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Thursday, September 12, 2002

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The President's Proposal :

- Strengthens capacity to prevent, identify, and respond to incidents of bioterrorism;
- Advances the President's Management Agenda by consolidating buildings and facilities management and other administrative offices;
- Continues implementation of the President's Faith-Based and Community Initiative;
- Completes the commitment to double funding for the National Institutes of Health;
- Builds on the 2002 Community Health Centers and National Health Service Corps Presidential Initiatives;
- Invests in activities to educate students on preventing unintended pregnancies and sexually transmitted diseases through abstinence;
- Enhances drug treatment to narrow the treatment gap;
- Enhances public health by investing in patient safety, food safety, and community-based disease prevention;
- Fully funds the President's child welfare initiatives;
- Reauthorizes major welfare programs maintaining funding for the Temporary Assistance for Needy Families program;
- Dedicates resources for immediate steps to improve and modernize Medicare benefits, consistent with the President's framework for strengthening Medicare, including a prescription drug benefit;
- Increases coverage and efficiency in the Medicaid and State Children's Health Insurance Program by giving states more flexibility to meet health care coverage goals; and
- Supports the President's health insurance tax credit by allowing states to use their health insurance purchasing pools to provide affordable private health insurance options.

Department of Health and Human Services

Tommy G. Thompson, Secretary

www.hhs.gov 202-619-0257

Number of Employees: 65,000

2002 Spending: \$459.4 billion

Divisions: Food and Drug Administration; Health Resources and Services Administration; Indian Health Service; Centers for Disease Control and Prevention; National Institutes of Health; Substance Abuse and Mental Health Services Administration; Agency for Healthcare Research and Quality; Centers for Medicare and Medicaid Services; Administration for Children and Families; Administration on Aging; Office of the Secretary; Office of the Inspector General; and Program Support Center.

The Department of Health and Human Services (HHS) is one of the largest federal departments, the nation's largest health insurer, and the largest grant-making agency in the federal government. The Department is charged with promoting and protecting the health and well-being of all Americans, and provides world leadership in biomedical and public health sciences. HHS addresses these objectives through an array of programs in basic and applied science, public health, income support, child development, and the financing of health and social services.

HHS Priorities

Fighting Bioterrorism

No HHS activity is now more important than its role in national bioterrorism preparedness. By Presidential directive, HHS is the lead federal agency in preparing to combat bioterrorism. HHS prevents, identifies, and responds to incidents of bioterrorism through the Office of the Secretary, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH).



National Pharmaceutical Stockpile supplies are stored strategically in secure locations around the country to ensure swift mobilization to the site of a disaster.

Through the CDC, HHS provides assistance to state and local entities to build increased laboratory capacity for quick and accurate identification of dangerous agents, and to enable rapid and secure communication. The CDC also maintains laboratory facilities to hold and study dangerous biological agents and works with the states to confirm the identity of such agents in the event of a potential attack. Existing and new funding will help improve and update these laboratories. HHS trains and maintains federal public health emergency response teams to be rapidly deployed in the first stages of a bioterrorist incident. HRSA works with states and the nation's hospitals to ensure their preparedness on a regional basis.



Secretary Thompson and New York State Health Commissioner Dr. Antonia Novello speak with rescue workers on September 13, 2001, at the site of the World Trade Center terrorist attacks.

HHS also maintains the National Pharmaceutical Stockpile, which is increasing its capacity to cover over 20 million individuals during 2002. To ensure that medicines and supplies can be quickly delivered to the site of an emergency, HHS is acquiring a national supply of antibiotics and smallpox vaccine, and is working to develop and approve innovative new drugs and therapeutics.

HHS is taking a new approach to managing and distributing funds for state and local bioterrorism preparedness. This process will ensure that public health departments, hospitals, emergency medical services, and other first responders develop integrated detection and treatment systems to provide a seamless response to potential acts of bioterrorism.

The FDA works to ensure the safety of the nation's food supply. The budget supports a substantial increase in the amount of safety inspections of FDA-regulated products imported into the country. In an effort to protect public health, the FDA will conduct three times the current inspections of imported foods to keep them from being used as a conduit for terrorism. The FDA will also improve blood screening processes to assure availability of a safe national supply of blood and related products in the event of an attack or its aftermath.

These HHS efforts were brought to national attention by the speedy delivery of medical supplies to New York on September 11th, and in the assistance provided to state and private parties involved in the subsequent anthrax attacks. The threat of bioterrorism is now a reality, and the budget includes resources to respond at HHS and across the government.

Measuring effectiveness is extremely difficult in this rapidly evolving area. So it is essential that assessments are conducted, planning procedures are established, and rigorous standards are lived up to. Under the leadership of the President, these steps will be taken at all levels of government.

A Citizen-Centered HHS: Streamlining Bureaucracy

A key objective of the President's Management Agenda is a more responsive, more "citizen-centered" federal government. In few federal agencies is the need for organizational reform more acute than at HHS, where a long history of decentralized decision-making has produced a Department with 13 operating divisions functioning with relative autonomy. As a result, a complex web of ever-proliferating offices has distanced HHS from the citizens it serves, and has produced a patchwork of uncoordinated and duplicative management practices that hinder its efforts to accomplish its mission efficiently.

This Administration is committed to solving this problem through Secretary Thompson's One Department initiative, which will eliminate unnecessary layers of bureaucracy and consolidate duplicative functions into unified offices. Streamlining efforts in 2003 will focus on HHS' human resources, public affairs, legislative affairs, and building and facilities management functions.

Talent Agencies

Currently, the Department does not leverage itself with respect to bringing on new talent by combining the resources of all of its agencies. The most recent example occurred at a recruiting fair in Puerto Rico the Program Support Center attended—along with several other HHS agencies, all with different booths and HR personnel, and all looking and appearing as separate government entities. The costs [were] all being borne individually by the different agencies.

HHS Workforce Analysis
June 2001

Human Resources. HHS today has 40 different human resources offices, all of which conduct independent—and often competing—recruitment, hiring, and training activities. In 2003, that number will be cut to four, as HHS consolidates personnel matters into offices in Baltimore, Rockville, and Bethesda, Maryland, and Atlanta, Georgia.

Public Affairs and Legislative Affairs. Currently, HHS has more than 50 public affairs offices and more than 20 legislative affairs offices. Spread throughout 13 operating divisions and dozens of bureaus, these offices deliver separate—and sometimes conflicting—messages. In 2003, this structure will be streamlined to create one office for public affairs and one centralized

legislative affairs office.

Which Of These Projects Would You Fund?

NIH Parking Facility: NIH is planning to construct a new \$14 million on-site parking facility to accommodate its employees, visitors, and patients. Since 1996, over 1,500 parking spaces have been lost because of new construction projects, including the Clinical Research Center and the East Child Care Center.

Indian Health Service Sanitation Facilities: Investment in sanitation facilities projects has contributed to improvements in American Indian/Alaska Natives (AI/AN) health status. However AI/AN homes are still seven times more likely to be without clean water than all other U.S. homes. One of IHS' most important missions is to construct sanitation facilities for AI/AN homes. IHS has identified a backlog of \$1.8 billion in sanitation construction projects but, within the overall IHS budget, is able to fund only two percent annually.

Buildings and Facilities Management. HHS agencies seek to make certain the nation's biomedical research and health care services are conducted in safe labs and hospitals. In the past, NIH, CDC, and HRSA each administered their own building maintenance and construction projects.

HHS' performance in building construction can be improved. One challenge facing the federal government's main social service agency is uneven project planning and oversight. HHS does not have a department-wide performance measure that articulates national priorities for health care facilities. As a result, construction projects often get selected for reasons other than merit, including congressional earmarks. The President's Budget addresses this challenge by: 1) concentrating leadership, programmatic expertise, and project oversight in the HHS Office of the Secretary; 2) instituting a comprehensive framework that prioritizes all capital projects across HHS; and 3) implementing a department-wide measure linked to program outcomes.

The budget consolidates facilities construction and maintenance activities for NIH, CDC, and HRSA in the Office of the Secretary so that HHS can manage buildings competitively across the Department. In 2004, FDA and IHS will be included in this consolidation. This consolidation will give HHS tremendous flexibility in allocating funding to the highest priority projects and is fully in line with the Secretary's vision for a unified HHS.

Promoting the President's Initiatives

The paramount goal is compassionate results, and private and charitable groups, including religious ones, should have the fullest opportunity permitted by law to compete on a level playing field, so long as they achieve valid public purposes, like curbing crime, conquering addiction, strengthening families and overcoming poverty.

President George W. Bush
January 29, 2001

Faith-Based and Community Initiative

On January 29, 2001, the President announced the Faith-Based and Community Initiative and, at the same time, created a White House office dedicated to this issue along with parallel offices at five key Departments: HHS, Justice, Housing and Urban Development, Labor, and Education. This initiative aims to enrich social services by drawing on the strengths of religious and community groups. These organizations have long played a critical role in furnishing their own aid, but have been unfairly or

unwisely excluded from playing a more direct role in delivering federally supported services.

The initiative expands the access of community and faith-based organizations on a non-discriminatory basis to existing federally funded programs.

Last summer, the White House Office on Faith-Based and Community Initiatives and the five departmental centers reviewed artificial regulatory or administrative barriers to full participation by faith-based organizations. The results were published in the August 2001 report, *Unlevel Playing Field: Barriers to Participation by Faith-Based and Community Organizations in Federal Social Service Programs*. The report found that many of the barriers to fuller participation were needlessly burdensome administrative creations. The Faith-Based and Community Initiative's part of the President's Management Agenda will measure the progress of the five Departments in removing these barriers. In addition, the budget funds the following four competitive grant programs, targeted at faith- and community-based organizations that can provide innovative services at the grassroots level.

Compassion Capital Fund: To build on the efforts of community-based, charitable organizations, the budget provides \$100 million to help small charities increase their capacity to deliver services and grants by financing the start-up costs of charitable organizations.

Unlevel Playing Field

- A funding gap exists between the government and the grassroots. Smaller groups, faith-based and secular, receive little federal support relative to the size and scope of services they provide.
- A widespread bias against faith- and community-based organizations in federal social service programs exists.
- There are some legislative restrictions, but many of the restrictive regulations are needlessly burdensome administrative creations.
- Charitable Choice legislation has been almost entirely ignored by federal administrators who have done little to help or require state and local governments to comply with new rules for faith-based service providers.

Unlevel Playing Field: Barriers to Participation by Faith-Based and Community Organizations in Federal Social Service Programs
White House, August 2001

Mentoring Children of Prisoners: The President recognizes that, as a group, the more than two million children with parents in prison have more behavioral, health, and educational problems than the population at large. Mentoring by caring adults serving as positive role models can brighten the outlook for these children. Therefore, the budget includes \$25 million for competitive grants to faith and community-based groups for programs providing mentors to children of prisoners.

Promoting Responsible Fatherhood: Over 25 million children live in homes without fathers. To assist non-custodial fathers to become more involved in their children's lives, the budget provides \$20 million in competitive grants to faith-based and community organizations.

Maternity Group Homes: The Administration also increases support to community-based maternity group homes by providing young, pregnant, and parenting women with access to community-based coordinated services such as childcare, education, job training, and counseling. The budget includes \$10 million in competitive grants to meet the needs of these women and their children.

Partnering with Faith-based and Community Organizations

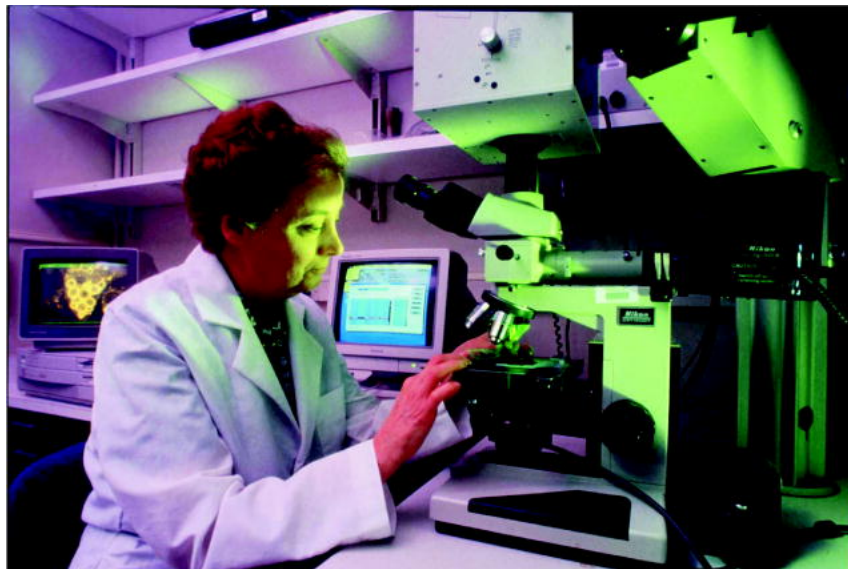
The San Antonio Weed & Seed Coalition consists of 120 community, neighborhood, and law enforcement organizations whose mission is to reduce drug-related crime and victimization. The coalition has helped to reduce crime in San Antonio by 43.5 percent from 1992–2000. One of the coalition partners, Love Demonstrated Ministries (LDMI), is a faith-based organization which focuses on youth offenders, gang members, and high risk youth. Over the past three years, 135 of 165 young offenders entering its Life Skills and Parenting Camp have graduated from LDMI, a success rate of 82 percent.

Charitable Tax Provisions: The Administration favors a charitable deduction for taxpayers who don't itemize their deductions on their tax returns of up to \$100 for singles and \$200 for joint returns in 2002, increasing in stages to \$500 for singles and \$1,000 for joint returns in 2012. This proposal would also permit tax-free distributions from IRAs for charitable contributions, increase the percentage limitation on corporate charitable contributions, and make several changes related to trusts and foundations. The effect on federal receipts would be \$2 billion in 2003, and \$41 billion for 2003–2012.

Individual Development Accounts (IDAs): The Administration also supports the establishment of additional IDAs, a savings vehicle designed to encourage assets development and help participants enter the financial mainstream. Program participants can withdraw accrued savings, matched contributions, and investment earnings for qualified expenses, such as higher education, homeownership, and business start-up.

The IDA initiative creates a tax credit available to financial institutions to generate matching contributions to participants' savings accounts. A 100 percent IDA tax credit would allow a bank to reduce its federal tax liability on a dollar-for-dollar basis for matching participant savings up to \$500 per year. For example, if a participant deposits \$500 into an IDA account, the bank would match this amount and claim a \$500 tax credit on their federal tax return. This initiative will create up to 900,000 accounts over the next six years.

The National Institutes of Health



Research is the lifeblood of NIH work.

Begun in 1887 as a one-room laboratory within the Marine Hospital Service, the National Institutes of Health has become the world's leading research institution for biomedical and behavioral research. NIH now supports more than 50,000 scientists working in 2,000 institutions across the United States. These scientists, with the help of federal grant support, have been making great advances in the prevention, diagnosis, and treatment of diseases. As we look to the future, medical science stands at the threshold of profound research advances that were unthinkable a decade ago. Researchers are identifying the genes responsible

for the abnormalities that cause many diseases. What researchers learn could help bring us closer to a cure for Alzheimer's, Parkinson's, cardiovascular disease, AIDS, diabetes, and other diseases.

During the presidential campaign, the President promised to double the budget of NIH by 2003 to \$27.2 billion, from the 1998 level of \$13.6 billion. The Administration is committed to fulfilling that promise. The budget includes the final installment of \$3.9 billion over 2002 needed to achieve doubling. With this increase, NIH will further its efforts to support research on diseases affecting the lives of Americans.

**2003 Budget Completes Doubling of the NIH Budget
(Discretionary budget authority in million of dollars)**

1998 NIH Budget	13,622
2003 NIH Budget—Doubles 1998 Funding Level	27,244
Adjustments for Accrual of Employee Pension and Annuitant Health Benefits	+91
2003 NIH Budget with Accrual Adjustments	27,335

This NIH funding increase will also finance important research needed for the war against terrorism. Over its history, NIH has been an important contributor to the nation's wartime efforts. During World War II, NIH was instrumental in developing the oxygen mask to prevent pilots from blacking out at high altitudes. Now, as the country faces new bioterrorism threats, NIH is prepared to research the effects of bioterrorism and develop treatments in the event of attack. The budget includes \$1.8 billion for bioterrorism research, including development of an improved anthrax vaccine, and laboratory and research facilities construction and upgrades related to bioterrorism.

Public/Private Partnership: A Major Step to an HIV Vaccine

The National Institute of Allergy and Infectious Diseases (NIAID), one of the National Institutes of Health, has entered into an agreement with Merck & Co. to collaborate on human testing of promising HIV vaccines developed by the company. Under the agreement, the vaccines will be evaluated in collaboration with NIAID's International HIV Vaccine Trials Network (HVTN). To date, 30 potential HIV vaccines have been evaluated in NIAID-supported clinical trials. With an estimated 5 million new HIV infections worldwide this year—about 14,000 each day—developing a vaccine against HIV is a top biomedical research priority. In the U.S., collaboration between the biomedical, pharmaceutical, medical, and public health communities have contributed to the steep decline in HIV/AIDS deaths and HIV/AIDS acquired through childbirth. By combining the laboratory strengths of NIAID's HVTN with Merck, rapid progress in evaluating the safety, immune response, and effectiveness of these vaccines is expected.

While the nation fights the war against terrorism, it also continues to fight the war on cancer. Each day more than 1,500 people in the United States die from this disease; the annual death toll from cancer exceeds fatalities from all wars fought by the United States in the last century. Thirty years ago, when the war on cancer was declared, many scientists believed that cancer was one disease that would have a single cure. Recent research indicates that cancer is actually hundreds of diseases, all of which require different treatment regimens. Promising research is leading to breakthroughs in treating various forms of cancer. The budget includes a \$5.5 billion investment in cancer research at the National Cancer Institute and other NIH Institutes.

The President recognizes research will advance the health and well being of Americans and those living beyond our borders. The budget continues to invest in the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis by allocating \$100 million of NIH funds for this effort.

NIH is composed of 25 institutes and centers with an overall mission to sponsor and conduct biomedical research and training

that leads to better health for all Americans. While the NIH conducts research in its own laboratories, the vast majority of its funding supports researchers through grants to them and to their universities, hospitals, and research institutions. Panels of scientists review grant requests and then fund them for their scientific merit. New knowledge often leads to the development of medical advances to treat and cure diseases. The budget expands scientific discovery by increasing the number of research grants funded. In 2003, NIH will support 35,920 grants, an increase of more than 8,800 from those underwritten in 1998.

NIH Research Grants								
		Actual				Estimate		
		1998	1999	2000	2001	2002	2003	
All Research Project Grants		27,073	28,715	30,669	32,546	34,686	35,920	
New Grants		7,578	8,566	8,880	9,186	9,377	9,854	
Continuing Grants		19,495	20,149	21,789	23,360	25,309	26,066	

Community Health Centers

Community health centers (CHCs) provide family-oriented, preventive and primary health care to over 11 million patients at over 3,400 sites. CHCs seek to improve the health status of underserved populations and provide access to critical health care services for the uninsured.



Doctor helping patient at a Community Health Center.

The budget builds on the 2002 Community Health Centers Presidential Initiative to increase and expand the number of health center sites by 1,200 in order to serve another 6.1 million patients by 2006. This expansion complements the President's proposals to increase health insurance coverage in private and public insurance programs, to help ensure that all Americans have access to health care. The professional care provided at health centers reduces hospitalizations and emergency room use and helps prevent more expensive chronic disease and disability. For example, while health center patients typically have high blood pressure rates far exceeding that of comparable racial, ethnic and socioeconomic groups, they are more than three times as likely to report that their blood pressure is under control compared to non-health center patients.

Increasing and Expanding Community Health Care Sites	New Community Health Care Sites Since 2001
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2001	3,307	—
2002	3,559	+252
2003	3,737	+430
2004	3,967	+660
2005	4,237	+930
2006	4,507	+1,200

National Health Service Corps

Community Health Centers often work with the National Health Service Corps (NHSC), the goal of which is to provide safety net support for the uninsured and underserved by directing health care professionals into medically underserved areas. The NHSC funds scholarships and loan repayments for health professionals who serve for a minimum of two years in areas suffering shortages of health professionals.

The 2002 President's Budget launched a management reform initiative to place NHSC clinicians in the neediest, underserved areas. This management reform initiative better defines areas of the country that have a shortage of health professionals. The budget increases funding for the NHSC and its sister program, the Nursing Education Loan Repayment Program, so that more health care providers will practice in underserved areas.

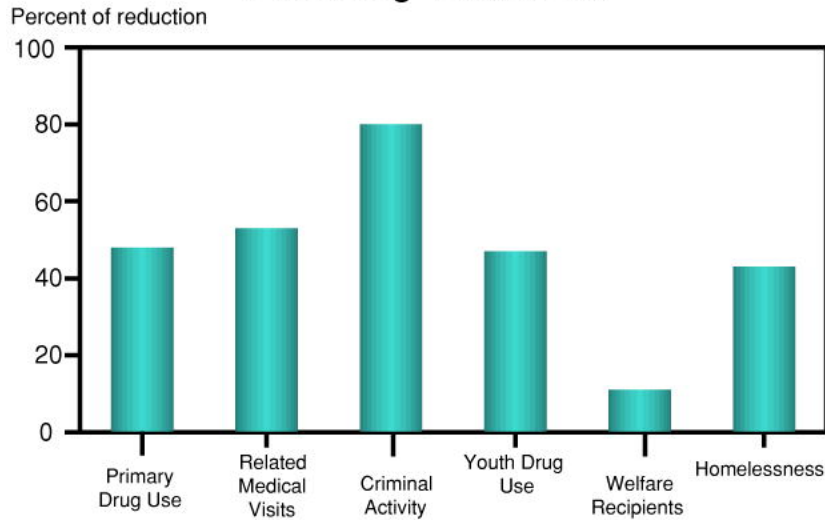
Promoting Abstinence

Teen pregnancy and out-of-wedlock sexual activity remain a major problem. In 1999, half of all high school students engaged in sexual activity, including eight percent before age 13. To ensure that more children receive the message that abstinence is the best option for avoiding unintended pregnancies and sexually transmitted diseases, the budget makes a substantial investment in abstinence education. The budget's more targeted performance measures also will evaluate abstinence education's effectiveness.

Drug Treatment Initiative

Research has consistently shown that drug abuse treatment can be effective in reducing drug use and the consequences of addiction. Yet many people go untreated. The Administration is committed to narrowing the drug treatment gap.

Negative Effects of Drug Use Fall Following Treatment



Source: National Treatment Improvement Evaluation Study, 1997, HHS.

According to a national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 129,000 people report that they were unable to obtain treatment for a drug problem, despite making an effort to get treatment. In the 2003 Budget, SAMHSA will support an estimated 52,000 additional drug abuse treatment slots to help narrow the treatment gap.

Narrowing the Treatment Gap Changes Lives

William Cope Moyers began experimenting with marijuana and alcohol as a teenager in the quiet suburbs of Long Island, New York. By the time he was 30 he was addicted to hard drugs and living in a crack house in Harlem. After his third treatment, Moyers succeeded in overcoming his addiction.

Today I hold a job and pay taxes, own a home, raise a family, and vote all because I got help in overcoming the ravages of my addiction to alcohol and drugs. I am living proof that comprehensive treatment works and pays great dividends to all of society.

William Cope Moyers,
Hazelden Foundation, Saint Paul, Minnesota

To capture the quarter-million people who recognize they are in need of treatment but are not seeking help, SAMHSA will work to improve linkages among drug treatment and mental health, healthcare, and criminal justice systems. SAMHSA will use newly available data on the drug treatment gap, by state, to guide grants and other assistance.

Enhancing Public Health

The 2003 Budget will make other targeted investments in public health improvement. The Administration will invest in patient safety and health care quality improvement, eliminating costly medical errors and encouraging more effective use of up-to-date methods of treatment. HHS will also increase FDA food safety inspections of high risk and imported foods. Finally, HHS will initiate innovative community grants to prevent and treat diabetes, asthma, and obesity.

Taking the Next Step in Reforming Welfare

The Administration's Welfare Reform Reauthorization Agenda

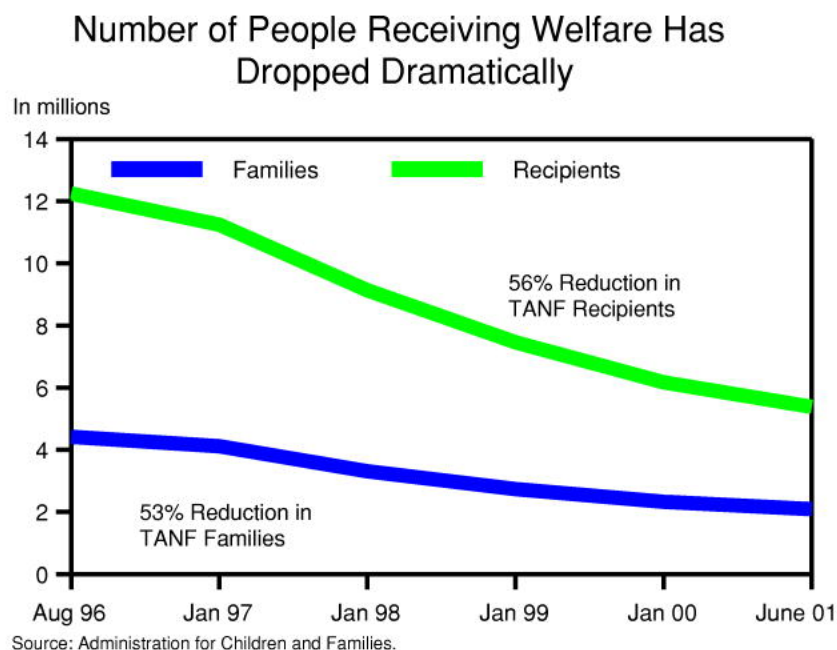
The budget includes a proposal that pursues the following three goals:

- **Continue Moving People to Self-Sufficiency.** The budget retains the approach of the 1996 legislation, which helped millions of people move from welfare dependence toward self-sufficiency. It builds upon this success by strengthening the work components while simplifying program administration.
- **Strengthen the Goals of Work and Independence.** The budget strengthens the requirements to work while providing more support to low-income workers. The proposal phases in stronger work participation requirements in Temporary Assistance for Needy Families. In the Food Stamp program, low-income workers would be able to own reliable transportation for getting to work. More former welfare recipients would receive the full child support payment.
- **Simplify Program Administration.** Complex program rules are administratively burdensome for both agencies and recipients. The budget would simplify complicated Food Stamp rules, and simplify the calculation of child support payments for families who have left welfare.

Additional Food Stamp provisions are described in the Department of Agriculture chapter.

Welfare Reform Reauthorization

In 1996, the Congress passed legislation to create the Temporary Assistance for Needy Families (TANF) program, replacing Aid to Families with Dependent Children and related welfare programs. TANF is a \$16.7 billion a year block grant with bonuses for high performance and reduced nonmarital births. States were given significant flexibility in designing the eligibility criteria and benefit rules for their TANF programs, which require and reward work in exchange for time-limited benefits.



TANF is probably the most successful federally funded domestic program in decades. Nationally, the TANF caseload (number of cash recipients) has declined 56 percent since the program's inception, while the percentage of welfare recipients

working has increased threefold. Due to state flexibility, an increasing portion of welfare dollars is now spent on services to help individuals retain and advance in their jobs.

Building on its success, the Administration proposes to reauthorize TANF. Specifically, it maintains block grant funding, provides for supplemental grants to address historical disparities in welfare spending among states, strengthens work participation requirements, retains state maintenance of effort requirements, and continues a system of high-performance bonuses. In addition, the budget proposes to reauthorize a modified contingency fund to assist states in times of severe economic downturns. Also as part of welfare reform reauthorization, the Administration will work across agencies to identify opportunities to better coordinate programs, simplify administration and support work.

The budget eliminates the current illegitimacy reduction bonus as there is no evidence that it encouraged states to develop initiatives to reduce out-of-wedlock births. The Administration is committed to encouraging the development of effective programs to reduce out-of-wedlock births and to promote family formation. The budget redirects the funds through a combination of grants, research, and technical assistance to develop a more effective approach to achieving this goal.

Reviewing the way child welfare services are structured and financed: Often criticized as complex and inflexible, the Administration will review federal child welfare programs to ensure an appropriate balance between flexibility and accountability that promotes the best outcomes for vulnerable children and families. In the year ahead, the Administration will have discussions with interested parties about this issue.

Child Support Enforcement: To benefit families who once received welfare, the budget allows states the option to provide them with the full amount of child support collected on their behalf. For current welfare recipients, the budget includes, also as a state option, federal matching for states to provide up to \$100 per month in child support collections to the family. These policies are offset by proposals that strengthen child support collection tools, collect a \$25 user fee from non-TANF families that benefit from the child support enforcement program, and require states to review child support orders more frequently.

Child Support Enforcement Successes

Sometimes the true value of automation gets forgotten amid its speed and efficiency. In the Child Support Enforcement Program, federal automation projects have revolutionized local governments' whole way of doing business. In Pennsylvania, for example, "Sylvia" and her 13-year-old daughter received welfare. Unfortunately, a wage attachment couldn't be used to collect child support from the noncustodial father, because he was self-employed. He neither paid child support regularly nor in full. Over time, because of his sporadic payments, outstanding child support payments grew to \$9,000. The father made payments of \$2 a week toward the back support, telling the judge that was the best he could do. But with the advent of the Financial Institution Data Match (FIDM) program, the county child support agency located about \$9,000 of his assets and seized them to pay off the entire amount of back support owed.

In another Pennsylvania case, the National Directory of New Hires was used to identify the new employment of an absent parent who had not paid any support since 1983. The parent skipped out on his new employment immediately, but the employer gave the local child support agency his forwarding address. Now, he pays \$100 in support every two weeks.

Promoting Safe and Stable Families

To strengthen states' ability to promote child safety, permanency, and well-being, the budget would increase funding for the Promoting Safe and Stable Families program to \$505 million, \$130 million over the 2002 level. These additional resources will help children remain with or return to their biological families if safe and appropriate, or to place children with adoptive families.

Education Assistance for Older Foster Children

The budget includes \$60 million in the Independent Living program to help older foster youth transition to adulthood and self-sufficiency after leaving foster care. Approximately 16,000 young people leave foster care each year. This initiative would provide vouchers of up to \$5,000 for education or vocational training to help youth aging out of foster care develop the skills to lead independent and productive lives.

Providing Health Care to Disabled, Elderly, and Low-Income Citizens

Through the Medicare, Medicaid, and SCHIP programs, the federal government spends over \$400 billion to increase access to high quality health care for nearly 80 million disabled, elderly, and low-income individuals. These programs face serious challenges, however, in furnishing affordable, efficient, and up-to-date benefits for these vulnerable groups. Through the budget, the Administration proposes to improve these programs so that they give beneficiaries the care they need today, and continue to do so tomorrow.



The Administration proposes to increase beneficiary access to prescription medicines.

Medicare

Medicare will spend over \$230 billion in 2003 on about 40 million senior and disabled citizens. Medicare was established in 1965 to address a serious national problem in health care: the elderly, especially those with limited incomes or costly health needs, often could not afford to buy health insurance. The program was later expanded to address similarly situated people with disabilities. Medicare thus improved access to quality health care. However, while the private health insurance market has made dramatic strides to update coverage and improve health outcomes over the last 40 years, Medicare has lagged behind.

The program's outdated benefit package does not cover prescription drugs, provide consistent coverage for many preventive treatments, support coordinated management of chronic diseases, or, for that matter, protect beneficiaries against the high cost of treating serious illnesses. Moreover, Medicare is not financially secure for the retirement of the Baby Boom generation. The Administration is committed to modernizing Medicare and addressing its financial security. In July 2001, the President announced the following framework:

The President's Principles for Strengthening Medicare

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

While nearly three-quarters of beneficiaries had prescription drug coverage in 1998, just over 10 million had no drug coverage at all. About one-half, or 5 million of these beneficiaries, had incomes below 175 percent of the poverty level—roughly \$19,000 for a family of two. Two million of these beneficiaries had incomes below the poverty level. Many of these beneficiaries do not qualify for Medicaid—which provides prescription drug coverage to low-income beneficiaries—because their incomes or assets are too high. Yet, their incomes are not high enough for them to afford to purchase drug coverage on their own.

Medicare's most pressing challenge is the lack of coverage for prescription drugs. ...Frank Van der Linden was a newspaper reporter, and a good one. Now he's being squeezed behind Medicare premiums and drug costs. Or Bob Cherry, he's a senior coordinator at the Florida Avenue Baptist Church, right here in Washington. He pays close to 40 percent of his income for prescription drugs and Medicare co-payments. Or Gwendolyn Black, who spends \$2,400 a year to put four healing drops a day into each of her eyes.

President George W. Bush
July 2001

A prescription drug benefit is part of the President's framework for strengthening Medicare, but this will take time. So, the Administration is taking steps now to assist beneficiaries with the greatest need. This year, HHS seeks to implement a Medicare-endorsed prescription drug card to give beneficiaries immediate access to drug discounts and other valuable pharmacy services. Medicare will endorse prescription drug cards that meet high standards for managing pharmacy services and providing discounts, and will give seniors the information they need to find the card that offers the best services and discounts for their needs. Medicare beneficiaries will be able to select one card that will grant them access to discounts on medicines, including rebates from manufacturers, and assistance from their neighborhood drugstores. Through the ability of cards to move market share, this program will give beneficiaries access to the same tools widely available to Americans with private insurance to get discounts from manufacturers. The Medicare-endorsed prescription drug card is neither a drug benefit nor a substitute for one. But it will give both beneficiaries and the Medicare program needed experience with competitive choices for prescription drug assistance so that a competitive drug benefit can be implemented more efficiently.

...[W]hen it comes to health care, 1965 is not the state of the art. We need to bring Medicare into the 21st Century, to expand its coverage, improve its services, strengthen its financing, and give seniors more control over the health care they receive.

President George W. Bush

July 2001

The budget builds upon the President's framework. It dedicates \$190 billion over 10 years for targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. To pave the way, the budget proposes immediate steps to begin to improve Medicare benefits, including an infrastructure for a prescription drug benefit and incentives to expand and maintain private health plan options. In addition to proposing some new funding to improve Medicare benefits, the budget also proposes new Medigap plans, a full view of Medicare solvency, and other program improvements. The budget also proposes efforts aimed at addressing Medicare's financial status, such as ensuring that Medicare payments are efficient and appropriate.

Providing Access to Prescription Drug Coverage. While drugs were not a standard part of health insurance coverage at Medicare's creation, today they are integral to modern medicine. Not only do they relieve pain and speed recovery, they may reduce health care costs by avoiding more costly treatments, hospitalizations, and complications.

With few exceptions, however, Medicare does not cover outpatient prescription drugs. Thus, many beneficiaries must get prescription drug coverage from other sources or pay out of pocket for medicine. In 1998, 73 percent of Medicare beneficiaries had some form of supplemental insurance with a drug benefit for at least part of the year.

The Administration also proposes to begin to phase in comprehensive drug coverage for lower-income Medicare beneficiaries up to 150 percent of poverty, as envisioned in all major prescription drug proposals. This proposal would allow states to expand drug coverage to Medicare beneficiaries up to 100 percent of poverty—about \$12,000 for a family of two—at current Medicaid matching rates, much like existing programs that subsidize Medicare premiums and cost-sharing for low-income Medicare beneficiaries. Further, as an added incentive for states to expand coverage up to 150 percent of poverty—about \$17,000 for a family of two—the federal government would pay 90 percent of the states' costs of expansion above 100 percent of the poverty level with states being responsible for the remaining 10 percent. This policy eventually would expand drug coverage for up to 3 million beneficiaries currently without prescription drug assistance.

Funding for Strengthening Medicare												
(In billions of dollars)												
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–2007	2003–2012
Steps Toward Modernization												
Low-Income Drug Assistance	1.2	2.6	3.9	5.5	7.5	8.9	10.0	11.2	12.4	13.9	20.7	77.1
Medicare+Choice ¹	0.6	1.2	1.5	–	–	–	–	–	–	–	3.3	3.3
Coordinated Care Plan Incentive Payments ²	0.1	0.1	0.2	–	–	–	–	–	–	–	0.4	0.4
Medicare Premium Assistance for Low-Income Seniors	0.1	–	–	–	–	–	–	–	–	–	0.1	0.1

New Medigap Plans	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.6	-1.3
Competitive Bidding for Durable Medical Equipment	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.5	-3.8
Medicare Secondary Payer	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	-1.0
Graduate Medical Education	-	-	-*	-*	-*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Medicare Modernization	-	-	-	12.6	15.6	16.0	16.6	17.6	18.3	19.3	28.2	116.0
Total Medicare Costs	1.7	3.4	5.1	17.5	22.5	24.3	25.9	27.9	29.8	32.2	50.1	190.2
¹ Medicare+Choice pricing reform sunsets when competitive reform is implemented.												
² These payments continue when competitive reform is implemented as part of Comprehensive Medicare Modernization.												
* \$50 million or less.												

Prescription Drug Waivers. Medicaid is the source of drug coverage for approximately four million Medicare beneficiaries, those whose incomes are low enough for them to be eligible for both programs. A number of states would like to use the Medicaid program to extend drug-only coverage to senior citizens and individuals with disabilities, who are not otherwise eligible for Medicaid.

States are also concerned about rising drug costs in Medicaid. Net of manufacturer rebates, prescription drug spending in Medicaid is expected to reach \$26 billion (\$15 billion federal share) in 2003 and to grow to almost \$62 billion (\$36 billion federal share) by 2012. States have been exploring common private-sector cost-control mechanisms like preferred drug lists and prior authorization to moderate drug spending, but Medicaid law and federal regulations make using these types of management tools more difficult.

The Administration will develop model drug waivers to allow states to both reduce drug expenditures and expand drug-only coverage to more Medicare beneficiaries. States would have the flexibility to use competitive approaches to provide drug benefits, including through Medicare-endorsed drug cards. These changes are a part of the Administration's overall strategy to provide Medicare recipients with access to prescription drugs and to take steps toward a universal, competitive Medicare drug benefit as envisioned in drug benefit proposals sponsored by members of Congress from both parties. Because several states have already expressed interest, waivers will increase significantly the number of Medicare beneficiaries with access to prescription drug coverage before a universal benefit can be fully implemented.

Sustaining and Enhancing Medicare+Choice. The absence of prescription drug coverage is not the only serious gap in the Medicare benefit package: beneficiaries who obtain coverage through Medicare+Choice do not feel secure that this benefit will continue to be available. Established in 1997, Medicare+Choice was intended to offer beneficiaries comprehensive private plan options for their health insurance coverage—and those private health plans that still participate in Medicare+Choice do just that. Such plans offer additional benefits, such as prescription drug coverage, vision and dental care, and usually at a price well below that of a comparable supplemental policy. However, the program faces significant challenges that threaten beneficiary choice. Few new types of plans, such as preferred provider organizations, have entered Medicare+Choice, and many have withdrawn.

Plans Exiting Medicare+Choice, 2000–2002

	2000	2001	2002
Contract Terminations	41	65	22

Affected Enrollees

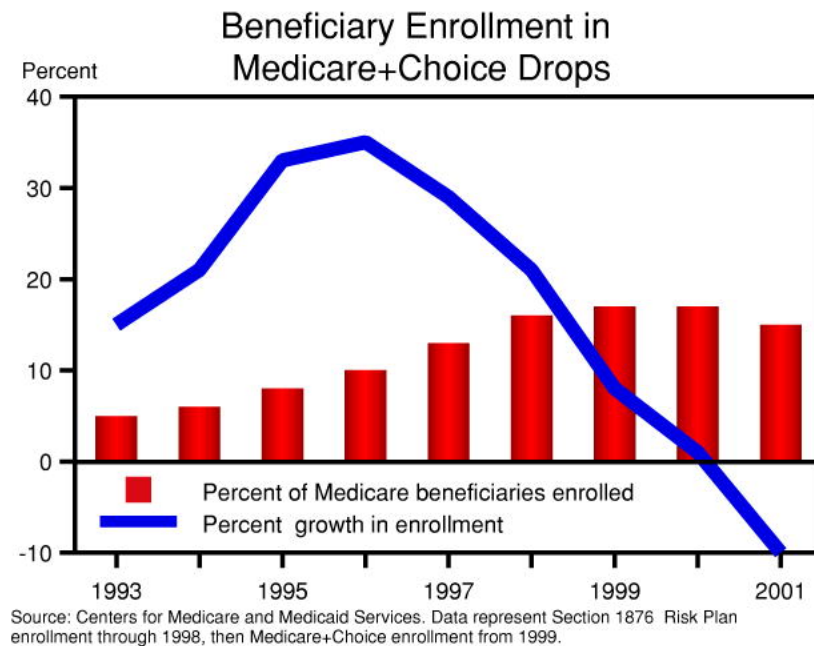
327,000

934,000

536,000

As plans exit, hundreds of thousands of beneficiaries must switch to a different Medicare+Choice plan or return to Medicare's Fee-For-Service program, which is usually more expensive for them. As a result, enrollment in Medicare+Choice has fallen dramatically.

The most important reason that private plans are withdrawing from Medicare, even as they continue to provide reliable and up-to-date coverage for other Americans, is that federal payments to Medicare+Choice have not kept pace with rising health care costs in many areas of the country. The pricing system that controls payments to Medicare+Choice plans has artificially held down payment increases to plans as health care costs have steadily risen. So, plans find it increasingly difficult to continue to provide beneficiaries with additional benefits and choices.



Preserving choice for Medicare's beneficiaries requires fixing Medicare+Choice's payment system so that existing plans remain in the program and new plans are encouraged to join. The budget proposes reforming the current payment system, which is failing Medicare beneficiaries. This includes tying plan payments to the health care cost increases plans are actually experiencing. It also includes adjusting payments to better reflect beneficiaries' health status. In addition, the budget gives managed care plans more flexibility in designing their plans and proposes bonus payments for new types of private plans that enter Medicare+Choice. The bonuses will encourage new managed care plans, such as PPOs, to enter Medicare+Choice, and will increase enrollment up to 400,000 people by 2007—more than seven percent of Medicare+Choice enrollment.

Modernizing Medigap. Medicare does not sufficiently protect beneficiaries against the high cost of medical care, particularly catastrophic medical expenses. Sicker beneficiaries generally pay a greater share of their health care costs. So, in contrast to private plans which might charge only \$100 per admission, Medicare charges beneficiaries over \$800 for each hospital stay. Then, there are the added deductibles and co-payments patients must absorb for physician and outpatient visits. In fact, on average, Medicare beneficiaries spend nearly \$3,000 a year out-of-pocket for medical expenses.

Due to Medicare's benefit limits, more than 85 percent of beneficiaries in traditional Medicare enroll in a plan to supplement

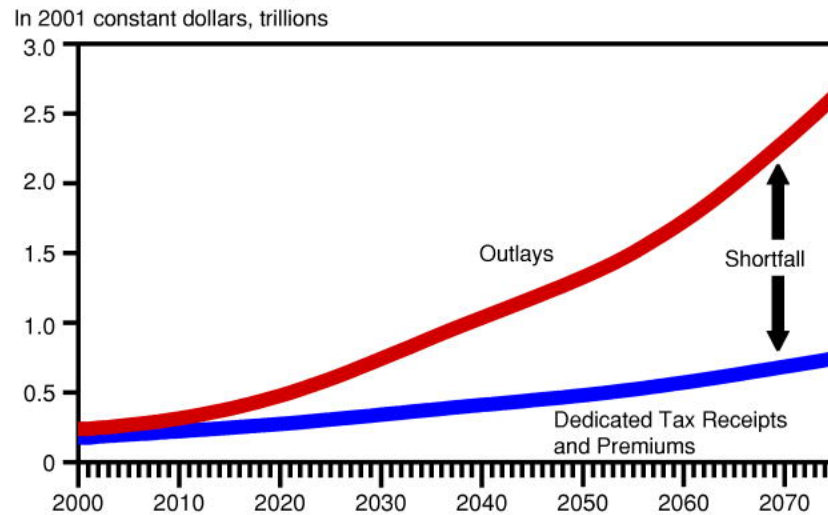
its coverage gaps. Some beneficiaries receive supplemental coverage through Medicaid or an employer, but more than one-quarter purchase Medigap coverage that typically has higher premiums.

Medigap plans are antiquated and poorly tailored to meet the health care needs of today. Unlike many private plans, they provide coverage for up-front deductibles, but offer only very limited prescription drug coverage. This first-dollar coverage drives up Medicare costs and beneficiary premiums. Premiums for plans that do not offer drugs have increased by 25 percent to 45 percent over the past three years, and premiums for plans with drugs have increased at an even greater rate.

As we move toward more comprehensive Medicare modernization, the 2003 Budget proposes to add two Medigap plans to the existing 10. These plans improve upon the existing ones by offering prescription drug coverage, protecting beneficiaries against catastrophic illness, and including nominal beneficiary cost sharing at a lower premium cost than the most popular Medigap plans today.

A Full View of Medicare's Solvency. The Medicare Hospital Insurance (HI) Trust Fund, which provides hospital insurance to seniors, will collect \$189 billion through payroll taxes and spend \$150 billion on benefits in 2003, yielding a \$39 billion surplus. Medicare's trust fund for the other half of the program, the Supplemental Medical Insurance (SMI) Trust Fund, is financed mainly from general revenue transfers and premiums. Currently, the best known measure of Medicare solvency considers only the HI Trust Fund.

Medicare Outlays Exceed Dedicated Tax Receipts and Premiums



Using this approach to solvency, the Medicare Trustees project that HI expenses will exceed new revenues (excluding interest income) by 2016, and the HI Trust Fund will head rapidly toward insolvency by 2029.

However, there is no comprehensive solvency measure accounting for the finances of both trust funds. This current view of solvency only tells half the story. The SMI program also is also running a large shortfall, since premiums collected from beneficiaries cover only about 25 percent of program costs. A comprehensive analysis of both trust funds reveals that the program is actually running a shortfall of \$553 billion over the next 10 years, not a surplus.

The singular focus on HI solvency underestimates the magnitude of Medicare's financial problem. The Medicare Trustees acknowledged this disconnect in their 2001 Trustees report when they stated, "Although this report focuses on the financial status of the HI Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions."

Thus, the budget proposes new comprehensive measures of solvency accounting for both the HI and SMI Trust Funds. This

larger view of Medicare's finances facilitates more careful planning for the future.

Measures of Medicare Solvency		
	Current Measure	New Comprehensive Measure
Hospital Insurance	-1.97	-1.97
Supplemental Medical Insurance	—	-3.37
Total	-1.97	-5.33
Total needed to balance the program in 75 years	\$4.7 trillion	\$12.9 trillion

The current measure of Medicare solvency looks only at the status of the HI Trust Fund. Under this measure of solvency, the HI Trust Fund has a deficit equal to 1.97 percent of taxable payroll, or \$4.7 trillion, over the next 75 years. This measure of solvency does not address the fact that the SMI Trust Fund is also running a shortfall, and the SMI Trust Fund will remain solvent only because of a growing infusion of general revenue funds. Thus, this measure does not provide a complete picture of Medicare's overall budgetary impact. The Administration is proposing additional measures of solvency that provide a more comprehensive view of the program's financial status by looking at both the HI and SMI Trust Funds. This measure of solvency acknowledges that SMI actually has a deficit equal to 3.37 percent of taxable payroll over the next 75 years. In combination, both trust funds have a deficit equal to 5.33 percent of taxable payroll, or \$12.9 trillion, over the next 75 years.

Additional Medicare Improvements:

- Medicare pays too much for medical equipment such as hospital beds and oxygen as well as for prosthetics and orthotics. The budget proposes a nationwide competitive bidding system for this equipment to encourage suppliers to provide quality services and supplies at lower prices than what Medicare currently pays.
- The Administration recognizes that Medicare's extremely complex provider payment systems, based on regulated prices, do not always function smoothly and equitably over time. For example, while the system Medicare uses to pay physicians has been working as intended, recent short-term adjustments have been large. At the same time, provisions that have held down growth of other payment systems toward historical growth rates are set to expire. The Administration is willing to work with the Congress to smooth out such payment adjustments through reforms in payment policy that, in both the short and long term, are budget neutral across provider payment updates.
- Medicare and the Federal Employees Health Benefits Program (FEHBP) finance health insurance for 2.1 million federal retirees and their dependents, yet the programs are neither formally coordinated nor offer insurance plans tailored to the federal retiree. The Administration will work with stakeholders to develop additional FEHBP options for retirees that improve choice by making available a full range of private health insurance options.
- Medicare sometimes pays too much in health insurance claims because it mistakenly pays when another insurer should have paid most or all of the claim. But Medicare rarely collects on these overpayments. To correct this, the budget proposes a requirement that insurers and those sponsoring group health plans periodically report those beneficiaries for whom Medicare could be the secondary payer.
- While Medicare pays for only a few outpatient drugs, the current Medicare payment mechanism results in the program overpaying billions of dollars, according to the HHS Inspector General, the General Accounting Office, and other witnesses who testified at recent hearings before the House Energy and Commerce Committee. Congress has expressed a clear bipartisan interest in addressing this issue while ensuring providers are adequately compensated for the cost of caring for patients. The Administration this year intends to improve the payment system for these drugs consistent with quality care.

- The budget proposes to extend the subsidy of Medicare premiums for certain qualified individuals.
- In addition, the budget proposes to continue steps already underway to address variations in graduate medical education payments.

Medicaid and the State Children's Health Insurance Program (SCHIP)

Medicaid. Almost 37 million individuals were enrolled in Medicaid in 2001. Medicaid covers one-fourth of the nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services. The elderly and disabled comprise one-third of Medicaid beneficiaries but account for two-thirds of Medicaid spending.

SCHIP. SCHIP was established in 1997 to make available approximately \$40 billion over 10 years for states to provide health care coverage to low-income, uninsured children. SCHIP gives states broad flexibility in program design while protecting beneficiaries through federal standards. Approximately 4.6 million children were enrolled in SCHIP programs in 2001.

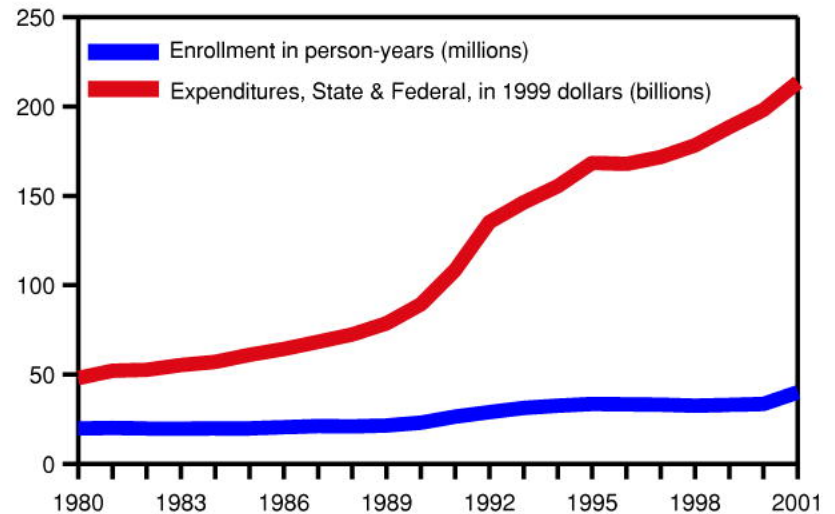
Both Medicaid and SCHIP rely on state and federal sharing of program expenditures, with the federal contribution based on state per capita income. The federal share of Medicaid ranges from 50 percent to 77 percent, with an average match rate of 57 percent. Medicaid spending will be an estimated \$280 billion (\$159 billion federal share) in 2003. SCHIP matching rates vary from 65 percent to 85 percent. About \$3.2 billion is available to states for SCHIP programs in addition to almost \$11 billion in unspent funds from previous years. According to HHS, more than 1 million additional people have gained Medicaid or SCHIP coverage since January 1, 2001.

The budget proposes several initiatives for the Medicaid and SCHIP programs. The first set gives states greater ability to expand health insurance coverage to targeted populations, while the second set promotes fiscal integrity.

Medicaid/SCHIP Reform. While there is considerable discretion under Medicaid, many states and other stakeholders have complained that the web of Medicaid laws and administrative guidelines are confusing, burdensome, and serve to limit state flexibility. The creation of the SCHIP program added further complexity to the already intricate rules for expanding coverage to low-income Americans. States frequently request additional flexibility through waivers to tailor their public programs to their specific insurance markets or to expand eligibility to the uninsured beyond mandatory populations. Additionally, many states have requested that the Administration grant the same flexibility in their Medicaid programs through waivers of Medicaid law and regulation that they have in their SCHIP programs. As a first step, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, which gives states the flexibility they need to design innovative ways to increase access to health insurance coverage for the uninsured.

The Administration will continue to build on the HIFA initiative by developing proposals that will give states: a) the statutory authority to provide broader coverage to low-income uninsured Americans; and b) the flexibility to design innovative programs without seeking waivers. States will be encouraged to use current resources to extend coverage to more of their neediest residents and reduce the number of people without health insurance coverage.

Medicaid Spending and Enrollment



Source: Centers for Medicare and Medicaid Services.

Health Insurance Flexibility and Accountability Demonstration Initiative

In August 2001, the Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. The HIFA initiative:

- Encourages states to develop comprehensive health insurance coverage approaches that utilize available Medicaid and SCHIP funding to address insurance coverage for individuals with incomes less than twice the official poverty level, who comprise most of the uninsured;
- Gives states the flexibility to increase health insurance coverage through support of private group health coverage;
- Simplifies the waiver application process by providing clear guidance and data templates; and
- Increases accountability within the state and federal partnership by ensuring that Medicaid and SCHIP funds are effectively being used to increase health insurance coverage.

On December 12, 2001, the Administration approved the first HIFA waiver for Arizona. The state plans to expand health coverage to parents of children enrolled in Medicaid or KidsCare (Arizona's SCHIP program) with family incomes between 100 percent and 200 percent of poverty. Arizona expects ultimately to provide health insurance to more than 25,000 currently uninsured adults. Arizona's HIFA waiver will explore ways to improve coordination between public and private coverage options for the uninsured using employer-sponsored insurance.

Extending the Availability of Expiring SCHIP Funds. The Balanced Budget Act of 1997 made funds available for state use in a two-step process. The first allows states three years to use their allotment. For the second step, HHS redistributes unused funds among the states. A year later remaining funds return to the U.S. Treasury. According to current estimates, \$3.2 billion in funds will return to the Treasury at the end of 2002 and 2003.

Medicaid/SCHIP Reform (In millions of dollars)												
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003– 2007	2003– 2012
New Freedom Initiative	8	15	39	64	81	92	100	107	115	120	207	741
Extension of Expiring SCHIP Funds	-10	90	250	60	60	20	*	10	10	20	450	510
Extension of Transitional Medicaid	350	—	—	—	—	—	—	—	—	—	350	350
Rationalizing Prescription Drug Payments	-290	-650	-1,090	-1,620	-1,800	-1,990	-2,200	-2,420	-2,660	-2,920	-5,450	-17,640
Effects of SSA and other proposals	-	17	-4	-20	-43	-69	-96	-126	-154	-184	-42	-671

Total	58	-528	-797	-1,516	-1,702	-1,947	-2,196	-2,429	-2,689	-2,964	-4,485	-16,710
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* 500 thousand or less.

The Administration proposes to extend the availability of these expiring funds until 2006. According to current estimates, this extension will allow every state to retain enhanced-match funds. This proposal will provide additional support for their current coverage levels as well as provide additional health insurance coverage to more Americans under the Administration's HIFA initiative.

Transitional Medicaid Assistance (TMA). TMA was created to provide health coverage for former welfare recipients after they entered the workforce. TMA extends up to a year of health coverage to families who lose eligibility for welfare-related Medicaid due to earnings from employment. This provision will expire September 30, 2002; however, the Administration proposes a one-year extension.

Program Integrity

Strengthening the fiscal integrity of Medicaid while ensuring that its beneficiaries have access to care remains a top Administration health priority. The joint federal-state nature of the Medicaid program promotes ownership and mutual investment in its activities. The complexity of Medicaid funding rules, however, has also made ensuring program integrity both more difficult and more vital. As program spending has grown over the years, so too have concerns that Medicaid dollars are not being used to provide services to eligible beneficiaries.

Undermining Medicaid's Program Integrity

Over the past year, HHS has been working to close a controversial Medicaid payment loophole that permits states to pay some public nursing homes and hospitals more than the actual costs of providing medical services. Through the loophole, health facilities may be required to return the excess payment to the state. States then get reimbursements from Uncle Sam beyond those intended under federal Medicaid law.

During 2000, one state made \$76 million in excess payments to 14 public nursing homes. Of the \$76 million, the nursing homes returned \$66 million to the state treasury and the state was able to use the money for non-Medicaid purposes. Now facing a budget crisis, the state in question seeks to expand this program to obtain more than \$250 million from the federal government to match additional payments made to nursing homes and subsequently returned to the state for non-Medicaid purposes.

The HHS Inspector General stated in September 2001, that unless curbed, this financing loophole threatens the financial stability of the Medicaid program.

Upper Payment Limits. The Administration proposes to build on past efforts to curb the costly Medicaid Upper Payment Limit (UPL) loophole by strengthening the management and enforcement of federal payment policies.

School-Based Health Services. Medicaid is authorized to pay for health services provided to Medicaid-eligible children pursuant to the Individuals with Disabilities Education Act (IDEA). In past years, billing inconsistencies have plagued the program because the federal government has never articulated clear guidance. In 2002, the Administration will release guides that will address all aspects of school-based Medicaid billing.

After issuing the guides, the Administration will address problematic areas within school-based health services. Often, school districts are not familiar with the Medicaid program and they do not have the administrative capacity to properly submit claims to the government. As a result, schools hire private consulting firms to assist them, paying them on a contingency fee basis for their services.

School-based Claims in Medicaid

Medicaid is authorized to reimburse schools for medical services including physical, occupational and recreational therapies as well as related administrative costs and transportation costs for many children enrolled in special education. Many school districts do not have the administrative capacity to submit Medicaid claims. As a result, school districts have come to rely on national consulting firms that help them claim Medicaid funds from the federal government.

In some cases where schools pay firms on a contingency fee basis, federal investigators have found evidence that consulting firms have advised school districts to overcharge the Medicaid program. A contingency fee is a form of payment in which a consulting firm retains a percentage of the federal Medicaid claim reimbursement. The General Accounting Office and the HHS Inspector General have found that Medicaid costs can be unsubstantiated and, in some cases, unallowable under consultants' guidance when a contingency fee is involved.

Ultimately, contingency fees divert money from school districts and create a financial incentive for consulting firms to submit questionable claims. This practice undermines the integrity of the Medicaid program and its ability to provide health care to Medicaid children.

Evidence from the General Accounting Office suggests that consulting firms incorrectly profit from Medicaid overpayments. The Administration believes that these practices should stop and is proposing a regulation to ban contingency fees in the area of school-based health services and will take strong action to end abuses.

Improving Medicaid Drug Payment Integrity. The drug rebate is currently one of the primary cost-control mechanisms in Medicaid. The rebate, which is the greater of the difference between a drug manufacturer's best price and its Average Manufacturer's Price (AMP) or a percentage specified in statute, has not changed substantially since its inception in 1990. The Administration proposes to improve the drug rebate system and more explicitly link state payment to pharmacies with the manufacturer rebates. The HHS Inspector General estimates that the disconnect between manufacturer rebates and pharmacy reimbursement is costing the states and federal government billions of dollars. In addition, the Administration proposes to ensure that all necessary price information is reported, and that states collect all rebates owed to them. States and the federal government will work together to ensure that Medicaid does not pay for prescription drugs that third parties, like private insurers, should cover.

Enhancing Medicare, Medicaid and SCHIP Program Integrity. HHS has realized early success in reducing Medicare payment errors, as evidenced in part by the declining Medicare error rate. Medicare's estimated error rate was 6.8 percent in 2000, roughly half of the 14 percent rate estimated in 1996, the first year that the Inspector General conducted an audit to estimate Medicare's overall error rate. Future successes will depend on further refinements and actions on Medicare program integrity measures. The budget proposes developing a Medicare fraud yardstick that will measure the magnitude of Medicare overpayments made in error and those that result from fraud.

HHS has not, however, devoted the same attention to Medicaid and SCHIP. In 2003, HHS will devote more resources to Medicaid and SCHIP program integrity. To that end, the budget proposes to strengthen federal oversight of states' financial practices and Medicaid program integrity efforts. This effort will include increasing the number of audits and evaluations of state Medicaid programs, reestablishing and elevating the importance of financial management oversight at Centers for Medicare and Medicaid Services (CMS), and outsourcing appropriate activities to private firms. The budget proposes to allocate \$10 million in Health Care Fraud and Abuse Control funding in 2003 to help finance this Medicaid and SCHIP program integrity initiative.

Other Expansions of Health Coverage

New Freedom Initiatives. On February 1, 2001, the President announced the New Freedom Initiative as part of a nationwide effort to further integrate people with disabilities into society. The President followed up on this commitment by asking federal agencies to work together to identify barriers to community living and propose solutions to eliminate them. As part of this effort,

the Administration proposes a number of new initiatives, including: the Direct Service Worker National Demonstration, in which HHS and a limited number of states will address shortages of community service direct care workers; a 10-year demonstration allowing states to set up home- and community-based alternatives for children currently receiving services in psychiatric residential treatment facilities; and two new national demonstrations allowing states to provide respite care services for adults, and respite care services for children with substantial disabilities.

Tax Credits for Health Insurance Coverage. Federal tax laws help finance private health insurance coverage. Most notably, employer contributions for health insurance premiums are excluded from employees' taxable income, a tax incentive of \$99 billion in 2003 and \$581 billion from 2003 to 2007. In addition, starting in 2003, self-employed individuals may deduct 100 percent of what they pay for health insurance for themselves and their families. All current law health-related tax incentives, including other provisions, will cost an estimated \$118 billion in 2003, and \$692 billion from 2003 to 2007.

To encourage private health insurance coverage, the budget proposes a new refundable tax credit for low- and moderate-income individuals and families who are neither covered by an employer plan nor enrolled in public programs, and who may have the most difficulty finding affordable health insurance today. To improve the tax credit's purchasing power, the Administration also proposes a health insurance tax credit buy-in as part of the 2003 Budget. This would permit certain tax credit recipients, at state option, to purchase private insurance through private purchasing groups, state-sponsored insurance purchasing pools, and high-risk pools. Additional details about the refundable health insurance tax credit can be found in the Federal Receipts chapter of *Analytical Perspectives*, as well as forthcoming Treasury Department publications.

The budget also includes new tax provisions to improve and permanently extend Medical Savings Accounts (MSAs), a new deduction for long-term care insurance premiums that will help those with long-term care costs, and an additional personal exemption to caretakers of family members in need of long-term care services. In addition, the budget would improve flexible spending accounts (FSAs) by allowing up to \$500 in unused benefits to be distributed as taxable income, rolled over into an MSA, or invested in a 401(K) or similar plan.

Congressional Earmarks

In 2002, the Congress earmarked funding for 690 projects in HHS, totaling \$532 million. The practice of earmarking grants bypasses the competitive peer and grant review processes. Further, earmarks undermine the Department's ability to reward effective programs by diverting resources to unrequested, non-competitive projects. For example, in 2002, 100 percent of the \$312 million appropriated for health facilities construction was earmarked by the Congress, leaving HHS with no discretion in deciding which construction projects would be funded. To eliminate the impact of earmarks, the Administration will consolidate facilities construction and maintenance activities to be managed competitively across the Department. This consolidation will also give HHS flexibility to set priorities and allocate funding accordingly.

Status Report on Select Programs

The Administration is reviewing programs throughout the federal government to identify strong and weak performers. The accompanying table displays selected HHS programs and their ratings.

Program	Assessment	Explanation
Health Resources and Services Administration (HRSA)—Community Health Centers	Effective	CHCs are effective at providing primary health care services and increasing health care access to uninsured and underserved patients regardless of their ability to pay.

HRSA—National Health Service Corps (NHSC)	Effective	Through scholarships and loan repayments, NHSC has placed over 22,000 health care providers in underserved areas over the last 29 years.
HRSA—Health Professions	Ineffective	Discussion appears below in the Improving Performance section of this chapter.
HRSA-Community Access Program (CAP)	Ineffective	CAP was initiated in 2000 to assist health care providers in integrating health care systems. CAP has yet to develop clear goals or performance measures.
Centers for Disease Control and Prevention (CDC)—Childhood Immunizations Program	Effective	The CDC and Medicaid Vaccine for Children programs together largely reach CDC's stated goal of reducing the number of vaccine-preventable cases of disease among children and ensure that children are appropriately immunized, although some management improvements are needed.
CDC—Chronic Diseases	Unknown	There is limited nationwide data on the impact of CDC-funded activities and health outcomes in the area of chronic diseases.
Administration for Children and Families (ACF)—Temporary Assistance for Needy Families (TANF)	Effective	Performance has exceeded expectations.
Indian Health Service (IHS)	Moderately Effective	IHS is moderately effective at providing health care services to Native Americans, reducing health disparity, constructing new and replacement hospitals, and managing self-governance activities.

Improving Performance

Health Resources and Services Administration

The mission of the Health Resources and Services Administration (HRSA) is to ensure access to health care for all Americans in partnership with states, universities and colleges, and other entities. HRSA has identified four broad strategies to guide its diverse grant portfolio: 1) eliminate barriers to care; 2) eliminate health disparities of minority populations; 3) assure quality of care; and 4) improve public health and health care systems.

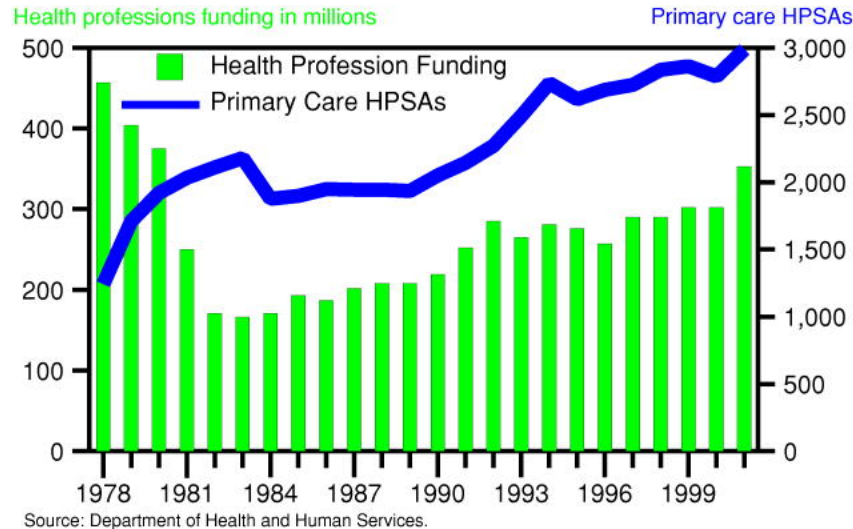
The budget reflects the Administration's commitment to ensure the efficient and effective use of resources to improve overall health and access by including funding increases to support new and expanded health care access points for those who lack any form of health care. The budget funds placement of more doctors, nurses, and other health care professionals in underserved

areas. The budget also streamlines and phases out activities that lack clear goals, have not proven to be effective, or could be accomplished through existing activities.

Health Professions Training Grants. The health professions training grants, awarded to institutions and individuals, were established over 40 years ago to address the supply and distribution of health professionals and the recruitment and retention of minorities in health professions schools. However, rather than improving the supply and distribution of health providers, the program has splintered into numerous small grants that address more than 40 objectives—some completely unrelated to the core intent of the training grant program. It is virtually impossible to measure the national impact of the grants and the annual multi-million dollar investment that funds them.

Despite 40 years of funding, most of the health professions grants have not proven to be effective because they do not accurately address current health professions problems. For example, since 1993, the number of residents enrolled in primary specialties has grown, but the demand for primary care physicians is still acute in health professional shortage areas. Over the last two decades, almost \$7 billion has been invested in health professions training grants and during this time the population of areas with shortages of primary care health professionals has increased by 140 percent.

Health Professions Funding and Health Profession Shortage Areas



Health professions training grants as currently administered do not provide an incentive for grant recipients to work in underserved areas. Most of those who receive federal health professions training support do not practice in underserved areas. As a result, health professions training grants effectively subsidize the education of students who do not help address the distribution problem. Of the roughly 20 percent who do serve in shortage areas, there is no data on how long they actually remain. For the size of this investment, totaling over \$375 million in 2002, more of our health professional shortage areas should be filled. In contrast, community health centers, subsidies for health insurance coverage, and other policies are more cost-effective approaches to improving access to care in underserved areas.

The 2003 Budget reforms health professions grants by eliminating those that are not the most efficient way to address health care workforce problems. The budget makes investments in two key areas: 1) increasing opportunities for minority and disadvantaged populations to enter in the health professions; and 2) warding off a potential future nursing shortage.

Minority enrollment in health professions programs has declined in recent years. Since 1996, the number of individuals from minority groups enrolled as first year medical students has dropped eight percent. The budget increases funding to finance scholarships for health professions students from disadvantaged backgrounds. These grants will be awarded to schools that have a successful program for recruiting and maintaining students from disadvantaged backgrounds. Students who receive these grants must demonstrate a commitment to serve in a public or non-profit health care site after graduation. The Administration is

committed to ensuring equal opportunity for minority and disadvantaged Americans in the health professions.

The nation's nursing corps is aging, and, unfortunately, few young people are considering nursing careers. The total number of full-time registered nurses per capita is expected to peak around 2007 and decline steadily thereafter as the largest groups of nurses retire. The situation will likely worsen due to a steady decline in nursing school enrollment and reasonable predictions of a growing demand for nursing services. The budget includes \$99 million to help boost the supply of nurses by providing grants to schools of nursing to help attract and educate the next generation of American nurses.

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with states and local communities, aids the nation's effort to prevent and treat mental illness and substance abuse. The budget funds the treatment of mental illness and the prevention and treatment of substance abuse.

A recent evaluation of SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) found that the formula grant is effective in helping states expand community mental health services, alcohol and drug treatment, and support services for homeless individuals facing a serious mental illness. Building on this success, the budget includes additional funds for PATH to reach out to 163,000 homeless individuals to help them recover from mental illness and substance abuse, find housing, and gain meaningful employment.

Administration for Children and Families

The Administration for Children and Families (ACF) runs programs that seek to promote the economic and social well-being of children, youth, and families. ACF focuses particular attention on low-income children, refugees, Native Americans, and the developmentally disabled.

Social Services Block Grant. The Administration funds the Social Services Block Grant (SSBG) at \$1.7 billion. This program provides flexible funds to states for social services for low-income individuals and families.

Head Start. The President has proposed to reform Head Start and return it to its original focus - getting children ready to learn. The budget provides an increase of \$130 million in 2003 to maintain participation and program quality. HHS and the Department of Education are forming a task force to assess ways to improve Head Start and lay the groundwork for its proposed transfer to the Department of Education as part of the program's reauthorization.

Low-Income Home Energy Assistance Program (LIHEAP). In response to Department of Energy forecasts of lower fuel costs, the budget contains \$1.7 billion to help low-income households cover home heating and cooling costs. This amount includes a contingency fund of \$300 million for unanticipated needs that may arise. The legislatively established formula currently used to distribute LIHEAP block grant funds to states is based on 20-year old population and winter heating cost data. The Administration is interested in options that would make block grant allocations more equitable by basing the formula on current home energy expenditures paid by low-income households.

Child Care. Child care is funded through both the Child Care and Development Block Grant (\$2.1 billion) and the Child Care Entitlement to States (\$2.7 billion).

Community Services Block Grant. The budget proposes to fund the Community Services Block Grant (CSBG) at \$570 million, a reduction of \$80 million from the 2002 level of \$650 million. The CSBG program provides a small fraction of the budget to a largely static group of organizations. Very little performance data exists on the outcomes from the CSBG funding. Consequently, this reduction was used to fund other high-priority, high-performing programs.

Administration on Aging

The budget proposes \$1.3 billion for Administration on Aging (AoA) programs. The budget proposes to merge the smaller Department of Agriculture Nutrition Services Incentive Program with AoA's nutrition programs. Although funding for home

and other meals programs for the elderly is now provided through both HHS and the Department of Agriculture, HHS is the lead agency and has greater interaction with the states and service providers. This merger will improve program oversight and streamline reporting requirements.

Strengthening Management

[T]he biggest challenge to HHS is the relative independence of all of the operating agencies. In other words, we are our own worst enemy.

HHS Program Support Center Workforce Analysis
June 2001

HHS will intensify its management reform efforts substantially in order to meet the ambitious objectives of the President’s Management Agenda. Because of the relative autonomy enjoyed by each of its 13 operating divisions, the Department currently finds itself with numerous different policies and practices in areas such as personnel management, information technology (IT), financial management, and program performance measurement.

The “Citizen-Centered HHS” section of this chapter (see above) describes the proliferation of duplicative personnel, public affairs, and legislative affairs functions within HHS, and outlines how the Administration will consolidate them into more efficient and effective offices. The Department also faces serious problems in several other management areas. HHS’ inadequate financial management systems failed to prevent \$12.5 billion in overpayments for services in its Medicare Fee-for-Service program in 2000. In the increasingly critical area of IT management, HHS faces numerous challenges created by an unnecessarily complicated infrastructure. The Department currently maintains seven separate networks using 10 different operating systems, and has as many computer servers as computer professionals—about 2,900 of each at last count.

Talking Past Each Other

Soon after his swearing in as head of HHS, Secretary Thompson experienced firsthand the Department’s chaotic computing environment. He discovered that he could not send an e-mail from his desk on the sixth floor of HHS’ Washington headquarters to another office in the same building just one floor away! The incompatibility of his own computer with others in the building forced the Secretary to resort to having important papers carried from office to office rather than sent instantly with just a “point and click.” This startling experience highlighted the need for dramatic change in HHS’ inadequate, uncoordinated IT systems. Today, the Secretary’s agenda includes more rigorous control of IT investment decisions, better coordination of IT systems, and a more streamlined deployment of IT personnel throughout the Department.

Finally, HHS has lagged in implementing bold, innovative ideas for opening federal positions that are commercial in nature to private competition. In 2003, HHS will compete some positions that could have been performed by the private sector long ago, such as locksmithing, plumbing, printing, TV studio production, web design, and facility security. The Department has begun to implement reforms by drafting a workforce restructuring plan, instituting performance-based contracts for all senior managers, leading federal government efforts on E-government projects, consolidating financial management systems, and identifying federal positions it will open up to private competition. Still, much more remains to be done.

Initiative	2001 Status

Human Capital—HHS has not implemented the comprehensive restructuring reforms needed to create a citizen-centered department. Excessive organizational layers persist, and planning for redeployment of managers to the front lines is incomplete. Workforce restructuring plans reflect a decentralized Department in which few operating divisions consider coordinating reform efforts. In 2003, HHS will consolidate 40 personnel offices into four, and more than 70 public affairs and legislative affairs offices into single offices for each function.	●
Competitive Sourcing—Though HHS has identified 1,621 positions that may be put up for competition, it has not yet met the President’s goal to conduct public-private competitions for 15 percent of its commercial positions by 2003. HHS will implement a competition plan that meets the President’s 15 percent goal, and will conduct competitions involving selected facilities, security, and fire protection functions.	●
Financial Management—HHS’ financial management systems have been non-compliant with federal laws and regulations since 1996, and its systems remain inadequate to produce reliable financial information. To solve these problems, HHS will begin implementation of a seven-year Unified Financial Management System project. The Department will also measure the level of erroneous federal payments to social programs administered by the states, and will work with the states to decrease these levels.	●
E-Government—HHS must assert central control of IT decision-making by coordinating IT development efforts across operating divisions and emphasizing elimination of duplicative IT projects. The Department must strengthen IT planning and address IT security issues, and must focus on converting paper transactions to computers to improve customer service and reduce private sector burden. To address IT management problems, HHS will consolidate IT staff, develop a comprehensive E-Gov strategy, and lead the federal government’s E-Grants and Health Informatics initiatives.	●
Budget/Performance Integration—HHS' annual performance plan, containing 15 volumes and nearly 750 performance measures, reflects a decentralized process with little value for making budget decisions. Rather than setting national health outcome goals, HHS reports narrowly on specific program outputs. HHS will link its budget with Departmental priorities and national health outcome goals; describe how program activities support each priority; and outline strategies and resources.	●

Department of Health and Human Services

(In millions of dollars)

	2001 Actual	Estimate	
		2002	2003
Spending:			
Discretionary Budget Authority:			
Food and Drug Administration	1,144	1,270	1,432
<i>Program Level</i>	<i>1,315</i>	<i>1,453</i>	<i>1,727</i>
Health Resources and Services Administration	5,603	6,141	5,395
<i>Program Level</i>	<i>5,603</i>	<i>6,141</i>	<i>6,014</i>
Indian Health Service	2,690	2,824	2,884

Centers for Disease Control and Prevention	3,817	4,177	4,011
<i>Program Level</i>	4,069	4,382	5,696
National Institutes of Health	20,447	23,333	27,335
Substance Abuse and Mental Health Services Admin	2,968	3,142	3,197
Agency for Health Research and Quality	107	3	–
<i>Program Level</i>	272	300	252
Centers for Medicare and Medicaid Services: ¹			
CMS Program Administration	2,293	2,466	2,538
<i>Program Level</i>	2,355	2,528	2,599
MedPAC/OCR/GDM/AHRQ Administration	13	17	18
Legislative proposal	–	–	-130
Administration for Children and Families:			
Existing law	12,399	12,939	13,028
Legislative proposal	–	131	30
Administration on Aging	1,104	1,201	1,342
Buildings and Facilities	175	250	184
Office of the Inspector General	42	45	50
Office of the Secretary	354	382	422
<i>Program Level</i>	439	539	612
Public Health and Social Services Emergency Fund	241	243	2,295
Subtotal, Discretionary budget authority adjusted ²	53,397	58,564	64,031
Remove contingent adjustments	-320	-343	-357
Total, Discretionary budget authority	53,077	58,221	63,674
Emergency Response Fund, Budgetary Resources:			
Bioterrorism	5	2,638	–
Response and Recovery	121	179	–
Total, Emergency Response Fund, Budgetary resources	126	2,817	–
<i>Total HHS Bioterrorism Spending</i>	300	2,830	4,329

Mandatory Outlays:			
Medicare:			
Existing law	214,061	222,723	228,951
Legislative proposal	–	–	1,680
Medicaid/SCHIP:			
Existing law	133,073	148,440	163,054
Legislative proposal	–	–	58
All other programs	–	–	–
Existing law	29,497	29,817	31,014
Legislative proposal	–	–	-6
Subtotal, Mandatory outlays adjusted ²	376,631	400,980	424,751
Contingent adjustments	–	–	104
Total, Mandatory outlays	376,631	400,980	424,855

¹ Amounts appropriated to SSA from HI/SMI accounts are included in the corresponding table in the Social Security Administration chapter.

² Adjusted to include the full share of accruing employee pensions and annuitants health benefits. For more information, see Chapter 14, "Preview Report," in *Analytical Perspectives*.

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