would save an estimated $358.5 billion over 10 years. Medicare savings would total $302.8 billion over 10 years by adjusting the structure of the Medicare benefit to encourage beneficiaries to seek value in their health care choices, and encouraging high-quality, efficient care, and increasing the availability of generic drugs and biologics. The Budget includes $55.7 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the FY 2013 discretionary budget request and these legislative proposals allow HHS to support the Administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Program Integrity and Oversight: The FY 2013 Budget continues to make program integrity a top priority. The Budget includes $610 million in discretionary funding for Health Care Fraud and Abuse Control (HCFAC), the full amount allowed under the Budget Control Act of 2011 (BCA). The Budget also proposes to fully fund discretionary program integrity initiatives at $581 million in FY 2012, consistent with the BCA. The discretionary investment supports the continued reduction of the Medicare fee-for-service improper payment rate; investments in prevention-focused, data-driven initiatives like predictive modeling; cost-avoidance activities; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives, including Medicare Strike Force teams and fighting pharmaceutical fraud.

From 1997 to 2011, HCFAC programs have returned over $20.6 billion to the Medicare Trust Funds, and the current three-year return-on-investment of 7.2 to 1 is the highest in the history of the HCFAC program. The Budget proposes a 10 year discretionary investment yielding a conservative estimate of $11.3 billion in Medicare and Medicaid savings and 16 program integrity proposals to build on the Affordable Care Act's comprehensive fraud fighting authorities for savings of an additional $3.6 billion over 10 years.

Additionally, the Budget includes funding increases for significant oversight activities. The request includes $84 million for the Office of Medicare Hearings and Appeals, an increase of $12 million, to continue to process the increasing number of administrative law judge appeals within the statutory 90-day timeframe while maintaining the quality and accuracy of its decisions. The Budget also includes $370 million in discretionary and mandatory funding for the Office of Inspector General (OIG), a 4 percent increase from FY 2012. This increase will enable OIG to expand CMS Program Integrity efforts in areas such as HEAT, improper payments, and focus on investigative efforts on civil fraud,

oversight of grants, and the operation of new Affordable Care Act programs.

Furthermore, the Affordable Care Act expands Durable Medical Equipment (DME) Competitive Bidding; a program which will save Medicare $25.7 billion over 10 years and help millions of Medicare beneficiaries save $17.1 billion over 10 years, as a result of competitive pricing, while continuing to ensure access to quality medical equipment from accredited suppliers. Additionally, the Budget proposes to extend some of the efficiencies of DME Competitive Bidding to Medicaid by limiting Federal reimbursement on certain DME services to what Medicare would have paid in the same state for the same services. This proposal is expected to save Medicaid $3.0 billion over 10 years.

Consolidate and Improve Activities Related to Prevention and Behavioral Health: The Budget includes $500 million within SAMHSA for new, expanded, and refocused substance abuse prevention and mental health promotion grants to states and tribes. To maximize the efficiency and effectiveness of its resources, SAMHSA will use competitive grants to identify and test innovative prevention practices and will leverage state and tribal investments to foster widespread implementation of evidence-based prevention strategies.

The Budget also consolidates funding for initiatives aimed at addressing chronic disease prevention. Chronic diseases and injuries represent the major causes of morbidity, disability, and premature death and heavily contribute to the growth in health care costs. The Budget aims to improve the health of individuals by focusing on prevention of chronic diseases and injuries rather than focusing solely on treating conditions that could have been prevented. Specifically, the Budget allocates $379 million, an increase of $129 million over FY 2012, to a new integrated grant program in CDC that refocuses disease-specific grants into a comprehensive program that will enable health departments to implement the most effective strategies to address these leading causes of death. Because many inter-related chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the burden of chronic disease.

COMPLETE THE IMPLEMENTATION OF THE RECOVERY ACT

The American Recovery and Reinvestment Act provided $140 billion to HHS programs, of which $110 billion had been spent by grant and contract recipients by the end of FY 2011. The vast majority of these funds helped state and local communities cope with the effects of the economic recession. Thousands of jobs were also created or saved, including subsidized employment and training for over 260,000 people through the Temporary Assistance for Needy Families (TANF) program Emergency Contingency Fund.

The Recovery Act provided states fiscal relief through a temporary increase in Federal matching payments of $84 billion for Medicaid and foster care and adoption assistance.

HHS Recovery Act funds are also making long-term investments in the health of the American people and the health care system itself. Beginning in FY 2011 and continuing for the next few years, HHS will invest more than $20 billion to support the implementation of health IT in the health care industry on a mass scale. This effort is expected to significantly improve the quality and efficiency of the U.S. health care system. In addition, $10 billion in Recovery Act funds were invested in biomedical research programs around the country, including a major effort to document genomic changes in 20 of the most common cancers and to build research laboratory capacity. Of more immediate impact, $1 billion has been supporting prevention and wellness programs, including projects in 44 communities with a total combined population of over 50 million aimed at reducing tobacco use and the chronic diseases associated with obesity.

HHS has also met the challenges of transparency and accountability in the management of its Recovery Act funds. More than 23,000 grantees and contractors with Recovery Act funding from HHS discretionary programs have submitted reports on the status of their projects over the last 10 quarters. More than 99 percent of the required recipient reports have been submitted on time and are available to the public on Recovery.gov; non-filers have been sanctioned. Finally, HHS Recovery Act program managers are working closely with the HHS Council on Program Integrity to ensure that risks for fraud, abuse, and waste are identified and steps are taken to mitigate those risks.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2011	2012	2013	2013 +/- 2012
Food and Drug Administration				
Budget Authority	2,404	2,508	2,519	+11
Outlays	1,985	2,574	2,499	-75
Health Resources and Services Administration				
Budget Authority	9,867	8,377	8,576	+199
Outlays	8,780	9,113	8,651	-462
Indian Health Service				
Budget Authority	4,228	4,464	4,581	+117
Outlays	4,176	4,972	4,722	-250
Centers for Disease Control and Prevention				
Budget Authority	6,473	6,857	6,218	-629
Outlays	6,740	6,760	6,400	-360
National Institutes of Health				
Budget Authority	30,620	30,852	30,852	–
Outlays	34,353	31,567	30,464	-1,103
Substance Abuse and Mental Health Services Administration				
Budget Authority	3,467	3,435	3,257	-178
Outlays	3,413	3,434	3,405	-29
Agency for Healthcare Research and Quality				
Program Level	392	405	409	+4
Outlays	115	294	145	-149
Centers for Medicare & Medicaid Services /1				
Budget Authority	773,825	757,220	823,166	+65,946
Outlays	773,504	757,068	829,307	+72,239
Administration for Children and Families /2				
Budget Authority	50,908	50,139	50,308	+169
Outlays	54,208	50,722	50,902	+180
Administration on Aging				
Budget Authority	1,507	1,492	1,949	+457
Outlays	1,555	1,491	1,752	+261

1/ Budget Authority includes Non-CMS budget authority for Hospital Insurance and Supplementary Medical Insurance for the Social Security Administration and Medicare Payment Advisory Commission.

2/ Includes rescission of $25 million in prior year Refugee funds.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2011	2012	2013	2013 +/- 2012
Office of the National Coordinator				
Budget Authority	42	16	26	+10
Outlays	463	971	419	-552
Medicare Hearings and Appeals				
Budget Authority	72	87	84	-3
Outlays	71	72	84	+12
Office for Civil Rights				
Budget Authority	43	41	39	-2
Outlays	41	42	40	-2
Departmental Management				
Budget Authority	694	529	541	+2
Outlays	371	657	440	-217
Prevention and Wellness				
Recovery Act Budget Authority	–	–	–	–
Outlays	22	18	–	-18
Health Insurance Reform Implementation Fund /3				
Budget Authority	–	–	–	–
Outlays	208	411	344	-67
Public Health and Social Services Emergency Fund				
Budget Authority	-584	568	642	+74
Outlays	1,702	1,898	1,881	-17
Office of Inspector General				
Budget Authority	50	50	59	+9
Outlays	94	75	60	-15
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)				
Budget Authority	556	606	626	+20
Outlays	701	1,009	621	-388
Offsetting Collections				
Budget Authority	-1,179	-1,224	-1,209	+15
Outlays	-1,179	-1,224	-1,209	+15
Total, Health and Human Services				
Budget Authority	**882,993**	**866,017**	**932,234**	**+66,217**
Outlays	**891,323**	**871,924**	**940,927**	**+69,003**
Full-Time Equivalents	73,704	74,948	76,341	+1,393

3/ Includes outlays for all agencies receiving resources from the fund.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

Discretionary Programs (Budget Authority): /1	FY 2011	FY 2012	FY 2013	FY 2013 +/- 2012
Food and Drug Administration	2,457	2,506	2,517	+12
Program Level	*3,690*	*3,832*	*4,486*	*+654*
Health Resources and Services Administration /2	6,272	6,215	6,077	-138
Program Level	*9,665*	*8,203*	*8,431*	*+288*
Indian Health Service	4,069	4,307	4,422	+116
Program Level	*5,140*	*5,386*	*5,502*	*+116*
Centers for Disease Control and Prevention	5,726	5,732	5,068	-664
Program Level	*10,995*	*11,196*	*11,236*	*+39*
National Institutes of Health /3	30,767	30,702	30,702	–
Program Level	*30,926*	*30,860*	*30,860*	–
Substance Abuse and Mental Health Services Administration	3,380	3,347	3,152	-196
Program Level	*3,599*	*3,565*	*3,423*	*-142*
Agency for Healthcare Research and Quality	–	–	–	–
Program Level	*392*	*405*	*409*	*+4*
Centers for Medicare & Medicaid Services /3 /4	3,587	3,820	4,821	+1,001
Program Level	*5,027*	*4,687*	*6,040*	*+1,353*
Administration for Children and Families	17,235	16,489	16,181	-309
Program Level	*17,241*	*16,495*	*16,186*	*-309*
Administration on Aging /3	1,998	1,971	1,978	+7
Program Level	*2,015*	*2,005*	*2,012*	*+7*
Office of the Secretary:				
General Departmental Management	480	474	306	-168
Program Level	*598*	*587*	*567*	*-21*
Office of Medicare Hearing and Appeals	70	72	84	+12
Office of the National Coordinator	42	16	26	+10
Program Level	*61*	*61*	*66*	*+5*
Office of Inspector General	50	50	59	+8
Program Level	*290*	*356*	*370*	*+14*
Office for Civil Rights	41	41	39	-2
Public Health and Social Services Emergency Fund	675	568	642	+74
Program Level	*1,090*	*983*	*1,057*	*+74*
Discretionary HCFAC /5	310	581	610	+29
Accrual for Commissioned Corps Medical Benefits	38	36	26	-10
Prevention Fund Activities Across HHS	–	*20*	*100*	*+80*
Discretionary Total /6	**77,198**	**76,928**	**76,711**	**-218**
One-time Rescissions /7	*-6,984*	*-6,768*	*-6,706*	*+62*
Discretionary Total Adjusted for Rescissions	**70,214**	**70,160**	**70,005**	**-156**

1/ Program level includes non-discretionary funding for activities traditionally funded with discretionary funding.

2/ The FY 2013 Budget transfers the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding is requested in HHS for FY 2013 and will be used to administer HEAL until the point of transfer. The funding level for HRSA without HEAL in FY 2013 is $6.074 billion.

3/ Figures for FY 2011 and FY 2012 include program transfers for comparability to the FY 2013 Budget.

4/ FY 2011 figure includes $176 million transfer from GDM. In FY 2011 and FY 2012, High-Risk Pool grants are displayed as discretionary funding for comparability with FY 2013.

5/ The President's Budget assumes an increase in the 2012 base funding to $311 million (which is fully offset) and the provision of an additional $270 million in funding allowed by the cap adjustment, consistent with the Budget Control Act of 2011.

6/ Includes amounts that count toward the discretionary caps, other than one-time rescissions.

7/ FY 2011 rescissions include $2.2B from CO-Ops, $3.5B from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) performance bonuses, $1.3B in flu balances and $25M from ACF. FY 2012 rescissions include $400M from CO-OPs and $6.37B from CHIPRA performance bonuses. The FY 2013 Federal Budget includes by $6.706B in proposed rescissions to CHIPRA performance bonuses. The FY 2013 Budget also includes General Provision language that would redirect $13M in unused abstinence education funding from ACF.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Mandatory Programs (Outlays):				
Medicare	480,202	479,553	523,749	+44,196
Medicaid	274,964	255,263	282,819	+27,556
Temporary Assistance for Needy Families /1	19,072	17,855	17,699	-156
Foster Care and Permanency	6,860	6,795	7,170	+375
Children's Health Insurance Program /2	8,633	9,903	10,227	+324
Child Support Enforcement	4,182	3,869	3,873	+4
Child Care	3,100	2,868	3,286	+418
Social Services Block Grant	1,787	1,908	1,792	-116
Other Mandatory Programs	7,185	10,987	10,929	-58
Offsetting Collections	-1,179	-1,224	-1,209	+15
Subtotal, Mandatory Outlays	804,806	787,777	860,335	+72,558
Total, HHS Outlays	**891,323**	**871,924**	**940,927**	**+69,003**

1/ Includes outlays for the TANF Contingency Fund and the Recovery Act's TANF Emergency Contingency Fund.

2/ Includes outlays for the Child Enrollment Contingency Fund.

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Program				
Foods	836	883	1,084	+201
Human Drugs	956	979	1,259	+280
Biologics	325	329	333	+4
Animal Drugs and Feeds	161	166	184	+18
Medical Devices	378	376	387	+11
National Center for Toxicological Research	61	60	59	-1
Center for Tobacco Products	421	455	482	+28
Headquarters and Office of the Commissioner	213	223	281	+58
FDA Consolidation at White Oak	42	44	62	+18
GSA Rental Payments	183	205	228	+23
Other Rent and Rent Related Activities	94	88	110	+23
Export Certification Fund	3	3	5	+1
Color Certification Fund	8	8	8	–
Priority Review Voucher User Fee	–	5	–	-5
Subtotal, Salaries and Expenses	3,681	3,823	4,481	+658
Buildings and Facilities	10	9	5	-3
Total, Program Level	**3,690**	**3,832**	**4,486**	**+654**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA) /1	667	702	713	+11
Medical Device (MDUFMA) /2	62	58	70	+12
Animal Drug (ADUFA)	19	22	31	+9
Animal Generic Drug	5	6	8	+2
Mammography Quality Standards Act (MQSA)	19	19	19	–
Family Smoking Prevention and Tobacco Control Act	450	477	505	+28
Export Certification Fund	3	3	5	+1
Color Certification Fund	8	8	8	–
Voluntary Qualified Importer Program (VQIP) Fee	–	–	–	–
Priority Review Voucher User Fee	–	5	–	-5
Food Reinspection Fee	–	15	15	+1
Food Recall Fee	–	12	13	+1
Subtotal, Current Law User Fees	1,233	1,326	1,386	+59
Proposed Law				
Food Registration and Inspection Fee	–	–	220	+220
Cosmetics Fee	–	–	19	+19
Food Contact Notification Fee	–	–	5	+5
Medical Products Reinspection Fee	–	–	15	+15
Biosimilars User Fee /3	–	–	20	+20
Human Generic Drug Fee /3	–	–	299	+299
International Courier User Fee	–	–	6	+6
Subtotal, Proposed Law User Fees	–	–	583	+583
Total, User Fees	**1,233**	**1,326**	**1,969**	**+643**
Total, Discretionary Budget Authority	**2,457**	**2,506**	**2,517**	**+12**
FTE	13,332	13,676	14,828	+1,152

1/ PDUFA expires October 1, 2012. FDA transmitted a reauthorization proposal to Congress on January 13, 2012.

2/ MDUFMA expires October 1, 2012.

3/ FDA transmitted a legislative proposal to Congress on January 13, 2012.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our Nation's food supply, cosmetics, and products that emit radiation. FDA also advances the public health by helping to speed innovations that make medicines more effective, safer, and more affordable, and by helping the public get the accurate, science-based, information they need to use medicines and foods to maintain and improve their health. Furthermore, FDA has responsibility for regulating the manufacture, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.

The FY 2013 Budget requests $4.5 billion for the Food and Drug Administration (FDA), a net program level increase of $654 million, or 17 percent, over FY 2012. The FDA Budget includes investments to continue to implement the FDA Food Safety Modernization Act (FSMA); advance medical countermeasures; improve the safety of the Nation's drugs and other medical products; facilitate greater trade with China by improving the safety of imports to the United States; and further develop and implement public health strategies to prevent youth from using tobacco and help adults to quit.

TRANSFORMING OUR FOOD SAFETY SYSTEM

The recent outbreak of listeria in cantaloupes are the latest illustration of the continuing need for a strong food safety system. FDA plays a critical role in helping to ensure that the food we eat is safe. The enactment of the FSMA in January 2011 provided FDA with the authority to address significant and longstanding gaps that have hindered the Agency's ability to protect U.S. food and feed supplies. These authorities include mandatory recall of tainted food and the ability to require food producers to implement preventative controls. In FY 2013, with a total funding level of $1.4 billion, FDA will continue to develop and implement an integrated national food safety system built on uniform regulatory program standards and strong oversight of the food supply.

The Budget proposes two user fees to enhance FDA's food safety efforts. The food inspection and food facility registration fee provides $220 million and will aid FDA with resources to ensure the safety and security of the Nation's food supply. With these resources, FDA will increase its capacity to establish an integrated national food safety system and further strengthen food safety inspection, response, and import review as mandated in FSMA. The food contact notification user fee provides $5 million to support FDA's food contact substance safety review program. Increased globalization of the packaging market and the continuing need for harmonization of various national standards for food packaging require a strong FDA presence in the food packaging arena, and the proposed user fee program will facilitate a stronger FDA presence.

ADVANCING MEDICAL COUNTERMEASURES

In recognition of our Nation's vulnerability to deliberate terrorist threats and naturally emerging infectious diseases, the President announced the Medical Countermeasure (MCM) Initiative in his 2010 State of the Union Address. In FY 2012, Congress provided $20 million for these activities. The FY 2013 President's Budget continues this priority initiative and increases the funding by $4 million to a total of $24 million.

With these resources, FDA will establish teams of public health experts to support the review of medical countermeasures and novel approaches to manufacturing MCMs. FDA will also examine the legal framework and the regulatory and policy approaches for MCM development and availability to ensure that they adequately support emergency preparedness and response.

PROTECTING PATIENTS

FDA is the global leader for regulating medical products. FDA regulatory actions assure that Americans have access to thousands of drugs and devices that are safe and effective for treating everything from seasonal allergies to life-threatening cancers. The FY 2013 Budget request will provide an investment of $1.7 billion for medical product safety.

The Budget proposes two new medical product user fees. The generic drug user fee provides $299 million to speed the approval of lower cost generic drugs, increasing access to the American public, and will have a positive impact on the entire health care system which relies on these lower-cost alternatives. The biosimilar user fee provides $20 million to

ensure sound funding for development of the scientific, regulatory, and policy infrastructure necessary for review of biosimilar applications, including resources for critical development-phase FDA consultation and review work. The Congressional Budget Office has estimated that the introduction of biosimilars, also known as generic biologics, to the health care system will generate approximately $7 billion in savings by the end of the decade.

REDUCING TOBACCO USE

Enacted in 2009, the Family Smoking Prevention and Tobacco Control Act provided FDA important new responsibilities for regulating the manufacture, marketing, and distribution of tobacco products, protecting public health, and reducing tobacco use by minors. In FY 2013, FDA will build on the regulatory and enforcement initiatives to protect the public health including: establishing tobacco product standards to reduce or eliminate harmful and potentially harmful ingredients found in tobacco products; expand its small business assistance program to help small tobacco manufacturers, distributors, and retailers comply with the Act; and implement public education campaigns to ensure that the public is educated and informed about the harms and addictiveness of tobacco product use. In total, the Budget includes $505 million in user fees for FDA to implement the Act.

Reducing the Sale of Tobacco to Minors

The Tobacco Control Act, passed in 2009, provides FDA with the authority to regulate tobacco products, including minimizing youth acquisition of these items. In an effort to ensure retailers do not sell tobacco products to minors, FDA began contracting with U.S. states for the purpose of conducting retail compliance inspections. FDA contracted with a total of 38 states in FY 2011 and conducted 24,419 compliance check inspections of retail establishments. In FY 2012, FDA plans to contract with additional states and fully implement the program in the states that already have contracts, allowing for a significant increase in the number of compliance check inspections of retail establishments that are able to be completed. FDA plans to more than triple the number of compliance check inspections to 84,000 in FY 2012 and 150,000 in FY 2013.

USER FEES

The Budget proposes seven new user fees, assumes the reauthorization of two user fees (prescription drug and medical device) that will expire on October 1, 2012, and reflects increases in existing user fees, which will provide critical resources for FDA to perform its public health mission. These fees add resources to FDA's budget and support specific activities conducted by the Agency.

In addition to the food safety and medical product user fees mentioned above, the Budget proposes three more user fees. The international courier user fee was proposed in FY 2012 and provides $6 million to support the activities related to the increased volume of FDA-regulated commodities, predominantly medical products, imported through express courier hubs. The cosmetic user fee provides $19 million to enhance international activities, improve communication and outreach, and improve the cosmetics science and research program. The reinspection fees, totaling $15 million, for medical products require manufacturers to pay the full costs of reinspections and associated follow-up work if they fail to meet FDA health and safety standards during an inspection.

FDA FACILITIES

The Budget requests $62 million for headquarters consolidation at the new FDA campus in White Oak, Maryland. These resources include $18 million to operationalize the Life Sciences Biodefense Laboratory at the White Oak facilities and enable FDA to continue to transition to the newly consolidated facility under construction by the General Services Administration The Life Sciences Biodefense Lab is an essential facility in protecting the Nation's blood supply and other biological products from emerging threats.

In FY 2013, the Budget provides $5 million to pay for necessary repair and maintenance of FDA-owned facilities nationwide.

Reauthorization of the Prescription Drug User Fee

The Prescription Drug User Fee Act (PDUFA) will expire October 1, 2012. This landmark legislation fundamentally changed the approval of prescription drugs, speeding the delivery of life-saving medications to the public. FDA published a notice in the Federal Register on September 12, 2011 to inform the public of proposed recommendations for PDUFA V reauthorization. FDA held a public meeting on October 24, 2011 to hear comments from the public. PDUFA V recommendations propose a total of $712 million for FY 2013 to enhance pre-market new drug and biologic review, ensure a strong financial footing for the PDUFA program, and transform the post-market safety system. The President's Budget supports the reauthorization of PDUFA.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Primary Care				
Health Centers	2,481	2,672	2,967	+295
ACA Mandatory (non-add)	*1,000*	*1,200*	*1,500*	*+300*
Health Centers Tort Claims	100	95	95	–
School Based Health Centers (ACA Mandatory)	50	50	50	–
Health Centers Construction (ACA Mandatory)	1,500	–	–	–
Free Clinics Medical Malpractice	.04	.04	.04	–
Hansen's Disease Programs	18	18	18	–
Subtotal, Primary Care	4,149	2,835	3,130	+295
Health Workforce				
National Health Service Corps	315	295	300	+5
ACA Mandatory (non-add)	*290*	*295*	*300*	*+5*
Training for Diversity	97	86	72	-15
Health Careers Opportunity Program (non-add)	*22*	*15*	–	*-15*
Health Workforce Information and Analysis	3	3	10	+7
Primary Care Training and Enhancement	39	39	51	+12
Oral Health Training	33	32	32	–
Pediatric Loan Repayment	–	–	5	+5
Interdisciplinary, Community-Based Linkages	72	71	39	-32
Area Health Education Centers (non-add)	*33*	*27*	–	*-27*
Behavioral Health Education and Training (non-add)	*3*	*13*	*8*	*-5*
Prevention Fund (non-add)	–	*10*	–	*-10*
Public Health Workforce Development	30	33	20	-14
Prevention Fund (non-add)	*20*	*25*	*10*	*-15*
Nursing Workforce Development	242	231	251	+20
Advance Education Nursing (non-add)	*64*	*64*	*84*	*+20*
Children's Hospital Graduate Medical Ed. (GME) Payments	268	265	88	-177
Teaching Health Centers GME Payments (ACA Mandatory)	230	–	–	–
Patient Navigator	5	–	–	–
Subtotal, Health Workforce	1,333	1,056	867	-188
Maternal and Child Health				
Maternal and Child Health Block Grant	656	639	640	+1
Heritable Disorders	10	10	10	–
Autism and Other Developmental Disorders	48	47	47	–
Traumatic Brain Injury	10	10	10	–
Sickle Cell Service Demonstrations	5	5	5	–
Universal Newborn Hearing Screening	19	19	19	–
Emergency Medical Services for Children	21	21	21	–
Healthy Start	104	104	104	–
Home Visiting (ACA Mandatory)	250	350	400	+50
Family to Family Health Info Centers (ACA Mandatory)	5	5	–	-5
Subtotal, Maternal and Child Health	1,128	1,208	1,255	+46

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
HIV/AIDS				
Emergency Relief - Part A	673	671	671	–
Comprehensive Care - Part B	1,308	1,356	1,422	+67
AIDS Drug Assistance Program (ADAP) (non-add)	*885*	*933*	*1,000*	*+67*
Early Intervention - Part C	206	215	236	+20
Children, Youth, Women, and Families - Part D	77	77	70	-8
Education and Training Centers - Part F	35	35	35	–
Dental Services - Part F	14	13	13	–
Public Health Service (PHS) Act Evaluation Funds	25	25	25	–
Subtotal, HIV/AIDS	2,337	2,392	2,472	+80
Health Care Systems				
Organ Transplantation	25	24	24	–
Cord Blood Stem Cell Bank	12	12	12	–
C.W. Bill Young Cell Transplantation Program	23	23	23	–
Poison Control Centers	22	19	19	–
340B Drug Pricing Program	4	4	10	+6
User Fee (non-add)	–	–	*6*	*+6*
Subtotal, Health Care Systems	87	83	89	+6
Rural Health				
Rural Health Outreach Grants	56	56	56	–
Rural Health Policy Development	10	10	10	–
Rural & Community Access to Emergency Devices	.24	1	–	-1
Rural Hospital Flexibility Grants	41	41	26	-15
State Offices of Rural Health	10	10	10	–
Radiogenic Diseases	2	2	2	–
Black Lung	7	7	7	–
Telehealth	12	12	12	–
Subtotal, Rural Health	138	138	122	-16
Other Activities				
Family Planning	299	294	297	+3
Program Management	162	160	163	+3
Vaccine Injury Compensation Program Direct Operations	6	6	6	–
Health Education Assistance Loan Direct Operations /1	3	3	3	–
National Practitioner Data Bank (User Fees)	20	28	28	–
Healthcare Integrity and Protection Data Bank (User Fees)	4	–	–	–
Total, Program Level	**9,665**	**8,203**	**8,431**	**+228**
Less Funds From Other Sources				
PHS Evaluation Funds	-25	-25	-60	-35
User Fees	-24	-28	-34	-6
ACA Mandatory Funding	-3,325	-1,900	-2,250	-350
Prevention Fund	-20	-35	-10	+25
Total, Funding from Other Sources	**-3,394**	**-1,988**	**-2,354**	**-366**
Total, Discretionary Budget Authority	**6,272**	**6,215**	**6,077**	**-138**
FTE	1,860	1,849	1,818	-31

1/ The FY 2013 Budget includes General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Within HRSA, funding for the administration of the HEAL program is requested in FY 2013 and will be used by HRSA to administer the HEAL program until the point of transfer. The total level of budget authority for HRSA without the HEAL program in FY 2013 is $6.074 billion.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration provides national leadership, program resources, and services needed to improve health care access for underserved populations.

The FY 2013 Budget includes $8.4 billion for the Health Resources and Services Administration (HRSA), a net increase of $228 million above FY 2012. HRSA is the principal Federal agency charged with improving access to health care to those in medically underserved areas and enhancing the capacity of the health care workforce. The FY 2013 Budget prioritizes investments in HRSA that will:

- Reduce barriers to care that contribute to disparities in health care utilization and health status;
- Support medical, dental, and mental and behavioral health care providers who bring their skills to areas with limited access to health care; and
- Assist states and communities to identify and address unmet service needs and workforce gaps in the health care system.

IMPROVING ACCESS TO HEALTH CARE IN UNDERSERVED AREAS

Health Centers: The Budget includes $3.1 billion for Health Centers, including $1.5 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund. The Budget will support more than 1,100 grantees that will provide comprehensive primary health care services to nearly 21 million patients at more than 8,700 delivery sites. In 2011, the Health Centers program created 67 new access points. Additionally, over 65 percent of health centers have fully acquired electronic health records systems. In FY 2013, HRSA will increase the number of health centers nationally recognized as Patient Centers Medical Homes by 25 percent, a crucial move in the national effort to build high-quality, comprehensive health care for those who need it most. The Budget also promotes a policy of steady and sustainable health center growth by managing Affordable Care Act resources over the long-term, including in years after FY 2015. This policy safeguards resources for existing health centers to continue services, and ensures available resources as mandatory appropriations decline and third party payments increase from expanded health insurance coverage under the Affordable Care Act.

The Health Centers budget also includes $95 million for the Health Centers Federal Tort Claims program which provides medical malpractice coverage for the increasing number of providers in health centers.

Improving Rural Health: The FY 2013 Budget includes $122 million for targeted rural health programs. This investment includes $56 million to continue collaborative models to improve health care access and quality for the 55 million Americans living in rural areas. The Budget provides $26 million to continue funding for all continuing Rural Hospital Flexibility grants; $20 million for research, technical assistance, and policy development to improve rural health outcomes; $12 million to expand access to quality care through telecommunications; and $7 million for screening and care for miners with occupation-related impairments.

IMPROVING CARE FOR AT-RISK POPULATIONS

HIV/AIDS: The Ryan White program provides services that reach over half a million individuals each year, representing the Federal Government's largest investment in the well-being of people living with HIV/AIDS. Recent scientific evidence shows that treatment not only improves and prolongs the lives of people living with HIV, but also drastically reduces the risk of spreading the virus. The FY 2013 request supports the National HIV/AIDS Strategy by including $2.4 billion, an increase of $80 million for the Ryan White program, to ensure that HIV-positive Americans get the best care and treatment possible. The total includes $1 billion for the AIDS Drug Assistance Program (ADAP), an increase of $67 million, to provided life saving and extending medications to 236,230 individuals, an additional 18,906 people living with HIV/AIDS. This significant Federal investment will provide access to lifesaving pharmaceuticals for all people living with HIV/AIDS eligible for ADAP, including those

individuals who have had difficulties getting medicines as states curtailed their programs. The Budget puts forth an investment based on current waiting lists projections, and with continued sufficient state contributions these resources will enable all people living with HIV/AIDS who lack access to health care to obtain life-saving medications. This approach is consistent with the National HIV/AIDS Strategy, which notes that success in reaching the goals is dependent on commitments from all parts of society.

In addition, the Budget provides $236 million, an increase of $20 million, to community-based providers who care for individuals with HIV/AIDS. These experienced providers care for individuals with HIV/AIDS in high-need areas with services including early intervention, core medical, and support services, as well as quality management, and administration.

Ryan White HIV/AIDS Program

A cornerstone of HIV/AIDS treatment and care is access and adherence to comprehensive antiretroviral medications. In FY 2013, $1 billion, an increase of $67 million, is requested for the Ryan White AIDS Drug Assistance Program, which provides these medications for low-income and underinsured individuals. In FY 2012, approximately 236,230 individuals are estimated to receive medications through the program.

Making Prescription Drugs Affordable: The FY 2013 request includes $10 million to improve access to potentially lifesaving drugs, an increase of $6 million above FY 2012, through the 340B program. Of the total requested, $6 million is funded through a new cost recovery fee. The fee will support increased monitoring of compliance with required price through manufacturers' reporting as the program expands. Participants in the 340B program include health centers, Indian Health Service tribal clinics, children's hospitals, critical access hospitals, Federally Qualified Health Centers and look-a-likes, and programs that target sexually transmitted disease and tuberculosis prevention and treatment.

BUILDING A HEALTH WORKFORCE FOR THE 21ST CENTURY

The Nation's health care system faces a growing demand for health care, particularly primary care, as the population ages and access to health services expands through reform. In order to enable more Americans to get the quality care they need to stay healthy, it is critical to make targeted investments that promote a sufficient health workforce.

The Budget includes a total of $867 million, including $310 million in mandatory funding, for programs that support the training and development of our Nation's health workforce with a particular emphasis on activities that promise to expand our health workforce capacity. Within this total, the Budget includes $88 million, a decrease of $177 million below FY 2012, to support the direct costs associated with training physicians within freestanding children's hospitals.

Health Workforce Capacity: The Budget includes $677 million, an increase of $49 million over FY 2012, to expand the number and improve the distribution of primary care, dental, and pediatric health providers.

In addition to supporting a National Health Service Corps field strength of over 7,100, the Budget will initiate investments that will expand the Nation's capacity to train 2,800 new primary care providers over five years. To this end, the Budget includes increases totaling $32 million over FY 2012 to expand the number of primary care nurse practitioners and physician assistants. It also includes an additional $5 million over FY 2012 for a new Pediatric Loan Repayment program to improve the distribution of pediatric specialists.

Data Collection and Analysis: Additionally, the Budget includes $10 million, an increase of $7 million over FY 2012, to support the National Center for Health Workforce Analysis. The Nation currently lacks cohesive and comprehensive information on the health workforce. Such data is essential for developing an approach to assessing and addressing health workforce shortages. The Budget will support the Center's work to develop reliable methodologies to analyze the Nation's health workforce and provide accurate data to inform both public and private policies and investments.

SUPPORTING HEALTHY FAMILIES

The Budget includes $1.3 billion to support federal and state partnerships that provide access to quality care to more than 30 million infant and children, such as cross-cutting programs and initiatives that support innovative solutions to improve maternal and child health and the quality of health services for the maternal and child health population.

Improving Maternal and Child Health: The FY 2013 Budget provides $1.3 billion to improve maternal and child health. This total includes $400 million in mandatory funding provided through the Affordable Care Act to implement evidence-based home visiting programs to improve health and developmental outcomes for families in at-risk communities. The request includes $640 million, an increase of $1 million, for the Maternal and Child Health Block Grant. The Budget includes $104 million, the same level as FY 2012, for 104 Healthy Start programs that reduce the incidence of risk factors that contribute to infant mortality and provide services to mothers in high-risk communities. Additionally, $47 million will go towards supporting children with autism spectrum disorders and their families through research, screening, and the promotion of evidence-based interventions.

The Budget includes $64 million for activities authorized under Traumatic Brain Injury, Universal Newborn Hearing Screening, and Emergency Medical Services for Children, which continue to provide targeted funding to communities in need of these services.

Expanding Access to Family Planning Services: The FY 2013 Budget includes $297 million, an increase of $3 million, to expand family planning services to low-income individuals by improving access to family planning centers and preventative services. This funding will provide services to nearly 5 million low-income women and men at more than 4,500 clinics each year.

Patient-Centered Medical Homes

Patient-centered medical homes emphasize care coordination and communication to transform primary care into what patients want it to be. Research shows that medical homes can lead to higher quality and lower costs and improve patients' and providers' reported experiences of care.

The HRSA Patient-Centered Medical Home initiative pays the costs of federally-qualified health centers and community health centers to become National Committee for Quality Assurance (NCQA)-recognized medical homes.

In FY 2011, HRSA awarded $47 million to support the training of 904 health center sites to provide upfront assistance to existing health centers. In FY 2013, over 25 percent of Health Centers will make the practice changes necessary to achieve NCQA recognition.

PROGRAM MANAGEMENT AND PUBLIC HEALTH ACTIVITIES

Program Management: The Budget requests $163 million to fund the infrastructure necessary to operate HRSA programs including rent, information technology, utilities, security, and agency oversight.

National Vaccine Injury Compensation Program: The Budget requests $6 million for the National Vaccine Injury Compensation Program to prepare for projected increases in claims and to continue reviews of over 5,600 claims from autism proceedings.

Supporting Transplantation: The Budget includes $59 million to support organ, bone marrow, and cord blood stem cell transplantation. Out of this total, $47 million supports a national system to ensure the fair allocation and distribution of organs and life-saving bone marrow transplants. It also includes $12 million to support the collection of approximately 7,500 new cord blood units by the end of FY 2013.

INDIAN HEALTH SERVICE

(dollars in millions)

	2011	2012	2013	2012 +/- 2013
Services				
Clinical Services:	3,877	4,006	4,108	+103
Contract Health Services (non add)	*780*	*844*	*898*	*+54*
Health Information Technology (non add)	*169*	*172*	*177*	*+5*
Preventive Health	144	147	151	+4
Contract Support Costs	398	471	476	+5
Tribal Management/Self-Governance	9	9	9	–
Urban Health	43	43	43	–
Indian Health Professions	41	41	41	–
Direct Operations	69	72	73	+1
Diabetes Grants	150	150	150	–
Subtotal, Services	4,730	4,938	5,049	+111
Facilities				
Health Care Facilities Construction	39	85	81	-4
Sanitation Facilities Construction	96	80	80	–
Facilities and Environmental Health Support	193	199	204	+4
Maintenance and Improvement	60	61	63	+2
Medical Equipment	23	23	23	–
Subtotal, Facilities	410	448	451	+3
Total, Program Level	**5,140**	**5,386**	**5,502**	**+116**
Less Funds From Other Sources				
Health Insurance Collections	-915	-922	-922	–
Rental of Staff Quarters	-6	-8	-8	–
Diabetes Grants 1/	-150	-150	-150	–
Total, Budget Authority	**4,069**	**4,307**	**4,422**	**+116**
FTE	15,485	15,614	15,773	+159

1/ These mandatory funds were appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008, and P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010.

INDIAN HEALTH SERVICE

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

The FY 2013 Budget requests $5.5 billion for the Indian Health Service (IHS), an increase of $116 million over FY 2012. The FY 2013 Budget prioritizes reducing health disparities in Indian Country though purchased care with the Contract Health Services program and by providing staff for new facilities. The Budget also supports Indian self-determination by supporting tribes that administer the health programs and facilities in their area. This expansion is a continuation of the Administration's policy to work toward fulfillment of the Federal Government's obligations to American Indians and Alaska Natives. The IHS discretionary budget has increased 32 percent since FY 2008.

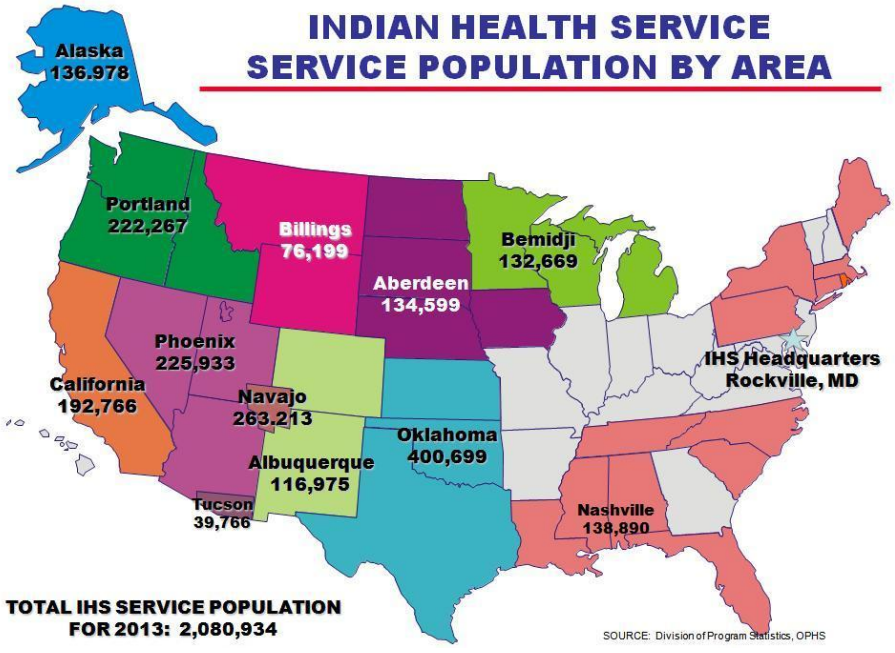
FULFILLING THE UNIQUE ROLE OF THE INDIAN HEALTH SERVICE

IHS, in partnership with the tribes, provides primary care, behavioral and community health, and sanitation services for a growing population of more than two million eligible American Indians and Alaska Natives. IHS and the tribes deliver comprehensive health services to members of more than 560 federally-recognized tribes through direct services in 45 hospitals; 320 health centers; and 287 health stations, school health centers, and Alaska village clinics. As part of the unique relationship between tribes and the Federal Government, IHS provides American Indians and Alaska Natives with preventive health care and direct medical care and contracts with hospitals and health care providers outside the IHS system to purchase care it cannot provide through its own network. IHS works with tribes to ensure their maximum participation in administering the programs that impact their communities. In addition to the provision of health care services, IHS builds sanitation systems to provide water and waste disposal for Indian homes; supports tribal self-governance through contract funding; and provides scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, to serve in areas with high provider vacancies.

STRENGTHENING THE INDIAN HEALTH SYSTEM

The Budget includes an increase of $116 million to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives.

Contract Health Services: The Budget includes $898 million, an increase of $54 million over FY 2012, and an increase of 55 percent since FY 2008, for the purchase of medical care from outside the IHS in cases where no IHS facility is available or when the IHS facility cannot provide the



services needed. In many areas, current funding levels limit services to cases involving potential loss of life or limb. The increase will support essential services such as inpatient and outpatient care, routine and emergency care, and medical support services such as diagnostic imaging, physical therapy, and laboratory services. These funds allow IHS to cover the cost of care for injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death among American Indians and Alaska Natives.

Construction: The Budget includes $81 million for Health Care Facilities Construction to continue outpatient facilities in San Carlos and Kayenta, Arizona. Once completed, these facilities are projected to collectively serve a user population of 29,623 patients.

Staffing New and Renovated Health Facilities: The Budget includes an additional $49 million to support staffing and operating costs for six new or expanded health facilities to be completed by FY 2013. Five of the facilities are joint venture projects in which IHS is partnering with a tribal entity, providing funds for staffing, equipping, and operating a facility, and the participating tribes cover the costs of design and construction. When these facilities are fully operational, they are projected to collectively serve a user population of 48,398 patients.

Health Insurance Reimbursements: In FY 2013, IHS estimates it will receive approximately $922 million in health insurance reimbursements through Medicare, Medicaid, and private insurers. These funds are essential for covering the costs of hiring additional medical staff, purchasing equipment, making necessary building improvements, and maintaining accreditation standards.

National Health Service Corps (NHSC)

IHS has partnered with HRSA to increase the number of IHS facilities eligible to participate in the NHSC. Participation in the NHSC will help IHS recruit and retain health providers. The number of IHS sites that are eligible to participate has increased from 102 in FY 2010 to 490. The number of NHSC providers placed in IHS facilities has already increased from 199 to 221, and the NHSC provided an additional 128,200 patient visits.

Program Integrity: IHS has initiated efforts to ensure IHS providers, staff, and managers have the knowledge, training, and support necessary to successfully perform their duties and ensure the IHS service population receives quality care. The Budget includes an increase of $1 million to strengthen oversight and ensure IHS policies for quality of care, human resources, and financial management are effectively implemented.

SUPPORTING INDIAN SELF-DETERMINATION

IHS recognizes that the tribes and tribal organizations are the most knowledgeable about the type of services needed in their communities and that the planning and delivery of health services at the local level ensures effective, quality health care. About 54 percent of the IHS budget is administered by tribes through the authority provided to them under the Indian Self-Determination and Education Assistance Act of 1975, which allows tribes to assume the administration of programs that were previously carried out by the Federal Government.

Ensuring Access to Care

The FY 2013 Budget prioritizes Contract Health Service funding for the fourth year. The Budget provides $898 million, an increase of $54 million over FY 2012, to cover the cost of care purchased outside the IHS system.

In many IHS areas, Contract Health Service funds only allow for coverage of cases involving potential loss of life or limb. The funding increase will cover the rising costs associated with medical inflation and will support an additional 31,705 outpatient visits, 1,116 patient travel trips, and 848 inpatient admissions, thereby reducing the number of cases deferred or denied. These funds, coupled with increases in recent years, are allowing some IHS areas to cover some preventive and specialty services.

Contract Support Costs: The Budget funds contract support costs at $476 million, an increase of $5 million over FY 2012 and an increase of 78 percent since FY 2008. Contract support funding enables tribes to develop the infrastructure needed to administer Federal programs. These funds provide tribes with additional support in the operation of their own health programs.

Consultation: One of the key components of the government-to-government relationship with the tribes is consultation, a process in which tribal governments and organizations play an integral role in the HHS budget and policy decision-making processes. In addition to extensive solicitation of tribal input on local-, area-, and national-level IHS operations, HHS holds an annual department wide budget consultation. This process gives tribal leaders the opportunity to identify their budget priorities, which are reflected in the FY 2013 Budget. In response to the President's Executive Order reaffirming the importance of consultation, IHS is continuing to work with tribes to improve its consultation practices and has incorporated the implementation of tribal recommendations into the IHS portion of the HHS Strategic Plan. Last year, IHS implemented seven tribal recommendations on the consultation process, including the formation of the IHS Director's Tribal Advisory Workgroup on Consultation and the posting of all letters to tribal leaders on the director's blog.

Recovery Funds have Improved IHS Infrastructure

Through the Recovery Act, IHS is increasing access to quality health care with construction and facility improvements for the American Indians and Alaska Natives living in rural and isolated communities.

- The new 138,000 square foot, 10-bed Cheyenne River Health Center in Eagle Butte, SD opened January 16, 2012. The first baby was born at the hospital the following week.
- The Nome, Alaska, hospital is 75 percent complete and is expected to open by December 2012. It will serve a population of 10,000 Alaska Natives over an area of 44,000 square miles.
- In partnership with Environmental Protection Agency Recovery Act programs, an additional 15,185 American Indian and Alaska Native homes now have safe drinking water.
- Recovery Act funds have allowed IHS to make inroads in reducing the backlog of essential maintenance and repairs of health care facilities. Of the 304 projects at more than 210 health care sites nationwide, over 70 percent have been completed.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	FY 2011	FY 2012	FY 2013	FY 2013 +/- 2012
Immunization and Respiratory Disease	748	779	721	-58
Section 317 Discretionary Program (non-add)	*589*	*621*	*562*	*-59*
Prevention Fund (non-add)	*100*	*190*	*72*	*-118*
Pandemic Influenza (non-add)	*156*	*155*	*155*	–
Balances from P.L. 111-32 Pandemic Flu (non-add)	*156*	–	*51*	*+51*
Vaccines For Children /1	3,953	4,006	4,271	+265
HIV/AIDS, Viral Hepatitis, STDs and TB Prevention	1,116	1,110	1,146	+36
Prevention Fund (non-add)	–	*10*	–	*-10*
Emerging and Zoonotic Infectious Diseases	304	304	331	+27
Prevention Fund (non-add)	*52*	*52*	*52*	–
Chronic Disease Prevention and Health Promotion	1,075	1,183	1,145	-39
Prevention Fund (non-add)	*301*	*427*	*512*	+85
Birth Defects, Developmental Disabilities, Disability & Health	136	137	126	-12
Prevention Fund (non-add)	–	–	*107*	*+107*
Environmental Health	170	140	133	-7
Prevention Fund (non-add)	*35*	*35*	*29*	*-6*
Injury Prevention and Control	144	138	138	–
Prevention Fund (non-add)	–	–	–	–
Public Health Scientific Services	468	462	505	+43
Prevention Fund (non-add)	*72*	*70*	*90*	+20
Occupational Safety & Health	387	467	420	-47
World Trade Center Program - Discretionary (non-add)	*22*	–	–	–
World Trade Center Program - Mandatory (non-add) /2	*71*	*174*	*171*	*-4*
Energy Employee Occupational Illness Compensation Program	55	55	55	–
Global Health	340	348	363	+15
CDC-Wide Activities and Program Support				
Preventive Health and Health Services Block Grant	80	80	–	-80
Public Health Leadership and Support	163	160	160	–
Prevention Fund (non-add)	*41*	*41*	*41*	–
Buildings and Facilities	–	25	–	-25
Business Services Support	362	395	369	-26
Subtotal, CDC-Wide Activities and Program Support	605	659	529	-131
Public Health Preparedness and Response				
State and Local Preparedness and Response Capability	664	657	642	-16
Prevention Fund (non-add)	*10*	–	–	–
CDC Preparedness and Response Capability	160	138	147	+9
Strategic National Stockpile	591	534	486	-47
Balances from P.L. 111-32 Pandemic Flu (non-add)	*69*	*30*	*47*	*+17*
Subtotal, Public Health Preparedness and Response	1,415	1,329	1,275	-54
Agency for Toxic Substances and Disease Registry	77	76	76	–
User Fees	2	2	2	–
Subtotal, Program Level	**10,995**	**11,196**	**11,236**	**+39**
Less Funds Allocated from Other Sources				
Vaccines for Children (mandatory)	-3,953	-4,006	-4,271	-265
Energy Employee Occupational Injury Comp. Prog. (mandatory)	-55	-55	-55	–
World Trade Center Program (mandatory)	-71	-174	-171	4
PHS Evaluation Fund Transfers	-352	-371	-668	-296
Balances from P.L. 111-32 Pandemic Flu	-225	-30	-98	-68
Prevention Fund	-611	-825	-903	-78
User Fees	-2	-2	-2	–
Total, Discretionary Budget Authority	**5,726**	**5,732**	**5,068**	**-664**
Total, Discretionary Program Level	**6,305**	**6,135**	**5,835**	**-301**
FTE	10,673	10,623	10,613	-10

1/ The FY 2011 level reflects actual obligations. The FY 2012 estimate reflects the anticipated transfer from Medicaid and does not include $3.1 million in recoveries and refunds for a total program level of $4.009.060 billion. The FY 2013 estimate reflects the anticipated transfer from Medicaid.

2/ The FY 2011 level reflects actual Federal obligations. The FY 2012 and FY 2013 levels reflect estimated Federal obligations.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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

The FY 2013 Budget request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.2 billion, an increase of $39 million above FY 2012. This total includes $903 million of the $1.25 billion available from the Prevention and Public Health Fund (Prevention Fund).

The Budget request increases support for core programs, such as domestic HIV/AIDS prevention; food safety; surveillance for healthcare associated infections (HAI); health statistics; global polio eradication; and improving the efficiency of state laboratories. The Budget prioritizes streamlined agency operations and includes targeted programmatic savings for completed, duplicative, and one time activities funded in FY 2012. The Budget request also carries forward $20 million in CDC wide contract and administrative savings enacted in FY 2012.

In addition, the Budget consolidates disease specific funding throughout the Agency to create comprehensive programs that enable state and local health departments to maximize public health impact by addressing the greatest needs in their communities. This new approach will improve overall health outcomes while also enhancing accountability around use of Federal resources.

HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

The Budget provides $1.1 billion for domestic HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STD), and Tuberculosis (TB), an increase of approximately $36 million above FY 2012. This net increase includes a $40 million increase for domestic HIV/AIDS and a $5 million decrease for TB prevention.

The Budget supports the goals of the National HIV/AIDS Strategy, focusing resources on high risk populations and allocating funds to state and localhealth departments to align resources to better match the burden of the epidemic across the United States.

Of the $40 million increase, $10 million will support implementation, data collection, and guideline development for national organizations and state and local education and health agencies to implement science based interventions in school settings to prevent HIV, STDs, and teen pregnancy. CDC will use the remaining $30 million increase to lower the HIV transmission rate; decrease the risk behaviors among persons at risk for acquiring HIV; increase the proportion of HIV infected people who know they are infected; and integrate services for populations most at risk of HIV, STDs, and Viral Hepatitis. In addition, the Budget provides both CDC and states the authority to transfer 10 percent of funds associated with the HIV/AIDS, Viral Hepatitis, STD, and TB lines across each budget line to improve coordination and service integration.

In FY 2013, CDC will use the $136 million requested for TB prevention to work with states to focus on the most urgent cases. CDC, in collaboration with its state and local partners, has implemented effective control efforts that have reduced TB cases to 11,181 in 2010, the lowest number of overall U.S. TB cases since national reporting began in 1953.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

CDC detects and tracks a range of microbes, responds to outbreaks of known infectious threats, and uses surveillance systems to quickly identify new infectious threats as they emerge. The FY 2013 Budget includes $331 million for Emerging and Zoonotic Infectious Diseases, an increase of $27 million above FY 2012. The budget for Emerging and Zoonotic Infectious Diseases includes targeted programmatic funding reductions to reduce low impact, disease specific programs and increases in funding for the detection and control of infectious diseases, the National Healthcare Safety Network,

and food safety. CDC will also use resources allocated from the Prevention Fund to support building states' epidemiology and laboratory capacity and implementing evidence based strategies to prevent HAI.

The Budget request includes an increase of $17 million above FY 2012 to support CDC's role in implementing the Food Safety Modernization Act. CDC will improve the detection and tracking of foodborne illness by strengthening data collection, analysis, and reporting, as well as by focusing on data usefulness. Public health practitioners will use this data to speed detection of and response to outbreaks. In addition, CDC will support five integrated Food Safety Centers of Excellence throughout the country at state health departments. These centers will identify and implement best practices in foodborne diseases surveillance, serve as model surveillance sites, and provide technical assistance and training for public health professionals at state, local, and regional levels across the country.

IMMUNIZATION AND RESPIRATORY DISEASES

Childhood vaccination coverage rates are at near record high levels and, as a result, cases of most vaccine preventable diseases in the United States are at or near record lows. Ensuring high immunization coverage levels, vaccine safety monitoring, and vaccine effectiveness studies are critical for preventing recurrent epidemics of diseases that could result in preventable illness, disability, and death.

CDC's $4.8 billion immunization program has two components: the mandatory Vaccines for Children (VFC) program, which in FY 2013 is estimated to be $4.3 billion, and the discretionary Section 317 program, which is funded at $562 million in the Budget. These two programs combined provide approximately 53 percent of the pediatric vaccines and 31 percent of the adolescent vaccines distributed in the United States each year. The discretionary Section 317 program provides funds to support state immunization infrastructure and operational costs and supplies many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2013 Budget includes $562 million for the Section 317 program, $59 million below FY 2012, a decrease due to one time activities funded in the Prevention Fund in FY 2012. Expansion of health reform will further increase access to immunization and decrease the number of uninsured and underinsured individuals served by the 317 program, resulting in cost savings.

Within this total, $25 million will continue demonstration projects to enable health departments to bill private insurance for immunization services provided to covered patients.

Preventing Disease through Immunization

The Affordable Care Act requires new health plans to cover recommended vaccines without charging a deductible, co-payment, or coinsurance. As health reform expands prevention services, the size of the uninsured and underinsured populations that the Section 317 Immunization Program serves is expected to decrease, resulting in program cost savings. In FY 2013, CDC is investing in state and local health department clinics to develop their capacity to bill private health insurance plans for immunization services provided to insured members. This approach will translate into significant cost savings which states can then use to increase outreach to at-risk populations with unmet needs.

PROMOTING HEALTH AND PREVENTING CHRONIC DISEASE

Chronic Disease Prevention and Health Promotion: Chronic diseases are among the most prevalent, costly, and preventable of all health problems. The Budget includes $1.1 billion, a decrease of $39 million below FY 2012, for Chronic Disease Prevention and Health Promotion, of which $512 million is funded through the Prevention Fund. While the Budget includes an increase of $140 million for the Coordinated Chronic Disease Program, cardiovascular disease prevention, and tobacco prevention, a net decrease is due to the elimination of the REACH program and one time funding from FY 2012.

The Budget allocates $146 million from the Prevention Fund for Community Transformation Grants, a decrease of $80 million below FY 2012. This level would fully fund all continuation and new grant awards in FY 2012 and 2013. The Community

Transformation Grant Program builds capacity to implement broad evidence and practice based policy, environmental, programmatic, and infrastructure changes in large counties and in states, tribes, and territories, including rural and frontier areas. These changes will lead to improved health outcomes for the most prevalent chronic illnesses. CDC will also use Prevention Fund resources to support the Million Hearts Initiative goal to reduce 1 million cardiovascular events over 5 years ($5 million), engage employers in wellness programs to promote health in the workplace where American adults spend much of their time ($4 million), and promote infant health through support of breastfeeding in hospitals ($2.5 million).

The Budget allocates $379 million, $129 million above FY 2012, for a coordinated grant program that refocuses activities from disease specific approaches into a Coordinated Chronic Disease Prevention and Health Promotion program that is more comprehensive in its approach to improve health outcomes and reduces health disparities by focusing on the leading causes of death and disability. Because many chronic disease conditions share common risk factors such as poor nutrition and physical inactivity, the new program will improve health outcomes by coordinating interventions that can simultaneously reduce the burden of multiple chronic diseases. CDC will fund state, local, and tribal health departments to strengthen chronic disease program coordination and support core activities such as surveillance, epidemiology, and evaluation. Investments will also support state, local, and tribal health departments to pursue fundamental public health improvement strategies, health systems change, and the promotion of clinical preventive service use. CDC will also provide performance awards for states that significantly improve health outcomes.

The Budget eliminates the REACH program and the Preventive Health and Health Services Block Grant because these activities are comparable to other CDC activities and CDC will address the goals of these activities through the Coordinated Chronic Disease Prevention Program and the Community Transformation Grants.

Birth Defects, Developmental Disabilities, Disability, and Health: The Budget includes $126 million for Birth Defects, Developmental Disabilities, Disability, and Health, $12 million below FY 2012, of which $107 million is funded through the Prevention Fund. The Budget eliminates activities with a limited public health impact and consolidates disease specific funding into three new competitive programs that are more comprehensive in their approaches to focus efforts on priority areas to maximize public health impact. In addition, in FY 2013, the Budget includes $21 million to support autism spectrum disorders research and surveillance.

PUBLIC HEALTH SCIENTIFIC SERVICES

The Budget includes $505 million, $43 million above FY 2012, of which $90 million is from the Prevention Fund, to strengthen and support the monitoring and analysis of key public health data and to use more efficient approaches to provide critical laboratory testing. Within the Prevention Fund allocation, CDC will invest $20 million in new activities to coordinate with public health laboratories to improve laboratory efficiencies through proven models, such as regionalizing testing in multi state laboratories. This initiative will support health departments' core work to maintain laboratory capacity. In addition, $10 million will maintain the development and dissemination of evidence based recommendations through CDC's Guide to

Building Local Public Health Capacity with the Prevention Fund

Of the $1.25 billion available through the Prevention and Public Health Fund in FY 2013, the Administration has allocated $903 million to CDC to reduce America's leading causes of disability, disease and death; promote early detection and response to disease outbreaks; grow the prevention workforce; and develop and spread evidence-based prevention strategies for the future. Prevention Fund programs are already delivering results. For instance, CDC-funded efforts supported 100,000 HIV tests to reduce the spread of disease and connect more people to care. They also supported the Guide to Community Preventive Services' rigorous analysis of community prevention programs to identify and promote what works. In addition, Prevention Fund resources are supporting more than 225 field investigations to stop outbreaks while training the next generation of public health leaders and enabling health departments to implement coordinated, effective, and proven chronic disease programs that promote healthy lifestyles.

Community Preventive Services, which policy makers, states, and communities rely on to implement interventions proven to work.

Health Surveillance and Statistics: The Budget includes $197 million for Health Surveillance and Statistics, an increase of $23 million over FY 2012. In FY 2013, CDC will use requested resources to obtain and use statistics to understand health problems; identify risk factors; support state electronic birth and death records implementation; guide programs and policy; and monitor the impact of health reform. Policy makers, researchers, and the public rely on data from these surveys to support decision making and research on health. Supporting electronic birth and death records is important to ensure accurate and complete reporting of vital events, conduct public health surveillance, and protect national security, as birth records are used to prove U.S. citizenship.

Public Health Workforce and Career Development: The Budget includes a total of $61 million, the same as FY 2012, to help ensure a prepared, diverse, and sustainable public health workforce through experiential fellowships and training programs.

ENVIRONMENTAL HEALTH

CDC's Environmental Health programs prevent illness, disabilities, and premature death caused by non infectious, non occupational environmental related factors. The Budget for Environmental Health includes $133 million, a net decrease of $7 million below FY 2012. The Budget includes a $4 million increase for environmental health programs and services for interventions to reduce risk and mitigate potential health impacts and $11 million in targeted programmatic reductions. The Budget's net reduction reflects the following cuts: $6 million below FY 2012 for the Environmental Public Health Tracking Program, a decrease of $3 million for Built Environment activities which duplicate the Community Transformation Grants, and a decrease of $2 million for Climate Change activities. The Budget includes $27 million for the consolidated Healthy Homes and Community Environments Program, which uses a multi-faceted approach to implement science based interventions to address the health impact of environmental exposures in the home, such as lead poisoning, and to reduce the asthma burden.

INJURY PREVENTION AND CONTROL

The Budget includes $138 million for Injury Prevention and Control programs in CDC, the same as FY 2012, to reduce premature deaths, disability, and the medical costs associated with injuries and violence. Program focuses include motor vehicle safety promotion and intimate partner and sexual violence prevention. CDC will continue to build state based injury prevention capacity; track and monitor injury trends; identify evidence based interventions; and disseminate key research findings. In FY 2013, CDC will improve the effectiveness of the Rape Prevention and Education Program by adding a focus on building the evidence base for sexual violence prevention while continuing investments in state prevention capacity.

IMPROVING PREPAREDNESS AND RESPONSE TO TERRORISM

The FY 2013 Budget provides $1.3 billion for biodefense and emergency preparedness activities in CDC, a decrease of $54 million below FY 2012, which includes a $16 million decrease to State and Local Preparedness to eliminate the Centers for Public Health Preparedness and to achieve efficiencies in managing preparedness grants to states. Within that total, $642 million is requested for Public Health and Emergency Preparedness (PHEP) grants, the same as FY 2012. The PHEP program will provide nearly $9.6 billion in funding from 2001 to 2013 for these efforts. These grants support local public health preparedness efforts and are coordinated with the Hospital Preparedness grants administered by the Assistant Secretary for Preparedness and Response (ASPR). Federal investments at state and local levels have resulted in great progress in preparing for public health emergencies. Additionally, ASPR and CDC are working together to improve the coordination of these grants at both the Federal and local levels and will issue the first comprehensive Funding Opportunity Announcement for preparedness grants in FY 2013. Due to enhanced alignment of preparedness grants within HHS, states will be able to make more efficient use of these resources—an imperative move in a constrained budget environment.

In FY 2013, $147 million is provided to support improving the CDC Preparedness and Response Capability, $9 million above FY 2012. CDC will use increased funds to rebuild internal capacity to protect the Nation's health security with a particular focus to detect and respond to chemical, biological, and nuclear terrorism. The Budget does not include funding for the Centers for Public Health Preparedness because this program has not demonstrated a significant public health impact. The Strategic National Stockpile request is $486 million, a decrease of $47 million below FY 2012, to support product replacement costs, acquire new products, and support security and management costs.

ADVANCING OCCUPATIONAL SAFETY AND HEALTH

The National Institute for Occupational Safety and Health is the primary Federal entity responsible for conducting research, making recommendations, and translating knowledge for the prevention of work related illness and injury. The FY 2013 Budget provides $420 million for Occupational Safety and Health programs, $47 million below FY 2012. This decrease is the net result of $44 million in targeted program reductions and a decrease of $4 million from one time contract costs in FY 2012 for administering provider payment for the World Trade Center (WTC) Health Program. The WTC program, funded with mandatory resources, supports monitoring and treatment services for responders of the September 11, 2001 attacks and non responders in the community affected by the attacks. The targeted reductions include the elimination of the Education and Research Centers and the National Occupational Research Agenda's Agricultural, Forestry, and Fishing Program.
In addition to the total for Occupational Safety and Health, $55 million in mandatory funding is provided for CDC's role in the Energy Employees Occupational Illness Compensation Program.

GLOBAL HEALTH

CDC's Center for Global Health develops and executes CDC's global health strategy, providing technical expertise to, and working in partnership with, ministries of health to implement programs to reduce the leading causes of mortality, morbidity, and disability around the world. The FY 2013 Budget includes $363 million, $15 million above FY 2012, to support the eradication of polio eradication in the remaining polio endemic countries of Afghanistan, India, Nigeria, and Pakistan, along with the three reinfected countries of Angola, Chad, and the Democratic Republic of the Congo, by the end of FY 2015. Continued U.S. Government support is necessary to achieve successful polio eradication, as the gains are fragile. CDC global polio activities aim to prevent mortality, morbidity, and suffering associated with polio in resource limited countries and to protect people in the United States from acquiring polio imported and transmitted into the United States or acquired abroad.

The Budget maintains support for other CDC global health programs such as the Global AIDS Program, which plays a vital role in implementation of the CDC responsibilities under the President's Emergency Plan for AIDS Relief. CDC's Global Health activities protect the U.S. and world populations from emerging global health threats and support the Administration's Global Health Initiative goals.

Making Strides in Global Health

CDC's Global Health Programs have significantly improved health outcomes abroad and reduced mortality from vaccine-preventable and infectious diseases. Over the past decade, CDC has contributed to the vaccination of 1 billion children for measles, contributing to a 78 percent reduction in global measles mortality in all ages from an estimated 733,000 deaths in 2000 to an estimated 164,000 deaths in 2008. CDC provided rapid response to 156 disease outbreaks and public health emergencies in 2010 (704 total since 2006), including febrile encephalitis, human H5N1 influenza, viral hemorrhagic fever, and cholera. In addition, CDC continues to play a significant role in the President's Malaria Initiative (PMI). For instance, in 2010, CDC procured more than 17 million insecticide-treated mosquito nets, protected more than 27 million residents by spraying their houses with residual insecticides, and procured more than 41 million artemisinin-based combination therapies. An intensification in these interventions through PMI and other efforts has reduced case mortality in children less than 5 years of age by 23–36 percent in PMI countries surveyed and has contributed to saving more than 200,000 lives over the past 9 years.

MANAGING CDC INFRASTRUCTURE AND HUMAN CAPITAL

The Budget includes $529 million in administrative and infrastructure activities to support CDC's mission critical efforts.

Public Health Leadership and Support: The Budget includes $160 million, the same as FY 2012, to support CDC's cross cutting areas that seek to ensure the effectiveness of public health programs and science. The Budget request continues support for the Office of State, Tribal, Local and Territorial Support, which provides guidance and oversight for CDC's resources and assets invested in health departments and other partner agencies.

Buildings and Facilities: CDC has made remarkable progress on its Master Plan through its investments to build and upgrade facilities and laboratories and has unobligated balances from FY 2012 to fund necessary repairs and improvements. Because of this progress and the unobligated balances, the FY 2013 Budget does not include new resources for construction or repairs and improvements.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

The Budget request for ATSDR is $76 million, the same as FY 2012. Managed as part of CDC, ATSDR leads Federal public health efforts at Superfund and other sites with known or potential toxic exposures. The Agency's mission is to use the best science, take responsive action, and provide trustworthy health information to the public to prevent and mitigate harmful exposures and disease related to toxic substance exposures. Within the funds requested, $2 million continues the epidemiologic studies of health conditions caused by non occupational exposures to uranium released from past mining and milling operations on the Navajo Nation.

In addition, in FY 2013, CDC will continue implementing the Medical Monitoring Program for Certain Environmental Health Hazards, for which the Affordable Care Act appropriated $23 million from FY 2010-FY 2014. This program provides screening, health education, and outreach services for residents of Libby, Montana, who have been exposed to asbestos.

NATIONAL INSTITUTES OF HEALTH

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Institutes				
National Cancer Institute	5,050	5,066	5,069	+3
National Heart, Lung and Blood Institute	3,065	3,075	3,076	+1
National Institute of Dental and Craniofacial Research	409	410	408	-2
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,939	1,945	1,942	-3
National Institute of Neurological Disorders and Stroke	1,619	1,624	1,625	–
National Institute of Allergy and Infectious Diseases	4,768	4,485	4,495	+10
National Institute of General Medical Sciences	2,368	2,427	2,379	-48
Eunice K. Shriver Natl Inst. of Child Health & Human Dev	1,316	1,320	1,321	+1
National Eye Institute	700	702	693	-9
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	683	685	684	-1
Interior Appropriation	79	79	79	–
National Institute on Aging	1,099	1,102	1,103	+1
Natl Inst. of Arthritis & Musculoskeletal & Skin Diseases	533	535	536	–
Natl Inst. on Deafness and Communication Disorders	414	416	417	+2
National Institute of Mental Health	1,475	1,479	1,479	+1
National Institute on Drug Abuse	1,049	1,052	1,054	+2
National Institute on Alcohol Abuse and Alcoholism	458	459	457	-2
National Institute of Nursing Research	144	145	144	–
National Human Genome Research Institute	511	512	511	-1
Natl Institute of Biomedical Imaging and Bioengineering	345	338	337	-1
Natl Institute on Minority Health and Health Disparities	276	276	279	+3
Natl Center for Complementary and Alternative Medicine	127	128	128	–
National Center for Advancing Translational Sciences	554	575	639	+64
Fogarty International Center	69	70	70	–
National Library of Medicine	371	373	381	+8
Office of the Director	1,454	1,457	1,429	-28
Buildings and Facilities	50	125	125	–
Total, Program Level	**30,926**	**30,860**	**30,860**	–
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	–
Type 1 Diabetes Research (NIDDK) /1	-150	-150	-150	–
Total, Discretionary Budget Authority	**30,767**	**30,702**	**30,702**	–
Labor/HHS Appropriation	**30,688**	**30,623**	**30,623**	–
Interior Appropriation	**79**	**79**	**79**	–
FTE	18,573	18,573	18,387	-186

1/ These mandatory funds were pre-appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008, and P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010.

NATIONAL INSTITUTES OF HEALTH

The mission of the National Institutes of Health is to advance fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy lives and reduce the burdens of illness and disability.

The FY 2013 Budget requests $30.9 billion for the National Institutes of Health (NIH), the same level as in FY 2012, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that spurs economic growth while advancing medical science. In FY 2013, NIH estimates it will support a total of 35,888 research project grants, including 9,415 new and competing awards.

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 2013, about 83 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 325,000 scientists and research personnel affiliated with over 3,000 organizations, including universities, medical schools, hospitals, and other research facilities. About 11 percent of the budget will support an in house, or intramural, program of basic and clinical research activities managed by world class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to national and global health challenges. Another six percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2013

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. NIH research generates discoveries which are opening new avenues for disease treatment and prevention, revolutionizing patient care, and generating substantial economic growth. In FY 2013, the $30.9 billion request will seek to take advantage of such discoveries by investing in basic research on the fundamental causes and mechanisms of disease, accelerating discovery through new technologies, advancing translational sciences, and encouraging new investigators and new ideas.

Investing in Basic Research: Approximately 54 percent of the NIH budget is devoted to basic biomedical and behavioral research that makes it possible to understand the causes of disease onset and

Recent Major Achievements

- An NIH-supported HIV prevention study was named "Top Scientific Breakthrough of 2011" by Science Magazine. The HPTN 052 clinical trial found that if HIV-infected individuals begin taking antiretroviral medicines when their immune systems are relatively healthy as opposed to delaying therapy until the disease has advanced, they are 96 percent less likely to transmit the virus to their uninfected partners.
- Five awardees of the NIH Director's Early Independence Award were named among the top "30 under 30" in Science and Innovation by Forbes Magazine in December 2011. The Early Independence Award is a new funding mechanism that provides an opportunity for exceptional junior scientists to start independent research careers at supportive institutions directly following completion of their graduate degrees or clinical residencies.
- The Mark O. Hatfield Clinical Research Center was awarded the 2011 Lasker-Bloomberg Public Service Award for serving as a model institution that has transformed scientific advances into innovative therapies and provided high-quality care to patients.

progression. As one example, in FY 2013, NIH plans to continue to pursue the exciting new frontier of micoRNAs, which are tiny snippets of RNA that control levels of protein production. MicroRNA research is expected to contribute to research to design new treatments for cancer, cardiovascular diseases, immune disorders, Parkinson's disease, and many other conditions. MicroRNA research is also being used to explore how viruses and environmental factors affect human gene expression, as well as to produce stem cells from adult skin cells.

Alzheimer's Disease Research

Over the last 40 years, a broad and intense research program, primarily supported and conducted by NIH, has provided important insights into Alzheimer's disease (AD). In FY 2013, NIH will support studies designed to gain a greater understanding of the risk factors that predispose someone to the disease and translate this understanding into new diagnostics and treatments; identify new strategies for interrupting the disease process; and test those strategies in individuals long before they show signs of this devastating disease. As an example, in FY 2013, NIH will renew support for the Alzheimer's Disease Cooperative Study (ADCS), the Nation's preeminent consortium devoted to the discovery, development, and testing of new interventions to prevent and treat AD, particularly those less likely to be developed by industry. Since its inception in 1991, ADCS has initiated 23 drug trials and 7 instrument development protocols. The ADCS was responsible for the discovery that donepezil can delay the onset of a clinical diagnosis of AD.

Accelerating Discovery Through Technology: Investigators are better able to reap the benefits of basic research discoveries through advanced technologies such as DNA sequencing, microarray technology, nanotechnology, new imaging modalities, and computational biology. In FY 2013, NIH plans to support further development and application of these advanced technologies. Advances in genome sequencing are essential to NIH's progress in using genomics to further our knowledge in the genetic variations contributing to common and complex disorders. Since the sequencing of the human genome more than ten years ago, the average fully loaded cost to sequence an entire genome has fallen from more than $100 million to about $7,700 currently, and will continue to drop on the way to an ultimate goal of under $1,000. Such a drop in sequencing cost is likely to lead to dramatic changes in how clinicians diagnose and treat disease and will enable researchers to make even more rapid and efficient progress in developing new diagnostic, treatment, and prevention tools. Additional new and innovative sequencing methods are also under development.

Advancing Translational Sciences: Recent insights into the molecular basis of disease have identified many promising new targets for therapeutic intervention and yielded an unprecedented potential for developing more effective diagnostics and therapeutics. In order to re-engineer the process of translating such scientific discoveries into new medical products in FY 2013, NIH will continue to implement the new National Center for Advancing Translational Sciences (NCATS), established in FY 2012. NCATS will serve as the Nation's hub for catalyzing innovations in translational science. Working closely with partners in the regulatory, academic, nonprofit, and private sectors while not duplicating work going on in the private sector, NCATS will strive to identify and overcome hurdles that slow the development of effective treatments and cures.

A prime example of the type of innovative projects that will be led by NCATS is the new initiative between NIH, the Food and Drug Administration, and the Defense Advanced Research Projects Agency to develop cutting edge chip technology. This new technology will allow researchers to screen for safe and effective drugs far more swiftly and efficiently than current methods allow. A great deal of time and money can be saved by testing drug safety and effectiveness much earlier in the product development process.

To meet the goals of NCATS, NIH has reorganized a wide range of preclinical and clinical translational science capabilities within NIH into an integrated scientific enterprise with a bold new agenda. The $639 million budget for NCATS is primarily a reallocation of funds from programs previously located in the NIH Office of the Director, the

National Human Genome Research Institute, and the now abolished National Center for Research Resources. Major components of NCATS include the Clinical and Translational Science Awards, the FDA NIH Regulatory Science program, the Office of Rare Diseases Research, parts of the Molecular Libraries program, and the Therapeutics for Rare and Neglected Diseases program. The FY 2013 Budget request for NCATS also includes $50 million, an increase of $40 million, for the Cures Acceleration Network (CAN) to accelerate the development of "high need cures" by reducing barriers between research discovery and clinical trials. The CAN program may also use up to 20 percent of its funds on flexible research authorities to enable transactions other than contracts, grants, and cooperative agreements to carry out its goals.

Encouraging New Investigators and New Ideas: The future vitality of biomedical science in the United States depends upon the NIH and its support for young scientists. NIH is currently engaged in an ongoing, systematic process of analyzing workforce and training needs to institute more effective mechanisms and policies for a 21st century biomedical workforce. In FY 2013, to encourage exceptionally promising new investigators and to speed the transition of talented trainees to independent researcher positions, NIH will continue to emphasize programs such as the NIH Director's New Innovator Award, the Lasker Clinical Research Scholars Program, the NIH Director's Early Independence Award, and the Pathway to Independence Award. NIH is also working to better understand the causes of and solutions to its insufficient track record in recruiting and advancing underrepresented racial and ethnic groups in biomedical and behavioral research.

A total of $775 million is requested in FY 2013 to support training 16,171 of the next generation of research scientists through the Ruth L. Kirschstein National Research Service Awards (NRSA) program. The Budget proposes a two percent stipend increase for NRSA predoctoral and postdoctoral research trainees.

Other Key Priorities: NIH estimates it will devote nearly $3.1 billion for research on HIV/AIDS in FY 2013. There is growing confidence that broad application of the results of NIH research could make possible the first AIDS free generation. Controlling and ultimately eliminating HIV/AIDS will require safe, effective vaccines and other preventive measures. Developing such vaccines remains a priority and one of NIH's greatest challenges. This effort will require significant advances in basic research to both better understand the virus and the disease and to develop new vaccine strategies. Consistent with FY 2012 congressional action, the FY 2013 Budget for the National Institute of Allergy and Infectious Diseases (NIAID) no longer includes funds to be transferred to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria; instead, funds for this program are requested in a single source within the budget of the Department of State.

NIH estimates that it will support 9,415 new and competing research project grants (RPGs) in FY 2013, an increase of 672 above FY 2012. The total number of RPGs is expected to be 35,888. NIH wide, the average cost of a new and competing RPG in FY 2013 is estimated to be about $431,000. In order to maximize resources for investigator initiated

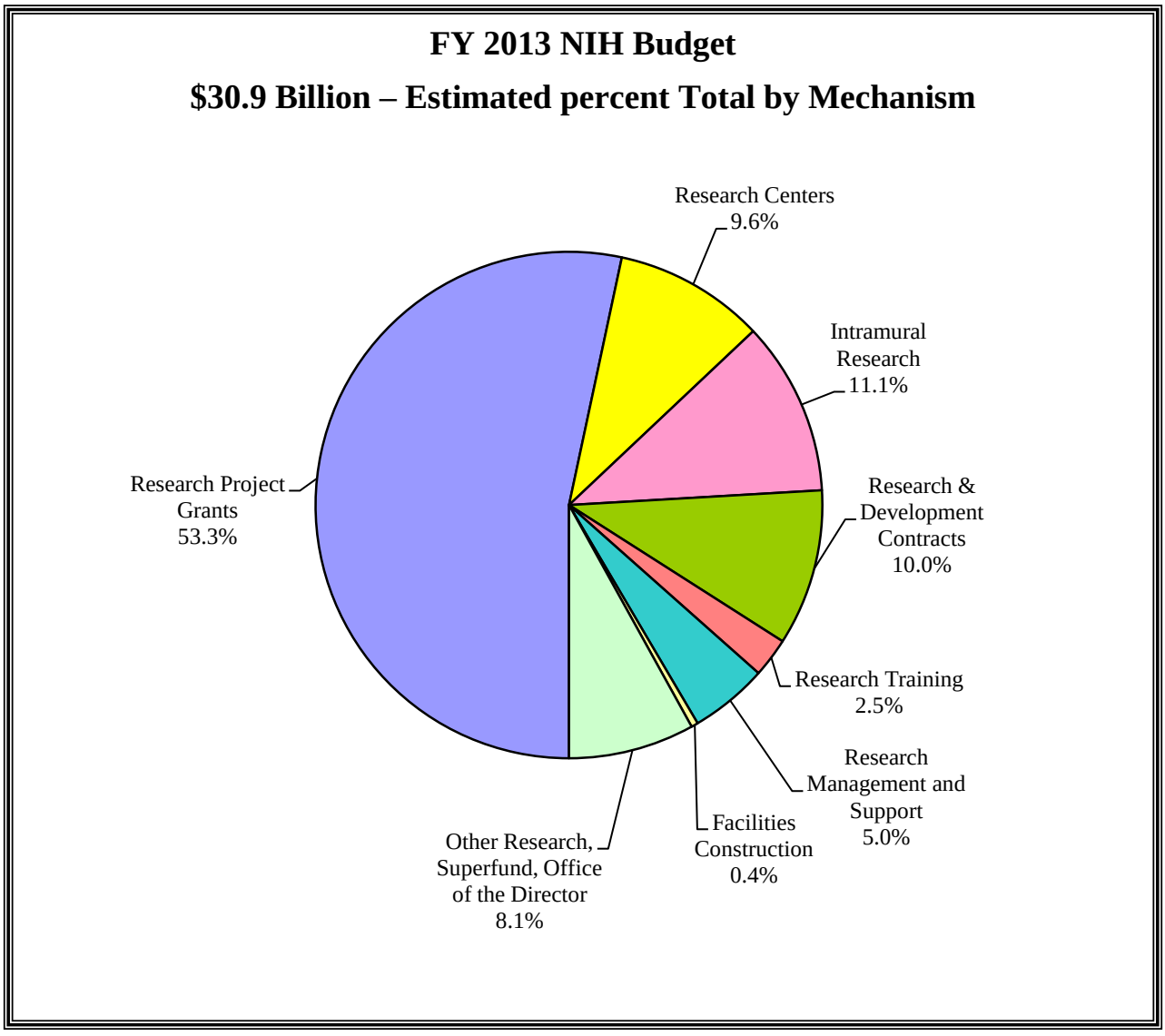
A New Generation of Cancer Treatments

There are hundreds of different types of cancer, each caused by glitches in DNA that trigger the uncontrolled growth of cells. Identifying the genetic changes that are associated with different types of cancers and understanding how such changes drive the disease process is moving forward at a breathtaking pace because of The Cancer Genome Atlas (TCGA) project. With a mission to characterize the genetic changes in 11,000 cases of human cancer by 2014, TCGA investigators expect to complete the analysis of at least 7,000 cases by 2013. These data will be made available for further research, and TCGA will also begin a series of studies on rare tumors. The TCGA results will lay the foundation for a new era in cancer care. Already, NIH investigators have conducted preclinical testing to evaluate three novel cancer interventions targeting specific genetic alterations that occur in cancer cells. Preclinical testing of agents determines suitability for moving forward with early phase clinical trials. The development of therapies that attack genetic abnormalities in cancer cells, while allowing normal cells to remain unharmed, will enable the management of cancer as a chronic condition and enhance the quality of life for cancer patients.

grants, and to continue to focus on resources for young, first time researchers, NIH intends in FY 2013 to discontinue outyear inflationary allowances for competing and continuation grants; reduce non-competing continuation grants by one percent below the FY 2012 level, and negotiate the budget's of competing grants to avoid growth in the average award size. NIH will also continue the current policy to equalize success rates of new investigators to those of established investigators. It will also establish a process for additional scrutiny and review by the Institute or Center Advisory Council of awards to any principal investigator with existing grants of $1.5 million or more in total costs.

INTRAMURAL BUILDINGS AND FACILITIES

A total of $133 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2013, the same level as in FY 2012, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2013, NIH will focus on upgrades to ensure essential safety and regulatory compliance, as well as on facility repairs and improvements to address the most critical utility systems, fire safety, and environmental deficiencies. The B&F mechanism total includes about $8 million requested within the National Cancer Institute budget for facilities projects at its Frederick, Maryland campus.



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

Mechanism	2011	2012	2013	2013 +/- 2012
Research Project Grants (dollars)	16,428	16,489	16,463	-26
[# of Non-Competing Grants]	*[26,166]*	*[25,614]*	*[24,837]*	*[-777]*
[# of New/Competing Grants]	*[8,706]*	*[8,743]*	*[9,415]*	*[+672]*
[# of Small Business Grants]	*[1,494]*	*[1,587]*	*[1,636]*	*[+49]*
[Total # of Grants]	*[36,366]*	*[35,944]*	*[35,888]*	*[-56]*
Research Centers	3,020	3,031	2,966	-64
Other Research	1,803	1,833	1,823	-10
Research Training	772	778	775	-2
Research and Development Contracts	3,227	2,968	3,076	+108
Intramural Research	3,407	3,408	3,429	+21
Research Management and Support	1,526	1,533	1,535	+2
Office of the Director	605	608	580	-28
[NIH Common Fund (non-add)]	*[543]*	*[545]*	*[545]*	–
Buildings and Facilities	58	133	133	–
NIEHS Interior Appropriation (Superfund)	79	79	79	–
Total, Program Level	**30,926**	**30,860**	**30,860**	–
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	–
Type 1 Diabetes Research (NIDDK) /1	-150	-150	-150	–
Total, Budget Authority	**30,767**	**30,702**	**30,702**	–
Labor/HHS Appropriation	**30,688**	**30,623**	**30,623**	–
Interior Appropriation	**79**	**79**	**79**	–
FTE	18,573	18,573	18,387	-186

1/ These mandatory funds were pre-appropriated in P.L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008, and P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Mental Health				
Mental Health Block Grant	399	439	439	–
PHS Evaluation Funds	21	21	21	–
Mental Health - State Prevention Grant	25	35	55	+20
CMHS - Programs of Regional and National Significance	359	286	248	-39
Prevention Fund (non-add)	*45*	*45*	*28*	*-17*
Children's Mental Health Services	118	117	89	-29
PATH Homelessness Formula Grants	65	65	65	–
Protection & Advocacy	36	36	36	–
Subtotal, Mental Health	1,022	999	952	-47
Substance Abuse Treatment				
Substance Abuse Block Grant	1,363	1,377	1,377	–
PHS Evaluation Funds	79	79	72	-7
CSAT - Programs of Regional and National Significance	429	423	364	-59
Prevention Fund (non-add)	*25*	*25*	*30*	*+5*
PHS Evaluation Funds	2	2	–	-2
Subtotal, Substance Abuse Treatment	1,873	1,881	1,813	-69
Substance Abuse Prevention				
Substance Abuse - State Prevention Grant	451	454	405	-50
Substance Abuse - State Prevention Grant (non-add)	–	–	*344*	*+344*
Block Grant 20% Prevention Set-Aside (non-add)	*341*	*344*	–	*-344*
Strategic Prevention Framework (non-add)	*110*	*110*	*60*	*-50*
CSAP - Programs of Regional and National Significance	76	76	66	-10
Prevention Fund (non-add)	–	–	*7*	*+7*
Subtotal, Substance Abuse Prevention	527	530	470	-60
Health Surveillance and Program Support				
Health Surveillance and Program Support	142	123	74	-49
Prevention Fund (non-add)	*18*	*18*	–	*-18*
PHS Evaluation Funds	29	27	72	+45
User Fees	–	–	2	+2
Behavioral Health - Tribal Prevention Grants	–	–	40	+40
Prevention Fund (non-add)	–	–	*40*	*+40*
Agency-Wide - Programs of Regional and National Significance	5	3	–	-3
Subtotal, Health Surveillance and Program Support	177	154	188	+33
Total, Program Level	**3,599**	**3,565**	**3,423**	**-142**
Less Funds From Other Sources				
PHS Evaluation Funds	-132	-130	-165	-35
User Fees	–	–	-2	-2
Prevention Fund	-88	-88	-105	-17
Total, Discretionary Budget Authority	**3,380**	**3,347**	**3,152**	**-196**
FTE	547	574	574	–

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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

The FY 2013 Budget requests $3.4 billion, of which $105 million is funded through the Prevention Fund, for the Substance Abuse and Mental Health Services Administration (SAMHSA), a decrease of $142 million below FY 2012. In order to maximize the effectiveness and efficiency of its resources, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more strategically by:

- Using competitive grants to identify and test innovative prevention and treatment interventions; and
- Leveraging state and tribal funding mechanisms to foster widespread implementation of proven practices.

As part of this effort, the Budget includes funding to maintain states' capacity to provide behavioral health services and to expand state and tribal substance abuse prevention and mental health promotion activities. The Budget reduces funding for tested competitive grant activities that will now be brought to scale through state-level funding streams.

SUBSTANCE ABUSE TREATMENT AND MENTAL HEALTH SERVICES

The Budget includes $1.9 billion for the Substance Abuse and Mental Health Block Grants to implement evidence-based treatment strategies nationwide and maintain the Nation's behavioral health treatment infrastructure.

Funding for treatment infrastructure has declined in recent years as many states have scaled back their investments in behavioral health in the face of budget shortfalls. The Budget largely maintains the FY 2012 funding level for these programs, which are anticipated to provide treatment services to over 8 million individuals in FY 2012. As access to health coverage—including mental health and substance abuse services—expands through increased access to health care, SAMHSA will work with states to use their Block Grant funds more strategically and with greater efficiency through the dissemination and implementation of evidence-based treatment strategies and interventions.

PREVENTION

Preventing substance abuse and mental illness is essential to achieving and maintaining overall health for the American people. In its 2009 report entitled *Preventing Mental, Emotional, and Behavioral Health Disorders Among Young People*, the Institute of Medicine concluded that proven practices exist to promote emotional health and prevent substance abuse disorders and mental illnesses and that these evidence-based approaches should be implemented nationwide.

The Budget includes $500 million, an increase of $11 million over FY 2012, for new, expanded, and refocused substance abuse prevention and mental health promotion grants to states and tribes to bring evidence-based prevention strategies to scale nationwide. SAMHSA will partner with states to use data-driven planning processes to identify and address problems in communities through the deployment of proven practices.

Substance Abuse State Prevention: The most recent data from the National Survey on Drug Use and Health indicate that, among those aged 12 and older, illicit substance use has been on the rise since 2008. These outcomes necessitate a revisited approach to substance abuse prevention efforts to ensure that limited resources are coordinated, targeted, and spent

SAMHSA Leverages Partnerships to Prevent Suicides

In December 2011, SAMHSA announced a first-of-its-kind partnership between the SAMHSA-funded National Suicide Prevention Lifeline and Facebook. A new Facebook service allows users to report suicidal comments they see posted by a friend, who will then receive an email encouraging them to call the Lifeline. This collaboration is part of a larger effort by the National Action Alliance for Suicide Prevention, which seeks to prevent suicides through public-private collaboration.

on proven strategies. The Budget includes $405 million for a new Substance Abuse State Prevention Grant to create a sustainable source of prevention funding for all states to employ evidence-based substance abuse prevention activities and address existing and emerging issues in high-risk communities. With this funding, SAMHSA will bring the Strategic Prevention Framework approach and other lessons learned from SAMHSA-funded grant programs to scale across the Nation in order to improve coordination and better leverage disparate substance abuse prevention resources.

Mental Health State Prevention: The Budget includes $55 million for a mental health state prevention effort through an expansion of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health). These grants will enable states to conduct evidence-based prevention and wellness interventions focused on children by targeting the common set of risk factors that lead to substance abuse and mental illness.

Behavioral Health Tribal Prevention: Within this total, the Budget includes $40 million for a new Behavioral Health Tribal Prevention Grant. Grants will be awarded to each of the 565 federally-recognized tribes to implement strategies to prevent substance abuse and suicides. SAMHSA will coordinate with the Indian Health Service (IHS) to implement community-based prevention strategies that complement the clinical services provided by IHS-funded providers.

TESTING AND DELIVERING TARGETED INTERVENTIONS

SAMHSA's Programs of Regional and National Significance have long fostered innovative solutions to emerging issues in substance abuse and mental health services. SAMHSA will continue testing and evaluating promising approaches to the Nation's most challenging behavioral health issues. The Budget includes $831 million, a decrease of $140 million below FY 2012, for Programs of Regional and National Significance and other competitive and targeted grant activities within SAMHSA's three Centers. The Budget discontinues funding for new awards in a number of well-established program areas. Resources are targeted to the testing of new practices and to maintaining and bolstering the state and tribal efforts necessary to implement and sustain evidence-based strategies nationwide.

For example, the Budget includes savings of $29 million from grants coming to a natural end in the Children's Mental Health Services program. Over a decade of national program evaluation data indicate that the systems of care model developed and promoted by the program on a community-by-community basis are successful at achieving a variety of outcomes including: mental health improvements, reductions in suicidal behavior, and reduced medical costs. In FY 2011, SAMHSA awarded grants to 24 states and the District of Columbia to develop strategic plans for expanding the systems of care model statewide. SAMHSA plans to continue working with states to move these models to scale through increasing access to third party payers as well as Mental Health Block Grant dollars.

Addressing Trauma: Trauma is a widespread, harmful, and costly public health problem that can increase individuals' risk for mental and substance use disorders, chronic physical diseases, and early death. The Budget includes a total of $49 million to develop and disseminate evidence-based approaches for identifying and treating trauma in children, adolescents, and adults.

The Budget includes $46 million, the same level as FY 2012, for the National Child Traumatic Stress Network to continue the development and dissemination of effective interventions for children exposed to traumatic events. It also includes $3 million for a new adult trauma screening and brief intervention demonstration. This project will draw upon existing screening frameworks in order to identify and help adults who have experienced past trauma.

Assisting in the Transition from Homelessness: Approximately 30 percent of the chronically homeless have a serious mental illness, and around two-thirds have a substance use disorder or chronic health condition that creates significant difficulties in accessing affordable, stable housing. The Budget dedicates a total of $139 million, the same level as FY 2012, for services to support individuals suffering from substance abuse and/or mental illness and facing homelessness.

Preventing Suicide:
The Budget provides $48 million, a decrease of $10 million below FY 2012, to prevent suicide. The Budget continues to invest in activities authorized by the Garrett Lee Smith Memorial Act that support intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations. The Budget sustains the capacity of the National Suicide Prevention Lifeline, a national hotline that routes calls across the country to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources. Reductions are made to one-time activities funded through the Prevention Fund in FY 2012.

Building on Positive Outcomes

Since 2004, SAMHSA has worked with 49 states, the District of Columbia, 8 territories, and 19 tribes and tribal organizations to undertake a 5-step process to establish the necessary infrastructure to effectively select, implement, and evaluate evidence-based substance abuse prevention programs. Through this process, known as the Strategic Prevention Framework State Incentive Grant (SPF-SIG), grantees have shown positive outcomes. For example, grantees have met or exceeded targets for decreasing past 30-day alcohol use among minors and adults for three consecutive years and have shown success in reducing past 30-day illicit drug use among adults.

The Budget proposes to build on these positive outcomes by expanding the scale of SPF-SIG efforts through the new Substance Abuse State Prevention Grant, which seeks to coordinate and target all state substance abuse prevention resources to evidence-based approaches and high-risk communities.

Disaster Response: The Budget includes $3 million for SAMHSA's disaster response activities, including an increase of $2 million for the Disaster Distress Helpline. Begun in 2010 to help individuals in the Gulf Coast cope with the stresses of the Deepwater Horizon oil spill, the Helpline is a nationally available crisis counseling line to provide information and support in the wake of international, national, and local disasters.

OTHER ACTIVITIES

Protecting Individuals With Mental Illness:
Individuals with mental illness and serious emotional disturbances who reside in treatment facilities are vulnerable to neglect and abuse. The Budget provides $36 million, the same level as FY 2012, to support state protection and advocacy systems to monitor residential treatment facilities. In 2010, more than 90 percent of substantiated complaints handled through these systems resulted in positive changes for clients.

Health Surveillance and Program Support:
The Budget includes $146 million, a decrease of $5 million below FY 2012, for the support of national survey efforts, the administration and monitoring of SAMHSA programs and grantees, and public awareness activities. Within this total are savings generated from efficiencies, consolidations, and the in-sourcing of select activities previously performed under contracts. Analyses conducted through SAMHSA's national surveys are used by federal, state, and local authorities, as well as by health care providers, to inform policymakers about substance use and mental disorders, the impact and treatment of these disorders, and the recovery process.

Data and Publication User Fees: The Budget includes a new user fee to offset increased costs of requests for special data analyses and bulk publications. Like other data user fees in HHS, the new fees will supplement existing resources to ensure that SAMHSA retains the capacity to provide quality services to the behavioral health field, adequately operate national surveys, and carry out rigorous evaluations of SAMHSA programs.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Health Costs, Quality and Outcomes Research (HCQO)				
Health Information Technology	28	26	26	–
Patient Safety Research	66	66	63	-3
Patient-Centered Health Research	29	41	72	+32
PCORTF Transfer (non-add) /1	*8*	*24*	*62*	*+38*
PHS Evaluation Fund (non-add)	*21*	*17*	*10*	*-7*
Crosscutting Activities	112	108	89	-19
Value	4	4	4	–
Prevention/Care Management	28	28	28	–
PHS Evaluation Funds (non-add)	*16*	*16*	*16*	–
Prevention and Public Health Fund (non-add)	*12*	*12*	*12*	–
Subtotal, Program Level, HCQO	266	272	281	+9
Subtotal, PHS Evaluation Funds, HCQO (non-add)	*246*	*236*	*207*	*-29*
Medical Expenditure Panel Surveys	59	59	59	–
Program Support	68	74	68	-6
Total, Program Level	**392**	**405**	**409**	**+4**
Less Funds From Other Sources				
PHS Evaluation Funds	-372	-369	-334	+35
Patient-Centered Outcomes Research Trust Fund	-8	-24	-62	-38
Prevention Fund	-12	-12	-12	–
Subtotal, Funds from Other Sources	-392	-405	-409	-4
Total, Discretionary Budget Authority	–	–	–	–
FTE /2	313	325	333	+8

1/ In FY 2011, AHRQ began to receive funds transferred from the Patient-Centered Outcomes Research Trust Fund to implement section 937 of the Public Health Services Act.

2/ FTE levels reflect all discretionary and mandatory funding sources and additional estimated FTE funded by reimbursable agreements.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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

The FY 2013 Budget includes a total program level of $409 million for the Agency for Healthcare Research and Quality (AHRQ), $4 million above the FY 2012 level. This total includes $334 million in Public Health Service (PHS) Evaluation Funds, a decrease of $35 million below FY 2012, $62 million from the Patient-Centered Outcomes Research Trust Fund as called for in the Affordable Care Act, and $12 million through the Prevention and Public Health Fund (Prevention Fund).

AHRQ conducts and supports a broad range of health services research within research institutions, hospitals, and health care systems that informs and enhances decision-making, and improves health care services, organization, and financing. The FY 2013 Budget continues support for core health services research on delivery system cost, quality, and outcomes. The Budget also supports the collection of information on health care expenditures and use.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2013 Budget includes $281 million, $9 million above FY 2012, to support research on a wide range of issues affecting the cost, quality, and effectiveness of health care. Research on health costs, quality, and outcomes is organized by six main research portfolios: health information technology; patient-centered health research; patient safety; prevention and care management; value; and crosscutting activities on health cost, quality, and outcomes.

Advancing Health Information Technology: The Budget includes $26 million, the same as FY 2012, for the AHRQ health information technology (health IT) research portfolio. This investment includes $19 million to support approximately 56 research grants that will generate evidence demonstrating the most effective and efficient use of health IT to improve health care delivery, safety, and quality. In addition, $7 million will support contract activities related to synthesizing and disseminating evidence on meaningful use of health IT and developing the tools and resources for various stakeholders to implement best practices.

To leverage resources and maximize their impact, AHRQ collaborates with other health IT partners across the Department. AHRQ-supported research findings, for example, have contributed to and served as the evidence basis for implementing the Office of the National Coordinator for Health Information Technology activities authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. In FY 2013, the development of a single HHS health IT website will enhance coordination across agencies. This efficiency will result in savings within AHRQ health IT dissemination activities.

Patient-Centered Health Research: The Budget includes a total of $72 million for Patient-Centered Health Research (also known as Patient-Centered Outcomes Research or Comparative Effectiveness Research) to advance research that compares the effectiveness of different health care treatment and strategy options and to provide patients, clinicians, and other stakeholders with timely, state-of-the-science, evidence-based information to enhance medical decision making.

Of this total, $62 million will be provided through the Patient-Centered Outcomes Research Trust Fund, established in the Affordable Care Act, to build research capacity and to translate and disseminate comparative clinical effectiveness research. Currently, through these resources, AHRQ is supporting projects to train researchers and to disseminate and identify the best methods to research findings available to different audiences. Project outcomes will inform the development of targeted dissemination strategies.

In FY 2013, AHRQ will invest the remaining $10 million to continue ongoing activities, including: reviewing and synthesizing current research;

generating evidence on the effectiveness of health care interventions; training researchers to develop a highly qualified pool of experts to support this type of research; and developing and disseminating products and tools in formats that will help patients make informed health care decisions. AHRQ will make strategic investments in core patient-centered health research activities, taking into consideration activities that are supported by the Patient-Centered Outcomes Research Trust Fund to avoid duplication. For example, the FY 2013 AHRQ budget does not invest in new training or dissemination activities since resources from the Trust Fund will be used to support these activities within AHRQ.

Enhancing Patient Safety: The Budget includes $63 million, a decrease of $3 million below FY 2012, for the AHRQ Patient Safety research portfolio. This portfolio supports several research activities which aim to prevent, mitigate, and decrease patient safety risks and gaps in health care quality. AHRQ addresses these goals by supporting Patient Safety Organizations, authorized by the Patient Safety and Quality Improvement Act, and by implementing best practices and conducting research to better understand and prevent adverse events in multiple health care settings.

In FY 2013, AHRQ will provide $34 million to support research activities that will enhance our knowledge about the most effective evidence-based strategies for preventing and reducing the incidence of healthcare-associated infections (HAIs). Of this total, $14 million, an increase of $4 million over FY 2012, will be invested specifically in several projects known collectively as the Comprehensive Unit-based Safety Program (CUSP) to prevent HAIs. These projects assist with implementing evidence-based practices to prevent common HAIs, including central-line associated blood stream and catheter-associated urinary tract infections, surgical site infections, and ventilator-associated pneumonia. This work complements and contributes to the CMS Innovation Center Partnership for Patients goal to reduce HAIs.

Prevention and Care Management: The Budget includes $28 million, the same as FY 2012, for the AHRQ Prevention and Care Management research portfolio which supports health system redesign activities to improve primary health care services delivery for high-quality, safe, and effective clinical prevention and chronic disease care. For example, in FY 2013, AHRQ will continue support for three Research Centers for Excellence in Clinical Preventive Services. In addition, AHRQ will continue tools and measurement development for use in a diverse range of health care settings, including patient-centered medical homes.

Of the total requested in FY 2013 for the Prevention and Care Management research portfolio, $11 million, including $7 million from the Prevention Fund, will continue to support the U.S. Preventive Services Task Force. The Task Force is an independent non-governmental panel focused on evaluating risks and benefits of clinical preventive services, making recommendations about which services should be incorporated into primary medical care, and identifying research priorities. AHRQ provides scientific and administrative support to the Task Force and also supports the Task Force by disseminating recommendations and assisting health care organizations to implement recommended clinical preventive services. In FY 2013, AHRQ will continue to focus on enhancing the quality of scientific support provided, as well as continue efforts to improve transparency and availability of information about Task

Improving Health Care Quality

The Comprehensive Unit-based Safety Program (CUSP) to prevent HAI encompasses several projects which assist with implementing evidence-based practices to prevent common HAIs, including: central-line associated blood stream infections, catheter-associated urinary tract infections, surgical site infections, and ventilator-associated pneumonia. CUSP also makes available tools to improve collaboration among clinicians and hospital leaders, provide staff training, and develop standard measurements of infection rates. Initial results from the central-line associated blood stream infection project, implemented nationwide in FY 2011, have led to a decrease of 35 percent in the number of this type of HAI among the 350 hospitals participating in the project. Building on this success, AHRQ will, in FY 2012, begin implementing phases of the nationwide catheter-associated urinary tract infection and safe surgery projects. In FY 2013, AHRQ will invest $14 million, an increase of $4 million above FY 2012, to expand these efforts and also begin the nationwide roll-out of the ventilator-associated pneumonia component of the project.

Force activities to the public.

Increasing Health Care Value and Other Research and Dissemination Activities: The Budget includes a total of $93 million, a decrease of $20 million below FY 2012, for AHRQ research focused on health care value and crosscutting issues related to improving health care quality, effectiveness, and efficiency.

Of this total, the Budget includes $4 million to achieve greater value in health care by reducing unnecessary costs and waste while also improving quality, enhancing transparency of information, and measuring and tracking useful information. In FY 2013, AHRQ will continue high-impact and successful programs such as My Own Network powered by AHRQ, also known as MONAHRQ, which is advancing quality improvement reporting. This web-based tool enables state and local data organizations, regional reporting collaboratives, hospitals, and health plans to easily and cost-effectively create a health care reporting website. By using hospital discharge data and other inpatient measures, the software analyzes, summarizes and displays information on quality of care, health care utilization, preventable hospitalizations, and rates of conditions and procedures. The recently-enhanced version of the program links users to other reports and data sources such as the CMS Hospital Compare, as well as to new scientific evidence and other information useful to state and local organizations.

AHRQ will also continue to support health services research on crosscutting topics related to quality effectiveness and efficiency and make the findings available to patients and other stakeholders. In addition AHRQ will coordinate the collection, measurement, and analysis of data which informs research and program priorities. AHRQ will support approximately 120 research grants totaling $36 million supporting these various research areas of focus. Specifically, $29 million will fund investigator-initiated projects which support innovative ideas and approaches in health costs, quality, and outcomes research to improve health care delivery.

In addition, AHRQ will continue funding the annual National Healthcare Quality and Disparities Reports and provide technical support to further develop and implement the National Strategy for Quality Improvement in Health Care published by HHS in March 2011.

Enhancing Patient Safety

AHRQ develops and distributes tools for patients and health care organizations to improve patient safety culture and ultimately improve quality and outcomes in various health care settings. In addition to developing resources, AHRQ is focusing on evaluating the use of tools by health care organizations and other stakeholders. To assess use, AHRQ uses the Hospital Survey of Patient Safety to gather information voluntarily provided by health organizations. AHRQ also tracks participation in Web-based resources, the use of electronic resources, and requests for products. In FY 2011, it was determined that 1,032 users from health care organizations were using AHRQ-developed tools to improve patient safety. Based on data collected, it is estimated that the number of users will grow to 1,300 users in FY 2013.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

The FY 2013 Budget includes $59 million, the same as FY 2012, for MEPS. MEPS include three interrelated survey components: household, medical provider, and insurance. These three surveys provide the only national source of annual data on how Americans use and pay for health care. Information collected and provided through MEPS serves a critical and unique role in supplying data used to project health care expenditures and utilization. MEPS also reports on access, expenses, insurance coverage, and health care quality. MEPS data is used by HHS agencies, other federal partners, and public and private stakeholders to better understand and estimate the impact of policies on various segments of the U.S. population. In FY 2013, MEPS will maintain the precision and analytical capacity in all three surveys to continue providing valuable data on health status, demographics, employment, and health care access and quality.

PROGRAM SUPPORT

The FY 2013 Budget includes $68 million, a decrease of $6 million below the FY 2012 level, to support agency-wide operational and administrative costs. AHRQ will implement several administrative efficiencies and prioritize operational functions for FY 2013. For example, AHRQ will reduce travel expenses by increasing the use of Web resources to conduct meetings.

CENTERS FOR MEDICARE & MEDICAID SERVICES
OVERVIEW

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law:				
Medicare /1	485,934	476,674	510,426	+33,752
Medicaid /2	274,964	255,119	282,699	+27,580
CHIP /3	8,633	9,903	10,227	+324
State Grants and Demonstrations	562	604	474	-130
Health Insurance Programs	3,420	4,639	4,053	-586
Center for Medicare and Medicaid Innovation	11	733	1,090	+357
Total Net Outlays, Current Law	**773,524**	**747,672**	**808,969**	**+61,297**
Adjusted Baseline:				
Prevent Reduction in Medicare Physician Payments	–	9,237	25,646	+16,409
Total Net Outlays, Adjusted Baseline	**773,524**	**756,909**	**834,615**	**+77,706**
Proposed Law:				
Medicare /4	–	485	-4,907	-5,392
Medicaid /4	–	155	190	+35
Health Insurance Programs	–	–	–	–
Program Management	–	–	100	+100
Total Proposed Law	–	**640**	**-4,617**	**-5,257**
Savings from Program Integrity Investments /5 /6	–	-424	-621	-197
Total Net Outlays, Proposed Law /7	**773,524**	**757,125**	**829,377**	**+72,252**
Additional Information:				
Total Savings from Program Integrity Investments /5 /6	–	-1,039	-1,428	-389

1/ Current law Medicare outlays net of offsetting receipts.

2/ Current law Medicaid outlays net of Qualified Individual (QI) program. Outlay costs of extending the QI program are reflected in Medicare. States pay the Medicare Part B premium costs for QI, which are in turn offset by a 100 percent reimbursement from Medicare Part B.

3/ Includes the Child Enrollment Contingency Fund.

4/ Includes proposal to extend the QI program through CY 2014; it is currently authorized through February 29, 2012.

5/ FY 2012 and FY 2013 include $1.0 billion and $1.4 billion respectively in non-PAYGO Scorecard savings from increased HCFAC investment and Social Security Disability reviews. A portion of these savings is assumed in current law.

6/ The President's Budget proposes to increase the 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with the Budget Control Act of 2011.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
OVERVIEW

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

The FY 2013 Budget estimate for the Centers for Medicare & Medicaid Services (CMS) is $829.4 billion in mandatory and discretionary outlays, a net increase of $72 billion above the FY 2012 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), private health insurance programs and oversight, program integrity efforts, and operating costs.

The Budget supports CMS's work to implement key provisions of the Affordable Care Act—landmark legislation that brings comprehensive insurance reforms, expanded coverage, and enhanced quality of health care to tens of millions of Americans. The Budget proposes additional targeted adjustments to Medicare and Medicaid that are projected to save $358.5 billion over the next decade. These reforms will strengthen the long-term sustainability of Medicare and Medicaid and increase the efficiency of the programs, while honoring core national commitments to the elderly, children, low-income families, and people with disabilities.

BUDGETARY REQUEST

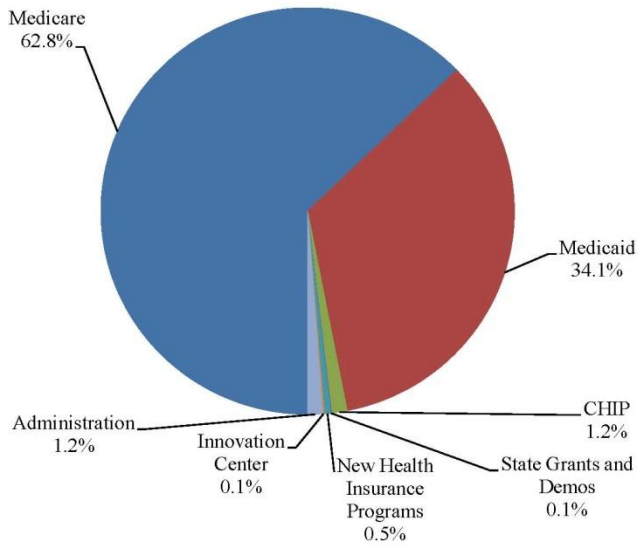
Medicare: The Budget includes projected Medicare savings of $302.8 billion over 10 years, including proposals to better align payments with the costs of care and strengthen incentives for providers to deliver high-quality care.

Medicaid: The Budget includes $55.7 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable. In addition, the Budget extends two important programs within Medicaid: the Transitional Medical Assistance program and Medicare Part B premium assistance for low-income Medicare beneficiaries.

Program Integrity: The Budget includes $610 million in discretionary program integrity resources, as part of a multi-year investment to enable HHS and the Department of Justice to detect, prevent, and prosecute health care fraud. These targeted efforts will save $11.3 billion over 10 years. The Budget also proposes a series of new authorities to strengthen program integrity oversight for Medicare, Medicaid, and CHIP. Of the total Medicare and Medicaid savings, our Program Integrity legislation proposals yield $3.6 billion in savings over 10 years.

Discretionary Program Management: The Budget makes a robust investment in CMS program management. The request anticipates substantial increases in CMS workload as demographic trends drive higher Medicare enrollment and CMS assumes new programmatic responsibilities as a result of the Affordable Care Act and other legislation. In particular, the Budget invests in the development of Affordable Insurance Exchanges, scheduled to begin operations in 2014. At the same time, the Budget reflects significant operational savings which result from CMS more efficiently serving beneficiaries.

CMS FY 2013 Net Outlays
Proposed Law - $829.4 Billion



MEDICARE

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law:				
Outlays				
Benefits Spending (gross) /1	551,408	544,922	587,951	+43,029
Less: Premiums Paid Directly to Part D Plans /2	-4,843	-5,544	-6,857	-1,313
Subtotal, Benefits Net of Direct Part D Premium Payments	**546,565**	**539,378**	**581,094**	**+41,716**
Related-Benefit Expenses /3	11,394	10,590	10,260	-330
Administration /4	7,672	10,104	9,612	-492
Total Outlays, Current Law	**565,632**	**560,072**	**600,966**	**+40,894**
Offsetting Receipts				
Premiums and Offsetting Receipts /5	-79,697	-83,398	-90,540	-7,142
Current Law Outlays, Net of Offsetting Receipts	**485,934**	**476,674**	**510,426**	**+33,752**
Adjusted Baseline				
Prevent Reduction in Medicare Physician Payments	–	9,237	25,646	+16,409
Savings from Program Integrity Investments /6	–	-413	-551	-138
Adjusted Baseline Outlays, Net of Offsetting Receipts	**485,934**	**485,498**	**535,521**	**+50,023**
Proposed Law:				
Medicare Proposals /7	–	215	1,333	+1,118
Premiums and Offsetting Receipts /5	–	–	-6,140	-6,140
Total Medicare Proposals, Net of Offsetting Receipts	–	**215**	**-4,807**	**-5,022**
Total Net Outlays, Adjusted Baseline and Proposed Law	**485,934**	**485,713**	**530,714**	**+45,001**
Mandatory Proposed Law:				
Mandatory Total Net Outlays, Proposed Law /8	**480,202**	**479,553**	**523,749**	**+44,196**
Additional Information:				
Total Savings from Program Integrity Investments /6	–	-943	-1,144	-201

1/ Represents all spending on Medicare benefits by either the Federal Government or beneficiaries. Includes Medicare Health Information Technology Incentives under both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) for the Social Security Administration.

2/ In Part D only, some beneficiary premiums are paid directly to plans and are netted out here because those payments are not paid out of the Trust Funds.

3/ Includes related benefit payments, including refundable payments made to providers and plans, transfers to Medicaid, and additional Medicare Advantage benefits.

4/ Includes CMS Program Management, non-CMS administration, HCFAC, and QIOs. Includes CMS Program Management non-trust fund outlays of $280 million in FY 2011, $1,501 million in FY 2012, and $368 million in FY 2013.

5/ Includes beneficiary premiums, state contributions to Part D, and other offsets.

6/ FY 2012 and FY 2013 include $943 million and $1.1 billion respectively in non-PAYGO Scorecard savings from increased HCFAC investment and Social Security disability reviews. A portion of these savings is assumed in current law.

7/ Includes SMI transfers to Medicaid of $215 million in FY 2012 and $635 million in FY 2013, to extend the Qualified Individuals (QI) Program. Includes $100 million in CMS Program Management non-trust fund proposals in FY 2013.

8/ Removes total Medicare discretionary amount: FY 2011- $5,732 million; FY 2012- $6,160 million; and FY 2013- $6,965 million.

In FY 2013, gross current law spending on Medicare benefits will total $588 billion. Medicare will provide health insurance to 52 million individuals who are 65 or older, disabled, or have end-stage renal disease (ESRD).

THE FOUR PARTS OF MEDICARE

Part A ($205 billion gross fee-for-service spending in 2013): Medicare Part A pays for inpatient hospital, skilled nursing facility, home health (related to a hospital stay), and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax split between employees and employers.

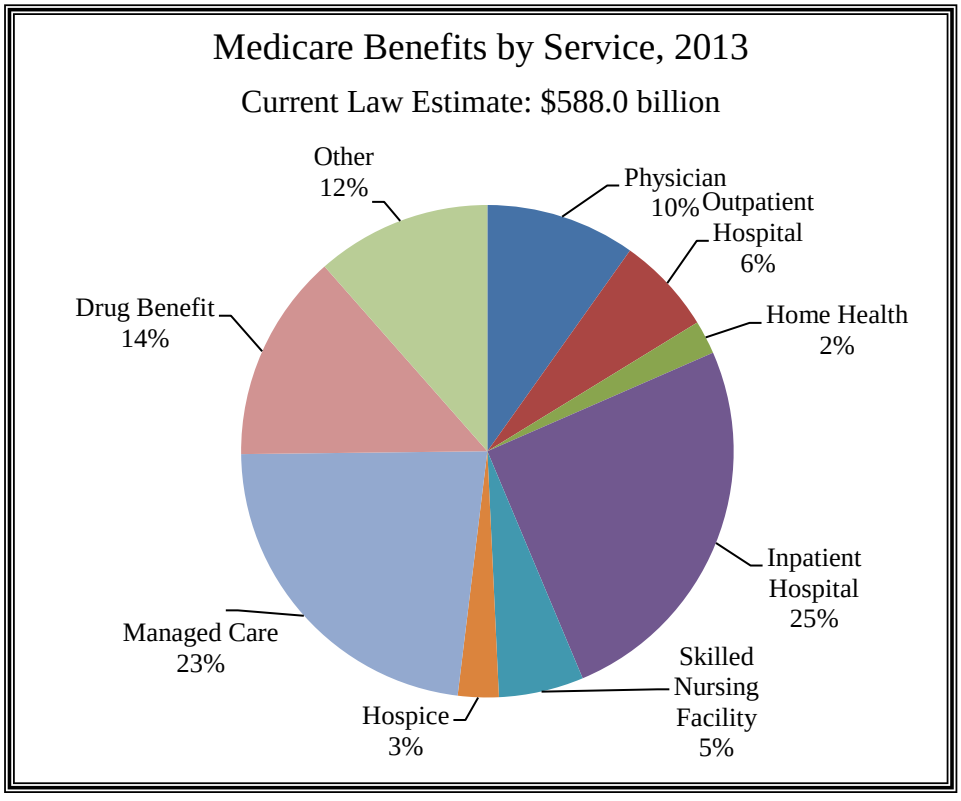
Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most services require a beneficiary co-payment or coinsurance. In 2012, beneficiaries pay a $1,156 deductible for a hospital stay of 1-60 days, and $144.50 daily coinsurance for days 21-100 in a skilled nursing facility.

Part B ($168 billion gross fee-for-service spending in 2013): Medicare Part B pays for physician, outpatient hospital, ESRD, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 92 percent of all Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

The standard monthly Part B premium is $99.90 in 2012, $15.50 lower than the 2011 premium. This premium decreased significantly from the 2011 standard premium in large part because most beneficiaries who were held harmless in 2011 under the statute (i.e. paid the same premium as in 2010) now pay the full 2012 premium. Since more beneficiaries are paying the full amount in 2012, CMS, when setting the premium level, was able to spread the cost of the Part B benefit over a larger population of beneficiaries and therefore could decrease the average premium relative to 2011. Current law protects existing beneficiaries from a reduction in Social Security benefits as a result of Medicare premium increases. In both 2010 and 2011, the Social Security cost-of-living adjustment was zero. However, the cost-of-living adjustment in 2012 is 3.6 percent.

Some beneficiaries pay a higher Part B premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married) will pay from $139.90 to $319.70 per month in 2012.

Part C ($134 billion in 2013): Medicare Part C, the Medicare Advantage (MA) program, pays MA plans a capitated monthly payment to provide all Part A and B services, and also Part D services, if offered by the plan. Plans can offer additional benefits or alternative cost sharing arrangements that are at least as generous as the standard Part A and B benefits



Medicare Enrollment

(enrollees in millions)

	2011	2012	2013	2013 +/-2012
Aged	40.2	41.5	43.0	1.5
Disabled	8.2	8.7	9.0	0.3
Total Beneficiaries	**48.4**	**50.2**	**52.0**	**1.8**

under traditional Medicare. Beneficiaries who choose to participate in Part C may pay monthly plan premiums in addition to the regular Part B premium, which vary based on the services offered by the plan and efficiency of the plan, to MA plans to cover all Medicare services plus any additional benefits.

In 2013, MA enrollment will total approximately 13 million. CMS data and a recent Government Accountability Office report confirm that Medicare beneficiary access to an MA plan remains strong and stable at 99.7 percent in 2012, premiums have decreased, MA supplemental benefits remain largely unchanged, and enrollment is growing.

Part D ($80 billion projected gross spending in 2013): Medicare Part D offers a standard prescription drug benefit with a 2012 deductible of $320 and an average estimated monthly premium of $30. Enhanced and alternative benefits are also available with varying deductibles and premiums. Beneficiaries who choose to participate are responsible for covering a portion of the cost of their prescription drugs; this portion may vary depending on whether the medication is generic or a brand name and how much the beneficiary has already spent on medications that year. Low-income beneficiaries are responsible for varying degrees of cost sharing, with co-payments ranging from $0 to $6.50 in 2012 and low or no monthly premiums.

For 2013, the number of beneficiaries enrolled in Medicare Part D is expected to increase by about 4 percent to 38 million, including about 11 million low-income subsidy (LIS) beneficiaries. In 2011, approximately 52.5 percent of those with Part D coverage were enrolled in a stand-alone Part D prescription drug plan, 31 percent were enrolled in a Medicare Advantage Prescription Drug Plan, and those remaining received the Retiree Drug Subsidy. Overall, approximately 90 percent of all Medicare beneficiaries received prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage.

2013 LEGISLATIVE PROPOSALS

The FY 2013 Budget includes a package of Medicare legislative proposals that will save $302.8 billion over 10 years by aligning payments with costs of care and strengthening provider payment incentives to promote high-quality care, and making structural changes that will reduce federal subsidies to high-income beneficiaries and create incentives for new beneficiaries to seek high-value services. Together, these measures will extend the Hospital Insurance Trust Fund solvency by approximately two years.

Align Medicare Drug Payments with Medicaid Policies for Low-Income Beneficiaries: Currently, drug manufacturers are required to pay specified rebates for drugs dispensed to Medicaid beneficiaries. In contrast, Medicare Part D plan sponsors negotiate with manufacturers to obtain plan-specific rebates at unspecified levels. Analysis has found substantial differences in rebate amounts and prices paid for brand name drugs under the two programs, with Medicare receiving significantly lower rebates and paying higher prices than Medicaid. This proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy, beginning in 2013. The proposal would require manufacturers to pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels. Prior to the establishment of Medicare Part D, manufacturers paid Medicaid rebates for drugs provided to the dual eligible population. [$155.6 billion in savings over 10 years]

Adjust Payment Updates for Certain Post-Acute Care Providers: The Medicare Payment Advisory Commission (MedPAC) analysis indicates that Medicare payments generally exceed the costs for care in post-acute settings. This proposal would gradually realign payments with costs through adjustments to payment rate updates for Inpatient

Closing the Coverage Gap

The following table displays Part D beneficiary cost savings for brand and generic drugs in the Part D coverage gap by year, until 2020. Beginning in 2020, cost sharing for beneficiaries will be set at only 25 percent.

Medicare Part D Coverage Gap Cost-Sharing by Year and Average Beneficiary Savings Per Year[1]

Year	Percent Cost Sharing Paid by Enrollee for Branded Drugs	Percent Cost Sharing Paid by Enrollee for Generic Drugs	Average Amount Saved per Enrollee who Reaches the Coverage Gap /3
2010 /2	100%	100%	$250
2011	50%	93%	$604
2012	50%	86%	$562
2013	47.5%	79%	$632
2014	47.5%	72%	$684
2015	45%	65%	$773
2016	45%	58%	$840
2017	40%	51%	$984
2018	35%	44%	$1,144
2019	30%	37%	$1,322
2020	25%	25%	$1,540

1/ Savings only apply to applicable beneficiaries who do not receive the low-income subsidy.

2/ Percent cost sharing does not include $250 rebate for each beneficiary who hit the coverage gap in 2010.

3/ Source (for 2011): CMS data. Source (for years 2012 and beyond): 2009 data generated by Acumen for the HHS Assistant Secretary for Planning and Evaluation (ASPE).

Rehabilitation Facilities (IRFs), Long-Term Care Hospitals, Skilled Nursing Facilities (SNFs), and Home Health agencies, by 1.1 percentage points beginning in 2014 through 2021. These adjustments build on recommendations from MedPAC's March 2011 Report to Congress, in which they recommend that Congress eliminate the payment updates for each of these provider types in 2012. Payment updates for those providers would not drop below zero. [$56.7 billion in savings over 10 years]

Reduce Medicare Coverage of Bad Debt: For most hospitals and SNFs, Medicare currently pays 70 percent of bad debts resulting from beneficiaries' non-payment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. Starting in 2013, this proposal would reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments, more closely aligning Medicare policy with private sector standards, which do not pay for bad debt. [$35.9 billion in savings over 10 years]

Better Align Graduate Medical Education Payments with Patient Care Costs: MedPAC has found that existing Medicare add on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal would partially correct this imbalance by gradually reducing these payments by a total of ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education Payments that encourage training of primary care residents and skills that promote high-quality and high-value health care delivery. [$9.7 billion in savings over 10 years]

Encourage Appropriate Use of Inpatient Rehabilitation Facilities (IRF): This proposal would adjust the standard for classifying a facility as an IRF. Under current law, at least 60 percent of patient cases admitted to an IRF must meet one or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Beginning in 2013, this proposal would reinstitute the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.3 billion in savings over 10 years]

Equalize Payments for Certain Conditions Commonly Treated in IRFs and SNFs: This proposal would adjust payments for three conditions involving hips and knees, as well as other conditions selected by the Secretary. While these conditions are commonly treated at both IRFs and SNFs, Medicare payments are significantly higher when services are provided in an IRF. Beginning in 2013, this proposal would improve financial incentives to encourage efficient and appropriate provision of care by reducing the disparity in Medicare payments between the settings. IRFs provide intensive inpatient rehabilitation that may not be appropriate for patients with relatively uncomplicated conditions that could be treated in a SNF. [$2.0 billion in savings over 10 years]

Adjust SNF Payments to Reduce Hospital Readmissions: The Affordable Care Act requires payment reductions starting in 2013 for hospitals with high rates of readmissions, many of which could have been avoided with better care. MedPAC analysis indicates that almost 14 percent of Medicare patients discharged from a hospital to a SNF are readmitted to the hospital for conditions that could potentially have been avoided. To promote similar high-quality care in SNFs, this proposal reduces payments by up to three percent for SNFs with high rates of care-sensitive, preventable hospital readmissions, beginning in 2016. [$2.0 billion in savings over 10 years]

Reduce CAH Reimbursement to 100% of Costs: Critical Access Hospitals (CAHs) are small, rural hospitals that provide their communities with access to basic emergency and inpatient care. CAHs receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently reimburses CAHs at 101 percent of reasonable costs. This proposal would reduce this rate to 100 percent beginning in 2013. [$1.4 billion in savings over 10 years]

Update Medicare Payments to More Appropriately Account for Utilization in Advanced Imaging: Medicare spending for imaging services paid for under the physician fee schedule has grown dramatically over the last decade due to an increase in the number and intensity of these services, though this growth has mediated somewhat in recent years. MedPAC has stated that these services may be mispriced and has supported Medicare payment changes for expensive imaging equipment. Beginning in 2013, this proposal implements a payment reduction for advanced imaging equipment to account for higher levels of utilization of certain types of equipment. [$820 million in savings over 10 years]

Prohibit CAH Designation for Facilities Less Than 10 Miles from Nearest Hospital: Beginning in 2014, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced rate. [$590 million in savings over 10 years]

Dedicate Penalties for Failure to Use EHRs Toward Deficit Reduction: The American Recovery and Reinvestment Act of 2009 established financial penalties for certain Medicare providers if they fail to adopt EHRs, beginning in 2015. These penalties are credited toward a special account starting in 2020. This proposal would instead dedicate these penalties to deficit reduction rather than to the Medicare Improvement Fund. [$590 million in savings over 10 years]

Increase Income-Related Premiums Under Part B and Part D: Under Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2017, this proposal would increase income-related premiums under Medicare Parts B and D by 15 percent (income related premiums would range between 40 percent and 90 percent depending on a person's income) and maintain the income thresholds associated with these premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. This proposal will help improve the financial stability of the Medicare program by reducing the Federal subsidy of Medicare costs for those beneficiaries who can most afford it. [$27.6 billion in savings over 10 years]

Introduce Part B Premium Surcharge for New Beneficiaries Purchasing Near First Dollar Medigap Coverage: Medicare requires cost sharing for various services, but Medigap policies sold by private insurance companies provide beneficiaries with additional coverage for these out-of-pocket expenses. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare costs and Part B premiums. This proposal would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with

Healthcare Associated Infections

CMS is the lead agency partnering with the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the Secretary working to improve patient safety and reduce the national rate of healthcare-associated infections (HAIs) by demonstrating significant, quantitative, and measurable reductions in hospital-acquired central-line associated bloodstream infections and catheter-associated urinary tract infections. HAIs are among the leading cause of morbidity and mortality in the United States. This intradepartmental priority performance goal aims to achieve a 25 percent reduction in central-line associated bloodstream infections and a 20 percent reduction in catheter-associated urinary tract infections by September 30, 2013. The Department has already started to achieve these goals, using CDC's National Healthcare Safety Network as a data source, AHRQ's Comprehensive Unit-based Safety Program, the Office of the Assistant Secretary for Health's "National Action Plan to Prevent HAIs: Roadmap to Elimination" for strategic direction, as well as leveraging the work of CMS' Quality Improvement Organizations and CMS' Innovation Center Partnership for Patients project.

particularly low cost-sharing requirements, effective in 2017. Other Medigap plans that meet minimum cost sharing requirements would be exempt from the surcharge. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium (or about 30 percent of the Part B premium). [$2.5 billion in savings over 10 years]

Modify Part B Deductible for New Beneficiaries: Beneficiaries who are enrolled in Medicare Part B are required to pay an annual deductible ($140 in CY 2012). To strengthen program financing, this proposal would apply a $25 increase to the Part B deductible in 2017, 2019, and 2021 for new beneficiaries. [$2.0 billion in savings over 10 years]

Introduce Home Health Copayments for New Beneficiaries: Medicare beneficiaries do not currently make co-payments for home health services. This proposal would create a co-payment for new beneficiaries of $100 per home health episode, starting in 2017. Consistent with MedPAC recommendations, this co-payment would apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. This proposal aims to encourage appropriate use of home health services while protecting beneficiary access. [$350 million in savings over 10 years]

Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth: Created by the Affordable Care Act, the Independent Payment Advisory Board (IPAB) has been highlighted by economists and health policy experts as a key contributor to Medicare's long-term solvency. Under current law, if the projected Medicare per capita growth rate exceeds a predetermined target growth rate, IPAB will recommend policies to Congress to reduce the Medicare growth rate to meet the target. To further moderate Medicare cost growth, this proposal would lower the target rate in 2018 and after from gross domestic product (GDP) per capita growth plus 1 percent to GDP per capita growth plus 0.5 percent. Some of the tools available to the IPAB include consideration of value-based benefit design and policies that promote integrated and coordinated care. IPAB recommendations would still be prohibited from increasing beneficiary premiums or cost-sharing and from restricting benefits. [no budget impact]

Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics: Beginning in 2013, this proposal would increase the availability of generic drugs and biologics by authorizing the Federal Trade Commission (FTC) to prohibit pay-for-delay agreements between brand and generic pharmaceutical companies that delay entry of generic drugs and biologics into the market. In these agreements, a brand name company settles its patent lawsuit by paying the generic firm to delay entering the market. This proposal will save money in the Medicare and Medicaid. [$8.6 billion in Medicare savings over 10 years]

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics: This proposal would modify the length of exclusivity on brand name biologics to encourage faster development of generic biologics while retaining appropriate incentives for research and development for the innovation of breakthrough products. Effective in 2013, it would award brand biologic manufacturers 7 years of exclusivity rather than 12 years under current law and prohibit additional periods of exclusivity for brand biologics due to minor changes

in product formulations, a practice often referred to as ever-greening. This proposal will save money in Medicare and Medicaid. [$3.7 billion in Medicare savings over 10 years]

Assumptions and Adjustments:

Physician Payments: To promote more honest and transparent budgeting, the Budget includes an adjustment totaling $429 billion over 10 years (FY 2013-FY 2022) to reflect the Administration's best estimate of the cost of future congressional action based on what Congress has done in recent years for physician payments. This adjustment does not signal a specific Administration policy, but rather a willingness to work with Congress to achieve permanent, fiscally responsible reform.

THE AFFORDABLE CARE ACT HIGHLIGHTS: STRENGTHENING MEDICARE

The Affordable Care Act takes numerous steps to strengthen the quality, accessibility, and sustainability of care provided to Medicare beneficiaries.

Accountable Care Organizations (ACOs): ACOs are a transformative aspect of the Affordable Care Act is the establishment of ACOs. ACOs are groups of doctors, hospitals, and other health care providers who join together voluntarily to deliver coordinated, high-quality care to the patients they serve. Coordinated care helps ensure that patients get the right care at the right time, with the goal of avoiding unnecessary duplication of services, preventing medical errors, and reducing Medicare costs.

Medicare has launched a three-part ACO initiative:

Part 1-Medicare Shared Savings Program: A fee-for-service program established by the Affordable Care Act, designed to improve beneficiary outcomes and increase value of care. Starting in 2012, ACOs that meet certain quality objectives and reduce overall expenditures get to share in the savings with Medicare and may be subject to losses. The final rule that implements this program was published on November 2, 2011. There are two start dates in 2012: April and July. CMS is currently accepting applications from prospective organizations. This program is expected to save Medicare $470 million over 4 years.

Part 2-Advance Payment ACO Model: A model sponsored by the CMS Innovation Center that tests whether pre-paying a portion of future shared savings could increase participation in the Medicare Shared Savings Program. Additional information can be found in the Innovation Center section.

Part 3-Pioneer ACO Model: An initiative sponsored by the Innovation Center for health care organizations and providers that already have experience coordinating care for patients across care settings. On December 19, 2011, CMS announced that 32 organizations from across the country have been selected to participate in the model. The first performance period began on January 1, 2012. Additional information can be found in the Innovation Center section.

Primary Care and Prevention: Beginning in 2011, primary care providers and surgeons in health professional shortage areas started receiving an additional 10 percent payment for primary care services or major surgical procedures, respectively. In addition, over 25.5 million people with Medicare reviewed their health status at a free Annual Wellness Visit or received other preventive services without cost sharing in 2011.

Coverage Gap Savings: The Affordable Care Act established a discount program for Medicare beneficiaries who reach the Part D coverage gap, or "donut hole." Beneficiaries fall into the coverage gap once their total drug spending exceeds an initial coverage limit ($2,930 in 2012), until they reach the threshold for qualified out-of-pocket spending ($4,700 in 2012), at which point they are only responsible for five percent of their drug costs. In 2013, if a non-LIS beneficiary reaches the coverage gap, he or she will pay 47.5 percent of the cost of covered Part D brand name drugs and biologics in the gap, compared to 50 percent in 2011 and 2012. In 2013, beneficiaries will pay 79 percent of the costs for all generic drugs in the coverage gap, a reduction of seven percentage points compared to 2012. Cost-sharing in the coverage gap will decrease each year until beneficiaries are required to pay only 25 percent of the costs of covered Part D drugs in 2020 and beyond.

In 2011, approximately 3.6 million beneficiaries reached the coverage gap and saved more than $2.1 billion on their medications due to the prescription drug discount program. These savings averaged about $604 per person.

Improving Quality and Value: Medicare continues its transformation from a passive payer to an effective purchaser of high-quality, efficient care. The Affordable Care Act established a value-based purchasing program for hospitals, and required CMS to develop plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers, as well as a hospital readmissions reduction program that requires the Secretary to reduce payments to hospitals that have a high rate of readmissions. Implementing these provisions will continue to be a high priority for CMS in FY 2013, which is the first year of quality-based payment adjustments for inpatient hospitals. The Affordable Care Act also requires CMS to implement a quality-based bonus payment for MA plans based on a 5-star rating system beginning in 2012. CMS has also promoted Medicare Advantage plan quality by exercising authority provided in the Affordable Care Act to protect beneficiaries against significant increases in beneficiary costs from one year to the next.

Data Availability: Under the Affordable Care Act, consumers and employers will now have the health care information they need to make more informed choices about their care. For years, consumers and employers could not obtain Medicare data that they could use to evaluate provider performance. CMS finalized a rule in December 2011 that provides qualified organizations access to Medicare data that can help them identify high-quality health care providers.

Reducing Costs: The Affordable Care Act includes numerous changes designed to control the growth in Medicare spending. These changes include small adjustments to certain provider payment updates, more closely aligning Medicare Advantage payments with those under traditional Medicare, program integrity enhancements, and creation of payment incentives to provide high-quality care.

CMS published two Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification regulations required by the Affordable Care Act. The first rule adopts operating rules for health plan eligibility and health care claims, and is projected to save $14.8 billion for the health care industry over 10 years. The other rule sets standards to help change the way the health care industry pays bills—from paper transfers to electronic—and is expected to save the industry approximately $2.4 to $3.6 billion over 10 years.

Additionally, in FY 2013, the Affordable Care Act expands the Durable Medical Equipment (DME) Competitive Bidding program from 79 to 100 metropolitan areas. The program is also expanding through a national competition for mail order diabetic testing supplies. As a result, millions of Medicare beneficiaries across the country will save money from competitive pricing while continuing to have access to quality medical equipment from accredited suppliers. CMS expects to save $25.7 billion over 10 years as a result of the DME Competitive Bidding program. Additionally, CMS expects beneficiaries will save $17.1 billion over 10 years in lower premiums and reduced co-payments as a result of this program.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

The mission of the Quality Improvement Organization (QIO) Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The new three year contract cycle, or 10th Statement of Work (SOW), was launched on August 1, 2011 and provides approximately $1.3 billion in funding for FYs 2011 2014. Through partnership and collaboration, the 10th SOW aligns the strengths of the QIO program with national quality goals that seek to continually improve health and health care for all Americans. As the on the ground experts to drive local change, QIOs provide a local infrastructure to achieve national goals which can translate into national quality improvement.

Major 10th SOW activities are organized around four priorities:

Beneficiary centered Care: Focus on case review, including beneficiary complaints and concerns related to early discharge from health care settings, and patient and family engagement.

Improve Individual Patient Care: Focus on patient safety with the goals of reducing health care acquired conditions by 40 percent, eliminating unnecessary physical restraints and reducing pressure ulcers in nursing homes, and improving the quality of care provided through value based purchasing. Integrate Care for Populations: Improve care transitions by striving, among other goals, to reduce 30 day hospital readmissions by 20 percent over three years.

Improve Health for Populations and Communities: Concentrate resources on prevention through increased screening and immunizations, as well as cardiovascular disease prevention. QIOs will also continue to improve the use of electronic health records (EHRs) for care management and prevention by working to promote, and assist physicians with, quality reporting.

Estimated QIO Funding 10th SOW (2011–2014)
(dollars in millions)

QIO Clinical Quality Improvement and Value Based Purchasing	
Improving Individual Patient Care	*$223.1*
Integrated Care for Populations	*$93.9*
Improving Health for Populations and Communities	*$101.7*
Care Reinvention through Innovative Spread	*$30.6*
Subtotal, Clinical Quality Improvement and Value Based Purchasing	**$449.3**
Infrastructure, Staff, and Special Initiatives	**$381.3**
Other Support Contracts	**$212.0**
Beneficiary Centered Care	**$181.0**
Value Based Purchasing Support	**$81.1**
Subtotal 10th SOW Funding	**$1,304.7**

QIO Performance Management Strategy: In the 9th SOW, QIOs made dramatic improvements in program oversight and monitoring, based in part on recommendations from the Institute of Medicine. These improvements continue into the 10th SOW, and include innovations in QIO contract management, ongoing performance and mid contract management reviews, and financial consequences for contractors that do not maintain predetermined performance levels.

Recent Legislative Changes to the QIO Program: The Trade Adjustment Assistance Extension Act of 2011 established new QIO authorities, consistent with the President's FY 2012 budget proposals. These changes enhance the review of contract performance and the ability to terminate contracts for poor performance in a manner consistent with federal acquisition regulations, extend the length of contracts from 3 to 5 years, expand the types of entities eligible for QIO contracts, allow QIOs to perform specialized functions and eliminate conflicts of interest among QIO work tasks, and provide flexibility with respect to the geographic scope of contracts to facilitate improved efficiency.

Medicare FY 2013 Budget Proposals

(dollars in millions, negative numbers reflect savings and positive numbers reflect costs)

	2013	2013 –2017	2013 –2022
Increase Value in Medicare Provider Payments			
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	-3,796	-48,770	-155,553
Adjust Payment Updates for Certain Post-Acute Care Providers	-30	-10,360	-56,670
Reduce Medicare Coverage of Bad Debts	-770	-12,840	-35,880
Better Align Graduate Medical Education Payments with Patient Care Costs	–	-3,750	-9,690
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-180	-1,050	-2,300
Equalize Payments for Certain Conditions Commonly Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	-140	-850	-2,010
Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions	–	-460	-1,950
Reduce Critical Access Hospital Reimbursement to 100% of Costs	-70	-570	-1,420
Update Medicare Payments to More Appropriately Account for Utilization of Advanced Imaging	-40	-330	-820
Prohibit Critical Access Hospital Designation for Facilities that are Less than 10 Miles from the Nearest Hospital	–	-220	-590
Dedicate Penalties for Failure to Use Electronic Health Records Toward Deficit Reduction	–	–	-590
Medicare Structural Reforms			
Increase Income-Related Premiums Under Medicare Part B and Part D	–	-1,430	-27,571
Introduce a Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap Coverage	–	-80	-2,530
Modify Part B Deductible for New Beneficiaries	–	–	-1,990
Introduce Home Health Copayments for New Beneficiaries	–	-10	-350
Strengthen IPAB to Reduce Long-Term Drivers of Medicare Cost Growth	–	–	–
Increase the Availability of Generic Drugs and Biologics			
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicare impact)	-545	-3,373	-8,610
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare impact)	-19	-627	-3,655
Reduce Fraud, Waste, and Abuse in Medicare (see Program Integrity section)	-10	-130	-450
Interactions /1	-2	268	8,112
Other Proposals			
Extend the Qualified Individuals (QI) Program /2	695	1,690	1,690
Total, Medicare Legislative Proposals	**-4,907**	**-82,892**	**-302,827**

Totals may not add due to rounding.

1/ Adjusts for savings realized through IPAB and other Medicare interactions.

2/ States pay the Medicare Part B premium costs for Qualified Individuals (QIs) that are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the QI program through CY 2014 are reflected in Medicare outlays.

PROGRAM INTEGRITY

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Budget Authority:				
HCFAC Discretionary /1	310	581	610	+29
HCFAC Mandatory /2	1,398	1,290	1,297	+7
Affordable Care Act (non-add) /3	*125*	*117*	*124*	*+7*
Small Business Jobs Act (non-add)	*100*	—	—	—
Total, Budget Authority	**1,708**	**1,871**	**1,907**	**+36**

1/ The President's Budget proposes to increase the 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with the Budget Control Act of 2011.

2/ Does not include Deficit Reduction Act funding for the CMS Medicaid Integrity Program, which is discussed separately under State Grants and Demonstrations.

3/ Includes the Affordable Care Act's inflation adjustment to the HCFAC mandatory base.

The FY 2013 Budget supports fraud prevention and the reduction of improper payments as top priorities of the Administration. The Budget proposes investing $610 million, $29 million above the full amount allowed for FY 2012 under the Budget Control Act (BCA) of 2011. All proposed discretionary Health Care Fraud and Abuse Control (HCFAC) program investments, including gradual growth over time, are consistent with the BCA and save $11.3 billion over 10 years. The Budget also proposes legislative changes that give HHS important new tools to enhance program integrity oversight; cut waste, fraud, and abuse in Medicare, Medicaid, and CHIP; and generate an additional $3.6 billion in program savings over 10 years. Additionally, a Social Security proposal strengthening disability reviews will result in an additional $4.5 billion in Medicare and Medicaid savings over ten years.

HEALTH CARE FRAUD AND ABUSE CONTROL FUNDING

The Administration's commitment to program integrity has led to numerous advancements in fraud detection and prevention. The FY 2013 Budget

HCFAC Multi-Year Investment and Savings

(dollars in millions)

	2012 Base	2013	2014	2015	2016	2017	2013 –2017	2013 –2022
Mandatory Base Funding /1	1,290	1,297	1,321	1,336	1,362	1,369	6,685	13,949
Discretionary Funding /2	581	610	640	672	706	725	3,353	7,285
Total Program Level	**1,871**	**1,907**	**1,961**	**2,008**	**2,068**	**2,094**	**10,038**	**21,234**
Savings from Discretionary Investment /3	**-900**	**-945**	**-991**	**-1,041**	**-1,094**	**-1,123**	**-5,194**	**-11,284**

1/ Totals do not include Deficit Reduction Act of 2005 funding for the Medicaid Integrity Program, which is discussed separately under State Grants and Demonstrations.

2/ The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with the Budget Control Act of 2011.

3/ Savings are attributable only to the discretionary investment. Savings are not scorable under PAYGO.

proposes to build on recent progress by increasing support for the HCFAC program through both mandatory and discretionary funding streams. The FY 2013 HCFAC program level is $1.9 billion. Of the total FY 2013 program level, $1.3 billion is mandatory funding and $610 million is requested in discretionary funding.

HCFAC Mandatory Funds: The $1.3 billion in mandatory funds for FY 2013 are financed from the Medicare Part A Trust Fund. This funding is allocated to: the Medicare Integrity Program (MIP); the HCFAC Account, which is divided annually among the HHS Office of Inspector General (OIG), other HHS agencies, and law enforcement partners at the Department of Justice (DOJ); and the Federal Bureau of Investigation (FBI). These dollars fund comprehensive efforts to combat health care fraud, waste, and abuse, including prevention-focused activities, improper payment reductions, provider education, data analysis, audits, investigations, and enforcement.

Return on Investment: Programs supported by HCFAC mandatory funds have a proven record of returning far more money to the Medicare Trust Funds than the dollars spent. The MIP return on investment averages 14 to 1, and MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade.

Reducing the Improper Payment Rate

In November 2009, the President issued an Executive Order laying out a strategy to cut the Medicare fee-for-service improper payment rate in half, to 5.4 percent, by FY 2012.

CMS has developed a comprehensive plan to achieve this goal. The following describes some key activities to reduce the improper payment rate:

- Increase and improve medical review by focusing on services or providers that are at a high-risk for improper payments;
- Use predictive modeling and robust data analysis to review claims for medically unlikely events;
- Help providers analyze their administrative claims data or billing patterns through various reports;
- Allow Recovery Auditors to review additional provider types and closely monitor the decisions made by the Recovery Auditors; and
- Implement a series of demonstrations targeted at payment practices with historically high improper payment rates.

The HCFAC Account 3-year rolling average return on investment is now a record 7.2 to 1. From 1997 to 2011, programs supported by the HCFAC account have returned over $20.6 billion to the Trust Funds. In FY 2011 alone, $4.1 billion was recovered, including $2.5 billion returned to the Medicare Trust Funds and $600 million in Federal Medicaid recoveries returned to the Treasury.

HCFAC Discretionary Funds: The FY 2013 Budget requests $610 million in discretionary HCFAC funding, an increase of $29 million above the full amount allowed for FY 2012 under the BCA. This $610 million will be allocated between CMS ($409.7 million), OIG ($102.5 million), and DOJ ($97.8 million). Additionally, because the Consolidated Appropriations Act of 2012 did not fully fund HCFAC consistent with the FY 2012 level included in the BCA, the President's Budget proposes to increase the FY 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the discretionary cap adjustment, consistent with the BCA.

The HCFAC discretionary investment supports efforts

Medicare Fraud Strike Force Successes

The Medicare Fraud Strike Force is a partnership between HHS and DOJ in nine health care fraud hot spots around the country. Strike Force teams use advanced data analysis techniques to identify high-billing levels so that interagency teams can target emerging or migrating schemes and chronic fraud by criminals masquerading as health care providers or suppliers.

In the 4 ½ years since its inception, Strike Force prosecutors filed more than 600 cases charging more than 1,150 defendants who collectively billed the Medicare program more than $2.9 billion. Strike Force prosecutors secured 663 guilty pleas and 74 others were convicted in jury trials. Additionally, 543 defendants were sentenced to imprisonment for an average term of nearly 42 months.

to reduce the Medicare fee-for-service (FFS) improper payment rate and initiatives of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) task force. The investment also supports Strike Force teams in cities where intelligence and data analysis suggest high levels of fraud; more rigorous data analysis; and an increased focus on civil fraud, such as off-label marketing and pharmaceutical fraud.

CMS will also make further investments in innovative and prevention-focused initiatives, such as the National Fraud Prevention Program. The program leverages sophisticated analytic tools in claims processing and provider enrollment to better identify fraudulent activity and high-risk applicants and then take swift and appropriate action to protect the Trust Funds. For example, under this national program, CMS uses a Fraud Prevention System to analyze all Medicare FFS claims with sophisticated algorithms to identify suspicious behavior, similar to the technology used in the credit card industry, and automated provider screening to compare information from public and private databases against enrollment applications to remove fraudulent providers from the Medicare program. In FY 2013 and beyond, CMS will continuously refine these technologies to better combat fraud, waste, and abuse in Medicare, Medicaid, and Children's Health Insurance Program (CHIP).

CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud, about $1.50 is saved or averted. Based on these projections, the $610 million in HCFAC discretionary funding, as part of a multi-year investment, will yield Medicare and Medicaid savings of $5.2 billion over 5 years and $11.3 billion over 10 years.

NEW AFFORDABLE CARE ACT AUTHORITIES

The Affordable Care Act includes an additional $350 million in program integrity resources over 10 years, plus an inflation adjustment. It provides unprecedented tools to CMS and law enforcement to protect Medicare, Medicaid, and CHIP from fraud, waste, and abuse.

CMS implemented many of these new authorities through rulemaking in 2011. The provider screening and fraud prevention rule created a rigorous risk-based screening process for all new and re-enrolling providers and suppliers enrolling in Medicare, Medicaid, or CHIP. Providers and suppliers are assigned to one of three fraud risk levels—limited, moderate, or high. Moderate and high-risk providers are subject to announced and unannounced site visits. High-risk providers and suppliers must undergo a fingerprint-based criminal background check. CMS now has express authority to temporarily halt the enrollment of providers or suppliers when significant potential for fraud, waste, or abuse exists by provider type, geographic area, or both. CMS can also suspend payments to a provider or supplier pending the investigation of a credible allegation of fraud.

Strengthening Program Integrity Tools

The FY 2013 Budget builds on the Affordable Care Act's unprecedented fraud-fighting authorities with 16 program integrity legislative proposals. These proposals enhance pre-payment scrutiny, increase penalties for improper actions, strengthen CMS's ability to implement corrective actions, and promote integrity in Federal-State financing while saving Medicare, Medicaid, and CHIP $3.6 billion over 10 years.

The Affordable Care Act also requires a face-to-face encounter between patient and doctor prior to certifying Medicare and Medicaid eligibility for the home health and hospice benefit. This requirement discourages fraud by ensuring patients do not receive unnecessary services as determined by a physician. CMS is also developing regulations for durable medical equipment (DME) face-to-face encounters. Additionally, the Affordable Care Act requires inclusion of national provider identifiers on all provider enrollment applications and claims; requires physicians and suppliers to maintain documentation of written orders for DME, home health, or other referrals upon request; expands Recovery Audit Contractors to Medicare Parts C and D and Medicaid; and requires compliance plans for providers and suppliers.

PROGRAM INTEGRITY LEGISLATIVE PROPOSALS

The Budget includes 16 legislative proposals to further strengthen program integrity for Medicare, Medicaid, and CHIP, saving $3.6 billion over 10 years.

Medicare:

Require Prepayment or Earlier Review for Power Mobility Devices: Historically, due to high payment rates, Power Mobility Devices (PMDs) have a high incidence of fraud and abuse. Pre-payment or earlier review of claims will deter fraud and prevent improper payments by validating medical necessity. CMS currently plans to test the effectiveness of using prior-authorization and pre-payment review on some PMDs through a demonstration. [$140 million in savings over 10 years]

Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records: Currently, providers and suppliers are required to update enrollment records to remain in compliance with the Medicare program. This proposal gives providers and suppliers an additional incentive to ensure up-to-date records, which provide important information to CMS—such as adverse legal actions—and reduce program vulnerability to fraud. [$90 million in savings over 10 years]

Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High-Risk Items and Services: Many current systems for ordering services lack mechanisms to determine whether the service is medically necessary or if the patient has seen a practitioner. An electronic Medicare claims ordering system could result in significant savings by preventing improper payments. [no budget impact]

Increase Scrutiny of Providers using Higher-risk Banking Arrangements to Receive Medicare Payments: Require providers to report the use of sweep accounts that immediately transfer funds from a financial account to an investment account in another jurisdiction preventing Medicare from recovering improper payments, and permit enhanced review of reporting providers. [no budget impact]

Require Prior Authorization for Advanced Imaging: The rapid growth in the number and intensity of imaging services over the last decade raises concerns about whether these services are being used appropriately. This proposal would adopt prior authorization for the most expensive imaging services to ensure that these services are used as intended and protect the Medicare program and its beneficiaries from unwarranted use. Many private health insurance companies require prior authorization for these services to manage spending growth. Furthermore, the Government Accountability Office has recommended that CMS consider prior authorization and other approaches to slow down spending growth for these services. [no budget impact]

Medicaid:

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid: States are currently authorized to implement prescription drug monitoring activities, but not all states havadopted such activities. Under this proposal, states will be required to monitor high-risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care. [$1.6 billion in savings over 10 years]

Strengthen Medicaid Third-Party Liability: Medicaid is the payer of last resort, and this proposal would affirm Medicaid's position by strengthening third-party liability under Medicaid to improve states' and providers' abilities to receive third-party payments for beneficiary services, as appropriate. This proposal allows states to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, allows states to collect medical child support where health insurance is available from a non-custodial parent, and allows Medicaid to recover costs from beneficiary liability settlements. [$1.5 billion in savings over 10 years]

Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States: Manufacturers are required to report a list of their covered outpatient drugs to CMS for Medicaid prescription drug coverage under current Federal law. Some manufacturers improperly report items that are not covered by Medicaid. This proposal requires full restitution to states for any covered drug improperly reported by the manufacturer on the

Medicaid drug coverage list. [$12 million in savings over 10 years]

Enforce Manufacturer Compliance with Drug Rebate Requirements: Under current law, CMS has authority to survey drug manufacturers, and OIG has authority to audit drug manufacturers. This proposal would allow more regular audits and surveys of drug manufacturers to ensure compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective. [no budget impact]

Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage: Current law requires manufacturers to list their prescription drugs with the Food and Drug Administration (FDA), but not all drugs on the market are properly listed. This proposal would require electronic listing of drugs with the FDA in order to receive Medicaid coverage and align Medicaid drug coverage requirements with Medicare requirements. [no budget impact]

Increase Penalties for Fraudulent Noncompliance on Rebate Agreements: Under Medicaid drug rebate agreements, drug manufacturers are required to report accurate information. This proposal would increase penalties collected from drug manufacturers that knowingly report false information under their drug rebate agreements for the calculation of Medicaid rebates. [no budget impact]

Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP: Federal regulations indicate that Federal funds may not be used as the state share for Medicaid unless authorized in Federal law to match other Federal funds. By codifying this principle in statute, this proposal would prevent states from using Federal funds to pay the state share of Medicaid or CHIP, unless specifically authorized under law to match Medicaid or CHIP funds. [no budget impact]

Consolidate Redundant Error Rate Measurement Programs: Alleviate state program integrity reporting requirements and create a streamlined audit program by consolidating the Medicaid Eligibility Quality Control (MEQC) and Medicaid Payment Error Rate Measurement (PERM) programs. [no budget impact]

Medicare and Medicaid:

Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse: Under current law, CMS can use the Recovery Audit Contractor (RAC) program recovery funds to administer the RAC program but cannot use these funds to implement corrective actions, such as new processing edits and provider education and training, to prevent future improper payments. This proposal addresses this funding restriction. [$240 million in savings over 10 years]

Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities: CMS is committed to protecting Medicare, Medicaid, and all other federal health care programs from potentially fraudulent providers. This proposal would expand the current authority to exclude individuals and entities from federal health programs if affiliated with a sanctioned entity by: eliminating the loophole in the current law that allows an officer, managing employee, or owner of a sanctioned entity to evade exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity. [$60 million in savings over 10 years]

Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers: In an effort to protect beneficiaries from illegal distribution of their identification numbers, this proposal would strengthen penalties for the knowing distribution of Medicare, Medicaid, or CHIP beneficiary identification or billing privileges. [no budget impact]

Predictive Modeling

CMS launched the Fraud Prevention System in June 2011, marking a significant shift from a pay and chase model to a pre-payment predictive modeling and claims screening model similar to technology used by the credit card industry. This approach screens all Medicare Part A, Part B, and Durable Medical Equipment (DME) claims through a series of predictive models to identify suspicious billing activity and emerging fraud trends. The system prioritizes leads for review by CMS's program integrity contractors, who investigate the leads and determine if intervention is needed to stop payment or law enforcement referral is warranted.

(dollars in millions, negative numbers reflect savings and positive numbers reflect costs)

	2013	2013 –2017	2013 –2022
Medicare			
Require Prepayment or Earlier Review for Power Mobility Devices	-10	-50	-140
Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records	–	-40	-90
Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services	–	–	–
Increase Scrutiny of Providers using Higher-risk Banking Arrangements to Receive Medicare Payments	–	–	–
Require Prior Authorization for Advanced Imaging	–	–	–
Medicaid			
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-40	-620	-1,550
Strengthen Medicaid Third-Party Liability	-110	-630	-1,525
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	-1	-5.5	-12
Enforce Manufacturer Compliance with Drug Rebate Requirements	–	–	–
Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage	–	–	–
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	–	–	–
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	–	–	–
Consolidate Redundant Error Rate Measurement Programs	–	–	–
Medicare & Medicaid			
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	–	-60	-240
Medicare [non-add]	–	*-30*	*-160*
Medicaid [non-add]	–	*-30*	*-80*
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	–	-10	-60
Medicare [non-add]	–	*-10*	*-60*
Medicaid [non-add]	–	–	–
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	–	–	–
Medicare [non-add]	–	–	–
Medicaid [non-add]	–	–	–
Total, Medicare Impact	-10	-130	-450
Total, Medicaid Impact	-151	-1286	-3,167
Total, Program Integrity Legislative Proposals	**-161**	**-1,416**	**-3,617**
Savings from Program Integrity Investments /1			
Return on Investment from Discretionary HCFAC Spending	-945	-5,194	-11,284
Return on Investment from Social Security Disability Review Spending	-483	-1,820	-4,487
Total, Program Integrity Savings	**-1,589**	**-8,430**	**-19,388**

1/ Includes non-PAYGO Scorecard savings from increased HCFAC investment and Social Security disability reviews. A portion of these savings is assumed in Current Law.

MEDICAID

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law:				
Benefits /1	260,880	240,234	267,964	+27,730
State Administration	14,083	14,885	14,735	-150
Total Net Outlays, Current Law	**274,964**	**255,119**	**282,699**	**27,580**
Proposed Law:				
Legislative Proposals /2	–	+155	+190	+35
Extend Qualified Individual (QI) Program /3	–	+215	+695	+480
Adjustment for QI Transfer from Medicare /3	–	-215	-695	-480
Total Net Outlays, Proposed Law	–	**255,274**	**282,889**	**+27,615**
Savings from Program Integrity Investments /4	–	-11	-70	-59
Total Net Outlays, Net of Program Integrity Investments	**274,964**	**255,263**	**282,819**	**+27,556**
Additional Information:				
Total Savings from Program Integrity Investments /4	–	-96	-284	-188

1/ Includes Vaccines for Children outlays.

2/ Includes proposal to extend Transitional Medical Assistance (TMA) currently authorized through February 29, 2012.

3/ States pay the Medicare Part B premium costs for Qualified Individuals (QIs) that are in turn offset by a 100 percent reimbursement from Medicare Part B. Costs of the proposal to extend the QI program through CY 2014 are reflected in Medicare outlays. The QI program is currently authorized through February 29, 2012.

4/ FY 2012 and FY 2013 include $96 million and $284 respectively in non-PAYGO Scorecard savings from increased HCFAC investment and Social Security disability reviews. A portion of these savings is assumed in current law.

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans and is a central component of our Nation's medical safety net, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In FY 2010, more than 1 in 5 individuals were enrolled in Medicaid for at least one month during the year, and in FY 2012, an estimated 57 million people on average will receive health care coverage through Medicaid.

HOW MEDICAID WORKS

Although the Federal Government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. The Federal Government matches state expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. On average, the Federal Government is expected to pay nearly 58 percent of state Medicaid expenditures in

Medicaid Enrollment
(person-years in millions)

	2011	2012	2013
Aged 65 and Over	4.8	5.0	5.1
Blind and Disabled	9.7	9.8	9.9
Children	27.4	27.9	27.8
Adults	12.6	12.9	13.1
Territories	1.0	1.0	1.0
Total	**55.6**	**56.6**	**56.9**

Source: CMS Office of the Actuary estimates

FY 2013 for Medicaid benefits, and in FY 2013, the Federal share of current law Medicaid outlays is expected to be nearly $283 billion.

States are currently required to cover individuals who meet certain minimum categorical and financial eligibility standards. Medicaid beneficiaries include children, pregnant women, adults in families with dependent children, the aged, blind and/or disabled, and individuals who meet certain minimum income eligibility criteria that vary by category. States also have the flexibility to extend coverage to higher income groups, including medically needy individuals through waivers and amended state plans. Medically needy individuals are those individuals who do not meet the income standards of the categorical eligibility groups, but incur large medical expenses such that when subtracted from their income, they fall within the financial eligibility standards. Beginning in 2014, the Affordable Care Act expands Medicaid eligibility to individuals under age 65 with family incomes up to 133 percent of the Federal poverty level (FPL) (or $29,726 for a family of four in 2012).

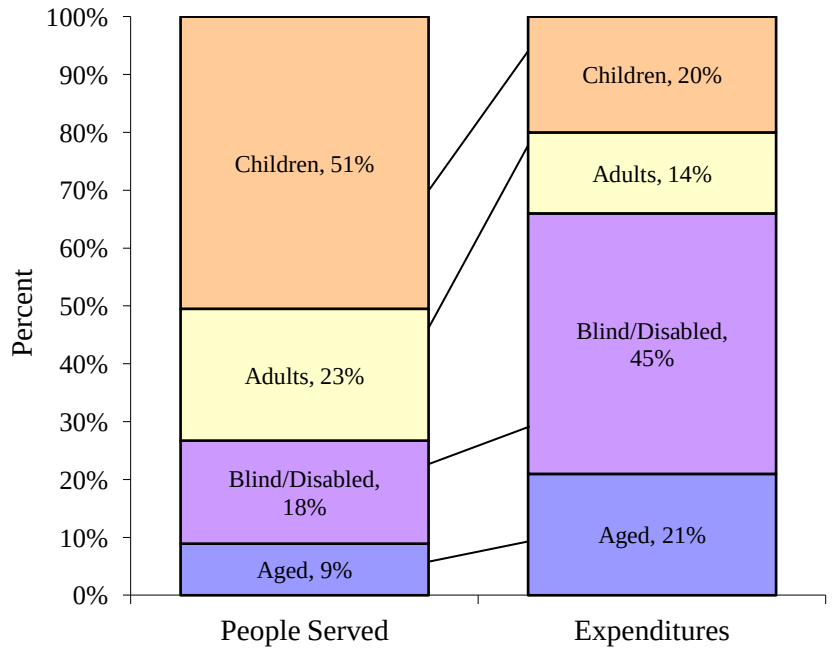
Under Medicaid, states must cover certain medical services and are provided the flexibility to offer additional benefits to beneficiaries. Medicaid has a major responsibility for providing long-term care services because Medicare and private health insurance often furnish only limited coverage of these benefits.

MEDICAID LEGISLATIVE PROPOSALS

The Budget includes $55.7 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. In addition, the Budget extends two important programs to allow continuity of coverage for beneficiaries.

Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017: Under current law, states face a patchwork of different federal payment contributions for individuals eligible for Medicaid and CHIP. Beginning in 2017, this proposal would replace these complicated federal matching formulas with a single matching rate specific to each state that

FY 2010 –
Percent of Medicaid Beneficiaries vs. Expenditures
by Eligibility Group /1



Source: CMS Office of the Actuary

1/ Totals and components exclude disproportionate share hospital expenditures, territorial enrollees and expenditures, and financial adjustments.

New Medicaid Tobacco Cessation Services

An estimated 11 percent of total Medicaid costs, approximately $22 billion, result from diseases directly caused by tobacco dependence.[1] To help reduce tobacco use in states, CMS released guidance on June 24, 2011, on tobacco cessation services for pregnant women in Medicaid and on tobacco quitlines.

The Affordable Care Act requires coverage of counseling and pharmacotherapy for cessation of tobacco use by pregnant women. These cessation services are also provided to children when medically necessary and states have the option to provide them to other specific beneficiary categories.

As part of the Administration's broader tobacco cessation policy, CMS will also allow states to claim the Federal administrative rate on costs of tobacco quitlines that follow evidence-based Public Health Service protocols. This policy is estimated to cost $507 million and will result in estimated net savings of approximately $465 million between FY 2013 through FY 2022 to the overall Medicaid baseline. By 2022, an estimated 1.65 million Medicaid beneficiaries are estimated to stop using tobacco as a result of these quitlines.

[1]Armour, B. S., E. A. Finkelstein, and I. C. Fiebelkorn. "State-level Medicaid Expenditures Attributable to Smoking." Preventing Chronic Disease 6.3 (2009): A84.

automatically increases if a recession forces enrollment and state costs to rise. [$17.9 billion in savings over 10 years]

Phase Down Medicaid Provider Tax Threshold Beginning in FY 2015: Some states finance portions of their Medicaid programs by requiring health care providers to satisfy the state share of Medicaid payments through taxation. Under this proposal, CMS would limit states' ability to use provider taxes to pay the state share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond. [$21.8 billion in savings over 10 years]

Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY 2021: As the number of uninsured people decreases due to the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of DSH funding needed. The Affordable Care Act includes annual aggregate DSH reductions for FY 2014 through FY 2020, but in FY 2021, allotments revert to levels prior to the Affordable Care Act that had been in effect. This proposal would rebase the FY 2021 allotments off the reduced FY 2020 amount in the Affordable Care Act, and determine future allotments from the rebased level using the current law methodology. [$8.3 billion in savings over 10 years]

Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates: Medicare is in the process of implementing innovative ways to increase efficiency for DME payments through the DME Competitive Bidding Program, which is expected to save Medicare more than $25.7 billion, and Medicare beneficiaries approximately $17.1 billion, over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting Federal reimbursement for a state's Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services. [$3.0 billion in savings over 10 years]

Expand State Flexibility to Provide Benchmark Benefit Packages: States currently have the option to provide certain populations with alternative benefit packages called benchmark or benchmark-equivalent plans in place of the benefits covered under a traditional Medicaid state plan. This proposal provides states the flexibility to require benchmark-equivalent benefit coverage for non elderly, non disabled adults with income that exceeds 133 percent of the FPL. [no budget impact]

Extend Transitional Medical Assistance (TMA) through CY 2013: The TMA program extends Medicaid coverage for at least 6 months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. This proposal extends

authorization and funding of the TMA program through December 31, 2013. Current law extends this program through February 29, 2012. [$815 million in costs over 10 years]

Extend the Qualified Individual (QI) Program through CY 2014: The QI program provides states 100 percent federal funding to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. This proposal extends authorization and funding of the QI program through December 31, 2014. Current law extends this program through February 29, 2012. [$1.7 billion in costs over 10 years]

Medicaid Program Integrity Proposals: The Budget includes a number of Medicaid program integrity proposals that strengthen the Department's ability to fight fraud, waste, and abuse in the Medicaid program. [$3.2 billion in savings over 10 years]

Establish Hold Harmless for Federal Poverty Guidelines: To protect access to programs, including Medicaid, for low-income families and individuals, this proposal would treat the Consumer Price Index for All Urban Consumers (CPI-U) adjustment for the poverty guidelines similarly to the treatment of the annual cost of living adjustments for Social Security Benefits. This proposal would establish a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the CPI-U. [no budget impact]

Improve Adult Health Care Quality in Medicaid

The Affordable Care Act established a quality measurement program for adults enrolled in the Medicaid program, building a foundation for tracking and improving the quality of care in Medicaid as coverage expands in 2014. On December 30, 2011, CMS released the initial core set of 26 quality measures and has a target of 60 percent of states reporting on at least three of these measures in FY 2013.

Medicaid Eligibility Expansion in the Affordable Care Act

The Affordable Care Act expands Medicaid eligibility to individuals with family incomes up to 133 percent of the Federal poverty level (FPL) in all states in 2014, or earlier at a State's option. Beginning on January 1, 2014, the Federal Government will pay 100 percent of state expenditures related to newly eligible individuals for the next three years. This increased FMAP rate will gradually decline beginning in 2017, to 90 percent in 2020 and beyond. As a result of the Affordable Care Act, an additional 34 million Americans are estimated to receive coverage through the Exchanges, Medicaid eligibility expansion, and other health insurance market reforms.

RECENT PROGRAM DEVELOPMENTS

Affordable Care Act (P.L. 111-148 and P.L. 111-152): In addition to expanding Medicaid eligibility, the Affordable Care Act makes improvements to health benefits for Medicaid beneficiaries and strengthens Medicaid program integrity efforts. The Affordable Care Act also improves services to Medicaid beneficiaries by the increasing emphasis on providing long-term care services in home and community based settings rather than institutions. This year, CMS began accepting applications for the Balancing Incentive Payment Program, and states can also receive an increased federal match under the Community First Choice Option to provide increased home and community based services.

Three percent Withholding Repeal and Job Creation Act (P.L. 112-56): This law amended the Internal Revenue Code to include all Social Security benefits in the calculation of modified adjusted gross income (MAGI) to determine eligibility for the premium tax credits in the Exchanges and for Medicaid.

Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78): This law extended the Qualified Individual (QI) program and Transitional Medical Assistance (TMA) program through February 29, 2012.

MEDICAID PROPOSALS

(dollars in millions, negative numbers reflect savings and positive numbers reflect costs)

	2013	2013 –2017	2013 –2022
Medicaid Proposals			
Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017	–	-3,400	-17,900
Phase Down Medicaid Provider Tax Threshold Beginning in FY 2015	–	-6,200	-21,800
Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY 2021	–	–	-8,250
Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates	-180	-1,190	-2,950
Expand State Flexibility to Provide Benchmark Benefit Packages	–	–	–
Extend Transitional Medical Assistance (TMA) through CY 2013 /1	640	815	815
Extend the Qualified Individual (QI) Program through CY 2014 /2	695	1,690	1,690
Adjustment for QI Transfer from Medicare /2	-695	-1,690	-1,690
Medicaid Program Integrity Proposals /3	-151	-1,286	-3,167
Total Outlays, Medicaid Proposals	**309**	**-11,261**	**-53,252**
Medicaid Interactions			
Establish Hold-Harmless for Federal Poverty Guidelines	–	–	–
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees /4	11	22	22
Eliminate Medicaid Recoupment of Birthing Costs from Child Support /5	–	30	80
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /6	–	-40	-170
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics /6	-130	-960	-2,380
Total Outlays, Medicaid Interactions	**-119**	**-948**	**-2,448**
Total Outlays, Medicaid Legislative Proposals	**190**	**-12,209**	**-55,700**

1/ Currently authorized through February 29, 2012.

2/ States pay the Medicare Part B premium costs for Qualified Individuals (QIs) that are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the QI program through CY 2014 are reflected in Medicare outlays. The QI program is currently authorized through February 29, 2012.

3/ See Program Integrity chapter for proposal descriptions.

4/ This proposal is included in the Social Security Administration's FY 2013 Budget Request.

5/ This proposal is included in the Administration for Children and Families' FY 2013 Budget Request.

6/ This proposal is a multi-agency proposal with savings to Medicaid.

CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2011	2012	2013	2013 +/-2012
Current Law:				
Children's Health Insurance Program	8,629	9,778	10,027	+249
Child Enrollment Contingency Fund	4	125	200	+75
Total Outlays	**8,633**	**9,903**	**10,227**	**+324**

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. The BBA appropriated almost $40 billion in mandatory funding to the program over 10 years (FY 1998 through FY 2007). The program was extended by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) through March 2009 with supplemental appropriations for states experiencing funding shortfalls in FY 2009. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized CHIP through FY 2013, providing an additional $44 billion in funding over 5 years and creating several new initiatives to improve and increase enrollment in the program. The Affordable Care Act (P.L. 111-148 and P.L. 111-152) extended funding for CHIP through FY 2015.

HOW CHIP WORKS

CHIP is a partnership between the Federal Government and states and territories to help provide low-income children with the health insurance coverage they need. The program improves access to health care and the quality of life for millions of vulnerable children under 19 years of age. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

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

States have a high degree of flexibility in designing their programs. They can implement CHIP by expanding Medicaid, creating a separate program, or a combination of both approaches. As of January 1, 2012, there were 13 Medicaid expansion programs, 17 separate programs, and 26 combination programs among the states, District of Columbia, and territories.

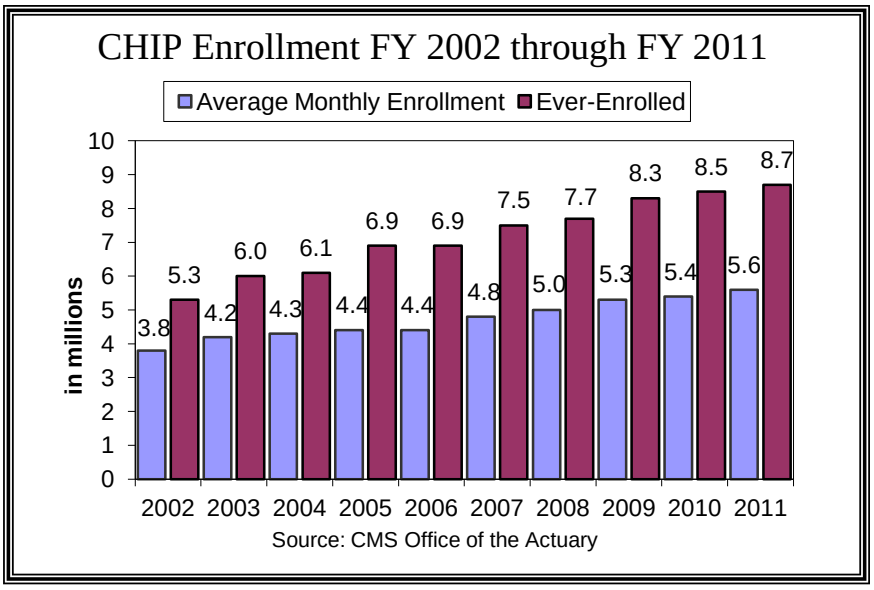
In FY 2011, the CMS Office of the Actuary estimated that 8.7 million individuals were enrolled in CHIP at some point during the year, an increase of 3.5 percent over FY 2010 enrollment.

Increasing Enrollment of Eligible Children

CMS' goal is to improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and in Medicaid. In FY 2010, CMS reported a 4.6 percent increase in CHIP enrollment (+337,244 children) and a 15 percent increase in Medicaid child enrollment (nearly 4.5 million additional children) over the FY 2008 baseline.

FY 2011: CHIP +9 percent over 2008; Medicaid +11 percent over 2008
FY 2012: CHIP +11 percent over 2008; Medicaid +17 percent over 2008
FY 2013: CHIP +13 percent over 2008; Medicaid +18 percent over 2008

Funding for CHIP allotments to states increased under CHIPRA by $44 billion over the baseline for 5 years (FY 2009-FY 2013). The Affordable Care Act extended funding for CHIP, providing $19.1 billion for FY 2014 CHIP allotments and $21.1 billion for FY 2015 CHIP allotments. This expansion allowed for better funding predictability at the state level. A Child Enrollment Contingency Fund was established for states that predict a funding shortfall based on higher than expected enrollment. The contingency fund received an initial appropriation of $2.1 billion in FY 2009 and is invested in interest bearing securities of the United States. The first and only contingency fund award to date was to the State of Iowa in FY 2011 in the amount of $28.8 million.



RECENT PROGRAM DEVELOPMENTS

Financing: In addition to extending funding for state allotments through FY 2015, the Affordable Care Act (P.L. 111-148 and P.L. 111-152) increased each state's enhanced federal match rate by 23 percentage points, not to exceed a total match rate of 100 percent, between FY 2016 and FY 2019.

Eligibility and Coverage: The Affordable Care Act made several changes to eligibility and coverage. States will now use simplified procedures to determine eligibility for coverage under a state's CHIP program. In addition, states may choose to provide CHIP coverage to children eligible for family coverage under a state health care employee plan, if the state meets certain conditions.

Enrollment and Retention Outreach:
The Affordable Care Act also increased funding originally provided in CHIPRA for grants and a national campaign to improve outreach and enrollment from $100 million to $140 million and extended its availability through FY 2015. Through this funding, CMS assists states in providing health care coverage to low-income children eligible for CHIP or Medicaid, but not yet enrolled. Forty states and the District of Columbia have taken up new options for improving retention and enrollment.

Improving Quality: CHIPRA provided $225 million over 5 years for activities that improve child health quality in Medicaid and CHIP, and in FY 2011, several states began their CHIPRA Quality Demonstrations. CMS activities included providing significant technical assistance to states on measurement of child health quality, partnering with the Agency for Healthcare Research and Quality to award grants to seven Centers of Excellence in Pediatric Quality Measures, and working with the Office of the National Coordinator for Health Information Technology to advance data collection methods for some of the CHIPRA initial core measures for use in electronic health records.

Performance Bonus Payments

In December 2011, CMS awarded $296.4 million to 23 states that made significant improvement in enrolling children in the Medicaid program in FY 2011.

To qualify for a bonus payment, states must perform 5 of 8 specific enrollment and retention activities set out in CHIPRA.

The list of states and their awards can be found at: http://www.insurekidsnow.gov/professionals/eligibility/performance_bonuses.html

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law Budget Authority:				
Incentives for Prevention of Chronic Diseases in Medicaid.....	100	–	–	–
Medicaid Emergency Psychiatric Demonstration	75	–	–	–
Medicaid Integrity Program	76	78	80	+2
Psychiatric Residential Treatment Demo and Evaluation	57	–	–	–
Money Follows the Person Demonstration	449	449	449	–
Money Follows the Person Evaluations	1	1	1	–
Expansion of State Long-Term Care Partnership Program /1	–	–	–	–
Ticket to Work Grant Programs	47	–	–	–
Total, Current Law Budget Authority	**805**	**528**	**530**	**+2**
Current Law Outlays:				
Incentives for Prevention of Chronic Diseases in Medicaid.....	–	40	24	-16
Medicaid Emergency Psychiatric Demonstration	–	20	23	+3
CHIP Outreach and Enrollment Grants /2	30	31	18	-13
CHIP Grants for Prospective Payment System Transition /2	1	1	3	+2
Medicaid Integrity Program	66	78	80	+2
Psychiatric Residential Treatment Demo and Evaluation	34	48	48	–
Money Follows the Person Demonstration	210	250	250	–
Money Follows the Person Evaluations	1	2	2	–
Expansion of State Long-Term Care Partnership Prog. /1 /2	–*	3	3	–
Ticket to Work Grant Programs	78	59	5	-54
Medicaid Transformation Grants /2	28	15	–	-15
Emergency Services for Undocumented Aliens /2	94	52	18	-34
Katrina Hurricane Relief /3	7	3	–*	-3
Alternate Non-Emergency Network Providers /2.....	13	2	–	-2
Total, Current Law Outlays	**562**	**604**	**474**	**-130**

1/ Budget authority has been comparably adjusted each year for the transfer of Expansion of State Long-Term Care Partnership Program to Administration on Aging beginning in FY 2012.

2/ Outlays are from prior year budget authority.

3/ FY 2010 and 2011 outlays are from FY 2006 budget authority.

* Outlays are less than $500,000.

STATE GRANTS AND DEMONSTRATIONS

The State Grants and Demonstrations budget funds a diverse set of program activities. Many activities were authorized in the Affordable Care Act, the Children's Health Insurance Program Reauthorization Act of 2009, the Deficit Reduction Act of 2005, and the Ticket to Work and Work Incentives Improvement Act of 1999. Such activities include strengthening Medicaid program integrity, supporting enrollment of children into Medicaid and the Children's Health Insurance Program (CHIP) through funding for outreach activities, and promoting prevention and wellness by providing grants to states to prevent chronic diseases.

AFFORDABLE CARE ACT

Incentives for Prevention of Chronic Diseases in Medicaid: The Affordable Care Act provides $100 million for states to award incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes related to chronic disease, including by adopting healthy behaviors. Funds are available until expended for the five-year period beginning calendar year 2011. CMS awarded grants to ten states in September 2011.

Medicaid Emergency Psychiatric Demonstration: The Affordable Care Act provides up to $75 million for a 3-year demonstration to provide Federal matching funds to states to provide inpatient emergency psychiatric care to Medicaid beneficiaries ages 21 to 64 in private psychiatric hospitals. Funding for this demonstration is available through December 31, 2015.

Extension of Existing Programs: The Affordable Care Act also extends the Money Follows the Person (MFP) demonstration and increases funding for the Medicaid Integrity Program by providing an inflation adjustment.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

Outreach and Enrollment Grants: CHIPRA appropriates $100 million from 2009 to 2013 for Outreach and Enrollment Grants in Medicaid and CHIP. The Affordable Care Act appropriates an additional $40 million for grants and extends its availability through FY 2015, yielding a total of $140 million. Of this amount, 10 percent is set aside for a national enrollment campaign, and an additional 10 percent is set aside to increase enrollment of Native Americans and Alaska Natives. The remaining $112 million is allocated for competitive grants to states, community-based organizations, tribes, providers, schools, and other groups to increase enrollment of children in Medicaid and CHIP.

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

In September 2011, CMS selected the following states to receive grants to provide incentives to Medicaid beneficiaries for engaging in healthy behaviors that reduce risk and improve outcomes related to chronic disease: Wisconsin, Minnesota, New York, Nevada, New Hampshire, Montana, Hawaii, Texas, California, and Connecticut. States receiving grants under MIPCD must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes, or, in diabetes cases, improving management of the condition.

States must use relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs. States will track beneficiary participation and outcomes, perform evaluation activities, report to the Secretary on process and lessons learned, and report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

Promoting Outreach and Enrollment in CHIP

- Since 2009, CMS has awarded nearly $90 million in grants to promote outreach and enrollment in CHIP.
- In 2011, CMS awarded over $40 million to states, community organizations, and tribal entities to perform outreach and enrollment activities in FY 2012. Awardees will report on achievements in enrollment and retention of children in Medicaid and CHIP to facilitate dissemination of best practices.
- These grants support the Secretary's "Connecting Kids to Coverage Challenge," calling on leaders at every level of government and the private sector to find and enroll the nearly five million uninsured children who are eligible for Medicaid and CHIP.

DEFICIT REDUCTION ACT (DRA) OF 2005

Medicaid Integrity Program: The Medicaid Integrity Program (MIP) was established by the DRA, and was modified in the Affordable Care Act. The DRA appropriated $75 million in FY 2009, and for each year thereafter, and the Affordable Care Act increased appropriations for FY 2011 and future years by inflation. States have the primary responsibility for combating fraud and abuse in the Medicaid program. HHS supports state efforts through contracting with eligible entities to carry out activities including reviews, audits, identification of overpayments, education activities, and technical support to states.

Money Follows the Person Demonstration (MFP): The MFP demonstration helps states to sustain their Medicaid programs while helping individuals achieve independence. States that are awarded competitive grants receive an enhanced Medicaid matching rate to help eligible individuals transition from a qualified institutional setting to a qualified home or community-based setting. Approximately $3.5 billion has been committed to 43 states and the District of Columbia, including the addition of 13 new state grantees in FY 2011 and the reactivation of the South Carolina grant awarded in FY 2007. The DRA established this demonstration and appropriated $1.75 billion through FY 2011. The Affordable Care Act provided an additional $2.25 billion, $450 million for each fiscal year starting in 2012 through 2016. Funding awarded to states in FY 2016 is available to states for expenditures through FY 2020. These additional appropriations will enable state grantees to continue to grow their home and community-based programs and increase the number of beneficiaries served while continuing to rebalance their long-term care systems between institutional and community settings. As of June 30, 2011, 16,600 individuals have transitioned to community services and supports under MFP.

PRIVATE HEALTH INSURANCE PROTECTIONS AND PROGRAMS

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law:				
State Exchange Grants /1	24	906	1,087	+181
Pre-Existing Condition Insurance Plan Program /2	402	1,565	2,055	+490
Early Retiree Reinsurance Program /2	2,975	1,973	28	-1,945
Consumer Operated and Oriented Plan (CO-OP) Program	–	93	803	+710
Rate Review Grants to States /2	12	80	80	–
Consumer Assistance Grants to States	7	22	–	-22
Total Outlays, Current Law	**3,420**	**4,639**	**4,053**	**-586**
Proposed Law Outlays:				
Accelerate the Issuance of State Innovation Waivers	–	–	–	–
Total Outlays, Proposed Law	**3,420**	**4,639**	**4,053**	**-586**

1/ The Affordable Care Act appropriates such sums as necessary for the Secretary to award grants to states to fund their Exchanges.

2/ This funding is available until expended.

The Affordable Care Act provides critical new protections for consumers with private health insurance, putting patients and consumers back in charge of their health care. A number of these protections have already been implemented, providing more benefits for patients and employers. Implemented protections include expanding access to affordable coverage for high-risk, high-cost individuals; increasing information on coverage options; and strengthening insurer accountability. Furthermore, beginning in 2014, millions of Americans will gain access to affordable coverage through the establishment of Affordable Insurance Exchanges (Exchanges) and the expansion of Medicaid.

Consumer Protections

Consumer Protection	Consumers Benefiting
Adult Child Coverage to Age 26	2,500,000
Elimination of Lifetime Limits	20,400
Prohibition on Insurance Rescissions	10,700
Elimination of Pre-Existing Condition Exclusions for Children Under Age 19 /1	162,000
Free Preventive Services	54,000,000
Establishment of Internal and External Appeals Rights	41,000,000
Restrictions on Cost Sharing for Out of Network Emergency Rooms	41,000,000
Choice of Health Care Professional	41,000,000

1/ HHS estimates 72,000 children would otherwise be uninsured and an additional 90,000 children are seeing coverage limitations lifted.

INSURANCE MARKET REFORMS FOR CONSUMER PROTECTION

Private Insurance Market Reforms: Many important Affordable Care Act protections are already in effect, providing an array of new rights and benefits to patients and consumers with private health insurance. For example, recent data show that from September 2010 to June 2011, 2.5 million young adults gained health coverage as a result of the option to stay on their parents' health insurance plans until age 26.

Health Insurance Coverage for Young Adults

The Affordable Care Act allows adult children to remain on their parents' policies until age 26. By allowing children to stay on a parent's plan, the law makes it easier and more affordable for young adults to get health insurance coverage and the number of young adults ages 19 to 25 who have health insurance has been increasing. HHS has developed a performance measure to track progress in expanding coverage for the uninsured, including young adults.

Due to the Affordable Care Act's Patient's Bill of Rights, nearly all group health plans and new individual market policies are prohibited from denying coverage to children because of a pre-existing condition, leading to 72,000 newly-insured children and a removal of coverage limitations for an additional 90,000 children.

Additionally, more than 20,000 consumers no longer have a lifetime limit on benefits, ensuring that patients can use their insurance coverage when they are sick and need it most, and annual dollar limits on benefits are being phased out. Furthermore, 41 million Americans in new plans can now appeal insurance company decisions to an independent reviewer and use the nearest emergency room without higher cost sharing, regardless of whether it is in network. In addition, 54 million Americans are now receiving expanded coverage of some preventive services without additional out-of-pocket payments, including colonoscopy screenings for colon cancer, Pap smears and mammograms for women, well-child visits, flu shots for all children and adults, and more.

Medical Loss Ratio (MLR): The Affordable Care Act requires insurance plans to spend at least 80 or 85 percent of expenditures, depending on the market, on health care benefits, or quality improvement activities. States have the option to require a higher MLR than the federal standard. Insurers that do not meet this standard must issue rebates and explanatory information to consumers for administrative costs above the MLR standard. The first round of rebates will be issued in August 2012. Insurers must submit their MLR information to CMS annually. The final rule, which took effect on January 1, 2012, provides clarification on the MLR policy regarding special insurance plans and how rebates are handled to ensure that consumers receive maximum value for their premium dollar.

Insurance Premium Rate Review: Insurers must submit to the Secretary and relevant state offices a justification for any premium increase greater than 10 percent prior to implementation of the increase. In November 2011, HHS issued the first federal rate review determination that deemed a rate increase was unreasonable.

On September 20, 2011, HHS announced approximately $109 million in grants to 28 states and the District of Columbia to further support the establishment of effective rate review programs. These grants support the hiring of new staff, improved dissemination of rate review information to consumers, and the enhancement of existing infrastructure required to establish state-run rate review programs. Another round of awards is currently planned for September 2012.

HealthCare.gov: HealthCare.gov increases transparency by bringing information and links to health insurance plans together, in one place, to make it easy for consumers and small businesses to learn about and compare their insurance options.

Supporting Health Insurance Coverage in States

The Affordable Care Act has provided funding support to states to assist in their implementation of important consumer protections and programs.

(dollars in millions)

Funding Source	Received Funds	Total Funding Awarded /1
Exchange Planning and Establishment Grants	49 States + DC + 4 Territories	734.5
Rate Review Grants	42 States + DC + 5 Territories	157.1
Consumer Assistance Grants	33 States + DC + 4 Territories	26.8

1/ Funding awarded as of December 31, 2011.

More than 600 insurers have provided information for more than 10,000 coverage plans across all states and the District of Columbia. Additionally, of the approximately 6.6 million visitors to the HealthCare.gov website in its first year, about 2 million used the Insurance Finder tool.

Among its features, HealthCare.gov provides information about rate increases to enhance consumers' purchasing and decision making abilities. In the future, the website will provide medical loss ratio percentages and explanations, health plan quality and performance metrics, and appeals and complaints data. HealthCare.gov will include this information for all health plans regardless of whether they are offered in an Exchange. As a result, it will be an essential tool for consumers researching their best health insurance plan options, both inside and outside of an Exchange.

PRIVATE HEALTH INSURANCE PROGRAMS

Exchanges: Starting in 2014, Exchanges will help individuals and small employers better understand their insurance options and assist them in shopping for, selecting, and enrolling in high-quality private health insurance plans. By providing one-stop shopping, Exchanges will make purchasing health insurance easier, more transparent, and more understandable, and will provide individuals and small businesses with more options and greater control over their health insurance purchases.

How Exchanges Work: States may establish their own Exchanges or HHS will operate a Federally-facilitated Exchange (FFE) in states that choose not to implement their own. In some cases, states may partner with HHS to operate some functions of an FFE. In addition to enrolling individuals and employees of small businesses in insurance coverage, Exchanges must also determine eligibility for premium tax credits and cost-sharing reductions, or Medicaid and CHIP; ensure health plans meet certain standards; operate a hotline and website to provide consumers access to assistance and health plan information; and assist individuals in locating and obtaining affordable health coverage.

FY 2013 will be an important year in the establishment of Exchanges as states begin to certify health plans, organize outreach campaigns, and ensure eligibility systems are in place for open enrollment in the fall of 2013.

State Grants for Planning and Establishment of Exchanges: The Affordable Care Act made grant funding available to states to plan for and establish their Exchanges. In 2011, 28 states and the District of Columbia received over $438 million in Establishment Grants to begin building their Exchanges. Additional grants will be awarded in FY 2012 and may be renewed through January 1, 2015. After their initial establishment, Exchanges will be self-funded through user fees or otherwise generate funding to support ongoing operations.

Exchange Establishment Grants

On November 29, 2011, Rhode Island was awarded $58.5 million for a Level Two Exchange Establishment Grant—the first Level Two award granted under this program. A Level Two award provides funding through 2014 for Rhode Island to establish the core components of a state-based Exchange including: IT infrastructure; a consumer support program; establishment of governance structures; health plan certification; and oversight and financial management systems. Twenty-seven other states and the District of Columbia have one-year Exchange Establishment funding and CMS will continue to award Establishment Grants in 2012.

Pre-Existing Condition Insurance Plan (PCIP) Program: The Affordable Care Act created the PCIP program to make health insurance available to uninsured Americans without access to affordable private insurance due to a pre-existing condition. This temporary program was launched on July 1, 2010, just 90 days after the law's enactment, and will be in place until January 1, 2014 when the Exchanges become operational and when insurance companies can no longer deny coverage or charge higher premiums to individuals with pre-existing conditions.

Twenty-seven states administer their own PCIP programs, while CMS operates the program in the remaining states and the District of Columbia. Funding for this program is limited to $5 billion to pay claims and administrative costs that are in excess of the premiums collected from enrollees in the

program. Individuals are eligible for the PCIP program if they have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of a health condition, and are U.S. citizens or residing in the United States legally. Eligibility is not based on an individual's income level. CMS engaged in a full-scale outreach campaign in 2011, and by the end of November 2011, the program had nearly 45,000 enrollees.

Initial data shows that the enrollees in the PCIP program have higher medical claims costs on average than the enrollees in the State High-Risk Pools that were already in place prior to the implementation of PCIP. Further, actuarial estimates of per member per year costs are more than double what the State High-Risk Pools have experienced in recent years. The top five medical diagnoses by cost of treatment in 2011 across the PCIP program include cancers, ischemic heart disease, degenerative bone diseases, transplants, and hemophilia.

Early Retiree Reinsurance Program (ERRP): Early retirees, ages 55 to 64, often face difficulties obtaining insurance in the current individual market because of age or chronic conditions. Additionally, the proportion of large employers offering retiree has declined by half in just 20 years, dropping from 68 percent in 1988 to 26 percent in 2011. ERRP provides assistance to sponsors of employment-based insurance that make coverage available to millions of early retirees and their families. ERRP payments must be used to reduce plan participants' costs, reduce plan sponsors' costs of providing coverage, or both.

Congress appropriated $5 billion for this temporary program, and as of early January 2012, nearly all of the funding has been paid to over 2,700 plan sponsors spanning every state in the Nation to help over 5 million individuals maintain coverage. Both large and small plan sponsors have benefited from the program, with one third of participating plans receiving $100,000 or less in total reinsurance payments from ERRP. As a result, in December 2011, CMS notified plan sponsors that claims incurred after December 31, 2011 would not be accepted.

Additionally, in FY 2012, CMS hired a program integrity contractor to begin conducting audits of plan sponsors, including the examination of the validity of claims submitted and the use of program funds. This work will continue in FY 2013 and FY 2014.

Consumer Operated and Oriented Plans (CO-OPs): The CO-OP loan program fosters the creation of new, private, nonprofit, member-governed health insurance plans. The statute calls for at least one CO-OP per state while permitting multiple CO-OPs in a state, provided there is sufficient funding to do so. The Affordable Care Act requires that any profits the CO-OP makes must be used to lower premiums, improve benefits, or improve the quality of health care delivered to plan members. CO-OPs will contribute to the success of the Exchanges by increasing competition in state insurance markets and by offering more choices to consumers.

The first and second rounds of applications to participate in the CO-OP program were received on October 17, 2011 and January 3, 2012. These applications reflect proposals to operate in most of the states, with multiple applications for a number of states. Subsequent applications are due quarterly through December 31, 2012. Application review and selection is based on the recommendations of external reviewers who evaluate applicants based upon on a defined set of criteria totaling 100 points as established in the CO-OP Funding Opportunity Announcement. CMS officials make final selection for awards. The first loan awards are expected to be made in early 2012.

Consumer Assistance Program (CAP) Grants: The Affordable Care Act provided grants to states and territories to establish or expand CAPs. CAPs assist consumers in the private insurance market with their coverage questions and problems and collect complaint data to identify private insurance market issues.

LEGISLATIVE PROPOSAL

Accelerate Issuance of State Innovation Waivers: This proposal allows states to develop innovative strategies to ensure their residents have access to high-quality, affordable health insurance starting in 2014, three years earlier than is currently permitted under section 1332 of the Affordable Care Act. As under current law, these strategies must provide affordable insurance coverage to at least as many residents within a given state as without the waiver and must not increase the Federal deficit. [no budget impact]

CENTER FOR MEDICARE AND MEDICAID INNOVATION

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Obligations:				
Innovation Models /1	51	1,581	1,207	-374
Innovation Supports	23	68	105	+37
Administrative Expenses	21	44	50	+6
Total, Innovation Center Obligations	**95**	**1,693**	**1,362**	**-331**
Outlays:	11	733	1,090	+357

1/ Many projects initiated in FY 2012 have substantial upfront costs, accounting for higher projected obligations.

The Center for Medicare and Medicaid Innovation ("Innovation Center") was established by Section 3021 of the Affordable Care Act. The Innovation Center is tasked with testing innovative health care payment and delivery models with the potential to improve quality of care and reduce Medicare and Medicaid expenditures. The Affordable Care Act appropriated $10 billion to support the Innovation Center activities initiated from FY 2011 to FY 2019.

Since its launch in November 2010, the Innovation Center has embarked on an ambitious research agenda. Models currently being developed and tested include Medicare payment reforms that encourage efficient and high-quality care, new approaches to better coordinate care for beneficiaries who are eligible for both Medicare and Medicaid, and new mechanisms to promote patient safety in hospitals. Numerous additional models are currently under development and will be tested in the coming months and years.

In its first year of operation (FY 2011), the Innovation Center obligated approximately $95 million. Obligations are projected to increase to $1.7 billion in FY 2012 and to $1.4 billion in FY 2013 as the portfolio of models being tested expands. In FY 2012 and FY 2013, roughly 97 percent of spending is projected to be on specific models and initiatives, as well as necessary Innovation supports, with the remainder dedicated to administrative costs.

INNOVATION CENTER MODELS

As of January 2012, the Innovation Center has begun testing several major payment and delivery system reforms. Each of these models will be comprehensively evaluated with the potential for expansion if they are shown to be effective at improving quality and reducing costs.

Partnership for Patients: The Partnership for Patients is a collaborative effort by CMS and more than 7,000 stakeholders across the Nation (including over 3,000 hospitals) to improve patient safety. The Partnership has set ambitious targets of reducing hospital-acquired conditions by 40 percent by 2013 (compared to a 2010 baseline) and reducing hospital readmissions by 20 percent over the same time period. Meeting these targets could save the health care system, including Medicare and Medicaid, tens of billions of dollars over the next several years.

In December 2011, the Innovation Center awarded $218 million to 26 regional hospital engagement networks. These networks will provide participating hospitals with education, resources, and support to help achieve the Partnership's goals.

HHS Health Care Innovation Challenge: Through the HHS Health Care Innovation Challenge, the Innovation Center will award up to $1 billion in grants to providers, payers, local governments, and other partners. Recipients will be selected based on

Innovation Center: Summary of Existing Projects

The following is a list of projects currently undertaken by the Innovation Center and planned demonstration period.

Model Name	Demonstration Period
FQHC Advanced Primary Care Demonstration	2012—2015
Pioneer Accountable Care Organizations	2012—2017
Advance Payment Accountable Care Organizations	2012—2014
Bundled Payments	2012—2016
Comprehensive Primary Care Initiative	2012—2015
State Demonstrations - Integrate Care for Dual Eligibles	2011—2015
Nursing Home Demonstration for Dual Eligibles	2012—2015
Partnerships for Patients	2011—2014
Health Care Innovation Challenge	2012—2015

their proposals to implement or expand compelling new models to improve care and reduce costs, with a particular focus on high-need populations and workforce development. CMS anticipates making awards in spring 2012, and recipients must implement their projects within six months of award.

Bundled Payments: The Bundled Payments for Care Improvement initiative seeks to better coordinate patient care by bundling Medicare payment for an episode of care involving multiple providers. Providers who apply to participate will have considerable flexibility in selecting which conditions to bundle, determining how payments will be allocated among participating providers, and defining an episode of care. Providers will be eligible to share in any savings to the Medicare program that result from this demonstration. The Innovation Center intends to roll out this demonstration in stages starting in 2012.

Accountable Care Organization Models: As part of CMS's effort to promote accountable care organizations (ACOs), the Innovation Center has launched two major initiatives. Both of these initiatives build upon the Medicare Shared Savings Program established by the Affordable Care Act.

The Pioneer ACO Model will allow health care organizations and providers that are already experienced in coordinating care for patients across care settings to move more rapidly to a population-based Medicare payment model. Pioneer ACOs will assume more risk than participants in the Shared Savings Program and must commit to having the majority of their revenues (across all payers) come from performance-based contracts in which payment depends on quality of care. In December 2011, the Innovation Center announced that 32 organizations had been selected to be Pioneer ACOs starting in January 2012.

The Advance Payment ACO Model will test whether pre-paying a portion of future shared savings can increase participation in the Medicare Shared Savings Program. Providing up-front payments to certain physician-led and rural organizations in the Shared Savings Program will allow these ACOs to make investments in infrastructure and staff in order to improve patient care and reduce costs. Advance payments will be recouped from the actual shared savings payments that ACOs earn. The Innovation Center is currently accepting applications from prospective organizations to participate in this model.

FQHC Advanced Primary Care Demonstration: In early FY 2012, the Innovation Center selected 500 federally-qualified health centers (FQHC) to participate in a three-year demonstration to evaluate the effect of an advanced primary care practice model (also known as a patient-centered medical home) on the quality and cost of care provided to Medicare beneficiaries. Participating health centers that pursue Level 3 status as a patient-centered medical home (as defined by the National Committee for Quality Assurance) are eligible for additional Medicare care management payments. This demonstration has the potential to improve quality and reduce costs for appoximately 195,000 Medicare beneficiaries.

Comprehensive Primary Care Initiative: In September 2011, the Innovation Center announced the Comprehensive Primary Care Initiative. In this initiative, CMS is inviting private payers and state Medicaid programs to partner with Medicare to

invest in primary care, which has been historically under-funded and under-valued in the United States. The Innovation Center is currently selecting payers in up to seven markets to participate in this demonstration. Once participating communities have been selected, the Innovation Center will solicit participation from primary care practices. Selected providers will then receive additional care coordination or similar payments from all participating payers, allowing them to transform their practices and make expanded services available to all patients.

Learning and Diffusion

The Innovation Center's work reflects a core belief that effective health system transformation requires continuous learning and sharing of best practices. A 2003 Institute of Medicine report highlighted that translating research into widespread clinical practice can take an average of 17 years. Efforts to encourage knowledge sharing among doctors and health provider, can accelerate clinical changes such as reducing the incidence of healthcare-associated infections (HAIs) or determining new strategies for coordinating care. To support each model's success through diffusion of clinical practices, the Innovation Center is investing in model-specific networks for shared learning and diffusion among providers, payers, and other stakeholders. Activities in model-specific learning networks may include facilitating meetings between similar providers to discuss barriers and best practices, or providing access to experts.

Dual Eligible Models: Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office. This office is charged with improving the coordination between the Federal and state governments for individuals enrolled in both the Medicare and Medicaid programs, often known as dual eligibles. The Medicare-Medicaid Coordination Office has partnered with the Innovation Center to pursue several promising approaches to improving care for Medicare-Medicaid beneficiaries.

Specifically, the Medicare-Medicaid Coordination Office has awarded contracts of up to $1 million each to 15 states to design person-centered approaches to coordinating care across primary, acute, and behavioral health and long-term supports and services for Medicare-Medicaid enrollees. Once states complete the design phase, they will be eligible to apply for additional Innovation Center funds for implementation. In addition, in October 2011, 38 states and the District of Columbia submitted letters of intent to potentially pursue one of two Medicare-Medicaid financial alignment (payment reform) models proposed by CMS. These models were designed to incentivize high-quality, coordinated care. Finally, the Medicare-Medicaid Coordination Office has announced an upcoming demonstration that will focus on reducing preventable inpatient hospitalizations among long-term residents of nursing facilities who are often eligible for both Medicare and Medicaid. CMS will begin accepting applications for this demonstration in 2012.

Innovation Advisors: In January 2012, the Innovation Center selected 73 leaders from across the health care industry to serve as Innovation Advisors. These individuals will work closely with the Innovation Center to develop and implement new payment and delivery models.

(dollars in millions)

	2011	2012	2013	2013 +/-2012
Discretionary Administration				
Medicare/Program Operations	2,276	2,609	3,618	+1,010
Federal Administration	684	791	793	+2
Survey and Certification	361	355	387	+32
Research	36	21	–	-21
State High-Risk Pools	55	44	22	-22
Total, Discretionary Budget Authority /1 /2 /3	**3,411**	**3,820**	**4,821**	**+1,001**
General Fund Allocation	176	–	–	–
Total, Discretionary Budget Authority incl. General Fund	**3,587**	**3,820**	**4,821**	**+1,001**
Mandatory Administration				
Affordable Care Act	588	139	139	–
American Recovery and Investment Act	140	140	140	–
Medicare Improvements for Patients and Providers Act	38	38	3	-35
Medicare and Medicaid Extension Act	200	–	–	–
Total, Mandatory	**966**	**317**	**282**	**-35**
Reimbursable Administration /4	475	550	537	-13
Subtotal, Discretionary and Mandatory	**5,027**	**4,687**	**5,640**	**+953**
Proposed Law (Mandatory)	–	–	400	+400
Total, Program Level, Proposed Law	**5,027**	**4,687**	**6,040**	**+1,353**
FTE /5	5,195	5,755	6,011	+256

1/ Numbers may not add due to rounding.

2/ FY 2011 and FY 2012 levels have been comparably adjusted each year for the SHIP transfer to AoA as follows: Program Operations -$50 million, Federal Administration -$2 million.

3/ State High-Risk Pools are classified as a mandatory activity in FY 2011 and FY 2012.

4/ Includes Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program education campaign, recovery audit contractors, and provider enrollment fees.

5/ FTE totals include FTE from other funding sources: HCFAC, State Grants, reimbursables, and mandatory appropriations. CMS will fund the following FTE from other sources: FY 2011 = 1,106; FY 2012 = 1,219; and FY 2013 =1,339.

The FY 2013 discretionary budget request for CMS Program Management is $4.8 billion, an increase of $1.0 billion above a comparable FY 2012 enacted level. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and to implement new health insurance reforms, such as Exchanges, contained in the Affordable Care Act.

BUDGET ACCOUNT SUMMARIES

Program Operations: The Program Operations request is $3.6 billion, an increase of $1.0 billion above a comparable FY 2012 enacted level. The Program Operations account funds mission-critical contractor and IT activities necessary to administer Medicare, Medicaid, and CHIP, the implementation of new private health insurance protections created

by the Affordable Care Act, and additional activities required by legislation. Top priority activities for FY 2013 include:

- *Ongoing Medicare Contractor Operations:* Approximately 29 percent, or $1.0 billion, of the FY 2013 Program Operations request supports ongoing contractor operations, an 8 percent increase from the FY 2012 level.

- *Research:* The Budget supports ongoing research activities that cannot be funded through other sources. CMS' FY 2013 request totals $25 million. The Medicare Current Beneficiary Service (MCBS) is funded at $16 million. The MCBS data aids CMS in determining payment policy, decision makers in crafting legislation, and the Congressional Budget Office and actuaries in developing cost estimates. Funding for demonstrations and other research activities totals $8.9 million, including Medicare and Medicaid projects.

- *Consumer and Beneficiary Education and Outreach:* The Budget includes $656 million for beneficiary education and outreach activities through the National Medicare Education Program and consumer support in the private insurance marketplace, including $290 million for the Affordable Insurance Exchanges. Private insurance consumer support activities include funding independent review organization contractors to externally review adverse benefit decisions for consumers and updating coverage fact labels to help consumers compare potential out-of-pocket costs for various coverage options.

- *IT Systems and Support:* The Budget includes $549 million for general IT systems and other support, such as systems to manage and administer Medicare Advantage and the Part D benefit, the Federally-facilitated Exchange and Exchange data services hub, and CMS's data center and telecommunications infrastructure. This request includes $246 million to modernize and transform CMS's enterprise-wide IT systems.

- *Medicaid and CHIP Operations:* The Budget requests $28 million to fund administrative activities to improve Medicaid and CHIP program operations and implement new responsibilities under the Affordable Care Act. Some of these activities include initiatives to improve enrollment of eligible individuals into Medicaid and CHIP and modernize data systems.

- *HealthCare.gov:* The Budget requests $18 million for updates to HealthCare.gov, a one-stop website that provides information, including health plan data and rate information, to enhance consumers' and small businesses' purchasing and decision making abilities. In the future, HealthCare.gov will provide additional information, such as medical loss ratio percentages and explanations, quality and performance metrics, and appeals and complaints data. Additionally, funding will support quality reviews of the data posted on HealthCare.gov and the Plan Finder tool.

- *Insurance Oversight:* The Budget requests $15 million for CMS contracts to ensure compliance with the private insurance provisions contained in the Affordable Care Act, notably the Medical Loss Ratio and Rate Review Premium provisions.

- *Exchange Operations:* In FY 2013, CMS will begin the process of certifying state-based Exchanges and will also begin major operations of the Federally-facilitated Exchange (FFE). In order for states to begin Exchange operations in January 2014, CMS must provide at least a conditional approval of state-based Exchanges by January 2013.

  Additionally, CMS will begin operations of the FFE in FY 2013 including receiving and evaluating submissions from issuers for qualified health plans in the FFE, contracting with entities to perform eligibility and enrollment functions,

Meaningful Use of Electronic Health Records (EHRs)

CMS and the Office of the National Coordinator for Health IT are working together to improve quality, reduce costs, decrease paperwork, and expand access to care through increased adoption and meaningful use of EHRs. HHS aims to increase the number of eligible providers who receive an incentive payment from the Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology from 80,000 in FY 2012 to 140,000 by the end of FY 2013.

quality and setting up financial management and oversight infrastructure. The Budget requests $574 million for FFE operations and oversight of state-based Exchanges in FY 2013.

- *Consumer Assistance Program (CAP) grants:* The Budget requests $30 million to provide Consumer Assistance Program (CAP) grants to states. As of July 15, 2011, CAPs across the Nation provided direct assistance to 150,199 consumers and assisted 17,304 consumers in filing appeals. Additionally, CAP grants allow states to provide vulnerable and underserved populations, including communities in rural and frontier areas, with personalized assistance not previously available.

Survey and Certification Frequencies

Type of Facility	2011 Enacted	2013
Long-Term Care Facilities /1	Every Year	Every Year
Home Health Agencies /1	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 3 Years	Every 3 Years
Accredited Hospitals	2% Per Year	2.2% Per Year
Organ Transplant Facilities	Every 3 Years	Every 4 Years
ESRD Facilities	Every 3 Years	Every 3 Years
Ambulatory Surgical Centers	Every 6 Years	Every 4 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Rural Health Clinics, Portable X-Ray	Every 6 Years	Every 6 Years

1/ Legislatively Mandated

Note: CMS is reviewing FY 2012 survey frequencies within the FY 2012 appropriation.

Federal Administration: For FY 2013, the President's Budget requests $793 million for CMS Federal administrative costs, a $2 million increase over the comparable FY 2012 enacted level.

Of this total, $632 million will support a Full-Time Equivalent (FTE) level of 4,672, an increase of 136 FTEs over FY 2012. This staffing increase will enable CMS to address the needs of a growing Medicare population, as well as oversee expanded responsibilities resulting from legislation passed in recent years.

Survey and Certification: The FY 2013 Survey and Certification request is $387 million, a $32 million increase over FY 2012. The $387 million request funds basic survey and certification program activities and initiatives in nursing home transparency, quality improvement, and program integrity. This increase from FY 2012 is needed to complete surveys at frequencies consistent with statutory and policy requirements, given continued growth in the number of participating facilities. Between FY 2005 and the end of FY 2013, the number of Medicare-certified facilities will have increased by 18 percent, from 48,943 to an estimated 57,602 facilities. CMS expects states to complete almost 25,000 initial surveys and re-certifications and over 51,000 visits in response to complaints in FY 2013.

Approximately 91 percent of the funding will go to state survey agencies to complete certifications and complaint visits. Surveys include mandated Federal inspections of long-term care facilities (i.e., nursing homes) and home health agencies, as well as Federal inspections of other key facilities. All facilities participating in the Medicare and Medicaid programs must undergo inspection when entering the program and on a regular basis

GAO and OIG Reports on Survey and Certification

Reports from the Government Accountability Office (GAO) and the HHS Office of Inspector General highlight the need for federal oversight to ensure quality of care. The GAO placed areas of survey and certification oversight, particularly nursing homes and dialysis facilities, into a high risk category indicating greater vulnerability to fraud, waste, abuse, and mismanagement. Maintaining survey and certification frequencies at or above the levels mandated by statute and policy is critical to ensuring federal dollars support high-quality care and protect beneficiaries from harm.

thereafter. CMS expects to publish the first conditions of participation for community mental health centers (CMHCs) in FY 2013, which will promote quality improvement in CMHCs by setting minimum quality and safety standards that these facilities will have to meet to maintain enrollment as a Medicare provider. However, CMS does not expect to begin CMHC surveys until the end of FY 2013, and therefore the Budget does not include CMHC survey funds.

Research, Demonstrations, and Evaluation: Beginning in FY 2013, ongoing research activities will be funded from Program Operations.

State High Risk Pools: The Budget requests $22 million for the State High Risk Pools, a $22 million decrease from FY 2012. The FY 2013 request provides sufficient funding for the State High Risk Pool program as states begin scaling down activities to transition to operational Affordable Insurance Exchanges in 2014.

National Medicare Education Program (NMEP): The total FY 2013 program level for NMEP is $359.6 million, an increase of approximately $37.4 million from the FY 2012 level. The NMEP program level includes funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and QIOs. In order to ensure that beneficiaries have accurate and up-to-date information on their coverage options and covered benefits, beneficiary education remains a top priority for CMS.

Of the total, $252.4 million, or 70 percent, supports the 1-800-MEDICARE call center which provides beneficiaries with access to customer service representatives who are trained to answer questions regarding the Medicare program. The request will support approximately 27 million calls with an average-speed-to-answer of 5 minutes. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations. CMS is using information from beneficiary fraud allegations in new ways, to compile provider-specific complaints, flag providers who have been the subject of multiple fraud complaints, and map shifts and trends in fraud allegations over time.

National *Medicare & You* Education Program (NMEP)

FY 2013 Program Level Request in Millions

Activity	2012	2013
Beneficiary Materials (e.g. Handbook).....	51.6	47.9
1-800-MEDICARE Toll Free Line.....	220.4	252.4
Internet.....	26.6	31.4
Community-Based Outreach /1	2.6	5.0
Program Support Services /2	21.1	22.9
Total, NMEP Program Level /3.....	**322.3**	**359.6**

1/ FY 2012 level includes a comparability adjustment of -$50 million to reflect the FY 2013 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

2/ Includes multi-media campaign and consumer research.

3/ Includes funding from Program Management, user fees, and QIOs (2012 only; 2013 QIO funding is TBD).

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Discretionary				
Budget Authority /1	17,235	16,489	16,181	-308
Mandatory				
Budget Authority	33,698	33,650	34,129	+479
Total, ACF Budget Authority /2	**50,933**	**50,139**	**50,310**	**+171**

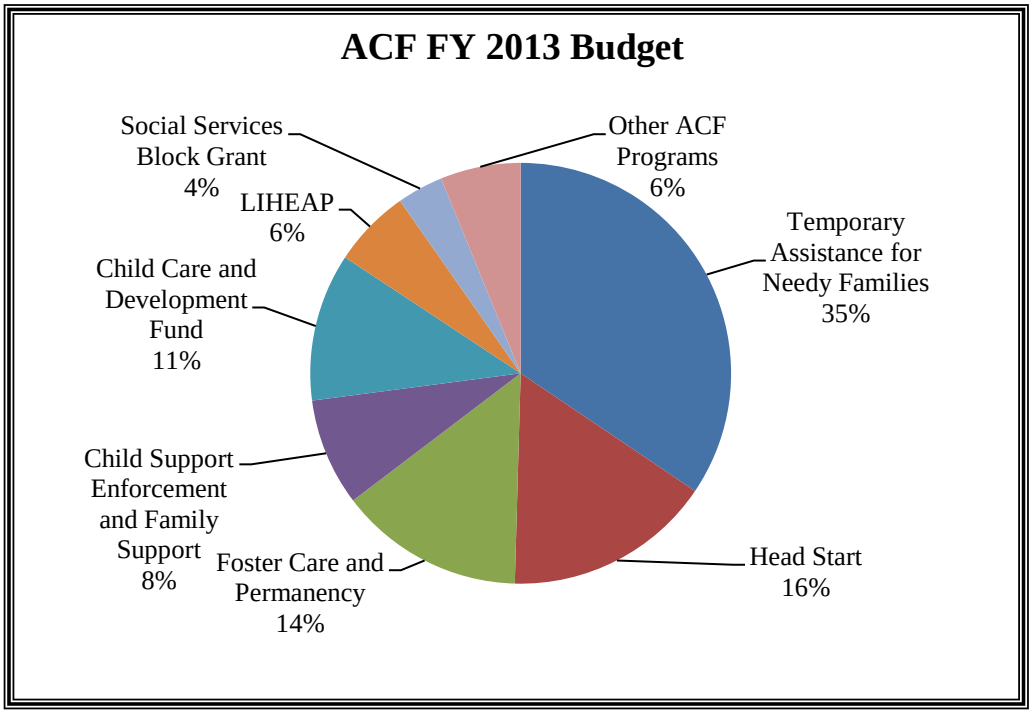
1/ The FY 2011 discretionary amount does not reflect the FY 2011 rescission of prior year Refugee funds.

2/ The FY 2013 total differs from the HHS Budget by Operating Division table due to rounding.

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

The FY 2013 Budget request for the Administration for Children and Families (ACF) is $50.3 billion. ACF works in partnership with states and communities to provide critical assistance to vulnerable families while helping families and children achieve a path to success. ACF programs find safe and supportive families for abused children, work with newly-arrived refugees as they start their new lives in America, and work with troubled teens to leave the streets and find opportunity. The Budget includes additional funding for Head Start, Child Care, and Refugee programs and supports important reforms in Head Start, Child Care, Child Support, and Foster Care. The Budget also creates a new program to reduce teen pregnancy among youth in foster care.

The mandatory Budget includes $17.4 billion for Temporary Assistance for Needy Families, $7.2 billion for Foster Care and related programs, $3.9 billion for Child Support Enforcement and Family Support, and $3.4 billion for Child Care Entitlement to States for FY 2013.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

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

(dollars in millions)

	2011	2012	2013	2012 +/- 2013
Head Start	7,560	7,969	8,054	+85
Child Care & Development Block Grant (discretionary)	2,223	2,278	2,603	+325
Refugee Programs				
Transitional and Medical Services (TAMS)	353	372	403	+31
Unaccompanied Alien Children	149	169	175	+6
Other Refugee Programs	228	227	227	–
Subtotal, Refugee Programs	729	768	805	+37
Child Welfare/Adoption Assistance	359	357	362	+5
Domestic Sex Trafficking	–	–	*5*	*+5*
Chaffee Education & Training for Foster Youth	45	45	45	–
Family Violence Prevention	133	133	139	+7
Adoption Incentives	39	39	39	–
Runaway and Homeless Youth Programs	115	115	115	–
Child Abuse	94	94	94	–
Promoting Safe and Stable Families (discretionary)	63	63	63	–
Developmental Disabilities	186	168	168	–
LIHEAP				
Formula Grants	4,501	3,472	2,820	-652
Contingency Fund	200	–	200	+200
Subtotal, LIHEAP Budget Authority	4,701	3,472	3,020	-452
Native Americans	49	49	49	–
Community Services Block Grant	679	677	350	-327
Other Community Services Programs, (incl.Healthy Foods)	49	55	50	-5
Subtotal, Community Service Programs	727	732	400	-332
Disaster Human Services Case Management	2	2	2	–
Social Services Research & Demonstration	6	6	14	+8
Disconnected Youth Initiative (non add)	–	–	*5*	*+5*
PHS Evaluation Funds (non-add)	*6*	*6*	*6*	–
Federal Administration	209	205	213	+8
Center, Faith Based/Community Initiatives (non add)	*1*	*1*	*1*	–
Total, Program Level	**17,241**	**16,495**	**16,186**	**-309**
Less Funds From Other Sources				
PHS Evaluation Funds	-6	-6	-6	–
Total, Discretionary Budget Authority /1	**17,235**	**16,489**	**16,181**	**-309**
FTE (including those financed with mandatory funds)	*1,338*	*1,338*	*1,362*	+24

1/ FY 2011 budget authority does not include rescission of $25 million in prior year Refugee funds.

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

The FY 2013 discretionary Budget request for the Administration for Children and Families (ACF) is $16.2 billion, a decrease of $309 million below FY 2012. The Budget invests in high-quality early education, which helps put children on a path to school success and opportunity and is a critical component to bolstering the nation's competitiveness. In addition, funding is prioritized for programs protecting society's most vulnerable members with key increases requested for refugees and vulnerable youth and to assist victims of domestic violence. The ACF discretionary budget also contributes to deficit reduction, including reductions totaling $784 million in LIHEAP and community services programs.

EARLY CHILDHOOD DEVELOPMENT

The Administration supports critical reforms in Head Start and Child Care that, combined with the Race to the Top – Early Learning Challenge Fund, are key elements of the Administration's broader education reform agenda. This coordinated approach is designed to improve our Nation's competitiveness by helping every child reach his or her full potential.

Head Start: The Budget requests over $8 billion for Head Start. The funding level is necessary to continue to serve 962,000 children, including approximately 114,000 infants and toddlers in Early Head Start.

On November 8, 2011 the President announced important new steps to improve the quality of services and accountability at Head Start programs across the country. Under these new rules, grantees that do not meet quality benchmarks will be required to compete against other organizations in their community for continued funding. Of the additional $85 million requested over FY 2012, $40 million would be used to support this effort by minimizing potential service disruptions in the transition between incumbent and new grantees. The request includes $2 million for monitoring of new grantees to ensure that they meet Head Start's critical mission—to help children from low-income families achieve their full potential and, in turn, help our country build tomorrow's workforce.

Child Care: The FY 2013 request for the Child Care and Development Fund is $6 billion, which includes $3.4 billion for the Child Care Entitlement (CCE) and $2.6 billion for the Child Care and Development Block Grant (CCDBG). The funding level represents a total increase of $825 million over FY 2012, and supports 1.5 million children – 70,000 more than would otherwise be served. The Budget also includes $300 million to build on existing quality infrastructure investments in the Race to the Top – Early Learning Challenge and the Child Care and Development Fund by directly investing in programs and teachers to help them meet and maintain higher quality standards. Additional competitively awarded funding would be available to States and Tribes that demonstrate a strong commitment to making significant strides in their ability to measure the quality of individual child care programs through a rating system or another system of quality indicators and to clearly communicate program-specific information to parents so they can make informed choices for their families. This proposal is consistent with the Administration's broader reauthorization principles, which focus on continuous quality improvement and provides more low-income children access to high-quality early care and learning settings to support children's success in school.

Taking Action to Improve Quality and Promote Accountability in Head Start Programs

In November 2011, President Obama announced historic steps to improve the quality of services and accountability at Head Start centers across the country. The Administration for Children and Families will implement new regulations that will – for the first time – require low-performing Head Start grantees that fail to meet a new set of rigorous benchmarks to re-compete for continued federal funding. This reform will help direct taxpayer dollars to the organizations that are most capable of providing high-quality Head Start services that will help children start school ready to succeed.

PROTECTING VULNERABLE INDIVIDUALS

Quality Rating and Improvement Systems

HHS has established a High Priority Performance Goal in the area of Early Childhood Education to improve the quality of early care and education programs for low-income children. As an indicator for this goal, the ACF Office of Child Care plans to work to expand the number of states with Quality Rating and Improvement Systems (QRIS) that meet high-quality benchmarks developed by HHS in coordination with the Department of Education. To date, 25 states have developed statewide QRIS that set standards for excellence for child care providers. QRIS provides pathways and support for child care providers to move up to higher standards of quality and increases parents' knowledge and understanding of the child care options available to them. The baseline for this developmental performance measure, once established, will reflect the number of states adopting these practices, which are the hallmarks of a strong QRIS. When implemented effectively, QRIS can help improve the overall quality of care available and, as a result, potentially improve child outcomes.

Refugee-Related Programs:
Refugees flee violence, persecution and even torture and ACF is charged with helping them to begin new lives in the United States. ACF also serves unaccompanied alien children as well as victims of trafficking and torture. Newly arriving refugees and certain other entrants are eligible for time-limited cash and medical assistance. These new arrivals receive needed medical care, job training, and English instruction so they can become self-sufficient as quickly as possible. ACF also aids in the fight against human trafficking by identifying victims and certifying them as eligible to receive federal benefits and services to the same extent as refugees so they can begin to rebuild their lives. Additionally, through a nationwide network of shelters, ACF provides a safe environment for unaccompanied alien children until they can be placed with U.S. relatives or other sponsors, repatriated to their home countries, age out, or receive relief under U.S. immigration law.

The Budget requests $805 million for refugee-related programs, an increase of $37 million. Additional funding will be used for rising medical costs as many refugees have spent their lives in camps where medical care is limited or non-existent. Funds will also support the growing number of unaccompanied alien children made eligible for benefits under the Trafficking Victims Protection Reauthorization Act of 2008.

Vulnerable Youth: The ACF Budget includes an additional $10 million for two new initiatives designed to protect adolescents as they make the transition to adulthood. Five million is included in Social Services Research and Demonstration as part of a cross–agency effort to identify and test new ways to strengthen services for disconnected youth—14- to 24-year-olds who are neither working nor in school. This $5 million will be utilized in close cooperation with an additional $5 million requested by the Department of Education and $10 million from the Department of Labor. Agencies will work together in 2012 to determine how to prepare disconnected youth for college and or career success. Approved FY 2013 pilots could streamline the intake process, better coordinate services for youth in multiple systems, or pilot new service models for specific high-risk youth groups like youth aging out of foster care.

The request also includes a $5 million competitive child welfare services grant program to combat youth domestic sex trafficking. Funds will be used to improve coordination among those systems most likely to come into contact with such youth (e.g., child welfare, law enforcement, courts, runaway and homeless youth grantees) and to train staff in such systems to better identify and serve this often misidentified population.

Family Violence Prevention: The Budget includes $139 million, an increase of $7 million, for Family Violence Prevention programs. Together these programs form the primary federal funding stream dedicated to the support of domestic violence shelters and services for victims of domestic abuse and their children. The increased funding will expand shelter capacity and support services and support increased call volume to the Domestic Violence Hotline.

Low Income Home Energy Assistance Program (LIHEAP): The Administration proposes to adjust LIHEAP funding for expected winter fuel costs and to target funds to those most in need. The request is $3 billion, $452 million below the FY 2012 level and $450 million above the amount provided in FY 2008 and previous years. The FY 2012 President's Budget requested $2.6 billion. While the cost of natural gas – the heating fuel used by most LIHEAP households –

has not risen in recent years, the cost of heating oil has been on the rise. Unlike households using fuels sold by regulated utilities (natural gas or electricity), households using home-delivered fuels (oil and propane) are not protected by laws prohibiting winter shut offs. With constrained resources, the Budget targets assistance where it is needed most. The request targets $2.8 billion in base grants using the state allocation Congress enacted for FY 2012. The request also includes $200 million in contingency funds, which will be used to address the needs of households reliant on home-delivered fuels should expected price trends be realized. Contingency funds would also be available to respond to weather or other emergencies.

HHS has taken a number of steps to better ensure that LIHEAP benefits are only provided to eligible household members. These steps include requiring LIHEAP grantees to describe their program integrity assurance systems and proposing legislation requiring grantees to collect applicant social security numbers for use in eligibility verification. The FY 2012 Appropriation reserves $3 million for training, technical assistance, and monitoring, up from $300,000 in previous years. The Budget builds on this expansion, continuing this level of investment for grantee training and monitoring, development of model fraud prevention systems, and evaluation of best practices among grantees.

STRENGTHENING COMMUNITIES

Native Americans: The Budget maintains funding at $49 million for competitive grants to improve the well-being of American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders. Funds are used primarily to strengthen community economic development by providing job training and supporting business expansion, financial literacy, and home ownership. Funds also support the preservation of Native languages and the protection of natural and cultural resources for current and future generations. In August 2011, ACF completed development of an agency-specific tribal consultation policy with a signing ceremony attended by representatives from 42 tribes.

Community Services Programs: The Budget includes $400 million for Community Services programs. This funding level includes $350 million for the Community Services Block Grant, a reduction of $327 million below FY 2012. The Budget proposes to use a system of standards and competition to target the funds to high-performing agencies that are most successful in meeting community needs. In support of the Healthy Food Financing Initiative, $10 million is available to fund community development corporations eliminate food deserts by improving access to grocery stores, farmers' markets, and other venues for healthy, affordable groceries. Additionally, $20 million is requested for the Community Economic Development program to sponsor enterprises providing employment, training, and business development opportunities for low-income Americans.

ENSURING PROGRAM EFFECTIVENESS

To continue to carry out its mission and contribute to governmentwide deficit reduction efforts, ACF must have a rigorous program evaluation capacity to ensure its programs remain cost effective. The Budget includes $14 million, an increase of $8 million over FY 2012, to maintain this capacity and make key service delivery improvements. Recent projects include employment retention and advancement, welfare-to-work strategies for the hard-to-employ, and projects to support the family formation goals of the Personal Responsibility and Work Opportunity Reconciliation Act. The additional $8 million includes $5 million for disconnected youth described earlier and a $3 million increase to help identify the features of early care and education that are most important in supporting early cognitive development.

Federal Administration: The Budget includes $213 million for ACF program administration, including pay and benefits for the majority of agency staff, an increase of $8 million over FY 2012. Additional funding will add 24 staff to implement critical Head Start reforms. Almost 1,700 grantees will be evaluated over the next three years and, for the first time in the history of this program, those that fall short of quality benchmarks, including classroom instruction, health and safety, and management, will have to compete for continued funding against other organizations in their communities. Additional funds are also included for increased program integrity activities across ACF, including more frequent on-site review and monitoring of grantees, more training and technical assistance workshops, and website development to provide additional information to grantees.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

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

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	2,917	–
Child Care and Development Fund (non-add) /1	*5,140*	*5,195*	*5,195*	–
Child Support Enforcement and Family Support	4,159	4,048	3,857	-191
Foster Care and Permanency	6,990	7,006	6,913	-93
Promoting Safe and Stable Families (mandatory only) /2	505	485	485	–
Temporary Assistance for Needy Families (TANF) /3	16,950	16,739	16,739	–
TANF Contingency Fund /4	334	612	612	–
Total, TANF (non-add)	*17,285*	*17,351*	*17,351*	*-1*
Children's Research and Technical Assistance /5	58	58	52	-6
Social Services Block Grant	1,785	1,785	1,785	–
Total, Current Law Budget Authority	**33,698**	**33,650**	**33,360**	**-290**
Proposed Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	3,417	+500
Child Care and Development Fund (non-add)	*5,140*	*5,195*	*6,020*	*+525*
Child Support Enforcement and Family Support	4,159	4,048	3,868	-180
Foster Care and Permanency	6,990	7,006	7,165	+159
Promoting Safe and Stable Families (mandatory only)	505	485	485	–
TANF	16,950	16,739	17,058	+319
TANF Contingency Fund	334	612	293	-319
Total, TANF (non-add)	*17,285*	*17,351*	*17,351*	–
Children's Research and Technical Assistance	58	58	58	–
Social Services Block Grant	1,785	1,785	1,785	–
Total, Proposed Law Budget Authority	**33,698**	**33,650**	**34,129**	**+479**

1/ The Child Care Development Fund includes mandatory funding from the Child Care Entitlement to States and discretionary funding from the Child Care and Development Block Grant.

2/ The total for Promoting Safe and Stable Families includes Abstinence Education, the Personal Responsibility Education Program, and Promoting Safe and Stable Families (mandatory).

3/ The Claims Resolution Act of 2010 extended all TANF grants through September 30, 2011 except for the Supplemental Grants for Population Increases. The supplemental grants were extended through June 30, 2011 resulting in a total of $211 million being available for FY 2011. Several Continuing Appropriations Resolutions for FY 2012 and the Temporary Payroll Tax Cut Continuation Act of 2011 extended the TANF program through February 29, 2012, but they did not authorize the supplemental grants for FY 2012.

4/ The Continuing Appropriations Act, 2011, appropriated to the fund $506 million in FY 2011 and $612 million in FY 2012. Subsequently, the FY 2011 appropriation was reduced to $334 million by the Claims Resolution Act of 2010.

5/ The FY 2012 estimate level reflects the Administration's proposal for an extension of the $6 million Child Welfare Study.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

The FY 2013 Budget request for ACF Mandatory programs is $34.1 billion. ACF serves the Nation's most vulnerable populations through mandatory programs such as Temporary Assistance for Needy Families (TANF), Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

The Budget supports important improvements in the foster care system, increases the number of children in high-quality child care, increases the child support that is paid to families, and promotes fathers' involvement in the lives of their children.

The Budget continues existing funding for the TANF program in FY 2013, proposes to restructure the contingency fund to make it more effective, and puts forth principles for reauthorization.

CHILD CARE ENTITLEMENT TO STATES

The Budget supports important improvements in the Child Care and Development Block Grant and the Child Care Entitlement to States. The Budget request for the Child Care Entitlement is an increase of $7 billion over 10 years, including an increase of $500 million in FY 2013. The request also includes a $325 million discretionary increase to the Child Care and Development Block Grant. Total child care funding for the Child Care and Development Fund is $6 billion in FY 2013. The Budget request supports additional funding for quality activities while maintaining the number of children receiving subsidies. In FY 2013, the request would enable 1.5 million children to receive child care assistance – 70,000 children more than could be served without the additional funding requested. These improvements, along with investments in the Race to the Top-Early Learning Challenge and Head Start, are key elements of the Administration's broader education agenda designed to help every child reach his or her academic potential and improve our Nation's competitiveness.

CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

The Budget request is $3.9 billion in budget authority in FY 2013 for Child Support Enforcement and Family Support Programs.

The Budget includes $2.2 billion over 10 years for an initiative to modernize the Child Support system and promote responsible fatherhood. Of those costs, $1.8 billion impacts the Child Support program, $303 million impacts Foster Care, and $80 million impacts Medicaid. Child Support Enforcement is a joint federal, state, tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The proposal promotes strong families and responsible fatherhood by ensuring that children benefit when parents pay support, promoting parenting time arrangements, and

Child Support Enforcement

The Child Support Enforcement (CSE) program continues to make strong gains in support orders and paternity establishment. In FY 2010:

- Child support collections increased by 0.6 percent to $26.6 billion.
- 1.7 million paternities were established and acknowledged.
- Paternity was established for 95 percent of all child support cases, exceeding the target of 94 percent.
- Child support orders were established for 80 percent of child support cases, which surpassed the target of 77 percent.
- For every dollar invested in the program, $4.88 in child support was collected, which exceeded the target of $4.77.
- Three tribal programs became comprehensive, fully operational program service providers, bringing the total number of comprehensive Tribal Child Support Enforcement Programs to 39.

improving enforcement tools. This proposal also includes funding specifically to encourage states to pass through child support payments to families.

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

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

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

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

FOSTER CARE AND PERMANENCY

The Budget request for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs is $7.2 billion in FY 2013 budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence. The Budget includes an increase in funding of $252 million in FY 2013 and $2.8 billion over ten years to support better well-being outcomes for children and families and to require that child support payments made on behalf of children in foster care be used in the best interest of the child.

Of the total request in FY 2013, $4.4 billion in budget authority, a $107 million increase above the FY 2012 enacted level, will support the Foster Care program, including maintenance payments to children and new incentive-based funds. The proposed level of funding will provide assistance and support to an estimated 165,000 children each month, which is a decline in the foster care caseload of about 3,300 fewer children as compared to FY 2012. This decrease is partially due to placement of more children in permanent settings. Some of the decline can be attributed to the erosion of eligibility under statute, as children's eligibility for federal foster care is tied to the former Aid to Families with Dependent Children income eligibility standards, which are increasingly outdated as they were not indexed to account for inflation.

Foster Care Legislative Proposal

The Budget includes $2.5 billion over 10 years to support a reform agenda based on the following principles:

- Creating financial incentives to improve child outcomes in key areas, by reducing the length of stay in foster care, increasing permanency through reunification, adoption, and guardianship, decreasing rates of maltreatment recurrence and any maltreatment while in foster care, and reducing rates of re-entry into foster care;
- Improving the well-being of children and youth in the foster care system, transitioning to permanent homes, or transitioning to adulthood, to include:
  - Ensuring proper oversight and monitoring for psychotropic medications;
  - Providing appropriate therapeutic services using the best research available on effective interventions;
  - Building capacity in child welfare and mental health systems to ensure effective interventions are available; and,
  - Training child welfare staff and clinicians to provide effective, evidence-based interventions that address the trauma and mental health needs of children in foster care.
- Reducing costly and unnecessary administrative requirements, while retaining the focus on children in need.

The Budget also includes $2.5 billion in budget authority for the Adoption Assistance program, an increase of $42 million above FY 2012 enacted. This reflects an increase in the number of children eligible for the Adoption Assistance program. An estimated average 459,500 children per month, an increase of 15,500 over FY 2012, will qualify for this assistance in FY 2013.

The Budget includes $90 million for the Guardianship Assistance program, an increase of $10 million above FY 2012 enacted, reflecting an increase in the number of children participating in Guardianship Assistance programs. Under this program, state title IV-E agencies provide a subsidy on behalf of a child to a relative who has been granted legal guardianship of that child. An estimated average 14,000 children per month, an increase of 3,000 over FY 2012, will participate in FY 2013.

The Budget also includes $140 million for the Chafee Foster Care Independence Program, the same level as in FY 2012. This program funds services for youth who will likely remain in foster care until they turn 18 and current or former foster children between the ages of 18 and 21.

The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2010, the latest year for which complete performance data are available. Working with the states, these programs support the goal of minimizing disruptions to the continuity of family and other relationships for children in foster care by decreasing the number of placement settings per year for a child in care. In FY 2010, 85 percent, or 5 points above the 80 percent target number, of children who had been in care less than 12 months had 2 or fewer placement settings. Placement stability is necessary for children and youth to be able to form and maintain consistent relationships with caretakers and other adults, which is a core skill for life-long success.

Pregnancy Prevention Program for Foster Care Youth

The FY 2013 Budget proposes to fund pregnancy prevention efforts targeted to foster care youth. The new program would provide competitive funds to local or state child welfare agencies with the strongest and boldest plans to reduce pregnancy for youth in foster care.

- Funding would derive from title V, Abstinence Education funds that are not drawn down by states.
- Grantees will be expected to fund the most effective approaches to pregnancy prevention in the foster care population and will not be limited to the title V definition of Abstinence Education.
- The program will build the evidence base for pregnancy prevention for foster care youth and adapt evidence-based models to fit the needs of this population. In addition, the program will focus on systemic changes to the foster care system and coordination among multiple agencies to impact teen pregnancy rates among youth in foster care.

PROMOTING SAFE AND STABLE FAMILIES

The Budget includes $485 million for Promoting Safe and Stable Families (PSSF). Of this amount, $345 million supports the mandatory portion of PSSF, $75 million supports the Personal Responsibility Education Program (PREP), $50 million supports Abstinence Education (see highlight on Pregnancy Prevention Program for Foster Care Youth), and $15 million supports the Family Connection Grants. Additionally, the Budget provides $63 million in discretionary funds for PSSF.

The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) reauthorized PSSF through FY 2016. This funding will continue support for a variety of state child welfare activities, including family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. Under the reauthorization, states are required to address the trauma children in child welfare have experienced and to have explicit protocols for oversight and monitoring of psychotropic medications.

In FY 2010 the percentage of children in foster care without a case plan goal was reduced to 3.3 percent, just short of the goal of 3.1 percent. By increasing the proportion of cases with a case plan goal developed in a timely manner, ACF is helping to

ensure that there is a focus on moving children from foster care to a permanent home.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

TANF provides $17.4 billion annually to states, territories, and eligible tribes to assist low-income families and improve employment and other outcomes. For FY 2012, the Short-Term TANF Extension Act (P.L. 112-35) extended all TANF grants except the Supplemental Grants through December 31, 2011. Subsequently, Section 312 of the Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78) extended all TANF grants except the Supplemental Grants through February 29, 2012. The Budget continues existing funding for the TANF program in FY 2013.

The Budget includes a proposal to restructure the Contingency Fund and make the Supplemental Grants for Population Increases a permanent part of TANF. When Congress takes up reauthorization, we want to work with lawmakers to strengthen the program's effectiveness in accomplishing its goals. This should include using performance indicators to drive program improvement and ensuring that states have the flexibility to engage recipients in the most effective activities to promote success in the workforce – including families with serious barriers to employment. We also want to work with Congress to revise the Contingency Fund to make it more effective during economic downturns.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG) is a capped entitlement which provides flexible grants to states according to population size for the provision of social services ranging from child care to residential treatment. States have broad discretion over the use of these funds. SSBG is funded at $1.8 billion for FY 2013, the same as FY 2012.

Cross-Agency Efforts to Increase Administrative Flexibility

In 2011, HHS and the U.S. Department of Agriculture's Food, Nutrition, and Consumer Services (FNCS), announced a time-limited policy allowing Federally-funded human services programs to benefit from investments in state eligibility systems made by state-operated Exchanges, Medicaid, and CHIP programs in preparation for new coverage expansions under the Affordable Care Act that begin in 2014.

This policy allows states to enhance the efficiency of their eligibility determinations by leveraging eligibility system investments for other programs and purposes. Programs that could benefit include TANF, the Child Care and Development Fund, and the Supplemental Nutrition Assistance Program (administered by FNS). Incremental costs for additional eligibility requirements needed for the inclusion of those programs must be charged entirely to the benefiting program. Effective August 10, 2011, this policy applies only to development costs for eligibility determination systems and ends on December 31, 2015.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

ACF Mandatory - Outlays Overview
(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Current Law Outlays:				
Child Care Entitlement to States…… .	3,100	2,868	2,877	+9
Child Care and Development Fund (non-add) /1……..	*6,084*	*5,167*	*5,107*	*-60*
Child Support Enforcement and Family Support……	4,182	3,869	3,862	-7
Foster Care and Permanency ……..	6,860	6,795	6,948	+153
Promoting Safe and Stable Families (mandatory only) /2……..	413	572	478	-94
Temporary Assistance for Needy Families (TANF) /3……...	17,116	16,538	17,017	+479
TANF Contingency Fund ……...	335	689	612	-77
TANF Emergency Fund (Recovery Act) /4……	1,621	628	70	-558
Total, TANF (non-add)……..	*19,072*	*17,855*	*17,699*	*-156*
Children's Research and Technical Assistance /5……...	51	56	65	+9
Social Services Block Grant……...	1,787	1,908	1,792	-116
Total, Current Law Outlays	**35,465**	**33,923**	**33,721**	**-202**
Proposed Law Outlays:				
Child Care Entitlement to States…….	3,100	2,868	3,286	+418
Child Care and Development Fund (non-add)……..	*6,084*	*5,167*	*5,747*	*+337*
Child Support Enforcement and Family Support……	4,182	3,869	3,873	+4
Foster Care and Permanency …….	6,860	6,795	7,170	+375
Promoting Safe and Stable Families (mandatory only)……..	413	572	478	-94
Temporary Assistance for Needy Families (TANF) ……..	17,116	16,538	17,306	+768
TANF Contingency Fund ……..	335	689	323	-366
TANF Emergency Fund …….	1,621	628	70	-558
Total, TANF (non-add)……..	*19,072*	*17,855*	*17,699*	*-156*
Children's Research and Technical Assistance …….	51	56	68	+12
Social Services Block Grant……...	1,787	1,908	1,792	-116
Total, Proposed Law Outlays	**35,465**	**33,923**	**34,366**	**+443**

1/ The Child Care Development Fund includes mandatory funding from the Child Care Entitlement to States and discretionary funding from the Child Care and Development Block Grant.

2/ The total for Promoting Safe and Stable Families includes Abstinence Education, the Personal Responsibility Education Program, and Promoting Safe and Stable Families (mandatory).

3/ The Claims Resolution Act of 2010 extended all TANF grants through September 30, 2011 except for the Supplemental Grants for Population Increases. The supplemental grants were extended through June 30, 2011 resulting in a total of $211 million being available for FY 2011. Several Continuing Appropriations Resolutions for FY 2012 and the Temporary Payroll Tax Cut Continuation Act of 2011 extended the TANF program through February 29, 2012, but they did not authorize the supplemental grants for FY 2012.

4/ The American Recovery and Reinvestment Act of 2009 appropriated $5 billion for FY 2009 and FY 2010 for the TANF Emergency Contingency Fund.

5/ The FY 2012 estimate level reflects the Administration's proposal for an extension of the $6 million Child Welfare Study.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

ACF Mandatory - Legislative Proposals in Outlays
(dollars in millions)

	2013	2013 –2017	2013 –2022
Child Care Entitlement	409	3,272	7,022
Child Support Enforcement and Family Support Programs /1	11	515	1,392
Foster Care and Permanency /2	222	1,353	2,763
Children's Research and Technical Assistance	3	26	56
Temporary Assistance for Needy Families (TANF)	–	–	–
Total, ACF Legislative Proposals	**645**	**5,166**	**11,233**

1/ The cost of the Child Support Enforcement (CSE) proposal to eliminate Medicaid recoupment of birthing costs, which costs $80 million over ten years, is reflected in the Medicaid account. The CSE outlays in this table are net of estimated savings in the Supplemental Nutrition Assistance Program ($441 million) and the Supplemental Security Income program ($21 million), which would result from this proposal.

2/ The Foster Care and Permanency outlays reflect the impact of a CSE proposal to require states to use the collections received on behalf of IV-E children in the best interest of the child. This proposal costs $303 million over 10 years.

ADMINISTRATION ON AGING

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Health and Independence				
Home & Community-Based Supportive Services	368	367	367	–
Nutrition Services	818	816	816	–
Native American Nutrition & Supportive Services	28	28	28	–
Preventive Health Services	21	21	21	–
Senior Community Service Employment Program /1	449	448	448	–
Aging Network Support Activities	8	8	8	–
Subtotal, Health and Independence	1,691	1,688	1,688	–
Caregiver Services				
Family Caregiver Support Services	154	154	154	–
Native American Caregiver Support Services	6	6	6	–
Alzheimer's Disease Demonstration Grants	11	4	10	+6
Lifespan Respite Care	2	2	2	–
Subtotal, Caregiver Services	174	166	172	+6
Protection of Vulnerable Older Adults				
Adult Protective Services	–	–	8	+8
Long Term Care Ombudsman Program	17	17	17	–
Prevention of Elder Abuse & Neglect	5	5	5	–
Senior Medicare Patrol Program	9	9	9	–
Elder Rights Support Activities	4	4	4	–
Subtotal, Protection of Vulnerable Older Adults	35	35	43	+8
Consumer Information, Access and Outreach				
Aging and Disability Resource Centers	16	16	10	-6
ACA Mandatory Funding (non-add)	*10*	*10*	*10*	–
State Health Insurance and Assistance Programs	52	52	52	–
Subtotal, Consumer Information, Access and Outreach	68	69	62	-7
Program Innovations	19	–	–	–
Chronic Disease Self Management /2	–	10	10	–
National Clearinghouse for Long Term Care Information /3	3	3	3	–
Health Care Fraud and Abuse Control /4	4	11	11	–
Aging Services Program Administration	20	23	23	–
Total, Program Level	**2,015**	**2,005**	**2,012**	**+7**
Less Funds from Other Sources				
Aging and Disability Resource Centers	-10	-10	-10	–
Chronic Disease Self Management /2	–	-10	-10	–
Health Care Fraud and Abuse Control /4	-3	-11	-11	–
National Clearinghouse for Long Term Care Information /3	-3	-3	-3	–
Subtotal, Funds from Other Sources	-16	-34	-34	–
Total, Discretionary Budget Authority	**1,998**	**1,971**	**1,978**	**+7**
FTE /5	121	121	135	+14

1/ The Budget proposes to transfer this program from the Department of Labor to HHS in FY 2013. The FY 2011 and FY 2012 figures are comparably adjusted.
2/ Funding is proposed to be provided from the Prevention and Public Health Fund.
3/ The Long-Term Care Clearinghouse is shown in this display comparably to FY 2013, though in FY 2011 funds were provided to the Centers for Medicare & Medicaid Services.
4/ Funding drawn from Medicare Trust Funds. FY 2013 is a placeholder amount indicating only prior year levels. The Secretary and Attorney General will determine final amounts.
5/ The FY 2011 and FY 2012 FTE figures do not include FTE of programs proposed to be transferred in FY 2013.

ADMINISTRATION ON AGING

The Administration on Aging helps elderly individuals maintain their dignity and independence in their homes and communities through coordinated, cost effective systems of long-term care across the United States.

The FY 2013 Budget requests $2.0 billion for the Administration on Aging (AoA), an increase of $7 million above FY 2012. AoA is focused on helping seniors live as independently as possible in their communities. AoA works across HHS to harmonize efforts to promote community living, which can both save federal funds and allow people to live with dignity where they prefer—in the communities they call home. The Budget prioritizes elder justice activities, protects critical programs like nutrition and caregiving support, and includes transfers of complementary programs currently administered by other federal organizations to better coordinate the activities that touch older Americans.

PROTECTING ELDERS FROM ABUSE, NEGLECT, AND EXPLOITATION

Data suggest that more than 10 percent, or 5 million older Americans, suffer from elder abuse, neglect, and exploitation annually. The Budget includes an increase of $8 million to fund Adult Protective Services demonstration grants to test innovative approaches to reducing and addressing elder abuse in states and tribal settings. The negative effects of even modest forms of abuse, neglect, and exploitation on the health and independence of seniors include dramatically higher (300 percent) morbidity and mortality rates than non-abused older people and increased likelihood of heart attacks, dementia, depression, chronic diseases, and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the health care system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely. The proposed competitive grants will support the design and implementation of better approaches to protect our Nation's older adults from abuse, enabling them to live in their homes with dignity and without fear. AoA will also provide leadership and program coordination as well as develop and disseminate best practices across state and local agencies.

In addition, the Budget includes $10 million, an increase of $6 million, to test evidence-based approaches to provide services to persons with Alzheimer's Disease and their families. These grants help individuals with Alzheimer's and the people who care for them to continue living in the community by funding supportive services including respite care, home health care, personal care, adult day care, and companion services to assist caregivers, families, and persons with Alzheimer's disease.

SUPPORTING FAMILY CAREGIVERS

The Budget includes a total of $172 million for Caregiver Services to support family and informal caregivers by providing information, counseling, training, respite, and other services. These caregiver programs enable older adults to remain independent and at home longer and at a lower cost for recipients and the Federal Government. The Budget will

Helping Prevent, Detect, and Respond to Elder Abuse

Elder abuse can take many forms. Financial exploitation, physical and emotional abuse, and neglect are all forms of abuse. The Budget includes $43 million for programs that provide a range of services designed to ensure the safety and well-being of elders and adults with disabilities who are in danger of being mistreated or neglected. These elder rights programs:

- Help states test methods to detect, prevent, and address elder abuse;
- Fund state support for long-term care ombudsmen who advocate on behalf of residents of long-term care facilities to ensure the protection of their rights and welfare; and
- Recruit and train senior volunteers to educate their peers on how to prevent, detect, and report Medicare fraud and abuse.

support 796,000 caregivers through at least one of these programs, including more than 128,000 caregivers who will have the opportunity to participate specifically in counseling, peer support groups, and training to help them manage the stresses of caregiving.

MAINTAINING HEALTH AND INDEPENDENCE

The Budget includes a total of $367 million to fund in-home and community-based services to help seniors maintain their independence and dignity. These services include transportation assistance; case management; referrals; help with personal care including eating, dressing, and bathing; and adult day care and physical fitness programs. Along with other sources, the Budget will support more than 18 million rides for critical daily activities such as visiting the doctor, pharmacy, or grocery stores; 30 million hours of assistance to seniors unable to perform daily activities; and nearly 8 million hours of adult day care, enabling working caregivers to remain on the job.

The Budget also requests a total of $816 million, the same as FY 2012, for nutrition services to ensure that millions of older adults have access to the nutritious food needed to stay healthy and decrease their risk of disability. Meals are served in congregate settings, giving seniors opportunities for vital social contact, as well as delivered to seniors' homes, reaching some of the most disabled members of the community who have not yet moved into institutional care. The Budget will support 219 million home-delivered and congregate meals for over 2 million elder individuals in a variety of community settings.

Chronic Disease Self-Management Programs

Nearly 27 percent of Americans aged 65 and older have diabetes and almost half have prediabetes, according to the Centers for Disease Control and Prevetion (CDC). In collaboration with CDC's Communities Putting Prevention To Work program, AoA awarded $27 million of Recovery Act funds to states for Chronic Disease Self-Management Programs that are designed to help older adults learn how to cope with chronic diseases, partly by increasing physical activity, improving nutrition, and communicating more effectively with their health care providers.

As of January 21, 2012, more than 82,000 individuals had participated in over 7,500 workshops in 48 states/territories. Of these, approximately 62,000 completed at least 4 out of 6 courses. The top three chronic conditions reported by participants were hypertension, arthritis, and diabetes. The average age of participants was 67 years old.

PROMOTING EFFICIENCY IN COMMUNITY-BASED SERVICE DELIVERY

The Budget includes $52 million, the same as FY 2012, to fund more than 12,000 counselors in more than 1,300 community-based organizations through the State Health Insurance Assistance Program. These individuals and groups will provide one-on-one outreach and counseling to seniors and other Medicare beneficiaries on issues like Medicare prescription drug plans, eligibility for low-income subsidies for both regular Medicare and prescription drugs coverage, Medicare Advantage options, long-term care insurance, and claims and billing problem resolution. This funding is currently administered by the Centers for Medicare & Medicaid Services. Moving this program to AoA will enable grantees, about two thirds of which are already state units on aging, to streamline their interaction with the government, which will produce administrative efficiencies and improve coordination.

The Budget also includes $448 million, the same as FY 2012, for the Senior Community Service Employment Program, and proposes to move it from the Department of Labor to AoA. This program provides unemployed older adults with community service training and opportunities for employment in non-profits and government agencies such as schools, libraries, and senior citizens programs. The participants are low-income older individuals with low to limited prospects for employment who can benefit from the social and supportive services provided by the AoA aging network. This move provides greater alignment with the agencies that provide supportive services and is designed to enhance the participants' employment prospects.

SUPPORTING EVIDENCE-BASED INITIATIVES AND ACCESS TO SERVICES

To ensure the continuation of a vibrant aging services network, AoA identifies, evaluates, and replicates the best models and practices nationwide across this network, funding lower-cost, non-medical services and supports. The Budget includes $10 million for Aging and Disability Resource Centers and $10 million to help individuals manage their chronic diseases, two examples of state-of-the-art approaches that AoA is continuing to replicate and evaluate in support of its core programs.

PROGRAM ADMINISTRATION

The Budget includes $23 million for program management and support activities. In addition to supporting staff, rent and other administrative needs, these funds include amounts necessary for a potential headquarters relocation.

NYU Caregiver Intervention

The New York University Caregiver Intervention is a spousal caregiver support program that showed, in a randomized-control trial, a savings of $122,000 per person with dementia by delaying institutionalization by an average of 557 days.

The Administration on Aging's Alzheimer's Disease Supportive Services Program funded this New York project and, based on the results, is testing a translation of this work to six other states.

OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
General Departmental Management Budget Authority /1.....	480	474	306	-168
Prevention and Public Health Fund.....	19	10	110	+100
PHS Evaluation Funds	65	69	117	+48
Health Care Fraud and Abuse Control	9	9	9	–
Pregnancy Assistance Fund.....	25	25	25	–
Total, GDM Program Level	**598**	**587**	**567**	**-21**
Prevention Fund Activities Across HHS	–	*20*	*100*	*+80*
FTE	1,583	1,446	1,446	–

1/ The FY 2011 BA shown here does not include the $176 million transferred outside GDM.

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

The FY 2013 Budget for General Departmental Management (GDM) is $567 million, a decrease of $21 million under the FY 2012 level. This Budget supports grant programs as well as those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 12 Staff Divisions and Offices in GDM.

Teen Pregnancy Prevention: The FY 2013 Budget includes $105 million to support community-based efforts to reduce teen pregnancy. In addition, $4 million is included for the evaluation of teen pregnancy prevention activities. Teen pregnancy prevention funds will be used for replicating programs that have proven effective through rigorous evaluation to reduce teenage pregnancy; for research and demonstration grants to develop, replicate, refine and test additional models and innovative strategies; and for training, technical assistance, and outreach. Collaborative efforts in teen pregnancy prevention will support innovative youth pregnancy prevention strategies which are medically accurate and age appropriate.

Office of Minority Health: The Budget includes $41 million for the Office of Minority Health, a decrease of $15 million. The Office of Minority Health will be leading the coordination and collaboration of minority health activities in HHS, and place less emphasis on program development and grant-making. This funding will enable the Office of Minority Health to continue health promotion, service demonstration, and educational efforts to prevent disease and reduce and ultimately eliminate disparities in racial and ethnic minority populations across the country. The Budget continues funding for all existing grants within the Office of Minority Health.

Minority HIV/AIDS: The Budget includes $54 million to support innovative approaches to HIV/AIDS prevention and treatment in minority communities disproportionately impacted by this disease. These funds will allow the Department to continue priority investments and public health strategies targeted to reduce the disparate burden of HIV/AIDS in racial and ethnic minority populations.

Office on Women's Health: The Budget includes $29 million for the Office on Women's Health, a decrease of $5 million from FY 2012. The Office of Women's Health will be leading the coordination and collaboration of women's health activities in HHS, and place less emphasis on program development and grant-making. This funding will allow the Office on Women's Health to continue support for the advancement of women's health programs through the promotion and coordination of research, service delivery, and education. These programs are carried out throughout the agencies and offices of HHS, with other government organizations, and with consumer and health professional groups.

Office of Global Affairs: The FY 2013 Budget includes $6 million, for the Office of Global Affairs, enabling the office to support global health policy leadership and coordination across HHS.

Acquisition Reform: An additional $4 million is included for the HHS portion of a governmentwide initiative in contract and acquisition reform. Funding will be used to increase the capacity and capabilities of the Department's acquisition workforce.

Other General Departmental Management: The FY 2013 Budget includes $324 million for the remainder of GDM. The Budget funds leadership, policy, legal, and administrative guidance to HHS components and also includes funding to continue ongoing programmatic activities. Those activities include disease prevention and health promotion, as well as public awareness campaigns. In addition, this Budget will strengthen program integrity by reducing fraud, waste, and abuse and increasing accountability.

OFFICE OF THE SECRETARY
OFFICE OF MEDICARE HEARINGS & APPEALS

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Program Level	**70**	**72**	**84**	**+12**
FTE	420	466	518	+52

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

The FY 2013 Budget request for The Office of Medicare Hearings and Appeals (OMHA) is $84 million, a net increase of $12 million over FY 2012. In order to hear cases under Title XVIII of the Social Security Act and related provisions in Title XI of the Act, we request funds from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Fund. By statute, Administrative Law Judge (ALJ) appeals are to be heard within 90 days after receipt of a request for a hearing from a Medicare appellant.

OMHA administers appeals in four field offices: Southern (Miami, Florida), Midwestern (Cleveland, Ohio), Western (Irvine, California), and Atlantic (Arlington, Virginia). OMHA extensively utilizes hearings held via video-teleconference (VTC) and telephone in order to provide appellants with timely and accessible hearings at low cost.

OMHA began processing cases on July 1, 2005; since then, it has received more than one million claims from across the United States for Medicare Parts A, B, C, and D appeals, as well as for Medicare entitlement and eligibility appeals. In FY 2011, OMHA began receiving additional claims resulting from the permanent expansion of the Recovery Audit Contractor (RAC) program, administered by the Centers for Medicare & Medicaid Services, to all 50 states. In FY 2011, OMHA received a total of 234,000 claims. OMHA expects to receive 35,000 RAC claims in FY 2012. OMHA projects that its FY 2013 caseload will increase to approximately 368,000 total claims, a 57 percent increase.

With the requested funding level of $84 million, OMHA will strive to process the increasing number of ALJ appeals within the statutory timeframe while maintaining the quality and accuracy of its decisions. OMHA will continue to utilize technology to offer appellants access to multiple hearing venues and services.

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

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Budget Authority	42	16	26	+10
PHS Evaluation Funds	19	45	40	-5
Total, Program Level	**61**	**61**	**66**	**+5**
FTE	147	172	191	+19

The Office of the National Coordinator for Health Information Technology is at the forefront of the administration's health IT efforts and is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide health information exchange to improve health care.

The FY 2013 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $66 million, $5 million above FY 2012. The Budget provides resources to continue supporting, and further advance, the progress that ONC has achieved in creating a nationwide health information technology (health IT) infrastructure in response to the mandates set forth in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

In addition, ONC will continue efforts to accelerate the adoption of health IT and help physicians achieve meaningful use of electronic health records (EHRs). The Budget also includes resources for ONC to serve as the Federal health IT leader.

ONC and the Centers for Medicare & Medicaid Services (CMS) are working closely together to register eligible professionals and hospitals to qualify for incentive payments from Medicare and Medicaid which are designed to encourage providers to adopt and meaningfully use EHRs. With incentive payments beginning in January 2011, ONC and CMS estimate 80,000 providers will have achieved meaningful use and received payments by the end of FY 2012.

More Than 100,000 Providers Working with Regional Extension Centers

The ONC Health IT Regional Extension Centers (RECs) has made great strides towards the program's goal to assist 100,000 providers adopt and demonstrate meaningful use of EHRs by FY 2014. To date, over 130,000 providers have registered to work with an REC. In a significant milestone, roughly one-third of all primary care providers and more than two-thirds of all rural providers in the country are now working with ONC grantees.

The providers working with RECs are a diverse group. Among them, half are from small private practices or small practice consortia, and over 20 percent are affiliated with critical access hospitals, rural health clinics, and other practices in medically underserved areas. In addition, 11 percent of providers are in public hospitals and 18 percent are in community health centers.

As of January 2012, nearly 60,000 REC-assisted providers had implemented EHRs with e-prescribing and quality reporting capabilities and over 5,000 of these providers have achieved meaningful use. The RECs will continue to assist these providers with adopting and meaningfully using EHRs in their practices.

ADOPTION

Reducing barriers to the adoption and meaningful use of EHRs is essential to improving the quality and efficiency of our health care system. The FY 2013 Budget includes $7.8 million, an increase of $2 million, to allow ONC to work with health care organizations and community organizations to share best practices to encourage adoption and meaningful use of health IT. In addition, this funding will support Regional Extension Centers to leverage their relationship with providers to support other HHS priority programs, such as the National Quality Strategy.

STANDARDS AND INTEROPERABILITY

The Budget includes $12 million for standards and interoperability work, which enables health information to be captured and exchanged among health IT systems, whether small physician practices or large hospital systems. Through these activities, ONC supports the:

- Creation of a life-cycle of standards and implementation specifications for health IT;
- Identification of existing or development of new standards, services descriptions, and implementations;
- Development and maintenance of certification criteria and certification process;
- Coordination of federal participation in health information exchange.

ONC also supports the Virtual Lifetime Electronic Record (VLER) project, a Presidential priority which is creating a unified electronic record for military personnel and veterans. Combined, these standards and interoperability activities enable ONC's efforts to promote adoption and meaningful use of EHRs; facilitate electronic health information exchange to improve health care quality and delivery; and, enable consumers to play a more central role in directing their care through the use of technology.

PRIVACY AND SECURITY

Privacy and security are critical to provider and consumer trust in electronic health information and participation in health information exchange. The Budget includes $5 million to assure that policies and practices are in place to keep health information private and secure in a rapidly changing environment. Key efforts include the evaluation and policy development of privacy and security protections for electronic health information in the evolving nationwide network. ONC will continue to coordinate the development and implementation of these policies with other federal partners as well as with the states, the territories, and foreign countries. To facilitate the private and secure implementation of EHR technology and Health Information Exchanges, ONC, in conjunction with other federal partners, will continue to identify good privacy and security practices and to develop and disseminate appropriate educational materials to health care providers and other stakeholders. ONC will also continue to explore security issues arising from patient-centered health care, such as secure electronic communications with patients.

HHS Promoting the Adoption and Meaningful Use of EHRs

ONC continues to partner with other federal agencies to encourage health care providers and hospitals to make the transition from paper records to certified EHRs in order to improve health care and control costs. Within HHS, CMS has supported this goal by the implementation of EHR Incentive programs.

- As of December 31, 2011, Medicare has made approximately $275 million in incentive payments to over 15,800 providers and over $1.1 billion to more than 600 hospitals.
- As of early January 2012, 43 states had launched State Medicaid Electronic Health Record Incentive Programs.
- Over $295 million in Medicaid incentive payments have been made to more than 15,100 professionals and over $850 million had been made to over 1,000 hospitals.

CMS and ONC expect even more providers and hospitals to take advantage of the program in the future.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Program Level	**41**	**41**	**39**	**-2**
FTE	266	266	256	-10

The Office for Civil Rights ensures equal, nondiscriminatory access to and receipt of all HHS services and that the privacy and security of health information is protected. In this way, OCR contributes to HHS's overall mission of improving the health and well-being of all Americans affected by its many programs.

The Budget includes $39 million for the Office for Civil Rights (OCR). OCR instituted a number of process improvements and administrative efficiencies from FY 2002 through FY 2010 including improved staff skill sets and case management techniques. Those improvements have made OCR more efficient and have enabled a decreased budget of $2 million from FY 2012.

The Budget maintains its programmatic focus on improved business practices and continues to support OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of federally-funded health and human services. In addition, the Budget supports OCR's expanded compliance responsibilities under the Privacy and Security Rules issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

OCR assesses compliance through complaint investigation, violation findings, resolution agreements, enforcement actions and monitoring, public education, technical assistance, compliance, civil rights reviews, and HIPAA audits.

As the Department's civil rights and health privacy law enforcement agency, OCR's key priorities in FY 2012 and FY 2013 include: (1) enforcing the HIPAA Privacy and Security Rule; (2) implementing statutory privacy protections for genetic information; (3) promoting adequate privacy protections in the use of health information technology and patient health information; (4) enforcing federal civil rights laws to increase non-discriminatory access to health care and human services including adoption, foster care, and Temporary Assistance for Needy Families; (5) promoting best practices for effective communication in hospital settings with persons who are deaf or hard of hearing, persons who are visually-impaired, and persons of limited English proficiency; (6) strategically disseminating an OCR-developed federal civil rights curriculum for medical schools to help narrow disparities in health care quality, access, and patient safety; (7) supporting appropriate services in the most integrated setting for persons with disabilities; and (8) promoting non-discrimination and privacy protections in emergency preparedness and response activities.

Through these varied efforts, OCR promotes integrity in the expenditure of federal funds and public trust and confidence in the health care system and its mission to maintain the privacy of protected health information while ensuring access to care.

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

Enforcing HIPAA: OCR investigates and resolves more than 9,000 complaints of alleged HIPAA violations annually. An example is the civil monetary penalty of $4.3 million assessed against Cignet Health in Maryland. In February of 2011, Cignet was fined $1.3 million for failing to provide 41 individuals with access to their medical records as required by the Privacy Rule. It was also fined $3 million for refusing to cooperate with OCR in the course of its investigation into the complaints.

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

Privacy and Security Provisions of the HITECH Act: OCR is in the final stages of the rulemaking process to implement HITECH Act provisions on the following areas: extend security and privacy rule liability to business associates; place new limitations on marketing and fundraising communications; prohibit the sale of protected health information; strengthen individuals' rights to electronic access and to request restrictions on access to personal health information.

In September 2009, the interim final rule implementing the breach notification provisions of HITECH went into effect. Health providers, insurers, and their business associates have reported 373 large breaches affecting almost 18 million individuals between September 2009 and October 2011. To fulfill statutory requirements under HITECH, in August 2011 OCR issued a Report to Congress that addressed the number and nature of breaches reported to the Department as well as the actions OCR took in response to those incidents.

Enforcing Compliance with Civil Rights Laws: OCR investigates and resolves nearly 3,000 administrative discrimination complaints annually. For example, in 2011, OCR entered into a statewide voluntary resolution agreement with the Rhode Island Department of Human Services that provides limited English proficiency clients improved access to programs and services, including access to Medicaid and other social service programs. Under the agreement, the Rhode Island Department of Human Services will ensure that the language access needs of its limited English proficiency clients are properly assessed and that appropriate language services are provided to clients in all of its programs.

In FY 2012 and FY 2013, OCR will continue to strengthen efforts to improve statewide compliance with civil rights laws. For example, in FY 2011, OCR entered into a settlement agreement with the State of Georgia regarding the state's failure to serve individuals with developmental disabilities and mental illness in the most integrated setting appropriate to those individuals' needs. As a result of this important statewide settlement agreement, more than 10,000 individuals with developmental disabilities and mental illness in Georgia will now have the opportunity to live in their home communities with appropriate support and services.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Discretionary Appropriation	50	50	59	+8
HCFAC Collections	12	12	12	–
Discretionary HCFAC 1/	30	98	102	+4
Mandatory HCFAC	198	196	197	+1
Total Funding, All Sources	**290**	**356**	**370**	**+14**
FTE	1,753	1,961	1,974	+13

1/ The President's Budget proposes to increase the 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

The Office of Inspector General's mission is to protect the integrity of Department of Health & Human Services programs as well as the health and welfare of program beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; providing industry guidance; and holding accountable those who do not meet program requirements or who violate federal laws.

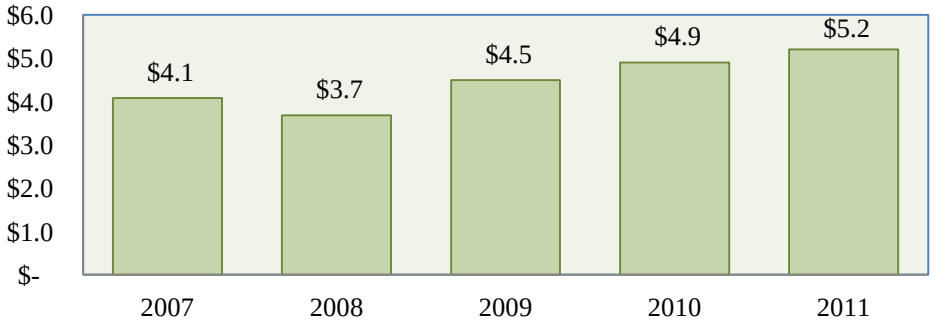
The FY 2013 Budget request for OIG is $370 million in mandatory and discretionary budget authority. This request includes $311 million for oversight of the Medicare and Medicaid programs. This will support the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and other program integrity efforts including reducing improper payments and focusing investigative efforts on civil fraud. The request also includes $59 million for oversight of HHS's other activities. These funds will enable OIG to maintain and expand existing HHS oversight efforts and to monitor the implementation of the Affordable Care Act and the operation of Affordable Care Act programs.

While specific activities in FY 2013 will be determined by OIG's annual work planning process, areas of potential oversight as reflected in OIG's assessment of the top management and performance challenges facing HHS are summarized below.

INTEGRITY OF MEDICARE AND MEDICAID

Preventing and Detecting Medicare and Medicaid Fraud: Medicare and Medicaid fraud continue to be significant challenges facing HHS. OIG has set the following strategic priorities for protecting the integrity of Medicare and Medicaid and the well being of beneficiaries in FY 2013:

OIG Expected Recoveries[1], FYs 2007 - 2011
(Dollars in Billions)



1/ Expected recoveries consist of financial receivables from any of the following: successful prosecutions, court-ordered restitution, and out-of-court settlements; audit disallowances that HHS management has agreed to recoup; and administrative enforcement actions during a given reporting period.

- Assessing program vulnerabilities and recommending actions to reduce improper payments and prevent fraud.
- Fostering a culture of compliance within the health care industry, both by issuing formal guidance and reaching out to other Federal and state agencies, stakeholder organizations, providers, and the public.
- Holding accountable perpetrators of Medicare and Medicaid fraud.
- Increasing OIG's capacity to effectively utilize data to target resources to areas with the greatest vulnerability.

Identifying and Reducing Improper Payments: Improper payments are a significant problem. In FY 2013, OIG will continue to identify and provide recommendations for addressing the core payment issues within the Department.

Patient Safety and Quality of Care: The Department faces challenges in ensuring the quality of care rendered through its health care programs. OIG's work offers recommendations to assist the Department in its efforts to address patient safety and quality of care.

Additional areas of potential CMS oversight:
- Integrity and security of information systems and data;
- Availability and quality of data for effective program oversight;
- Oversight of CMS program and benefit integrity contractors;
- Ensuring integrity in Medicare and Medicaid benefits delivered by private plans; and
- Avoiding waste in health care pricing methodologies.

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

Grants Management and Administration of Contract Funds: In FY 2013, OIG will provide the Department with vital information that will help hold accountable grantees and contractors that manage large grant awards and contracts and ensure the integrity of these significant expenditures.

Ensuring the Safety of the Nation's Food Supply: Recent OIG reports found that food recall inefficiencies, inadequate food facility inspections, and recordkeeping issues impair FDA's ability to effectively resolve food emergencies. OIG will continue to evaluate the Department's management of food safety issues.

Oversight of the Approval, Safety, and Marketing of Drugs and Devices: OIG will continue to focus on public health agencies responsible for drug and medical device safety. These agencies are required to have policies and programs in place that create safeguards to ensure the integrity of medical research endeavors, protect human research subjects, and provide for pre approval and post approval monitoring of regulated medical products and treatments.

Government Ethics Programs: OIG has long been involved in oversight and enforcement related to the Department's ethics program. Prior OIG work identified vulnerabilities in HHS oversight of outside activities and potential conflicts of interest. OIG will continue to monitor these issues in FY 2013.

INTEGRITY OF HEALTH CARE REFORM IMPLEMENTATION

In FY 2013, OIG will continue to focus on the implementation and operation of Affordable Care Act programs. Ongoing challenges include the magnitude, complexity, and novelty of programs; compressed implementation timelines; and marketplace dynamics. Assessing the integrity of these programs is essential to ensuring that they operate with economy and efficiency and are protected from fraud, waste, and abuse.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

(dollars in millions)

	2011	2012	2013	2013 +/- 2012
Office of the Secretary, ASPR				
Preparedness and Emergency Operations	30	30	25	-5
National Disaster Medical System (NDMS)	52	53	52	–
Hospital Preparedness	375	375	255	-120
ESAR-VHP	6	5	1	-4
Medical Countermeasure Dispensing	–	–	5	+5
BARDA	387	415	547	+132
Policy and Planning	19	16	15	-1
Strategic Investor	–	–	50	+50
Operations	44	33	33	–
Subtotal, ASPR	913	926	982	+56
Other Office of the Secretary:				
Security and Strategic Information	7	6	7	+1
Cybersecurity	57	40	40	–
Parklawn Lease Replacement	35	–	–	–
HHS Lease Replacement	–	–	17	+17
Medical Reserve Corps	12	11	11	–
Subtotal, Other Office of the Secretary	111	58	75	+18
Pandemic Influenza:				
Annual Funding	65	–	–	–
Subtotal, Pandemic Influenza	65	–	–	–
Total, Program Level	**1,090**	**983**	**1,057**	**+74**
Less Funds From Other Sources:				
Use of BioShield Balances	415	415	415	–
Total, Discretionary Budget Authority	**675**	**568**	**642**	**+ 74**
FTE	625	628	628	–

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

The Public Health and Social Services Emergency Fund directly supports the Nation's ability to prepare for, respond to, and recover from the health consequences of naturally occurring and manmade threats.

To enhance the Nation's preparedness against bioterrorism and other public health threats, the FY 2013 Budget includes $1.057 billion for the Public Health and Social Services Emergency Fund (PHSSEF) in the Office of the Secretary. In addition, pandemic influenza preparedness activities will be supported using unobligated balances. The Budget includes nearly $4.5 billion for bioterrorism, pandemic influenza, and emergency preparedness activities across the Department.

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2013 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $1.057 billion, an increase of $74 million above FY 2012. The Budget will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to, and recover from the adverse health effects of public health emergencies and disasters.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) is the lead for the Federal Government for public health and medical services response efforts under the National Response Framework. ASPR coordinates the bioterrorism and emergency preparedness activities of HHS agencies, develops and coordinates national policies and plans, provides program oversight, and serves as the Secretary's public health emergency representative to other federal, state, and local agencies. The Budget requests $982 million for ASPR, an increase of $56 million from FY 2012.

The Budget includes $547 million, an increase of $132 million over FY 2012, for the Biomedical Advanced Research and Development Authority (BARDA). This total includes $415 million to be made available from current BioShield Special Reserve Fund balances to supplement these activities. BARDA will support the development of existing and promising next generation medical countermeasures to mitigate the medical consequences of potential chemical, biological, radiological, and nuclear threat events. Funding in FY 2013 will be targeted to continue implementing the recommendations of the Medical Countermeasure Review, including development of broad spectrum antibiotics and furthering the development of advanced influenza vaccine manufacturing facilities. The FY 2013 request also provides $50 million to establish a strategic investment organization. This organization will be an independent firm that will provide capital and business support to new and small companies conducting research on medical countermeasures. Funding will also support BARDA's management of Project BioShield and implementation of the Department's Pandemic Influenza Plan.

In FY 2013, $255 million is requested for Hospital Preparedness, which is a -$120 million reduction from FY 2012. Between FY 2002 and FY 2013, the program will have provided nearly $5 billion for cooperative agreements to states, cities, and territories to strengthen the capability of hospitals and health care systems to plan for, respond to, and recover from all hazards events. In FY 2013, a portion of these funds will be used for competitive grants and to maintain formula grants at a reduced level. In addition to these funds, the Centers for Disease Control and Prevention (CDC) is separately providing $642 million to state and local public health departments to support local public health preparedness activities. Great progress in preparing for public health emergencies has been made with the Federal investment at the state and local level. The Hospital Preparedness Program was reduced because enhanced alignment of preparedness grants within HHS will allow states to make more efficient use of these resources, which is imperative in a constrained budget environment.

The Budget also includes $5 million to continue the HHS medical countermeasure dispensing demonstration project with the United States Postal Service (USPS). The USPS is a unique Federal entity because it reaches the home of every American and can be a significant asset in the distribution of medical countermeasures to the public in the event of

a public health emergency. With these funds, ASPR and the USPS will be conducting exercises to help improve implementation in the future.

The Budget provides $52 million for the National Disaster Medical System (NDMS) to maintain emergency readiness response improvements. The request will support training, exercises, medical equipment, and other deployable assets for over 100 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and other NDMS teams critical to our Nation's capacity to respond to a terrorist attack or other public health emergency.

The Budget also supports ASPR's efforts to provide HHS and U.S. Government stakeholders with health security related policy and by bolstering planning efforts to support the implementation of the National Health Security Strategy objectives.

Cybersecurity: The Budget request provides $40 million for cybersecurity to protect the Department's information technology infrastructure from cyber attacks by providing continuous security monitoring for all HHS systems, assets, and services. Funding will support the final stages of the Trusted Internet Connection (TIC), to consolidate the Department's internet traffic, and implementation of the Department of Homeland Security's Einstein security monitoring solution.

This funding will support a departmentwide collaboration to identify and address security vulnerabilities. Additionally, this will enhance departmentwide computer systems intrusion detection capabilities, security information event management systems, and network forensics capabilities.

Security and Strategic Information: The Budget includes $7.4 million for Security and Strategic Information to improve the efficiency of processing HHS security clearances and ensure physical security across the Department. These funds will also support the development, maintenance, and operation of policy and programming in areas of physical security, personnel security, communications security, and strategic information.

Medical Reserve Corps: Comprised of medical and public health volunteers, the Medical Reserve Corps contributes its expertise to local public health initiatives on an ongoing basis. The Budget request includes $11 million for the Medical Reserve Corps in FY 2013, a decrease of $1 million from FY 2012.

Joplin, Missouri Tornado Response

ASPR coordinated the efforts across HHS for the governmentwide response to the disaster in Joplin, Missouri when an EF5 tornado struck the town on May 22, 2011. HHS activated the National Disaster Medical System and deployed approximately 100 individuals from the Disaster Mortuary Operational Response and Family Assistance Teams to Missouri.

Missouri completed planning exercises testing their Mobile Medical Unit, HAvBED reporting, interoperable communications, evacuation plans, fatality management, and activation of their state ESAR-VHP program shortly before the tornado struck, destroying over 20 percent of Joplin's infrastructure, including the 370-bed St. John's Regional Medical Center.

- 183 patients were evacuated from the severely damaged hospital within 90 minutes;
- Local responders treated 500 patients in emergency departments and between 400 and 600 patients in established triage areas within 12 hours of the incident;
- A 60-bed mobile hospital was deployed to support emergency, surgery, imaging, lab, and inpatient care. Hospital Preparedness Grants enabled the purchase of this facility, which served, on average, 130 patients per day;
- St. John's recent implementation of electronic health records (EHRs) enabled them to use or transfer all their patients' medical records within hours after the tornado struck.

Highlighted Bioterrorism Preparedness Activities: In addition to ASPR, many of the agencies and offices across HHS play important roles in ensuring that the country is prepared for and able to respond to a bioterrorist attack or significant public health emergency. In addition to funding in the PHSSEF, another $3.5 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for CDC, FDA, NIH, ACF, and the Office of the Secretary.

Other PHSSEF Activities: The Budget includes $17 million for centrally managed HHS lease replacement costs. These funds will support efforts to consolidate leases throughout the Department, provide a more flexible and efficient mechanism for replacing or renewing leases, as well as managing fit out and associated moving costs.

PANDEMIC INFLUENZA

In FY 2013, vital pandemic influenza preparedness activities will be continued using existing funding primarily from previous pandemic influenza supplemental appropriations. Specifically, funding will be used to advance the Nation's pandemic preparedness through continued investments in: developing next generation recombinant and molecular vaccine technologies; expanding domestic vaccine manufacturing capacity; developing antigen sparing adjuvant technology; creating new and better influenza antiviral drugs; and supporting technologies that help us identify influenza.

While the H1N1 pandemic response has been the focus of HHS's most recent pandemic investments, the threat of a pandemic caused by H5N1 or other strains is still present. Recently, a novel H3N2 virus was identified in the United States and the continued investments in public health surveillance assisted the rapid identification of the strain across four states. Lessons learned from H1N1 additionally strengthened HHS's rapid response to the emerging H3N2 virus, which included development of a reference strain for vaccine development purposes, manufacture of a test vaccine, and initiation of a clinical study for vaccine effectiveness and dosage requirements.

To protect against potential influenza virus resistance to existing antivirals, HHS also supports development of new antiviral drugs. HHS continues to support Phase 3 clinical studies of a new neuraminidase inhibitor candidate, peramivir, for parenteral administration during life threatening cases of severe seasonal or pandemic influenza. This new drug was made available to treat severely ill individuals under an Emergency Use Authorization during the H1N1 pandemic.

In addition to using existing funds in the PHSSEF to support pandemic influenza activities, a total of $474 million is requested in the FY 2013 budgets of the CDC, FDA, and NIH to finance ongoing pandemic preparedness activities including:

- Maintaining international and domestic surveillance and detection capabilities, including identification of vaccine virus strains and emerging viruses with pandemic potential;
- Improving pandemic preparedness and response capabilities on the national, state, and local levels; and
- Improving the Nation's ability to contain a potential pandemic flu outbreak.

Cell-Based Influenza Vaccine Manufacturing

In December 2011, HHS dedicated the first U.S. cell-based influenza manufacturing plant in Holly Springs, North Carolina. Cell-based technology, compared to fertilized eggs, provides for faster and more flexible production of influenza vaccine, which could reduce vaccine delivery time during a pandemic.

This public-private partnership between HHS and Novartis Vaccines and Diagnostics, Inc. will be maintained under contract for at least 25 years.

During a pandemic, the facility may be able to produce up to 25 percent of the vaccine required in the United States and may be adapted for vaccine for other known and unknown emerging infectious diseases.

ABBREVIATIONS AND ACRONYMS

A

ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
AD	Alzheimer's Disease
ADAP	AIDS Drug Assistance Program
ADUFA	Animal Drug User Fee Act
ADCS	Alzheimer's Disease Cooperative Study
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Administration on Aging
ASPR	Assistant Secretary for Preparedness and Response

B

BA	Budget Authority
B&F	Buildings and Facilities
BARDA	Biomedical Advanced Research and Development Authority
BBA	Balanced Budget Act of 1997
BCA	Budget Control Act of 2011

C

CAH	Critical Access Hospital
CAN	Cures Acceleration Network
CCDBG	Child Care and Development Block Grant
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMHC	Community Mental Health Centers
CMHS	Center for Mental Health Services
CMS	Centers for Medicare & Medicaid Services
CPI-U	Consumer Price Index for All Urban Consumers
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSE	Child Support Enforcement
CUSP	Comprehensive Unit-based Safety Program
CY	Calendar Year

D

DOJ	Department of Justice
DME	Durable Medical Equipment
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospitals

E

EHR	Electronic Health Record
ERRP	Early Retiree Reinsurance Program
ESRD	End Stage Renal Disease

F

FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFE	Federally-Facilitated Exchange
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FQHC	Federally-Qualified Health Center
FSMA	Food Safety Modernization Act
FTE	Full-Time Equivalent
FY	Fiscal Year

G

GAO	Government Accountability Office
GDM	General Departmental Management
GDP	Gross Domestic Product
GINA	Genetic Information Non-Discrimination Act
GME	Graduate Medical Education
GSA	General Services Administration

H

HAI	Healthcare-Associated Infections
HCFAC	Health Care Fraud and Abuse Control
HCQO	Health Costs, Quality and Outcomes Research
HEAL	Health Education Assistance Loan
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRSA	Health Resources and Services Administration

I

IHS	Indian Health Service
IPAB	Independent Advisory Board
IRF	Inpatient Rehabilitation Facilities
IT	Information Technology

ABBREVIATIONS AND ACRONYMS

L

LIHEAP	Low Income Home Energy Assistance Program

M

MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MAC	Medicare Administrative Contractor
MCBS	Medicare Current Beneficiary Service
MCM	Medical Countermeasures
MDUFA	Medical Device User Fee Act
MedPAC	Medicare Payment Advisory Commission
MEPS	Medical Expenditure Panel Surveys
MFP	Money Follows the Person
MIP	Medicaid Integrity Program
MLR	Medical Loss Ratio
MQSA	Mammography Quality Standards Act

N

NCATS	National Center for Advancing Translational Sciences
NCQA	National Committee for Quality Assurance
NDMS	National Disaster Medical System
NHSC	National Health Service Corps
NIAD	National Institute of Allergy and Infectious Diseases
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NLM	National Library of Medicine
NMEP	National Medicare & You Education Program
NRSA	National Research Service Awards

O

OCR	Office for Civil Rights
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPDIV	Operating Division
OS	Office of the Secretary

P

PAYGO	Pay-As-You-Go Act of 2010
PCIP	Pre-Existing Condition Insurance Plan
PDUFA	Prescription Drug User Fee Act
PHEP	Public Health and Emergency Preparedness
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PMDS	Power Mobility Devices
PSSF	Promoting Safe and Stable Families

Q

QI	Qualified Individual
QIO	Quality Improvement Organization
QRIS	Quality Rating and Improvement Systems

R

RAC	Recovery Audit Contractor
REACH	Racial and Ethnic Approaches to Community Health
REC	Regional Extension Center
RDS	Retiree Drug Subsidy
RPG	Research Project Grant

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	Skilled Nursing Facilities
SOW	Statement of Work
SPF-SIG	Strategic Prevention Framework State Incentive Grant
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
STAFFDIV	Staff Division
STD	Sexually Transmitted Diseases

T

TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCGA	The Cancer Genome Atlas
TIC	Trusted Internet Connections
TMA	Transitional Medical Assistance

V

VFC	Vaccines for Children
VLER	Virtual Lifetime Electronic Record
VTC	Video Teleconference

W

WTC	World Trade Center