U.S. Department of Health and Human Services
200 Independence Avenue S.W., Washington, D.C. 20201

This document also available at http://www.hhs.gov/about/hhsbudget

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

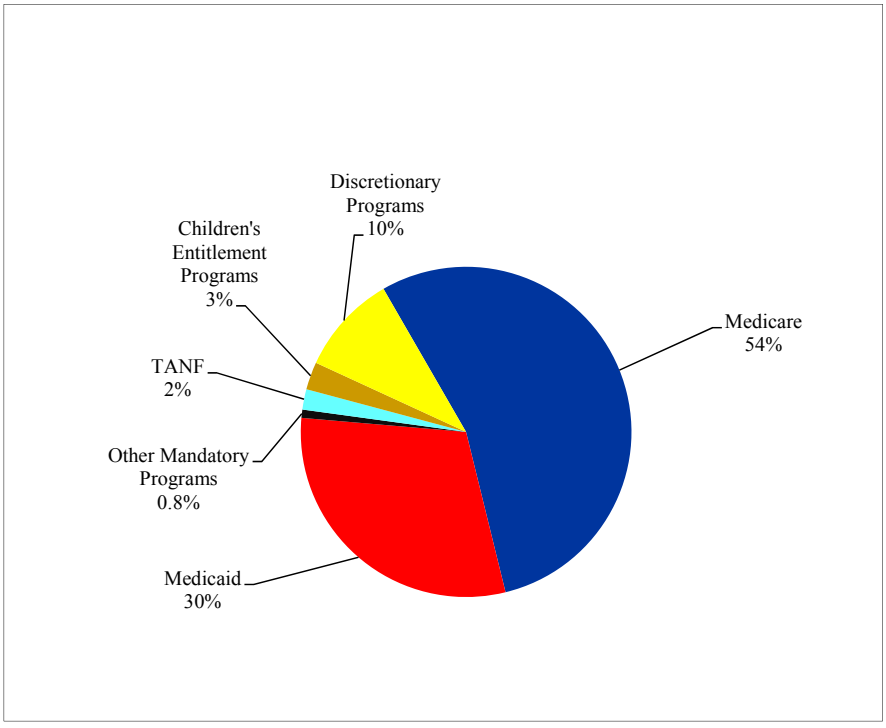
FY 2012 President's Budget for HHS

(dollars in millions)

	2010	2011	2012
Budget Authority	**848,626**	**900,586**	**885,789**
Total Outlays	**854,174**	**909,072**	**891,597**
Full-Time Equivalents	71,047	73,051	75,808

Composition of the FY 2012 Budget

$892 Billion in Outlays



General Notes

Detail in this document may not add to the totals due to rounding. Budget data in this book are presented "comparably" with the FY 2012 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2012. This approach is consistent with past practice, and allows increases and decreases in this book to reflect true funding changes.

In addition - consistent with past practice – the FY 2010 figures herein reflect the final enacted levels. The FY 2011 discretionary figures reflect a continuing resolution level and the FY 2011 mandatory figures reflect current law and mandatory proposals reflected in the Budget.

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

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

The Budget for the Department of Health and Human Services (HHS) invests in health care, disease prevention, social services, and scientific research consistent with the President's goals. These investments will enable HHS to protect and promote the health of all Americans and provide essential human services that promote opportunity and provide needed assistance for individuals and families.

The President's FY 2012 Budget for HHS totals $891.6 billion in outlays. The Budget proposes $79.9 billion in discretionary budget authority. The Budget supports the goals of HHS including to: Transform Health Care; Advance Scientific Knowledge and Innovation; Advance the Health, Safety, and Well-Being of the American People; Increase Efficiency, Transparency, and Accountability of HHS Programs; and, Strengthen the Nation's Health and Human Service Infrastructure and Workforce.

TRANSFORM HEALTH CARE

Expanding Access to Coverage and Making Coverage More Secure: The Affordable Care Act expands access to affordable coverage to millions of Americans and increases consumer protections to ensure individuals have coverage when they need it most. These reforms create an important foundation of patients' rights in the private health insurance market and put Americans in charge of their own health care. As a result, we have already implemented historic private market reforms including eliminating pre-existing condition exclusions for children; prohibiting insurance companies from rescinding coverage and imposing lifetime dollar limits on coverage; and enabling adult children to stay on their parent's insurance plan up to age 26. The Affordable Care Act also established new programs to lower premiums, such as the Pre-Existing Condition Insurance Plans Program and the Early Retiree Reinsurance Program. The Act provides Medicare beneficiaries access to free preventative services and increases access to prescription drugs under Medicare Part D by closing the coverage gap, known as the "donut hole," by 2020 so that seniors no longer have to fear being unable to afford their prescriptions. It also covers recommended preventative services with no cost sharing and provides for an annual wellness visit to all beneficiaries.

Beginning in 2014, State-based health insurance Exchanges will create affordable, quality insurance options for many Americans who previously did not have health insurance coverage, had inadequate coverage, or were vulnerable to losing the coverage they had. Exchanges will make purchasing private health insurance easier by providing eligible consumers and small businesses with "one-stop-shopping" where they can compare across plans. New premium tax credits and cost-sharing reductions will also increase the affordability of coverage and care. The Affordable Care Act will also extend Medicaid coverage to millions of low-income individuals who were previously not eligible for coverage, granting them access to affordable health care.

Ensuring Access to Quality, Culturally Competent Care for Vulnerable Populations: The Budget includes $3.3 billion for the Health Centers Program, including $1.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund, to expand the capacity of existing health center services and create new access points. The infusion of funding provided through the Affordable Care Act, combined with the discretionary request for FY 2012, will enable health centers to serve 900,000 new patients and increase access to medical, oral, and behavioral health services to a total of 24 million patients.

Improving Health Care Quality: The Affordable Care Act contains numerous provisions designed to ensure that patients receive safe, high quality care.

Innovative payment and delivery reforms such as bundled payments for a single episode of care and the formation of Accountable Care Organizations will promote better coordinated and more efficient care. New value-based purchasing programs for hospitals, Medicare Advantage plans, and other health providers and organizations will reward those who deliver high quality care, rather than simply incentivizing a high volume of services. The new Center for Medicare and Medicaid Innovation ("Innovation Center") will develop, test, and implement new models of payment and delivery that will promote higher quality and lower costs. Similarly, the new Centers for Medicare & Medicaid Services' (CMS) Federal Coordinated Health Care Office will work in a complementary manner to provide higher quality and better integrated care for those who are eligible for both Medicare and Medicaid.

Reducing Health Care Costs: New innovative delivery and payment approaches will lead to both more efficient and higher quality care. For example, provisions in the Affordable Care Act designed to reduce health care acquired conditions and preventable readmissions will both improve patient outcomes and reduce unnecessary health spending. The Innovation Center will pursue new approaches that not only improve quality of care, but also lead to cost savings for Medicare and Medicaid, along with private sector partners. In addition, the Act contains other provisions designed to put health spending on a more sustainable and affordable trajectory. Rate adjustments for Medicare providers and insurers participating in Medicare Advantage will promote greater efficiency in the delivery of care. Meanwhile, new rules for private insurers, such as medical loss ratio standards and enhanced review of premium increases, will lead to greater value and affordability for consumers.

Combating Healthcare Associated Infections: HHS's implementation of the Affordable Care Act will include using infection rates as a metric for hospital value-based purchasing and working with States, through the issuance of a proposed rule, to assess the appropriate adjustments to Medicaid payments for healthcare-associated infections. The FY 2012 Budget includes $86 million to the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the Office of the Secretary, of which $20 million is funded in the Prevention and Public Health Fund (Prevention Fund), to reduce healthcare-associated infections. In FY 2012, HHS will continue research on health-care associated infections and tracking infections through the National Healthcare Safety Network. HHS will also identify and respond to new healthcare-associated infections by conducting outbreak and epidemiological investigations. In addition, HHS will implement, and ensure adherence to, evidence-based prevention practices to eliminate healthcare-associated infections. HHS activities, including those that the Innovation Center sponsors, will further the infection reduction goals of the Department's Action Plan to Prevent Healthcare-Associated Infections.

Health Services for 9/11 World Trade Center Attacks: To implement the James Zadroga 9/11 Health and Compensation Act, the FY 2012 Budget includes $313 million in mandatory funding to provide medical monitoring and treatment to responders of the September 11, 2001 World Trade Center attacks and to others directly affected by the attacks. In addition to supporting medical monitoring and treatment, HHS will use funds to establish an outreach program for potentially eligible individuals, collect health data on individuals receiving benefits, and establish a research program on health conditions resulting from the World Trade Center attacks.

ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

Accelerating Scientific Discovery to Improve Patient Care: The Budget includes $32.0 billion for the National Institutes of Health (NIH), an increased investment of $745 million over the FY 2010 enacted level, to support innovative basic and clinical research that promises to deliver better health and drive future economic growth. In FY 2012, NIH estimates it will support a total of 36,852 research project grants, including 9,158 new and competing awards.

Recent advances in the biomedical field, including genomics, high-throughput biotechnologies, and stem cell biology, are shortening the

pathway from discovery to revolutionary treatments for a wide range of diseases, such as Alzheimer's, cancer, autism, diabetes, and obesity. The dramatic acceleration of our basic understanding of hundreds of diseases; the establishment of NIH-supported centers that can screen thousands of chemicals for potential drug candidates; and the emergence of public-private partnerships to aid the movement of drug candidates into the commercial development pipeline are fueling expectations that an era of personalized medicine is emerging where prevention, diagnosis, and treatment of disease can be tailored to the individual and targeted to be more effective. To help bridge the divide between basic science and therapeutic applications, NIH plans to establish in FY 2012 the National Center for Advancing Translational Sciences (NCATS), of which one component would be the new Cures Acceleration Network. With the creation of NCATS, the National Center for Research Resources will be abolished and its programs transferred to the new Center or other parts of NIH.

Advancing Patient-Centered Health Research: The Affordable Care Act created the Patient-Centered Outcomes Research Institute to help get relevant, high quality information to patients, clinicians and policy-makers so that they can make informed health care decisions. The Patient-Centered Outcomes Research Trust Fund will fund this independent Institute, and related activities within HHS. In FY 2012, the Budget includes $620 million in AHRQ, NIH and the Office of the Secretary, including $30 million from the Trust Fund, to invest in core patient-centered health research activities and to disseminate research findings, train the next generation of patient-centered outcomes researchers, and improve data capacity.

Advancing Health Information Technology: The Budget includes $78 million, an increase of $17 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate health information technology (health IT) adoption and promote electronic health records (EHRs) as tools to improve the health of individuals and transform the health care system. The increase will allow ONC to assist health care providers in becoming meaningful users of health IT.

Medical Countermeasures: The HHS Medical Countermeasure Review, which was released in August 2010, described a new strategy focused on forging partnerships, minimizing constraints, modernizing regulatory oversight, and supporting transformational technologies. The Budget enhances the initiatives identified in the review. The request includes $665 million for the Biomedical Advanced Research and Development Authority, an increase of $345 million over FY 2010, to improve existing and develop new next-generation medical countermeasures to mitigate the medical consequences of potential chemical, biological, radiological, and nuclear threats. As recommended in the review, the Budget also includes $100 million to establish a strategic investment corporation that would function as a public-private venture capital fund providing companies developing medical countermeasures with the necessary financial capital and business acumen to improve the chances of successful development of new medical countermeasure technologies and products. The Budget includes $70 million for FDA, which builds off of the $170 million request in FY 2011, to establish teams of public health experts to support the review of medical countermeasures and novel manufacturing approaches and examine the legal framework and regulatory and policy approaches. Additionally, NIH will dedicate $55 million towards expanding the Concept Acceleration Program, which individually helps shepherd investigators who have promising, early-stage, medical countermeasure products, but limited product development experience, to more rapidly develop and test their products to the clinical evaluation stages. Finally, the Budget includes $655 million, an increase of $59 million over FY 2010, for the Strategic National Stockpile to replace expiring products, support BioShield acquisitions, and fill gaps in the stockpile inventory.

ADVANCE THE HEALTH, SAFETY, AND WELL-BEING OF THE AMERICAN PEOPLE

Child Support and Fatherhood Initiative: The Budget includes $305 million in FY 2012 aimed at encouraging the pass through of all current monthly child support collections to TANF families. Recognizing that healthy families need more than

financial support alone, the proposal would also increase resources for access and visitation services to support and facilitate non-custodial parents' access to and visitation with their children. The Budget request includes additional funding for short term incentive payments to States for two years and for other improvements to support program efforts.

Reform and Reauthorize the Foster Care Financing System: The Budget includes an additional $250 million in mandatory funds in FY 2012 to provide incentives to States to align performance with improved outcomes for children in foster care and those who are receiving in-home services from the child welfare system in order to prevent entry or re-entry into foster care.

TANF Reauthorization: The Budget request extends all TANF programs for one year, including Family Assistance Grants, Healthy Marriage and Responsible Fatherhood grants, and Supplemental Grants for Population Increase. When TANF reauthorization is considered, the Administration would be interested in exploring with Congress a variety of strategies to strengthen the program's ability to improve outcomes for families and children including helping more parents succeed as workers by building on the recent successes with subsidized employment; using performance indicators to drive program improvement; and preparing the program to respond more effectively in the event of a future economic downturn.

Enhancing the Quality of Early Care: The Budget proposes a reauthorization of the Child Care and Development Fund, and includes $6 billion in discretionary and mandatory funding. These resources will enable 1.7 million children to receive child care services. The Administration is proposing to reform the child care program through reauthorization legislation that serves more low-income children in safe, healthy, and nurturing child care settings that are highly effective in promoting early learning; supports parental employment and choice by providing information to parents on quality; promotes continuity of care; and strengthens program integrity and accountability Additionally, the President's Budget includes $8.1 billion for Head Start, which will continue to serve 968,000 children. The Administration is also working to implement key provisions of the Head Start Reauthorization, including requiring low-performing programs to compete for funding, that will improve program quality. These reforms and investments, in conjunction with the Administration's investments in the Early Learning Challenge Fund, are key elements of the Administration's broader education agenda designed to help every child reach his or her academic potential and improve our Nation's competitiveness.

Improving Health Outcomes of American Indian and Alaska Natives: The President is committed to improving health outcomes and providing health care for American Indian and Alaska Native communities. The Budget includes nearly $5.7 billion, an increase of $589 million, which will enable the Indian Health Service (IHS) to focus on reducing health disparities, ensuring that IHS services can be supplemented by care purchased outside the Indian health system where necessary, supporting Tribal efforts to deliver quality care, and funding health facility and medical equipment upgrades. These investments will ensure continued improvement to support the Administration's goal of significantly reducing health disparities for American Indians and Alaska Natives.

Transforming Food Safety: The Administration is committed to transforming our Nation's food safety system to one that is stronger and more reliable for American consumers. This Budget reflects the President's vision of a safer food safety system by including $1.4 billion, an increase of $333 million over FY 2010 for the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) food safety activities. Coupled with the enactment of the FDA Food Safety Modernization Act (the Act), which was signed into law on January 4, 2011, HHS will continue to modernize and implement an integrated National food safety system. HHS plans to work with Congress to enact additional food safety fees to support the full implementation of the Act. CDC will improve the speed and accuracy of foodborne illness outbreak detection and investigation, while FDA will focus on establishing produce safety standards and working with manufacturers to implement preventative controls in an effort

to avoid an outbreak of tainted food.

Preventing and Treating HIV/AIDS: The Budget supports the goals of the National HIV/AIDS Strategy to reduce HIV incidence, increase access to care and optimize health outcomes for people living with HIV, and reduce HIV-related health disparities. The request focuses resources on high-risk populations and allocates funds to State and local health departments to align resources to the burden of the epidemic across the United States. The Budget includes $2.4 billion, an increase of $85 million, for HRSA's Ryan White program to expand access to care for persons living with HIV/AIDS who are otherwise unable to afford health care and related support services. The Budget also includes $858 million for domestic HIV/AIDS Prevention in CDC, an increase of $58 million, which will help CDC decrease the HIV transmission rate; decrease risk behaviors among persons at risk for acquiring HIV; increase the proportion of HIV infected people who know they are infected; and integrate services for populations most at risk of HIV, sexually transmitted diseases, and viral hepatitis. In addition, the Budget proposes that up to one percent of HHS discretionary funds appropriated for domestic HIV/AIDS activities, or approximately $60 million, be provided to the Office of the Assistant Secretary for Health to foster collaborations across HHS agencies and finance high priority initiatives in support of the National HIV/AIDS Strategy. Such initiatives would focus on improving linkages between prevention and care, coordinating Federal resources within targeted high-risk populations, enhancing provider capacity to care for persons living with HIV/AIDS, and monitoring key Strategy targets.

Addressing the Leading Causes of Death and Disability: Chronic diseases and injuries represent the major causes of morbidity, disability, and premature death and contribute to the growth in health care costs. The Budget aims to improve the health of individuals by focusing on prevention of chronic diseases and injuries rather than focusing solely on treating conditions that could have been prevented. Specifically, the Budget includes $705 million for a new competitive grant program in CDC that refocuses disease-specific grants into a comprehensive program that will enable health departments to implement the most effective strategies to address the leading causes of death. Because many chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the burden of chronic disease. In addition, the allocation of the $1 billion available in the Prevention Fund will improve health and restrain the growth of health care costs through a balanced portfolio of investments. The FY 2012 allocation of the Fund builds on existing investments and aligns with the vision and goals of the National Prevention and Health Promotion Strategy under development. For instance, the CDC Community Transformation Grants create and sustain communities that support prevention and wellness where people live, learn, work and play through the implementation, evaluation, and dissemination of evidence-based community preventive health activities.

Preventing Substance Abuse and Mental Illness: The Budget includes $535 million within the Substance Abuse and Mental Health Services Administration (SAMHSA) for new, expanded, and refocused substance abuse prevention and mental health promotion grants to States and Tribes. To maximize the effectiveness and efficiency of its resources, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more thoughtfully and strategically. SAMHSA will use competitive grants to identify and test innovative prevention practices and will leverage State and Tribal investments to foster the widespread implementation of evidence-based prevention strategies through data driven planning and resource dissemination.

Ensuring Safety and Improving Access to Medical Products: FDA is the global leader for regulating medical products and the Administration is dedicated to ensuring that all drugs and medical devices that enter the market are safe and effective for the American consumer. The Budget provides $1.4 billion for FDA to enhance the safety oversight of medical products and to establish a pathway for the approval of generic biologics thus allowing greater access to life saving biological products that are safe and effective.

Supporting Older Adults and their Caregivers: The Budget includes $60 million, an increase of $21 million over FY 2010, to help seniors live in their communities without fear of abuse, and includes an increase of $96 million for caregiver services, like counseling, training, and respite care, to enable families to better care for their relatives in the community. The Budget also proposes to transfer a Department of Labor program that provides community service opportunities and job training to unemployed older adults to HHS. As part of this move, a new focus will be placed on developing professional skills that will enable participants to provide services that allow fellow seniors to live in their communities as long as possible.

Refugee Programs: The Budget requests $825 million to provide time limited cash and medical assistance to newly arrived refugees and to provide shelter for unaccompanied alien children until their claims for immigration relief are resolved or they can be placed with relatives or other sponsors. Major factors expected to increase costs are continued high unemployment, which increases the length of time newly arrived refugees need cash and medical assistance, and additional services, such as expanded home studies, required by the reauthorization of Unaccompanied Alien Children program. An additional $25 million is requested to provide emergency services to especially vulnerable refugees – widows, the elderly, the homeless, those with serious medical problems – who are struggling in the current economy.

Protecting Against Pandemic Influenza: While responding to the H1N1 influenza pandemic has been the focus of the most recent pandemic investments, the threat of a pandemic caused by H5N1 or other strains has not diminished. HHS is currently implementing pandemic preparedness activities in response to lessons learned from the H1N1 pandemic in order to strengthen the Nation's ability to respond to future health threats. Balances from the FY 2009 supplemental appropriations are being used to support recommendations from the HHS Medical Countermeasure Review and the President's Council of Advisors on Science and Technology. These multi-year activities include advanced development of influenza vaccines and the construction of a new cell-based vaccine facility in order to quickly produce vaccine in the U.S., as well as development of next generation antivirals, rapid diagnostics, and maintenance of the H5N1 vaccine stockpile.

In addition to pandemic influenza activities funded with existing balances, the Budget includes $242 million for ongoing pandemic influenza preparedness activities at the CDC, NIH, and FDA for international activities, virus detection, communications, and research. Just as previous pandemic influenza investments, including the development of rapid diagnostics to detect new strains and the development and procurement of adjuvants and antivirals, provided a strong platform for the H1N1 response, new and continued pandemic influenza activities will enhance the Nation's preparedness and protect Americans from future influenza outbreaks.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORKFORCE

Strengthening the Health Workforce: A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes $1.3 billion, including $315 million in mandatory funding, within HRSA to support a strategy which aims to promote a sufficient health workforce that is deployed effectively and efficiently and trained to meet the changing needs of the American people. The Budget will initiate investments that will expand the capacity of institutions to train over 4,000 new primary care providers over five years.

Expanding Public Health Infrastructure: The FY 2012 Budget supports State and local capacity so that health departments are not left behind. Specifically, the Budget requests $73 million, of which $25 million is funded in the Prevention Fund, for the CDC public health workforce to increase the number of trained public health professionals in the field. CDC's experiential fellowships and training programs create an effective, prepared, and sustainable health workforce to meet emerging public health challenges. In addition, the Budget requests $40 million in the Prevention Fund to support CDC's Public Health Infrastructure Program.

This program will increase the capacity and ability of health departments to meet national public health standards in areas such as information technology and data systems, workforce training, and regulation and policy development.

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILITY OF HHS PROGRAMS

Strengthening Program Integrity: Strengthening program integrity is a top priority of the President and the Secretary. The Budget includes $581 million in discretionary funding, a $270 million increase over FY 2010, to expand prevention-focused, data-driven, and innovative initiatives to improve CMS program integrity. The Budget request also supports the expansion of up to 20 Strike Force cities to target Medicare fraud in high risk areas and the President's goal of cutting the Medicare fee-for-service error rate in half by 2012. The proposed ten year discretionary investment yields $10.3 billion in Medicare and Medicaid savings, a return of about $1.5 to $1 for every dollar spent. In addition, the Budget includes a robust package of program integrity legislative proposals to expand HHS program integrity tools and produce $32.3 billion in savings over ten years.

In addition, the Affordable Care Act provides unprecedented tools to CMS and law enforcement to enhance Medicare, Medicaid, and Children's Health Insurance Program (CHIP) program integrity. The Act enhances provider screening to stop fraudsters from participating in these programs in the first place, gives the Secretary the authority to implement temporary enrollment moratoria for fraud hot spots, and increases law enforcement penalties. Additionally, the continued implementation of the Secretary's Program Integrity Initiative seeks to ensure that every program and office in HHS prioritizes the identification of systemic vulnerabilities and opportunities for waste and abuse, and implements heightened oversight.

Implementing the Recovery Act: The American Recovery and Reinvestment Act provides $138 billion to HHS programs as part of a government-wide response to the economic downturn. HHS-funded projects around the country are working to achieve the goals of the Recovery Act by helping State Medicaid programs meet increasing demand for health services; supporting struggling families through expanded child care services and subsidized employment opportunities; and by making long-term investments in health information technology (IT), biomedical research and prevention and wellness efforts. HHS made available a total of $118 billion to States and local communities through December 31, 2010; recipients of these funds have in turn spent $100 billion by the same date. Most of the remaining funds will support a signature Recovery Act program to provide Medicare and Medicaid incentive payments to hospitals and eligible health care providers as they demonstrate the adoption and meaningful use of electronic health records. The first incentive payments were made January 5, 2011. More than 23,000 grantees and contractors of HHS discretionary programs have to submit reports on the status of their projects each calendar quarter. These reports are available to the public on Recovery.gov. For the quarter ending December 31, 2010, 99.6 percent of the required recipient reports were filed timely. Recipients that do not comply with reporting requirements are subject to sanctions.

HHS BUDGET BY OPERATING DIVISION

(mandatory and discretionary dollars in millions)

	2010	2011	2012
Food and Drug Administration			
Program Level	3,286	3,373	4,360
Budget Authority	2,601	2,364	2,746
Outlays	2,117	2,339	2,608
Health Resources and Services Administration			
Budget Authority	8,387	11,289	9,198
Outlays	8,569	9,595	10,479
Indian Health Service			
Budget Authority	4,202	4,202	4,773
Outlays	4,350	4,442	4,862
Centers for Disease Control and Prevention			
Budget Authority	6,787	7,135	6,702
Outlays	6,957	6,670	7,122
National Institutes of Health			
Budget Authority	30,934	30,936	31,979
Outlays	33,052	33,201	33,802
Substance Abuse and Mental Health Services			
Budget Authority	3,431	3,520	3,387
Outlays	3,325	3,440	3,483
Agency for Healthcare Research and Quality			
Program Level	403	417	390
Outlays	80	103	299
Centers for Medicare & Medicaid Services[1]			
Budget Authority	734,057	787,722	778,119
Outlays	732,896	787,165	776,981
Administration for Children and Families			
Budget Authority	51,659	50,681	50,682
Outlays	56,370	55,188	51,252
Administration on Aging			
Budget Authority	1,523	1,526	2,447
Outlays	1,512	1,488	1,966
Office of the National Coordinator			
Budget Authority	42	42	57
Outlays	115	540	400
Medicare Hearings and Appeals			
Budget Authority	71	71	81
Outlays	64	71	81
Office for Civil Rights			
Budget Authority	41	41	47
Outlays	34	35	46

[1]Budget Authority includes Non-CMS Budget Authority for Hospital Insurance and Supplementary Medical Insurance for the Social Security Administration and MEDPAC.

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2010	2011	2012
Departmental Management			
Budget Authority	539	536	524
Outlays	497	450	565
Prevention and Wellness			
Recovery Act Budget Authority	-	-	-
Outlays	10	8	31
Health Insurance Reform Implementation Fund[2]			
Budget Authority	1,000	-	-
Outlays	21	450	420
World Trade Center Health Program Fund			
Budget Authority	-	70	313
Outlays	-	63	301
Public Health and Social Services Emergency Fund			
Budget Authority	3,982	1,040	595
Outlays	4,890	4,367	2,755
Office of Inspector General			
Budget Authority	75	50	53
Outlays	91	107	62
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)			
Budget Authority	646	638	686
Outlays	575	627	682
Offsetting Collections			
Budget Authority	-1,351	-1,277	-6,580
Outlays	-1,351	-1,277	-6,580
Total, Health and Human Services			
Budget Authority	**848,626**	**900,586**	**885,789**
Outlays	**854,174**	**909,072**	**891,597**
Full-Time Equivalents	71,047	73,051	75,808

[2]Includes outlays for all agencies receiving resources from the fund.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2010	2011	2012
Discretionary Programs (Budget Authority)			
Food and Drug Administration	2,364	2,362	2,744
FDA Program Level	*3,286*	*3,373*	*4,360*
Health Resources and Services Administration 1/ & 2/	7,492	7,480	6,808
HRSA Program Level	*8,072*	*10,879*	*9,046*
Indian Health Service	4,052	4,052	4,624
IHS Program Level	*5,100*	*5,116*	*5,689*
Centers for Disease Control and Prevention 3/	6,474	6,475	5,894
CDC Program Level	*10,884*	*11,395*	*11,255*
National Institutes of Health	31,084	30,785	31,829
NIH Program Level	*31,243*	*30,943*	*31,987*
Substance Abuse and Mental Health Services Administration	3,431	3,432	3,387
SAMHSA Program Level	*3,583*	*3,651*	*3,649*
Agency for Healthcare Research and Quality	--	--	--
AHRQ Program Level	*403*	*417*	*390*
Centers for Medicare & Medicaid Services 4/	3,368	3,423	4,397
CMS Program Level (Excluding Discretionary HCFAC) 5/ & 6/	*4,393*	*4,839*	*5,410*
Administration for Children and Families	17,333	17,336	16,179
ACF Program Level	*17,339*	*17,342*	*16,185*
Administration on Aging 7/ & 8/	2,388	2,389	2,238
AoA Program Level	*2,432*	*2,402*	*2,251*
General Departmental Management 3/	490	490	364
OS Program Level	*603*	*613*	*663*
Office for Civil Rights	41	41	47
Office of the National Coordinator	42	42	57
ONC Program Level	*61*	*61*	*78*
Medicare Hearings and Appeals	71	71	81
Office of Inspector General	50	50	53
OIG Program Level	*290*	*290*	*366*
Health Care Fraud and Abuse Control (Discretionary)	*311*	311	581
HCFAC Program Level (inc. all Medicaid Integrity)	*1,559*	*1,785*	*1,930*
Public Health and Social Services Emergency Fund 9/	957	1,042	595
PHSSEF Program Level	*1,566*	*1,347*	*1,360*
Health Insurance Reform Implementation Fund	*107*	*538*	--
Medicare Eligible Health Care Accruals (Comm. Corps)	*36*	*38*	*39*
World Trade Center (Mandatory)	--	70	313
Offset for PHS Evaluation Funds (Prog. Level)	-1,004	*-1,004*	*-1,479*
HCFAC Funds in Agency Prog. Levels or DOJ 10/	*-452*	*-486*	*-611*
Total, Discretionary Budget Authority	**79,987**	**79,820**	**79,915**
Total, Program Level	***89,611***	***93,721***	***93,010***
Discretionary Outlays	**89,255**	**90,677**	**87,405**

1/ Comparable adjustment to Program Level in FY 2010 and FY 2011 to reflect proposed transfer of Health Education Assistance Loan program to Department of Education.

2/ For comparability with the FY 2012 request, the FY 2010 budget totals for HRSA include all funding that was reallocated or transferred to support State AIDS drug programs in FY 2010. Of this amount, $3 million is technically FY 2009 Budget Authority.

3/ CDC and GDM comparability adjustment in FY 2010 and FY 2011 to show the transfer of Office of Global Health Affairs activities to CDC.

4/ The CMS Program Management budget authority for FY 2010 differs from the presentation in the President's Budget, which misclassified approximately $320 million of mandatory funding as discretionary.

5/ Excludes One-Time ACA funding within Program Level.

6/ The FY 2010 level does not include $55 million in funding for State High Risk Pools, which was re-based as mandatory rather than discretionary.

7/ The FY 2010 and FY 2011 levels include a comparability adjustment to reflect the transfer of the State Health Insurance and Assistance Program from CMS to AoA.

8/ FY 2010 and FY 2011 comparably adjusted to reflect transfer of the Senior Community Service Employment Program to AoA from the Department of Labor.

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

10/ In addition to HCFAC amounts in Agency program levels, $25 million is shown in OIG for Medicaid Integrity (FY 2010); and the following amounts transferred to the Department of Justice (DOJ): $211 million in FY 2010, $220 million in FY 2011 and $283 million in FY 2012.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2010	2011	2012
Mandatory Programs (Outlays):			
Medicare	446,616	489,319	485,804
Medicaid	272,771	276,249	269,068
Temporary Assistance for Needy Families 1/	20,420	19,477	18,049
Foster Care and Adoption Assistance	6,972	6,892	7,236
Children's Health Insurance Program 2/	7,887	9,169	9,981
Child Support Enforcement	4,423	3,619	3,780
Child Care	2,723	2,741	3,477
Social Services Block Grant	2,035	2,011	1,802
Other Mandatory Programs	2,423	10,195	11,595
Offsetting Collections	-1,351	-1,277	-6,600
Subtotal, Mandatory Outlays	764,919	818,395	804,192
Total, HHS Outlays	**854,174**	**909,072**	**891,597**

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

2/ Includes outlays for the Child Enrollment Contingency Fund in FY 2011 and FY 2012.

RECOVERY ACT

(dollars in millions)

Discretionary Programs

	Total Resources Available	Outlays 2009-2010	Outlays 2011	Outlays 2012
Health Resources and Services Administration				
Health Centers Modernization, Renovation, and Repair	1,500	514	361	360
Health Center Services	500	363	137	0
National Health Service Corps	300	153	108	13
Health Professions	200	45	115	15
Subtotal, Health Resources and Services Administration	**2,500**	**1,075**	**721**	**388**
Indian Health Service				
Buildings and Facilities /1	415	265	91	50
Health Information Technology	85	63	16	6
Subtotal, Indian Health Service	**500**	**328**	**108**	**56**
National Institutes of Health				
Scientific Research	8,200	2,948	3,280	1,704
Extramural Lab Construction and Renovation	1,000	18	82	100
Buildings and Facilities	500	50	123	145
Shared Instrumentation grants/contracts	300	96	114	60
Subtotal, National Institutes of Health	**10,000**	**3,113**	**3,599**	**2,009**
Administration for Children and Families				
Child Care and Development Block Grant (CCDBG)/2	2,000	1,377	623	0
Early Head Start	1,100	332	768	0
Head Start	1,000	499	415	59
Community Services Block Grant (CSBG)	1,000	820	179	0
Strengthening Communities Fund	50	15	31	4
Subtotal, Administration for Children and Families	**5,150**	**3,044**	**2,016**	**63**
Administration on Aging				
Congregate Nutrition Services	65	60	5	0
Home-Delivered Nutrition Services	32	30	2	0
Native American Nutrition Services	3	2	1	0
Subtotal, Administration on Aging	**100**	**92**	**8**	**0**
Office of the Inspector General	**17**	**7**	**5**	**5**
HHS Information Technology Security	**50**	**38**	**12**	**0**
Health Information Technology (ONC) /3	**2,000**	**58**	**503**	**882**
Prevention and Wellness				
Section 317 Immunization Program (CDC)	300	202	98	0
Healthy Communities Initiative (CDC,AoA, OS)	650	32	355	187
Healthcare Associated Infections (CDC, CMS)	50	10	30	10
Subtotal, Prevention and Wellness	**1,000**	**244**	**483**	**197**
Patient-Centered Health Research/Comparative Effectiveness				
AHRQ	300	18	66	127
NIH	400	88	150	140
Department-wide	400	17	77	160
Subtotal, Patient-Centered Health Research	**1,100**	**123**	**293**	**427**
Total, HHS Recovery Act Discretionary Outlays	**22,417**	**8,122**	**7,748**	**4,027**

1/ This does not include $90 million in Sanitation funds from EPA.

2/ Includes $9.8 million transferred to the Department of the Interior/Buraeu of Indian Affairs.

3/ These funds remain available though Dec. 31, 2012. Total resources and outlays include $20 million transferred per statute to the National Institute of Standards and Technology (NIST) in the Department of Commerce.

RECOVERY ACT

(dollars in millions)

Mandatory Programs

	Outlays			
	2009 -2021	**2009 - 2010**	**2011**	**2012**
Centers for Medicare & Medicaid Services (CMS)				
Medicaid				
Temporary Increase in Medicaid FMAP/1	84,512	71,012	13,500	0
Temporary Increase in Disproportionate Share Hospital Payments	234	234	0	0
Transitional Medical Assistance (TMA) Extension/2	915	510	395	10
Qualified Individuals (QI) Extension	417	267	150	0
Protections for Indians under Medicaid and CHIP/2	190	15	10	10
Interaction of FMAP Increase with other Medicaid Provisions	115	95	20	0
Subtotal, Medicaid	**86,383**	**72,133**	**14,075**	**20**
Medicare & Medicaid Health Information Technology Incentives				
Medicare Incentives to Providers	5,590	0	640	2,830
Medicaid Incentives to Providers	12,351	0	1,619	854
State Administrative Costs for Medicaid HIT Implementation	1,592	9	140	144
Subtotal, Medicare & Medicaid HIT Incentive Payments	**19,533**	**9**	**2,399**	**3,828**
CMS Administration				
Medicare HIT Implementation	745	13	140	173
Medicaid HIT Implementation	300	3	51	47
Subtotal, CMS Administration of HIT Incentive Payments	**1,045**	**16**	**191**	**220**
Total, CMS HIT Funding (non-add)	*20,578*	*25*	*2,590*	*4,048*
Medicare				
Moratorium on Medicare Regulations (Hospice, IME Reduction)/3	200	300	**	**
Medicare Moratoria CMS Administration	2	2	0	0
Subtotal, Medicare	**202**	**302**	**0**	**0**
Administration for Children and Families				
TANF Emergency Fund/4	5,000	2,681	1,972	232
TANF Supplemental Grants	319	231	88	0
Child Support Enforcement	1,955	1,413	542	0
FMAP Increase for Foster Care and Adoption Assistance/1	922	667	211	41
Subtotal, Administration for Children and Families	**8,196**	**4,991**	**2,813**	**273**
Medicaid and Foster Care FMAP Increase Implementation	**5**	**4**	**1**	**
Office of the Inspector General	**31**	**9**	**19**	**3**
Total, HHS Recovery Act Mandatory Outlays	**115,395**	**77,464**	**19,498**	**4,344**
Total, HHS Recovery Act Discretionary Outlays	**22,417**	**8,122**	**7,748**	**4,027**
Total, HHS Recovery Act Outlays	**137,812**	**85,586**	**27,245**	**8,371**

** Numbers round to zero.

1/ Amounts reflect FMAP assistance provided in the Recovery Act (P.L. 111-5), available through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act (P.L. 111-226) extended the enhanced FMAP provision at a phased-down rate through June 30, 2011, providing an estimated $13.6 billion in additional assistance for Medicaid and Foster Care, Adoption Assistance and Guardianship.

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

3/ Policies had costs of $300 million in FY 2009, and small savings in each year thereafter, resulting in a net cost of $200 million.

4/ This estimate includes $8.4 million transferred to the Department of the Interior's Bureau of Indian Affairs.

*Actual obligations and outlays are reported to HHS on a weekly basis. For the most up-to-date information on obligations and outlays, see the website: www.hhs.gov/recovery.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Program				
Foods	783	781	1,035	+252
Human Drugs	877	941	1,152	+275
Biologics	304	318	368	+64
Animal Drugs and Feeds	155	155	176	+22
Medical Devices	367	367	395	+28
National Center for Toxicological Research	59	59	60	+2
Center for Tobacco Products	217	217	455	+238
Headquarters and Office of the Commissioner	198	203	289	+91
FDA Consolidation at White Oak	41	42	69	+27
GSA Rental Payments	171	173	214	+44
Other Rent and Rent Related Activities	88	91	124	+36
Export/Color Certification Fund	10	10	10	--
Subtotal, Salaries and Expenses	3,270	3,357	4,347	+1,077
Buildings and Facilities	12	12	13	+1
National Center for Natural Products Research	3	3	--	-3
Total, Program Level	**3,286**	**3,373**	**4,360**	**+1,074**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA)	578	667	856	+278
Medical Device (MDUFMA)	57	57	67	+10
Animal Drug (ADUFA)	17	17	22	+4
Animal Generic Drug	5	5	6	+1
Mammography Quality Standards Act (MQSA)	19	19	19	--
Family Smoking Prevention and Tobacco Control Act	235	235	477	+242
Export/Color Certification Fund	10	10	10	--
Voluntary Qualified Importer Program (VQIP) Fee	--	--	71	+71
Food and Feed Export Certification Fee	--	--	1	+1
Food Reinspection Fee	--	--	15	+15
Food Recall Fee	--	--	12	+12
Subtotal, Current Law User Fees	922	1,011	1,557	+634
Proposed Law				
Medical Products Reinspection Fee	--	--	14	+14
Human Generic Drug	--	--	40	+40
International Courier User Fee	--	--	5	+5
Subtotal, Proposed Law User Fees	--	--	60	+60
Total, User Fees	**922**	**1,011**	**1,616**	**+694**
Total, Budget Authority	**2,364**	**2,362**	**2,744**	**+380**
Initiative				
FDA Food Safety (non-add)	1,051	1,049	1,375	+324
FTE	12,381	12,381	14,436	+2,055

FOOD AND DRUG ADMINISTRATION

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

The FY 2012 Budget requests $4.4 billion for the Food and Drug Administration (FDA), a net program level increase of $1 billion, or 33 percent, over FY 2010. The FDA Budget includes increased investments to implement the newly enacted FDA Food Safety Modernization Act, advance medical countermeasures, improve the safety of the Nation's drugs, and other medical products, and further develop and implement public health strategies to prevent youth from using tobacco and help adults to quit.

TRANSFORMING OUR FOOD SAFETY SYSTEM

FDA plays a critical role in helping to ensure that the food we eat is safe. On January 4, 2011, President Obama signed into law historic food safety legislation which contains broad new authorities for FDA. These authorities include mandatory recall of tainted food and the ability to require food producers to implement preventative controls. This new law complements actions that the Administration has already taken to improve food safety and addresses many of the key recommendations of the President's Food Safety Working Group, including support for an approach to food safety that leverages the efforts of Federal, State, and local regulatory and public health agencies.

In FY 2012, with an increase in food safety resources of $324 million, and a total funding level of $1.4 billion, FDA will continue to develop and implement an integrated national food safety system built on uniform regulatory program standards, and strong oversight of the food supply.

IMPROVING NUTRITION

In FY 2012, FDA will conduct extensive outreach and education to assist in the implementation of new menu and vending machine labeling requirements as provided in the Affordable Care Act. FDA will train State, local and tribal officials on the new requirements provided in the statute and will provide funding through contracts to these entities to conduct inspections for compliance.

ADVANCING MEDICAL COUNTERMEASURES

In recognition of our Nation's vulnerability to deliberate terrorist threats and naturally emerging infectious diseases, President Obama announced the Medical Countermeasure Initiative in his 2010 State of the Union Address. In August 2010, HHS released a report of an extensive review of the Federal government's system to develop medical countermeasures (MCM). This report contained key steps the Administration would take to modernize the Nations's MCM enterprise. As the Secretary stated, "Our Nation must have a system that is nimble and flexible enough to produce medical countermeasures quickly in the face of an attack or threat…By moving towards a 21st century countermeasures enterprise with a strong base of discovery, a clear regulatory pathway, and agile manufacturing, we will be able to respond faster and more effectively to public health threats." To implement this initiative, the Budget proposes an increase of $70 million for advancing MCMs at FDA.

FDA Food Safety Modernization Act

On January 4, 2011, President Obama signed into law, the FDA Food Safety Modernization Act; historic food safety legislation that will enable FDA to better protect the public's health by strengthening America's food safety system. This law allows FDA to focus more on prevention food safety problems rather than primarily reacting to these problems after they occur. For the first time, FDA will have the ability to establish and require that manufacturers set product safety standards and implement preventative controls for food facilities. Building a new food safety system based on prevention will take time, and FDA is committed to an open process with opportunity for input from all stakeholders.

These funds are in addition to the $170 million allocated to FDA for MCM activities that was provided in the FY 2011 Budget Amendment. With these resources, FDA will establish teams of public health experts to support the review of medical countermeasures and novel approches to manufacturing MCMs. FDA will also examine the legal framework and the regulatory and policy approaches for MCM development and availability to ensure that they adequately support emergency preparedness and response.

PROTECTING PATIENTS

FDA is the global leader for regulating medical products, and FDA regulatory actions assure that Americans have access to thousands of drugs and devices that are safe and effective for treating everything from seasonal allergies to life-threatening cancers. The FY 2012 Budget request will provide an investment of $1.4 billion for medical product safety, which is an increase of $124 million above FY 2010. This increase will allow FDA to invest in tools to assure the safety of increasingly complex drugs, medical devices, and biological products. The Budget also supports greater access to affordable generic drugs and biologic products. In FY 2012, the Budget requests an additional $15 million to allow FDA to begin to establish a regulatory pathway for the approval of generic biologic products as authorized by the Affordable Care Act.

REDUCING TOBACCO USE

On June 22, 2009, the President signed the Family Smoking Prevention and Tobacco Control Act, which provided FDA important new responsibilities for regulating the manufacture, marketing and distribution of tobacco products, protecting public health and reducing tobacco use by minors. In FY 2012, FDA will build on the regulatory and enforcement initiatives to protect the public health that began in FY 2009 including: banning the sale of cigarettes with fruit and clove flavors and prohibiting the use of descriptors such as "light," "low," and "mild" from tobacco products. FDA will also continue its work to establish a list of harmful and potentially harmful ingredients of tobacco products. In total, the Budget includes $477 million in user fees for FDA to implement the new tobacco control law.

USER FEES

The Budget proposes one new user fee, re-proposes two fees, and provides increases in existing user fees, which will afford critical resources to FDA to perform its public health mission. These fees are additive in nature and support specific activities conducted by FDA.

The new international courier user fee provides $5 million to support the activities related to the increased volume of FDA-regulated commodities, predominantly medical products, imported through express courier hubs. The generic drug user fee of $40 million will give Americans greater access to safer and more affordable generic drugs. The reinspection fees, totaling $14 million, for medical products require manufacturers to pay the full costs of reinspections and associated follow-up work if they fail to meet FDA health and safety standards during an inspection. As authorized by law, the Budget also provides an additional $634 million for current law user fees including the four new user fees authorized in the FDA Food Safety Modernization Act.

REGULATORY SCIENCE AND FDA FACILITIES

The Budget requests $69 million for headquarters consolidation at the new FDA campus in White Oak, Maryland. These resources include $24 million to operationalize the Life Sciences Biodefense Laboratory at the White Oak facilities and will enable FDA to continue to transition to the newly consolidated facility under construction by the General Services Administration (GSA).

Access to Generic Biologics

The Affordable Care Act requires FDA to establish a regulatory pathway for approving generic biologics. The number and importance of biological products used to manage serious diseases is steadily increasing. In many cases, a brand name biological product costs $15,000 to $150,000 or more per patient per year. Unfortunately, evidence suggests that patients who are not able to afford expensive biological products may suffer severe adverse health consequences. Providing FDA the authority to approve generic biologic versions of these biological products not only offers the potential for substantial savings, but also allows for greater patient access to these life saving products.

The Life Sciences Biodefense lab is an essential facility in protecting the Nation's blood supply and other biological products from emerging threats.

The Budget also requests an increase of $44 million for GSA rental payments and other rent and rent related costs. In FY 2012, the Budget provides $13 million to pay for necessary repair and maintenance of FDA-owned facilities nationwide.

FDA-TRACK

FDA has created FDA-TRACK, the first Federal agency-wide performance management program. FDA-TRACK analyzes and reports monthly performance on 114 offices and eight key initiatives. Each quarter, the FDA-TRACK team analyzes monthly performance data from each office and initiative, and FDA conducts more than 20 briefings where responsible office directors present data to the FDA leadership, bringing together the most senior officials to facilitate face-to-face communication, performance analysis, and decision making. Results are posted on the FDA-TRACK website (http://www.fda.gov/AboutFDA/Transparency/Track/), allowing the public to monitor progress on over 600 performance measures and 100 key projects. To date, the website has attracted over 100,000 visitors and 5,000 monthly subscribers, and was selected as a flagship initiative for the HHS Open Government Plan.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Primary Care				
Health Centers	2,141	3,146	3,222	+1,080
ACA Mandatory (non-add)	--	1,000	1,200	+1,200
Health Centers Tort Claims	44	44	96	+52
School Based Health Centers (ACA Mandatory)	50	50	50	--
Health Centers Construction (ACA Mandatory)	--	1,500	--	--
Free Clinics Medical Malpractice	.04	.04	.04	--
Hansen's Disease Programs	18	18	18	--
Subtotal, Primary Care	2,253	4,758	3,386	+1,133
Health Workforce				
National Health Service Corps	141	432	418	+277
ACA Mandatory (non-add)	--	290	295	+295
Training for Diversity	97	97	108	+11
Health Workforce Information and Analysis	3	3	20	+17
Primary Care Training and Enhancement	237	39	140	-97
ACA Prevention Fund (non-add)	200	--	--	-200
Oral Health Training	33	33	50	+17
Interdisciplinary, Community-Based Linkages	72	72	97	+25
Geriatric Programs (non-add)	34	34	44	+10
Behavioral Health Education and Training (non-add)	3	3	18	+15
State Health Workforce Development Grants	6	--	51	+45
ACA Prevention Fund (non-add)	5	--	--	-5
Teaching Health Centers Planning Grants	--	--	10	+10
Public Health Workforce Development	24	30	25	+1
ACA Prevention Fund (non-add)	15	20	15	--
Nursing Workforce Development	290	244	333	+43
ACA Prevention Fund (non-add)	45	--	--	-45
Nursing Workforce Diversity (non-add)	16	16	20	+4
Comprehensive Geriatric Education (non-add)	5	5	5	--
Home Health Aide Demonstration Project (ACA Mandatory)	5	5	5	--
Children's Hospital Graduate Medical (GME) Education Payments	317	318	--	-317
Teaching Health Centers GME Payments (ACA Mandatory)	--	230	--	--
Patient Navigator	5	5	--	-5
Subtotal, Health Workforce	1,230	1,507	1,257	+27
Maternal and Child Health				
Maternal and Child Health Block Grant	661	662	654	-6
Heritable Disorders	10	10	10	--
Congenital Disabilities	.50	.50	.50	--
Autism and Other Developmental Disorders	48	48	55	+7
Traumatic Brain Injury	10	10	10	--
Sickle Cell Service Demonstrations	5	5	5	--
Universal Newborn Hearing Screening	19	19	19	--
Emergency Medical Services for Children	21	22	21	--
Healthy Start	105	105	105	--
Home Visiting (ACA Mandatory)	100	250	350	+250
Family to Family Health Information Centers (ACA Mandatory)	5	5	5	--
Subtotal, Maternal and Child Health	984	1,136	1,235	+251

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
HIV/AIDS				
Emergency Relief - Part A	679	679	679	--
Comprehensive Care - Part B	1,279	1,254	1,359	+80
AIDS Drug Assistance Program (ADAP) (non-add)	835	835	880	+45
AIDS Drug Assistance (Supplemental) (non-add)	25	--	60	+35
Early Intervention - Part C	206	207	212	+5
Children, Youth, Women, and Families - Part D	78	78	78	--
Education and Training Centers - Part F	35	35	35	--
Dental Services - Part F	14	14	14	--
Public Health Service (PHS) Act Evaluation Funds	25	25	25	--
Subtotal, HIV/AIDS	2,315	2,291	2,401	+85
Health Care Systems				
Organ Transplantation	26	26	26	--
Cord Blood Stem Cell Bank	12	12	14	+2
C.W. Bill Young Cell Transplantation Program	23	24	27	+3
Poison Control Centers	29	29	29	--
340B Drug Pricing Program	2	2	10	+8
User Fee (non-add)	--	--	5	+5
Medical School Development (ACA Mandatory)	100	--	--	-100
State Health Access Grants	74	75	--	-74
Subtotal, Health Care Systems	267	168	101	-166
Rural Health				
Rural Health Policy Development	10	10	10	--
Rural Health Outreach Grants	56	56	57	+1
Rural & Community Access to Emergency Devices	3	3	--	-3
Rural Hospital Flexibility Grants	41	41	26	-15
Delta Health Initiative	35	35	--	-35
State Offices of Rural Health	10	10	10	--
Denali Project	10	10	--	-10
Radiogenic Diseases	2	2	2	--
Black Lung	7	7	7	--
Telehealth	12	12	12	--
Subtotal Rural Health	185	186	124	-61
Other Activities				
Healthy Weight Collaborative (ACA Prevention Fund)	5	--	5	--
Congressional Projects	337	338	--	-337
Family Planning	317	317	327	+11
Program Management	147	147	171	+24
Vaccine Injury Compensation Program Direct Operations	7	7	7	--
Health Education Assistance Loan Direct Operations 1/	--	--	--	--
National Practitioner Data Bank (User Fees) 2/	24	24	28	+5
Total, Program Level	8,072	10,879	9,046	+975
Less Funds From Other Sources				
PHS Evaluation Funds	-25	-25	-280	-255
User Fees	-24	-24	-33	-10
ACA Mandatory Funding	-260	-3,330	-1,905	-1,645
ACA Prevention Fund	-271	-20	-20	+251
Total Funding from Other Sources	-579	-3,399	-2,238	-1,659
Total, Budget Authority 3/	7,492	7,480	6,808	-684
FTE	1,602	1,750	1,695	+93

1/ FY 2010 and FY 2011 funding levels are shown comparably to reflect the proposed transfer of the program to the Department of Education.

2/ The Healthcare Integrity and Protection Data Bank will be merged into the National Practitioner Data Bank in FY 2012. The FY 2010 and FY 2011 funding levels are shown comparably.

3/ For comparability with the FY 2012 request, the FY 2010 budget totals for HRSA include all funding that was reallocated or transferred to support State AIDS drug programs in FY 2010. Of this amount, $3 million is technically FY 2009 Budget Authority.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

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

The FY 2012 Budget includes $9 billion for the Health Resources and Services Administration, a net increase of $975 million above the FY 2010 program level. HRSA is the principal Federal agency charged with improving access to health care to those in medically underserved areas and enhancing the capacity of the health care workforce.

BUILDING A HEALTH WORKFORCE FOR THE 21ST CENTURY

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

The Budget includes $1.3 billion, including $315 million in mandatory funding, to support a health workforce strategy that expands the capacity and improves the distribution of the primary care workforce; encourages interprofessional training; focuses on elder care; reduces disparities in the health workforce; and develops the capacity to track and analyze health workforce-related data.

The Budget does not request funding to subsidize the fewer than 60 freestanding children's hospitals that currently receive monthly graduate medical education payments.

Primary Care Workforce Capacity and Distribution: In addition to supporting a record-high National Health Service Corps field strength of 10,680, the Budget will expand the Nation's capacity to train over 4,000 new primary care providers—including physicians, physician assistants, and nurse practitioners—over five years. This primary care focus is part of a total investment of $1 billion, including $310 million made available through the Affordable Care Act, to continue the President's initiative to increase the number and improve the distribution of primary care, dental, public health, and behavioral health providers.

Team-Based Care: New, innovative models for the delivery of health care services that employ team-based care—including medical homes and accountable care organizations—hold promise for a more effective and efficient health care system. The Budget includes new cross-programmatic initiatives which will support training and practice reforms to ensure that health professionals can work more effectively within interprofessional teams.

Geriatrics and Elder Care: The Budget includes $54 million, an increase of $11 million over FY 2010, to improve access to quality health care for America's growing elderly population by educating both students and practitioners in the care of geriatric patients.

Diversity: The Budget includes $163 million, an increase of

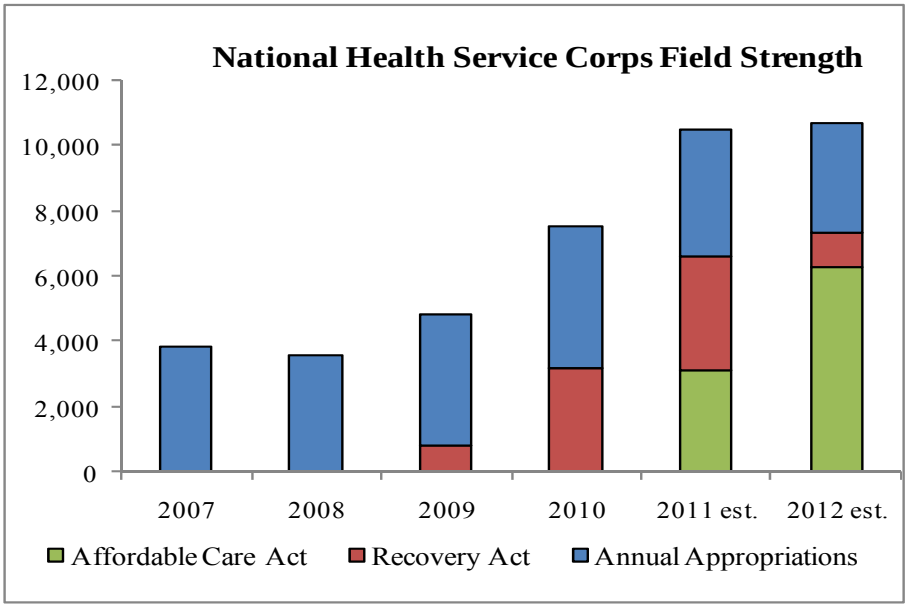
Strengthening the Primary Care Workforce

Experts have long projected a shortage of primary care providers due to an aging population and a decline in the number of medical students choosing primary care. As more Americans gain health insurance coverage through the Affordable Care Act, it is vital that investments be made in the Nation's primary care workforce to ensure that these Americans have access to the quality, affordable services they need to stay healthy.

In FY 2010, HRSA awarded $250 million to support the training of 1,700 new primary care providers over five years and help States develop plans to increase their primary care workforce by 10 to 25 percent. The Budget builds on this progress by initiating investments that will train an additional 4,000 primary care providers.

$16 million over FY 2010, to improve the diversity of the Nation's health workforce. Increasing the diversity of the health workforce is key to reducing health disparities related to socioeconomic, geographic, and ethnicity factors.

***Data and Analysis*:** The Budget includes $20 million, an increase of $17 million over FY 2010, to support the National Center for Health Workforce Analysis. The Nation currently lacks cohesive and comprehensive information on the health workforce. Such data is essential for developing an approach to assessing and addressing health workforce shortages. The Budget will support the Center's work to develop reliable methodologies to analyze the Nation's health workforce and provide accurate data to inform both public and private policies and investments.



IMPROVING ACCESS TO HEALTH CARE IN UNDERSERVED AREAS

Health Centers: The Budget includes $3.3 billion for Health Centers, including $1.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund. Through continued investments in new access points and medical capacity expansion, the Health Center program will support more than 1,100 grantees that will provide comprehensive primary health care services to 24 million patients at more than 8,000 delivery sites.

Within the total for Health Centers, $96 million, an increase of $52 million, will support medical malpractice coverage for an increasing number of Health Center clinicians.

Improving Rural Health: The FY 2012 Budget includes $124 million, a reduction of $61 million, for targeted rural health programs. This includes $57 million, an increase of $1 million, to implement collaborative models to improve health care access and quality for the 55 million Americans living in rural areas. This total also includes $26 million to continue funding for all continuing Rural Hospital Flexibility grants; $20 million for research, technical assistance, and policy development to improve rural health outcomes; $12 million to expand access to quality care through telecommunications; and $7 million for screening and care for miners with occupation-related impairments. No funding is requested to continue congressionally-directed projects as such activities can be effectively accomplished through the competitive grant process.

PROTECTING AT-RISK POPULATIONS

HIV/AIDS: The Ryan White program provides services that reach over half a million individuals each year, representing the Federal government's largest investment in the wellbeing of people living with HIV/AIDS. The FY 2012 request supports the President's National HIV/AIDS Strategy by including $2.4 billion, an increase of $85 million, to address the unmet health needs of people living with HIV by providing primary health care and vital health-related support services that enhance access to and retention in care. Within the total referenced above, $940 million supports AIDS drug assistance, an increase of $80 million to support States that are struggling to meet their population's pharmaceutical needs for HIV care.

Making Prescription Drugs Affordable: The FY 2012 request includes $10 million to improve access to potentially lifesaving drugs, an increase of $8 million above FY 2010 through the 340B program. Of the total requested, $5 million is funded through a new cost recovery fee, which will support increased monitoring of compliance with required price ceilings through manufacturers' reporting, as the program expands to include authorized activities from the Affordable Care Act. Participants in the 340B program include health centers, Indian Health Service tribal clinics, sexually transmitted disease and tuberculosis programs, and children's hospitals.

SUPPORTING HEALTHY FAMILIES

The Budget includes $1.6 billion to support healthy families through key investments in maternal and child health, and family planning services.

Improving Maternal and Child Health: The FY 2012 Budget provides $1.2 billion to improve maternal and child health. This includes $350 million in mandatory funding provided through Affordable Care Act to identify and implement evidence-based home visiting programs to improve health and developmental outcomes for families in at-risk communities. The request includes $654 million, a reduction of $6 million, for the Maternal and Child Health Block Grant, and directs more funds to States through the elimination of categorical projects. The Budget includes $105 million, the same level as FY 2010, for 104 Healthy Start programs that reduce the incidence of risk factors that contribute to infant mortality and provide services to mothers in high-risk communities. Additionally, $55 million, a $7 million increase, is included for the President's Initiative to support children with autism spectrum disorders and their families through research, screening, and the promotion of evidence-based interventions.

Supporting Transplantation

Each year, nearly 18,000 people in the United States are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is the best treatment option. The C.W. Bill Young Cell Transplantation Program works to facilitate an increase in the number of unrelated blood stem cell transplants for patients in need, including for racial/ethnic minorities who have historically faced challenges in finding suitably matched donors.

In FY 2010, nearly 2.5 million potential stem cell donors of minority race/ethnicity were listed on the Program's donor registry, up from 2.2 million in FY 2009. In FY 2012, the budget provides $27 million to continue to improve the chances of finding a suitably matched donor and to improve access to potentially life-saving transplant therapy.

Expanding Access to Family Planning Services: The FY 2012 Budget includes $327 million, an $11 million increase, to expand family planning services to low-income individuals by improving access to family planning centers and preventative services. This funding will provide services to nearly 5 million low-income women and men at more than 4,500 clinics each year.

PROGRAM MANAGEMENT AND PUBLIC HEALTH ACTIVITIES

National Vaccine Injury Compensation Program: The Budget requests $7 million for the Vaccine Injury Compensation Program to prepare for projected increases in claims and to continue reviews of over 4,800 claims from autism proceedings.

Supporting Transplantation: The Budget includes $66 million to support organ, bone marrow, and cord blood stem cell transplantation. Within this total, $26 million supports a national system to develop policies to ensure the fair allocation and distribution of organs. It also includes $27 million to support the National Bone Marrow Donor Registry and $14 million to support the collection of approximately 8,900 new cord blood units by the end of FY 2012.

Program Management: The Budget requests $171 million, an increase of $24 million, to fund rent, information technology, utilities, security, and agency oversight of its programs. This increase will support one-time facilities extension costs, as well as resources for improved program management operations.

Improving Access in Underserved Areas

HRSA awarded $2 billion in Recovery Act funds through its Community Health Centers programs for construction, medical equipment, health information technology, new service sites, and increased demand for services. As a result of this funding, these health centers served more than 3.3 million patients, including 1.8 million uninsured patients. In addition, more than 1,100 health centers received funding to build new or expand existing facilities in order to serve more people.

Palmetto Health Council in Decatur, Ga., for example, received $8 million to expand delivery of primary health care services at its centers in an economically depressed rural region. Funding has allowed the creation and expansion of three delivery sites, resulting in health care services for 2,693 new patients, of whom 85 percent are uninsured. On August 31, 2010, Palmetto broke ground for its 21,300 square foot facility, designed to be certified LEED Gold by the U.S. Green Building Council and include geothermal energy. The center is using local labor and regionally-supplied building materials.

INDIAN HEALTH SERVICE

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Services				
Clinical Services:	3,845	3,861	4,284	+439
Contract Health Services (non add)	*779*	*779*	*949*	*+169*
Preventive Health	144	144	157	+12
Contract Support Costs	398	398	462	+63
Tribal Management/Self-Governance	9	9	9	--
Urban Health	43	43	47	+4
Indian Health Professions	41	41	42	+1
Direct Operations	69	69	74	+5
Diabetes Grants	150	150	150	--
Subtotal, Services	4,699	4,715	5,224	+525
Facilities				
Health Care Facilities Construction	29	29	85	+56
Sanitation Facilities Construction	96	96	80	-16
Facilities & Environmental Health Support	193	193	211	+18
Maintenance & Improvement	60	60	65	+4
Medical Equipment	23	23	25	+2
Subtotal, Facilities	401	401	465	+64
Total, Program Level	**5,100**	**5,116**	**5,689**	**+589**
Less Funds From Other Sources				
Health Insurance Collections	-891	-908	-908	-17
Rental of Staff Quarters	-6	-6	-8	-1
Diabetes Grants 1/	-150	-150	-150	--
Total, Budget Authority	**4,052**	**4,052**	**4,624**	**+571**
FTE	15,824	15,995	16,120	+296

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

INDIAN HEALTH SERVICE

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

The FY 2012 Budget requests $5.7 billion for the Indian Health Service (IHS), an increase of $589 million over FY 2010. The Budget prioritizes reducing health disparities in Indian Country and improving the Indian health system. This expansion is a continuation of the Administration's policy to work toward fulfillment of the Federal government's obligations to American Indians and Alaska Natives. As the President stated at the December, 2010 Tribal Nations conference, "We know that Native Americans die of illnesses like diabetes, pneumonia, flu – even tuberculosis – at far higher rates than the rest of the population...And closing these gaps is not just a question of policy, it's a question of our values – it's a test of who we are as a Nation."

FULFILLING THE UNIQUE ROLE OF THE INDIAN HEALTH SERVICE

IHS, in partnership with Tribes, provides primary care, behavioral and community health, and sanitation services for a growing population of more than 1.9 million eligible American Indians and Alaska Natives. IHS provides comprehensive health services to members of more than 560 Federally recognized Tribes through direct services in 45 hospitals; 293 health centers; and 304 health stations, school health centers, and Alaska village clinics. As part of the unique relationship between Tribes and the Federal Government, IHS provides American Indians and Alaska Natives with preventive health care and direct medical care, and contracts with hospitals and health care providers outside the IHS system to purchase care it cannot provide through its own network. IHS works with Tribes to ensure their maximum participation in administering the programs that impact their communities. In addition to the provision of health care services, IHS builds sanitation systems to provide water and waste disposal for Indian homes; supports Tribal self-governance through contract funding; and provides scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, to serve in areas with high provider vacancies.

STRENGTHENING THE INDIAN HEALTH SYSTEM

The Budget includes significant funding increases to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives.

Population Growth and the Cost of Providing Care: The Budget reflects a sustained investment in the wellbeing of a growing population of American Indians and Alaska Natives. The Indian population is growing at a faster rate than the United States population as a whole, and the IHS service population is expected to increase by 26,000 (1.3 percent) in FY 2012. The Budget includes an additional $252 million to cover population growth and inflation. The Budget includes an increase of $54 million for the Indian Health Care Improvement Fund, a targeted investment aimed at creating a more equitable funding distribution across service sites.

Contract Health Services: IHS purchases health care from outside the IHS system in cases where no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet. The Budget includes $949 million, an increase of $169 million, for the purchase of medical care, including essential services such as inpatient and outpatient care, routine and emergency care, and medical

The Indian Health Care Improvement Act Permanent Authorization

The Indian Health Care Improvement Act was permanently authorized in the Affordable Care Act. New authorities funded in the FY 2012 Budget include a mental health telemedicine program that will connect providers with at-risk youth in remote locations, and a heath care facility modular construction feasibility study. The Act also authorizes IHS to enter into agreements with the Department of Veterans Affairs and the Department of Defense to share medical facilities and expands authorities for urban Indian organizations.

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

Construction: The Budget includes $85 million for Health Care Facilities Construction to begin work on a Youth Treatment Facility in Northern California, and to continue construction of a hospital in Barrow, Alaska and two outpatient facilities in San Carlos and Kayenta, Arizona. Once completed, these facilities are projected to collectively serve a user population of 38,380 patients.

Sanitation Facilities Construction: IHS provides potable water and waste disposal facilities, and has been successful in reducing the rates of infant mortality, gastroenteritis and other environmentally-related diseases by about 80 percent since 1973. IHS has a balance of funds available for this program that will allow a reduction of $16 million while maintaining the current level of activity.

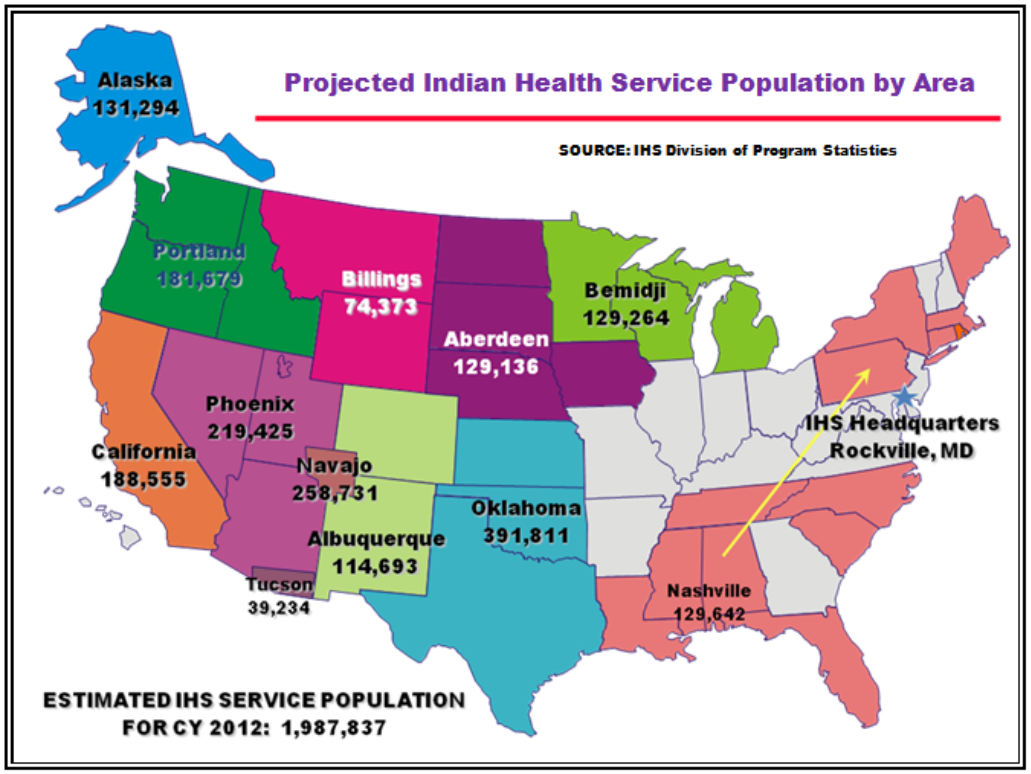
Ensuring Access to Care

The FY 2012 Budget prioritizes Contract Health Service funding for the third year. The Budget provides $949 million, an increase of $169 million to cover the cost of care purchased outside the IHS system.

This funding increase will support an additional 218,070 outpatient visits, 7,930 patient travel trips, and 5,732 inpatient admissions, thereby reducing the number of cases deferred or denied.

Staffing New and Renovated Health Facilities: IHS construction funds are targeted to expand service at sites experiencing overcrowding by building new and renovating existing facilities. These expansions require new staff and operating support. An additional $72 million is included in the FY 2012 Budget to support staffing and operating costs for six new or expanded health centers to be completed by FY 2012. Three of the facilities are joint venture projects, where IHS is partnering with a Tribal entity to provide funds for staffing, equipping, and operating a facility, and participating Tribes cover the costs of design and construction. When these facilities are fully operational, they will meet the increasing demand for services at their sites.

Health Insurance Reimbursements: IHS relies on the collection of third party resources for as much as 50 percent of the operating budgets for some facilities. In FY 2012, IHS estimates it will receive approximately $908 million in health insurance reimbursements for the provision of care to people covered by Medicare, Medicaid, and private insurers. These funds are essential



Depression Intervention

Depression is often a factor contributing to suicide, domestic and intimate partner violence, and alcohol and substance abuse. Early identification allows providers to plan interventions and treatment to reduce the impact of depression, including the reduction of suicide rates, which are disproportionately high in Indian communities. IHS increased the proportion of patients aged 18 and older who are screened for depression from 24 percent in FY 2007, to 52 percent in FY 2010. IHS has set a target of 56 percent for FY 2012.

for covering the costs of hiring additional medical staff, purchasing equipment, making necessary building improvements, and maintaining accreditation standards.

Program Integrity: The Budget includes funding to strengthen oversight and ensure IHS policies in the areas of quality of care, human resources, and financial management are effectively implemented. The goal of IHS program integrity efforts is to ensure IHS providers, staff, and managers have the knowledge, training, and support necessary to successfully perform their duties and the IHS service population receives quality care.

SUPPORTING INDIAN SELF-DETERMINATION

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

Contract Support Costs: The Budget includes $462 million for contract support costs, an increase of $63 million.
Contract support funding enables Tribes to develop the infrastructure needed to administer Federal programs. These funds provide Tribes with additional support in the operation of their own health programs. This investment will allow IHS to increase funding significantly to Tribes with existing self-determination agreements to ensure they have the resources to successfully manage programs at the local level.

Consultation: One of the key components of the government-to-government relationship with Tribes is consultation, in which Tribal governments and organizations play an integral role in the agency's budget and policy decision-making processes. In addition to extensive solicitation of Tribal input used to determine the way IHS operates at the local, area, and national level, HHS holds an annual department-wide budget consultation. This process gives Tribal leaders the opportunity to express their budget priorities, which are reflected in the FY 2012 Budget. In response to the President's Executive Order reaffirming the importance of consultation, IHS is continuing to work with Tribes to improve its consultation practices and to incorporate the implementation of Tribal recommendations into the IHS portion of the HHS Strategic Plan.

IHS Priorities

Through extensive Tribal consultation, the IHS has established four Agency priorities to lead, manage, and support the delivery of comprehensive health care services to American Indians and Alaska Natives. The priorities are as follows:

1. Renew and strengthen our partnership with Tribes,
2. In the context of national health reform, bring reform to IHS,
3. Improve the quality of and access to care, and
4. Make all work accountable, transparent, fair, and inclusive.

Health Care Infrastructure

The Recovery Act provided $500 million through the Indian Health Service (IHS) for the construction of health care facilities, building maintenance and improvement, water and wastewater sanitation projects, the purchase of critical medical equipment and health information technology to serve the federally recognized American Indian and Alaska Native (AI/AN) communities. This funding supported the replacement of two hospitals with state-of-the-art medical facilities, and the purchase of ambulances, CT scanners, and other vital equipment.

One of the new facilities is the Eagle Butte Health Center, that will serve 10,000 AI/AN people. This innovative project will employ ground source heat pumps, saving 60 percent of the energy consumed by conventional heating and cooling systems. The funds will also build 133 staff quarters in this remote location to house health care providers.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Infectious Diseases				
Immunization and Respiratory Disease	721	821	722	--
Section 317 Discretionary Program (non-add)	*561*	*662*	*562*	--
ACA Prevention Fund (non-add)	--	*100*	*62*	*+62*
Pandemic Influenza (non-add)	*156*	*156*	*156*	--
Balances from P.L. 111-32 Pandemic Flu (non-add)	--	--	--	--
Vaccines For Children	3,761	3,899	4,031	+270
HIV/AIDS, Viral Hepatitis, STDs and TB Prevention	1,119	1,089	1,188	+69
ACA Prevention Fund (non-add)	*30*	--	*30*	--
Emerging and Zoonotic Infectious Diseases	281	313	349	+68
ACA Prevention Fund (non-add)	*20*	*52*	*60*	*+40*
Subtotal, Infectious Diseases	5,882	6,122	6,289	+407
ACA Prevention Fund (non-add)	*50*	*152*	*152*	*+102*
Chronic Disease Prevention and Health Promotion	949	1,167	1,186	+236
ACA Childhood Obesity Demonstration Project (non-add)	*25*	--	--	*-25*
ACA Prevention Fund (non-add)	*59*	*301*	*460*	*+401*
Child Health, Disabilities, and Blood Disorders	144	144	144	--
Environmental Health	181	216	138	-43
ACA Prevention Fund (non-add)	--	*35*	*9*	*+9*
Injury Prevention and Control	149	149	168	+19
ACA Prevention Fund (non-add)	--	--	*20*	*+20*
Preventive Health and Health Services Block Grant	100	100	--	-100
Public Health Scientific Services	441	490	494	+53
ACA Prevention Fund (non-add)	*32*	*82*	*70*	*+38*
Occupational Safety & Health	430	430	315	-115
Energy Employee Occupational Illness Compensation Program (non-add)	*55*	*55*	*55*	--
World Trade Center Program - Disc. (non-add)	*71*	*71*	--	*-71*
Global Health /1	354	354	381	+27
Public Health Leadership and Support	194	185	163	-32
ACA Prevention Fund (non-add)	*50*	*41*	*41*	*-9*
Buildings and Facilities	69	69	30	-39
Business Services Support	367	367	417	+51
Public Health Preparedness and Response				
State and Local Preparedness and Response Capability	761	761	651	-110
CDC Preparedness and Response Capability	166	166	147	-19
Strategic National Stockpile	596	596	655	+59
Balances from P.L. 111-32 Pandemic Flu (non-add)	--	--	*30*	*+30*
Subtotal, Public Health Preparedness and Response	1,522	1,523	1,453	-70
Agency for Toxic Substances and Disease Registry	100	77	76	-23
ACA Medical Monitoring - Environmental Health Hazards (non-add)	*23*	--	--	*-23*
User Fees	2	2	2	--
Subtotal, Program Level	**10,884**	**11,395**	**11,255**	**+371**
Less Funds Allocated from Other Sources				
Vaccines for Children (mandatory) /2	-3,761	-3,899	-4,031	-270
Energy Employee Occupational Injury Compensation Program (mand.)	-55	-55	-55	--
PHS Evaluation Transfers	-352	-352	-490	-138
Balances from P.L. 111-32 Pandemic Flu	--	--	-30	-30
ACA non-Prevention Fund	-48	--	--	+48
ACA Prevention Fund	-192	-611	-753	-561
User Fees	-2	-2	-2	--
Total, Discretionary Budget Authority	**6,474**	**6,475**	**5,894**	**-580**
Total, Discretionary Program Level	**6,829**	**6,830**	**6,416**	**-412**
FTE	10,186	10,336	10,386	+50

/1 Adjusts FY 2010 levels comparable with FY 2011 and FY 2012.
/2 The FY 2011 estimates for the Vaccines for Children Program reflect the anticipated transfer from Medicaid and do not include $6.551 million in unobligated balances from FY 2010, for a total program level of $3,905.644 million. VFC is funded through the Medicaid appropriation.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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

The FY 2012 Budget request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.3 billion, an increase of $371 million above FY 2010. This total includes $753 million of the $1 billion available from the Prevention and Public Health Fund (Prevention Fund).

The Budget request increases support for the prevention and control of infectious diseases; global polio eradication; the Strategic National Stockpile; injury prevention; chronic disease prevention; and health surveillance and statistics.

The Budget includes targeted programmatic savings for completed, duplicative, and one-time activities funded in FY 2010 and $100 million in administrative savings. In addition, the Budget consolidates disease-specific funding throughout the agency to create comprehensive programs that enable health departments to maximize public health impact by addressing the greatest needs in their communities. This new approach will improve overall health outcomes while also enhancing accountability of Federal resources.

PROTECTING THE NATION AGAINST INFECTIOUS DISEASES

The Budget includes a total of $6.2 billion for Infectious Diseases, of which $152 million is funded from the Prevention Fund, and of which $4 billion is mandatory funding for the Vaccines for Children (VFC) program.

HIV/AIDS, Viral Hepatitis, STD and TB Prevention: The Budget provides $1.2 billion for domestic HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STD), and Tuberculosis (TB), an increase of $69 million above FY 2010. The FY 2012 Budget proposes that both CDC and the States have the authority to transfer five percent of funds associated with the HIV/AIDS, Viral Hepatitis, STD, and TB lines across each budget line to improve coordination and service integration.

The Budget supports the goals of the National HIV/AIDS Strategy by focusing resources on high-risk populations and allocating funds to State and local health departments to align resources to match the burden of the epidemic across the United States. In addition, the Budget provides an additional $10 million for Enhanced Comprehensive HIV Prevention Planning, which funds the twelve jurisdictions most affected by AIDS. The increased funds in FY 2012 will help CDC decrease the HIV transmission rate; decrease the risk behaviors among persons at risk for acquiring HIV; increase the proportion of HIV-infected people who know they are infected; and integrate services for populations most at risk of HIV, STDs and Viral Hepatitis.

Immunization and Respiratory Diseases: Due to advances in biotechnology, children can now be protected from more vaccine preventable diseases. In 1985, vaccines for seven diseases were available and recommended for routine use in children in the United States. Now, vaccines for 16 diseases are available and routinely recommended for children and adolescents.

CDC's $4.6 billion immunization program has two components: the mandatory VFC program and the discretionary Section 317 program. These two programs combined provide nearly 50 percent of the pediatric vaccines and thirty percent of the adolescent vaccines distributed in the United States each

CDC Prevention Fund Investments

Of the $1 billion available through the Prevention and Public Health Fund in FY 2012, the Administration has allocated $753 million to CDC to build on prior investments in areas such as public health infrastructure; community and State prevention; and tobacco and obesity prevention. In FY 2010, CDC Prevention Fund investments strengthened the infrastructure and the capacity of health departments. For instance, Arkansas trained epidemiologists in foodborne outbreak investigation and is developing a public awareness campaign to stress the importance of reporting foodborne disease episodes to the health department. The campaign's goals are to increase reporting of foodborne illnesses by 20 percent in the first year and by 40 percent in the second.

year. The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2012 Budget includes $562 million for the Section 317 program. Within this total, $7 million will continue demonstration projects to enable health departments to bill private insurance for immunization services provided to covered patients.

The FY 2012 Budget includes $349 million for Emerging and Zoonotic Infectious Diseases, an increase of $68 million above FY 2010. This level is the net result of targeted programmatic reductions to eliminate low-impact disease-specific programs and of increases for the Quarantine Program, Emerging Infectious Diseases, Food Safety, and the National Healthcare Safety Network. Within this total, $40 million from the Prevention Fund will support State epidemiology and laboratory capacity. The increase for the Quarantine Program will pay for the costs of persons isolated and quarantined under Federal and State laws. The other increases will allow CDC to prevent and control infectious diseases through activities such as surveillance, outbreak investigations, and research.

PROMOTING HEALTH AND PREVENTING CHRONIC DISEASE

Chronic Disease Prevention and Health Promotion: The Budget includes $1.2 billion, an increase of $236 million above FY 2010, for Chronic Disease Prevention and Health Promotion, of which $460 million is funded through the Prevention Fund. Chronic diseases are among the most prevalent, costly, and preventable of all health problems. The Budget redirects $705 million, an increase of $72 million above FY 2010, for this new competitive grant program that refocuses activities from disease-specific programs into a program that is more comprehensive in its approach. Because many chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the burden of chronic disease. CDC will award grants to health departments to implement evidence-based strategies that will address the leading causes of death and health disparities. In addition, CDC will award grants to academic health centers to develop, test, and evaluate effective interventions to reduce chronic conditions and to national organizations to provide technical assistance, training and support to health departments. CDC will provide performance awards for States that significantly improve health outcomes. For this new comprehensive program, CDC will build on major accomplishments from *Communities Putting Prevention to Work* communities funded through the American Recovery and Reinvestment Act (Recovery Act) and the Affordable Care Act.

The Budget eliminates duplicative community grant programs and the Preventive Health and Health Services Block Grant because CDC will address the goals of these activities through the new comprehensive grant program and the Community Transformation Grants.

Childhood Obesity Demonstration Project

In FY 2012, CDC will continue administering the Childhood Obesity Demonstration Project for which the Affordable Care Act appropriated $25 million over five years. The Demonstration Project seeks to develop a comprehensive and systematic model that could be implemented nationally to children who are eligible for services under the Children's Health Insurance Program.

Birth Defects, Developmental Disabilities, Disability, and Health: The Budget includes $144 million for Birth Defects, Developmental Disabilities, Disability, and Health, the same as FY 2010. The Budget proposes consolidating disease-specific funding into three new competitive programs that are more comprehensive in their approaches to address critical public health issues more effectively. In addition, in FY 2012, CDC will continue research and surveillance of autism spectrum disorders.

PUBLIC HEALTH SCIENTIFIC SERVICES

The Budget includes $494 million, $53 million above FY 2010, to improve public health surveillance and infrastructure. This net increase includes a decrease for the genomics program and increases for public health workforce, and healthcare surveillance and statistics. CDC's Public Health Scientific Services strengthens and supports the monitoring and analysis of key public health information, which is translated and shared among public health entities.

Health Surveillance and Statistics: The Budget includes $197 million for Health Surveillance and Statistics, an increase of $38 million over FY 2010, to obtain and use statistics to understand health problems, recognize emerging trends, identify risk factors, support electronic birth records in all 50 States, guide programs and policy, and to monitor the impact of health reform. Policy-makers, researchers, and the public rely on data from these surveys to support decision making and research on health.

Public Health Workforce and Career Development: The Budget includes a total of $73 million to help ensure a prepared, diverse, and sustainable public health workforce through experiential fellowships and training programs.

ENVIRONMENTAL HEALTH

The Budget includes $138 million for Environmental Health, which is $43 million below FY 2010, due to targeted programmatic reductions. Within this total, $9 million in the Prevention Fund finances a portion of the Environmental Public Health Tracking Program.

CDC's Environmental Health programs prevent illness, disabilities, and premature death caused by non-infectious, non-occupational environmental related factors. CDC has been successful in reducing the level of childhood lead poisoning. The Budget consolidates the asthma, childhood lead poisoning and healthy homes programs into one comprehensive program of $33 million, which is a decrease of $33 million below FY 2010. In addition, the Budget eliminates the Built Environment Program and reduces the Climate Change Program by $1 million to focus resources on interventions and programs with an ability to make a significant public health impact.

INJURY PREVENTION AND CONTROL

The Budget includes $168 million for Injury Prevention and Control programs in CDC, an increase of $19 million above FY 2010, to reduce premature deaths, disability, and the medical costs associated with injuries and violence, such as motor vehicle safety, and intimate partner and sexual violence prevention. CDC will use FY 2012 funds to build State-based injury prevention capacity; track and monitor injury trends; identify evidence-based interventions; and to disseminate key research findings. Within this total, $20 million in the Prevention Fund will address unintentional injuries, which is one of the top leading causes of death.

IMPROVING PREPAREDNESS AND RESPONSE TO TERRORISM

The FY 2012 Budget provides $1.45 billion for biodefense and emergency preparedness activities in CDC, a decrease of $70 million below FY 2010. Within that total $643 million is requested for the Public Health and Emergency Preparedness (PHEP) grants, a decrease of $72 million below FY 2010. The PHEP program will provide nearly $9 billion in funding from 2001-2012 for these efforts. These grants support local public health preparedness efforts, and are coordinated with the Hospital Preparedness grants administered by the Assistant Secretary for Preparedness and Response (ASPR). Great progress in preparing for public health emergencies has been made with the Federal investment at the State and local level. Additionally, ASPR and CDC are working together to improve the coordination of these grants at both the Federal and local levels. Due to enhanced alignment of preparedness grants within HHS, States will be able to make more efficient use of these resources, which is imperative in a constrained budget environment.

In FY 2012, $146 million is provided to support improving the CDC Preparedness and Response Capability, $19 million below FY 2010. The Budget does not include funding for the Centers for Public Health Preparedness and the Advanced Practice Centers.

The Strategic National Stockpile request is $655 million, an increase of $59 million over FY 2010 to support increasing product replacement costs, acquire new

Communities Putting Prevention to Work

In FY 2010, CDC launched the $650 million *Communities Putting Prevention to Work* Recovery Act initiative to improve access to nutrition, increase physical activity, and decrease smoking prevalence and exposure to second-hand smoke. Of the $650 million, CDC awarded a total of $373 million to 44 communities, reaching over 50 million Americans, to implement evidence-based prevention and wellness strategies. Communities are already making progress. For example, In San Antonio, the Metropolitan Health District implemented a menu labeling nutrition program for restaurants, and healthier options have been made available at over 100 restaurant locations citywide.

products, and support security and management costs.

Advancing Occupational Safety and Health

The National Institute for Occupational Safety and Health (NIOSH) is the primary Federal entity responsible for conducting research, making recommendations, and translating knowledge for the prevention of work-related illness and injury. The FY 2012 Budget provides $315 million for Occupational Safety and Health programs, $115 million below FY 2010. This decrease is primarily the result of eliminating discretionary funding for the World Trade Center Program. The Budget includes $313 million in mandatory funding, which is reflected in the Office of the Secretary, for the implementation of the James Zadroga 9/11 Health and Compensation Act. With these funds, HHS will support treatment and monitoring services for responders of the World Trade Center attacks and for non-responders in the community directly affected by the attacks. The Budget for NIOSH also includes targeted programmatic reductions for less effective programs, including the Education and Research Centers and the Agricultural, Forestry, and Fishing Program within the National Occupational Research Agenda.

Within the total for Occupational Safety and Health, $55 million in mandatory funding is included for CDC's role in the Energy Employees Occupational Illness Compensation Program.

Global Health

CDC's Center for Global Health develops and executes CDC's global health strategy, providing technical expertise to, and working in partnership with, ministries of health to implement programs that aim to reduce the leading causes of mortality, morbidity and disability. The FY 2012 Budget includes $381 million, $27 million above FY 2010, for Global Health programs to protect the U.S. and world populations from emerging global health threats and to support the goals of the Administration's Global Health Initiative. Increased funds will also strengthen public health capacity abroad, such as by training and sustaining a quality global public health workforce. The Budget includes $112 million, an increase of $11 million above FY 2010, to support the eradication of polio in remaining endemic countries by the end of FY 2012.

The Budget continues to support CDC's ability to rapidly detect and respond to infectious disease outbreaks and threats; to prevent and control malaria and other parasitic diseases; to improve maternal and child health through the Afghanistan Health Initiative; and to support Health Diplomacy. In addition, the Budget maintains support for other CDC global health programs, including the Global AIDS Program, which plays a vital role in implementation of the CDC responsibilities under the President's Emergency Plan for AIDS Relief.

Reducing Healthcare-Associated Infections

The FY 2012 Budget includes $47 million for CDC's Healthcare Associated Infections (HAI) activities, an increase of $32 million above FY 2010. CDC's HAI activities promote healthcare quality through the prevention of HAIs, including those caused by pathogens such as Methicillin-resistant Staphylococcus aureus (MRSA), C. difficile, and multi-drug resistant gram-negative bacteria. Research has shown that implementation of CDC HAI prevention recommendations can reduce HAIs by 70 percent and virtually eliminate some types of infections. Implementation of these recommendations will save lives, reduce suffering, and result in healthcare cost savings of $3 billion to $8 billion annually in acute care settings alone. CDC collects data on HAIs through the National Healthcare Safety Network (NHSN). The number of hospitals participating in the NHSN has increased to more than 3,900 facilities as of December 2010. Data reported to NHSN in 2009 showed a 20 percent reduction in central-line associated bloodstream infections nationally, as measured by the standardized infection ratio.

Managing CDC Infrastructure and Human Capital

The Budget includes $610 million in administrative and infrastructure activities to support CDC mission-critical efforts.

Public Health Leadership and Support: The Budget includes $163 million, of which $41 million is funded through the Prevention Fund, $32 million below FY 2010, to support cross-cutting areas in CDC that seek to ensure the effectiveness of public health programs and science. The decrease eliminates one-time congressional projects and reduces funding for public health improvement. The Budget request continues support for the new Office of State, Tribal, Local and

Territorial Support, which provides guidance and oversight for the investment of CDC resources and assets in health departments and other partner agencies.

Buildings and Facilities: CDC has made remarkable progress on its 10-year Master Plan through its investments to build and upgrade facilities and laboratories. Because of this progress, the FY 2012 Budget includes $30 million, $39 million below FY 2010, which supports repairs and improvements.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

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

In addition, in FY 2012, CDC will continue implementing the Medical Monitoring Program for Certain Environmental Health Hazards, for which the Affordable Care Act appropriated $23 million from FY 2010-FY 2014. This program provides screening, health education, and outreach services for residents of Libby, Montana, who have been exposed to asbestos.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2010	2011 *	2012	2012 +/- 2010
Institutes				
National Cancer Institute	5,101	5,099	5,196	+95
National Heart, Lung and Blood Institute	3,095	3,094	3,148	+53
National Institute of Dental and Craniofacial Research	413	413	420	+7
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,957	1,957	1,988	+31
National Institute of Neurological Disorders and Stroke	1,635	1,635	1,664	+29
National Institute of Allergy and Infectious Diseases	4,816	4,510	4,916	+100
National Institute of General Medical Sciences	2,051	2,050	2,102	+52
Eunice K. Shriver Natl Inst. of Child Health & Human Dev	1,329	1,328	1,352	+23
National Eye Institute	707	706	719	+12
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	689	689	701	+11
Interior Appropriation	79	79	81	+2
National Institute on Aging	1,110	1,109	1,130	+20
Natl Inst. of Arthritis & Musculoskeletal & Skin Diseases	539	539	548	+9
Natl Inst. on Deafness and Communication Disorders	419	418	426	+7
National Institute of Mental Health	1,490	1,489	1,517	+27
National Institute on Drug Abuse	1,059	1,059	1,080	+21
National Institute on Alcohol Abuse and Alcoholism	462	462	469	+7
National Institute of Nursing Research	146	146	148	+3
National Human Genome Research Institute	516	516	525	+9
Natl Institute of Biomedical Imaging and Bioengineering	316	316	322	+6
Natl Institute on Minority Health and Health Disparities	211	211	215	+3
National Center for Research Resources	1,268	1,268	1,298	+30
Natl Center for Complementary and Alternative Medicine	129	129	131	+2
Fogarty International Center	70	70	71	+1
National Library of Medicine	359	374	395	+36
Office of the Director	1,177	1,176	1,298	+122
Buildings and Facilities	100	100	126	+26
Total, Program Level	**31,243**	**30,943**	**31,987**	**+745**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	-150	-150	--
Total, Budget Authority	**31,084**	**30,785**	**31,829**	**+745**
Labor/HHS Appropriation	**31,005**	**30,706**	**31,748**	**+743**
Interior Appropriation	**79**	**79**	**81**	+2
FTE	18,362	18,412	18,412	+50

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

*The 2010 Labor, HHS, and Educations Appropriations Act included a total of $4,818,275,000 for NIAID, of which $304,000,000 was transferred from the Biodefense Countermeasures account in the Department of Homeland Security. Since there are no funds remaining in that account in 2011, under the current law continuing resolution (P.L. 111-317), there can be no transfer to NIAID. The Administration supports replacing this transfer with budget authority for NIAID in 2011.

NATIONAL INSTITUTES OF HEALTH

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

The FY 2012 Budget requests $32.0 billion for the National Institutes of Health (NIH), an increase of $745 million, or 2.4 percent, over the FY 2010 level.

Through the application of genomic research and high-throughput technologies, breakthroughs in our understanding of the causes of many diseases and the identification of new targets and pathways for the development of new therapeutics are clearly within reach. For example, a decade ago, diagnosis of cancer was based on the organ involved and treatment depended on broadly aimed therapies that often diminished a patient's quality of life. Today, research in cancer biology is moving treatment toward more effective and less toxic therapies tailored to the genetic profile of each patient's cancer. NIH-funded researchers are also uncovering information about genes and the environment that will help point the way toward more personalized, targeted treatments for other diseases. New insights into molecular mechanisms represent new opportunities for NIH to straighten and shorten the pathway from discovery to health. This expectation is grounded in several recent developments: the dramatic acceleration of our basic understanding of hundreds of diseases; the establishment of NIH-supported centers that enable academic researchers to use such understanding to screen thousands of chemicals for potential drug candidates; and the emergence of public-private partnerships to aid the movement of drug candidates into the commercial development pipeline.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. Its budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2012, about 83 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 325,000 scientists and research personnel affiliated with over 3,000 organizations, including universities, medical schools, hospitals, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to national and global health challenges. Another 6 percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2012

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. In FY 2012, NIH will use the $32.0 billion Budget to support

NIH Disease Accomplishments

NIH is continuing to make progress in combating major diseases. As just a few examples of accomplishments made by NIH-supported scientists in 2010:

- The first results from a large clinical trial testing candidate microbicides that use anti-retrovirals (ARVs) found that incorporating an ARV into a gel for women was more than 50 percent protective against HIV infection.
- The National Lung Screening Trial found that screening with low-dose computed tomography (CT) can decrease lung-cancer deaths among current and former heavy smokers by 20 percent.
- In mammals, hair cells in the inner ear that are essential for both hearing and balance cannot regenerate when they die or are damaged. Mouse embryonic and induced pluripotent stem cells were used to generate new hair cells. This work offers a major new avenue for treating deafness.
- Significant progress was made toward developing a universal flu vaccine that would confer longer term protection against multiple influenza virus strains and make yearly flu shots a thing of the past.

The Cancer Genome Atlas

The Recovery Act appropriated $10 billion directly to NIH, of which $8.2 billion was designated for scientific research, and $1.8 billion for scientific facilities and equipment. One example is $178 million for The Cancer Genome Atlas (TCGA) project to accelerate its ground-breaking work of identifying and cataloguing genomic changes in 20 of the most common malignancies, including prostate, breast, ovarian, brain, and pancreatic cancers, and adult leukemia. The TCGA will provide unprecedented insights into the molecular basis of cancer, setting the stage for developing a new generation of personalized, targeted and more effective drugs and diagnostics to fight the disease. The Recovery Act funds helped speed every aspect of the project, from tissue collection to genome characterization and sequencing and the development of new tools for data analysis.

innovative research across the spectrum from basic to clinical, with a focus on one major area of extraordinary opportunity, and three other themes that are exceptionally ripe for investment and critical to improving the health of the American people.

A Groundbreaking New Program at NIH – The National Center for Advancing Translational Sciences: Recent insights into the molecular basis of disease have identified many promising new targets for therapeutic intervention and yielded an unprecedented potential for developing more effective diagnostics and therapeutics. NIH is proposing to establish a new National Center for Advancing Translational Sciences (NCATS) on October 1, 2011, in order to place the agency in a pivotal position to re-engineer the pipeline for diagnostics and therapeutics discovery and development. NCATS will catalyze innovation at crucial junctures in the pipeline, spur new public-private partnerships, and facilitate the regulatory review process through recent initiatives including the NIH-FDA Leadership Council and a research program in Regulatory Science. At this time, NIH also plans to abolish the existing National Center for Research Resources (NCRR); its programs will be transferred to the new Center or to other parts of NIH.

NCATS will align and bring together in one organization a number of trans-NIH programs that are inherently cross-cutting. As an example, the Cures Acceleration Network (CAN), for which $100 million is requested in FY 2012, will play a leading role in the effort to accelerate the development of "high need cures" through the reduction of barriers between research discovery and clinical trials. The CAN initiative may use up to 20 percent of its funds on flexible research authorities to enable transactions other than contracts, grants, and cooperative agreements to carry out its goals.

Other components expected to be a part of NCATS are the Clinical and Translational Science Awards (CTSA) program and the Therapeutics for Rare and Neglected Diseases (TRND) program. The FY 2012 Budget requests $485 million for CTSAs, which fund a nationwide consortium of biomedical research institutions united around the goals of accelerating therapeutics development, engaging communities in clinical research efforts and training clinical and translational investigators. NIH also plans to double support for the TRND program in FY 2012, to a total of $50 million.

In FY 2012, NIH will also emphasize the following three scientific areas that the agency views as instrumental in paving the way for more rapid scientific advances across all areas of human health and disease, including global applications:

Technologies to Accelerate Discovery: The critical first step in developing more effective therapies for diseases that affect millions of Americans every day, such as heart disease, cancer, and Alzheimer's disease, is illuminating the complex causes of disease. Investigators are better able to take this step with such advanced technologies as DNA sequencing, microarray technology, nanotechnology, new imaging modalities, and computational biology. In FY 2012, NIH plans to support further development and application of these advanced technologies.

Enhancing the Evidence Base for Health Care Decisions: NIH's aim is not only to spur the development of new treatments, but also to support rigorous programs for assessing and ensuring their effectiveness

within populations and for individuals. Research in personalized medicine is essential to fulfilling the agency's mission and will enhance the evidence base for decision-making in clinical practice.

New Investigators, New Ideas: The future vitality of biomedical science in the United States depends upon the NIH and its support for young scientists. In FY 2012, NIH will emphasize two programs. The NIH Director's New Innovator Award, for which $80 million is requested in FY 2012, supports exceptionally creative new investigators with potentially high-impact projects. The Early Independence Program, for which $8 million is requested, will enable our most talented young scientists to move directly from a doctoral degree to an independent research career.

As part of the President's initiative in FY 2012 to emphasize support for science, technology, engineering, and mathematics (STEM) education programs, the budget proposes a four percent stipend increase for predoctoral and postdoctoral research trainees supported by NIH's Ruth L. Kirschstein National Research Service Awards program. A total of $794 million is requested in FY 2012 for this training program. The proposed increase in stipends will allow NIH to continue to attract high-quality research trainees that will be available to address the Nation's future biomedical, behavioral, and clinical research needs.

Genome Sequencing

Goal: By 2011, reduce the fully loaded cost of sequencing a human genome to $25,000.

Performance: Significant reductions in the cost of sequencing the human genome have improved our understanding of diseases and advanced biomedical research technology. To achieve greater knowledge in the genetic variations contributing to common and complex disorders, it is necessary to sequence large volumes of genomes. NIH aims to rapidly reduce the current cost of sequencing the genome from $50,000 in 2009 to $25,000 by the end of 2011. NIH has already achieved reductions in the total costs, currently at $31,125, and remains on track to meet this goal by increasing efficiency, improving technology, and reducing computational expenses. By 2012, NIH aims to further reduce the cost of sequencing the human genome to $15,000.

Other Key Priorities: Focusing on recent discoveries regarding cancer genomes, NIH will continue in FY 2012 to pursue the leading edge of discovery in basic cancer science, and develop new cancer treatments and methods for prevention and early detection of cancer. For Alzheimer's disease, NIH is partnering with the private sector to find new methods for early diagnosis, and to support early drug discovery and preclinical drug development. Ongoing research into environmental factors, early detection, and novel treatments will transform our understanding of autism spectrum disorders.

NIH estimates it will devote nearly $3.2 billion for research on HIV/AIDS in FY 2012. Controlling and ultimately eliminating HIV/AIDS will require safe, effective vaccines and other preventive measures. Developing such vaccines remains a priority and one of NIH's greatest challenges. This effort will require significant advances in basic research to both better understand the virus and the disease and to develop new vaccine strategies.

In addition to these funds, the budget for the National Institute of Allergy and Infectious Diseases (NIAID) includes $300 million, the same level as in FY 2010, to help support the United States Government's $1.3 billion contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria in FY 2012.

NIH will also contribute $20 million to the National Robotics Initiative in FY 2012 in areas such as home care; personalized care for special needs populations and robotic wellness/ health promotion; robot-assisted recovery, rehabilitation, and behavioral therapy; surgical and interventional robots, and high-throughput robot technologies.

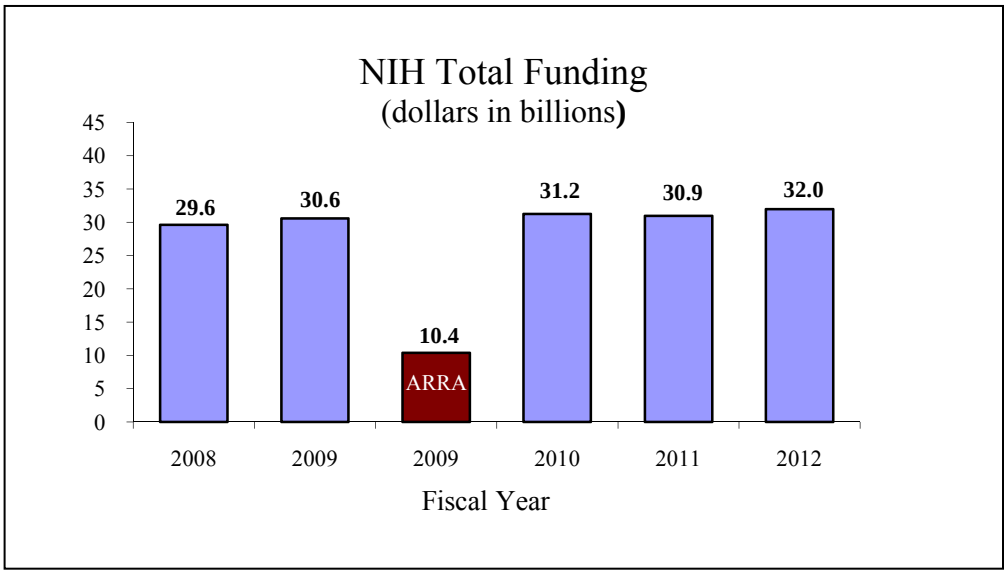
In response to recommendations in the Secretary's Medical Countermeasures Review, NIH will spend $55 million in

FY 2012 to expand the Concept Acceleration Program within NIAID. This program dedicates NIH staff to individually help shepherd investigators who have promising, early-stage, medical countermeasure products, but limited product development experience, to more rapidly develop and test their products through to the clinical evaluation stages.

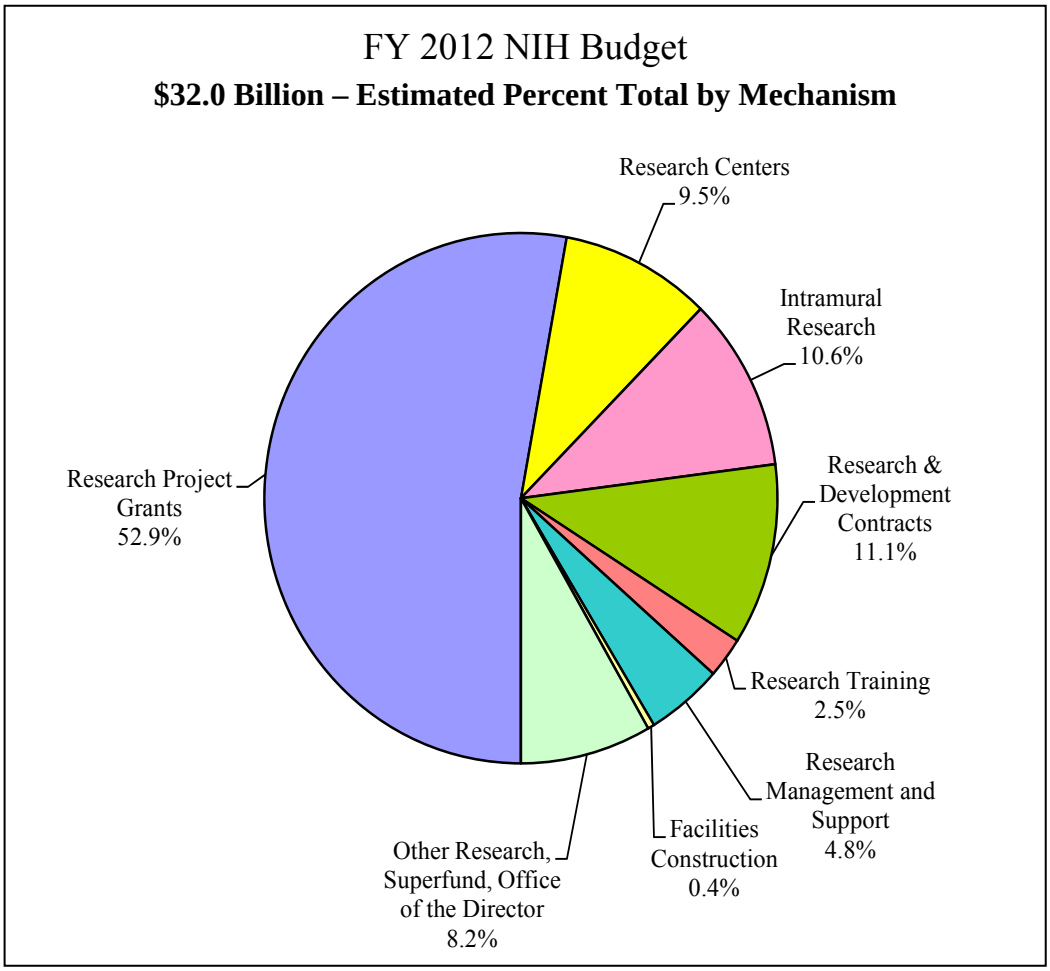
NIH estimates that it will support 9,158 new and competing research project grants (RPGs) in FY 2012, with the total number of RPGs expected to be 36,852. The average cost of a new and competing RPG in FY 2012 will be about $433,000.

INTRAMURAL BUILDINGS AND FACILITIES

A total of $134 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2012, an increase of $26 million above FY 2010, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2012, NIH will focus on upgrades to ensure essential safety and regulatory compliance, as well as on facility repairs and improvements to address the most critical utility systems, fire safety, and environmental deficiencies. Within the B&F mechanism total, $8 million is appropriated to the National Cancer Institute for facilities projects at its Frederick, Maryland campus.



ARRA (American Recovery and Reinvestment Act) funds were available for obligation in both FY 2009 and FY 2010. ARRA funding for NIH included a $400 million transfer from the Agency for Healthcare Research and Quality for patient-centered health research.



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

	2010	2011 *	2012	2012 +/- 2010
Mechanism				
Research Project Grants (dollars)	16,473	16,390	16,909	+436
[# of Non-Competing Grants]	*[25,738]*	*[25,936]*	*[26,019]*	*[+281]*
[# of New/Competing Grants]	*[9,386]*	*[8,734]*	*[9,158]*	*[-228]*
[# of Small Business Grants]	*[1,685]*	*[1,658]*	*[1,675]*	*[-10]*
[Total # of Grants]	*[36,809]*	*[36,328]*	*[36,852]*	*[+43]*
Research Centers	3,078	3,008	3,036	-41
Other Research	1,794	1,813	1,820	+25
Research Training	775	782	794	+19
Research and Development Contracts	3,456	3,258	3,545	+89
Intramural Research	3,340	3,351	3,390	+50
Research Management and Support	1,508	1,523	1,538	+30
Office of the Director	633	632	742	+109
[NIH Common Fund (non-add)]	*[544]*	*[544]*	*[557]*	*[+13]*
Buildings and Facilities	108	108	134	+26
NIEHS Interior Appropriation (Superfund)	79	79	81	+2
Total, Program Level	**31,243**	**30,943**	**31,987**	**+745**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	-150	-150	--
Total, Budget Authority	**31,084**	**30,785**	**31,829**	**+745**
Labor/HHS Appropriation	**31,005**	**30,706**	**31,748**	**+743**
Interior Appropriation	**79**	**79**	**81**	**+2**
FTE	18,362	18,412	18,412	+50

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

* The 2010 Labor, HHS, and Educations Appropriations Act included a total of $4,818,275,000 for NIAID, of which $304,000,000 was transferred from the Biodefense Countermeasures account in the Department of Homeland Security. Since there are no funds remaining in that account in 2011, under the current law continuing resolution (P.L. 111-317), there can be no transfer to NIAID. The Administration supports replacing this transfer with budget authority for NIAID in 2011.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Substance Abuse Block Grant	1,455	1,455	1,494	+40
Mental Health Block Grant	421	421	435	+14
State, Tribal, and Community Prevention Grants	480	481	535	+55
Substance Abuse State Prevention (non add)	*455*	*456*	*395*	*-60*
Mental Health State Prevention (i.e., Project LAUNCH) (non add)	*25*	*25*	*90*	*+65*
Behavioral Health Tribal Prevention (Prevention Fund) (non add)	--	--	*50*	*+50*
Innovations & Emerging Issues	831	881	790	-41
Mental Health (non add)	*348*	*363*	*291*	*-57*
Substance Abuse Prevention (non add)	*76*	*76*	*69*	*-6*
Substance Abuse Treatment (non add)	*408*	*433*	*393*	*-15*
Children's Mental Health Services	121	121	121	--
PATH Homeless Grants	65	65	65	--
Regulatory & Oversight Functions	55	55	55	--
Protection and Advocacy (non add)	*36*	*36*	*36*	--
Public Awareness & Support	14	14	14	-1
Performance & Quality Information Systems	37	38	13	-24
Program Management	102	120	128	+26
St. Elizabeths	1	1	--	-1
Total, Program Level	**3,583**	**3,651**	**3,649**	**+67**
Less Funds from Other Sources:				
PHS Evaluation Funds	-132	-132	-170	-38
Affordable Care Act Prevention Fund	-20	-88	-93	-73
Total, Budget Authority	**3,431**	**3,432**	**3,387**	**-44**
FTE	537	537	544	+7

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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

The FY 2012 Budget requests $3.6 billion, of which $93 million is funded through the Prevention Fund, for the Substance Abuse and Mental Health Services Administration, an increase of $67 million over FY 2010. In order to maximize the effectiveness and efficiency of its resources, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more thoughtfully and strategically by:

- Using competitive grants to identify and test innovative prevention and treatment interventions;
- Leveraging State and Tribal funding mechanisms to foster widespread implementation of proven practices; and
- Streamlining support activities.

As part of this effort, the Budget includes additional funding to maintain States' capacity to provide behavioral health services and to expand State and Tribal substance abuse prevention and mental health promotion activities, while reducing funding for proven competitive grant activities that will now be implemented through State-level funding streams.

TREATMENT

The Budget includes $1.9 billion, an increase of $54 million over FY 2010, for the Substance Abuse and Mental Health Block Grants to implement evidence-based treatment strategies nationwide and maintain the Nation's behavioral health treatment infrastructure.

Funding for treatment infrastructure has declined in recent years as many States have scaled back their investments in behavioral health in the face of budget shortfalls. As access to health services—including mental health and substance abuse services—expands, SAMHSA will work with States to use their Block Grant funds more strategically and with greater efficiency through the dissemination and implementation of evidence-based treatment strategies and interventions.

Putting Emerging Prevention Science to Work

In a 2009 report entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, the Institute of Medicine (IOM) reviewed research, advances, challenges, and Federal efforts in the promotion of mental health and the prevention of mental illness and substance use disorders. The IOM made the following key recommendations:

- Expand mental health prevention and promotion efforts;
- Identify strategies to target resources to at-risk communities; and
- Evaluate, disseminate, and continually improve innovative evidence-based prevention practices.

The Budget expands mental health State prevention efforts, directs States to use data-driven approaches to direct prevention resources to at-risk communities, and utilizes SAMHSA's competitive grants to identify and test innovative prevention practices for ultimate dissemination through State-level prevention funding streams.

PREVENTION

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

The Budget includes $535 million, an increase of $55 million over FY 2010, for new and expanded substance abuse prevention and mental health promotion grants to States and Tribes to bring evidence-based prevention strategies to scale nationwide. SAMHSA will partner with States to use data-driven planning processes to identify and address problems in communities through the

deployment of proven practices.

***Substance Abuse State Prevention*:** Within this total, the Budget includes $395 million for a new Substance Abuse State Prevention Grant by combining disparate substance abuse prevention funding streams to States to avoid duplication, improve coordination, and better leverage resources. The most recent data from the 2009 National Survey on Drug Use and Health indicate that illicit substance use increased from 2008 among those aged 12 and over. The Budget will create a sustainable source of prevention funding for all States to employ evidence-based substance abuse prevention practices to address existing and emerging issues in high-risk communities.

Mental Health State Prevention: The Budget includes $90 million for a mental health State prevention effort through an expansion of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health). These grants will enable States to conduct evidence-based prevention and wellness interventions focused on children by targeting the common set of risk factors that lead to substance abuse and mental illness.

Behavioral Health Tribal Prevention: The Budget includes $50 million for a new Behavioral Health Tribal Prevention Grant. Grants will be awarded to each of the 565 Federally-recognized Tribes to implement strategies to prevent alcohol and substance abuse and prevent suicides. SAMHSA will coordinate with the Indian Health Service (IHS) to implement community-based prevention strategies that complement the clinical services provided by IHS-funded providers.

TESTING AND DELIVERING TARGETED INTERVENTIONS

The Innovations and Emerging Issues activities will be used to identify emerging issues in substance abuse and mental health prevention and treatment, foster innovative solutions, and evaluate new ways of addressing them in order to ultimately move evidence-based practices and policies into the Nation's behavioral health system. The Budget includes $976 million, a decrease of $41 million below FY 2010, for Innovations and Emerging Issues and other competitive and targeted grant activities. The Budget discontinues funding for new awards in a number of fully tested program areas while reinvesting the savings in the testing of new practices and in bolstering the State-level efforts necessary to implement and sustain evidence-based strategies nationwide.

Supporting Military Families: Many military families experience stress and behavioral health consequences as the result of prolonged deployments. The Budget includes $10 million for a new Military Families Initiative to address the behavioral health needs of military service personnel and their families. The Budget will support 10 States in a two-phased planning and implementation process to improve and enhance the coordination of and access to prevention, treatment, and recovery support services for military members and their families.

Improving Health Information Technology: The adoption of health information technology within the behavioral health system holds promise for improving behavioral health outcomes by improving care coordination and quality of care. The Budget includes $4 million for a new effort to work with States in implementing pilot projects for the use of electronic health records by behavioral health providers.

Establishing Prevention Prepared Communities: The Budget includes $23 million for a community-level initiative to implement comprehensive, evidence-based community prevention programs that serve young people during their at-risk years. The Budget will support 30 communities in identifying their predominant substance abuse and mental health issues and selecting and implementing the appropriate evidence-based strategies to target the risk and protective factors contributing to these issues.

Improving Children's Mental Health: Coordinated systems of mental health care for children are proven to sustain mental health improvements, improve school attendance and achievement, reduce suicide-related behaviors, decrease the utilization of inpatient hospital care, and significantly reduce contacts with law enforcement. The Budget includes $121 million, the same level as FY 2010, for

Children's Mental Health Services for the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders and their families.

Assisting in the Transition from Homelessness: Approximately one-fifth of homeless individuals also have serious mental illness. The Budget dedicates a total of $154 million, an increase of $12 million, for services to support individuals suffering from mental illness and facing homelessness. Included within this funding is $16 million for a new collaborative Housing and Homeless Initiative with the Department of Housing and Urban Development that will combine health, behavioral health, and other support services to move and maintain chronically homeless individuals with mental and substance use disorders into permanent supportive housing.

Providing Screening and Brief Intervention: Early identification and interventions can decrease total health care costs by impeding progression to addiction. The Budget provides $29 million, the same level as FY 2010, for substance abuse screening and interventions within general medical and primary care settings.

Preventing Youth Violence: SAMHSA collaborates with the Departments of Education and Justice through local partnerships to implement best practices for education, justice, law enforcement and mental health services through the Safe Schools/Healthy Students program. The Budget includes $94 million, the same as FY 2010, for the prevention of youth violence. SAMHSA-supported interventions foster early childhood development of mental and physical health, reduce or delay the onset of emotional and behavioral problems, and treat children with serious emotional disturbances.

Primary and Behavioral Health Care Integration

The Primary and Behavioral Health Care Integration program supports the coordination and integration of primary care services into publically-funded community behavioral health care settings to ensure that individuals with mental illness receive the primary care that they need to prevent illness and stay physically healthy.

In FY 2010, SAMHSA awarded $34 million, including $20 million from the Affordable Care Act's Prevention and Public Health Fund, to support the integration of primary care into the services offered by 56 community behavioral health agencies nationwide and to jointly establish with the Health Resources and Services Administration a national resource center to provide training and technical assistance to community behavioral health programs, community health centers, and other primary care organizations. The Budget includes $34 million to continue these activities.

Preventing Suicide: The Budget dedicates $48 million, the same as FY 2010, to prevent suicide. The Budget continues to invest in activities authorized by the Garrett Lee Smith Memorial Act that support intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations. The Budget sustains the capacity of the national hotline that routes calls across the country to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources.

Fostering Community Resilience: Many Americans continue to experience heightened levels of stress and anxiety associated with financial and job insecurity. The Budget invests $5 million, the same as FY 2010, to continue to promote stress reduction and behavioral health. In addition to these targeted resources, broader investments made by SAMHSA in the prevention and treatment of mental health and substance abuse disorders will continue to play a key role in facilitating resilience and recovery.

OTHER ACTIVITIES

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

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

Improving Public Awareness and Support: Many Americans are not getting the help they need for behavioral health, and many opportunities for prevention and early intervention are being missed. The Budget includes $14 million to consolidate public awareness activities to better deploy marketing approaches that combine sound public health practices with evidence-based communication strategies.

Consolidating Performance and Quality Information Systems: The Budget includes $13 million, a decrease of $24 million, for grantee quality reporting systems across SAMHSA. Consolidation and improved coordination will produce efficiencies and improve the usefulness of performance measurement and quality improvement activities.

Health Surveillance and Program Support: The Budget includes $128 million, an increase of $26 million, for the support of national survey efforts and the administration of SAMHSA programs. The majority of this increase will support data collection and analysis, including increased costs associated with ongoing efforts as well as enhancing data collection on drug related emergency room visits and deaths. Analyses conducted through SAMHSA's national surveys are used by Federal, State, and local authorities, as well as health care providers, to inform policymakers regarding substance use and mental disorders, the impact and treatment of these disorders, and the recovery process.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Health Costs, Quality and Outcomes Research				
Health Information Technology	28	28	28	-0
General Patient Safety Research	91	91	65	-26
Patient-Centered Health Research	21	29	46	+25
*PCORTF Transfer**	--	*8*	*24*	*+24*
Crosscutting Activities	112	112	92	-20
Value	4	4	4	--
Prevention/Care Management	21	28	23	+2
Prevention and Public Health Fund	*6*	*12*	--	*-6*
Subotal, Health Costs, Quality and Outcomes	276	291	257	-20
Medical Expenditure Panel Surveys	59	59	59	+1
Program Support	68	68	74	+7
Total, Program Level	**403**	**417**	**390**	**-12**
Less Funds From Other Sources				
PHS Evaluation Funds	-397	-397	-366	-31
Patient-Centered Health Research Trust Fund	--	-8	-24	+24
Prevention Fund	-6	-12	--	-6
Subtotal, Funds from Other Sources	-403	-417	-390	-12
Total, Budget Authority	--	--	--	--
FTE	300 **	300	304	+4

* Beginning in FY 2011, AHRQ will receive funds transferred from the Patient-Centered Outcomes Research Trust Fund (PCORTF) to implement section 937 of the Public Health Services Act.

** Excludes 12 FTE that were funded from the American Recovery and Reinvestment Act.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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

The FY 2012 Budget includes $390 million for the Agency for Healthcare Research and Quality (AHRQ), $12 million below the FY 2010 level. This total includes $366 million in PHS Evaluation Funds and a transfer of $24 million from the Patient-Centered Outcomes Research Trust Fund as called for in Affordable Care Act.

AHRQ conducts health services research within the Department and sponsors research in institutions, including leading universities, hospitals, and health care systems, to inform decision-making and improve health care clinical services, organization, and financing. The FY 2012 Budget supports health services research on delivery system costs, quality and outcomes, as well as data collection and analysis on health care expenditures and use. The Budget proposes savings due to the completion of one-time projects in FY 2010 that no longer need to be funded.

HEALTH COSTS, QUALITY, AND OUTCOMES

The Budget includes a total of $257 million, $20 million below the FY 2010 program level, to support research on health care cost, quality, effectiveness and efficiency. Of this total $233 million is in PHS Evaluation Funds.

AHRQ conducts research focused on six priorities: patient-centered health research, health information technology, patient safety, prevention and care management, value, and crosscutting activities on health cost, quality and outcomes.

Patient-Centered Health Research: The FY 2012 Budget includes a total of $46 million for Patient-Centered Health Research, which supports research comparing the effectiveness of different treatment options. This program provides a broad range of stakeholders with timely and usable state-of-the-science information to enhance decision-making.

Of the total for this type of research, AHRQ will receive $24 million from the Patient-Centered Outcomes Research Trust Fund (PCORTF) established through the Affordable Care Act to disseminate comparative clinical effectiveness research findings and to build research capacity.

In FY 2012, AHRQ will synthesize and evaluate current medical data, and conduct new research through its "Developing Evidence to Inform Decisions about Effectiveness Network", which conducts studies on outcomes, comparative clinical effectiveness, safety, and appropriateness of health care services. In FY 2012, AHRQ will strategically broaden its focus to areas that are aligned with the needs of patient, clinicians, and other stakeholders.

AHRQ also makes patient-centered health research findings and products available to consumers, clinicians, and policy makers, through its translation and dissemination efforts, and continues to strengthen the patient-centered health research infrastructure by supporting training of the next generation of researchers. In FY 2012, AHRQ will support on-going projects initiated in previous years as well as activities funded by PCORTF.

Investing in Health IT: The Budget includes $28 million for health information technology (health IT) research. This investment will support on-going projects to advance the quality, safety, and efficiency of health care through the use of health IT.

AHRQ translates, disseminates, and conducts health IT research to provide stakeholders and partners across the Federal Government with evidence-based information and tools. The health IT program continues to work in collaboration with the Office of the National Coordinator for Health Information Technology to implement the health IT research center authorized in the Health Information Technology for Economic and Clinical Health Act (HITECH).

The FY 2012 Budget level for health IT will support 46 research and training grants funded at $14 million. These projects aim to improve the quality and safety of care by demonstrating best approaches to broader diffusion, implementation, and effective use of health IT. In addition, AHRQ will support $13 million in

contracts related to synthesizing and disseminating evidence on meaningful use of health IT and developing the tools and resources for various stakeholders to implement best practices.

Supporting Patient Safety Activities: The FY 2012 includes $65 million, a decrease of $26 million below FY 2010, to support the patient safety research portfolio. AHRQ generates knowledge to prevent, mitigate, and decrease medical errors and threats, supports implementation of the Patient Safety and Quality Improvement Act, and addresses gaps in health care quality.

Included within the FY 2012 total is $34 million for projects that will reduce and prevent healthcare- associated infections (HAIs). Of this total, $10 million will be invested specifically in projects to assist with implementation of evidence-based practices to prevent common HAIs, such as central-line associated blood stream infections and catheter-associated urinary tract infections.

Current research projects that prevent the occurrence of central-line associated blood stream infections are now operational in every State, Puerto Rico, and the District of Columbia. These projects provide evidence-based practices, tools and training in hospital intensive care units (ICU). In FY 2012, AHRQ will continue to expand the program to more hospitals in each State and to more health care settings beyond the ICU.

AHRQ's research budget was decreased by $26 million below the FY 2010 level. Of this total, $25 million is attributed to a one-time investment in FY 2010 for multi-year medical liability reform projects which AHRQ continues to implement and monitor.

Advancing Patient Safety

Improving the safety of health care remains a high priority for HHS. AHRQ contributes to this important area by making available a broad range of evidence-based resources for use by health care organizations to improve patient safety and prevent and reduce the incidence of medical threats and errors. In FY 2010, a total of 86 AHRQ tools were available to health care providers including research summaries, training tools, surveys on patient safety culture, and access to web based patient safety networks. AHRQ will continue to increase the number of resources to a total of 92 in FY 2011 and 98 in FY 2012.

Prevention and Care Management: In FY 2012, AHRQ will invest $23 million, an increase of $2 million over the FY 2010 Program Level, for research and dissemination activities in prevention and care management. AHRQ will conduct research to improve primary care and clinical outcomes, support clinical decision-making for preventive services, and implement activities that improve care through health systems redesign.

Of the total requested in FY 2012 for the Prevention and Care Management research portfolio, $11 million will support the US Preventive Services Task Force (USPSTF). AHRQ provides scientific and administrative support to the USPSTF, which is an independent panel tasked with evaluating risks and benefits of clinical preventive services, making recommendations about which services should be incorporated into primary medical care, and identifying research priorities. As described in the Affordable Care Act, in addition to providing technical and research assistance, AHRQ will support and coordinate dissemination of USPSTF recommendations and provide technical assistance to facilitate implementation of clinical preventive services recommendations by health care organizations.

Advancing Other Research and Dissemination Activities: Achieving greater value in health care reduces unnecessary costs and waste while also improving quality and enhancing transparency of information. AHRQ will invest $4 million in FY 2012 to continue and enhance projects in health care value such as My Own Network powered by AHRQ, also known as MONAHRQ, which provides States and communities with software to publically report comparative quality improvement data.

In addition, the Budget also includes $92 million, a reduction of $20 million below FY 2010, for crosscutting research in a range of topics related to improving quality, effectiveness and efficiency in health care. AHRQ will support innovative health services research, coordinate data collection, measurement and analysis, and disseminate and translate research findings. The Budget includes $33 million for investigator initiated research

Improving the Quality of Care

Understanding patient experiences is an important component of improving the quality of health care delivery. The Consumer Assessment of Healthcare Providers and Systems program is a multi-year public and private initiative that uses comprehensive and standardized surveys to collect information on patient experiences with ambulatory and facility-level care. Patients report data on topics ranging from communication to accessibility of services which is used to create quality improvement tools for consumers and providers. In FY 2012, AHRQ will invest $3 million to begin the fourth phase of this initiative.

projects and also continues to support core data and measurement activities related to the Healthcare Cost and Utilization Project and the annual National Healthcare Quality and Disparities Reports.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

As the only national source of annual data on how Americans use and pay for health care, MEPS serves as a vital source of data for public and private projections of health care expenditure and utilization. AHRQ collects information on medical access, use, expenses, insurance coverage and quality using three survey components: household, medical provider, and insurance. With an investment of $59 million, MEPS will continue to provide valuable data as well as measures on health status, demographic characteristics, employment, and access to and quality of health care. At this level of funding, survey sample sizes will ensure precision and full analytical capacity in all three surveys.

PROGRAM SUPPORT

The FY 2012 Budget includes $74 million, an increase of $7 million over FY 2010, to support operational and administrative costs across the agency. The increase in FY 2012 will primarily fund required General Services Administration tenant improvement rental costs. In addition, AHRQ will support four additional full time equivalents in FY 2012 to implement responsibilities of the USPSTF.

CENTERS FOR MEDICARE & MEDICAID SERVICES

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law:				
Medicare /1	451,702	495,242	475,510	-19,732
Medicaid /2	272,771	276,249	269,365	-6,884
CHIP /3	7,887	9,169	9,981	+812
State Grants and Demonstrations	531	615	518	-97
New Health Insurance Programs	6	5,344	3,802	-1,542
Center for Medicare and Medicaid Innovation	0	546	801	+255
Total Net Outlays, Current Law	**732,897**	**787,165**	**759,977**	**-27,188**
Proposed Law:				
Medicare /4	0	0	18,070	+18,070
Medicaid /4	0	0	-190	-190
State Grants and Demonstrations	0	0	20	+20
Total, Proposed Law	**0**	**0**	**17,900**	**+17,900**
Savings from Program Integrity Investments /5	0	0	-895	-895
Total Net Outlays, Proposed Law /6	**732,897**	**787,165**	**776,982**	**-10,183**

1/ Current law Medicare outlays net of offsetting receipts.
2/ Net outlays net of Qualified Individual (QI) program.
3/ Includes the Child Enrollment Contingency Fund.
4/ Outlay costs of extending the QI program are reflected in Medicare. States pay the Medicare Part B premium costs for QI, which are are in turn offset by a reimbursement from Medicare Part B.
5/ Savings not scoreable under PAYGO rules
6/ Total net proposed law outlays equal current law outlays plus the impact of proposed legislation and offsetting receipts.

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

The FY 2012 Budget request for the Centers for Medicare & Medicaid Services (CMS) is $777 billion in mandatory and discretionary outlays, a net decrease of $10.2 billion below the FY 2011 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), new health insurance programs and protections, program integrity efforts, and operating costs.

On January 26, 2011, CMS absorbed the functions of the Office of Consumer Information and Insurance Oversight. CMS will support consumer protections and promote access for those purchasing private insurance.

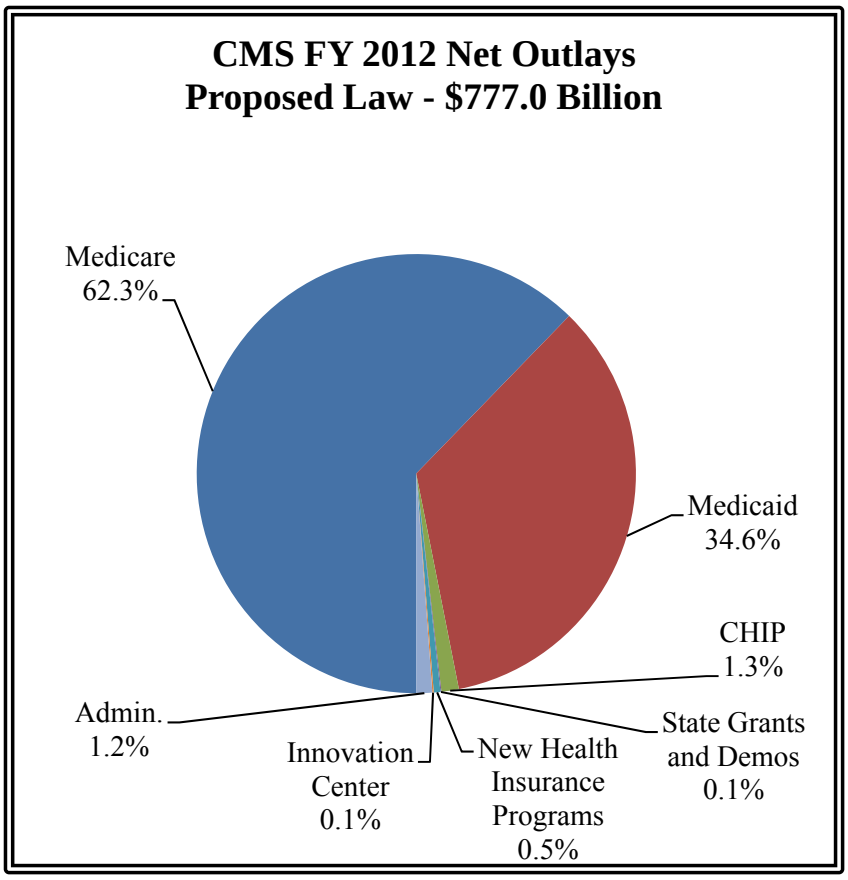
RECENT LEGISLATION

The Affordable Care Act is landmark health care legislation that brings comprehensive insurance reforms, expanded coverage, and enhanced quality of health care to all Americans. CMS has a central role to play in implementing key provisions of this legislation, including: expanding benefits and access for

Center for Medicare and Medicaid Innovation

The Affordable Care Act created the Center for Medicare and Medicaid Innovation ("Innovation Center"), a new office within CMS, charged with rapidly developing, testing, and implementing innovative payment and delivery system reforms to Medicare and Medicaid. The Innovation Center has the twin goals of reducing costs and improving quality of care. Funded at $10 billion over ten years, the Innovation Center has identified several promising models to test and is working with key industry and community stakeholders to identify additional promising reforms.

Medicare and Medicaid enrollees; enhancing consumer protections for purchasers of private insurance; laying the groundwork for State-based Health Insurance Exchanges (Exchanges), which begin coverage in January 2014; and implementing reforms to improve quality and efficiency in the health care payment and delivery system. The FY 2012 Budget supports CMS efforts in each of these areas.



BUDGETARY REQUEST

Program Integrity: The Budget makes fighting health care fraud and reducing improper payments a top priority. These efforts will safeguard public funds and send a clear message that fraud and waste in our health programs will not be tolerated. The Budget includes a $270 million increase in discretionary program integrity resources as part of a multi-year investment to enable HHS and its partners to take ground-breaking steps to detect, prevent, and prosecute health care fraud and save $10.3 billion over ten years. The Budget also proposes a series of new authorities that will strengthen existing program integrity oversight in Medicare and Medicaid. These investments will show real, measurable results, saving $32.3 billion over ten years.

Medicare: The Budget includes savings proposals to offset the costs of two years of physician relief from cuts resulting from the Sustainable Growth Rate (SGR) formula, and a commitment to work with Congress to provide longer-term relief.

Medicaid: The Budget includes $1.2 billion to extend two important programs within Medicaid: the Transitional Medical Assistance program and Medicare Part B premium assistance for low-income Medicare beneficiaries, in addition to savings proposals to strengthen Medicaid.

Discretionary Program Management: The Budget makes a robust investment in CMS program management. These funds will support efforts to improve the sustainability of Medicare, Medicaid, and CHIP, transform the way CMS pays providers, and improve the quality of care received by beneficiaries. These funds will also allow CMS to develop the infrastructure to perform important new functions, including the development and operation of the new Exchanges, and the implementation of crucial consumer protections to provide more security to those with private coverage.

Recovery Act Electronic Health Records Incentive Payments

The Medicare and Medicaid Electronic Health Record (EHR) incentive programs, created as part of the Recovery Act, were launched in 2011. Hospitals and eligible professionals began registering for the programs on January 3. Eleven states opened registration for their Medicaid EHR incentive payment programs in January, and the first incentive payments were issued by Kentucky and Oklahoma on January 5.

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law:				
Outlays				
Benefits Spending (gross) /1	513,590	559,898	548,115	-11,783
Less: Premiums Paid Directly to Part D Plans /2	-4,161	-4,857	-5,647	-790
Subtotal, Benefits Net of Direct Part D Premium Payments	**509,429**	**555,041**	**542,468**	**-12,573**
Related-Benefit Expenses/3	9,399	10,739	10,582	-157
Administration /4	6,883	8,922	9,530	608
Total Outlays, Current Law (CL)	**525,711**	**574,702**	**562,580**	**-12,122**
Offsetting Receipts				
Premiums and Offsetting Receipts /5	-74,009	-79,460	-87,070	-7,610
Current Law Outlays, Net of Offsetting Receipts	**451,702**	**495,242**	**475,510**	**-19,732**
Proposed Law:				
Physician Update	0	0	18,602	18,602
Other Medicare Proposals	0	0	-465	-465
Offsetting Receipts	0	0	-67	-67
Total Medicare Proposed Law	**0**	**0**	**18,070**	**18,070**
Savings from Program Integrity Investment	0	0	-788	-788
Total Net Outlays, Net of Program Integrity Investment /6	**451,702**	**495,242**	**492,792**	**-2,450**
Mandatory Proposed Law:				
Mandatory Total Net Outlays, Proposed Law /7	**446,616**	**489,319**	**485,804**	**-3,516**

1/ Represents all spending on Medicare benefits by either the Federal government or beneficiaries. Includes Medicare Health Information Technology Incentives under both HI and SMI.

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

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

4/ Includes Trust Fund and non-Trust Fund Program Management, non-CMS administration, HCFAC, and QIOs.

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

6/ FY 2012 includes $788 million in non-PAYGO scorecard savings from increased HCFAC investment and Social Security disability review, and also includes a SMI transfer of $495 million to Medicaid to extend the Qualified Individuals (QI) Program.

7/ Removes total Medicare discretionary amount: FY 2010- $5,085 million; FY 2011- $5,923 million; FY 2012- $6,989 million

In FY 2012, gross current law spending on Medicare benefits will total $548 billion. Medicare will provide health insurance to 50 million individuals who are either 65 or older, disabled, or have end–stage renal disease (ESRD).

Medicare Enrollment (enrollees in millions)				
	2010	**2011**	**2012**	**2012 +/- 2011**
Aged	39.4	40.2	41.4	+1.2
Disabled	7.9	8.3	8.7	+0.4
Total Beneficiaries	**47.3**	**48.5**	**50.1**	**+1.6**

THE FOUR PARTS OF MEDICARE

Part A ($203 billion gross fee-for-service spemding in 2012):
Medicare Part A pays for inpatient hospital, skilled nursing facility, home health (related to a hospital stay), and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax split between employees and employers.

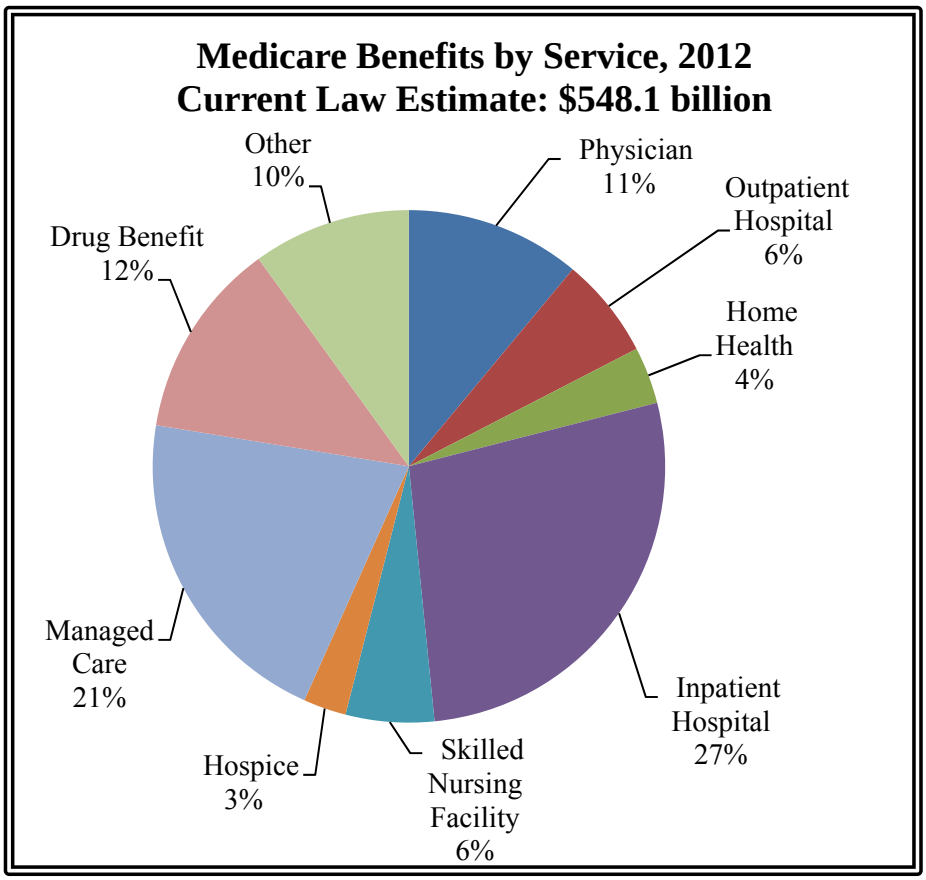
Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most services require a beneficiary co-payment or coinsurance. In 2011, beneficiaries pay a $1,132 deductible for a hospital stay of 1-60 days, and $141.50 daily coinsurance for days 21-100 in a skilled nursing facility.

Part B ($163 billion gross fee-for-service spending in 2012):
Medicare Part B pays for physician, outpatient hospital, ESRD, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 92 percent of all Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

The standard monthly premium is $115.40 in 2011. However, most beneficiaries will continue to pay a $96.40 monthly premium, the same level as 2009, because current law protects existing beneficiaries from a reduction in Social Security benefits as a result of Medicare premium increases. In both 2010 and 2011, the Social Security cost-of-living adjustment was zero.

Some beneficiaries pay a higher Part B premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married) will pay from $161.50 to $369.10 per month.

Part C ($114 billion in 2012):
Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including health maintenance organizations, preferred provider organizations, special needs plans, and private fee-for-service plans. MA



enrollment will total approximately 12 million in 2012.

Medicare pays MA plans a capitated monthly payment to provide all Parts A and B services (and also Part D services if offered by the plan). Plans can also offer additional benefits or alternative cost sharing arrangements that are at least as generous as the standard Part A and B benefits under traditional Medicare. Beneficiaries pay monthly premiums to MA plans to cover all Medicare services plus any additional benefits. The premium varies depending on the services offered by the plan and the efficiency of the plan; therefore, MA plans may charge a premium in addition to the regular Part B premium.

Part D ($68 billion gross spending in 2012): Medicare Part D offers a standard prescription drug benefit with a 2011 deductible of $310 and an average monthly premium of about $30. For low-income beneficiaries, varying degrees of cost sharing are available with co-payments ranging from $0 to $6.30 in 2011 and low or no monthly premiums.

For 2012, there will be about 32 million beneficiaries in Medicare Part D, including about 11 million low-income subsidy (LIS) beneficiaries. About 66 percent of those with Part D coverage are enrolled in stand-alone Part D prescription drug plans and 34 percent are enrolled in a Medicare Advantage Prescription Drug Plan (MA-PD). Overall, approximately 87 percent of all Medicare beneficiaries receive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage.

Closing the Coverage Gap

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

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

Year	*Percent Cost Sharing Paid by Enrollee for Branded Drugs*	*Percent Cost Sharing Paid by Enrollee for Generic Drugs*	*Average Amount Saved per Enrollee who Reaches the Coverage Gap /2*
2010 /1	100%	100%	$250
2011	50%	93%	$526
2012	50%	86%	$562
2013	47.5%	79%	$632
2014	47.5%	72%	$684
2015	45%	65%	$773
2016	45%	58%	$840
2017	40%	51%	$984
2018	35%	44%	$1,144
2019	30%	37%	$1,322
2020	25%	25%	$1,540

/1 Percent cost sharing does not include $250 rebate for each beneficiary who hit the coverage gap in 2010.
/2 Source: 2009 data generated by Acumen for the HHS Assistant Secretary for Planning and Evaluation (ASPE).

The Affordable Care Act: Strengthening Medicare

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

Improved Prescription Drug Coverage: In 2010, over three million Part D beneficiaries who reached the coverage gap and did not have LIS coverage through the gap qualified to receive a $250 rebate check. Beginning January 1, 2011, if a beneficiary without LIS reaches the coverage gap, he or she will receive a 50 percent discount at the point of sale on covered Part D brand name drugs and biologics. In 2011, beneficiaries will pay 93 percent of the costs for all generic drugs in the coverage gap, a reduction of seven percent compared to 2010. Cost-sharing in the coverage gap will be reduced each year until beneficiaries are required to pay only 25 percent of the costs of covered Part D drugs in 2020 and beyond.

Income-Based Part D Premiums: Beginning in 2011, Part D premiums will be adjusted for beneficiaries whose modified adjusted gross income (MAGI)

exceeds thresholds established for the Part B income-related premium. Beneficiaries whose MAGI exceeds $85,000 (single) and $170,000 (married) will be assessed a higher premium, with the premium increasing as beneficiary income increases.

Increased Access to Primary and Preventive Care: Starting in 2011, primary care providers and surgeons in health professional shortage areas will receive an additional 10 percent payment for primary care services or major surgical procedures. In addition, annual wellness visits are now included in the Medicare benefit free of charge, encouraging beneficiaries to make yearly trips to their doctors and receive preventive services. The new law also ensures that beneficiaries have access to recommended preventive services with no cost sharing.

Better Quality of Care: Medicare continues to move towards becoming a purchaser of quality care, rather than just a payer of volume-based claims. The Act establishes value-based purchasing programs for hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers, as well as a hospital readmissions reduction program that requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning in October 2012. The Act also requires CMS to implement a quality-based bonus payment for MA plans based on a 5-star rating system, beginning in 2012.

Improved Program Sustainability: The Act takes numerous steps to improve Medicare's fiscal situation, strengthening the program's long-term sustainability. Slower increases in payment rates for certain providers, combined with strengthened quality standards and incentives, will encourage providers to become more efficient and value driven. Adjustments to Medicare Advantage rates, starting in 2012, will eliminate overpayments to plans, and bring managed care reimbursement in-line with spending on fee-for-service beneficiaries. Additionally, the new Independent Payment Advisory Board will propose changes in Medicare reimbursement should costs exceed the rate of growth specified in the Act.

Innovations in the Delivery of Care: The Act tests ideas through demonstrations that can improve the quality of care and the efficiency of the delivery system. Examples include the shared savings program for Accountable Care Organizations (ACOs), scheduled to begin in early 2012, which aims to reduce fragmented care. Providers would receive a portion of any savings to the Medicare program that result from effectively coordinating high-quality care. Also expected to begin in early 2012, the Medicare Independence at Home demonstration uses home-based primary care teams directed by physicians and nurse practitioners to improve health outcomes and reduce expenditures. To coordinate and sustain the introduction of new ideas to improve care delivery, the Act also created the Center for Medicare and Medicaid Innovation (Innovation Center). Working with private sector partners across the country, this new center has already identified several promising models to test. The Innovation Center's identification of successful models is expected to have positive implications for the health care system at large.

Physician Payment Relief and Offsetting Savings
(Dollars in Billions)

	5-Year	10-Year
Provide Physicians Relief From Scheduled SGR Cuts For 10 Years	**144.4**	**369.9**
Provide SGR Relief Through 2013	**54.4**	**54.4**
Offsets to Provide Relief Through 2013*	**-17.2**	**-62.2**
Program Integrity	*-9.1*	*-32.3*
Pharmaceuticals	*-4.4*	*-12.9*
Hospitals	*0.0*	*-4.2*
QIOs	*-0.9*	*-3.3*
Other Proposals	*-2.4*	*-9.6*
Interactions	*-0.5*	*0.1*
Provide SGR Relief From 2014 Onward	**90.0**	**315.4**
Offset Cost of Providing SGR Relief From 2014 Onward	**-90.0**	**-315.4**

** Offsets include HHS and OPM savings*

FY 2012 Administrative Policies

Achieve Administrative Savings Through Gaining Efficiencies: The Budget includes an allowance for administrative savings of $10 billion over 10 years.

FY 2012 LEGISLATIVE PROPOSALS

Physician Payment Relief:

In December, the Administration worked with Congress to offset the cost of legislation preventing an imminent decrease in physician payments due to the Medicare Sustainable Growth Rate (SGR) formula. The Budget goes further and proposes to continue the zero percent update, and offset the cost of this shift for the next two years with specific savings. Beyond the next two years, the Administration is determined to work with Congress to put in place a long-term plan to reform physician payment rates in a fiscally responsible way, and to craft a reimbursement system that gives physicians incentives to improve quality and efficiency, while providing predictable payments for care furnished to Medicare beneficiaries.

Reforming the Quality Improvement Organizations (QIO) Program:

The Budget includes a set of QIO proposals to enhance the program's administrative operations and bring QIO contracting principles in line with other government contracts, such as the Medicare Administrative Contracts, by introducing competition and performance incentives. The proposals enhance contract review and termination processes; allow additional quality organizations to compete for QIO contracts, alleviating peer review conflict of interest concerns; and require the Secretary to determine the geographic scope of the QIOs, fostering contract efficiencies. These proposals are also consistent with the recommendations made in the 2006 Institute of Medicine's report on the QIO program.

Larger Geographic Scope: Expand the scope of QIO State contracts to include national entities and multiple QIOs within a geographic area, thereby increasing competition and contract efficiencies. [Effective upon enactment]

Expanded Pool of Contractors: Provide the Secretary with discretion to contract with other types of quality organizations to perform QIO functions. This proposal will allow work to be assigned to a QIO or quality organization based on performance, expertise, and cost-effectiveness. [Effective upon enactment]

Eliminate the Conflict of Interest Between Beneficiary Protection and Quality Improvement: Allow CMS to award QIOs and other quality organizations contracts within a State or region to different contractors for administrative case review and quality improvement functions. This option will alleviate conflict of interest concerns in which the contractor is responsible for building provider relationships to improve quality while also holding providers accountable for failures in the delivery of care. [Effective upon enactment]

Longer Contract Length: Extend the contract length from three to up to five years to allow for more rigorous evaluation, enhance the scope of contract services rendered, and reduce the heavy start-up burden for QIOs. [Effective upon enactment]

Change Contract Termination Procedures: Enhance the Secretary's ability to terminate underperforming QIOs and end the lengthy panel review process that can delay contract changes that promote program effectiveness and efficiency. This action will align QIO contracting with Federal Acquisition Regulations. [Effective upon enactment]

Improving Medicare Program Operations:

Redirection of Electronic Health Records Penalties: The American Recovery and Reinvestment Act of 2009 established financial penalties for certain Medicare providers if they fail to adopt electronic health records. This proposal would dedicate these penalties to improving Medicare program financing. [Effective CY 2020]

Non-CMS Proposals Impacting Medicare:

Shift Future Enrollees from the USFHP to Medicare/TRICARE for Life: Future military retirees

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

	Funds
QIO Clinical Quality Improvement…….	$393
Data Processing and Special Initiatives……..	$262
Other Support Contracts…….	$220
Protecting Beneficiaries and the Trust Funds…….	$208
**Actual Adjusted 9th SOW Funding …….. **	**$1,083**
New 9th SOW Activities…….....	$72
**Total Estimated Obligations…….. **	**$1,155**

enrolling in the Uniformed Services Family Health Plan (USFHP) would lose eligibility for USFHP coverage upon reaching age 65 and becoming eligible for Medicare. Affected military retirees who transfer to Medicare would remain eligible for supplemental TRICARE-for-Life coverage.

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics: The Affordable Care Act created a pathway for the FDA approval of generic biologics, providing a 12 year exclusivity period. This proposal would shorten the exclusivity period from 12 to 7 years. It would also prohibit manufacturers who revise their product from extending their exclusivity period, a process known as "evergreening." [Effective FY 2012. Note: this proposal will also result in Medicaid savings.]

Prohibit Drug Companies from Delaying Availability of New Generic Drugs: This proposal would give the Federal Trade Commission the authority to prohibit "pay-for-delay" agreements between brand and generic pharmaceutical companies that delay entry of generic drugs into the market. Currently, brand name companies are allowed to pay generic companies through anticompetitive agreements intended to keep generic drugs off the market. This practice leads to increased costs for insurers and consumers. [Effective FY 2012. Note: this proposal will also result in Medicaid savings.]

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

The current 9th Contract Cycle has included significant reforms to the management of the program and increased the expected performance of the QIOs. The major goals of the 9th Contract Cycle include preventing illness, increasing the safety of care, reducing health care disparities, and promoting the use of efficient and high quality care.

As a result of QIO efforts, several thousand pressure ulcers were prevented in nursing homes, inappropriate physical restraints were dramatically reduced, care coordination was improved after discharge from hospitals resulting in reductions in readmissions and potentially avoidable admissions, and contributions were made to the reduction of healthcare associated infections. The final stages of the 9th Contract Cycle will continue to focus on achieving the national priorities to improve patient care.

Clinical Quality Efforts: Under the 9th Contract Cycle, clinical care efforts have focused on preventing disease, improving the coordination of care to avoid unnecessary re-hospitalizations, identifying and intervening in the area of health care disparities, and increasing patient safety. QIOs also responded to quality of care complaints from beneficiaries and made information available to support public reporting.

Performance Management Strategy: The 9th Contract Cycle included several innovations in QIO contract management, including ongoing performance management reviews, mid-contract performance assessments, and financial consequences for contractors who do not maintain pre-specified performance levels.

Reduce Hospital-Acquired Infections

Postoperative surgical site infections (SSI) are a major cause of patient morbidity, mortality, and health care cost. Infection increases intensive care unit admission by 60 percent, and the risk of hospital readmission by five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection. Aligned with the Patient Safety Theme of the QIO 9th Contract Cycle CMS measures the percentage of timely antibiotic administration. In FY 2009, 95.6 percent of Medicare-funded surgeries had timely antibiotic administration, surpassing the FY 2009 target of 89 percent and reflecting a 4 percentage point improvement over the FY 2008 rate. Today, CMS has increased its targets for both 2011 and 2012 and continues to work towards preventing healthcare-associated infections, including through relevant provisions of the Affordable Care Act.

MEDICARE PROPOSALS

(dollars in millions)

	2012	2012-2016	2012-2021
Legislative Proposals			
Physician Payment Relief:			
Provide Physicians Relief From Scheduled SGR Cuts For 10 Years	**18,602**	**144,376**	**369,853**
Provide SGR Relief Through 2013 [non-add]	*18,602*	*54,405*	*54,405*
Savers/Budget Neutral:			
Reforming the Quality Improvement Organizations (QIO) Program*:			
Require the Secretary to Determine the Geographic Scope of QIO Contracts	-20	-600	-2,220
Expand Pool of Contractors Eligible for QIO Work	0	-50	-170
Eliminate the Conflict of Interest Between Beneficiary Protection and QI Activities for QIOs	-10	-200	-710
Extend the QIO Contract Length From Three Years Up to Five Years	0	-30	-160
Align QIO Contract Terminations With Federal Acquisition Regulations	0	0	0
Promote Lower Pharmaceutical Costs*:			
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	0	-300	-2,180
Prohibit Brand and Generic Drug Companies From Delaying the Availability of New Generic Drugs	-430	-2,570	-6,460
Medicare Program Integrity (see Program Integrity section)*	-500	-3,530	-8,620
Improving Medicare Program Operations*:			
Dedicate EHR Penalties to Improving Medicare Program Financing	0	0	-3,230
Subtotal, Savers/Budget Neutral	-960	-7,280	-23,750
Interactions	-67	-512	59
Specified Medicare Savings Offsetting Cost of Physician Relief [non-add]	*-1,027*	*-7,792*	*-23,691*
Other Proposals:			
Extend the Qualified Individuals (QI) Program	495	495	495
Shift Future Enrollees From Uniformed Services Family Health Plan Into Medicare/TRICARE	0	50	530
Total, Legislative Proposals	**18,070**	**137,129**	**347,187**
Administrative Policies			
Achieve Administrative Savings Through Gaining Efficiencies	-1,000	-5,000	-10,000
Subtotal, Administrative Policies	-1,000	-5,000	-10,000
Total: Medicare Legislative and Administrative	**17,070**	**132,129**	**337,187**

* Specified Medicare savings to offset physician payment relief through 2013

The FY 2012 Budget makes fighting health care fraud a priority by investing $270 million in new discretionary resources above the FY 2010 level. The Budget proposes a package of legislative changes that will give HHS new tools that enhance program integrity oversight, strengthen the Medicare, Medicaid, and CHIP programs, and generate $32.3 billion in program savings over ten years.

Health Care Fraud and Abuse Control (HCFAC) Account

(dollars in millions)

	2011 Base	2012	2013	2014	2015	2016	2012-2016
Mandatory Base Funding /1	1,398	1,272	1,267	1,291	1,306	1,331	6,467
Discretionary Funding /2	311	581	610	640	672	706	3,208
Total Program Level	**1,709**	**1,853**	**1,877**	**1,931**	**1,978**	**2,037**	**9,675**
Savings from Discretionary Investment /3:	**-485**	**-750**	**-890**	**-930**	**-990**	**-1,040**	**-4,600**

/1 These totals do not include funding for the Medicaid Integrity Program, which is discussed separately under State Grants and Demonstrations.

/2 FY 2011 assumes an FY 2010 continuing resolution level.

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

PROGRAM INTEGRITY SUCCESSES

The Administration has made program integrity a top priority, and this commitment has led to numerous advancements in fraud detection and prevention. The FY 2010 Health Care Fraud and Abuse Control (HCFAC) Report showed a record $4 billion in recoveries and the highest return on investment (ROI) since the inception of the HCFAC program. Additionally, CMS has taken great strides in moving from a "pay and chase" model to a prevention-focused model that stops fraudulent providers from entering our programs and halts improper payments from going out the door.

In April 2010, CMS realigned its internal organizational structure to consolidate most of the Medicare and Medicaid program integrity activities under a new Center for Program Integrity (CPI). Through this reorganization, CMS has pursued a more strategic and coordinated approach with respect to Medicare, Medicaid, and CHIP; increased collaboration on anti-fraud initiatives with other Federal agencies, States, law enforcement partners, and the private sector; and refocused its strategic vision on prevention and innovation.

CMS supported a Florida demonstration to assess the effectiveness of a coordinated data mining partnership between the State Medicaid Agency and the Medicaid Fraud Control Unit. CMS also promoted partnerships with the private sector to evaluate predictive analytics like those used by credit card companies in order to detect fraud in the Medicare program. To further these efforts, Congress appropriated $100 million in the Small Business Jobs Act of 2010 to expand the implementation of predictive analytics in Medicare, Medicaid, and CHIP.

During the past year, CMS, along with its Federal partners, held Regional Health Care Fraud Prevention Summits in Miami, Los Angeles, Brooklyn, and Boston to bring together Federal, State, and local partners, beneficiaries, providers, and stakeholders to share best practices. Three additional regional fraud summits are planned in Detroit, Las Vegas, and Philadelphia this year.

CMS has also worked with the Administration on Aging to increase the number of Senior Medicare Patrol volunteers fighting fraud in their communities; launched a national fraud prevention campaign through radio, television, and print ads to teach beneficiaries how to protect themselves against fraud; and is redesigning beneficiary notices to help beneficiaries detect suspicious activities by making them easier to understand.

With increased resources in FY 2012, CMS will build on the successes and momentum of the past year and implement prevention-focused activities to move away from a pay and chase model that mitigates the problem on the margins rather than solving it.

HEALTH CARE FRAUD AND ABUSE CONTROL FUNDING

The FY 2012 Budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2012 HCFAC program level is $1.85 billion, $369 million above the FY 2010 level. Of the total FY 2012 program level, $1.27 billion is mandatory funding and $581 million is requested in discretionary funding.

HCFAC Mandatory Funds:
The $1.27 billion in mandatory funds for FY 2012 are financed from the Medicare Part A Trust Fund. This funding is allocated to: 1) the Medicare Integrity Program (MIP); 2) the HCFAC Account, which is divided annually among the HHS Office of Inspector General (OIG), other HHS agencies, and law enforcement partners at the Department of Justice (DOJ); and 3) the Federal Bureau of Investigation (FBI). These dollars fund comprehensive efforts to combat health care fraud, waste, and abuse, including prevention activities, provider education, data analysis, audits, investigations, and enforcement.

Return on Investment:
Programs supported by HCFAC funds have a proven record of returning money to the Medicare Trust Fund for each dollar spent.

The MIP ROI averages 14 to 1. MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade.

The HCFAC Account three-year rolling average ROI is now a record 6.8 to 1. From 1997 to 2010, programs supported by the HCFAC Account have returned over $18 billion to the Trust Fund. In FY 2010 alone, $2.86 billion in recoveries were returned to the Trust Fund and $683 million in Medicaid recoveries were returned to the Treasury.

HCFAC Discretionary Funds:
To continue and expand program integrity efforts and successes over the past year, the FY 2012 Budget requests $581 million in discretionary HCFAC funding, an increase of $270 million over FY 2010. This total will be allocated as follows:

- CMS: $389.9 million
- OIG: $97.6 million
- DOJ: $93.1 million

This investment supports efforts to reduce the Medicare fee-for-service (FFS) improper payment rate by 50 percent and initiatives of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) task force, including an expansion of up to 20 Strike Force cities, and an increased focus on civil fraud, such as off-label marketing and pharmaceutical fraud.

The increased funding also allows CMS to deploy new and innovative efforts including: state-of-the art data analytics and national pre-payment edits to prevent potentially wasteful, abusive, or fraudulent payments before they occur; the build out of a Compromised Numbers Database; further expansion of the Integrated Data Repository; enhancements to the Do Not Pay List; and the development of Geospatial Complaint Maps to help target priorities and

Reducing the Improper Payment Rate

In November 2009, the President issued an Executive Order laying out a strategy to reduce improper payments rates across government, and in June 2010, the President announced that the Administration would cut the Medicare fee-for-service improper payment rate in half by FY 2012 to eliminate billions of dollars in payment errors.

The FY 2012 Budget request supports this important initiative with a wide array of actions including:

- Increasing the number of claims subject to pre-payment review;
- Expanding education on the proper billing for common errors;
- Enhancing medical review for high risk durable medical equipment, including face-to-face requirements;
- Implementing predictive modeling for use in medical review;
- Applying the use of electronic health records in medical review to create greater efficiencies; and
- Developing and executing corrective actions.

identify geographic "fraud hot spots."

CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud, about $1.50 is saved or averted. Based on these projections, the $581 million in HCFAC discretionary funding, as part of a multi-year investment, will yield Medicare and Medicaid savings of $4.6 billion over five years and $10.3 billion over ten years.

Medicare Fraud Strike Force Successes

The Medicare Fraud Strike Force is a partnership between HHS and DOJ in health care fraud hot spots around the country. Strike Force cases are data driven and target individuals and groups that are actively involved in ongoing fraud as well as emerging and migrating schemes perpetrated by criminals masquerading as health care providers and suppliers.

In the three and a half years since their inception, Strike Force teams brought 465 cases charging more than 829 defendants with criminal health care fraud offenses who collectively billed the Medicare program more than $1.9 billion. Strike Force prosecutors secured 481 guilty pleas and 358 defendants were sentenced to imprisonment, with an average sentence of 44 months.

NEW AFFORDABLE CARE ACT PROTECTIONS

The Affordable Care Act (the Act) is the most comprehensive legislative step forward to fight fraud. The Act provides an additional $350 million in program integrity resources over ten years, plus an inflation adjustment, as well as unprecedented tools to CMS and law enforcement to protect the Medicare, Medicaid, and CHIP programs from fraud, waste, and abuse.

Important new tools include targeted, enhanced enrollment screening to prevent fraudulent providers from entering the Medicare, Medicaid, and CHIP programs. The Act also gives the Secretary the authority to issue temporary enrollment moratoria and impose enhanced payment suspension actions for credible allegations of fraud. CMS published the final rule on these important new tools to strengthen fraud prevention efforts and protect the Trust Funds on January 24, 2011.

Additionally, the Act requires inclusion of the National Provider Identifier on all provider enrollment applications and claims; requires physicians and suppliers to maintain documentation of written orders for durable medical equipment, home health, or other referrals upon request; expands data sharing across all Federal health care payers; expands Recovery Audit Contractors to Medicare Parts C and D and Medicaid; and requires compliance plans for providers and suppliers.

NEW PROGRAM INTEGRITY PROPOSALS

The Budget includes 19 new legislative proposals to strengthen program integrity for Medicare, Medicaid, and CHIP, saving $32.3 billion over ten years.

Medicare:

Recover Erroneous Payments from Insurers Participating in MA: Require the extrapolation of the error rate found in the risk adjustment data validation (RADV) audit samples to the entire MA contract payment when recouping overpayments. [Effective upon enactment]

Reporting of "Sweep Accounts": Require providers to report the use of "sweep accounts" that immediately transfer funds from a financial account to an investment account, often in another jurisdiction, for receipt of Medicare payment; and permit enhanced review of reporting providers. [Effective FY 2012]

Penalties for Outdated Enrollment Records: Authorize civil monetary penalties or other intermediate sanctions for providers who do not update enrollment records. Updated enrollment records provide important information to CMS on the providers in Medicare, such as adverse legal actions. This proposal gives providers and suppliers additional incentive to ensure their enrollment information is up to date, which reduces program vulnerability to fraud. [Effective FY 2012]

Universal Product Numbers (UPNs) on Claim Forms: Study the use of UPNs on claims forms for Medicare reimbursement to facilitate appropriate payment and detection of fraud. [Effective FY 2012]

Medicare Claims Ordering System: Create a Medicare claims ordering system and require electronic submission of

orders for certain high risk services, such as DME and home health, prior to payment of a claim in order to validate that a physician or other eligible professional ordered the service. [Effective CY 2014]

Review of Power Wheelchair Claims: Require prepayment or earlier review for all power wheelchair claims. Allowing CMS to conduct prepayment or earlier review on power wheelchair claims to ensure they meet the existing criteria for coverage will reduce improper payments and prevent fraud. [Effective FY 2012]

Medicaid:

Use of Provider Taxes to Pay State Share of Medicaid: Limit States' ability to use provider taxes to pay the State share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond. Restricting the use of provider taxes was recommended by the National Commission on Fiscal Responsibility and Reform. [Effective FY 2015]

Strengthen Third-Party Liability: Strengthen third-party liability under Medicaid to improve States' and providers' abilities to receive third-party payments for beneficiary services, as appropriate. This proposal allows States to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, and allows providers to collect medical child support where health insurance is derived from a non-custodial parent, and to recover Medicaid expenditures from beneficiary liability settlements. [Effective FY 2012]

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid: Require States to monitor high-risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care. [Effective FY 2012]

Repayment of Rebates for Improper Reporting: Require drug manufacturers to repay States for improperly reported items for Medicaid-covered prescription drug coverage. This proposal requires full restitution to States for any covered drug improperly reported by the manufacturer on the Medicaid drug coverage list. [Effective FY 2012]

Manufacturer Compliance with Drug Rebate Requirements: Conduct regular audits of drug manufacturer compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective. [Effective FY 2012]

Penalties for Fraudulent Noncompliance on Rebate Agreements: Increase penalties collected from drug manufacturers for fraudulent noncompliance with Medicaid prescription drug rebate agreements. [Effective FY 2012]

Proper Listing of Drugs with FDA: Require drugs to be properly listed with the FDA in order to receive Medicaid coverage. This proposal aligns Medicaid coverage requirements with Medicare requirements. [Effective FY 2012]

Prevent Use of Federal Funds to Pay State Medicaid or CHIP Share: Prevent States from using Federal funds to pay the State share of Medicaid or CHIP, unless authorized under law to specifically match Medicaid or CHIP funds. [Effective FY 2012]

Strengthening Program Integrity Tools

The FY 2012 Budget includes 19 program integrity legislative proposals to build on the new authorities provided by the Affordable Care Act and save $32.3 billion over 10 years. These proposals enhance pre-payment scrutiny, expand auditing, increase penalties for improper actions, strengthen CMS' ability to implement corrective actions, and promote integrity in Federal-State financing.

Medicare and Medicaid:

Participation Exclusion for Affiliation With Sanctioned Entity: Give the Secretary additional permissive authority to exclude providers from participation in Federal health care programs if they are affiliated with an entity that has been sanctioned. [Effective FY 2012]

Retain a Percentage of Recovery Audit Contractor (RAC) Recoveries: Allow CMS to use a portion of RAC recovery funds for corrective actions, such as new processing edits and provider education and training to prevent future improper payments. [Effective FY 2012]

Provide Flexibility in Implementing Predictive Analytics: Current law requires the Secretary to broadly implement predictive analytics technologies, even when more cost-effective tools may be available. This proposal allows the Secretary to have increased flexibility to target this technology toward areas with the greatest return on investment. [Effective FY 2012]

Fraud Debt in Bankruptcy Proceedings: Limit the discharge of health care fraud debts in bankruptcy proceedings. [Effective FY 2012]

Penalties for Illegal Distribution of Beneficiary Identification Numbers: Strengthen penalties for the knowing distribution of Medicare, Medicaid, or CHIP beneficiary identification numbers. [Effective FY 2012]

PROGRAM INTEGRITY INITIATIVE

(dollars in millions)

	2012	2012-2016	2012-2021
Legislative Proposals			
***Medicare*:**			
Recover Erroneous Payments From Insurers Participating in Medicare Advantage	-490	-2,950	-6,160
Require Providers to Report Use of "Sweep Accounts" For Receipt of Medicare Payment	0	0	0
Allow CMPs Or Intermediate Sanctions For Providers Who Do Not Update Enrollment Records	0	-30	-80
Conduct a Study on Use of Universal Product Number (UPN) on Claim Forms to Improve Payment Accuracy	0	0	0
Create a Medicare Claims Ordering System to Validate Physician Orders For Certain High-Risk Services	0	-330	-1,760
Require Prepayment Or Earlier Review For All Power Wheelchairs	-10	-90	-240
***Medicaid*:**			
Phase Down Medicaid Provider Tax Threshold Beginning in FY 2015	0	-3,510	-18,370
Strengthen Medicaid Third-Party Liability	-65	-650	-1,620
Track High Prescribers and Utilizers of Prescription Drugs	-80	-1,270	-3,450
Require Manufacturers That Improperly Report Items For Medicaid Drug Coverage to Fully Repay States	-10	-50	-125
Enforce Drug Rebate Agreements	0	0	0
Increase Penalties on Drug Manufacturers For Fraudulent Non-Compliance With Drug Rebate Agreements	0	0	0
Require Drugs to be Properly Listed With the FDA to Receive Medicaid Coverage	0	0	0
Prohibit Federal Funds From Being Used as Medicaid/CHIP State Share Unless Specifically Authorized by Law	0	0	0
***Medicare & Medicaid*:**			
Permit Provider Exclusion From Federal Health Care Programs if Affiliated With a Sanctioned Entity	0	0	-50
Medicare [non-add]	*0*	*0*	*-50*
Medicaid [non-add]	*0*	*0*	*0*
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	0	-50	-230
Medicare [non-add]	*0*	*-30*	*-160*
Medicaid [non-add]	*0*	*-20*	*-70*
Modify Small Business Act Provisions on Predictive Analytics to Maximize Cost-Effectiveness	0	-90	-100
Medicare [non-add]	*0*	*-90*	*-100*
Medicaid [non-add]	*0*	*0*	*0*
Limit the Discharge of Debt in Bankruptcy Proceedings in Cases of Fraudulent Activity	0	-40	-150
Medicare [non-add]	*0*	*-10*	*-70*
Medicaid [non-add]	*0*	*-30*	*-80*
Strengthen Penalties For Illegal Distribution of Beneficiary Identification Numbers	0	0	0
Medicare [non-add]	*0*	*0*	*0*
Medicaid [non-add]	*0*	*0*	*0*
Total, Medicare Impact	-500	-3,530	-8,620
Total, Medicaid Impact	-155	-5,530	-23,715
Total, Program Integrity Legislative Proposals	**-655**	**-9,060**	**-32,335**
Savings from Discretionary HCFAC Investment			
Return on Investment/1	-750	-4,600	-10,270
Total, Savings from HCFAC Investment	**-750**	**-4,600**	**-10,270**
Total, Program Integrity Savings	**-1,405**	**-13,660**	**-42,605**

* All specified program integrity savings offset physician payment relief through 2013.
Savings estimates do not include all interactions.
/1 Savings not scorable under PAYGO rules.

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law:				
Benefits /1	262,697	263,394	256,556	-6,838
State Administration	10,074	12,856	12,808	-48
Total Net Outlays, Current Law	**272,771**	**276,249**	**269,365**	**-6,884**
Proposed Law:				
Legislative Proposals	--	--	-190	-190
Extend Qualified Individual (QI) Program \2			+495	+495
Adjustment for QI Transfer from Medicare \2	--	--	-495	-495
Total Net Outlays, Proposed Law	**272,771**	**276,249**	**269,175**	**-7,074**
Savings from Program Integrity Investment \3	--	--	-107	-107
Total Net Outlays, Net of Program Integrity Investment	**272,771**	**276,249**	**269,068**	**-7,181**

Totals may not add due to rounding.

1/ Includes Vaccines for Children outlays.

2/ States pay the Medicare Part B premium costs for QIs, which are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the QI program are reflected in Medicare outlays.

3/ FY 2012 includes $107 million in non-PAYGO scorecard savings from increased program integrity investment.

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

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

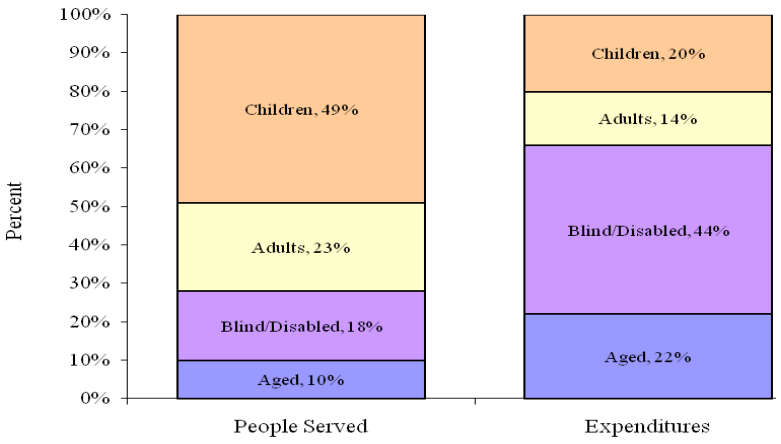
Medicaid beneficiaries include children, the aged, blind, and/or disabled, and people who meet certain minimum income eligibility criteria. States also have the flexibility to extend coverage to higher income groups through waivers and amended State plans. The Affordable Care Act expands Medicaid eligibility to non-elderly individuals with family incomes up to 133 percent of the Federal poverty level (FPL). In FY 2012, the Federal share of current law Medicaid outlays is expected to be $269 billion.

Medicaid Enrollment
(enrollees in millions)

	2010	2011	2012
Aged 65 and Over	4.8	4.9	5.0
Blind and Disabled	9.5	9.6	9.7
Children	26.8	28.3	29.0
Adults	11.9	12.2	12.4
Territories	1.0	1.0	1.0
Total	**53.9**	**56.0**	**57.0**

Source: CMS Office of the Actuary estimates.

FY 2009 – Percent of Medicaid Beneficiaries vs. Payments (by beneficiary group)[1]



Source: 2010 Actuarial Report on the Financial Outlook for Medicaid (CMS Office of the Actuary).

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

This is a $7 billion (2.5 percent) decrease below FY 2011 spending, mainly due to the end of the Recovery Act's temporarily increased match rate.

HOW MEDICAID WORKS

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

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

As required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), HHS published a core set of child health quality measures in December 2009. CMS has developed a new performance goal to measure State adoption of these measures.

- FY 2011 target: At least 70 percent of States report on 1 core measure to CMS.
- FY 2012 target: At least 80 percent of States report on 5 core measures to CMS.

FY 2012 LEGISLATIVE PROPOSALS

Extend the Qualified Individuals (QI) Program: Extend authorization and funding of the QI program through September 30, 2012. The QI program pays the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. Current law extends this program through December 31, 2011, and this proposal would allow States to receive 100 percent Federal funding through the end of FY 2012.

Extend Transitional Medical Assistance (TMA): Extend authorization and funding of the TMA program through September 30, 2012. The TMA program extends Medicaid coverage for at least 6 months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. Current law extends this program through December 31, 2011.

Establish Hold-Harmless for Federal Poverty Guidelines: Establishes a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the Consumer Price Index for All Urban Consumers (CPI-U). To protect access to programs, inlcuding Medicaid, for low-income families and individuals, this proposal would treat the CPI-U adjustment for the poverty guidelines similarly to the treatment of the annual cost-

Temporary Increase in Medicaid FMAP

The Recovery Act provided a temporary increase in the Federal medical assistance percentage (FMAP) to help States maintain health coverage and services for low-income individuals and children in a time of reduced State revenues and increased Medicaid enrollment. P.L. 111-226 extended the enhanced FMAP assistance at phased-down levels through June 30, 2011.

of-living adjustments for Social Security Benefits.

Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY 2021: As the number of uninsured individuals decreases as a result of the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of DSH funding needed. The Affordable Care Act includes annual aggregate DSH reductions for FY 2014 through FY 2020, but allotments revert to levels prior to the Affordable Care Act in FY 2021. This proposal would rebase the FY 2021 allotments to maintain the FY 2020 level of reductions in the Affordable Care Act, and determine future allotments from the rebased level using current law methodology.

Limit Medicaid Reimbursement of Durable Medical Equipment Based on Mediare Rates: The Medicare program is in the process of implementing innovative ways to increase efficiency for payment of DME through the DME Competitive Bidding Program, which is expected to save more than $17 billion in Medicare expenditures over ten years. This proposal extends some of these efficiencies to Medicaid, by limiting Federal reimbursement for a State's aggregate Medicaid spending on certain DME services to what Medicare would have paid in the same State for the same services.

Medicaid Program Integrity Proposals: The President's Budget includes a number of Medicaid program integrity proposals that strengthen the Department's ability to fight fraud, waste, and abuse in the Medicaid program. For more information on these proposals, see the chapter on Program Integrity.

Enhanced Federal Matching Rate for Medicaid Eligibility Systems

To help States prepare for Medicaid expansion in 2014, CMS has proposed making eligibility determination systems eligible for an enhanced Federal matching rate of 90 percent for development costs through 2015 and 75 percent for ongoing maintenance and operations. This enhanced matching rate represents a significant increase above the 50 percent matching rate currently available for such systems.

States will need to meet performance standards and conditions for their Medicaid technology investments (including traditional claims processing and eligibility systems) to receive the enhanced matching rate. These standards will encourage States to use modern and efficient technology in the Medicaid program.

RECENT PROGRAM DEVELOPMENTS

Affordable Care Act (P.L. 111-248 and P.L. 111-152)

In addition to expanding Medicaid eligibility, the Affordable Care Act makes improvements to health benefits for beneficiaries and strengthens Medicaid program integrity efforts to detect fraud and abuse. One example of how the Affordable Care Act improves services to Medicaid beneficiaries is the increased emphasis on providing long-term care in a community setting instead of an institution. The Affordable Care Act provides financial incentives to States for increasing access to home and community-based services for Medicaid beneficiaries and removes structural barriers to allow States to more easily implement the changes needed to improve these services.

Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P.L. 111-312)

This legislation amends the treatment of tax refunds for determining eligibility in a number of Federal programs. Tax refunds received between January 1, 2010 and December 31, 2012 will be exempt from an individual's eligibility determination for Medicaid.

MEDICAID PROPOSALS

(dollars in millions)

	2012	2012 -2016	2012 -2021
Medicaid Proposals			
Extend Transitional Medical Assistance (TMA)…….....	240	665	665
Rebase Disproportionate Share Hospital (DSH) Allotments in FY 2021.....	--	--	-4,170
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates.....	-210	-2,350	-6,400
Extend the Qualifying Individual (QI) Program /1….....	495	495	495
Adjustment for QI Transfer from Medicare /1.....	-495	-495	-495
Medicaid Program Integrity Proposals /2 *.....	-155	-5,530	-23,715
Total, Medicaid Proposals	**-125**	**-7,215**	**-33,620**
Medicaid Impacts			
Establish Hold-Harmless for Federal Poverty Guidelines…….....	--	--	--
Supplemental Security Income (SSI) Extension for Refugees /3.....	45	95	95
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /4 *.....	--	-30	-160
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs /4 *.....	-110	-850	-2,330
Total, Medicaid Interactions	**-65**	**-785**	**-2,395**
Total, Medicaid	**-190**	**-8,000**	**-36,015**

1\ States pay the Medicare Part B premium costs for QIs, which are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the QI program are reflected in Medicare outlays.

2\ See Program Integrity chapter for proposal descriptions.

3\ This proposal is included in the Social Security Administration's FY 2012 Budget Request.

4\ This proposal is a multi-agency proposal with savings to Medicaid. See Medicare chapter for proposal descriptions.

*Specified Medicaid savings to offset physician relief through 2013.

CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law:				
Children's Health Insurance Program	7,887	9,069	9,781	+712
Child Enrollment Contingency Fund	--	100	200	+100
Total Outlays	**7,887**	**9,169**	**9,981**	**+812**

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

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized CHIP through FY 2013, providing an additional $44 billion in funding over five years and creating several new initiatives to improve and increase enrollment in the program. The Affordable Care Act (P.L. 111-148) extended funding for CHIP through FY 2015.

HOW CHIP WORKS

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

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

States have a high degree of flexibility in designing their programs. They can implement CHIP by expanding Medicaid, creating a separate title XXI program, or a combination of both approaches. As of January 1, 2011, there were 13 Medicaid expansion programs, 17 separate programs, and 26 combination programs among the States, District of Columbia and Territories.

In FY 2010, an estimated 8.5 million individuals were enrolled in CHIP at some point during the year. This represents an increase of 2.4 percent over FY 2009 enrollment.

Funding for CHIP allotments to States increased under CHIPRA by $44 billion over the baseline for five years (FY 2009-FY 2013). This expansion allowed for better funding predictability at the State level. A Child Enrollment Contingency Fund was established for States that predict a funding shortfall based on higher than expected enrollment. The contingency fund received an initial appropriation of $2.1 billion in FY 2009 and is invested in interest bearing securities of the United States. The Affordable

Performance Bonus Payments

In December 2010 CMS awarded $206 million to 15 States that made significant improvement in enrolling children in Medicaid and title XIX CHIP programs in FY 2010.

- To qualify for a bonus payment, States must perform five of eight specific enrollment and retention activities set out in CHIPRA.
- Bonus payments were awarded to the following States that exceeded a target enrollment figure: Alabama, Alaska, Colorado, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, New Jersey, New Mexico, Ohio, Oregon, Washington, and Wisconsin.

Care Act extended funding for CHIP at $19.1 billion in FY 2014 and $21.1 billion in FY 2015.

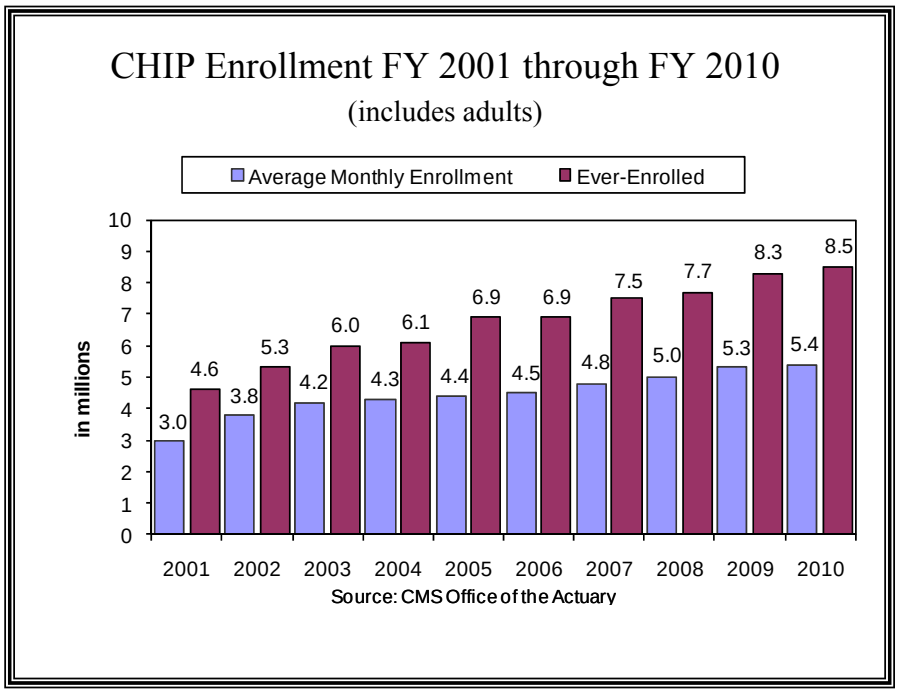
RECENT PROGRAM DEVELOPMENTS

Affordable Care Act (P.L. 111-248)

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

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

Enrollment and Retention Outreach: The Act also increased funding originally provided in CHIPRA for grants and a national campaign to improve outreach and enrollment from $100 million to $140 million and extended its availability through FY 2015. Through this funding CMS assists States in providing health care coverage to low-income children eligible for CHIP or Medicaid, but not yet enrolled. Forty States and the District of Columbia have taken up new options for improving retention and enrollment. (See highlight on Increasing Enrollment of Eligible Children.) All of these activities support the Secretary's challenge to Federal officials, States, local governments, community organizations, and faith leaders to find and enroll the five million uninsured children who are eligible for CHIP and Medicaid.



Improving Quality: CHIPRA provided $225 million over five years for activities that improve child health quality in Medicaid and CHIP. FY 2010 CMS activities included publishing a core set of child health quality measures for use under Medicaid and CHIP, partnering with the Agency for Healthcare Research and Quality (AHRQ) to develop new child health quality measures, awarding a contract for a model electronic health record for children, and providing technical assistance to States in developing quality improvement programs. Ten States and child health providers received grant funding to conduct demonstrations for improving quality of children's health care under CHIP and Medicaid.

Increasing Enrollment of Eligible Children

The Administration's goal is to improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and in Medicaid. In FY 2009, CMS reported a 5 percent increase in CHIP enrollment (+275,153 children) and a 7 percent increase in Medicaid child enrollment (nearly 2 million children) over the FY 2008 baseline.

FY 2010: CHIP +5 percent over 2008; Medicaid N/A

FY 2011: CHIP +9 percent over 2008; Medicaid +11 percent over 2008

FY 2012: CHIP +11 percent over 2008; Medicaid +12 percent over 2008

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law Budget Authority:				
Incentives for Prevention of Chronic Diseases in Medicaid	--	100	--	-100
Medicaid Emergency Psychiatric Demonstration	--	75	--	-75
CHIP Outreach and Enrollment Grants	40	--	--	--
Medicaid Integrity Program	75	76	77	+1
Psychiatric Residential Treatment Demo and Evaluation	53	57	--	-57
Money Follows the Person Demonstration	399	449	449	--
Money Follows the Person Evaluations	1	1	1	--
Expansion of State Long-Term Care Partnership Program	3	3	3	--
Ticket to Work Grant Programs	46	47	--	-47
Drug Surveys and Reports	5	--	--	--
Total, Current Law B.A.	**622**	**633**	**530**	**-103**
Proposed Law Budget Authority:				
Wireless Innovation (WIN) Fund	--	--	20	+20
Current Law Outlays:				
Incentives for Prevention of Chronic Diseases in Medicaid	--	--	10	10
Medicaid Emergency Psychiatric Demonstration	--	--	5	5
CHIP Outreach and Enrollment Grants	14	35	34	-1
CHIP Grants for Prospective Payment System Transition	-- *	2	3	+1
Medicaid Integrity Program	68	92	77	-15
Psychiatric Residential Treatment Demo and Evaluation	24	19	19	--
Money Follows the Person Demonstration	146	250	250	--
Money Follows the Person Evaluations	-- *	2	2	--
Expansion of State Long-Term Care Partnership Program	1	4	3	-1
Ticket to Work Grant Programs	90	65	65	--
Drug Surveys and Reports	--	-- *	--	--
Medicaid Transformation Grants /1	35	42	--	-42
Emergency Services for Undocumented Aliens /1	108	75	50	-25
High Risk Pools/1	-- *	3	--	-3
Katrina Hurricane Relief /1/2	26	10	--	-10
PACE Funds for Outlier Costs /1	--	-- *	--	--
Alternate Non-Emergency Network Providers /1	19	16	--	-16
Total, Current Law Outlays	**531**	**615**	**518**	**-97**
Proposed Law Outlays:				
Wireless Innovation (WIN) Fund	--	--	20	+20
Total Net B.A., Proposed Law	**622**	**633**	**550**	**-83**
Total Net Outlays, Proposed Law	**531**	**615**	**538**	**-77**

1/ Outlays are from prior year budget authority.

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

* Outlays are less than $500,000

STATE GRANTS AND DEMONSTRATIONS

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

AFFORDABLE CARE ACT

Incentives for Prevention of Chronic Diseases in Medicaid: The Affordable Care Act (the Act) provides $100 million for States to award incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes related to chronic disease, including through the adoption of healthy behaviors. (See highlight box for more information on this initiative.) This program is effective from FY 2011 to FY 2015.

Medicaid Emergency Psychiatric Demonstration: The Act provides $75 million in FY 2011 for a demonstration to provide funding to States to pay institutions for mental disease that are not publicly owned or operated to provide emergency medical services necessary to stabilize non-elderly Medicaid-eligible adults. Funding for this demonstration will be awarded to eligible States, and is available through December 31, 2015.

Extension of Existing Programs: The Act also extends the Money Follows the Person demonstration and expands the State Long-Term Care Partnership Program (see below).

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

Outreach and Enrollment Grants: CHIPRA provides funding for Outreach and Enrollment Grants in the CHIP. CHIPRA appropriates $100 million for grants from FY 2009 through FY 2013. The Act appropriates an additional $40 million for grants through FY 2015, yielding a total of $140 million available for outreach and enrollment grants. Of this amount, $14 million is set aside for a national enrollment campaign. The remaining $126 million is allocated for competitive grants to States, community-based organizations, Tribes, providers, schools, and other groups to increase enrollment of children in Medicaid and CHIP, including $14 million dedicated specifically to increase enrollment of Native Americans and Alaskan Natives.

Grants for Transitioning to a Prospective Payment System: CHIPRA provided $5 million for grants to States to help Federally Qualified Health Centers and Rural Health Clinics transition to a prospective payment system for CHIP. CMS awarded grants to

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

In early 2011, CMS plans to announce the availability of funding for grants to States to provide incentives to Medicaid beneficiaries for engaging in healthy behaviors that reduce risk and improve outcomes related to chronic disease. States receiving grants under MIPCD must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition.

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

four states in FY 2010: California, Michigan, Colorado, and Pennsylvania.

DEFICIT REDUCTION ACT (DRA) OF 2005

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

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

Alternatives to Psychiatric Residential Treatment Facilities for Children: This five-year demonstration (FY 2007 – FY 2011) authorized by the DRA provided nine States with $56 million in funding to provide home and community-based services as alternatives to psychiatric residential treatment facilities for individuals under the age of 21. Through September 30, 2010, 2,397 children have been served in psychiatric residential treatment facilities under this demonstration.

Money Follows the Person Demonstration: The DRA established this demonstration, and the Affordable Care Act extends the demonstration through FY 2016 with additional funding. The demonstration helps States to sustain their Medicaid programs while helping individuals achieve independence. States awarded competitive grants get a limited, increased Medicaid matching rate for transitioning individuals from an institutional setting to a qualified home or community-based setting, and as of December 31, 2010, 11,221 individuals have transitioned to community care under MFP. $1.5 billion of funding was committed to 30 States and the District of Columbia for the first five years of this demonstration. The additional $2.3 billion in funding from the Affordable Care Act will enable these States to continue their work and allow new States to apply for the program.

Expansion of State Long-Term Care Partnership Program: The expansion of the State Long-Term Care (LTC) Partnership Program, enacted under the DRA, established authority for all States to implement LTC partnership plans that provide a dollar for dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual. The Act extended the LTC partnership through FY 2015 with additional funding.

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

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

Medicaid Integrity Program

Percentage Return on Investment: To evaluate implementation and success of the Medicaid Integrity Program (MIP), CMS has developed a measure to demonstrate the program's return on investment (ROI). Through the program, CMS employs Medicaid Integrity Contractors who review and audit provider claims to identify potential fraud, abuse, and overpayments. Overpayments identified and recouped are compared to the total Federal funding for the Medicaid Integrity Contractors to establish ROI. In FY 2009, these efforts yielded a 175 percent ROI which was well above the target of greater than 100 percent. These targets will be rebased for future years due to changes in the ACA that may impact ROI. As of January 2011, FY 2010 ROI data is not yet available. The target ROI for FY 2012 is greater than 150 percent.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) OF 1999

TWWIIA of 1999 authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. The Medicaid Infrastructure Grants, established in Section 203, continue through FY 2011.

LEGISLATIVE PROPOSAL

Wireless Innovation (WIN) Fund: As the President said in his State of the Union address to the Nation, "Within the next five years, we'll make it possible for businesses to deploy the next generation of high-speed wireless coverage to 98 percent of all Americans."

As part of the President's proposal, the WIN fund finances the experimentation and development of emerging wireless technologies in the health care sector to create a world-leading wireless network as part of a critical platform for economic growth. The Budget proposes $20 million in FY 2012, and in each fiscal year through FY 2016 for this fund.

Promoting Outreach and Enrollment in CHIP

- In 2009 and 2010, CMS awarded nearly $50 million to States, community organizations, and tribal entities to perform outreach and enrollment activities through September 2011. Awardees will report on achievements in enrollment and retention of children in Medicaid and CHIP to facilitate dissemination of best practices.
- These grants support the Secretary's "Connecting Kids to Coverage Challenge," calling on leaders at every level of government and the private sector to find and enroll, the nearly five million uninsured children who are eligible for Medicaid and CHIP.

(dollars in millions)

Total Budget Authority

	2010	2011	2012	2012 +/- 2011
Current Law Budget Authority:				
State Exchange Grants /1	such sums	such sums	such sums	N/A
Pre-Existing Condition Insurance Plan Program /2	5,000	--	--	--
Early Retiree Reinsurance Program /2	5,000	--	--	--
Rate Review Grants to States /2	250	--	--	--
Consumer Operated and Oriented Plan (CO-OP) Program /3	6,000	--	--	--
Total Budget Authority, Current Law	**16,250**	**--**	**--**	**--**

Total Outlays

	2010	2011	2012	2012 +/- 2011
Current Law:				
State Exchange Grants /4	1	249	400	+151
Pre-Existing Condition Insurance Plan Program /2	4	1,430	1,562	+132
Early Retiree Reinsurance Program /2	1	3,584	1,386	-2,198
Rate Review Grants to States /2	--	71	66	-5
Consumer Operated and Oriented Plan (CO-OP) Program /3	--	10	388	+378
Total Outlays, Current Law	**6**	**5,344**	**3,802**	**-1,542**

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

2/ This funding is available until expended.

3/ The Affordable Care Act requires loans and grants to be awarded prior to July 1, 2013.

4/ The FY 2011 estimate does not reflect expected outlays for Exchange Establishment grants; HHS will update estimates when State proposals for costs related to establishing an Exchange are available.

Note: Funding for Consumer Assistance Grants to States is displayed in Program Management.

NEW HEALTH INSURANCE PROTECTIONS AND PROGRAMS

The Affordable Care Act (the Act) provides critical new protections for consumers with private health insurance. Further, it will expand affordable coverage to millions of uninsured Americans starting in 2014 through the establishment of State-based Health Insurance Exchanges (Exchanges) and the expansion of Medicaid. Until then, the Act creates temporary programs that provide access to coverage for high-risk, high-cost individuals.

INSURANCE MARKET REFORMS FOR CONSUMER PROTECTION

HHS has already implemented a number of provisions providing an array of new rights and benefits for consumers, including new rules that help put consumers in charge of their health care, new benefits for patients and employers, greater accountability for insurers, expanded information on coverage options, and more.

Elimination of Pre-Existing Condition Exclusions for Children: New health plans in the individual market and all group health plans may not impose any pre-existing condition exclusion for children under age 19. The same rule will apply for enrollees of all ages after January 1, 2014. A recent analysis found that up to 129 million non-elderly Americans have at least one pre-existing condition that could threaten their access to health care and health insurance without this protection. The report can be found at the website: http://www.healthcare.gov/center/reports/preexisting.html.

Consumer Protections Effective Dates*

Elimination of Pre-Existing Condition Exclusions for Children Under Age 19	9/23/2010
Prohibition on Insurance Rescissions	9/23/2010
Adult Child Coverage to Age 26	9/23/2010
Elimination of Lifetime Limits	9/23/2010
Restrictions on Annual Limits	9/23/2010
Restrictions on Cost Sharing for Out of Network Emergency Rooms	9/23/2010
Choice of Health Care Professional	9/23/2010
Establishment of External Appeals Process	9/23/2010
Free Preventive Services	9/23/2010
Establishment of Medical Loss Ratio Requirements	1/1/2011
Proposed Establishment of Premium Rate Review Requirements	7/1/2011

*Provisions take effect at the start of a plan year after the effective date.

Prohibition on Insurance Rescissions: Health plans may no longer rescind a beneficiary's coverage except in cases of fraud or intentional misrepresentation.

Adult Child Coverage to Age 26: An adult child who does not have access to employer coverage may stay on a parent's policy until age 26.

No Lifetime Limits: The application of lifetime limits are prohibited in all health plans and insurance policies issued or renewed. This important protection will prevent Americans who suffer from costly medical conditions from losing their insurance coverage when they need it most.

Restrictions on Annual Limits: Annual limits are banned for most plans beginning in 2014 and are phased out for all employer and new individual market plans issued or renewed. These plans are not allowed to set annual limits lower than $750,000 beginning September 23, 2010; $1.25 million beginning September 23, 2011, and $2 million beginning September 23, 2012, unless HHS provides a waiver to the plan to prevent a significant loss of access or increase in premiums.

Restrictions on Cost Sharing for Out-of-Network Emergency Rooms: New health plans that provide any coverage for services in a hospital emergency room will not be able to require prior approval before a patient seeks emergency care at an out-of-network hospital. In addition, the plan will not be able to require higher co-payments or co-insurance for such care than would be charged at an in-network hospital.

Consumer Appeal Rights: Consumers in new plans will have the right to a swift and objective appeal of decisions made by health plans, including claims denials and rescissions of coverage. This protection includes the right to appeal decisions made by a health plan through the plan's internal process and the right to appeal adverse decisions made by a health plan to an outside, independent entity, no matter what State a patient lives in or what type of health coverage they have. When fully implemented, it is estimated

that these new rights will protect up to 88 million Americans by 2013.

Choice of Health Care Professional: Patients in new plans covered by new regulations can select an available primary care doctor or pediatrician of their choice from a plan's provider network, and women can see an OB-GYN without needing a referral.

Medical Loss Ratio (MLR): Plans in the large group market are required to meet an 85 percent MLR, and those in the small group and individual markets are required to meet an 80 percent MLR, with certain exceptions. These ratios represent the percentage of a health plan's expenditures that must be spent on benefits or quality improving activities. Plans that do not meet these minimum requirements are required to pay rebates to their enrollees. The Secretary will report MLR ratios annually.

Insurance Premium Rate Review: The Secretary is required to establish a process for the annual review of unreasonable premium rate increases. Insurers must submit to the Secretary and relevant States a justification for any unreasonable increase prior to its implementation. This information will be prominently displayed on the insurer's website and on HHS's website.

HealthCare.gov: On July 1, 2010, HHS established HealthCare.gov, providing the most comprehensive resource available for individuals and small businesses around the country to identify affordable health insurance options. By January 17, 2011, HealthCare.gov contained information for consumers about more than 7,500 health insurance plans available in the individual market. This information includes premium estimates, detailed comparative information about covered benefits, and information about issuer underwriting practices so consumers can estimate their likelihood of being turned down or charged more for coverage.

HealthCare.gov has increased transparency and enabled consumers to make more informed decisions regarding their health insurance choices. Of the 4 million visitors to the website to date, 1.3 million used the HealthCare.gov Insurance Finder tool. In the future, HealthCare.gov will include additional information to enhance consumers' purchasing and decision making abilities, including medical loss ratios, quality and performance data, and appeals and complaints.

NEW HEALTH INSURANCE PROGRAMS

Exchanges: Starting in 2014, Exchanges will give millions of Americans and small businesses access to affordable health insurance coverage. Exchanges will help individuals and small employers better understand their insurance options, and help them shop for, select, and enroll in high-quality, competitively-priced private health insurance plans. The Exchanges will also facilitate receipt of tax credits to offset premium costs and cost-sharing assistance, as well as help eligible individuals enroll in other Federal or State insurance programs. By providing one-stop shopping, Exchanges will make purchasing health insurance easier, more transparent, and more understandable, and will provide individuals and small businesses with more options and greater control over their health insurance purchases.

How Exchanges Work: States may establish their own Exchanges and HHS will operate an Exchange in States that choose not to implement their own. In addition to enrolling individuals in insurance coverage, Exchanges must also certify health plans as "qualified," operate a hotline and website to provide consumers access to assistance and health plan information, and establish a navigator program to award grants to entities to assist individuals in locating and obtaining affordable health coverage.

State Grants for Planning and Establishment of Exchanges: Section 1311 of the Affordable Care Act made grant funding available to States to plan for and establish their Exchanges. Territories that commit to establishing an Exchange may also receive grant funding. On September 30, 2010, HHS awarded $48.8 million to 48 States and the District of Columbia to begin planning for their Exchanges. Additional planning and establishment grants will be awarded in FY 2011 and may be renewed through January 1, 2015. After initial implementation, Exchanges will be self-funding.

Pre-Existing Condition Insurance Plan (PCIP) Program: The Affordable Care Act created the PCIP program to make health insurance available to uninsured Americans who cannot access affordable private insurance due to a pre-existing condition. This temporary program will be in place until January 1, 2014, when the Exchanges become operational and can provide more affordable options for individuals with pre-

existing conditions, and when insurance companies can no longer deny coverage or charge higher premiums for individuals with pre-existing conditions.

The PCIP program is available in all 50 States and the District of Columbia. Twenty-seven States administer their own PCIP programs, while CMS operates the program in the remaining States and the District of Columbia.

All PCIP programs cover a wide range of health benefits, including primary and specialty care, hospital care, diagnostic testing, prescription drugs, home health and hospice care, skilled nursing, preventative health, and maternity care. The benefit package reflects the items and services most commonly covered by the existing State High Risk Pools and most needed by individuals with pre-existing conditions. Cost-sharing for enrollees is capped in all plans, and the maximum out-of-pocket limit is capped at $5,950 in 2011.

Premiums in the program are capped at 100 percent of the standard individual market rate for coverage in a PCIP service area and cannot vary by gender or by age by a factor of more than 4 to 1. Some States offer multiple plans with deductibles ranging from $500 to $5,000. The current monthly premium for a 50-year-old in the Federally-administered PCIP program ranges between $267 and $605. In 2011, the Federally-administered PCIP program offers three plan options and lower premiums than in 2010.

Individuals are eligible for the PCIP program if they have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of a health condition, and are a U.S. citizen or residing in the U.S. legally. Eligibility is not based on an individual's income level. Individuals enrolled in a PCIP who subsequently move to another State are not subject to the six month waiting period.

Early Retiree Reinsurance Program (ERRP): The number of employers that provide health coverage to early retirees has significantly eroded over the years. Early retirees often face difficulties obtaining insurance due to their age or chronic conditions. To make health benefits more affordable and provide employer-based plans with financial assistance in providing such benefits, the Affordable Care Act created the ERRP. ERRP provides support to sponsors of certified health benefit plans for early retirees, their spouses, and dependents. The program reimburses plan sponsors for 80 percent of health care claims costs of early retirees between a cost threshold of $15,000 and cost limit of $90,000, adjusted each year by the Consumer Price Index.

As of January 25, 2011, over 5,000 plan sponsors have been approved since the program's inception. Plan sponsors represent a wide variety of employers, including businesses, State and local governments, unions, schools and other educational institutions, religious organizations, and non-profit organizations. Plan sponsors are able to request reimbursement for claims for approved plan years dating back to June 1, 2010**.** As of January 25, 2011, nearly $1 billion has been provided to plan sponsors to support their continued coverage of early retirees, spouses, and dependents.

HHS is closely monitoring the program, and as further data become available on implementation, we look forward to working with Congress to address emerging issues.

Rate Review Grants to States: The Act provides $250 million for grants to States, the District of

Early Innovator Grants to States

In early 2011, HHS will award funding for competitive grants to States or groups of States to develop innovative Exchange systems. These systems will collect and verify eligibility information and help enroll consumers into qualified health plans. This initiative promotes efficient use of Federal resources as all States will be able to learn from the work of these early innovators and incorporate these models into their Exchanges. This initiative is coordinated with an initiative to provide States increased funding to update their eligibility and enrollment systems for Medicaid and CHIP (see Medicaid chapter).

Maximizing Plans on Healthcare.gov

As of October 1, 2010, 56 percent of known open individual health insurance market plans, not including association plans, were represented on Healthcare.gov with accurate plan data. There were substantial increases in the number of issuers and the number of plans from October 1 to November 15, 2010, a strong indicator that CMS is on track to hit its ambitious target of 85 percent of known open, individual health insurance plans represented on the Insurance Finder tool in FY 2012.

Columbia, and the Territories to enhance their rate review process. An awardee can receive no less than $1 million and no more than $5 million in any one grant year through FY 2014.

Consumer Assistance Program Grants: The Act provides $30 million for grants to States to establish or expand independent consumer assistance programs. These programs help consumers navigate insurance choices to find the most affordable coverage that meets their needs; assist with enrollment into health coverage; collect data on consumer inquiries and complaints to identify problems in the marketplace; educate consumers on their new rights and responsibilities; and assist consumers with filing complaints and appeals.

Consumer assistance capacity is essential to a properly functioning insurance marketplace, and in order to successfully operate Exchanges, States must develop additional consumer assistance capacities. To encourage the integration of consumer assistance services into Exchanges, States may develop their capacities to provide assistance to individuals and small businesses as part of their Exchange Planning and Establishment Grants.

Consumer Operated and Oriented Plan (CO-OP) Program: The CO-OP program will award grants and loans to foster the creation of qualified nonprofit health insurance plans in the individual and small group markets in all States. Any profits the issuer makes are required to be used to lower premiums, improve benefits, or improve the quality of health care delivered to the members of the plan. The CO-OP program will determine qualified nonprofit issuers and provide loans for start-up costs and repayable grants to enable issuers to meet State solvency requirements. The program may also provide repayable grants to enable the Secretary to encourage the establishment of CO-OPs in States where no issuer applies. The first loans and repayable grants are expected to be made in FY 2012.

Supporting Health Insurance Coverage in States

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

(dollars in millions)

Funding Source	Received Funds	Total Funding Awarded /1
Exchange Planning Grants	48 States + DC	48.8
Rate Review Grants	45 States + DC	46.0
Consumer Assistance Grants	35 States + DC + 4 Territories	27.2

/1 Funding awarded as of January 20, 2011.

PROGRAM MANAGEMENT

(dollars in millions)

	2010	2011	2012	2012 +/-2010
Discretionary Administration				
Program Operations /1	2,291	2,291	3,062	+771
Federal Administration /1	695	695	859	+164
Survey and Certification	347	347	400	+53
Research	36	36	31	-5
State High-Risk Pools /2	0	55	44	+44
Total, Discretionary	**3,368**	**3,423**	**4,397**	**+1,029**
Mandatory Administration				
Affordable Care Act /3	347	588	139	-208
American Recovery and Reinvestment Act	140	140	140	--
Medicare Improvements for Patients and Providers Act	35	38	38	+3
Medicare and Medicaid Extenders Act	--	200	--	--
State High-Risk Pools /2	55	--	--	-55
Total, Mandatory	**577**	**966**	**317**	**-260**
Reimbursable Administration /4	430	429	676	+246
Subtotal, Discretionary and Mandatory /5	**4,375**	**4,818**	**5,390**	**+1,015**
FTE /6	4,722	4,958	5,735	+1,013

1/ FY 2010 and FY 2011 levels have been comparably adjusted each year for the SHIP transfer to AoA as follows: Program Operations -$45.0 million, Federal Administration -$2.0 million.

2/ State high risk pools were classified as mandatory in FY 2010.

3/ FY 2010 includes $30.0 million for the Consumer Assistance Grants.

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

5/ Totals for FY 2010, FY 2011, and FY 2012 do not include CMS HCFAC wedge amounts.

6/ FTE totals include FTE from other funding sources, including HCFAC, State Grants, reimbursables, the Recovery Act, and the Affordable Care Act. CMS will fund the following FTEs from these other sources: FY 2010 – 446 FTEs; FY 2011 - 680 FTEs; FY 2012 - 818 FTEs. Fiscal years 2010 and 2011 exclude staffing funded from Affordable Care Act Implementation Fund.

The FY 2012 discretionary budget request for CMS Program Management is $4.4 billion, an increase of $1.0 billion over comparably adjusted FY 2010. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and to implement new health insurance reforms contained in the Affordable Care Act. With the funding requested for FY 2012, CMS will make targeted investments and increase security in information technology (IT), achieve optimal staffing levels, maintain survey frequencies, administer new laws, augment its research agenda, and administer basic operations.

BUDGET ACCOUNT SUMMARIES

Program Operations: The Program Operations request is $3.1 billion, an increase of $771 million above FY 2010. The Program Operations account funds mission-critical contractor and IT activities necessary to administer the Medicare, Medicaid, and CHIP programs, the implementation of new private health insurance protections created by the Affordable Care Act, and additional activities required by legislation. Top priority activities for FY 2012 include:

- *Ongoing Medicare Contractor Operations:* Approximately 33 percent, or $1.0 billion, of the FY 2012 Program Operations request supports ongoing contractor operations, 2.0 percent below the FY 2010 level. These savings have been achieved due to a multi-year commitment to radically reform Medicare's contracting system. Despite numerous bid protests delaying the reform process, CMS plans to complete the conversion to 15 Part A/B Medicare Administrative Contractors and four durable medical equipment Medicare Administrative Contractors by early 2012. Contracting reform will generate $3.6 billion in Trust Fund savings over the next five years (FY 2012 – FY 2016) through more accurate payment of claims.

- *Beneficiary Education and Outreach:* The Budget includes $333 million for beneficiary education and outreach activities through the National Medicare Education Program (described in a later section). This does not include user fees or funding for outreach activities conducted by QIOs.

- *Healthcare Integrated General Ledger and Accounting System (HIGLAS):* The Budget requests $168 million for continued implementation of and maintain HIGLAS, a state-of-the-art accounting system for CMS. Of this total, $134 million supports ongoing HIGLAS operations at CMS contractors (MACs and the remaining legacy contractors), and $34 million will be used to transition additional MACs to HIGLAS. HIGLAS yields significant savings and efficiencies through more rapid recovery collections, resulting in $275 million in estimated earned interest through FY 2010.

- *IT Systems and Support:* The Budget includes $661 million for general IT systems and other support, such as systems to manage and administer Medicare Advantage and the Part D benefit and CMS's data center and telecommunications infrastructure. This request includes $244 million to modernize and transform CMS's enterprise-wide IT systems.

- *Medicaid and CHIP Operations:* The Budget requests $37 million to fund administrative activities to improve Medicaid and CHIP program operations and implement new responsibilities under the Affordable Care Act. Some of these activities were previously funded under the Federal Administration line of the Program Management account.

- *HealthCare.gov:* HealthCare.gov provides consumers with a one-stop shopping website where they can compare basic information about health insurance plans in order to make more informed decisions about their insurance coverage. The Budget requests $38 million

to continue systems realignment to ensure that the website provides appropriate transparency to consumers.

- *Insurance Oversight:* The Budget requests $28 million for CMS contracts to ensure compliance with the private insurance provisions contained in the Affordable Care Act.

- *Health Insurance Exchange Operations:* HHS is requesting $236 million to fund operations of the Office of Health Insurance Exchanges. This funding request will support activities such as technical assistance to States, Exchange development in States that choose not to establish their own, and IT systems.

- *Consumer Support:* The Budget requests $28 million for consumer support activities to help individuals, including helping consumers in States without consumer assistance programs navigate the private health insurance market. Additionally, Independent Review Organization contractors will provide an external review process on adverse benefit decisions, for consumers with new plans in States without a complaint process.

Federal Administration: For FY 2012, the President's Budget requests $859 million for CMS Federal administrative costs, a $164 million increase over the comparably adjusted FY 2010 enacted level.

Of this total, $655 million will support a Full Time Equivalent (FTE) complement of 4,917, an increase of 641 FTE over FY 2010. This staffing increase will enable CMS to administer increasing responsibilities resulting from legislation passed in recent years, such as the Affordable Care Act, the Recovery Act, and MIPPA.

Survey and Certification: The FY 2012 Survey and Certification request is $400 million, a $53 million increase over FY 2010. The $400 million request funds basic survey and certification program activities and new initiatives in nursing home transparency, quality improvement, and program integrity. This increase from the FY 2010 budget is needed to complete surveys at frequencies consistent with statutory and policy requirements, given inflation and growth in the number of facilities.

Surveys include mandated Federal inspections of long-term care facilities (i.e., nursing homes) and home health agencies, as well as Federal inspections of other key facilities. All facilities participating in the Medicare and Medicaid programs must undergo inspection when entering the program and on a regular basis thereafter. As CMS continues to target healthcare associated infections, this funding request allows CMS to continue the enhanced survey process in Ambulatory Surgical Centers to target infection control deficiencies, with a survey frequency of every 4 years. Once Conditions of Participation (COPs) are finalized, surveys of community mental health centers (CMHCs) will begin in FY 2012 for the first time. Previously there were no COPs for CMHCs, which limited the ability to improve quality of care at poorly performing centers because no mechanism existed to terminate them from Medicare participation.

Approximately 81 percent of the funding will go to State survey agencies to complete certifications and complaint visits. Between FY 2005 and FY 2012, the number of Medicare-certified facilities is expected to grow by 17 percent, from 48,940 to 57,200 facilities. CMS expects States to complete almost 25,800 initial surveys and re-certifications and approximately 53,650 complaint visits in FY 2012.

Reduce Prevalence of Pressure Ulcers in Nursing homes

The prevalence of pressure ulcers in nursing homes is an accepted indicator of quality of care in nursing homes. CMS is encouraged by the downward trend in pressure ulcer prevalence. CMS has met or exceeded its targets since FY 2004, including most recently in FY 2009, when the nursing home pressure ulcer prevalence of 7.6 percent was lower than the FY 2009 target of 8.2 percent, and reflected an improvement over the FY 2008 rate of 8 percent. This recent success can be attributed to CMS' new survey guidance and follow up with States, as well as greater collaboration between the State survey agencies and the Quality Improvement Organizations (QIOs). CMS anticipates that its *Advancing Excellence in Americans' Nursing Homes* campaign will continue the momentum.

Recent reports from the Government Accountability Office (GAO) and the HHS Office of Inspector General highlight the need for Federal oversight to ensure quality of care. The GAO placed aspects of survey and certification, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating greater vulnerability to fraud, waste, abuse, and mismanagement. Maintaining survey and certification frequencies at or above the mandatory and policy levels is critical to ensuring Federal dollars support only quality care.

Research, Demonstrations, and Evaluation: The FY 2012 Research, Demonstrations, and Evaluation request is $31 million, a $4 million decrease below FY 2010.

The Medicare Current Beneficiary Survey (MCBS) is fully funded at $15.7 million. A continuous, multi-purpose survey that represents the Medicare population, MCBS data aids CMS in determining payment policy, decision-makers in crafting legislation, and the Congressional Budget Office and actuaries in developing cost estimates. Funding for demonstrations and other research totals $13 million, including Medicare and Medicaid projects that could not be performed under other authorities. The Budget also includes $2.5 million for Real Choice Systems Change grants that assist States in improving community-based support systems that enable people with disabilities and long-term illnesses to live and participate in the community.

Survey and Certification Frequencies

Type of Facility	2010	2011 CR	2012
Long-Term Care Facilities /1	Every Year	Every Year	Every Year
Home Health Agencies /1	Every 3 Years	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 3 Years	Every 5 Years	Every 3 Years
Accredited Hospitals	2% Per Year	Not funded	3.3% Per Year
Organ Transplant Facilities	Every 3 Years	Every 5 Years	Every 3 Years
ESRD Facilities	Every 3 Years	Every 4 Years	Every 3 Years
Ambulatory Surgical Centers /2	Every 6 Years	Every 5 Years	Every 4 Years
Community Mental Health Centers	N / A	N / A	Every 4 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation	Every 6 Years	Every 10 Years	Every 6 Years

/1 Legislatively Mandated

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

State High Risk Pools: For FY 2012, the President's Budget requests $44 million for the State High Risk Pools, a $11 million decrease from FY 2010.

This program provides grants to States to fund qualified high-risk health insurance pools for individuals who have conditions that may cause private health insurance to be unavailable or unaffordable. Grants are awarded to States under this program to partially cover losses incurred by States in connection with the operation of the pools and to provide supplemental benefits. The Affordable Care Act includes a maintenance of effort requirement for the State High Risk Pools as a condition for State participation in the Pre-Existing Condition Insurance Plan (PCIP) program. Individuals enrolled in the State High Risk Pools are not eligible for the new PCIP program due to statutory eligibility requirements (see "New Health Insurance Protections and Programs").

National Medicare Education Program (NMEP): The total FY 2012 program level for NMEP is $404 million, an increase of approximately $53 million from the FY 2010 level. The NMEP program level includes funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and QIOs. Beneficiary education remains a top priority for CMS, in order to ensure that beneficiaries have accurate and up-to-date information on their coverage options and covered benefits.

Of the total, $286 million, or 71 percent, supports the 1-800-MEDICARE call center, which provides customer

service in English and Spanish. The request is $41 million higher than the FY 2010 level to support 28 million calls.
The remaining NMEP funding supports other important beneficiary education activities. $53 million will be used to develop and distribute beneficiary education materials, including nearly 47 million *Medicare & You* handbooks, 3 million more than in FY 2010. Another $41 million will support websites enhancements and 427 million page views at www.medicare.gov, 17 million more page views than FY 2010. Finally, NMEP includes $22 million for program support services and a multi-media Medicare education program to inform beneficiaries about their benefits, changes made to their benefits, and plan choices. The Budget proposes to transfer the State Health Insurance Assistance Program (SHIP) to AoA.

National *Medicare* Education Program (NMEP)

FY 2012 Program Level Request in Millions

Activity	2010	2012
Beneficiary Materials (e.g. Handbook).....	$51.00	$52.70
1-800-MEDICARE Toll Free Line	$244.80	$285.60
Internet/1.....	$34.10	$41.00
Community-Based Outreach /2.....	$2.40	$3.00
Program Support Services /1/3.....	$18.90	$21.70
Total, NMEP Program Level /4.....	**$351.2**	**$404.0**

/1 FY 2012 QIO funding amounts are not included, as the 10th contract cycle has yet to be approved. This impacts the FY 2011 funding levels of the Internet and Program Support Services.

/2 Reflects SHIP program transfer to AoA.

/3 Includes multi-media campaign and consumer research.

/4 Includes funding from Program Management, user fees and QIOs.

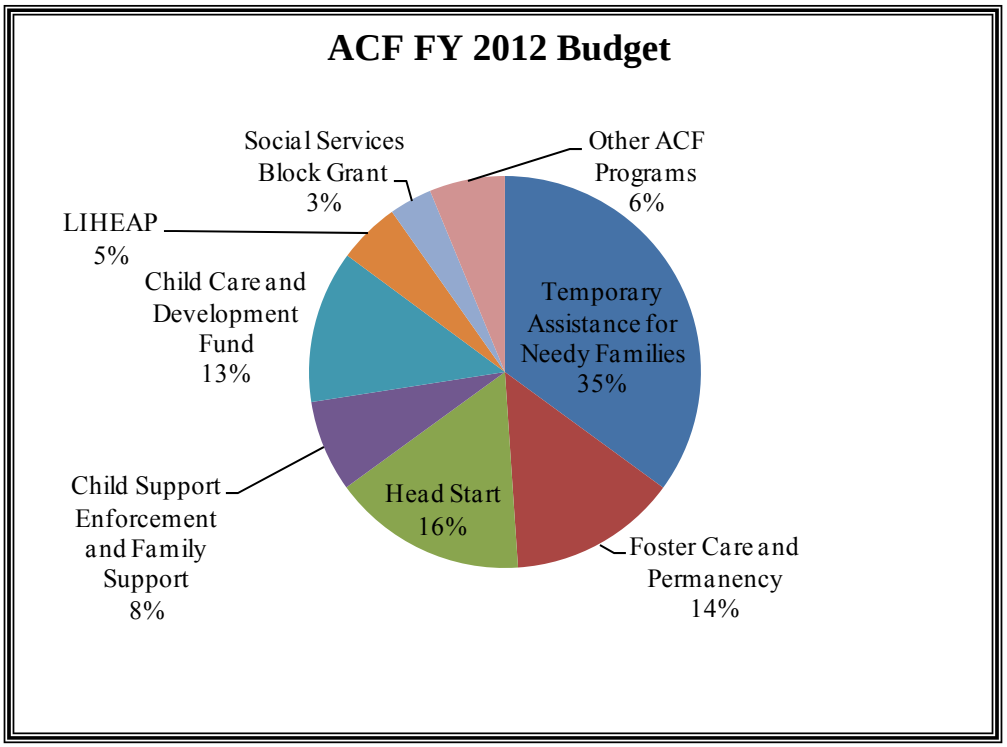
ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

	2010	2011	2012
Discretionary			
Program Level	17,339	17,342	16,185
Budget Authority	17,333	17,336	16,179
Mandatory			
Budget Authority	34,325	33,344	34,502
Total, ACF Budget Authority	**51,658**	**50,680**	**50,681**

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

The FY 2012 Budget request for the Administration for Children and Families (ACF) is $50.7 billion. ACF works in partnership with States and communities to provide critical assistance to vulnerable families while helping families and children get on a path to success. ACF finds safe and supportive families for abused children, helps parents find jobs, works with newly arrived refugees as they start their new lives in America, and works with troubled teens to leave the streets and find a path toward hope and opportunity. The Budget includes additional funding for Head Start and Refugee programs, and supports important reforms in child care, child support, and foster care.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

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

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Head Start	7,234	7,235	8,100	+866
Child Care & Dev. Block Grant (disc)	2,127	2,127	2,927	+800
Adoption Incentives	40	40	50	+10
Runaway and Homeless Youth Programs	116	116	121	+5
Education & Training for Foster Youth	45	45	45	--
Child Abuse	97	97	97	--
Child Welfare/Adoption Assistance	360	360	360	--
Adoption Opportunities (non add)	*26*	*26*	*39*	*+13*
Children's Health Act (non add)	*13*	*13*	--	*-13*
Refugee Programs				
Transitional and Medical Services (TAMS)	353	353	394	+41
Unaccompanied Alien Children (UAC)	149	149	177	+28
Social Services and Other Refugee Programs	228	228	253	+25
Subtotal, Refugee Programs	731	731	825	+94
LIHEAP				
Formula Grants	4,510	4,510	1,980	-2,530
Contingency Fund	590	590	590	--
Subtotal, LIHEAP Budget Authority	5,099	5,100	2,570	-2,530
Native Americans	49	49	49	--
Family Violence Prevention	133	133	140	*6*
Promoting Safe and Stable Families (disc)	63	63	63	--
Developmental Disabilities	187	187	163	-23
State Councils (non add)	*75*	*75*	*75*	--
Voting Access, Disabled (non add)	*17*	*17*	--	*-17*
Proj. of National Significance (non add)	*14*	*14*	*8*	*-6*
Strengthening Communities Fund	--	--	20	+20
Community Services Block Grant	700	700	350	-350
Assets for Independence	24	24	24	--
Other Community Services Programs	49	49	20	-29
Subtotal, Community Service Programs	773	773	394	-379
Mentoring Children of Prisoners	49	49	25	-24
Disaster Human Services Case Management	2	2	2	--
Social Services Research & Demonstration	20	20	3	-17
PHS Evaluation Funds (non-add)	6	6	6	--
Subtotal, Social Services R&D	25	25	9	-17
Center for Faith Based/Community Initiatives	1	1	1	--
Federal Administration	208	208	225	16
Total, Program Level	**17,339**	**17,342**	**16,185**	**-1,154**
Less Funds From Other Sources				
PHS Evaluation Funds	-6	-6	-6	--
Total, Budget Authority	**17,333**	**17,336**	**16,179**	**-1,154**
FTE (including those financed with mandatory funds)	*1,331*	*1,374*	*1,398*	*+67*

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY PROGRAMS

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

The FY 2012 discretionary Budget request for the Administration for Children and Families (ACF) is $16.2 billion, a decrease of $1.2 billion from the FY 2010 enacted level. The President's Budget prioritizes investments in early learning as an important way to promote opportunity and academic success to reduce poverty and the need for assistance over the longer term. The Budget includes an additional $1.7 billion to support nearly 1 million children in Head Start and, combined with mandatory funds, 1.7 million children in child care assistance programs. At the same time, the budget reflects tough choices that are required to advance the Administration's deficit reduction goals. Funding for the Low Income Home Energy Assistance Program is $2.6 billion, a $2.5 billion reduction below FY 2010, but comparable to annual program funding levels through FY 2008. The budget includes a $350 million reduction to the Community Services Block Grant and targets funding to high quality programs, and does not request funding for several smaller programs that have not demonstrated results.

Head Start: The Budget requests $8.1 billion for Head Start. This funding level is necessary to continue to serve 968,000 children – the number served in FY 2010 – including approximately 114,000 infants and toddlers in Early Head Start.

Child Care: The FY 2012 request for the Child Care and Development Block Grant (CCDBG) is $2.9 billion. The request also includes $3.4 billion for the Child Care Entitlement to States (CCE). The FY 2012 request serves 1.7 million children. The Budget supports an important set of reforms in child care that would raise the bar on quality in child care programs. These changes would be effectuated through reauthorization of the CCDBG and CCE programs. The Administration's principles for reauthorization include serving more low-income children in safe, healthy, and nurturing child care settings that are highly effective in promoting early learning; supporting parental employment and choice by providing information on quality; promoting continuity of care; strengthening program integrity and accountability; and streamlining across the spectrum of early childhood programs. These reforms, along with investments in the Early Learning Challenge Fund and Head Start, are key elements of the Administration's broader education reform agenda designed to help every child reach his or her academic potential and improve our Nation's competitiveness.

Head Start Expansion

ACF has awarded $2.1 billion in Recovery Act funds to expand Head Start and Early Head Start enrollment, and improve the quality of these programs. As a result of Recovery Act Early Head Start expansion funding, Creative Minds in Newport, Vermont has been able to keep their existing infant and toddler program open and increase enrollment by nearly 50 percent.

PROTECTING CHILDREN AND OTHER VULNERABLE POPULATIONS

Adoption Incentives: To ensure that as many children as possible grow up in stable and loving families, ACF provides bonuses to States that increase the number of children adopted from their public foster care systems. Bonuses are also awarded for adoption of difficult to place children, those nine and older and those with special needs. The number of qualifying public agency adoptions continues to increase, from 50,740 in FY 2007 to 54,372 in FY 2009 (the most recent year for which complete data are available). The Budget includes $50 million, a 26 percent increase above FY 2010, to cover anticipated State bonus payments due to increased adoptions for which States can claim incentive payments.

Mentoring Children of Prisoners: In addition to experiencing disruption in the relationship with their parents, children of incarcerated adults often struggle with the economic, social, and emotional burdens of their parent's incarceration. Since 2003, HHS has sought to foster more positive outcomes among this population by funding projects that match volunteer mentors with children of prisoners. Despite best efforts, fewer than 40 percent of these matches endure more than twelve

months, which is a critical threshold for achieving positive outcomes. The FY 2012 budget reduces the level of investment in this program by $24 million, while modifications are made to improve its effectiveness.

Other Programs for Children, Youth and Families:
The Budget maintains funding for Promoting Safe and Stable Families to continue support for States' efforts to prevent child abuse and to promote family preservation. It maintains other funding for Child Abuse Prevention programs, which improve investigations of abuse, training for child protection workers, and the overall capacity of States to prevent and treat child abuse and neglect. The Budget also includes $121 million for Runaway and Homeless Youth programs, to make grants to public and private organizations that operate shelters for youth and provide supportive services, such as transitional living programs and maternity group homes. An additional $5 million is included in FY 2012 for demonstrations to address sex trafficking of runaway and homeless youth, which is a growing problem in this population. To continue to provide post secondary educational assistance to foster care youth ages 16-21, the Budget includes $45 million for educational training vouchers of up to $5,000 per participant for expenses like tuition, books, and other fees.

Family Violence Prevention:
The Budget includes $140 million, an increase of $6 million, for family violence prevention programs, which is the primary Federal funding stream dedicated to the support of domestic violence shelters and services for victims of domestic violence and their dependents. This funding will be used to expand shelter capacity and support services, and support increased call volume to the Domestic Violence Hotline.

Refugee Programs: Among the vulnerable populations that ACF serves are refugees who have been forced out of their home countries, unaccompanied alien children who have been apprehended by the Department of Homeland Security or other law enforcement agencies, and victims of trafficking and torture. Newly arrived refugees, and certain other entrants, are eligible for time-limited cash and medical assistance as well as English instruction and job training to help them become economically self-sufficient as quickly as possible. Victims of international trafficking are identified, made eligible for refugee benefits, and provided additional services such as housing assistance and counseling. Unaccompanied alien children reside in ACF shelters until their immigration cases are resolved or they can be placed with relatives or other sponsors.

The Budget requests $825 million for these programs, including a $25 million increase for refugee social services, which the Administration also requested in FY 2011. These funds would provide enhanced services to especially vulnerable refugees – widows, the elderly, the homeless, those with serious medical problems – who are struggling in the current economy. The Budget request is $94 million more than FY 2010. Major factors expected to increase costs for refugee programs in FY 2011 and FY 2012 are continued high unemployment, which increases the length of time newly arrived refugees need cash and medical assistance, and additional services required by the reauthorization of the Unaccompanied Alien Children program, such as expanded home studies.

Developmental Disabilities: The President's Budget includes $163 million, a reduction of $23 million, to improve access to consumer-centered support services for individuals with developmental disabilities. This funding is also used to protect the legal and human rights of individuals with disabilities. Within this total, funding for Voter Access is discontinued because States have not expended available funds in a timely way, and funding for Projects of National Significance is reduced by $6 million.

Low Income Home Energy Assistance Program (LIHEAP):
LIHEAP includes two components, a State formula grant and a contingency fund used to target additional funds to states in response to emergencies such as extreme heat or cold waves. The Budget includes $2.0 billion for the formula grant, a decrease of $2.5 billion below FY 2010 but the same as amount as provided in FY 2008 and previous years. Energy prices are volatile but the Department of Energy predicts home heating costs this winter will be slightly less than they were for the winter of 2007 – 2008. The Budget also includes $590 million for the contingency fund, the same as FY 2010.

STRENGTHENING COMMUNITIES

Native Americans: The Budget includes $49 million, the same as FY 2010, to improve the wellbeing of American Indian, Alaska Native, Native Hawaiian, and other Pacific Islander communities by strengthening local economies, creating jobs, and improving health care. Funds are provided for economic self sufficiency, job training and business development, as well as for other aspects of community health including responsible fatherhood, healthy relationships, and elder care. Funds also support the preservation of Native language and culture, and the protection of community natural resources for current and future generations.

Improving Teacher Training

The percentage of Head Start and Early Head Start teachers with an Associate's degree or higher, or a relevant credential, increased from 80 percent in FY 2007 to 85 percent in FY 2010, meeting the FY 2010 target.

Community Service Programs: The President's Budget includes $394 million for Community Services Programs. This funding level includes $350 million for the Community Services Block Grant, a reduction of $350 million. The Budget includes a proposal to introduce competition into the program to ensure that funding is directed to the highest-quality programs and to expand oversight with the goal of improving program effectiveness and outcomes. In support of the Healthy Food Financing Initiative, $20 million is included to provide funding for community development corporations to develop projects specifically targeted toward improving access to grocery stores, farmers markets, and other venues for fresh groceries. Additionally, $20 million is included for the Strengthening Communities Fund, to improve the capacity of nonprofits to serve their neighborhoods.

ENSURING PROGRAM EFFECTIVENESS

ACF is committed to ensuring that only programs with demonstrated effectiveness receive continued funding. The Budget includes $9 million to maintain a rigorous agency-wide research and evaluation capacity. Funding is included for an evaluation of early childhood education programs to better understand which factors are most important to support early cognitive development.

Federal Administration: The Budget includes $225 million for ACF program administration, an increase of $16 million over FY 2010. Additional funding is requested for program integrity activities to ensure that ACF programs are effectively administered. New resources will also be devoted to carrying out major new program responsibilities such as the grantee designation renewal system established by the Head Start reauthorization to ensure that only high quality grantees receive Head Start funding.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY SPENDING

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

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law B.A.:				
Child Care Entitlement to States	2,917	2,917	2,917	--
Child Care and Development Fund (non-add) /1	*5,043*	*5,044*	*5,044*	--
Child Support Enforcement and Family Support	4,666	4,064	3,505	-559
Foster Care and Permanency	7,335	6,622	7,006	+384
Supporting Healthy Families and Adolescent Development (mandatory only) /2	505	505	505	--
Temporary Assistance for Needy Families (TANF) /3	17,059	16,951	16,740	-211
TANF Contingency Fund /4	--	334	612	+278
Total, TANF (non-add)	*17,059*	*17,285*	*17,352*	*+67*
Children's Research and Technical Assistance	58	58	52	-6
Social Services Block Grant	1,785	1,785	1,785	--
Total, Current Law B.A.	**34,325**	**33,236**	**33,122**	**-114**
Proposed Law B.A.:				
Child Care Entitlement to States	2,917	2,917	3,417	+500
Child Care and Development Fund (non-add)	*5,043*	*5,044*	*6,344*	*+1,300*
Child Support Enforcement and Family Support	4,666	4,064	3,810	-254
Foster Care and Permanency	7,335	6,622	7,256	+634
Supporting Healthy Families and Adolescent Development (mandatory only)	505	505	505	--
TANF	17,059	17,059	17,059	--
TANF Contingency Fund	--	334	612	+278
Total, TANF (non-add)	*17,059*	*17,393*	*17,671*	*+278*
Children's Research and Technical Assistance	58	58	58	--
Social Services Block Grant	1,785	1,785	1,785	--
Total, Proposed Law B.A.	**34,325**	**33,344**	**34,502**	**+1,158**

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

2/ The total for Supporting Healthy Families and Adolescent Development includes Abstinence Education, the Personal Responsiblity Education Program, and Promoting Safe and Stable Families (mandatory).

3/ The Claims Resolution Act of 2010 extended all TANF grants through September 30, 2011 except for the Supplemental Grants for Population Increases. The supplemental grants were extended through June 30, 2011 resulting in a total of $211 million being available for FY 2011.

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

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

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY PROGRAMS

The FY 2012 Budget request for ACF Mandatory programs is $34.5 billion and includes legislative proposals that are subject to Statutory Pay-As-You-Go (PAYGO) Act procedures. The Administration intends to work with Congress to fully offset these costs and the Budget request includes proposals that can be used as offsets. ACF serves the Nation's most vulnerable populations through mandatory programs such as Temporary Assistance for Needy Families (TANF), Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

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

The Budget continues existing funding for the TANF program in FY 2012 and puts forth broad principles for reform.

CHILD CARE ENTITLEMENT TO STATES (CCE) AND LEGISLATIVE REFORM AGENDA

The Budget calls for important reforms in the Child Care and Development Block Grant and the Child Care Entitlement to States. The FY 2012 request for the Child Care Entitlement is $3.4 billion, an increase of $500 million over FY 2011. The request also includes an $800 million discretionary increase to the Child Care and Development Block Grant over the FY 2011 CR level. Total child care funding for the Child Care and Development Fund (CCDF) is $6.3 billion in FY 2012, an increase of $1.3 billion over FY 2011. The Budget request supports additional funding for quality activities while allowing for a modest increase in the number of children receiving subsidies. In FY 2012, the request would enable 1.7 million children to receive child care assistance – approximately 220,000 more than could be served in the absence of these additional funds. These reforms, along with investments in the Early Learning Challenge Fund and Head Start, are key elements of the Administration's broader education agenda designed to help every child reach his or her academic potential and improve our Nation's competitiveness.

CHILD SUPPORT ENFORCEMENT (CSE) AND FAMILY SUPPORT PROGRAMS

Child Support Enforcement is a joint Federal, State, Tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The FY 2012 President's Budget request is $3.8 billion in net budget authority for Child Support Enforcement and Family Support Programs.

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

Affordable Care Act

The Affordable Care Act provided annually for FY 2010 through FY 2014:

- $75 million for the Personal Responsibility Education Program (PREP) to educate youth on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections;
- $50 million for Abstinence Education to enable States to provide education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock; and,
- $85 million for Health Profession Opportunity Grants to support the establishment and maintenance of training, education, and career advancement programs to address health care professions workforce needs. TANF recipients and other low-income individuals are eligible to receive education and training.

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

CHILD SUPPORT ENFORCEMENT (CSE) LEGISLATIVE PROPOSALS

The Budget includes a Child Support and Fatherhood initiative to promote strong family relationships by encouraging fathers to take responsibility for their children, changing policies so that more of fathers' support reaches their children, and continuing a commitment to vigorous enforcement. The Budget increases support for States to pass through child support payments to families, rather than retaining those payments, and requires States to establish access and visitation arrangements as a means of promoting father engagement in their children's lives. The Budget also provides a temporary increase in incentive payments to States based on performance, which continues an emphasis on program outcomes and efficiency and will foster enforcement efforts. The initiatives would cost $305 million in FY 2012.

The proposal also requires States to amend their uniform interstate child support laws to ensure efficient international child support case processing as required by The Hague Child Support Treaty.

Child Support Enforcement

The Child Support Enforcement (CSE) program continues to make strong gains in support orders and paternity establishment. In FY 2009:

- Child support collections totaled $26.4 billion.
- 1.8 million paternities were established and acknowledged, representing a slight increase over FY 2008.
- CSE met the 94 percent paternity establishment rate target in 2009.
- CSE surpassed its target for establishing child support orders, generating support orders for 79 percent of all child support cases, which is two percentage points above the target of 77 percent for 2009.
- For every dollar invested in the program, CSE collected $4.78 in child support, exceeding the target of $4.70. CSE aims to increase the cost effectiveness ratio to $4.80 by FY 2012.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

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

FOSTER CARE AND PERMANENCY LEGISLATIVE REFORM PRINCIPLES

The Budget request for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs is $7.3 billion in budget authority. These programs, authorized by title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence. The Budget includes an increase in funding of $250 million in FY 2012 to support a reform agenda focused on improving outcomes for children. (See text box.)

Of the total request in FY 2012, $4.5 billion in budget authority will support the Foster Care program, including maintenance payments to children and new incentive-based funds (see text box). This is a $571 million increase from the FY 2011 level. The proposed level of funding will provide assistance and support to an estimated 166,800 children each month, about 4,500 fewer children than in FY 2011. This decrease is partially due to placement of more children in permanent settings. It is also due to a reduction in the foster care children funded under the Federal program because the income eligibility criteria required by statute is tied to the former Aid to Families with

Dependent Children program eligibility rules which are increasingly outdated.

The Budget also includes $2.5 billion in budget authority for the Adoption Assistance program, an increase of $15 million above the FY 2011 level. This increase reflects a rise in the number of children participating in the Adoption Assistance program, as well as outlays resulting from the extension of the enhanced FMAP match rates for maintenance payments for an additional two quarters through June 30, 2011. An estimated average 470,400 children per month, an increase of 19,800 over FY 2011, will have payments made on their behalf.

In FY 2012, the Budget includes $80 million for the Guardianship Assistance program, an increase of $48 million above FY 2011 reflecting an increase in the number of children participating in Guardianship Assistance programs, which provides funds to title IV-E agencies to provide a subsidy on behalf of a child to a relative granted legal guardianship of that child. The $80 million also includes the impact of extending the enhanced FMAP match rate for maintenance payments for an additional two quarters through June 30, 2011. An estimated average 13,900 children per month, an increase of 7,900 over FY 2011, will have payments made on their behalf in FY 2012.

The Budget also includes $140 million in budget authority for the Chafee Foster Care Independence Program, the same level as in FY 2011. This program funds services for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21.

Foster Care Legislative Proposal

The Budget includes a new initiative of $250 million to incentivize improvements in foster care by:

- Creating financial incentives to improve child outcomes in key areas by reducing the length of stay in foster care; increasing permanency through reunification, adoption, and guardianship; decreasing rates of maltreatment recurrence and any maltreatment while in foster care; and reducing rates of re-entry into foster care.
- Improving the well-being of children and youth in the foster care system, transitioning to permanent homes, or transitioning to adulthood.
- Reducing costly and unnecessary administrative requirements, while retaining the focus on children in need.
- Using the best available research available on child welfare policies and interventions to help Sates achieve further declines in the number of children who need to enter or remain in foster care, to better reach families with more complex needs, and to improve outcomes for children who are abused, neglected or at risk of abuse or neglect.
- Expanding our evidence base by allowing demonstrations that enable States to test innovative strategies that improve outcomes for children and reward States for efficient use of Federal and State resources.

Foster Care and Permanency Performance: The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2009, the latest year for which complete performance data are available. Working with the States, these programs supported the goal of minimizing disruptions to the continuity of family and other relationships for children in Foster Care by decreasing the number of placement settings per year for a child in care. In FY 2009, almost 85 percent of children who had been in care less than 12 months had no more than two placement settings, exceeding the target of 80 percent.

SUPPORTING HEALTHY FAMILIES AND ADOLESCENT DEVELOPMENT

The Budget includes $505 million for Supporting Healthy Families and Adolescent Development. Of this amount, $75 million supports PREP, $50 million supports Abstinence Education (see text box), and $380 million supports the mandatory portion of Promoting Safe and Stable Families.

Promoting Safe And Stable Families (PSSF): The Budget maintains funding for PSSF to ensure continued support for a variety of important State child welfare activities, including family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. This program has two distinct funding streams; one discretionary and one mandatory. The total FY 2012

Budget request for PSSF is $443 million. The mandatory portion of this Budget request provides funding for this capped entitlement at $380 million.

Promoting Safe and Stable Families Performance: In FY 2009 the percentage of children in Foster Care without a case plan goal was reduced to 3.6 percent, exceeding the goal of 5.4 percent. By increasing the proportion of cases with a case plan goal developed in a timely manner, ACF is helping to ensure that there is a focus on moving children from Foster Care to a permanent home.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

TANF provides $17.1 billion annually to States, Territories, and eligible Tribes to assist low income families and improve employment and other outcomes. The Deficit Reduction Act of 2005 (DRA) (P.L. 109-171) reauthorized TANF through FY 2010 and the Claims Resolution Act of 2010 (P.L. 111-291) extended it through FY 2011.

The recession has put enormous pressure on low-income families and TANF. The American Recovery and Reinvestment Act (P.L. 111-5) made several temporary changes to the TANF program to help States facing rising expenditures for TANF recipients and other low-income families. In 2009 and 2010, the Recovery Act's $5 billion TANF Emergency Fund provided assistance to 49 States, the District of Columbia, Puerto Rico, the Virgin Islands and 25 Tribes (see text box).

The Continuing Appropriations Act, 2011 (P.L. 111-242) appropriated $506 million for the Contingency Fund in FY 2011 and $612 million for FY 2012. Subsequently, the FY 2011 appropriation was reduced to $334 million by the Claims Resolution Act of 2010 (P.L. 111-291). P.L. 111-291 also extended TANF through September 30, 2011, with the exception of Supplemental Grants for Population Increases. These supplemental grants were extended through June 30, 2011 with a total of $211 million appropriated for FY 2011.

TANF LEGISLATIVE PROPOSALS

The President's Budget continues existing funding for the TANF program in FY 2012. The Budget also includes resources to fund the FY 2011 Supplemental Grants for Population Increases at the level provided in prior years. When TANF reauthorization is considered, the Administration would be interested in exploring with Congress a variety of strategies to strengthen the program's ability to improve outcomes for families and children, including helping more parents succeed as workers by building on the recent successes with subsidized employment, using performance indicators to drive program improvement; and preparing the program to respond more effectively in the event of a future economic downturn.

SOCIAL SERVICES BLOCK GRANT (SSBG)

SSBG is a capped entitlement which provides flexible grants to States for the provision of social services ranging from child care to residential treatment. States have broad discretion over the use of these funds. SSBG funds are allocated to States according to population size. SSBG is funded at $1.7 billion for FY 2012, the same as the FY 2011 level.

Recovery Act's TANF Emergency Contingency Fund Supports Subsidized Employment

During FY 2009 and FY 2010, ACF awarded $5 billion to States, Territories and Tribes for increases in subsidized employment, basic assistance expenditures, and short-term non-recurrent benefits. Of these funds, $1.3 billion was awarded for subsidized employment to support a wide range of employment programs, including transitional jobs, summer job programs for low-income youth, and supported work programs for individuals with disabilities or other barriers to employment.

ACF MANDATORY - CURRENT LAW OUTLAYS

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Current Law Outlays:				
Child Care Entitlement to States	2,723	2,741	3,096	+355
Child Care and Development Fund (non-add) /1	*5,868*	*5,438*	*5,303*	*-135*
Child Support Enforcement and Family Support	4,423	3,619	3,536	-83
Foster Care and Permanency	6,972	6,892	7,016	+124
Supporting Healthy Families and Adolescent Development (mandatory only) /2	351	478	494	+16
Temporary Assistance for Needy Families (TANF) /3	17,513	17,026	16,863	-163
TANF Contingency Fund	477	457	612	+155
TANF Emergency Fund (ARRA) /4	2,430	1,972	232	-1,740
Total, TANF (non-add)	*20,420*	*19,455*	*17,707*	*-2,713*
Children's Research and Technical Assistance	55	60	53	-7
Social Services Block Grant	2,035	2,011	1,802	-209
Total, Current Law Outlays	**36,979**	**35,256**	**33,704**	**-1,552**
Proposed Law Outlays:				
Child Care Entitlement to States	2,723	2,741	3,477	+736
Child Care and Development Fund (non-add)	*6,061*	*5,619*	*6,299*	*+680*
Child Support Enforcement and Family Support	4,423	3,619	3,780	+161
Foster Care and Permanency	6,972	6,892	7,236	+344
Supporting Healthy Families and Adolescent Development (mandatory only)	351	478	494	+16
Temporary Assistance for Needy Families (TANF)	17,513	17,048	17,205	+157
TANF Contingency Fund	477	457	612	+155
TANF Emergency Fund	2,430	1,972	232	-1,740
Total, TANF (non-add)	*20,420*	*19,477*	*18,049*	*-1,428*
Children's Research and Technical Assistance	55	60	55	-5
Social Services Block Grant	2,035	2,011	1,802	-209
Total, Proposed Law Outlays	**36,979**	**35,278**	**34,893**	**-385**

1/ The Child Care Development Fund includes mandatory funding from the Child Care Entitlement to States and discretionary funding from the Child Care and Development Block Grant.
2/ The total for Supporting Healthy Families and Adolescent Development includes Abstinence Education, the Personal Responsiblity Education Program, and Promoting Safe and Stable Families (mandatory).
3/ The Claims Resolution Act of 2010 extended all TANF grants through September 30, 2011 except for the Supplemental Grants for Population Increases. The supplemental grants were extended through June 30, 2011 resulting in a total of $211 million being available for FY 2011.
4/ The American Recovery and Reinvestment Act of 2009 appropriated $5 billion for FY 2009 and FY 2010 for the TANF Emergency Contingency Fund.

ACF MANDATORY LEGISLATIVE PROPOSALS

(outlays in millions)

	2011	2012	2012 - 2016	2012 - 2021
Child Care Entitlement	--	**381**	**3,242**	**6,992**
Child Support Enforcement and Family Support Programs	--	**244**	**1,236**	**2,430**
Children's Research and Technical Asst. - Child Welfare Study	--	**2**	**6**	**6**
Foster Care and Permanency /1	--	**220**	**1,354**	**2,834**
Temporary Assistance for Needy Families (TANF)	**22**	**342**	**406**	**406**
Total, ACF Proposals	**22**	**1,189**	**6,244**	**12,668**

1/ The Child Support Enforcement (CSE) proposal requires States to use the collections received on behalf of IV-E children in the best interest of the child. This results in an increase over the Child Welfare baseline of $370 million over ten years and reduces the increase to the CSE baseline by the same amount.

ADMINISTRATION ON AGING

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Health and Independence				
Home & Community-Based Supportive Services	368	368	416	+48
Nutrition Services	819	819	819	--
Preventive Health Services	21	21	21	--
Native American Nutrition & Supportive Services	28	28	28	--
Aging and Disability Resource Centers	24	24	13	-10
ACA Mandatory Funding (non-add)	*10*	*10*	*10*	--
Aging Network Support Activities	8	8	8	--
Subtotal, Health and Independence	1,268	1,268	1,306	+38
Caregiver Services				
Family Caregiver Support Services	154	154	192	+38
Native American Caregiver Support Services	6	6	8	+2
Alzheimer's Disease Supportive Services Program	11	11	11	--
Lifespan Respite Care	3	3	10	+8
Subtotal, Caregiver Services	175	175	222	+48
Protection of Vulnerable Older Adults				
Adult Protective Services	--	--	17	+17
Native American Elder Rights (non-add)	--	--	*2*	*+2*
Long-Term Care Ombudsman Program	17	17	22	+5
Prevention of Elder Abuse & Neglect	5	5	5	--
Senior Medicare Patrol Program	13	13	13	--
Elder Rights Support Activities	4	4	4	--
Subtotal, Protection of Vulnerable Older Adults	39	39	60	+21
State Health Insurance and Assistance Programs	47	47	47	--
Community Living Assistance Services and Supports	--	--	120	+120
Senior Community Service Employment Program /1	825	825	450	-375
Chronic Disease Self-Management Programs	--	--	10	+10
Medicare Enrollment Assistance /2	30	--	--	-30
Program Innovations	28	28	12	-16
Earmarks (non-add)	*6*	*6*	--	-6
Program Administration	20	20	25	+5
Total, Program Level	**2,432**	**2,402**	**2,251**	**-181**
Less Funds from Other Sources				
Aging and Disability Resource Centers	-10	-10	-10	--
Health Care Fraud and Abuse Control /2	-4	-3	-3	--
Medicare Enrollment Assistance /2	-30	--	--	+30
Subtotal, Funds from Other Sources	-44	-13	-13	+30
Total, Budget Authority	**2,388**	**2,389**	**2,238**	**-151**
FTE /3	100	111	176	+76

/1 The Budget proposes to transfer this program from the Department of Labor to HHS in FY 2012. The FY 2010 and FY 2011 funding for this program is displayed comparably.

/2 Funding from Medicare Trust Funds.

/3 FY 2010 and FY 2011 FTE figures do not include staff working on the Community Living Assistance Services and Supports Program, the Senior Community Service Employment Program, the State Health Insurance and Assistance Program, or Adult Protective Services. The FY 2012 FTE figure includes 55 FTE for these programs.

ADMINISTRATION ON AGING

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

The FY 2012 Budget requests $2.3 billion for the Administration on Aging (AoA), a reduction of $181 million below the comparable level for FY 2010. The Budget prioritizes the protection of elderly Americans from abuse, and reiterates the Administration's commitment to older adults, their families, and informal caregivers. The request leverages efficiencies by adding complementary programs currently administered by other Federal organizations.

PROTECTING ELDERS FROM ABUSE, NEGLECT, AND EXPLOITATION

More than one million older Americans suffer from elder abuse annually. The Budget includes first time funding for Adult Protective Services demonstration grants, $15 million of which is authorized under the Elder Justice Act of 2010, and $2 million of which is to fight elder abuse in Tribal settings. This funding will support the design and implementation of better approaches to protect our Nation's older adults from abuse, enabling them to live in their homes with dignity and without fear.

In addition, the Budget includes $22 million, an increase of $5 million, to support long-term care ombudsmen in their role as advocates for residents of nursing homes and other adult residential care facilities. As part of this program, more than 10,000 trained individuals regularly visit and monitor long-term care facilities, resolve problems of individual residents, and provide a voice for those unable to speak for themselves.

SUPPORTING FAMILY CAREGIVERS

The Budget includes $96 million for a Caregiver Initiative to support family and informal caregivers by providing information, counseling, training, respite, and other services. These include transportation, personal care and case management to help caregivers care for their loved ones at home. Data from AoA's national surveys of caregivers indicate that almost half of caregivers who have nursing home-eligible loved ones do not feel their family members would have been able to stay in their home without these services. As part of this initiative, the Budget includes $10 million, an increase of $8 million, for respite services to provide a much needed break to those in a caregiving role for family members across the lifespan.

Combined, these caregiver programs enable older adults to remain independent and at home longer and less expensively. The Budget will support 850,000 caregivers, including more than 163,000 caregivers that will participate in counseling, peer support groups, and training to help them manage the stresses of caregiving.

MAINTAINING HEALTH AND INDEPENDENCE

The Budget includes a total of $416 million to fund in-home and community-based services to help seniors maintain their independence and dignity. These services include transportation assistance; case management; referrals; help with personal care including eating, dressing, and bathing; and adult day care and physical fitness programs. The Budget will support more than 18 million rides for critical daily

Helping Prevent, Detect, and Respond to Elder Abuse

Elder abuse can take many forms. Financial manipulation, emotional abuse, and neglect are all forms of abuse. The Budget includes an additional $21 million to improve adult protective services programs that provide a range of services designed to ensure the safety and well-being of elders and adults with disabilities who are in danger of being mistreated or neglected. This Elder Rights Initiative will:

- Help States test methods to detect and prevent elder abuse;
- Expand State support for long-term care ombudsmen, who advocate on behalf of residents of long-term care facilities to ensure the protection of their rights and their welfare; and
- Support Native American and Alaska Native Tribes in the development of informational, legal, and supportive services to fight elder abuse.

Impact of the Recovery Act

AoA awarded $100 million in Recovery Act funding to provide meals to older Americans in need. This included $65 million for congregate nutrition services provided at senior centers and other community sites, $32 million for home-delivered nutrition services, and $3 million for Native American nutrition programs.

The number of seniors served by these programs has exceeded original estimates. As of September 30, 2010, more than 21 million meals were served to over 1.1 million seniors.

In New York, for example, this funding enabled a local senior nutrition program to provide an additional 13,489 meals to 334 elderly individuals. Included in this list were 96 new meal participants who, without this funding, would have been placed on a waiting list. Of the 334 seniors served, 59 were between the ages of 90 and 101. This funding has helped these individuals remain independent in their homes.

activities such as visiting the doctor, pharmacy, or grocery stores; 25 million hours of assistance to seniors unable to perform daily activities; and over 6 million hours of adult day care, enabling working caregivers to remain on the job.

The Budget also requests a total of $819 million, the same level as FY 2010, for nutrition services to ensure that millions of older adults have access to the nutritious food needed to stay healthy and decrease their risk of disability. The Budget will support 193 million home delivered and congregate meals to over 2 million elder individuals in a variety of community settings.

PROMOTING EFFICIENCY IN COMMUNITY-BASED SERVICE DELIVERY

The Budget includes $47 million, the same level as FY 2010, to fund more than 12,000 counselors in more than 1,300 community-based organizations through the State Health Insurance Assistance Program. These individuals and groups will provide one-on-one outreach and counseling to current and potential Medicare beneficiaries on issues like Medicare prescription drug plans, Medicare Advantage options, long-term care insurance, and claims and billing problem resolution. Until this year, this funding has been administered by the Centers for Medicare & Medicaid Services. Moving this program to AoA will enable grantees, about two-thirds of which are already working with AoA on other projects, to streamline their interaction with the government, which will produce administrative efficiencies.

The Budget includes $450 million for the Senior Community Service Employment Program, and proposes to move it from the Department of Labor to AoA. This program provides unemployed older adults with work-based training in non-profits and government agencies. As part of this move, a new focus will be placed on helping seniors develop skills to deliver services to other seniors who need assistance to remain in the community instead of institutional settings. For example, program participants could be trained to serve as a home care aide, or to assess and modify homes to make them more accessible to aging residents. While the proposed funding level represents a reduction of $375 million from FY 2010, the planned realignment will yield benefits for those developing new professional skills as well as those they serve.

SUPPORTING EVIDENCE-BASED INITIATIVES AND ACCESS TO SERVICES

AoA funding ensures the continuation of a vibrant aging services network. AoA identifies, evaluates, and replicates the best models and practices nationwide through this network, funding lower-cost, non-medical services and supports. The Budget includes $13 million for Aging and Disability Resource Centers and $10 million for Evidence-Based Disease Prevention programs, two examples of state-of-the-art approaches that AoA is continuing to evaluate and replicate in support of its core programs. In addition to these programs, the Budget requests $20 million for ongoing activities of national significance and for other innovative approaches to further strengthen the core programs.

PROVIDING AMERICAN WORKERS ACCESS TO A LONG-TERM CARE FINANCING PLAN

The Budget includes funding for a new, voluntary, self-directed

long-term care insurance resource for American workers known as the Community Living Assistance Services and Supports (CLASS) Program. Participants in the program, which was established under the Affordable Care Act, will be able to purchase community living assistance services and supports that will allow them to remain independent under a variety of future health circumstances. Establishing this program creates a significant new opportunity for Americans to prepare themselves financially for long-term care needs in a manner that will allow them to remain in their homes for as long as possible. When fully implemented, the benefits will be entirely paid for by individual premium contributions.

PROGRAM ADMINISTRATION

The Budget includes $145 million for program management and support activities. Of this total, $120 million is to manage the new program of community living assistance services and supports referenced above, with the remaining $25 million directed towards costs of other aging services programs, including additional staff to undertake the Elder Justice Initiative and to more effectively reach out to States, Territories, and Tribes. This funding will allow AoA to more effectively and efficiently address the needs of the growing aging population.

OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
General Departmental Management Budget Authority.....	490	491	364	-126
Prevention and Public Health Fund…….....	12	19	135	+123
Evaluation Activities.....	65	65	127	+62
Health Care Fraud and Abuse Control.....	10	13	13	+3
Pregnancy Assistance Fund…….……..	25	25	25	--
Total GDM Program Level	602	613	664	+62
FTE	1,337	1,370	1,439	+102

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

The FY 2012 Program Level Budget request for General Departmental Management (GDM) is $664 million, a net increase of $62 million above the FY 2010 enacted level. This request supports some grant programs as well as those activities associated with the Secretary's roles in administering and overseeing the organization, programs and activities of the Department. These activities are carried out through 12 Staff Divisions and Offices in GDM.

Teen Pregnancy Prevention: The FY 2012 Budget request to support community-based efforts to reduce teen pregnancy totals $110 million, same as the FY 2010 enacted level. In addition, $4 million in PHS Evaluation Funds will be available in FY 2012 to effectively evaluate teen pregnancy prevention activities and another $4 million will be available for a Federal evaluation initiative. Teen pregnancy prevention efforts managed through the newly established Office of Adolescent Health (OAH), in the Office of the Assistant Secretary for Health, will coordinate and collaborate with Centers for Disease Control and Prevention (CDC) and the Administration on Children and Families (ACF) in implementing teenage pregnancy prevention programs. Teen pregnancy prevention funds will be used for: replicating programs that have proven effective through rigorous evaluation to reduce teenage pregnancy; research and demonstration grants to develop, replicate, refine and test additional models and innovative strategies; and training, technical assistance and outreach. Collaborative efforts in teen pregnancy prevention will support innovative youth pregnancy prevention strategies which are medically accurate and age appropriate.

Office of Minority Health: The FY 2012 Budget request for Office of Minority Health of $58 million is an increase of $2 million over the FY 2010 enacted level. This funding will enable the Office of Minority Health to enhance disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities in racial and ethnic minority populations across the country.

***Minority HIV/AIDS*:** In FY 2012 $54 million in PHS evaluation funding will be available to support innovative approaches to HIV/AIDS prevention and treatment in minority communities disproportionately impacted by this disease. These funds will allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

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

Commissioned Corps: The FY 2012 Budget request includes $7 million for the continued support of the Public Health Service's Commissioned Corps. At the direction of the Surgeon General activities will focus on force readiness officer field training infrastructure and management and operating cost. Due to investments over time in transformation and recruitment the Commissioned Corps is able to sustain its commitment to responding to emerging public health threats and improve response operations.

Office of Global Health Affairs: The FY 2012 Budget request is $9 million, a $2 million increase over FY 2010 enacted level. This increase will enable the Office of Global Health Affairs to support global health policy leadership and coordination.

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

Other General Departmental Management (GDM): The FY 2012 Budget request includes $377 million for the remainder of GDM. The request funds leadership, policy, legal, and administrative guidance to HHS components, and also includes funding to continue ongoing programmatic activities including disease prevention and health promotion and public awareness campaigns. In addition, GDM funds will be used for Departmental direction for strengthening program integrity by reducing fraud, waste, and abuse and by holding programs accountable.

OFFICE OF THE SECRETARY
OFFICE OF MEDICARE HEARINGS & APPEALS

(dollars in millions)

	2010	2011	2012	2012 +/-2010
Total, Program Level	71	71	81	+10
FTE	368	395	424	+56

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

The FY 2012 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $81 million, a net increase of $9.87 million over FY 2010. Funds are requested from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, to hear cases under Title XVIII of the Social Security Act and related provisions in Title XI of the Act.

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

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

OMHA began processing cases on July 1, 2005; since then, it has received more than 904,000 claims from across the United States for Medicare Parts A, B, C, and D appeals, as well as Medicare entitlement and eligibility appeals. Beginning in FY 2011, OMHA will also receive additional claims resulting from the permanent expansion to all 50 States of the Recovery Audit Contractor (RAC) program, administered by the Centers for Medicare & Medicaid Services. The demonstration phase of the RAC program which ran in FY 2008 and FY 2009 included only five States. Full implementation of the permanent program was planned for FY 2010 but was delayed. During FY 2010, OMHA received a total of 194,000 claims. OMHA projects that its FY 2012 caseload will increase to approximately 274,000 total claims (a 41 percent increase over FY 2010).

With the requested funding level of $81 million, OMHA will continue to process its ALJ appeals workload within the statutory timeframe while maintaining the quality and accuracy of its decisions. OMHA will continue to utilize technology and to offer appellants access to multiple hearing venues and services.

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

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Budget Authority	42	42	57	+15
PHS Evaluation Funds	19	19	21	+2
Total, Program Level	**61**	**61**	**78**	**+17**
FTE	83	149	189	+106

The FY 2012 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $78 million, $17 million above FY 2010. The FY 2012 Budget will enable HHS to continue implementing the Health Information Technology for Economic and Clinical Health (HITECH) Act, accelerating the adoption of health information technology (health IT), and helping physicians achieve meaningful use of electronic health records (EHRs). The FY 2012 President's Budget also includes resources for ONC to serve as the Federal health IT leader. These roles are vital to achieving the goals of the President's health IT initiative and improving health care for all Americans.

ONC and the Centers for Medicare & Medicaid Services (CMS) are working closely to register eligible professionals and hospitals to qualify for "meaningful use" incentive payments from Medicare and Medicaid, which are designed to encourage providers to adopt and meaningfully use EHRs. Incentive payments begin in calendar year 2011 and ONC and CMS will continue to execute these payments.

Beacon Communities

ONC awarded $250 million in Recovery Act funding to 17 Beacon Communities in which clinicians, hospitals, and consumers work together using health IT, to achieve meaningful improvements in the quality and efficiency of health care, and overall population health in the community.

Through the Keystone Beacon Community project in Pennsylvania, for example, four hospitals and as many as 280 primary care and specialty physicians are forming a partnership to improve patient outcomes and decrease their health care costs. Through the use of health IT, the Keystone Beacon Community will emphasize timely and effective care coordination for patients to better manage chronic disease, as well as optimize transitions of care.

In addition to funds requested for ONC, the FY 2012 Budget request for other HHS divisions that support health IT goals includes $27.5 million in the Agency for Healthcare Research and Quality (AHRQ) to advance the use of health IT to enhance patient safety and $1.3 million in the Office of Civil Rights (OCR) to strengthen and enforce EHR privacy rules.

ADOPTION

Reducing barriers to the adoption and meaningful use of EHRs is essential to improving the quality and efficiency of our health care system. The FY 2012 budget includes $6.5 million for ONC to work with Regional Extension Centers (RECs) in reaching Stage 2 of meaningful use, support Communities of Practice for RECs, and assist large hospitals, health care systems, and EHR vendors to achieve meaningful use.

STANDARDS AND INTEROPERABILITY

Both nationwide common standards and the

Regional Extension Centers

Though the Recovery Act, Regional Extension Centers (RECs) are assisting providers in becoming meaningful users of certified electronic health record (EHR) technology. By the end of FY 2010, almost 12 thousand priority primary care providers, in small practices, rural and underserved areas, had registered to receive services from the RECs. Since that time registration has continued to increase on a month-to-month basis. Between 5,300 and 9,300 providers are now registering each month, a significant increase.

There are 62 RECs contributing to this goal of helping providers become meaningful users of EHRs. For example, the North Carolina Area Health Education Center received $13.6 million to support the adoption, implementation, and meaningful use of EHRs among small, rural, and underserved primary care providers in North Carolina. The project is helping providers use health IT effectively to improve the quality of health care services throughout the state and lower costs. To date, AHEC has registered 1,454 primary care providers for services with the REC.

interoperability of EHRs are critical elements of the national health IT agenda and are important to achieving the President's health IT goals. The FY 2012 Budget request includes $23 million to support the development of health data standards necessary to enable the interoperability of EHRs, and to ensure that standards are available for both private sector and Federal use. This funding will support standards development, testing and implementation, as well as the expansion of the standards and interoperability framework to enable the repurposing of health data for public health purposes, clinical research, and quality improvement.

ONC will also continue standards development activities, which include actions recommended by the Health IT Policy Committee and the Health IT Standards Committee.

The FY 2012 Budget request includes $2 million for maintaining health information exchange network capabilities. In FY 2012 ONC will also continue supporting the Nationwide Health Information Network (NwHIN) and support expanding health information exchange capabilities. This investment includes operational support and on-boarding of new participants through conformance and interoperability testing. In 2011, ONC will establish an effective governance mechanism for the NwHIN, with the goal of it attaining a self-sustaining business model.

PRIVACY AND SECURITY

The FY 2012 Budget includes $5.9 million to support the continued development of important Federal privacy and security protections of electronic health information, and State consensus efforts to address protections for personal health information. Ensuring adequate Federal protections and facilitating multi-State collaboration is essential to building public confidence and trust in nationwide health information exchange. ONC will also work with other Federal agencies to protect and secure the transmission of health information over computer networks through a health IT cybersecurity program.

In FY 2012, ONC will continue working with partners, such as OCR, CMS, States, and other stakeholders to protect patients' health information.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Total, Program Level	41	41	47	+6
FTE	230	266	280	+50

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

The FY 2012 Budget request is $46.7 million for the Office for Civil Rights (OCR). The Budget supports OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services, pursuant to Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1964; Title II of the Americans with Disabilities Act of 1990; Titles VI and XVI of the Public Health Services Act (Hill-Burton Act); the Multi-Ethnic Placement (MEPA); the Age Discrimination Act of 1975; and Title IX of the Education Amendments of 1972 and Section 1557 of the Affordable Care Act of 2010.

In addition, the Budget supports OCR's significantly expanded compliance responsibilities under the Privacy and Security Rules issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA), and supports the creation of ten regional office privacy advisors as mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

OCR assesses compliance through:

- Complaint investigation, violation findings, resolution agreements, enforcement actions, and monitoring;
- Public education;
- Technical assistance; and
- Compliance/civil rights reviews

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

As the Department's civil rights and health privacy law enforcement agency, OCR's key priorities in FY 2011 and FY 2012 are: ensuring understanding of and compliance with the HIPAA Privacy and Security Rules; implementing statutory privacy protections for genetic information; promoting adequate privacy protections in the use of health information technology and patient health information; enforcing Federal civil rights laws to increase non-discriminatory access to health care and human services, including adoption, foster care, and Temporary Assistance for Needy Families (TANF); promoting best practices for effective communication in hospital settings with persons who are deaf or hard of hearing and persons of limited English proficiency; strategically disseminating an OCR-developed Federal civil rights curriculum for medical schools to help narrow disparities in health care quality, access and patient safety; supporting appropriate services in the most integrated setting for persons with disabilities; and promoting non-discrimination and privacy protections in emergency preparedness and response activities.

Through these varied efforts, OCR promotes integrity in the expenditure of Federal funds and

public trust and confidence in the health care system maintaining the privacy of protected health information while ensuring access to care.

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

Enforcing HIPAA: OCR investigates and resolves more than 9,000 complaints of alleged HIPAA violations annually. A noteworthy example of OCR enforcement action was a 2010 resolution agreement for $1 million with RiteAid for improper disposal of personal health information. RiteAid agreed to implement a robust corrective action plan that requires Privacy Rule-compliant policies and procedures for safeguarding patient information during disposal, employee training and employee sanctions for noncompliance.

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

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

In October 2009, the interim final rule implementing the breach notification provisions of HITECH went into effect. In FY 2010, OCR received 197 notifications involving breaches affecting 500 or more individuals. OCR is in the process of determining the underlying causes of the breaches and ensuring that appropriate corrective action is taken by the covered entities.

Enforcing Compliance with Civil Rights Laws: OCR investigates and resolves nearly 3,000 administrative discrimination complaints annually. For example, in 2010, OCR entered into a Voluntary Compliance Agreement with the Wisconsin Department of Children and Families (DCF). Under the agreement, DCF will ensure that when Wisconsin families seek income assistance and help finding employment, they will have an equal opportunity to participate in the TANF program, without regard to race, color, or national origin (including limited English proficiency).

In FY 2011 and FY 2012, OCR will strengthen efforts to improve statewide compliance with civil rights laws. For example, in FY 2010, OCR entered into a state-wide settlement agreement with the Florida Department of Children and Families (DCF). As required by Section 504 and Title II of the ADA, DCF will provide qualified sign language interpreters and other auxiliary aids and services to deaf and hard-of-hearing persons. After a complaint investigation, OCR issued a Violation Letter of Finding to DCF in response to DCF's noncompliance. DCF delivers a variety of health and human services programs, including adoption, child and adult protective services, and TANF, as well as mental health and substance abuse treatment to an estimated total state population of three million deaf or hard-of-hearing residents.

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

(dollars in millions)

	2010	2011	2012	2012 +/- 2011
Retirement Pay	344	386	418	+32
Survivors Benefits	24	28	31	+3
Medical Pay - Active Duty Retirees and Survivors	73	104	115	+11
Accrued Medical Benefits for over -65	36	38	39	+1
	477	**556**	**603**	**+47**

1/ The FY 2010 amount has been adjusted to reflect an anticipated increase in average force *Appendix, Budget of the United States Government, Fiscal Year 2011* includes $38 million, the amount adjusted to reflect the revised on-board projections for FY 2010. In addition, medical benefits for FY 2010 were revised from $73 million to $93 million. This reflects an upward adjustment in the amount of $20 million to the September 30, 2010 end of year actual. This adjustment is needed to pay out any additional FY 2010 medical claims received in FY 2011.

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The FY 2012 Budget of $603 million is a net increase of $47 million over FY 2011. This Budget request provides for annuities retirement payments of retired Public Health Service (PHS) Commissioned Corps Officers and payments to survivors of deceased retired officers; and medical care to active duty PHS commissioned officers, retirees, and dependents of members and accrued medical benefit payments for PHS Commissioned Corps officers and beneficiaries over age 65.

The Budget also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, and dependents of deceased members. This account includes payments to the Department of Defense Medicare-eligible Retiree Healthcare Funds for the accrued costs of health care for beneficiaries over the age of 65.

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

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2010	2011	2012	2012 +/- 2010
Discretionary Appropriation	50	50	53	+3
PHS Evaluation	--	--	10	+10
HCFAC Collections	6	12	12	+6
Discretionary HCFAC	30	30	98	+68
Mandatory HCFAC	179	198	193	+14
Medicaid Integrity Program	25	--	--	-25
	--	--	--	--
Total Funding, All Sources	**290**	**290**	**366**	+76
FTE	1,582	1,712	1,976	+394

The Office of Inspector General's mission is to promote program economy, efficiency and effectiveness; and detect and prevent fraud, waste, and abuse. In fulfilling its mission, OIG ensures integrity protects the well-being of beneficiaries; provide industry guidance; and holds accountable those who do not meet program requirements or who violate Federal laws.

The FY 2012 Budget request for the Office of Inspector General (OIG) is $366 million in mandatory and discretionary budget authority. The request will enable OIG to protect program integrity and the well-being of program beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws.

Activities in FY 2012 will be determined by OIG's annual work planning process and the assessment of the top management and performance challenges facing HHS. The mission is accomplished by conducting audits, investigations, evaluations and inspections; recommending corrective action for vulnerabilities identified during these inquiries; referring suspected criminal action for prosecution, imposing administrative sanctions such as exclusions from Federal health programs and civil monetary penalties, and providing industry guidance to HHS program participants.

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

INTEGRITY OF HEALTH CARE REFORM IMPLEMENTATION

In FY 2012, OIG will continue to oversee the implementation of the Affordable Care Act (the Act). Under the Act, the Department has broad new responsibilities. Many of the activities have occurred and will continue to occur with short implementation timelines. The magnitude of Departmental expenditures, coupled with the Act's significant impact on providers, insures, employers, and beneficiaries will necessitate extensive oversight to ensure the Act programs operate efficiently and effectively and are protected from fraud, waste and abuse.

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

In FY 2012, OIG efforts to combat fraud waste, and abuse in the Medicare, Medicaid, and CHIP programs will be guided by five principles. These principles offer a framework for implementing programs, as well as designing and implementing integrity safeguards.

- Enrollment: Scrutinize individuals and entities that seek to participate as providers and suppliers prior to their enrollment in health care programs.
- Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

- Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.
- Oversight: Vigilantly monitor programs for fraud, waste, and abuse.
- Response: Respond swiftly to detected fraud, impose appropriate punishment to deter others, and promptly remedy program vulnerabilities.

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

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

Public Health Emergency Preparedness and Response: Recent natural disasters, such as hurricanes, wildfires, floods, and the outbreak of the H1N1 virus, highlight the importance of a comprehensive national public health infrastructure that is prepared to respond rapidly and capably to emergencies. The ability to effectively prepare for and respond to a public health emergency requires planning, coordination, and communication across a range of entities, including Federal agencies; States, localities, and tribal organizations; the private sector; individuals and families; and international partners. In FY 2012 OIG will continue its work in monitoring the public and private sectors' preparedness for and response to public health emergencies.

Grant and Contract Oversight: HHS receives and distributes more grant money than all other Federal agencies combined. In FY 2009, the Department awarded over $364 billion in grants. With the passage of the Recovery Act and ACA, the Department's grant portfolio has changed in size, scope, and complexity. In addition to awarding grants, the Department awarded over $20 billion in contracts in FY 2009. In FY 2012 OIG will continue providing oversight to ensure that HHS grants are appropriately monitored and managed throughout the grant life-cycle and will assess the mechanisms in place to ensure that proper procedures are used to award and fund grants, account for expenditures, and verify that grant dollars are only used for authorized purposes.

CROSS-CUTTING ISSUES THAT SPAN THE DEPARTMENT

Health Information Technology: HHS has a significant role in advancing the development and implementation of a national health information network. OIG will continue its oversight efforts of HHS health information technology (health IT) programs and objectives by monitoring HHS efforts to integrity of information systems through which health information is transmitted and stored to prevent fraud, waste, and abuse and the integrity of the Department's programs to promote health IT.

Government Ethics Programs and Conflicts of Interest of Department Employees: OIG has long been involved in oversight and enforcement related to the Department's ethics program. Prior OIG work identified vulnerabilities in HHS oversight of outside activities and potential conflicts of interest. In FY 2012 OIG will continue to focus on the effectiveness of the HHS ethics program.

Oversight of the Affordable Care Act

An area of focus will be identifying key vulnerabilities and prioritizing oversight resources. Based on OIG's experience in auditing, evaluating, and investigating fraud, waste, and abuse, areas that warrant vigilant HHS oversight in FY 2012 and in future years include:

- Programs implemented under expedited timeframes;
- Programs involving data collection to ensure accuracy and completeness of data;
- Grant and loan programs; and
- Payment accuracy.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

	2010	2011	2012	2012 +/- 2010
Office of the Secretary, PHSSEF				
Assistant Secretary for Preparedness and Response (ASPR):				
Preparedness and Emergency Operations	30	30	35	+5
National Disaster Medical System (NDMS)	52	53	53	+0
Hospital Preparedness	417	417	375	-42
ESAR-VHP	6	6	5	-1
Medical Countermeasure Dispensing	10	10	5	-5
BARDA*	320	320	665	+345
Policy and Planning	19	19	16	-3
Strategic Investor*	--	--	100	+100
Operations	37	37	39	+2
Co-Located Office Facility	--	--	10	+10
Subtotal, ASPR	891	892	1,302	+411
Other Office of the Secretary:				
Haiti Earthquake Supplemental	220	--	--	-220
Office of Security and Strategic Information	5	5	6	+2
CyberSecurity	27	27	40	+13
Parklawn Lease Replacement	70	70	--	-70
Medical Reserve Corps	13	13	11	-1
Subtotal, Other Office of the Secretary	334	114	58	-276
Pandemic Influenza:				
No-Year Funding	276	276	--	-276
Annual Funding	65	65	--	-65
Subtotal Pandemic Influenza	341	341	--	-341
Total Program Level, PHSSEF	**1,566**	**1,347**	**1,360**	**-206**
Less Funds From Other Sources:				
Use of BioShield Balances	609	305	765	+156
Total BA, PHSSEF	**957**	**1,042**	**595**	**-362**
Transfer of Funds				
Transfer of Project BioShield from DHS to HHS	2,424	--	--	-2,424

*FY 2012 Funds are from existing BioShield SRF funds by making those funds available for advanced development and the Strategic Investor in addition to procurement contracts.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

To enhance the Nation's preparedness against bioterrorism and other biological threats, the FY 2012 Budget includes $1.4 billion for the Public Health and Social Services Emergency Fund (PHSSEF). In addition, pandemic influenza preparedness activities will be supported using unobligated balances. The FY 2012 Budget request includes approximately $5 billion for bioterrorism, pandemic influenza, and emergency preparedness activities across the Department.

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2012 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $1.4 billion, an increase of $355 million above FY 2010. The PHSSEF Budget request will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to, and recover from the adverse health effects of public health emergencies and disasters.

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

The Budget requests $1.3 billion for ASPR, an increase of $411 million. In December 2009, Secretary Sebelius announced a review of the public health countermeasures enterprise with the goal of improving our ability to prepare for, respond to, and recover from public health threats. That review was completed in August 2010, and a budget amendment was sent to Congress to request the authorities necessary to implement the recommendations. The FY 2012 request builds off of these recommendations.

The Budget includes $665 million, which is to be made available from current BioShield Special Reserve Fund balances, for the Biomedical Advanced Research and Development Authority (BARDA). BARDA will continue support for the development of existing and new promising next-generation medical countermeasures to mitigate the medical consequences of potential chemical, biological, radiological, and nuclear threat events. This funding level is an increase of $345 million over FY 2010. Funding in FY 2012 will be targeted to continue the implementation of the recommendations of the Medical Countermeasure Review, including support for the multi-use facilities, which provide manufacturing capacity for needed MCMs, while also providing expertise to small businesses that are being supported by BARDA. Funding will also support BARDA's management of

Medical Countermeasure Review

The Medical Countermeasure Review was released in August 2010, and had five major recommendations:

- Improve Regulatory Science at FDA by making major investments in needed science capacity.
- Establish Flexible Manufacturing and Core Service partnerships that will assist companies in many aspects of developing and licensing a product, while providing MCM manufacturing capacity.
- Expand the product translation pipeline at the National Institutes of Health's National Institute of Allergy and Infectious Disease.
- Address the advanced development needs for influenza vaccine to solve problems with sterility and potency testing that slow down the ability to quickly produce a new flu vaccine.
- Create a Strategic Investment Firm to find ways to fund an alternative capital market and to provide expert advice to companies that may not have the resources to get it otherwise.

A budget amendment was submitted to Congress shortly after the release of the Review to support these recommendations, and HHS has already begun implementing most of these recommendations. The FY 2012 request will continue to support these critical activities.

Project BioShield and implementation of the Department's Pandemic Influenza Plan.

The FY 2012 request provides $100 million from BioShield balances to establish a strategic investment organization. This organization will be an independent firm that will provide capital and business support to new and small companies conducting research on new medical countermeasures.

The ASPR budget request includes $34 million for Preparedness and Emergency Operations, an increase of $5 million over FY 2010. The increase in funds will be used to prepare for and respond to National Special Security Events and other planned and unplanned events with the potential for public health impacts, for a total of $15 million.

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

In the FY 2012 Budget, $5 million is included to continue the HHS medical countermeasure dispensing demonstration project with the United States Postal Service (USPS), of which up to $4 million may be transferred to the USPS. The USPS is a unique Federal entity because it reaches the homes of every American, and can be a significant asset in the distribution of medical countermeasures to the public in the event of a public health emergency. ASPR and the USPS will be conducting exercises to help improve implementation in the future.

In FY 2012, $375 million is requested for Hospital Preparedness, which from FY 2002 to FY 2012 will have provided over $4.3 billion for cooperative agreements to States, cities, and territories to strengthen the capability of hospitals and healthcare systems to plan for, respond to and recover from all-hazards events. In addition to these funds, CDC is separately providing $643 million to State and local public health departments to support local public health preparedness activities. Both of the grants are funded 10 percent below FY 2010. Great progress in preparing for public health emergencies has been made with the Federal investment at the State and local level. Due to enhanced alignment of preparedness grants within HHS, States will be able to make more efficient use of these resources, which is imperative in a constrained budget environment.

The Budget also requests $65 million to support ASPR strategic oversight and operational coordination for preparedness and response activities, $8.5 million above FY 2010. This total includes a $10 million increase to co-locate the majority of ASPR staff in a single facility, instead of the current five sites. These activities are key to improving ASPR's ability to prepare for and responding to public health emergencies, as well as implementing the National Health Security Strategy, and the Medical Countermeasure Review. In FY 2012 ASPR will not be supporting the International Early Warning Surveillance program, since it is those activities can be supported elsewhere in the Department, which is a $3.3 million reduction from FY 2010.

Cybersecurity: The Budget request provides $40 million for cybersecurity, an increase of $3 million, to protect the Department's information technology infrastructure from cyber attacks by providing continuous security monitoring for all HHS systems, assets, and services. This funding will support a Department-wide collaboration to identify and address security vulnerabilities, specifically advancing the trusted internet connection initiative. Additionally, this will enhance Department-wide

Deepwater Horizon Response

ASPR coordinated the efforts across HHS for the government-wide response to the Deepwater Horizon oil disaster, including policy coordination with HHS operating and staff divisions and other federal departments to resolve public health and medical policy issues surrounding the oil spill. HHS activated the National Disaster Medical System (NDMS) to make additional medical personnel available to Gulf States affected by the oil spill. The five-person medical team from the NDMS and U.S. Public Health Service staffing the mobile medical unit in Venice, La., had seen nearly 630 patients for respiratory conditions, skin conditions, routine clinic visits, gastrointestinal conditions, and for eye related injuries. In late August, ASPR worked with BP and the local medical community to transition this care from NDMS teams to local provider teams contracted by BP.

computer systems intrusion detection capabilities, security information event management systems, and network forensics capabilities.

Medical Reserve Corps: Comprised of medical and public health volunteers, the Medical Reserve Corps (MRC) contributes its expertise to local public health initiatives on an ongoing basis. The Budget request includes $11 million for MRC in FY 2012, a decrease of $1.4 million. MRC will reduce funding for support contracts while maintaining support and service for MRC units at the local level.

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

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

PANDEMIC INFLUENZA

In FY 2012, vital pandemic influenza preparedness activities will be continued using existing balances primarily from previous pandemic influenza supplemental appropriations. Specifically, funding will be used to advance the Nation's pandemic preparedness through continued investments in developing next generation recombinant and molecular vaccine technologies; expanding domestic vaccine manufacturing capacity; developing antigen-sparing adjuvant technology; creating new and better influenza antiviral drugs; and supporting technologies that help us identify influenza.

On June 24, 2009, Congress appropriated $7.65 billion to HHS to respond to the 2009 H1N1 influenza pandemic and to support preparedness activities for future pandemics, including $1.85 billion in direct appropriations and $5.8 billion in appropriations contingent upon Congressional notification. During the response to the H1N1 pandemic, these funds supported vaccine production, distribution, and administration; antiviral drugs; domestic and international surveillance; communications and community mitigation; and laboratory support for virus detection. Just over $2 billion was obligated to purchase vaccine and adjuvant products and ancillary supplies for administration of the vaccine. In addition, $1.5 billion was provided to support State, local, and hospital preparedness activities, and for vaccination campaign planning and implementation.

While the H1N1 pandemic response has been the focus of HHS's most recent pandemic investments, the threat of a pandemic caused by H5N1 or other strains has not diminished. Lessons learned from the H1N1 pandemic will strengthen our ability to

Vaccine Manufacturing Improvement Initiative

In August 2010, HHS began implementing recommendations from the President's Council of Advisors on Science and Technology with a new influenza vaccine manufacturing improvement initiative to shorten the time frame for production of pandemic influenza vaccines. This effort involves BARDA, NIH, CDC, and FDA, along with vaccine manufacturers, and consists of the following three projects:

- *Vaccine seed optimization*: In September 2010, BARDA awarded a contract totaling $23.1 million to Novartis for the development of more productive virus seeds for influenza vaccine manufacturing.
- *Sterility assay development*: BARDA awarded a contract to Rapid Micro Biosystems in September 2010 totaling $6.7 million to develop more rapid sterility testing for vaccines and biologics using digital technologies.
- *Potency assay development*: CDC, FDA, and BARDA are developing a modernized potency test for inactivated influenza vaccines, which helps determine dosage levels.

respond to future health threats. For instance, while scientists did a remarkable job identifying the virus and producing an FDA licensed vaccine in less than six months, challenges in manufacturing the vaccine underscored the need to continue to invest in next-generation technology and build vaccine production capacity in the United States. Just as prior pandemic preparedness investments supported a robust response to the H1N1 pandemic, continued investment in critical activities will better prepare us for responding to future pandemics.

Several new and continued efforts related to influenza vaccine development and manufacturing, as well as antiviral development, are currently underway. In September 2010, HHS renewed a three-year contract totaling $57 million to continue a secure egg supply and other essential raw materials for vaccine production. In addition, a new solicitation to support development of additional vaccine candidates using recombinant or molecular technologies was issued in September 2009, with contract awards expected in early 2011. For additional manufacturing capacity, HHS posted a draft solicitation in September 2010 to establish Centers of Innovation for Advanced Development and Manufacturing in the United States. These Centers are expected to provide advanced development and manufacturing capabilities for medical countermeasures to address national security needs and to manufacture pandemic influenza vaccine in an emergency. HHS also began a manufacturing improvement initiative in August 2010 to reduce the time required to produce influenza vaccine.

To protect against potential influenza virus resistance to existing antivirals, HHS also supports development of new antiviral drugs. HHS continues to support Phase 3 clinical studies of a new neuraminidase-inhibitor candidate, peramivir, for parenteral administration during life-threatening cases of severe seasonal or pandemic influenza. This new drug was made available to treat severely ill individuals under an Emergency Use Authorization during the H1N1 pandemic. In August 2010, HHS issued a solicitation for the advanced development of antiviral drugs and biologicals against the influenza virus to target novel mechanisms of action or to enhance effects of present classes of influenza antivirals.

In addition to using existing funds in the PHSSEF to support pandemic influenza activities, a total of $242 million is requested in the FY 2012 budgets of the CDC, FDA, and NIH to finance ongoing pandemic preparedness activities including:

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

ABBREVIATIONS AND ACRONYMS

A

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

B

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

C

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

D

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

E

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

F

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

G

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

H

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

ABBREVIATIONS AND ACRONYMS

I

IHS	Indian Health Service
IME	Indirect Medical Education
IRS	Internal Revenue Service
IT	Information Technology

L

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

M

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

N

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

O

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

P

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

Q

QIO	Quality Improvement Organization

R

ROI	Return on Investment
RPG	Research Project Grant

S

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

T

TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TMA	Transitional Medical Assistance

U

UAC	Unaccompanied Alien Children

V

VFC	Vaccines for Children
VTC	Video Teleconference

ABBREVIATIONS AND ACRONYMS