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MEETING THE HEALTH AND HUMAN SERVICES CHALLENGES OF THE 21st CENTURY

HIGHLIGHTS

The FY 2000 budget for the Department of Health and Human Services (HHS) builds on President Clinton's commitment to the health and well-being of our Nation. Our budget confronts the challenges of sustaining an aging population. It provides quality, affordable health care to working families, and gives our children a safe and healthy childhood. The FY 2000 budget aggressively attacks health threats and it mobilizes our scientific genius to make America a healthier—and safer—home. And, it continues our fight against health care fraud, waste, and abuse.

With our Nation enjoying unparalleled economic success, we now have the unprecedented opportunity to advance the health status and well-being of American families. Our budget plan:

- ***SUPPORTS RETIREMENT WITH DIGNITY***

by expanding support for informal care-givers, improving options for quality long-term health care for the elderly and disabled, implementing a nursing home quality initiative, and modernizing Medicare;

- ***PROMOTES QUALITY, AFFORDABLE HEALTH CARE FOR OUR WORKING FAMILIES***

by improving access to health insurance options for Americans—including early retirees and those with disabilities who want to work— providing access to health care for uninsured workers, and improving care provided to racial or ethnic minorities, people living with AIDS, victims of domestic violence, and the mentally ill;

- ***ADVOCATES A SAFE AND HEALTHY CHILDHOOD***

by making child care safe, available, and affordable, enhancing the Children's Health Insurance Program (CHIP) and Medicaid outreach, funding Head Start and an approximately $20 billion child care proposal, promoting immunizations, innovative treatments for asthma, and excellence in children's hospitals, curtailing threats to health such as youth smoking, and easing transitions from foster care to self-sufficient adulthood;

- ***MOBILIZES OUR SCIENTIFIC GENIUS***

by creating superior public health surveillance, reinforcing public health regulation and inspection, modernizing the Food and Drug Administration, enhancing food safety, expanding health research, and replacing antiquated laboratories; and,

- ***IMPROVES THE FISCAL SOUNDNESS AND MANAGEMENT OF HHS PROGRAMS***

by increasing accountability and management flexibility, and emphasizing performance measurement for all HHS programs.

TOTALS

The FY 2000 President's Budget for HHS totals $400.3 billion in outlays, an increase of $24.8 billion, or 6.6 percent, over the comparable FY 1999 amount. The discretionary portion of the HHS budget totals $42.1 billion in budget authority, an increase of 4.4 percent over the FY 1999 level.

SUPPORTING RETIREMENT WITH DIGNITY

Two thirds of the five million Americans with significant limitations due to illness or disability who require long-term care are

older Americans. Half of all caregivers themselves are older than 65 years, and are also highly vulnerable to a decline in their own health status. Moreover, the number of Americans older than 65 years will double over the next 3 decades, from 34.3 million to 69.4 million. This rapid aging of the population intensifies the urgency for developing quality long-term care options.

Our long-term care initiative assists caregivers who enhance the lives of our increasingly elderly population. Private insurance rarely covers long-term care which requires major out-of-pocket expenses. This initiative addresses the daily needs of our Nation's steadily growing elderly population by directly assisting caregivers, educating the elderly and people with disabilities about long-term care issues and options, and promoting new promising strategies for long-term care.

National Family Caregiver Support Program

HHS proposes $125 million in FY 2000 to serve approximately 250,000 families nationwide with this new program. Seven million informal caregivers help disabled older persons live in their communities. This initiative provides for basic support services for caregivers, such as counseling and training, respite care, home health services, and referral.

The initiative supports families who care for elderly relatives with chronic illnesses or disabilities by enabling States to create "one-stop shops" which provide quality respite care, information about community-based long-term care services, and counseling and support, including training for complex care needs.

Long-Term Care Information Campaign

Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care services. Furthermore, many are unaware which services may best meet their needs. Our budget proposes a $10 million nationwide campaign to provide all 39.8 million Medicare beneficiaries with relevant information regarding Medicare covered services, how to identify quality private long-term care, and how to access information about home and community-based care services.

Expansion of Home and Community-Based Options

This initiative gives States the option of expanding Medicaid eligibility for people with incomes up to 300 percent of the Supplemental Security Income level who meet nursing home eligibility requirements but want to live in their communities. This initiative costs $5 million in FY 2000, for a total of $110 million over five years.

Nursing Home Quality Initiative

The HHS FY 2000 budget includes $60 million to implement the President's Nursing Home Initiative announced in July, 1998. In FY 1999, HHS began phasing-in key provisions of the initiative. This budget request allows the Health Care Financing Administration (HCFA) and other components of the Department to fully implement all provisions of the President's initiative.

Funding will be provided for State surveys of nursing homes, Federal surveyor oversight and developing a national criminal abuse registry to screen potential nursing home employees. These funds will also ensure adequate legal resources for the Office of the General Counsel and the Departmental Appeals Board to provide judicial hearings and handle administrative and court litigation in a timely manner.

Medicare Buy-In for Early Retirees

The FY 2000 budget enables Americans aged 62-65 to buy into Medicare by paying a full premium and extends the option of coverage until age 65 for those workers whose companies terminated retiree health coverage. This initiative costs a net of $1.3 billion over five years, although these costs are completely offset by proposed Medicare savings in the FY 2000 budget.

PROMOTING QUALITY, AFFORDABLE HEALTH CARE FOR AMERICA'S WORKING FAMILIES

The President's goal is to expand access to health care for more Americans, including displaced workers, the disabled, and pregnant women and children. This budget provides critically needed mental health services, supports health care for Native Americans, and enhances services for victims of domestic violence.

Furthermore, our budget advances opportunities for people with disabilities to return to work with this unprecedented initiative. Many Americans with disabilities want to work, but that work can end their access to Medicare and Medicaid services. This budget includes several proposals that create options to provide continual health care to this population.

INCREASING HEALTH CARE ACCESS FOR THE UNINSURED

Our goal is to provide basic care at the right time and the right place for those who need it. Nearly 43 million Americans lack medical coverage. This $1 billion investment spread over 5 years will improve medical care for many of the Nation's uninsured adults by encouraging collaboration between primary care providers and hospitals to ensure that patients receive appropriate treatment. Ultimately, this initiative will provide approximately 100 grants to communities to assist them in organizing and delivering health care to the Nation's growing cadre of low-income workers and others who lack health insurance. This initiative also will help communities acquire basic health services which are often in short supply for the uninsured. It encourages collaborations among local health departments, independent community health centers, public hospitals and hospitals affiliated with medical schools.

MEDICARE BUY-IN FOR DISPLACED WORKERS

The FY 2000 budget allows displaced workers over age 55 access to Medicare by offering those who involuntarily lose their jobs and health insurance a buy-in option. This initiative costs a net of $0.1 billion over five years, although these costs are offset by proposed Medicare savings in the FY 2000 budget.

EXPANDING OPPORTUNITIES FOR THE WORKING DISABLED

The President commits $20 million in FY 2000 and $857 million over five years in Medicare and Medicaid spending to support opportunities for people with disabilities to return to work without losing their health care. The initiative increases flexibility for States to set higher income and resource standards for Medicaid. It also provides incentive grants to States to expand Medicaid coverage for the working disabled and to build the capacity to provide home and community based services in order to provide an alternative to institutional care. In addition, the initiative would allow people with disabilities who leave Social Security Disability Insurance in the next 10 years to go to work but continue receiving free Medicare Part A coverage.

ENSURING ACCESS TO AIDS THERAPIES (RYAN WHITE)

The FY 2000 budget proposes an increase of $100 million in Ryan White treatment activities. In total, the FY 2000 budget proposes $1.5 billion in Federal

spending for activities authorized by the Ryan White/CARE Act. This represents a 7 percent increase over FY 1999 levels.

Providing Critical Mental Health Prevention and Treatment Services

The FY 2000 President's Budget provides a $70 million, or 24 percent, increase for the Mental Health Block Grant, which provides integral support to States for services to people with mental illness. In addition to increasing funding for this vulnerable population, our budget requests a $5 million, or 19 percent, increase for the Projects for Assistance in Transition from Homelessness (PATH) program. This program provides supportive services to homeless persons with a mental illness.

Reducing Racial Disparities in Health Status

Despite improvements in the Nation's overall health outcomes, minority groups still disproportionally bear the burden of disease and illness. The FY 2000 budget includes $145 million for health education, prevention, and treatment services for minority populations to mitigate the differences in health outcomes. Of this amount, $35 million supports community based research and demonstration projects to reduce health disparities among racial and ethnic minorities.

Providing Quality Care to Native Americans

HHS advances through this budget our efforts to provide quality care to Native Americans. As a whole, they suffer a greater disease burden than other American populations. The $170 million increase for the Indian Health Service (IHS) in FY 2000 provides additional clinical, preventive, and environmental health services, increases contract support payments for those tribes who provide their own health services, and provides for additional maintenance of IHS hospitals and clinics. This investment helps tribes meet their unique health services challenges and reaffirms the Administration's dedication to improving the health status of all Americans.

Curtailing Violence Against Women

The FY 2000 budget includes $27 million to curtail violence against women. Specifically, this budget invests in enhancing services and changing social norms. Over 4,200 women are murdered each year by someone they know and intimate partners commit over half of those murders. HHS proposes $23 million to provide counseling and shelter for domestic violence victims and enhance other services, and includes $4 million to improve public education about domestic violence.

Family Planning

This budget promotes family planning services to help American women prevent over 1 million unintended pregnancies each year. The President's Budget proposes an additional $25 million over the FY 1999 appropriation to serve 4,600 family planning clinics. This funding expands efforts to reduce unintended pregnancies and sexually transmitted diseases for groups with high unintended pregnancy rates. These efforts will promote responsibility for healthy reproductive lifestyles emphasizing hard to reach populations.

Advocating a Safe and Healthy Childhood

The FY 2000 budget for HHS promotes health and secures health services for our Nation's children. First, it includes a significant new commitment to child care. It also provides States with additional funds for children's health insurance outreach, advances innovations in asthma treatment, promotes excellence in children's hospitals,

and extends Medicaid eligibility to foster children.

MAKING CHILD CARE SAFE, RELIABLE, AND AFFORDABLE

Working families deserve affordable, quality child care. The Administration in this budget meets the challenge of making quality child care more accessible. This comprehensive initiative comprises approximately $20 billion over five years for HHS and the Departments of Treasury and Education. The initiative helps working families access and pay for child care, along with helping States and communities improve the safety and quality of care.

HHS proposes a $7.5 billion expansion over five years of the Child Care and Development Block Grant Act (CCDBG). These entitlement funds help working parents pay for care and—when combined with child care funds from welfare reform—enable States to provide child care assistance to over 2.4 million children by 2004. This represents an increase of over 1 million children above the 1997 level. Funds will be allocated to States by a matching formula and distributed to families to help them pay for child care. The FY 2000 budget request also contains $1.2 billion in discretionary child care funds for the CCDBG in FY 2001.

This budget proposes an Early Learning Fund to enhance early childhood development, and improve emergent literacy and school readiness. This initiative, totaling $3 billion over five years, provides matched challenge grants for States to distribute to communities for improving early learning and the quality and safety of child care.

CHIP AND MEDICAID OUTREACH

This outreach initiative informs children and their caregivers about CHIP and Medicaid, and gives States flexibility to provide innovative and effective approaches to increasing outreach activities.

IMPROVING ASTHMA TREATMENTS

The President's Budget proposes $50 million in demonstration grants to States for testing innovative asthma disease management techniques for children enrolled in Medicaid. This would help those children receive the most appropriate care to control their asthma. Participating States will measure the program's success in averting asthma related crises such as decreased emergency room visits and hospital stays to judge the success of the project in improving asthmatic children's quality of life.

PROMOTING EDUCATIONAL EXCELLENCE IN CHILDREN'S HOSPITALS

The budget proposes $40 million to support graduate medical education at free-standing children's hospitals. These hospitals play an essential role in the education of our physicians. They train 25 percent of all pediatricians and over half of many pediatric subspecialties.

ENHANCING HEAD START

The Head Start program ensures that low-income children start school prepared to learn. The FY 2000 budget request seeks $5.3 billion, an increase of $607 million over FY 1999, for Head Start to serve an additional 42,000 children. This level of funding provides Head Start to a total of 877,000 children and their families. The Administration thus reinforces its commitment to enrolling one million children by 2002. Plans include improving program quality, obtaining safer equipment, improving classroom facilities, and reducing staff turnover.

EASING THE TRANSITION FROM FOSTER CARE TO SELF-SUFFICIENT ADULTHOOD

Once they turn 18 years old, foster care youths become ineligible for maintenance payments. Each year, approximately 16,000

youths age out of foster care and 9,000 youths run away from the foster care system. These teens often lack the resources and the support they need to be self-sufficient. Consistent with the Department's efforts to move families from welfare to work, the FY 2000 President's Budget includes a package of legislative proposals aimed at assisting these former foster youths in their transition to living alone. This package proposes $50 million in FY 2000, and $275 million over the next five years.

The proposals include increasing funds for the Independent Living Program and the Runaway and Homeless Youth Transitional Living Program, supporting the Living Expenses of Youths in Transitional Living Programs, and providing Medicaid coverage for emancipated youths to age 21.

PROTECTING CHILDREN FROM TOBACCO

The FY 2000 budget combats smoking among young people. This budget builds on gains made in the 1998 State Attorneys General Tobacco Settlement and takes significant new steps to defend public health.

The HHS FY 2000 budget includes $61 million of additional funds for tobacco related activities. Of this amount, $27 million expands the Centers for Disease Control and Prevention's (CDC's) State-based tobacco prevention activities, and $34 million supports the FDA's outreach and enforcement activities.

The Administration again will support legislation which confirms the FDA's authority to regulate tobacco products, to halt advertising targeted at children, and to ensure that cigarettes are not sold to minors.

PROMOTING CHILDHOOD IMMUNIZATIONS

The budget proposes $1.1 billion for childhood immunizations, including the Vaccines for Children program and CDC's discretionary immunization program. The Nation surpassed its childhood vaccination goals for 1997—90 percent or more of America's toddlers received each basic childhood vaccine—as a result of the Administration's initiative. The incidence of vaccine-preventable diseases such as diphtheria, tetanus, measles and polio are at all-time lows. Expanded funding will permit continued high levels of childhood immunization. The FY 2000 budget also includes $83 million to eradicate polio, an increase of $17 million.

MOBILIZING OUR SCIENTIFIC GENIUS

In FY 2000, our budget renews the Administration's commitment to protect public health and promote scientific expertise. It focuses on:

IMPROVING DISEASE SURVEILLANCE

This budget calls for major improvements in public health disease surveillance. Surveillance activities in the infectious disease, food safety, and bioterrorism initiatives ($65 million) would be coordinated into a new National Electronic Disease Surveillance Network. Our Nation currently lacks a standardized, nationwide system for collecting and analyzing epidemiological information on communicable disease outbreaks. This network would establish a strong communication link between the local medical community and the public health sector to provide an integrated surveillance system.

EXPANDING FDA RESOURCES

HHS proposes to expand resources available to the FDA to comply with the Nation's drug, food, and medical device laws and improve the Nation's adverse event reporting system. The budget increases of $15.3 million for injury reporting, $52.2 million for product safety assurance, and $11 million for premarket application

review are necessary for FDA to meet its statutory requirements and public expectations. In addition, $15.3 million invests in preventing product related injuries.

ENSURING FOOD SAFETY

The FY 2000 budget enhances food safety. HHS funding would increase by $40 million over the 1999 level for the Administration's inter-agency food safety initiative. The FDA, CDC, and the Department of Agriculture will continue to coordinate efforts to ensure a safer national food supply.

SUPPORTING RESEARCH

This initiative continues our wise investments in biomedical science and health care quality research. Scientific advancements for tomorrow hinge on strategic investments made today.

The National Institutes for Health (NIH) spearheads worldwide efforts to advance health through medical science. We request $15.9 billion for NIH, an increase of $320 million. At this level, NIH would fund nearly 30,000 extramural research projects. Moreover, the FY 2000 budget proposes a program level increase of $35 million, or 20 percent, over FY 1999 for the Agency for Health Care Policy and Research (AHCPR). Their efforts include bridging the gap between science and health care, and research to improve cost-effectiveness and quality of care, especially among the diseases that affect Medicare and Medicaid costs the most.

Lastly, the Administration again proposes a three year demonstration to encourage higher participation for Medicare beneficiaries in NIH sponsored cancer clinical trials. Only three percent of cancer patients participate in clinical trials; many scientists believe that greater participation in these trials could improve results.

RESPONDING TO BIOTERRORISM

HHS is charged with the responsibility to prepare for and respond to the medical and public health consequences of a bioterrorist event. The President proposes for FY 2000 a total of $230 million for HHS to prepare for possible incidents of bioterrorism. As global threats to peace persist, the potential for domestic terrorism in America remains high. Bioterrorism is a pernicious threat because it can affect a large population, go undetected for days or weeks, and cause secondary illness or death if the agent is communicable. Developing surveillance and laboratory capacity to competently and professionally respond to a biological attack is urgent and of the utmost importance.

Key elements of this initiative include $72 million to improve deterrence, surveillance and communications, establish regional labs for identifying and diagnosing biological and chemical agents, and develop rapid toxin screening. It includes $52 million for the national pharmaceutical stockpile and provides $67.7 million for research and expedited regulatory review of improved drugs and vaccines. The budget also increases funding for local Metropolitan Medical Response Systems to $16.5 million to provide for 25 local emergency medical teams to respond to emergencies involving biological or chemical weapons.

IMPROVING MANAGEMENT

HHS includes more than 300 programs and represents over 20 percent of all Federal outlays, administering more grant dollars than all other Federal agencies combined. Effective performance of our agencies requires good management. Our initiatives include:

REFORMING HCFA MANAGEMENT

HCFA administers Medicare, Medicaid, and CHIP, and oversees State health insurance regulation of individual and small group markets. The agency faces the

important challenge of modernizing its administrative infrastructure—coordinating the work of dozens of contractors as well as State and territorial governments—while providing superior customer service to almost 70 million beneficiaries. HCFA is further reforming its operations in order to adapt to the changing health care market and increase its accountability as a prudent purchaser of health care.

COMBATING MEDICARE AND MEDICAID FRAUD, ABUSE, AND WASTE

As a result of the Administration's overall efforts as well as prior year judgments, settlements, and administrative impositions, the Federal government in 1998 collected $296 million in cases resulting from health care fraud and abuse, of which $271 million was returned to the Medicare Trust Fund, and $9 million was recovered as the Federal share of Medicaid. HCFA's main focus on preventing and detecting fraud and abuse is through the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control (HCFAC) account.

Under the Health Insurance Portability and Accountability Act of 1996, funding to combat health care fraud, waste, and abuse increases in FY 2000 for both MIP and HCFAC. MIP increases $70 million in FY 2000 while HCFAC increases $20 million. These additional funds will help the Department's efforts, with the assistance of the Department of Justice, to protect the integrity of the Medicare trust funds and the General Fund.

The FY 2000 budget also includes new proposals to combat Medicare fraud, waste, and abuse. These include eliminating excessive overpayments for the drug Epogen and mark-ups for other outpatient drugs, requiring private insurance companies to provide secondary payer information so that Medicare does not pay for services that should be paid by another insurer, reducing the misuse of partial hospitalization services, and expanding the use of "Centers of Excellence" as a permanent part of Medicare. These proposals are expected to save the Medicare trust funds $240 million in FY 2000 and $2.9 billion over five years.

This budget also works to reduce Medicaid fraud. First, States would be allowed to suspend or restrict eligibility for beneficiaries who have been convicted of certain crimes in State courts. The second proposal would prevent debarred individuals from continuing to bill Medicaid by affiliating themselves with other providers. This provision closes the loophole by prohibiting providers and provider organizations in good standing from hiring or establishing affiliations with debarred individuals.

ENSURING Y2K COMPLIANCE

Solving the Year 2000 computer conversion problems is one of the Department's highest priorities. HHS is striving to meet the challenge of ensuring millennium compliance in our information systems by the Administration's deadline of March 31, 1999. As of December 31, 1998, 85 percent of HHS mission critical systems were Year 2000 compliant. We are confident that we will have all of our systems compliant by next year. In fact, we believe that 100 percent of our internal HHS systems will be compliant by March 31, 1999. Although a few external Medicare contractor systems may take until June 1999 to reach compliance, HCFA has progressed remarkably in the last quarter. In FY 2000, HHS estimates $165 million will be spent on Year 2000 compliance activities; $150 million of this amount will be for HCFA.

MEASURING PERFORMANCE UNDER GPRA

The FY 2000 HHS Performance Plan contains goals and measures for the more than 300 programs HHS administers. For example, to reduce the disproportionate cost of diabetes to the American Indian and

Alaskan Native populations, IHS will increase by 3 percent the proportion of IHS clients with diagnosed diabetes who have improved their glycemic control. CDC and the HHS Office of Emergency Preparedness will implement a plan designed to ensure the ready availability of a national pharmaceutical stockpile to respond to terrorist use of potential biological or chemical agents, including the ability to protect 4 million civilians from an anthrax attack.

MEETING THE CHALLENGES

The HHS FY 2000 budget request meets the health and human services demands of a new century. It addresses the needs of our rapidly growing population of older Americans while it protects health and opportunity for our children. It expands access to America's health care system and it supports the research base that is so important for future health advances. This budget also maintains our commitment to a results-oriented, customer-focused Department of Health and Human Services.

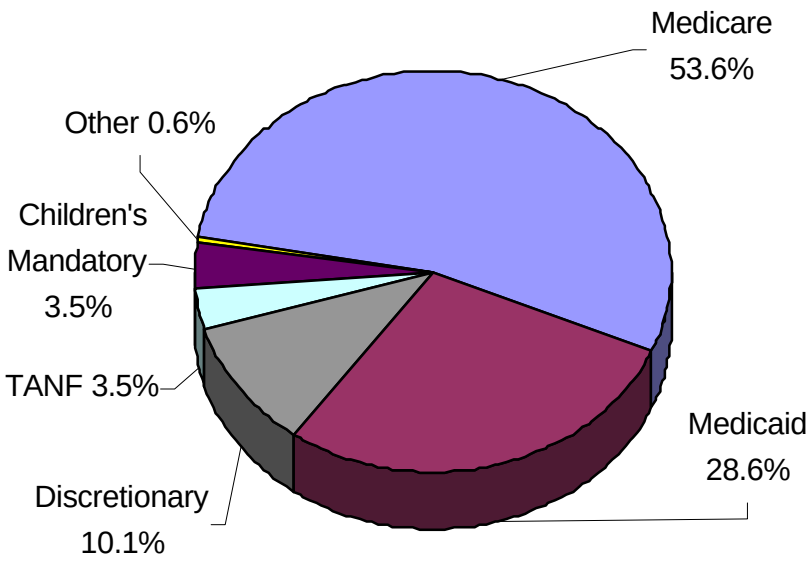
In short, the FY 2000 budget keeps faith with the Administration's vision of a 21st Century America where every family can get ahead and no family is left behind.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$359,529	$379,278	$403,647	+$24,369
Outlays	$350,558	$375,525	$400,320	+$24,795
FTE	57,671	60,125	61,847	+1,722

PRESIDENT'S BUDGET FOR HHS
FY 2000



HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Food and Drug Administration:				
Program Level	$1,062	$1,134	$1,350	+$216
BA	924	982	1,142	+160
Outlays	837	981	1,111	+130
Health Resources and Services Administration:				
BA	3,721	4,363	4,291	-72
Outlays	3,459	4,006	4,274	+268
Indian Health Service:				
BA	2,129	2,272	2,442	+170
Outlays	2,146	2,237	2,338	+101
Centers for Disease Control and Prevention:				
BA	2,387	2,646	2,823	+177
Outlays	2,409	2,441	2,654	+213
National Institutes of Health:				
BA	13,659	15,640	15,960	+320
Outlays	12,483	14,019	15,453	+1,434
Substance Abuse and Mental Health Services:				
BA	2,198	2,488	2,627	+139
Outlays	2,235	2,331	2,519	+188
Agency for Health Care Policy and Research:				
Program Level	147	171	206	+35
BA	90	100	27	-73
Outlays	77	101	90	-11
Health Care Financing Administration:				
BA	297,438	312,210	335,233	+23,023
Outlays	293,921	314,860	333,074	+18,214

HHS BUDGET BY OPERATING DIVISION, CONTINUED

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Administration for Children and Families:				
BA	36,581	37,699	38,060	+361
Outlays	32,589	33,890	37,949	+4,059
Administration on Aging:				
BA	871	882	1,048	+166
Outlays	834	864	971	+107
Departmental Management/Civil Rights /1:				
BA	211	593	614	+21
Outlays	200	442	534	+92
Office of Inspector General:				
BA	118	129	152	+23
Outlays	127	128	152	+24
Health Care Access for the Uninsured:				
BA	0	0	25	+25
Outlays	0	0	4	+4
Program Support Center Entitlements:				
BA	244	255	268	+13
Outlays	283	205	262	+57
Receipts:				
BA	-1,042	-980	-1,065	-85
Outlays	-1,042	-980	-1,065	-85
Total, HHS:				
BA	$359,529	$379,278	$403,647	+$24,369
Outlays	$350,558	$375,525	$400,320	+$24,795
Full-time Equivalents	57,671	60,125	61,847	+1,722

1/ FY 1999 and FY 2000 include funds appropriated as part of the Public Health and Social Services Emergency Fund. This does not include the President's January 1999 request to transfer an additional $93 million in FY 1999 Y2K emergency supplemental funds to HHS.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Mandatory Programs (Outlays):				
Medicare	$190,893	$202,942	$214,656	+$11,714
Medicaid	101,234	108,534	114,660	+6,126
Temporary Assistance for Needy Families	13,286	13,071	14,090	+1,019
Foster Care and Adoption Assistance	4,451	4,939	5,491	+552
Social Services Block Grant	2,441	2,050	2,445	+395
Children's Health Insurance	5	1,437	1,936	+499
Child Care	2,028	2,302	3,660	+1,358
Family Support Payments	2,171	2,738	2,941	+203
Other Mandatory	879	904	990	+86
Receipts/Financing Offsets	-1,042	-980	-1,065	-85
Subtotal, Mandatory (Outlays)	**$316,346**	**$337,937**	**$359,804**	**+$21,867**
Discretionary Programs (BA):				
Food and Drug Administration	$924	$982	$1,142	+$160
Health Resources and Services Administration	3,612	4,115	4,148	+33
Indian Health Service	2,099	2,242	2,412	+170
Centers for Disease Control and Prevention	2,384	2,643	2,820	+177
National Institutes of Health	13,632	15,613	15,933	+320
Substance Abuse and Mental Health Services	2,148	2,488	2,627	+139
Agency for Health Care Policy and Research	90	100	27	-73
Health Care Financing Administration	1,789	1,947	1,822	-125
Administration for Children and Families	8,354	8,672	9,433	+761
Administration on Aging	871	882	1,048	+166
Office of the Secretary /1	243	622	671	+49
Subtotal, Discretionary (BA)	**$36,146**	**$40,305**	**$42,083**	**+$1,778**
Subtotal, Discretionary (Outlays)	**$34,212**	**$37,588**	**$40,516**	**+$2,928**
Total, HHS Outlays	**$350,558**	**$375,525**	**$400,320**	**+$24,795**

1/ FY 1999 and FY 2000 include funds appropriated as part of the Public Health and Social Services Emergency Fund. This does not include the President's January 1999 request to transfer an additional $93 million in FY 1999 Y2K emergency supplemental funds to HHS.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$925	$982	$1,142	+$160
Program Level	$1,062	$1,134	$1,350	+$216
Outlays	$837	$981	$1,111	+$130
FTE	8,904	8,944	9,653	709

SUMMARY

The FY 2000 budget request for the Food and Drug Administration (FDA) is $1,350 million in program level, including $195 million in industry-specific user fees. This 18 percent increase over FY 1999 is targeted to the food safety initiative ($30.0 million), the youth tobacco prevention initiative ($34.0 million), the bioterrorism initiative ($13.4 million) and FDA's other core activities ($95.5 million).

FDA is the principal consumer protection agency of the Federal government. FDA's critical mission is to protect the public health through the prevention of injury or illness due to unsafe or ineffective products. FDA identifies health problems associated with FDA-regulated products and assess the origin and impact of these health problems. FDA makes every effort to prevent problems that would expose the public to hazards and monitors the marketplace to ensure compliance with the laws and regulations.

FOOD AND DRUG ADMINISTRATION MODERNIZATION ACT OF 1997

The Food and Drug Administration Modernization Act of 1997 (FDAMA) was signed into law by President Clinton in November of 1997. This critical legislation updates the regulation of food, medical products and cosmetics, and prepares the FDA for the 21st century. The new law builds on FDA modernization efforts already underway which have reduced drug and medical device approval times to record lows while maintaining consumer protections. This budget request expands the resources available to FDA to carry out its mission and comply with the drug, device and food laws. Significant workforce increases are necessary for FDA to accomplish these goals.

In November 1998, FDA issued a Plan for Statutory Compliance to the Congress and the Nation. The Plan outlined the innovative approaches the Agency will take to meet the complex public health challenges of the next century. A total of $95.5 million in budget increases are requested to address plan priorities including injury reporting, product safety assurance, and premarket review.

INJURY REPORTING

The requested increase of $15.3 million will be devoted to the prevention of medical and veterinary product-related injury. Current estimates of the incidence of death and injury associated with proper use of medical products is considerable, and is projected to grow.

A recent article describing the incidence of adverse drug reactions in hospitalized patients published in the *Journal of the American Medical Association* (JAMA) estimated that in 1994, 106,000 deaths and 1.3 million serious injuries occurred. It is estimated that nearly one million patient injuries and deaths each year can be attributed to user error with FDA regulated medical products.

FDA will use the requested increase to develop and maintain adequate monitoring programs to aid in the timely identification of new or emerging health hazards associated with FDA-regulated products. FDA intends to move as rapidly as possible to an integrated, fully electronic adverse event reporting system. FDA is uniquely positioned to receive and analyze adverse event information. As the regulatory agency responsible for ensuring the safety and efficacy of regulated products, FDA's mission clearly includes protecting the American public from the risk of marketed products.

PRODUCT SAFETY ASSURANCE

The $52.2 million requested increase for product safety assurance will be used to help FDA meet its statutory time frames for inspections. For drugs, biologics, animal drugs and medical devices, the goal is to inspect each manufacturer every two years. For warehouse facilities, FDA's goal is an inspection every four years.

This funding will enable the Agency to focus on technical assistance to enhance industry compliance and integrate public health regulation with the States through contracts, partnerships, training and information sharing. Instead of the traditional approach of hiring additional FDA inspectors, this increased funding will be used to buy additional inspections through contracts with the States and to establish a national database of inspection statistics that will be available to local, State and Federal health officials. This should improve the inspectional programs of all parties by eliminating duplication of effort and substantially increasing inspectional coverage.

Twenty-three million dollars are targeted for the construction of FDA field laboratories and support facilities. Funds will be used to begin the first phase of constructing the Los Angeles laboratory ($20 million) and to continue construction on the final phase of the Arkansas Regional Laboratory project ($3 million). These facilities are vital to FDA efforts to improve and modernize the scientific, regulatory inspectional capabilities of the Agency.

PREMARKET REVIEW

The requested $28 million increase, which includes $17 million in new user fees, for premarket application review will allow FDA to continue to reengineer and automate its review processes. It will help FDA provide more productive interactions with industry through up-to-date guidance review, industry education and reviewer training. Also, FDA will be better able to target laboratory support on emerging technologies and provide on-time, science-based interactive application reviews. FDA has come a long way, with the help of the Prescription Drug User Fee Act (PDUFA), in improving premarket review times for new drugs and biologics, but there is still more work to be done in other product areas.

FOOD SAFETY INITIATIVE

In the United States, up to 33 million illnesses and 9,000 deaths per year can be attributed to food-related hazards. Persons with lowered immunity due to HIV/AIDS, those on medications for cancer treatment and organ transplantation, and the elderly and very young are among the population groups with increased susceptibility to foodborne hazards. FDA is requesting $79 million, an increase of $30 million, to fund advances in the President's Food Safety

Initiative. Estimates of the annual cost of medical treatment and lost productivity from the seven major foodborne pathogens vary widely from $6.6 billion to $37.1 billion. The food safety funding will continue the improvements that guarantee a safe food supply.

FDA is working with the CDC and the Department of Agriculture to identify the greatest public health risks and design strategies to reduce these risks. The size and complexity of the U.S. food system requires significant involvement of government at all levels. The FDA has a varied industry to regulate and has relied on selective monitoring. The requested increase in food safety funding will allow FDA to increase inspectional resources and better direct those resources to the areas of greatest need that will result in the greatest benefit to the American public. The FDA workforce needs to significantly expand to accomplish the necessary activities.

FDA has explored ways to strengthen systems of surveillance, inspection, research, risk assessment, and education. At the center of this initiative, FDA has the following goals:

- Surveillance: Respond to increased outbreak reporting, and expand monitoring for antimicrobial resistance.
- Inspections: increase Frequency of Inspections for high-risk establishments, and more than double inspections of foreign food processors.
- Education: Focus efforts at the retail level where over 1/3 of outbreaks occur.
- Research and Risk Assessment: rapid methods to identify pathogens, and better data bases to better target food safety resources.

YOUTH TOBACCO PREVENTION

Three thousand young people become regular smokers each day and nearly one thousand of them will die prematurely. To reverse this trend, FDA will increase its resources aimed at youth tobacco prevention activities. The requested $68 million, an increase of $34 million, will continue FDA's efforts to enforce retailer carding of young people and promote understanding of this rule. At the end of FY 1998 FDA had contracts with 43 States and territories. FDA hopes to have contracts with all 50 States and all of the territories by FY 2000. It is estimated that between 500,000 and one million retailers may sell tobacco products. Thus, enforcement of the FDA final rule is a major job for the States and the Agency.

FDA also is responsible for outreach to retailers and product regulation. Tobacco control experts indicate that the combination of compliance checks and an active outreach program maximizes retailer compliance with the access restrictions. In the absence of comprehensive tobacco legislation, FDA must work especially hard to reduce the availability and appeal of tobacco products to children and teenagers. With a long-term goal of a 50 percent decline in young people's use of tobacco within seven years of implementation of the FDA program, FDA must continue and strengthen its current program.

BIOTERRORISM INITIATIVE

FDA requests $13.4 million as part of the Public Health and Social Services Emergency Fund. The DHHS anti-bioterrorism initiative constitutes a Department-wide strategy to plan for and implement activities that will address the range of issues and concerns that arise from countering a terrorist attack involving bioweapons.

DHHS has the sole responsibility of preparing for and responding to the medical and public health consequences of a

bioterrorist event. Within the Department, FDA has the ability and responsibility to regulate the drug and biological products which will be used to treat and prevent the toxicity of chemical, biological, radiological or nuclear substances. This is particularly difficult when definitive studies in humans cannot be ethically conducted to demonstrate the efficacy of these products. FDA has drafted a proposal that will allow animal data to be used to establish the efficacy of these drug and vaccine products.

FDA requests additional funds to ensure the expeditious development and licensure of new products such as vaccines for anthrax and botulinum. The proposed program would ensure the availability of experts in this area to expedite the licensing process of these vaccines. Expeditious development and licensing of these vaccines is a primary goal of the FDA and vital to protecting the health of the Nation.

SEAFOOD INSPECTION PROGRAM

The FY 2000 President's Budget provides $3 million in appropriated funds for training, other administrative and transitional costs to transfer the program to FDA. This transfer includes a significant number of seafood inspectors. The Seafood Inspection Program, currently under our Department of Commerce, provides voluntary inspections and certification services for fish and fishery products on a fee-for-service basis under the authority of the Agricultural Marketing Act of 1946. The program addresses issues of wholesomeness, economic integrity and quality in the seafood industry. Legislation will be proposed to make the program a performance-based organization (PBO) as part of the Vice President's initiative to reinvent government. PBOs have greater managerial flexibilities that allow for improved organizational performance.

USER FEES

The FY 2000 budget request for FDA includes $195 million in proposed law and current law user fees, including seafood inspection fees ($13 million) discussed previously. This includes $145 million for the Prescription Drug User Fee Act (PDUFA) and $15 million for the Mammography Quality Standards Act (MQSA). PDUFA authorizes the collection of user fees for reviewing drug applications and was reauthorized as part of the FDA Modernization Act of 1997.

The budget also includes $17 million in new proposed law user fees. These new fees would be used for the review of direct and indirect food additive petitions and to enhance review of medial device applications.

FDA OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Salaries and Expenses:				
Foods	$204	$232	$276	+$44
Drugs	449	459	507	+48
Medical Devices	157	160	186	+26
National Center for Toxicological Research	31	32	34	+2
Tobacco	34	34	68	+34
Other Activities	88	87	87	0
Other Rent & Rent Related Activities	26	26	26	0
Seafood Inspection--Transfer	0	0	16	+16
Subtotal, Salaries and Expenses	**$989**	**$1,029**	**$1,200**	**+$171**
GSA Rental Payments	$46	$88	$100	+$12
Buildings and Facilities	21	11	32	+20
Certification Fund	4	4	4	0
Export Certification	2	1	1	0
Bioterrorism (Funds from other Sources)	0	0	13	+13
Total, Program Level	**$1,062**	**$1,134**	**$1,350**	**+$216**
Less User Fees:				
Current Law:				
PDUFA	$117	$132	$145	+$13
MQSA	14	15	15	0
Certification Fund	4	4	4	0
Export Certification	2	1	1	0
Seafood Inspection--Transfer	0	0	13	+13
Proposed Law:				
Foods	0	0	10	+10
Medical Devices	0	0	7	+7
Subtotal, User Fees	**$137**	**$152**	**$195**	**+$43**
Less Funds from Other Sources: Bioterrorism	0	0	13	+13
Total, Budget Authority	**$925**	**$982**	**$1,142**	**$160**
FTE	8,904	8,944	9,653	709

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$3,612	$4,115	$4,148	+$33
Program Level	$3,624	$4,130	$4,172	+$42
Outlays	$3,289	$3,786	$4,063	+$277
FTE	1,869	1,942	1,931	-11

SUMMARY

The FY 2000 budget request for the Health Resources and Services Administration (HRSA) is $4.2 billion, a net increase of $42 million over FY 1999. HRSA's mission is to improve access to essential health care for millions of Americans who are medically underserved because they are uninsured, live where health care is scarce, and/or have HIV/AIDS or other health problems. HRSA assists in expanding and enhancing health care for all pregnant women and children. HRSA also contributes toward increasing the diversity and distribution of health care professionals.

HRSA programs work towards eliminating the many barriers that limit access and provide high quality primary health care services to low income individuals and families, many of whom are racial and ethnic minorities with dramatic disparities in health status.

Best known among HRSA's efforts to provide access to needed health care are the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, Health Centers, the National Health Service Corps, the Maternal and Child Health Services Block Grant, and health professions training grants.

HIV/AIDS – RYAN WHITE

As a result of the widespread use of combination anti-retro viral therapy, the AIDS death rate in 1997 dropped to its lowest level in nearly a decade. AIDS Drug Assistance Programs (ADAP), funded by HRSA through formula grants to States under the Ryan White CARE Act, assure that low income and uninsured individuals living with HIV/AIDS benefit from these life-saving treatments. The FY 2000 request of $1.5 billion includes a total increase of $100 million (7 percent) for all Ryan White treatment activities. Of the total $1.5 billion request, $783 million is for formula grants to States, more than half ($496 million) is earmarked for ADAP. ADAP is a Federal-State partnership that in FY 1998 served 106,000 individuals and enabled 42 States to increase the number of drugs provided, consistent with the Department's *Guidelines for the Use of Anti-Retro viral Agents in HIV-Infected Adults and Adolescents*.

Even as people with HIV/AIDS are living longer, the disease is exacting a higher toll among racial and ethnic minorities. In 1997, 47 percent of those newly diagnosed with HIV infection were African American and 20 percent were Hispanic. In the fall of 1998, HHS announced an initiative to reduce

the burden of HIV/AIDS in racial and ethnic minority communities, where CARE Act programs are critically important. In FY 1998, approximately 41 percent of those served by Ryan White programs were African American and 25 percent were Hispanic.

To continue to offer people living with HIV/AIDS the best hope of a longer and better life, the request includes $130 million for early intervention programs. Included in this amount is an increase targeted to minority communities to provide state-of-the-art clinical care to an estimated 10,000 people living with HIV/AIDS through the 60 new Early Intervention Service programs that first received planning grant support in FY 1999. The agency also plans to provide 60 new planning grants in FY2000.

The budget also contains $48 million to support grants for coordinated HIV services and access to research for children, youth, women, and families. Additionally, the request includes $20 million for AIDS Education and Training Centers, which annually trains more than 70,000 health care providers to better serve people living with HIV disease.

HEALTH CENTERS

For low income and uninsured individuals and families, HRSA's 746 community and migrant health centers with 3,000 sites, including 128 health care programs for the homeless and 20 health care programs for residents of public housing, provide an essential health care safety net. The most recent data indicates that HRSA-supported health centers and the National Health Service Corps provide high quality, comprehensive primary health care to 10.9 million individuals.

For FY 2000, the HRSA request for health centers is $945 million, a $20 million increase. Within this total request, the agency will support a $70 million investment in eliminating health disparities among racial and ethnic minorities. More than two-thirds of those who rely on health centers for primary care are racial and ethnic minorities, who experience certain health problems, including diabetes, asthma, hypertension, and certain cancers at much higher rates than whites.

The initiative to eliminate disparities will build on health centers' record of success in improving the health of racial and ethnic minorities. Examples of this record include:

- African Americans and Hispanics who receive care for hypertension at HRSA-supported health centers are three times as likely to report blood pressure under control than their peers.
- Health center patients who are diabetic are twice as likely to have necessary blood tests on schedule.
- Minority women receiving care from health centers have significantly higher rates of up-to-date mammograms and pap tests.
- Health center patients insured through Medicaid are more likely to have much lower rates of hospitalization for conditions that can be treated in an outpatient setting than other Medicaid beneficiaries.

To further reduce racial and ethnic disparities in health, HRSA health centers in FY 1999 and 2000 will mount aggressive efforts to combat diabetes and other diseases that particularly affect minorities.

FAMILY PLANNING

Access to family planning services reduces the incidence of unintended pregnancy and improves pregnancy spacing, contributing to healthier starts for children and healthier reproductive lifestyles. Access to family planning services is of particular importance for low-income women and adolescents who are at high risk for unintended pregnancy and sexually

transmitted diseases, including HIV. The FY 2000 President's budget for the Title X Family Planning program is $240 million, $25 million over the FY 1999 appropriation. From 1991 to 1996 there was a 6 percent decline in first births to teenagers, while the rate of second births for teens was down by 21 percent. In addition, from 1991-1997, birth rates to non-Hispanic white teens and black teens have dropped by 16 percent and 23 percent respectively.

While there has been a decline in unintended pregnancy, it remains disturbingly high in the vulnerable populations served by Title X. This proposed spending increase in FY 2000 will allow the Title X program to provide family planning services to an additional 500,000 persons, for a total of 5 million persons and expand its efforts in reducing unintended pregnancies and STDs for groups with high unintended pregnancy rates. Title X will also expand its efforts to promote responsibility for healthy reproductive lifestyles with emphasis on hard to reach populations such as males, substance abusers and the homeless, and continue to develop culturally and linguistically appropriate education and communication activities.

SERVICES TO MOTHERS AND CHILDREN

A major service population of all HRSA programs are low income and uninsured women and children. Because adequate health care during pregnancy and childhood is key to the future health of the Nation, HRSA also supports programs especially targeted to improving health care for all women and children, including children with special health care needs. The FY 2000 request for these programs is $804 million, a $4 million increase. The total includes $695 million for the Maternal and Child Health Services Block Grant, a Federal-State partnership that builds community-based systems of care that respond to local needs and $105 million for Healthy Start, an initiative that helps communities with high rates of infant mortality to develop innovative models of maternal and infant health care.

The FY 2000 request includes $4 million to support a new program that will promote newborn hearing screening. States will receive grants to develop and expand State-wide newborn hearing screening and intervention programs and to link them with other community diagnostic and support services.

The request also includes the third year of the $50 million annual mandatory appropriation for abstinence education.

CRITICAL CARE PROGRAMS

The FY 2000 request includes a total of $22 million, an increase of $2 million to support a comprehensive approach to emergency care. This is a particular problem in rural and remote regions not universally prepared to respond to all health emergencies. This program consolidates and expands HRSA's emergency care efforts to meet the Nation's critical care needs. The program will strengthen emergency medical services for children, emergency medical service systems, services for victims of traumatic brain injuries and their families, and improve the quality of services for victims of accidental poisoning. The initiative will train and equip emergency personnel to cope with these special populations and situations.

HEALTH PROFESSIONS

Federal assistance helps assure that the Nation's health care professions workforce is diverse and distributed to meet the needs of its citizens. HRSA's health professions training programs increase the number of under-represented racial and ethnic minorities in the health professions and encourage health professionals to practice in the Nation's 3,000-plus medically underserved communities. Minority providers are more likely both to serve the

Nation's increasingly diverse population and to care for underserved people.

The FY 2000 request continues HRSA efforts to achieve a better balanced health care workforce. The request includes $252 million, a $50 million reduction. Within this overall funding level HRSA will focus resources on programs which will help disadvantaged students and reflects the Administration's goals to move away from broad-based, categorical programs. Within this is a $16 million increase for the Centers of Excellence and the Health Careers Opportunity programs, both of which have records of success in recruiting and retaining promising racial and ethnic minority students in health professions training. Reductions will be taken in broad-based categorical programs that address expanding the supply of primary care, public health, and other disciplines.

In addition, the request includes $40 million for a new Children's Hospitals Graduate Medical Education program that will provide temporary financial assistance for graduate medical education at free-standing children's hospitals. These hospitals train 25 percent of all pediatricians and the majority of pediatric specialists.

OTHER HRSA PROGRAMS

This budget proposes $374 million for all remaining HRSA programs, including rural health and telehealth, Rural Hospital Flexibility Grants, Hansen's disease services, Black Lung clinics, organ donation and transplantation programs, the National Bone Marrow Donor Registry, Nursing Loan Repayment, Payment to Hawaii, the National Health Service Corps, and HRSA's internal program management. Funds are not requested for Federal claims related to the administration of vaccines before October 1, 1988. In FY 1999, $100 million was appropriated to address all outstanding claims and remains available until expended. Funds are also not requested for one-time construction and renovation projects for which $65 million was appropriated in FY 1999.

HRSA OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Ryan White Activities	$1,149	$1,411	$1,511	+$100
Consolidated Health Centers	825	925	945	+20
Family Planning	203	215	240	+25
MCH Block Grant	678	695	695	0
Healthy Start	96	105	105	0
Universal Newborn Hearing Screening	0	0	4	+4
Critical Care Programs	16	20	22	+2
Health Professions Programs:				
Training for Diversity	89	93	109	+16
Community-Based Linkages	51	54	37	-17
Primary Care Medicine and Dentistry	77	80	0	-80
Public Health Workforce Development	9	9	0	-9
Workforce Information and Analysis	1	1	1	0
Nursing Workforce Development	63	65	65	0
Children's Hospitals GME	0	0	40	+40
Subtotal, HP	**$290**	**$302**	**$252**	**-$50**
Rural Health/Telehealth	44	76	76	0
Hansen's Disease Services Programs	22	24	19	-5
Organ Transplantation/Bone Marrow	18	28	28	0
Black Lung/Facilities/Nurse Loan/Comm Scholor	7	7	7	0
National Health Service Corp	115	116	116	0
Program Management	121	126	128	+2
National Practitioner Databank	12	12	16	+4
Health Integ. & Prot. Databank	0	3	8	+5
Health Care Facilities	28	65	0	-65
Subtotal, Disc. Program Level	**$3,624**	**$4,130**	**$4,172**	**+$42**
Less Funds Allocated From Other Sources:				
Databank User Fees	-12	-15	-24	-9
Total, Discretionary BA	**$3,612**	**$4,115**	**$4,148**	**+$33**
Abstinence Education	50	50	50	0
Medical Facilities Guar & Loan Fund	6	1	1	0
HEAL Liquidating Account	30	37	32	-5
Vaccine Injury Compensation	0	100	0	-100
Total, HRSA Program Level	**$3,698**	**$4,303**	**$4,231**	**-$72**
FTE	1,869	1,942	1,931	-11

INDIAN HEALTH SERVICE

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$2,099	$2,242	$2,412	+$170
Program Level	2,460	2,652	2,822	+170
Outlays	2,128	2,219	2,301	+82
FTE	14,516	14,750	15,040	+290

SUMMARY

The Indian Health Service (IHS) proposes an FY 2000 budget of $2.8 billion, an increase of $170 million over FY 1999. This 8 percent increase in budget authority is a continuing demonstration of Federal commitment to providing quality health care to American Indians and Alaska Natives.

The $2.8 billion total budget also includes Medicare, Medicaid, and private health insurance collections provided for treatment of Indian people (estimated at $375 million in FY 2000). A recent agreement with the Health Care Financing Administration will increase Medicare and Medicaid collections by $82 million for services provided between FY 1998 and FY 2000.

The 8 percent increase proposed for IHS is the result of a highly successful consultation process conducted with Indian people. This process began with budget workshops conducted with tribal representatives in all twelve IHS regions and culminated in meetings between tribal and urban Indian leaders and high ranking officials from both HHS and OMB. During these discussions the need to expand access in the face of a growing population of eligible Indian people in order to reduce the gap in health disparities between Indian people and other Americans was highlighted. For example, the mortality rates for tuberculosis, chronic liver disease and cirrhosis, and accidents, are all more than three times as high for Indian people as they are for non-Indians.

AGENCY DESCRIPTION

IHS and tribes provide medical care to an estimated 1.5 million American Indians and Alaska Natives who are members of some 560 Federally recognized tribes. This medical and dental care is provided through a network of 49 hospitals, 209 outpatient facilities and 285 health stations and school health clinics located primarily in Oklahoma, the Northern Plains, along the Pacific Coast, Alaska, and the Southwest. This network includes the provision of mental health and alcohol/substance abuse prevention and treatment services and the purchase of medical care from the private sector (i.e., Contract Health Services).

IHS also devotes a significant portion of its budget to providing preventive health care including the construction of sanitation systems. While the bulk of IHS services are provided in areas on or near reservations, IHS also provides grants to support the operation of 34 urban health programs in cities with substantial numbers of Indian people.

CLINICAL, PREVENTIVE, AND ENVIRONMENTAL HEALTH

The FY 2000 budget includes $2.2 billion for clinical, preventive, and environmental health activities, an increase of $118 million, or 6 percent.

POPULATION INCREASES

The budget contains an additional $33 million to maintain access to health care as the Indian population increases. Since 1990, the population eligible for service has increased by 25 percent. Within these funds, $24 million is for the Contract Health Services program which purchases health care from the private sector. Per capita funding has not kept pace with medical inflation over that past several years limiting IHS's capacity to pay for more than the most serious types of injuries and illnesses. The increase will allow IHS to provide 2,000 additional hospital days and 13,000 additional visits to doctors and dentists. Also included is an increase of $9 million to staff newly opened outpatient facilities at Hopi, AZ, and Lame Deer, MT, and for the newly opened hospital at Talihina, OK.

HEALTH INITIATIVES

The budget contains a $31 million increase to provide additional services in several key areas which have been selected through consultations between IHS and tribal representatives. These areas include dental and mental health ($13 million), environmental health and injury prevention ($8 million), and alcohol/substance abuse prevention & treatment ($1 million). The budget also includes an additional $6 million for women's health problems (e.g., breast & cervical cancer, violence, aging issues) and $3 million to increase outreach activities including home visits. The funding increase for outreach activities represents a shift in emphasis towards more highly trained outreach workers. A $10 million increase is included for public health nurses. Community health representatives are funded at a reduced level.

INCREASING EQUITY AMONG TRIBES

About 60 percent of the IHS budget is used to operate hospitals and outpatient clinics in existing locations. This large investment in fixed health facilities makes it difficult to address inequities in health service levels available to different tribes. The budget includes an increase of $11 million dollars to increase equity among tribes by providing additional services to those tribes with the highest levels of need.

OPERATING EXPENSES/ INFORMATION TECHNOLOGY

The budget also contains an increase of $43 million for increased staff and lease costs and to purchase additional information technology and telecommunications equipment.

MEDICAID RATE INCREASE

IHS and HCFA continue their cooperative effort to ensure that IHS hospitals and clinics receive Medicare and Medicaid reimbursement on the same basis as other Medicare and Medicaid providers. Based on an extensive review of hospital based cost data, IHS Medicaid inpatient rates will rise by 40 percent between 1997 and 1999 while Medicaid outpatient rates will increase by 13 percent. IHS estimates that these new rates will result in collections totaling $375 million in FY 2000. These rate changes will result in an additional $82 million becoming available for services such as hiring of additional staff, staff training, purchasing additional equipment & supplies, and making improvements to existing space.

TRIBAL CONTRACT SUPPORT COSTS

The FY 2000 budget includes $239 million for Contract Support Costs (CSC), an increase of $35 million , or

17 percent, over FY 1999. CSC are additional costs which tribes incur when they take over the operation of local health programs from the IHS. Tribal organizations currently operate 12 of the hospitals and 385 of the other health facilities through contracts with IHS authorized by the Indian Self-Determination Act. In FY 2000, tribes will receive approximately 42 percent of IHS's total budget, to provide health services to their members.

Recent growth in the number of tribes wishing to contract with IHS has exceeded the amount of funds available for this purpose, resulting in a backlog of unfunded CSC for new contracts of approximately $65 million. Congress addressed this situation by providing an increase of $35 million for CSC in FY 1999. At the same time, Congress also imposed a moratorium on new contracting to allow CSC funding to catch up with the demand. IHS is currently working with tribes on an equitable way to distribute the additional funds in both years.

With the additional funds included in the FY 2000 budget, IHS will also be able to provide support for the new contracts anticipated for FY 2000. IHS will continue to consult with tribes over long term solutions to meeting their CSC needs as part of its overall mission to raise the health of Indian people to the highest possible level.

URBAN HEALTH

The FY 2000 budget includes $29 million for this activity, an increase of $3 million or 11 percent compared to FY 1999. Additional funding will provide health care for Indian people living in urban areas, specifically through the upgrading of urban program information systems which will improve these programs' ability to access non-IHS funds. For example, urban health grantees are eligible to become Federally Qualified Health Centers (FQHCs) and 25 percent are able to provide all of the core FQHC services.

SANITATION AND FACILITY CONSTRUCTION

The FY 2000 budget includes a total of $135 million for sanitation and facility construction. An increase of $5 million is requested, including $3 million to provide additional sanitation for Indian homes as well as to clean up open dumps, and $2 million to increase the amount of health facility construction above the FY 1999 level.

Within the request, IHS will fund a total of $43 million for facility construction in FY 2000. IHS will continue construction of two Arizona facilities, the Fort Defiance Hospital (Navajo tribe) and the Parker Outpatient Facility (Colorado River tribes). The Hopi Outpatient Clinic (also in Arizona) was fully funded in FY 1999. IHS also proposes $4 million to complete the designs of two outpatient facilities, Red Mesa in Arizona and Pawnee in Oklahoma, and $3 million for additional modular dental units.

MAINTENANCE AND IMPROVEMENT/EQUIPMENT

The FY 2000 budget proposes a total of $67 million, an increase of $8 million, for maintenance and improvements for IHS facilities and to purchase additional medical equipment for IHS facilities. Additional funds will be used for deferred maintenance & improvement projects (e.g., new heating, ventilation, and air conditioning systems to improve air quality) and to purchase ambulances.

IHS OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
SERVICES:				
Clinical Services	$1,804	$1,917	$2,018	+$101
Contract Health Services non-add	*373*	*386*	*410*	*+24*
Preventive Health	83	87	92	+5
Contract Support Costs	169	204	239	+35
Self Governance and Tribal Management Grants	11	12	12	0
Urban Health	25	26	29	+3
Direct Operations/Indian Health Professions	76	79	80	+1
Diabetes Funding /1	30	30	30	0
Subtotal, Services	**$2,198**	**$2,355**	**$2,500**	**+$145**
FACILITIES:				
Environmental Health & Facility Support	$102	$108	$120	+$12
Sanitation & Health Facility Construction	103	130	135	+5
Maintenance & Improvement and Equipment	57	59	67	+8
Subtotal, Facilities	**$262**	**$297**	**$322**	**+$25**
Total, Program Level	**$2,460**	**$2,652**	**$2,822**	**+$170**
Reimbursements:				
Health Insurance Collections	-$326	-$375	-$375	$0
Diabetes Funding	-30	-30	-30	0
Rental of Staff Quarters	-5	-5	-5	0
Subtotal, Reimbursements	**-$361**	**-$410**	**-$410**	**$0**
Total, Budget Authority	**$2,099**	**$2,242**	**$2,412**	**+$170**
FTE	14,516	14,750	15,040	+290

1/These mandatory funds are appropriated in the Balanced Budget Act of 1997.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$2,384	$2,643	$2,820	+$178
Program Level	$2,521	$2,915	$3,116	+$201
Outlays	$2,409	$2,438	$2,651	+$213
FTE	7,093	7,522	7,631	+109

SUMMARY

The FY 2000 budget requests a total of $3.1 billion for the Centers for Disease Control and Prevention (CDC), an increase of $201 million, or seven percent, over the FY 1999 level. This includes $118 million in funds provided through the Public Health and Social Services Emergency Fund (PHSSEF) for CDC activities related to bioterrorism.

CDC is the leading public health agency responsible for promoting health and quality of life by preventing and controlling disease, injury and disability. CDC works with States, local public health agencies, and partners throughout the Nation and the world to accomplish this mission. Together, they monitor health, detect and investigate disease outbreaks and other health problems, conduct research, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training.

RESPONDING TO BIOTERRORIST THREATS

The budget includes $118 million in the PHSSEF, along with $20 million in infectious diseases, for CDC's response to the threat of chemical and biological terrorism. Of this amount, $40 million will support disease surveillance activities which are addressed under Infectious Diseases. Bioterrorist attacks are likely to be surreptitious and symptoms will frequently resemble less serious diseases at first. Public health officers must be able to obtain, analyze, and share surveillance information rapidly if they are to prevent widespread death, disability and societal disruption caused by terrorist attacks.

Funding also will support the following activities:

- Expanding epidemiological capacity which will better prepare States to detect and respond to disease outbreaks caused by bioterrorism.
- Expanding laboratory capacity that will ensure a lethal biological agent released anywhere in the country can be quickly identified.
- Developing a rapid toxic screen that can quickly identify up to 150 potential chemical threats released in a terrorist attack.
- Creating and maintaining a civilian pharmaceutical stockpile that would be used in the event of a bioterrorist attack.

INFECTIOUS DISEASES

The budget includes $182 million for infectious diseases, an increase of $44 million, or 32 percent, over the FY 1999 level.

FOOD SAFETY INITIATIVE

Foodborne diseases are estimated to cause 9,000 deaths and 6.5 to 33 million illnesses in the United States each year. Recent disease outbreaks of E coli 0157: H 7, and various strains of Salmonella demonstrate the need for expanded investment in food safety.

The budget proposes $29.5 million for food safety, an increase of $10 million, or 51 percent, above the FY 1999 level. These funds will support activities under the Food Safety Initiative in which CDC participates with FDA and USDA. CDC will expand PulseNet, the national network of public health labs that perform DNA "fingerprinting" of disease causing bacteria. The number of labs using PulseNet to identify E coli 0157:H 7 will expand from 29 to 40. An increase of 33 new labs, for a total of 40, will have the ability to identify new strains of *Salmonella*.

EMERGING INFECTIOUS DISEASES

Dramatic increases in international commerce and travel, changes in the environment, and increasing stresses on our public health infrastructure have contributed to both the emergence and the rapid transmission of drug resistant and new and resurgent bacteria, fungi, parasites, and viruses. The recognition in late 1997 of H5N1 influenza in Hong Kong highlights the potential for new diseases to emerge.

Emerging infectious diseases contribute substantially to the burden of disease borne by the American public. For example, the last two influenza pandemics, with more than 70,000 deaths occurring in 1957 and 28,000 in 1968, totaled an estimated $32 billion in direct and indirect costs.

The budget proposes a total of $94.1 million for emerging infectious diseases, an increase of $15 million, or 19 percent above the FY 1999 level. Of this amount, $5 million would fund planning and education activities for Hepatitis C, and $10 million would fund emerging infectious disease surveillance, which will enhance the ability of State and local public health officials to respond to multi-State outbreaks of diseases and to share information, both among themselves and with CDC officials, about emerging infectious disease emergencies and trends.

IMPROVED SURVEILLANCE

Disease surveillance is an integral part of many of CDC's programs –especially its Infectious Disease program and Response to Bioterrorist Threats.

The budget proposes a major improvement in the coordination of public health surveillance and communication. Surveillance activities in bioterrorism ($40 million) emerging infectious diseases ($15 million) and food safety ($10 million) would be combined to support the National Electronic Disease Surveillance Network Initiative (NEDSNI). This initiative will integrate CDC's surveillance activities into a National system that will collect and analyze epidemiological information on the occurrence of communicable diseases. In addition, the network will establish a link between the public health and medical communities for obtaining surveillance information electronically.

LABORATORY CAPACITY

The FY 2000 budget also includes $32 million to be directed to construction projects at two infectious disease laboratory sites. With $22 million of these funds CDC will complete the construction of a laboratory dedicated to measles, food-borne diseases, rotavirus and the Antibiotic Resistance Units of the Hospital Infections

Program. The remaining $10 million will fund the construction of several support laboratories that will replace facilities constructed during the 1940s. (Funding for these projects is included under the line item, "Buildings and Facilities.")

ADOLESCENT SMOKING AND HEALTH

Smoking is the leading preventable cause of death in the United States. The health ravages caused by tobacco use continue to escalate each year, especially among teens, as one million young people become regular smokers. Studies show that over 80 percent of adult smokers became regular smokers before the age of 18. Preventing the next generation of young people from initiating this habit will significantly improve health for future generations and reduce health care costs.

The multi-billion settlement States have made with the tobacco industry provides a historic opportunity to protect generations of teenagers from the negative health effects of smoking. The budget includes $101 million for CDC support of State tobacco control, an increase of $27 million, or 36 percent, above the FY 1999 level. With these funds, CDC will provide States the capacity to conduct science-based tobacco control programs proven to be effective in reducing teen-smoking.

In FY 2000, CDC's two anti-smoking initiatives for States, the American Stop Smoking Intervention Study (ASSIST — transferred from the National Institutes of Health), and Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT), will be combined into the National Tobacco Control Program (NTCP). The NTCP will build on the foundation laid by the IMPACT program and the research findings of the ASSIST program, as well as the lessons learned in States with tobacco use prevention programs. The grants to States will increase by 29 percent, from $51 million in FY 1999 to $66 million in FY 2000. Support will be expanded for the following activities:

- Educational and communications programs to depict the hazards of tobacco use and reduce the demand for tobacco products;
- School-based prevention and cessation programs;
- State and local efforts to protect nonsmokers, especially children, from exposure to environmental tobacco smoke;
- Training and technical assistance for local communities to implement tobacco prevention strategies; and,
- Data collection and evaluation of program impact.

CHILDHOOD IMMUNIZATION

The Childhood Immunization Initiative (CII) has been a major Administration priority for over six years. Delivery of safe and effective vaccines is the most cost-effective method of preventing illness. This investment has enabled the Nation to continue to exceed the goal of at least 90 percent of 2-year-old children receiving the most critical vaccines. According to the National Immunization Survey, vaccination rates as of June 1998 include the following:

- 95 percent of 2-year-olds had received three of the four doses of a diphtheria, tetanus, pertussis vaccine (DTaP);
- 91 percent had received three or more doses of polio vaccine;
- 91 percent had received a measles vaccine.

In 1998, vaccine-preventable disease levels continued to be at, or near, record low levels according to the following provisional case numbers:

- 89 cases of measles compared to over 27,000 cases in 1990.
- One case of diphtheria and 34 cases of tetanus were reported in 1998.
- 260 cases of *Haemophilus influenzae* since 1991.

The goal for the year 2000 is to ensure that at least 90 percent of all two-year-olds receive the full series of vaccines and a vaccination system is built that will sustain and further improve high coverage levels.

The FY 2000 immunization budget is $1.1 billion. Total funding includes $545 million in entitlement funding for the Vaccines for Children (VFC) program, through which Medicaid pays for vaccines for uninsured Medicaid eligible children and Native Americans. VFC funding is $21 million less than in FY 1999, as the new Children's Health Insurance Program is reducing the number of uninsured children.

The discretionary component of the immunization budget is $526 million, $77 million more than in FY 1999. Of this increase, $60 million will be used to purchase vaccines to immunize underinsured children through the public health system. This increase is needed to provide all the vaccines now recommended by the National Advisory Committee on Immunization Practices (ACIP). These include vaccines for rotavirus (the leading cause of severe diarrhea in infants), and catch-up vaccinations for hepatitis B and the second dose of MMR for adolescents who have not previously received the complete series.

The request for FY 2000 also includes $99 million for global polio and measles eradication, an increase of $17 million over FY 1999. While world-wide polio cases were reduced 85 percent between 1988 and 1998, a major international increase in effort will be needed to reach the World Health Organization's goal to eliminate polio in the year 2000.

DEMONSTRATIONS TO REDUCE HEALTH DISPARITIES IN MINORITY POPULATIONS

Race and ethnicity correlate with persistent, and often growing, health disparities among U.S. populations. This increasing problem demands national attention. In response to the President's Initiative on Race, HHS is committed to developing a comprehensive strategy to reduce health disparities among ethnic and minority groups.

CDC budget includes $35 million to continue and expand new research/demonstration projects in communities across the country which address six identified areas of health disparities: infant mortality, cancer, heart disease, diabetes, HIV infections, and child and adult immunizations. These communities will be able to apply these funds to address health problems that they perceive as their greatest needs.

HIV/AIDS AND STDS

The budget includes $667 million for HIV/AIDS, a $10 million increase over FY 1999. This increase will initiate a "Know Your HIV Status" campaign. This initiative will target minority populations.

The budget includes $131 million for STD prevention and control, a $7 million increase. The relationship between HIV and other STDs has been well-documented in worldwide studies which conclude that presence of another STD increases by two to five times the risk that an exposed person will develop HIV. As a result, preventing and treating STDs decreases the likelihood of HIV transmission.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (NIOSH)

NIOSH establishes and disseminates scientific and public health information necessary to ensure safe and healthful working conditions for millions of American working men and women. Research will continue to include occupational lung disease, musculoskeletal injuries, cancers, traumatic injuries, reproductive disorders, neurotoxic disorders, cardiovascular disease, noise-induced hearing loss, dermatologic conditions, and protective equipment. These efforts will help to address solutions to occupational disease and workplace safety concerns in those fields where the dangers are the greatest. CDC's budget includes $212 million for NIOSH, an increase of $12 million over the FY 1999 level. This increase will support the National Occupational Research Agenda (NORA), NIOSH's research program developed cooperatively with academic centers and industry.

VIOLENCE AGAINST WOMEN

Nearly 2 million American women experienced domestic or sexual violence in 1996. The budget includes a total of $75 million, an increase of $11 million above the FY 1999 level, for CDC to support the Department's Initiative to combat Violence Against Women (VAW). CDC has a key role in ensuring that the Department's response to VAW – including both prevention and service delivery – is supported by science. CDC will use its approach of improving public health prevention to work with State and community partners to help increase the effectiveness of VAW practitioners. Specifically, CDC and its partners will use a scientific approach to evaluate services and bring in new partners, such as businesses and educational institutions, to improve service delivery and provide prevention opportunities.

INJURY PREVENTION

In addition to funds for Violence Against Women, the budget includes $65.5 million for injury prevention, an increase of $2 million, or three percent, above the FY 1999 level. Funds will support the Safe USA initiative which will collect and analyze information on the number of injuries in the nation and how they are caused. With this information, CDC will help communities identify their injury problems, spend their resources wisely, and know if their efforts are making a difference.

HEALTH STATISTICS

The budget includes $110 million, an increase of $15 million over the FY 1999 level, for expanded support of HHS health survey and data collection efforts. In FY 2000 the entire request for NCHS will be provided through inter-agency funds transfers. Major statistical systems operated by NCHS track change in health and health care, plan, target, and assess the effectiveness of public health programs, and identify health problems, risk factors, and disease patterns in the United States. These funds will be used to expand the National Vital Statistics program ($1 million), the National Health Interview Surveys ($3 million), the National Health and Nutrition Examination Survey (NHANES; $1 million), and start new targeted surveys ($3.5 million). $6 million would be used to strengthen CDC's intramural statistical program.

PREVENTIVE HEALTH BLOCK GRANT

The Preventive Health Block Grant would be funded at $120 million (plus $45 million in Crime Bill funding), which is $30 million below the FY 1999 level. The grant provides States with funds for preventive health services, not covered by

other grants, to reduce preventable morbidity and mortality and improve quality of life for all Americans. The funds are allocated to the States, the District of Columbia, Territories, and eligible Indian Tribes and Tribal Organizations that apply.

AGENCY FOR TOXIC SUBSTANCES DISEASE RESEARCH (ATSDR)

ATSDR is funded through Superfund, which is managed by the Environmental Protection Agency. ATSDR performs public health activities related to Superfund Toxic Waste sites. These include health consultations, epidemiological surveillance, profiles of the health effects of hazardous substances, and education of health care providers near Superfund sites. EPA's budget proposes $64 million for ATSDR in FY 2000, a decrease of $12 million.

CDC OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Centers for Disease Control and Prevention:				
Infectious Diseases	$113	$138	$182	+$44
Emerging Infectious Diseases (non-add)	*59*	*79*	*104*	*+25*
Food Safety (non-add)	*15*	*20*	*30*	*+10*
Heart Disease and Health Promotion	74	128	155	+27
Tobacco (non-add)	*28*	*74*	*101*	*+27*
Immunization/1	430	449	526	+77
Race and Health Demonstration Projects	0	10	35	+25
Sexually Transmitted Diseases	112	124	131	+7
HIV/AIDS	625	657	667	+10
Diabetes and Other Chronic Diseases	60	80	80	0
Breast and Cervical Cancer	143	159	159	0
Occupational Safety and Health	187	200	212	+12
Injury	56	64	76	+13
Violence Against Women (non-add)	*0*	*0*	*11*	*+11*
Health Statistics	85	95	110	+15
1% Evaluation (non-add)	*59*	*68*	*110*	*+42*
Prevention Research	0	15	15	0
Preventive Health Block Grant	194	195	165	-30
Crime Bill/ Rape Prevention	*45*	*45*	*45*	*0*
Tuberculosis	118	120	120	0
Cancer Registries	24	24	24	0
Environmental Disease Prevention/1	54	67	67	0
Childhood Lead Poisoning	38	38	38	0
Prevention Centers	8	14	14	0
Epidemic Services	67	86	85	-1
Buildings and Facilities	22	18	40	+22
Office of the Director	34	31	30	-1
1% Evaluation (non-add)	*.7*	*.7*	*0*	*-1*
Bioterrorism/2 (PHSSEF)	0	124	118	-6
EPA Superfund Allocation (ATSDR)	74	76	64	-12
Mandatory Budget Authority (Diabetes)	3	3	3	0
User Fees	1	1	1	0
Subtotal , Program Level	**$2,521**	**$2,915**	**$3,116**	**+$201**
Less Funds Allocated from Other Sources :				
Bioterrorism (PHSSEF)	0	124	118	+6
1% Evaluation (Health Statistics)	59	68	110	-41
EPA Superfund Allocation (ATSDR)	74	76	64	+12
Mandatory Budget Authority (Diabetes)	3	3	3	0
User Fees	1	1	1	0
Total, Budget Authority	**$2,384**	**$2,643**	**$2,820**	**$178**
FTE	7,093	7,522	7,631	+109

1/FY 1999 Enacted reflects a comparable transfer from the Public Health and Social Services Emergency Fund of $28 million for polio and measles and $5 million for the environmental health lab.
2/ Includes $1.85 M in FY 1999 for Nuclear Weapons Radiation Study

NATIONAL INSTITUTES OF HEALTH

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$13,622	$15,613	$15,933	+$320
Program Level	$13,717	$15,709	$16,018	+$309
Outlays	$12,475	$13,995	$15,426	+$1,431
FTE	15,159	16,217	16,618	+401

SUMMARY

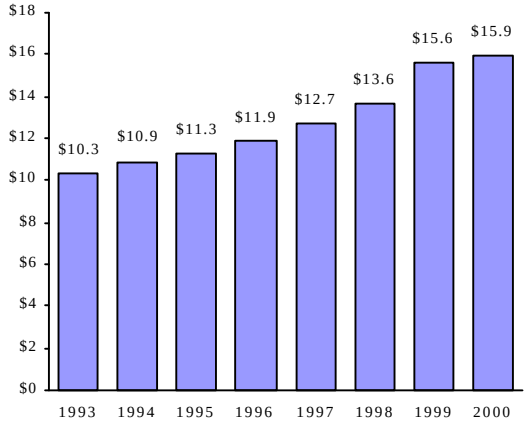
The FY 2000 budget requests $15.9 billion for the National Institutes of Health (NIH), an increase of $320 million, or 2.1 percent, over the FY 1999 level. Within this total, NIH research will grow by 2.4 percent (+$369 million), while Buildings and Facilities funds (including $40 million of advanced appropriations), will decline by 25 percent (-$49 million). The FY 2000 request, combined with last year's 14.6 percent increment, represents a 17 percent increase over two years.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. The Institutes and Centers funded by NIH's 25 appropriations support research activities that extend from basic research exploring the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention and to population-based analyses of health status and needs. The missions of individual Institutes and Centers may focus on a given disease, such as cancer, mental illness, or infectious diseases; on a particular organ, such as the heart, kidney, or eye; or on a stage of development, such as childhood or old age. In other instances, a mission might encompass cross-cutting needs and opportunities, such as the development of research resources or the sequencing of the human genome.

Approximately 82 percent of the funds appropriated to NIH flows out to the extramural community, which supports research by more than 50,000 researchers affiliated with some 2,000 university, hospital, and other research facilities in all 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and points abroad. A small percentage of the budget – approximately 10 percent – supports a core program of basic and clinical research activities administered and staffed by NIH's own physicians and scientists. The remaining 8 percent provides for research

NIH FUNDING HISTORY

(Dollars in billions)



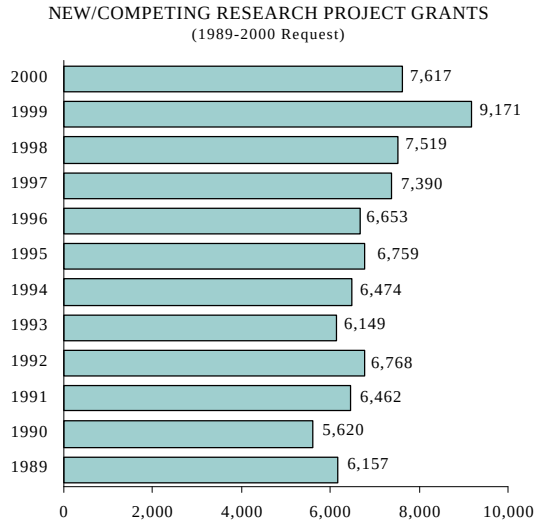
management and support, agency administration, and intramural facilities.

RESEARCH THEMES

New advances for preventing and treating disease, never before thought possible, are within our reach. With the increases provided in FY 1999 and requested for FY 2000, NIH plans to focus on four programmatic themes: 1) exploiting genomics by accelerating the human genome project; expanding work on model animal systems; learning to gather and use complex biological information; and building bioinformatics; 2) reinvigorating clinical research by recruiting, training, and retaining clinical investigators; strengthening clinical research centers; supporting clinical trials, networks, and databases; and developing partnerships with managed care, foundations, industries and other Federal agencies; 3) harnessing the expertise of allied disciplines, such as chemistry, engineering, computer science, mathematics, optics, and physics in order to work with medical scientists in, for example, designing new drugs; imaging molecules, chromosomes, cells, and organs; developing biomaterials; and analyzing bioinformatics and clinical data; and 4) reducing health disparities at home and abroad through research, training, testing interventions, and building international research capacity.

RESEARCH PROJECT GRANTS

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) continues to be NIH's highest funding priority. These grants support new and experienced investigators in broad-based research programs. In FY 2000, the NIH budget provides $8.8 billion, a 2.5 percent increase over FY 1999, to fund nearly 30,000 projects, the highest total level ever. This represents an additional 317 total grants over FY 1999. NIH estimates it will support 7,617 new and competing RPGs in FY 2000. While this number is 1,554 below FY 1999 levels, a total of 16,788 new and competing grants will have been awarded over the two year period beginning in 1999. In order to meet basic funding obligations for non-competing grants and to maximize the number of new/competing grants within the overall budget, NIH has chosen not to provide an increase in the average cost of new awards for FY 2000, nor to provide inflationary increases for non-competing awards. New and competing awards are being provided an 11.4 percent average cost increase in FY 1999, which raised the average cost of a new award to about $285,000. NIH will maintain this new higher level of grant support for new awards in FY 2000.



RESEARCH TRAINING

Promises for advancement in medical research are dependent on a continuing supply of new investigators with new ideas. The FY 2000 budget for NIH includes $512 million for individual and institutional research training grants to support nearly 15,700 predoctoral and postdoctoral research trainees, approximately the same level as in FY 1999.

HIV/AIDS Research

The FY 2000 budget requests a total of $1.8 billion for AIDS-related research in NIH. This is an increase of $35 million, or 2.0 percent over the FY 1999 level. It represents a 71 percent increase in funding for NIH AIDS-related research since FY 1993.

Investment in HIV/AIDS research has led to many advances against this disease. Ground-breaking NIH research in basic biology has led to a revolution in drug design and diagnostic methods that are benefitting the fight not only against AIDS, but also against many other life-threatening diseases. This basic research has been the foundation for the development of a new class of drugs, known as protease inhibitors, that are extending the length and quality of life for many HIV-infected individuals. But many problems remain. It is critical to develop simpler, less toxic, and cheaper drug regimens. The search for a safe and effective vaccine to prevent infection remains one of the highest research priorities. NIH is focusing research on behavioral and biomedical interventions to prevent transmission. For example, NIH-sponsored clinical trials demonstrated that the administration of AZT to HIV-infected pregnant women and to their infants dramatically reduced the rate of HIV transmission from mother to infant. NIH intervention research is also focused on populations at risk, particularly women and minorities.

The FY 2000 President's budget includes all of NIH's AIDS-related funds in a single appropriation account for the Office of AIDS Research (OAR), consistent with the provisions of the NIH Revitalization Act of 1993. The Director of OAR will transfer funds to the Institutes in accordance with the scientific priorities of the annual comprehensive plan for AIDS research developed by OAR along with the Institutes. The Administration supports a consolidated AIDS appropriation within NIH as a vital part of ensuring a coordinated and flexible response to the AIDS epidemic.

New National Center for Complementary and Alternative Medicine

Consistent with the FY 1999 Omnibus Consolidated and Emergency Supplemental Appropriations Act, NIH plans to establish a new National Center for Complementary and Alternative Medicine (NCCAM). A separate appropriation for NCCAM is requested for FY 2000. This new Center will be funded at $50 million in FY 2000, excluding its AIDS activities which are budgeted in the OAR request. Working with other NIH Institutes, NCCAM plans in FY 2000 to undertake several large clinical trials, expand support for the CAM Research Center Grants to do studies in children and in persons with cardiovascular disease, and continue support for research training and career development for prospective CAM investigators.

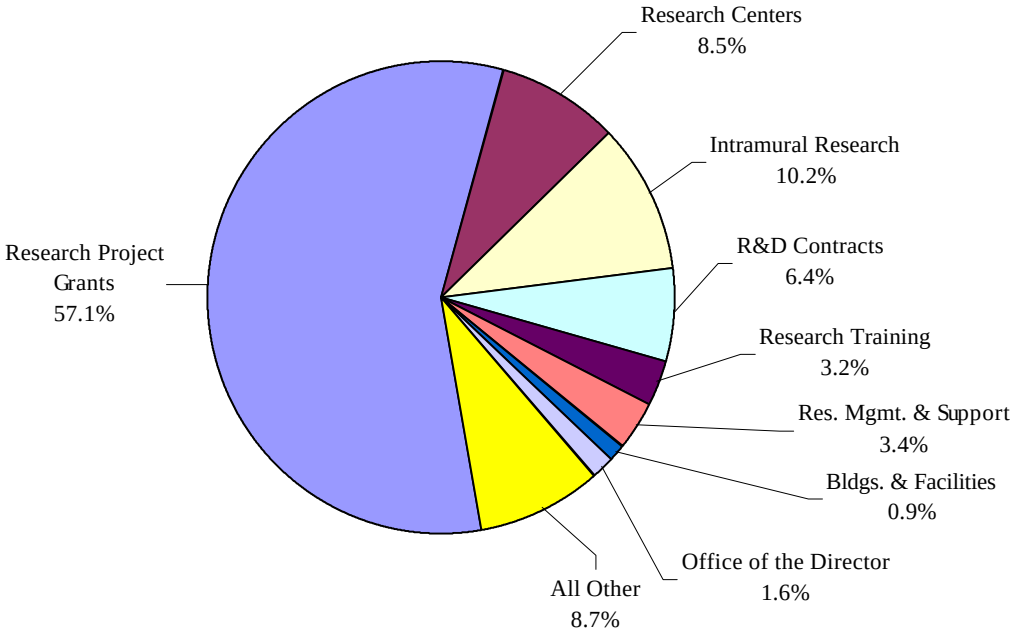
Clinical Research Center

FY 2000 marks the final year of funding for the new Mark O. Hatfield Clinical Research Center. Last year, Congress appropriated $40 million in advance for FY 2000, completing the phased funding of the total $310 million construction cost. This new facility will replace the existing hospital of the current Clinical Center, which is more than 40 years old. The NIH Clinical Center is the core clinical research facility at NIH and the largest of its kind in the world. It accommodates approximately 25 percent of all Federally funded outpatient visits associated with clinical research and nearly half of all the Federally funded clinical research beds in the Nation. Construction on the new facility started in 1998 and is expected to be completed in 2002.

CLINICAL CENTER FINANCING

The Clinical Center is supported jointly by the NIH Institutes. Following an extensive internal review, NIH is revising the way Institutes support the Center. Under this new approach, the Institutes' shares of support will be based on the size of their intramural research program. The FY 2000 budget request includes a budget neutral adjustment by Institute for this new Clinical Center assessment method. FY 1998 and FY 1999 Institute funding data has been made comparable for this adjustment.

FY 2000 NIH Budget
$15.9 Billion - Percent of Total by Mechanism



NIH OVERVIEW (by Institute/Center)

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Institutes:				
National Cancer Institute	$2,306	$2,668	$2,733	+$65
National Heart, Lung, and Blood Institute	1,508	1,719	1,760	+41
National Institute of Dental and Craniofacial Research	201	220	226	+5
Natl Inst. of Diabetes & Digestive & Kidney Disease.	858	979	1,003	+23
National Institute of Neurological Disorders & Stroke	749	870	891	+21
National Institute of Allergy & Infectious Diseases	656	771	789	+18
National Institute of General Medical Sciences	1,033	1,166	1,194	+28
Natl Inst. of Child Health and Human Development	607	678	694	+16
National Eye Institute	346	387	396	+9
National Institute of Environmental Health Sciences	335	382	391	+9
National Institute on Aging	518	598	613	+14
Natl Inst. Of Arthritis & Musculoskeletal & Skin Dis.	269	303	310	+7
Natl Inst. On Deafness & Communication Disorders	199	230	235	+6
National Institute of Mental Health	642	741	759	+18
National Institute on Drug Abuse	365	419	429	+10
National Institute on Alcohol Abuse and Alcoholism.	212	243	249	+6
National Institute for Nursing Research	58	64	65	+2
National Human Genome Research Institute	219	265	272	+6
National Center for Research Resources	370	459	470	+11
Natl Center for Complementary & Alternative Med	20	49	50	+1
Fogarty International Center	18	23	23	+1
National Library of Medicine	157	177	181	+4
Office of the Director	181	213	218	+5
Office of AIDS Research 1/	1,603	1,798	1,834	+35
Buildings & Facilities	195	191	108	-83
B&F Advanced Funding	0	0	40	+40
EPA Superfund Allocation (NIEHS)	58	60	49	-12
ONDCP Forfeiture Fund Transfer (NIDA)	10	10	10	0
Diabetes Research 2/	27	27	27	0
Subtotal, Program Level	**$13,717**	**$15,709**	**$16,018**	**+$309**
Less Funds Allocated from Other Sources:				
EPA Superfund Allocation (NIEHS)	-$58	-$60	-$49	+$12
ONDCP Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
Diabetes Research 2/	-27	-27	-27	0
Subtotal, Budget Authority	**$13,622**	**$15,613**	**$15,933**	**+$320**
FTE	15,159	16,217	16,618	+401

1/ FY 1999 figure includes $6.1 million of facilities funds related to the new Vaccine Research Facility.
2/ These funds were pre-appropriated in the Balanced Budget Act of 1997.

NIH OVERVIEW (by Mechanism)

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Mechanism:				
Research Project Grants	$7,530	$8,560	$8,778	+$218
[No. of Non-Competing]	*[19,526]*	*[20,473]*	*[22,344]*	*[+1,871]*
[No. of New/Competing]	*[7,519]*	*[9,171]*	*[7,617]*	*[-1,554]*
[Total No. of Grants]	*[27,045]*	*[29,644]*	*[29,961]*	*[+317]*
SBIR/STTR Grants	269	310	317	+7
Research Centers	1,168	1,323	1,348	+25
Research Training	428	511	512	+1
R&D Contracts	804	1,019	1,016	-3
Intramural Research	1,434	1,561	1,619	+58
Other Research	904	1,156	1,204	+48
Research Management and Support	497	536	542	+6
National Library of Medicine	161	181	186	+4
Office of the Director	221	257	263	+6
Buildings and Facilities	207	198	108	-89
B&F Advanced Funding	0	0	40	+40
EPA Superfund Allocation (NIEHS)	58	60	49	-12
ONDCP Forfeiture Fund Transfer (NIDA)	10	10	10	0
Diabetes Research 1/	27	27	27	0
Subtotal, Program Level	**$13,717**	**$15,709**	**$16,018**	**+$309**
Less Funds Allocated from Other Sources:				
EPA Superfund Allocation (NIEHS)	-$58	-$60	-$49	+$12
ONDCP Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
Diabetes Research 1/	-27	-27	-27	0
Subtotal, Budget Authority	**$13,622**	**$15,613**	**$15,933**	**+$320**
FTE	15,159	16,217	16,618	+401

1/ These funds were pre-appropriated in the Balanced Budget Act of 1997.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$2,148	$2,488	$2,627	+$139
Program Level	$2,198	$2,488	$2,627	+$139
Outlays	$2,235	$2,331	$2,519	+$188
FTE	551	576	567	-9

SUMMARY

The FY 2000 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $2.6 billion, a net increase of $139 million or 5.6 percent over the FY 1999 enacted level. The SAMHSA budget focuses on enhancing mental health and substance abuse services through capacity building programs such as the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness, the Targeted Treatment Capacity Expansion, and the Substance Abuse Prevention and Treatment Block Grant programs.

The Substance Abuse and Mental Health Services Administration provides national leadership to ensure that knowledge, based on science and state-of-the-art practice, is effectively used for the prevention and treatment of addictive and mental disorders. Further, SAMHSA strives to improve access and reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities. Through its Centers — Mental Health Services (CMHS), Substance Abuse Prevention (CSAP), and Substance Abuse Treatment (CSAT) — SAMHSA supports a portfolio of programs to develop, test, and transfer new methods and models for treating substance abuse and mental health disorders and preventing substance abuse. The FY 2000 SAMHSA budget supports these efforts through its Knowledge Development and Application activities.

Last fall, CSAT funded three new activities designed to improve treatment services for youth. New grants were awarded to identify effective treatment regimens for substance abusing adolescents that were useful for replication in other communities with priority for those programs that provide treatment for adolescent heroin users. The second area funded, in conjunction with the National Institute on Alcohol Abuse and Alcoholism, was research to develop efficacious treatment for adolescent alcohol abusers and alcoholics. For the third, CSAT began a multi-site study of the impact of managed care on adolescent treatment services in the public sector. This study will focus on service use and outcomes of treatment for adolescents under managed care and fee for service medical plans.

MENTAL HEALTH

Each year approximately 44 million American adults experience some form of mental disorder, of these, 10 million are serious mental illnesses. Further, an estimated 3.5 to 4 million children and adolescents between the ages of 9 through 17 experience a serious emotional disturbance. It is estimated that fewer than one in four of these persons receives treatment for the disorder.

To increase access to mental health services, SAMHSA seeks a total of $359 million for the Mental Health Block Grant (MHBG), an increase of $70 million, or 24 percent over FY 1999. The MHBG program assists States in creating comprehensive, community-based systems of care for adults with a serious mental illness and children with a severe emotional disturbance. These funds play an integral role in reducing hospitalizations. The availability of cost effective community-based systems is critical to address the needs of persons who are no longer institutionalized. In addition, the budget seeks an additional $5 million, 19 percent, for the Projects for Assistance in Transition from Homelessness (PATH) program. PATH, a State formula grant program, provides funds for outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health services; alcohol or drug treatment; staff training, linkages to primary care; and supportive services. The number of contacts made through PATH will increase by approximately 13,000 and will improve the quantity of services provided to enrolled PATH clients such as linkages to health, education and job services, provide case management and match clients with appropriate housing.

The FY 2000 budget will continue the new $40 million program CMHS initiated in FY 1999 to support the delivery and improvement of mental health services in our nation's schools. This ambitious program is designed as a comprehensive, interagency collaborative approach linking local and State mental health service providers with schools. School districts will implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

CLOSING THE PUBLIC SUBSTANCE ABUSE TREATMENT GAP

Nationwide, there continues to be a great need for additional capacity to treat chronic users of illegal drugs. The Office of National Drug Control Policy estimates that 2.4 million persons could potentially benefit from treatment services and are unable to obtain them. A 1996 survey showed that for every dollar spent on treatment, $5.60 is returned in public savings from reduced use of welfare, food stamps, Medicaid funds, crime, and reduced imprisonment. The SAMHSA request will support substance abuse treatment for an additional 20,000 persons through Federal funds. The FY 2000 budget includes a total of nearly $2 billion for substance abuse activities.

The FY 2000 total budget for the Targeted Treatment Capacity Expansion program of $110 million is an increase of $55 million over FY 1999. The Targeted Capacity Expansion program addresses the treatment gap by supporting rapid and strategic responses to the demand for alcohol and drug treatment services, with a special focus on emerging drug problems. The goal of the program is to create or expand integrated creative and community-based responses to targeted, well-documented substance abuse capacity problems, and allow communities to meet the needs of special populations.

This budget also seeks a total of $1.6 billion, an increase of $30 million in FY 2000, plus advanced appropriations of $100 million in FY 2001 for the Substance Abuse Prevention and Treatment Block Grant. The Block Grant, the cornerstone of States substance abuse programs, provides support for over 7,000 community based treatment organizations across the U.S. In addition, the Block Grant –through its set-aside –will continue to support the expanded National Household Survey on Drug Abuse (NHSDA). NHSDA will provide estimates of the prevalence of alcohol, drug and tobacco use in the 50 States and the District of Columbia. In 1999, SAMHSA will introduce computer assisted survey methods to the NHSDA in order to improve the precision of the survey data.

SUBSTANCE ABUSE PREVENTION

SAMHSA's 1997 National Household Survey on Drug Abuse (NHSDA) estimates that 13.9 million Americans used an illicit drug in the past month. Adolescent use of alcohol, tobacco, marijuana and other illicit drugs continues at unacceptable levels. Moreover, the U.S. Census projects a significant increase in the number of 12 to 20-year-olds over the next 15 years. This projection signals a continuing need to enhance and build on those prevention programs that work and to encourage development of new and more effective programs in the future.

The SAMHSA budget seeks a total of $139 million for Knowledge Development and Application, Targeted Capacity Expansion and High Risk Youth programs to continue building a knowledge base in substance abuse prevention and to promote wide dissemination and adoption of best practices in the field. In addition, the CSAP Targeted Capacity Expansion programs, including the State Incentive Grants, will continue to focus on addressing specific and immediate prevention service capacity needs within states and communities.

PROGRAM MANAGEMENT

The budget includes an increase of $5 million for Program Management activities to support SAMHSA as it addresses important issues such as children's mental health, the relationship between drug abuse and the changing demographics of the AIDS epidemic, and responding to rapidly emerging substance abuse treatment gaps.

SAMHSA OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Mental Health:				
Mental Health Block Grant	$275	$289	$359	+$70
PATH Homeless Formula Grant	23	26	31	+5
Knowledge Development and Application	58	98	98	0
Children's Mental Health Services	73	78	78	0
Protection and Advocacy	22	23	23	0
Subtotal, Mental Health	**$451**	**$514**	**$589**	**+75**
Substance Abuse:				
Targeted Capacity Expansion	$92	$134	$189	+55
Substance Abuse Treatment	*25*	*55*	*110*	*+55*
Substance Abuse Prevention	*67*	*79*	*79*	*0*
Substance Abuse Block Grant	1,360	1,585	1,615	+30
Knowledge Development and Application	215	195	169	-26
Substance Abuse Treatment	*131*	*117*	*117*	*0*
Substance Abuse Prevention	*84*	*79*	*53*	*-26*
High Risk Youth	6	7	7	0
National Data Collection Activities	18	0	0	0
Subtotal, Substance Abuse	**$1,691**	**$1,921**	**$1,980**	**+$59**
Program Management	56	53	58	+5
Total, Program Level	**$2,198**	**$2,488**	**$2,627**	**+$139**
Less Funds Allocated from Other Sources:				
Advance Appropriation to P.L. 104-121 /1	*-50*	*0*	*0*	*0*
Total Discretionary BA	**$2,148**	**$2,488**	**$2,627**	**+$139**
FTE	551	576	567	-9

/1 The additional $50 million was provided only in FY 1998.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Program Level	$147	$171	$206	+$35
Budget Authority	$90	$100	$27	-$73
Outlays	$77	$101	$90	-$11
FTE	260	275	285	+10

SUMMARY

The FY 2000 request for the Agency for Health Care Policy and Research (AHCPR) provides a program level of $206 million, an increase of $35 million, or 21 percent, over FY 1999. This includes $27 million in direct appropriations and $179 million in inter-agency transfers. The Budget reflects a major commitment to ensure that the knowledge gained through health care research is translated into measurable improvements in the American health care system. The FY 2000 budget will:

- Expand work to translate the findings of completed research into everyday medical practice;
- start new research for future health care quality improvements in priority areas, especially among the diseases that have the greatest impact on Medicare and Medicaid costs;
- improve the decision-support tools and information available to medical providers, consumers, and policy makers; and,
- include a special focus on closing the health care gaps affecting racial and ethnic minorities.

AHCPR promotes the creation and use of science-based information, often through partnerships with medical societies, managed care providers, and health care payers. For example, it supports 12 Evidence-based Practice Centers (EPCs). Each center focuses on a medical problem that is common or expensive (especially for Medicaid and Medicare), assessing the current science on what works best for that medical problem. Each center has a major partner — such as the American Academy of Pediatrics or a major insurer —who will implement the center's findings.

Other examples of partnerships include the National Guideline Clearinghouse (jointly maintained with the American Medical Association and the American Association of Health Plans), and the Consumer Assessments of Health Plans Study (CAHPS). The National Committee for Quality Assurance (which accredits managed care plans) recently adopted CAHPS to help consumers and employee benefit program managers select care based on quality, not just price. Ninety million consumers will benefit from CAHPS in 1999.

HEALTH COSTS, QUALITY, AND OUTCOMES

Research on Health Costs, Quality and Outcomes is funded at $168 million in FY 2000, an increase of +$27 million. This research focuses heavily on illnesses with high Medicare and Medicaid costs, and will enable HHS to implement the scientific recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

CHRONIC DISEASES

AHCPR will direct $9 million to conduct research on chronic diseases, with special emphases on asthma and diabetes (including $2.5 million in MEPS).

First, AHCPR's investment in research on pharmaceuticals and the establishment of the new Centers for Education and Research on Therapeutics will include studies on the effectiveness, cost-effectiveness and quality of prescribing practices for chronic illnesses.

Second, AHCPR will develop new ways to measure the quality of care for chronic illnesses, help four more States implement those that are available now through the Healthcare Cost and Utilization Project, and collect and analyze data on the quality and cost of care.

Third, AHCPR will establish cooperative projects with one or more health care networks focusing on ways to implement current medical knowledge on ways to prevent the complications of chronic illnesses and reduce related hospitalizations.

REDUCING RACIAL AND ETHNIC HEALTH DISPARITIES

AHCPR will direct $10 million in research on eliminating health disparities for minority populations. Many of these result from provider, patient, and organizational factors that hinder the appropriate use of medical science. AHCPR's plans include:

- Research on factors affecting minority health outcomes – $4.5 million
- Improved information on the quality of care – $1.6 million
- Partnerships with health delivery sites to translate research into practice – $4 million.

LONG-TERM CARE

Measuring the quality of long-term care is uniquely difficult. AHCPR plans to use $1.5 million to develop better ways to measure this quality, and conduct research important to Medicaid recipients.

VIOLENCE AGAINST WOMEN

Some health care systems have implemented innovative approaches to prevent, screen and treat domestic violence, but there is little research that assesses their value. AHCPR will work with health plans, clinicians, and researchers to support up to three longitudinal studies of the outcomes and effectiveness of these medical interventions. This $1 million research effort is part of a broader Departmental initiative to curtail violence against women.

MEASURING THE IMPACT OF CHANGES IN THE HEALTH CARE MARKETPLACE

Changes in the way health care is bought and sold has had a major impact on the health care the average American receives. Managed care, competition, and value-based purchasing are three of the more important changes. At least $2 million in research will be directed to provide timely information on these effects to consumers and decision-makers.

MEDICAL EXPENDITURE PANEL SURVEYS

AHCPR's Medical Expenditures Panel Surveys (MEPS) are funded at $36 million in FY 2000, an increase of $8 million. MEPS provides detailed, national data on the health

care services Americans use, how much they cost, and who pays. This increase will provide policy makers more information on the quality and cost of care for chronic diseases, including cardiovascular disease and diabetes. For example, policy makers will get better information on use of medicines that reduce subsequent hospital stays. This information can help target health improvements efforts by health plans, the State and Federal governments, and the medical community. Targeted sample size increases in the household survey will provide better information for racial and ethnic populations. This information will help target efforts to reduce health disparities, and track progress of various health services.

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority.....	$297,438	$312,210	$335,233	+$23,023
Outlays.....	$293,921	$314,860	$333,074	+$18,214
FTE /1.....	3,942	4,267	4,282	15

1/ In FY 2000, 50 FTEs are being paid from the Public Health and Social Services Emergency Fund for millennium compliance.

AHCPR OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Research on Health Costs, Quality, and Outcomes.....	$108	$141	$168	+$27
Medical Expenditures Panel Surveys.....	$36	$28	$36	+$8
Program Support.....	$2	$2	$2	$0
Subtotal, program level.....	**$146**	**$171**	**$206**	**+$35**
Less Transfers: PHS Inter-agency.....	-$56	-$71	-$179	-$108
Total , BA.....	**$90**	**$100**	**$27**	**-$73**
FTE.....	267	275	285	+10

1/ FY 1999 numbers do not include $420,000 in Y2K funds.

HEALTH CARE FINANCING ADMINISTRATION

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$297,438	$312,210	$335,233	+$23,023
Outlays	$293,921	$314,860	$333,074	+$18,214
FTE /1	3,942	4,267	4,282	15

1/ In FY 2000, 50 FTEs are being paid from the Public Health and Social Services Emergency Fund for millennium compliance.

SUMMARY

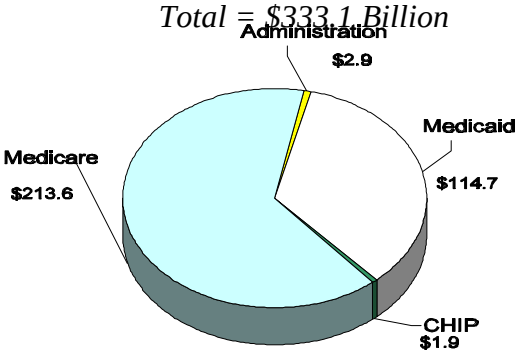
The FY 2000 budget request for the Health Care Financing Administration (HCFA) is $333.1 billion to cover Medicare and Medicaid, the Children's Health Insurance Program (CHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and HCFA's operating costs (see chart for the distribution of spending). This budget reflects an increase of $18.2 billion over FY 1999. Spending for the Medicare, Medicaid, and CHIP programs represent 82.7 percent of the total HHS budget for FY 2000.

The President's FY 2000 budget includes several legislative proposals for HCFA. Major initiatives will enable thousands of people aged 55-65 to buy into Medicare, and also provide assistance for disabled Medicare and Medicaid beneficiaries who return to work. This budget proposes several new endeavors to continue the fight against waste, fraud, and abuse in the Medicare program. In addition Medicare payment reforms will tighten payments for certain services. New user fee legislation in HCFA's discretionary budget will enable HCFA to meet the new workload demands while more effectively administering the program.

States will be given the option to extend Medicaid coverage for certain groups, such as qualified alien children and pregnant women. To serve Medicaid beneficiaries better, the budget offers more choices to Medicaid long-term care recipients and provides grants to the States to retrain providers in asthma management techniques. Medicaid will more efficiently target spending through cost allocation and changes in drug reimbursement laws. Finally, the budget proposes increased CHIP money to provide more equitable funding for children's health care in the U.S. territories and increased spending on CHIP outreach activities.

HCFA FY 2000 Net Outlays

Total = $333.1 Billion



MEDICARE

SUMMARY

Medicare is the Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 2000, the program will serve approximately 39.8 million eligible individuals. Medicare consists of three parts:

- Part A—Hospital Insurance (HI) Pays for inpatient hospital care, some skilled nursing facility care, home health care related to a hospital stay, and hospice care. The HI program is funded through the HI Trust Fund. The Trust Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).
- Part B—Supplementary Medical Insurance (SMI) Part B coverage is optional. However, 94 percent of those enrolled in Part A enroll in Part B. Part B pays for medically necessary physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, home health care, and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. Enrollees pay about 25 percent of Part B costs, and the remaining income comes from general revenue.
- Part C— The Medicare+Choice Program, which is available to most beneficiaries, offers beneficiaries the option of receiving their Medicare benefits through private organizations such as managed care plans. Currently about 16 percent of beneficiaries have chosen to enroll in a Medicare+Choice plan.

LEGISLATIVE PROPOSALS

In Medicare, the FY 2000 budget includes proposals to: extend Medicare coverage to population groups at risk of losing health coverage, combat fraud, waste and abuse in the program, and ensure Medicare payment for provider services is appropriate and cost-efficient.

The two initiatives designed to assist vulnerable population groups are a Medicare buy-in for early retirees and displaced workers and extended Medicare coverage for working disabled beneficiaries. Together, these proposals cost $1.7 billion over five years. The costs associated with these proposals will be offset by savings initiatives proposed in this budget.

MEDICARE BUY-IN

A major initiative in this Budget provides the opportunity for certain individuals between the ages of 55-65 to buy in to Medicare. These individuals are among the most difficult to insure, have less access to health care, and are twice as likely as 45-54 year olds to have health problems. The three initiatives that constitute this proposal will:

- Enable Americans ages 62-65 to buy into Medicare, by paying a full premium;
- Provide vulnerable displaced workers over 55 access to Medicare by offering those who have involuntarily lost their jobs and their health insurance a similar buy-in option;
- Provide Americans over 55, whose companies terminate their retiree health coverage, a new insurance

option, by extending "COBRA" continuation coverage until age 65.

WORKING DISABLED PROPOSAL

Another major initiative in the FY 2000 Budget extends Medicare coverage for those disabled individuals who return to work. Currently, disabled individuals who return to work must pay the full Part A premium after 39 months in order to continue in Medicare. This proposal provides lifetime coverage under Part A if a disabled person who loses Social Security because of their ability to work enrolls during the first 10 years after enactment, thereby removing a significant disincentive to work inherent in the current system.

FIGHTING FRAUD, WASTE, AND ABUSE

In the continuing effort to ensure that the Medicare program effectively manages Medicare dollars, the budget proposes the following initiatives, totaling about $2.9 billion over five years:

- Eliminate the physician mark-up for outpatient drugs by limiting Medicare payment to 83 percent of the average wholesale price;
- Reduce misuse of partial hospitalization services by: prohibiting providers from furnishing partial hospitalization services in a beneficiary's home or other inpatient or residential setting, allowing the Secretary to establish more stringent standards for community mental health centers, and imposing civil monetary penalties when a physician falsely certifies the need for these services;
- Require private insurance companies to provide Medicare Secondary Payer information;
- Reduce Medicare's reimbursement rate for Epogen (EPO) by $1 to better reflect current market prices, and;
- Make the Centers of Excellence program, which was successfully tested as a demonstration, a permanent part of the Medicare program.

PAYMENT REFORMS

Despite the slow-down in Medicare growth over recent years, there is still evidence to suggest that Medicare pays too much for some services and has not benefitted from cost-efficiencies that have occurred in the marketplace. In an effort to ensure Medicare continues to pay appropriately for services furnished to beneficiaries, the budget includes savings proposals totaling $7.5 billion over five years to:

- Not update the hospital payment rates for the twelve months of FY 2000;
- Reduce from 55 to 45 the percentage Medicare pays hospitals for bad debt and extend this policy to providers beyond hospitals;
- Reduce the lab fee schedule ceiling from 74 to 72 percent; and;
- Limit Medicare payment for orthotics and prosthetics to the national median.

MANAGED CARE OPTIONS

Medicare offers beneficiaries a variety of coverage options. Beneficiaries may choose to remain in the traditional fee-for-service program or join a managed care plan. In fee-for-service, beneficiaries choose from almost any doctor, hospital, or health care provider. In managed care, beneficiaries receive virtually all care from the plan's doctors and health care providers.

The Balanced Budget Act of 1997 (BBA) expanded the types of plans available to beneficiaries including provider sponsored

organizations (PSO) and preferred provider organizations (PPO).

Currently, more than 6 million or about 16 percent of beneficiaries, are enrolled in a managed care plan. Enrollment in managed care has grown dramatically over the last five years. While some managed care organizations have recently decided to dis-enroll from the Medicare program, the overall growth trend has not been greatly affected.

Medicare pays a set monthly amount, or capitated amount, to managed care plans for each beneficiary enrolled. Managed care plans have been attractive to beneficiaries because they generally cover more services and have fewer out of pocket costs than fee-for-service.

MEDICARE SPENDING GROWTH

Under current law, Medicare benefit outlays are projected to increase from $236.6 billion in FY 2000 to $296 billion in FY 2004. The program is expected to grow at 5.8 percent per year during this period. Part A benefit outlays are projected to grow from $136.1 billion in FY 2000 to $170.4 billion in FY 2004, also at an average annual growth rate of 5.8 percent. Part B benefit outlays will grow from $100.5 billion in FY 2000 to $125.6 billion in FY 2004. The Part B average annual growth rate during the projection period is 5.7 percent.

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM (HCFAC)

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes the HCFAC Program to combat health care fraud, waste, and abuse. Included within this overarching program is the Medicare Integrity Program (MIP) and the HCFAC Account. Through the efforts of HCFA and its partners, these programs return multiple dollars to the Medicare Trust Funds for each dollar spent fighting fraud, waste, and abuse. HIPAA established a stable and reliable funding source for these efforts and the Secretary's Operation Restore Trust (ORT) initiative has guided the Departments efforts. Following a successful demonstration phase, the ORT initiative has gone nationwide and MIP and HCFAC Account spending have been at the heart of this new effort.

The Medicare Integrity Program was established from the Medicare payment safeguard program under HCFA's discretionary Program Management budget. The base of the program consists of activities such as financial audits of provider cost reports, medical and utilization reviews, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are also earmarked to support efforts in detecting and investigating program fraud and abuse. HCFA will also fund provider education and training activities associated with anti-fraud activities and audits of managed care plans.

In FY 2000, HIPAA authorizes $630 million for MIP, a $70 million increase over FY 1999. Within this level, HCFA will continue its policy of funding activities that will stop unnecessary payments before they leave the trust funds through pre-payment review and provider education. These actions should help lower the payment error rate cited in recent Chief Financial Officer's reports.

The Medicare Hospital Insurance Trust Fund also funds the HCFAC Account. This Account funds much of the health care investigational and prosecutorial activities of the HHS Office of Inspector General and the Department of Justice. The HCFAC Account will increase $20 million in FY 2000 over FY 1999 to $158 million.

PEER REVIEW ORGANIZATIONS

Peer Review Organizations (PROs) were established in Title IX of the Social Security Act, Part B, to serve the following functions:

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

Currently, HCFA is negotiating the sixth round of contracts with PROs. The latest contracts will focus on National Health Improvement Initiatives, a program to prevent payment errors, and the continued maintenance of the Clinical Data Abstraction Centers.

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	1998	1999	2000	+/-
Beneficiaries Enrolled (in Millions):				
Hospital Insurance (HI)	38.6	39.0	39.4	0.4
Supplementary Medical Insurance (SMI)	36.6	36.9	37.2	0.3

(Dollars in millions) /1

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Current Law:				
HI Benefits	$134,320	$130,990	$136,116	+$5,126
SMI Benefits	75,782	91,012	100,521	+$9,509
Subtotal, Medicare Benefits	**$210,102**	**$222,002**	**$236,637**	**+$14,635**
Administration /2	$2,587	$2,998	$3,118	+$120
HCFAC /3 (including Medicare Integrity Program)	522	760	744	-$16
Peer Review Organizations (PROs)	222	368	295	-$73
Transfers to Medicaid	0	60	90	+$30
Total Outlays, Current Law	**$213,433**	**$226,188**	**$240,884**	**+$14,696**
Premiums	20,751	21,299	22,969	1,670
Total Net Outlays, Current Law	**$192,682**	**$204,889**	**$217,915**	**+$13,026**
Proposed Legislation::				
Medicare Benefits	$0	$0	-$1,243	-$1,243
Proposed User Fees	0	0	-194	-$194
Premiums	0	0	0	$0
Total Medicare Savings	**$0**	**$0**	**-$1,437**	**-$1,437**
Total, Net Outlays, Proposed Law	**+$192,682**	**+$204,889**	**+$216,478**	**+$11,589**

/ 1 Numbers may not add due to rounding.
/ 2 Includes Administration payments to SSA and other non-HCFA agencies.
/ 3 Health Care Fraud and Abuse Control, includes FBI, excludes OIG.

MEDICAID

SUMMARY

Medicaid is a jointly funded Federal-State program that provides medical assistance to certain groups of low-income people and others with special health care needs. In FY 2000, it will cover approximately 33.8 million individuals including children, the aged, blind, and/or disabled and people who are eligible to receive federally-assisted income maintenance payments. Under current law, the Federal share of Medicaid outlays is expected to be about $115 billion in FY 2000. This is a $6 billion (6 percent) increase over projected FY 1999 spending.

LEGISLATIVE PROPOSALS

There are approximately 11.5 million uninsured children under age 18 in the country, of whom approximately 4 million are eligible for Medicaid, but not enrolled. Millions of other children are eligible for health care under Children's Health Insurance Program (CHIP).

States will be given the option to extend coverage for certain groups, such as older foster children and immigrants who lost coverage due to welfare reform. They will also be given more flexibility to use administrative funds that were made available to States at enhanced match under the welfare reform law to identify people who are eligible for, but not enrolled in, Medicaid and CHIP. These proposals are expected to increase Federal spending by about $1 billion over five years.

In FY 2000, the budget includes $50 million in grants to States to retrain providers in asthma management techniques.

Over five years, the budget proposes to improve choices in long-term care options and to assist the disabled in returning to work.

The FY 2000 budget also contains Medicaid proposals that will save the Federal government $1.3 billion (net) over the next five years. This reduction reflects $1.2 billion in savings from changes in administrative cost allocation (net of Medicaid savings and related TANF increases) combined with $125 million in savings from changes in drug reimbursement laws. These savings proposals partially offset the new spending proposals.

INCREASE AND EXPAND THE USE OF THE OUTREACH FUND:

Permit States to expand the use of a special $500 million Medicaid fund (authorized by the welfare reform statute) now aimed at outreach for children losing welfare, to fund outreach to other children eligible for Medicaid and to new children eligible for CHIP. This proposal would also remove the 2000 sunset.

EXTENDED COVERAGE FOR CHILDREN FORMERLY IN FOSTER CARE:

Permit States to extend Medicaid coverage to low-income children up to age 21 who were in foster care but who left that system at age 18. This vulnerable population would be assured of access to health care under Medicaid as they continue to prepare for adulthood.

HEALTH CARE FOR PREGNANT IMMIGRANTS:

Give States the option to extend Medicaid to pregnant qualified aliens who entered the country after August 22, 1996. Coverage would be identical to that provided to other pregnant Medicaid beneficiaries. This proposal ensures that the children to whom these women give birth, who will be

U.S. citizens, will get the best possible start in life.

MEDICAID FOR IMMIGRANTS WITH RESTORED SSI:

Restore SSI for qualified aliens, regardless of age, who entered the country after August 22, 1996, who become disabled at any time after they entered, and who have been here at least five years. Under current law, these individuals are barred from SSI under restrictions imposed by the welfare reform law enacted in 1996. In most States, restoring SSI would mean restoring Medicaid because their eligibility was based on receipt of SSI.

STATE OPTION TO COVER LEGAL IMMIGRANT CHILDREN UNDER MEDICAID AND/OR CHIP:

Give States the option to extend Medicaid and Children's Health Insurance Program (CHIP) coverage to qualified alien children who entered the country after August 22, 1996. These children lost eligibility for Medicaid coverage due to changes in Federal law under welfare reform.

SIMPLIFYING TRANSITIONAL MEDICAID

This budget proposes to simplify and improve transitional Medicaid programs to help the working poor whose income makes them ineligible for the traditional Medicaid program. By eliminating burdensome reporting requirements this proposal would help beneficiaries retain temporary health insurance through Medicaid until they can afford private health insurance.

ASTHMA DISEASE MANAGEMENT INITIATIVE:

Gives States incentives to train providers in effective disease management techniques. This proposal would provide $50 million, on a competitive basis, to selected State Medicaid programs to test and evaluate the effectiveness of innovative disease management approaches to identify and treat pediatric asthma. These efforts are intended to provide an incentive for more effective use of ongoing Medicaid funds for outreach, case management, and treatment benefits to reduce costly asthma-related medical crises (such as emergency room visits and hospital stays) and to improve quality of life (such as school attendance) for children with asthma and their families.

MEDICAID BUY-IN FOR WORKING DISABLED (JEFFORDS/KENNEDY):

Provides incentives under both Medicaid and Medicare for persons with disabilities to work without losing their health care coverage. In Medicaid, it builds on the current option created by the Balanced Budget Act of 1997 (BBA). Under the current option, States may expand Medicaid eligibility to workers with disabilities with earned income up to 250 percent of poverty, and they may require these individuals to pay a State-established premium to qualify. The proposal expands this Medicaid buy-in option in two ways: by allowing States to cover people with disabilities with earned income above 250 percent of poverty, and by lifting or relaxing current limits on assets and on unearned income.

Three hundred million dollars over 5 years will be allocated for a demonstration program that will allow participating States to provide Medicaid to individuals with health conditions that can reasonably be expected to develop to a level of severity that would qualify them for SSI or SSDI in the future.

One hundred fifty million dollars over 5 years will be made available to States to take advantage of one or both of the new eligibility options. These new grant funds can be used by States to: develop infrastructures to support individuals with disabilities so they can work; build capacity to provide home and community-based services to people of all ages with

disabilities; help transition current nursing home residents to the community if they so choose and can do so safely; and for outreach campaigns to connect individuals with disabilities to services.

PERMIT HIGHER INCOME ELIGIBILITY STANDARD FOR PEOPLE NEEDING INSTITUTIONAL LEVEL OF CARE:

States would have the option to extend Medicaid to individuals with incomes up to 300 percent of SSI ($1500 per month in 1999) if the State determines them to need an institutional level of care and if they receive services under the plan. States would be permitted to target this eligibility option to individuals receiving specific kinds of long-term care services, for example, personal care services. Under current law, an individual may only qualify for Medicaid under the higher income level if they enter a nursing home or if they are served under a State's home and community-based waiver program for long-term care. This proposal allows for equity between settings, and ensures that individuals have a real choice and are not, in effect, forced into entering a nursing home.

INCREASE BBA DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA:

This proposal provides for a one year increase of $9 million to the DSH cap for the District in FY 2000. This is the cost of recalculating the FFP for the original base year number for DC ($23 million) to reflect the increase in FMAP for the District from 50 percent to 70 percent.

MEDICAID SAVINGS PROPOSALS

CHILD SUPPORT ENFORCEMENT:

See ACF Entitlement section for description.

REBATES FROM GENERIC DRUG MANUFACTURERS:

Currently, brand name drug manufacturers must pay an additional dollar-for-dollar rebate to the Medicaid program if they increase the price of their drugs in excess of increases in the consumer price index-urban (CPI-U). Generic drug manufacturers are not subject to this requirement in the drug rebate program because it was believed that generic drug prices would not rise faster than inflation. Recent price increases in generic drugs have demonstrated the need for the CPI-U adjustment for generic as well as brand name drugs.

COST ALLOCATION:

This proposal addresses projected Federal cost increases in the Medicaid program arising from changes in the way States charge costs to the Federal government to administer the Food Stamp, Medicaid, and Temporary Assistance for Needy Families (TANF) programs. Similar to the Agricultural Research bill passed last year, this legislation would direct the Secretary to reduce each State's Medicaid grant award by the amount of administrative costs charged to AFDC in each State's TANF base year that could have legitimately been charged to Medicaid. This proposal does not prevent States from using funds from their TANF block grants to cover the shortfall.

BACKGROUND

Medicaid is a voluntary program, initiated and administered by States. State expenditures for medical assistance are matched by the Federal government using a formula based on per capita income in each State relative to the national average. Matching rates for FY 2000 are projected to range from 50 to 77 percent for medical assistance payments. The Federal matching rate on average is approximately 57 percent.

Historically, most individuals' eligibility for Medicaid has been based on qualifying

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

Medicaid covers children under the age of six and pregnant women whose family income does not exceed 133 percent of the Federal poverty level. Medicaid coverage of children aged 6 through 18, born after September 30, 1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid.

In addition, Medicaid pays Medicare premiums and cost-sharing for Medicare for certain low-income seniors and disabled individuals.

Under BBA, two new Medicaid eligibility groups consisting of low-income Medicare beneficiaries were created, Qualified Individuals (QIs) 1 and 2. QI1s are Medicare beneficiaries with incomes from 120 to 135 percent of the poverty level. This group is eligible for a full subsidy of their Part B premiums. QI2s are Medicare beneficiaries with incomes from at least 135 to 175 percent of the poverty level. This group is eligible for a partial subsidy of their Part B premiums.

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

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. In FY 1997, Medicaid growth was 3.9 percent. In FY 1998, Medicaid growth was 5.9 percent. These are the lowest growth rates since the early 1980s. The decline in the rate of Medicaid increases is due to many factors, including legislative changes (such as limits on provider specific taxes and donations), decreases in the projected growth of SSI caseloads, higher employment, and State efforts to control costs.

WAIVER ACTIVITY

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates and certification standards, and developing alternative health care delivery programs. In addition, waivers of various portions of Federal law are also available to States.

Numerous States have restructured eligibility and coverage under Medicaid through the use of Section 1115 demonstration waivers. A number of States are using Section 1115 waivers to reform health care by expanding coverage without

increasing the amount the Federal government would spend otherwise. Since 1993, this Administration has approved 18 Section 1115 demonstrations in Arkansas, Delaware, Florida, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee and Vermont, and has committed to working cooperatively with additional States to support innovative ideas. When fully implemented, these waivers will extend health care coverage to approximately 1.1 million Americans who were previously not covered by Medicaid.

CHANGES IN MEDICAID DUE TO THE BALANCED BUDGET ACT

The BBA of 1997 required HCFA to make sweeping changes in the Medicaid program. Among the changes to the program were:

DSH REDUCTIONS:

The BBA reduced the amount of money available to States for Disproportionate Share Hospital (DSH) allotments. Additionally, the Federal funds available for funding Institutions for Mental Diseases (IMD) through the DSH program have been limited.

MEDICARE PART B TRANSFER:

This provision established capped allotments to States for five years to pay the Medicare Part B premiums for certain low-income Medicare beneficiaries. There is currently an Administrative effort to inform and educate Medicare beneficiaries of these new coverage options

STREAMLINED ELIGIBILITY:

- Allow qualified entities to determine a child to be presumptively eligible for Medicaid based on preliminary data.
- States have the option to make children continuously eligible for Medicaid for a year, regardless of changes in family income.

MANAGED CARE:

For most eligibles, States may mandate enrollment in managed care systems without going through the Federal waiver process. The implementing regulation for this provision includes many patient protections called for in the President's Patient Bill of Rights.

MEDICAID OVERVIEW

(average enrollees in thousands)

	1998	1999	2000
Enrollment:			
Aged 65 and Over	4,200	4,300	4,300
Blind and Disabled	6,400	6,500	6,700
Needy Adults	6,200	6,200	6,300
Needy Children	16,100	16,200	16,500
Total	**32,900**	**33,200**	**33,800**

(outlays in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Current Law				
Benefits \1	$96,409	$102,793	$108,803	+$6,009
State Administration	4,825	5,740	6,018	+$278
Total Net Outlays, Current Law \2	**$101,234**	**$108,534**	**$114,821**	**+$6,287**
Proposed Legislation:				
Savings	0	0	-310	-310
Costs	0	0	149	+149
Subtotal, Proposed Legislation	**$0**	**$0**	**-$161**	**-$161**
Total Net Outlays, Proposed Law \3	**$101,234**	**$108,534**	**$114,660**	**+$6,126**

/1 Includes Vaccine for Children Outlays.

/2 Starting in FY 2000, these numbers do not include the Medicaid outlays associated with CHIP.

/3 Numbers may not add due to rounding.

CHILDREN'S HEALTH INSURANCE PROGRAM

SUMMARY

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This program makes an unprecedented investment in improving the quality of life for millions of vulnerable children. From 2000 to 2004, HHS will make $18 billion available to States to purchase meaningful health care coverage for millions of low-income, uninsured children. Today, there are an estimated 11 million children—one in seven— who are uninsured. The majority of these children live in families that earn too much to qualify for Medicaid, but not enough to purchase private insurance. Title XXI targets these children and helps them obtain health insurance.

IMPLEMENTATION STATUS

HHS has been working closely with States to help promote understanding of the new law. HHS has published guidance on CHIP to help States develop and implement their Title XXI plans. The Department has sponsored nine regional conferences to help inform States of all of the options available to help cover children under Title XXI.

As of January 1999, 50 plans had approved CHIP plans and were implementing their programs. Additionally, 18 plan amendments to previously approved plans have been submitted. So far, 8 have been approved.

Outreach to ensure that as many eligible children as possible are enrolled in CHIP continues to be a priority. In February 1998, the President issued an Executive Memorandum to Federal agencies requesting a nationwide outreach effort. A Federal Interagency Taskforce, comprised of more than 10 Federal agencies, has been convened to develop strategies and implement comprehensive outreach programs.

LEGISLATIVE PROPOSALS

AID FOR THE TERRITORIES:

In FY 2000, the budget proposes an increase of $34 million under CHIP for Puerto Rico and the other four territories, fulfilling the President's promise to, provide more equitable funding for children's health care in the insular areas.

OUTREACH FUNDING:

The FY 2000 budget proposes to allow states to use up to 3 percent of their CHIP benefit spending amount for outreach activities and removes outreach expenditures from the 10 percent administrative cap under CHIP. This proposal makes funds available to States for outreach in FY 2001-2003.

CHIP FOR THE TERRITORIES OF AMERICAN SAMOA AND THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS (CNMI):

This proposal would grant to American Samoa and CNMI relief from some Title XXI requirements that are inconsistent with their existing Medicaid programs. The increase in these territories' flexibility will enable them to use CHIP and expand health insurance coverage to eligible children.

BACKGROUND

The Children's Health Insurance Program is a voluntary program carried out by the States. States have a high degree of flexibility in designing their programs. They can implement CHIP by either: 1) creating a new, non-Medicaid Title XXI separate State program, 2) expanding Medicaid, or 3) developing a combination of both

approaches. Generally, uninsured children in families at or below 200 percent of the poverty level who are not eligible for Medicaid are eligible for CHIP.

Under the new program, States have flexibility in choosing what benefits to provide children. Benefits under Title XXI State programs must be identical to a "benchmark plan," or the benefits must be actuarially-equivalent to a benchmark plan within certain parameters. Benchmark plans include: the Federal Employees Health Benefits Package standard Blue Cross/Blue Shield preferred provider option, a widely available State employee plan, or the HMO coverage plan with the largest commercial enrollment in the State. Medicaid expansions under Title XXI must provide the Medicaid package. Finally, cost-sharing for participating children under Title XXI is allowed, but limited.

States receive Federal reimbursement for expenditures under Title XXI based on an enhanced Medicaid matching rate which ranges from 65 to 85 percent.

State allotments are capped and are based on a formula described within the CHIP statute. States must have an approved child health plan by the end of the FY 1999 to receive their FY 1998 and FY 1999 allotment.

States must take steps to ensure that Title XXI funds are not used to cover children who would otherwise receive employer-sponsored insurance or Medicaid. The statute includes several provisions aimed at preventing such substitution.

CHILDREN'S HEALTH INSURANCE PROGRAM

OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Total Outlays3, Current Law	**$5**	**$1,437**	**$1,900**	**+$463**
Proposed Legislation::				
Child Health Costs.....	$0	$0	$36	**+$36**
Total Outlays,.....	**$5**	**$1,437**	**$1,936**	**+$499**

/1 Numbers may not add due to rounding

/2 Since Child Health is appropriated through 2007 in the enacting legislation, the total outlays request under current law for Child Health represent an estimate of program spending in 1999

/3 Because States have the option to expand children's health insurance coverage through a State grant program, Medicaid, or a combination of the two, outlays are split between the Children's Health Insurance Program and Medicaid

PROGRAM MANAGEMENT

SUMMARY

HCFA's FY 2000 Program Management appropriation request is $2,016.1 million, a $69 million increase over the FY 1999 appropriation. This appropriation level does not include $150 million for millennium compliance activities funded separately through Public Health and Social Services Emergency Fund (PHSSEF).

The Budget also includes proposed user fees totaling $194.5 million. The enactment of these user fees would offset the appropriation by the amount of the proposal. To facilitate this process, the Administration has included "trigger" language in the Budget. If a fee is enacted, the appropriation would be reduced automatically by the amount of the new fees expected. If the user fees are enacted, HCFA's budget authority request would be $1,822 million.

The Program Management account provides resources for administering the Medicare, Medicaid, and Children's Health Insurance Program, as well as enforcing State insurance requirements. The Program Management account provides the staff and resources necessary to administer these programs, totaling $347 billion. HCFA implements statutory changes and coordinates the work of contractors, State agencies, and the provider and beneficiary communities to ensure the smooth operation of these programs. HCFA also safeguards the integrity of the Medicare Trust Funds and the General Fund.

While workloads have continued to increase every year, the Program Management budget decreased in constant dollars by 11 percent from FY 1994 to FY 1998. This required HCFA to find more cost effective methods to accomplish its mission and goals as established in its strategic plan. This has been especially difficult since the responsibilities of the agency were greatly expanded in that same time period. With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA), HCFA must now implement a number of new programs, such as the Children's Health Insurance Program, new managed care options, and enforcement of State insurance requirements under HIPAA. In the FY 1999 appropriation, Congress provided HCFA its total requested level of Program Management funding as well as an additional $4 million for the new Nursing Home Initiative and the opportunity to augment HCFA's Y2K compliance efforts. These additional resources have facilitated improved program management.

MILLENNIUM COMPLIANCE

The HHS FY 2000 budget request includes $150 million for HCFA millennium compliance, funded separately as part of the Public Health and Social Services Emergency Fund (PHSSEF). The $150 million from the PHSSEF will be used to continue renovation and testing of non-mission critical systems, convert temporary coding solutions to permanent coding solutions, continue outreach efforts to the provider community and the States, and continue contingency planning.

NURSING HOME QUALITY INITIATIVE

The Department's FY 2000 budget includes a total of $60.1 million in discretionary and mandatory resources to implement the President's Nursing Home Initiative announced last July, including money for HCFA, the Office of the General Counsel, and Departmental Appeals Board. In FY 1999, HHS began to phase-in key provisions of the initiative, such as: strengthening the definition of a poor

performing nursing home, conducting more frequent surveys of repeat offenders, staggering survey start-times, and performing focused survey reviews of nursing home efforts to reduce the incidence of bed sores, malnutrition, and dehydration. The FY 2000 request will allow HCFA and other components of the Department to fully implement all provisions of the initiative.

The majority of the $60.1 million for the initiative --$50.6 million-- resides in HCFA's budget request. This includes $35 million in discretionary program management funds to: strengthen State surveyor inspection and enforcement efforts, establish a national patient abuse registry, and improve Federal oversight of State surveyor efforts. HCFA's budget also includes $15.6 million in mandatory Medicaid funds to supplement State inspection and enforcement activities in dually-certified and Medicaid-only nursing homes.

The remaining $9.5 million will ensure adequate legal resources for the Office of the General Counsel and Departmental Appeals Board to provide judicial hearings and handle administrative and court litigation in a timely manner.

NURSING HOME INITIATIVE	**FY 2000**
Funding Source	*millions*
HCFA:	
Discretionary	
Medicare Survey and Certification.....	18.1
Federal Administration.....	16.9
Mandatory	
Medicaid Survey and Certification.....	15.6
Subtotal, HCFA.....	$50.6
Departmental Management:	
Discretionary	
Office of the General Counsel.....	6.7
Departmental Appeals Board.....	2.8
Subtotal, Departmental Managemen	$9.5
Total, Nursing Home Initiative.....	**$60.1**

HCFA MANAGEMENT REFORM

HCFA, in cooperation with the Department of Health and Human Services (DHHS) and the Office of Management and Budget (OMB), has begun the development of a management reform initiative that will increase HCFA's flexibility to operate as a prudent purchaser of high quality health care services while also increasing accountability. This initiative follows upon HCFA's recent reorganization and includes components that would increase program and management flexibility and increase accountability to constituencies.

HCFA's vital core functions– modernizing Medicare, detecting fraud and abuse, providing beneficiary and provider education, implementing legislative changes, processing claims, providing increased beneficiary choices, and managing Federal/State Medicaid and CHIP programs –continue to expand. To meet these expanding challenges, it is necessary to move toward a stable and reliable funding source for HCFA Program Management activities. As HCFA and HHS achieve reform and accomplish some of the objectives noted above, the Administration will consider legislative proposals to increase the stability of HCFA's funding.

IMPLEMENTING THE BALANCED BUDGET ACT OF 1997 (BBA) AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HCFA has fully implemented more than half of the 335 individual BBA provisions affecting HCFA programs and made substantial progress on many of the remaining provisions. While working on the BBA, HCFA is simultaneously meeting the Year 2000 computer challenge. As recommended by independent consultants, HCFA has made the difficult choice to postpone a few BBA provisions that would have jeopardized HCFA's Y2K activity.

In FY 2000, HCFA will continue to work on the development of new payment methods, including prospective payment for home health agencies, inpatient rehabilitation facilities, and outpatient hospital care, and risk adjustment for Medicare+Choice plans. HCFA will also launch the new competitive bidding demonstration for durable medical equipment. The President's budget also includes a request to increase the authorization of the Medicare+Choice information campaign by an additional $50 million to $150 million. HCFA's plans to educate beneficiaries about their choices include national distribution of a new Medicare handbook and holding local health information fairs to assist beneficiaries during the November 1999 open enrollment season.

HCFA will also implement a number of HIPAA activities in FY 2000. HCFA will continue its work in developing industry-wide standards for certain administrative and financial health care transactions outlined in HIPAA's administrative simplification provisions. HCFA is also charged with overseeing and, in cases where States do not implement insurance protections, enforcing insurance reform provisions. The FY 2000 request provides funding for these activities.

INFORMATION TECHNOLOGY

HCFA is developing a new architecture for its information technology needs and a capital assets plan to guide its systems formation.

Meanwhile, HCFA must improve its information technology capabilities in FY 2000 to support BBA and HIPAA activities. The agency must improve system security, redesign its managed care system to support the new Medicare + Choice program, and collect encounter data from managed care plans as required by the BBA.

MEDICARE CONTRACTORS

By law, the Medicare program is administered through private organizations that are referred to as contractors. Contractors' responsibilities include processing claims and making benefit payments, performing certain functions to ensure the appropriateness of Medicare payments and to protect the Medicare Trust Funds, developing management improvements called productivity investments, and responding to the needs of its many customers and stakeholders, Medicare beneficiaries, and the provider community.

The Medicare Contractor program level budget will increase $4 million, from $1,270 million in FY 1999 to $1,274 million in FY 2000. The three key contractor activities are claims processing, beneficiary and provider services, and productivity investments.

The FY 2000 contractor budget also proposes $93 million in user fees allowing the Secretary to: assess a $1 fee on any claim not submitted electronically, assess a fee for duplicate or unprocessable claims submitted by providers, and charge providers and suppliers a fee to cover the costs of initially enrolling and renewing enrollment in the Medicare program.

Approximately 64 percent of the FY 2000 contractor program level request, or $809 million, has been designated for claims processing, an 8 percent decrease from FY 1999. Over the last eight years, HCFA's success in controlling processing costs has resulted in reduced unit costs of processing claims, allowing the agency to process an expected 925 million claims in FY 2000 within statutorily limited processing times. This workload level represents a 1.1 percent decrease over FY 2000 estimates and is attributable to beneficiaries taking advantage of Medicare + Choice options offered under BBA. HCFA anticipates that increased managed care enrollment will

continue to slow the growth in claims and billings.

Beneficiary and provider services comprise 23 percent of the Medicare Contractors FY 2000 program level request, or $294 million. This amount will maintain funding for the Medicare beneficiary toll-free telephone lines, timely hearings and reconsiderations, prompt responses to provider and beneficiary inquiries, provider education and training, and Medicare participating physicians activities. HCFA will continue its innovative use of audio response units (ARUs) for telephone inquiries, as well as continuing its use of the telephone to conduct hearing reviews and reconsiderations. These activities demonstrate HCFA's efforts toward more cost-effective management and a greater commitment to providing better customer service. With increased activity in the area of fraud and abuse, HCFA expects activity in beneficiary communications and in hearings and appeals will also increase sharply.

The budget request allocates $104 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. Productivity investment costs include expanding the new customer-oriented toll-free system, greater standardization of contractor systems, and redesigning the managed care processing system. Also within productivity investments are the non-renewal costs associated with contractors who leave the program.

FEDERAL ADMINISTRATION

For FY 2000, the President's budget requests $482.5 million for HCFA's Federal administrative costs. This is an increase of $26.7 million over the FY 1999 budget. This request supports a staffing level of 4,282 FTE, an increase of 15 FTE over 1999 levels. This total includes 50 FTE dedicated to Y2K activities. Funding for the Y2K FTE will come from the Public Health and Social Services Emergency Fund. The funding level will also support the extensive data processing requirements for the Medicare and Medicaid programs, as well as necessary maintenance and enhancement of HCFA's many automated data systems.

Also included in the FY 2000 Federal administration budget is a $36.7 million user fee authorizing the Secretary to collect initial registration and annual renewal fees from Medicare+Choice managed care plans. With this funding level, HCFA will carry out its many new HIPAA and BBA activities. An increasing number of States have chosen not to perform all or part of their insurance enforcement duties under HIPAA.

Under HIPAA, HCFA is responsible for performing these duties on behalf of the States within its discretionary administrative budget. Similarly, Federal Administration dollars must fund new BBA activities such as reviewing new managed care plans under Medicare+Choice as well as administering the Children's Health Insurance Program. The President's budget also includes $16.9 million in new resources for the Nursing Home Quality Initiative, $10 million to establish a national patient abuse registry and $6.9 million to improve Federal oversight of State surveyor efforts.

RESEARCH, DEMONSTRATIONS AND EVALUATION

The FY 2000 budget requests $55.0 million for the Research, Demonstrations and Evaluation program, which is $5 million more then the enacted level in FY 1999. HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and our other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States

to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and CHIP programs.

Basic research funds will also be used to support Departmental themes including, Supporting Long-Term Care through the study of Medicaid waivers for home and community-based care, Protecting Vulnerable Populations by designing a study to look at barriers to care among vulnerable populations, and Working for our Nations Children by developing data sets to track the effects of welfare reform and the Children's Health Insurance Program.

In addition to basic research, this budget fully funds the Medicare Current Beneficiary Survey, which has recently been expanded to include Medicare+Choice beneficiaries. Finally, the budget includes $12 million for research activities associated with the Balanced Budget Act of 1997.

SURVEY AND CERTIFICATION

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries to ensure compliance with Federal health, safety, and program standards.

HCFA's FY 2000 budget proposes $204.3 million to fund its survey and certification activities, a 19.5 percent increase over the FY 1999 appropriated level. Included in this total is $18.1 million to implement key portions of the President's Nursing Home Initiative announced last July. With this money, HCFA will eliminate the grace period for nursing homes found guilty of a second offense that causes actual harm to residents; conduct more frequent inspections of nursing homes with repeat violations; and conduct more focused reviews of a nursing home's ability to prevent bed sores, dehydration, and malnutrition during the annual survey process.

The FY 2000 budget also proposes two survey and certification user fees totaling $65 million. Under these proposals, the Secretary or States would be allowed to charge user fees to cover the full cost of facilities' initial surveys ($10 million) and 33 percent of the costs for recertification surveys ($55 million) in FY 2000. The latter proposal will eventually result in 100 percent user fee recovery by FY 2002.

Another $179.1 million of the total survey and certification request will fund direct survey activities, such as: annual inspections of nursing homes and the continued 36-month recertification cycle for home health agencies, as required by law; and a 15 percent recertification cycle for non-long-term care facilities (e.g., ESRD facilities, hospices, rural health clinics, and ambulatory surgical centers).

The remaining $7.0 million in the FY 2000 survey and certification request will fund base support contract activities, most notably the development of the Quality Improvement and Evaluation System (QIES). QIES is an information system containing quality outcome data that surveyors can use to better target on-site inspections of poor performing providers.

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The President's FY 2000 Budget includes a number of user fees as well as a contracting reform package to assist HCFA in entering the 21st Century as a more efficient and cost effective organization.

PAPER CLAIM USER FEE:

Allows the Secretary to assess a $1 fee on any claim not submitted electronically. This fee could be waived at the discretion of the Secretary due to compelling circumstances. Due to Y2K activities, this

user fee could not be instituted prior to the second half of the fiscal year ($55 million).

DUPLICATE CLAIM USER FEE:

Allows the Secretary to assess a fee for duplicate or unprocessable claims submitted by providers. Due to Y2K activities, this user fee could not be instituted prior to the second half of the fiscal year ($17.8 million).

PROVIDER REGISTRATION FEE:

Authorizes the Secretary to collect fees from providers and suppliers (not managed care plans) to cover the costs associated with initial registrations and subsequent renewals to the Medicare program ($20 million).

MEDICARE+CHOICE ORGANIZATION USER FEE:

Authorizes the Secretary to collect fees from Medicare+Choices managed care plans to cover the costs associated with initial registrations and annual renewals to the Medicare program ($36.7 million).

SURVEY AND CERTIFICATION USER FEES:

Authorizes the Secretary to impose or require the State to impose a user fee for initial certification surveys and for recertification surveys. The initial survey user fee will cover the total cost of the survey, starting in FY 2000 ($10 million). The recertification survey fee will only cover 33 percent of costs in FY 2000, but will increase to cover 66 percent of costs in FY 2001, and 100 percent of costs by FY 2002 ($55 million).

CONTRACTING REFORM:

These provisions give the Secretary of Health and Human Services increased flexibility in contracting for claims processing, payment, and other Medicare intermediary and carrier functions. The provision brings the Medicare contracting authority into closer alignment with the general government contracting rules contained in the Federal Acquisition Regulation (FAR), while preserving certain essential flexibility in the awarding and renewal of contracts currently available to the Secretary under Medicare law.

MANDATORY LEGISLATIVE PROPOSALS

CANCER CLINICAL TRIALS

In addition, the Administration is proposing new mandatory legislation permitting payment for the care of beneficiaries participating in cancer clinical trials as part of a three-year demonstration.

This demonstration will provide information on the cost of coverage of the cancer clinical trials while affording access to cutting edge experimental treatment. Beginning in FY 2001, $750 million would be provided for this demonstration.

NURSING HOME INITIATIVE

The Administration plans to submit legislation to Congress requiring nursing homes to conduct criminal background checks of employees and establishing a national registry of nursing home workers found to have abused residents. The cost to conduct background checks and to query the national registry will be financed through user fees.

HCFA will also seek legislation to allow more types of nursing home employees, with proper training, to perform crucial nutrition and hydration functions.

SURVEY AND CERTIFICATION

A recent HCFA study found that survey unit costs vary widely across States and that no clear set of factors can explain this variation. The study recommended further investigation into what may account for these variations. HCFA recognizes this problem and plans to submit a legislative proposal this year to correct it, working in

consultation with our partners in the States, regional offices, and provider community.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

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

The CLIA program is fully operational, with about 160,500 laboratories registered with HCFA; about 28 percent of the laboratories are subject to routine inspection (every 2 years) under the program. Workloads for each inspection period include a three percent sample review of the 17,800 accredited laboratories, and surveys of 29,000 non-accredited laboratories.

NATIONAL MEDICARE EDUCATION PROGRAM

In the 2000 budget, HCFA will continue to fund activities that will help beneficiaries understand and assess their options under the Medicare+Choice program.

The National Medicare Education Program (NMEP) will fund activities to inform beneficiaries of their options – including traditional Medicare, HMOs, and PPOs – and provide complete and comprehensible information about these options to facilitate their decision-making process. The Budget provides an additional $50 million to improve and expand the NMEP.

In FY 2000, the NMEP will fund the following activities: mailings to beneficiaries with generic information about Medicare, plus specific information on plans available in their area; a toll-free telephone service available to all beneficiaries staffed by customer service representatives able to provide information on available plans; www.medicare.gov, the user-friendly internet site that provides comparative information on plans by zip-code; as well as other initiatives involving State and local entities.

PROGRAM MANAGEMENT OVERVIEW

Program Management – discretionary
(dollars in millions)

	FY 1998 Approp.	FY 1999 Enacted	FY 2000 Request	Request +/- Enacted
Medicare Contractors	$1,216	$1,270	$1,274	$4
Survey and Certification	154	171	204	33
Federal Administration	367	456	483	27
Research	52	50	55	5
HCFA Discretionary Budget Authority	**$1,789**	**$1,947**	**$2,016**	**$69**
CLIA	43	43	43	-
Sale of Data/FQHMO applications	-	2	2	-
Medicare + Choice Information	95	95	100	5
Subtotal	**1,927**	**2,087**	**2,161**	**74**
Medicare + Choice Information Proposed Increase	-	-	50	50
CLIA User Fees -- Current Law	-43	-43	-43	0
Sale of Data/FQHMO applications -- Current Law	0	-2	-2	0
Managed Care User Fees -- Current Law	-95	-95	-100	-5
Proposed User Fees	0	0	-244	-244
Proposed BA (including New User Fees)	**$1,789**	**$1,947**	**$1,822**	**-$125**
Proposed Outlays	**$1,789**	**$1,947**	**$1,822**	**-$125**
FTE /1	3,942	4,267	4,282	15

/1 In FY 2000, 50 FTEs are being paid out of the $150 million for the Y2K compliance effort funded out of the Public Health and Social Services Emergency Fund (PHSSEF).

Program Management – Mandatory
(obligations in millions \1)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Clinical Trials	0	0	10	+10
Total	**$0**	**$0**	**$10**	**+$10**

/1 Numbers may not add due to rounding

HCFA SUMMARY

(dollars in millions) /1

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Current Law:				
Medicare Trust Fund	$213,433	$226,188	$240,884	+14,696
Medicaid	101,234	108,534	114,821	+6,287
CHIP	5	1,437	1,900	+463
Total Outlays, Current Law	**+$314,672**	**+$336,159**	**+$357,605**	**+21,446**
Premiums	-$20,751	-$21,299	-$22,969	-1,670
Total Net Outlays, Current Law	**+$293,921**	**+$314,860**	**+$334,636**	**+$19,776**
Proposed Law:				
Medicare	$0	$0	-$1,243	-$1,243
Medicaid	0	0	-161	-161
CHIP	0	0	36	+36
User Fees	0	0	-194	-194
Total	0	0	-1562	-1,562
Total Net Outlays, Proposed Law /2	**$293,921**	**$314,860**	**$333,074**	**$18,214**

/1 Numbers may not add due to rounding

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

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority:				
Discretionary	$8,354	$8,673	$9,432	+$759
Entitlement	$28,227	$29,027	$28,627	-$400
Total	$36,581	$37,700	$38,059	+$359
Outlays:				
Discretionary	$7,919	$8,478	$8,995	+$517
Entitlement	$24,670	$25,412	$28,954	+$3,542
Total	$32,589	$33,890	$37,949	+$4,059

SUMMARY

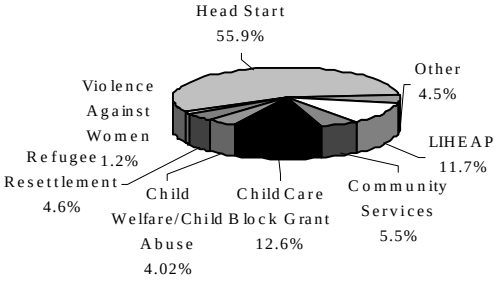
The FY 2000 budget request for the Administration for Children and Families (ACF) totals $38 billion, of which $9.4 billion is discretionary dollars and $28.6 billion is entitlement budget authority. The Administration for Children and Families is the Department's lead agency for programs that promote the economic and social well-being of families, children, individuals, and communities. Its programs, including Head Start, family violence, child care, child support, foster care and adoption, and Temporary Assistance for Needy Families (TANF), are at the heart of the Federal effort to strengthen families and give all children a chance to succeed. In addition, ACF has responsibility for a range of social services and income assistance programs which support low-income families across the country.

ACF has worked, over a number of years, toward overhauling the nation's welfare system, which culminated in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). ACF is responsible for the implementation of this legislation including responsibility for administering the Temporary Assistance for Needy Families, Child Support Enforcement, and child care programs.

DISCRETIONARY PROGRAM SUMMARY

The budget includes $9.4 billion for discretionary programs in FY 2000. Through a wide array of activities, ACF assists States and local communities in promoting opportunities for children and their families to grow, learn and thrive. By providing resources to States and community-based organizations, ACF helps to promote child development, meet the needs of the disabled, and support other special populations including refugees and Native Americans.

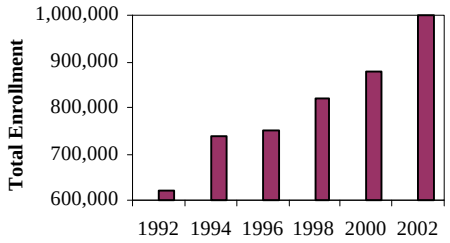
FY 2000 Discretionary Request $9.4 Billion



HEAD START

In FY 2000, the President's Budget is seeking $5.3 billion for Head Start to serve an additional 42,000 children. This request, an increase of $607 million over FY 1999, will provide a total of over 877,000 children and their families with a Head Start experience. Since 1993, enrollment in Head Start has grown by 17 percent, from 713,903 children in 1993 to 835,000 children in 1999. The President remains committed to reaching the goal of enrolling one million children in Head Start by 2002.

Moving Toward One Million Children in 2002



In 1998, the Head Start program was reauthorized. This bipartisan legislation strengthened America's premier early childhood development program and ensured that low-income children start school ready to learn. The law places emphasis on further improvements in program quality, authorizing funding for activities aimed at reducing class size; improving classroom facilities; enhancing staff training; improving school readiness; obtaining safer and better equipment, reducing staff turnover; and attracting and retaining well-trained staff members.

The reauthorization legislation has also reinforced our commitment to infants and toddlers by doubling the size of the Early Head Start program by FY 2002. Early Head Start funds in FY 2000 will exceed $420 million. Early Head Start was established in FY 1995 in recognition of the mounting evidence that the earliest years are the most important to children's growth and development. In FY 2000, these funds will support nearly 45,000 infants and toddlers and their families. Children and families enrolled in Early Head Start will receive early, continuous, intensive and comprehensive child development and family support services.

VIOLENCE AGAINST WOMEN

Violence against women is a serious problem in our society today affecting families all across the country. According to the DOJ/HHS *National Violence Against Women Survey*, 25 percent of surveyed women have been raped and/or physically assaulted by an intimate partner in their lifetime – an estimated 1.5 million women annually in the United States.

The President's Budget includes $119 million for ACF's Violence Against Women programs, including $102 million for the Grants for Battered Women's Shelters program. This is an increase of $14 million over FY 1999, and part of a broader Departmental initiative to curtail violence against women. These funds will enhance the services provided to women and their families, as well as change the social norms that permit violence against women to occur.

The Grants for Battered Women's Shelters program helps States and Tribes provide immediate shelter and related services to victims of abuse and their dependents as well as domestic violence awareness activities. These funds will be used to provide a total of 40,000 (*verifying number with ACF*) survivors of domestic violence and sexual assault with counseling, shelter, and other services. Also included is $1 million for the Domestic Violence Hotline and $15 million for the Sexual Abuse Prevention for Runaway, Homeless and Street Youth program.

These funds, an increase of $183 million over FY 1999, will support affordable, quality child care for low-income working parents. Of these funds, $173 million will support activities that improve the quality of child care. Ten million dollars will be set aside for research, demonstration and evaluation activities. Recently, ACF solicited input from over 500 experts in the child care field in shaping its child care research agenda.

These funds are part of an Administration initiative to help working families find safe and affordable child care. The FY 2000 budget includes $4.1 billion in mandatory child care funding. More on the child care initiative and the mandatory child care component can be found in the ACF entitlement section.

COMMUNITY SERVICES PROGRAMS

Community Services Block Grant:

The Community Services Block Grant program provides States, territories, and Indian Tribes with a flexible source of funding to help reduce poverty, including services to address employment, education, housing assistance, energy and health services. In FY 2000, $500 million is requested for the Block Grant.

The budget does not include funds for previously supported discretionary community services programs, i.e., Community Economic Development, Community Food and Nutrition, National Youth Sports, and Rural Community Facilities.

Individual Development Accounts:

The Assets for Independence Act of 1998 authorized funds for a new program to empower low-income individuals to save for a home, post-secondary education, or a new business, at a match rate ranging from $0.50 to $4.00 for every dollar saved. In FY 2000, $20 million is requested for an Individual Development Accounts demonstration, which is double the FY 1999 funding level. In FY 2000, 60 non-profit organizations will receive grants to administer an IDA demonstration, serving a total of 13,560 low-income individuals.

RUNAWAY AND HOMELESS YOUTH

The budget requests $64 million for the Runaway and Homeless Youth program. This program provides grants for the provision of outreach, temporary shelter, family reunification, drug education and prevention, and other services to runaway and homeless youth. An additional $5 million for the Transitional Living program will assist over 600 runaway and homeless youth, including youth from foster care, in making the transition to independent living. Transitional Living Programs teach young people the skills they need to live independently while maintaining contact, as appropriate, with their families, and avoiding long-term dependency on social welfare services. Homeless youth receive shelter and services (including counseling, life skills training, educational advancement, and job attainment) for up to 18 months.

DEVELOPMENTAL DISABILITIES

The Developmental Disabilities program helps States to ensure that all persons with developmental disabilities are able to access services for enhanced independence, productivity, integration, and inclusion in the community. The FY 2000 request for Developmental Disabilities is $119 million. Of this amount, $4 million is included to provide systems of support to families of children with disabilities.

CHILD WELFARE/CHILD ABUSE

In FY 2000, ACF is requesting $406 million in funding for a range of programs that help States and local communities protect children by strengthening families and preventing abuse. Of this, $27 million is requested for

Adoption Opportunities. This amount will support grants to facilitate the adoption process and provide technical assistance to enable States to increase the number of children adopted, especially children with special needs.

SOCIAL SERVICES RESEARCH

The FY 2000 budget includes a total of $27 million for social services research, of which $6 million is discretionary funding. Research and evaluation efforts will continue to focus on moving families from welfare to work, promoting responsible parenthood, and fostering child well-being. The results of this research provide credible information about welfare reform strategies and family and child well-being outcomes. Of these funds, $21 million is mandatory funding made available by PRWORA.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The budget request for LIHEAP is $1.1 billion in FY 2001. Because this program is advance appropriated, $1.1 billion for FY 2000 has already been provided in the FY 1999 appropriation. The budget also requests $300 million in emergency contingency funds in FY 2000. The emergency contingency funds are available for release upon request of the President, due either to natural disaster or other emergency. This can include extreme temperatures or high fuel prices.

LIHEAP provides heating and cooling benefits to approximately 4.3 million households each year. Of the recipient households, approximately 34 percent includes an elderly member, 32 percent include a person with a disability, 49 percent include a child under age eighteen, and 22 percent of recipients do not receive any public assistance at all. Many beneficiaries are working low-income families who are unable to meet their heating/cooling costs.

REFUGEE AND ENTRANT ASSISTANCE

The budget request for the Refugee and Entrants Assistance Program in FY 2000 is $443 million. This request will provide eight months of benefits for an estimated 80,000 refugees and 20,000 Cuban/Haitian entrants admissions in FY 2000. Of the funds requested, ACF will allocate $221 million to Transitional and Medical Services, $160 million to Social Services, $49 million to Targeted Assistance, and $5 million to Preventive Health. The program is committed to ensuring that Social Services grants emphasize job placement, language skills, community support, and citizenship training efforts. The Budget also includes $7.5 million to fully fund the domestic treatment activities newly authorized by the Torture Victims Relief Act.

FEDERAL ADMINISTRATION

The Federal Administration request is $150 million, an increase of $6 million. This level is expected to fund approximately 1,510 full time equivalent staff. These funds will be used for critical travel and monitoring activities. They will also provide partial payment for necessary information technology investments and data collection on key ACF programs, and fund pay and rent increases.

ACF OVERVIEW: DISCRETIONARY SPENDING

(dollars in millions)

DISCRETIONARY PROGRAMS:	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Head Start	$4,347	$4,660	$5,267	+$607
Violence Against Women	103	105	119	+14
Child Care & Development Block Grant /1	1,002	1,000	1,173	+173
Research and Evaluation Fund	0	0	10	+10
Subtotal, CCDBG	$1,002	$1,000	$1,183	+$183
Community Services Block Grant	490	500	500	0
Individual Development Accounts	0	10	20	+10
Discretionary Programs	51	54	0	-54
Subtotal, Community Services	$541	$564	$520	-$44
Runaway and Homeless Youth	58	59	64	+5
Developmental Disabilities	114	119	119	0
Child Welfare/Child Abuse	401	404	406	+2
Adoption Incentives	0	20	20	0
Native Americans	35	35	35	0
Social Services Research	26	27	6	-21
Pre-Appropriated Research/Evaluation /2	12	12	21	+9
Subtotal, Social Services Research	$38	$39	$27	-$12
LIHEAP /1	1,160	1,100	1,100	0
Refugee and Entrant Assistance	423	436	443	+7
Federal Administration	144	144	150	+6
Pre-Appropriated Federal Administration /3	8	8	9	+1
Subtotal, Federal Administration	$152	$152	$159	+$7
Total, Program Level	**$8,374**	**$8,693**	**$9,462**	**+$769**
Less Funds Allocated from Other Sources:				
Pre-Appropriated Research/Evaluation /2	12	12	21	+9
Pre-Appropriated Federal Administration /3	8	8	9	+1
Total, Discretionary Budget Authority	**$8,354**	**$8,673**	**$9,432**	**+$759**
FTE	1,569	1,530	1,510	-20

/1 FY 1999 Appropriation (P.L. 105-277) provides advanced FY 2000 funding
/2 Authorization for $12 million of these funds expired in FY 2000
/3 1%/2% funds (Public Law 104-193)

ENTITLEMENT PROGRAM SUMMARY

SUMMARY

The Department's FY 2000 ACF Budget includes $29 billion in outlays for entitlement programs. This total includes pre-appropriated funding for the Temporary Assistance for Needy Families (TANF) program and the Child Care Entitlement to States. The ACF entitlement budget also requests funding for increases in Child Care, Child Support Enforcement; Foster Care, Adoption Assistance, and Independent Living; Promoting Safe and Stable Families; and, the Social Services Block Grant.

In FY 2000, ACF continues its efforts at moving families from welfare to work. The historic Child Care Initiative allows ACF to support working families and the foster youth initiative will help troubled youth gain independence.

CHILD CARE ENTITLEMENT TO STATES

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (referred to as welfare reform) amended the Child Care and Development Block Grant Act (CCDBG) by consolidating the former child care programs. All States receive discretionary funds, mandatory funds and matching funds. These funds help States provide for subsidies to working families and require States to spend a minium of 4 percent of the funds to improve the quality and availability of healthy and safe child care for all families. Additional amounts of the discretionary funds are also set-aside for quality improvements and for school-age care.

For FY 2000, welfare reform authorized and pre-appropriated entitlement funds (matching and mandatory) of $2.4 billion for child care programs to allow States maximum flexibility in developing child care programs. These funds, combined with $1.2 billion in discretionary child care funding, will further the Administration's commitment to supporting working families and moving families from welfare to work.

The child care entitlement portions of the fund include the following:

- Mandatory Child Care - Mandatory funds are allocated to grantees based on historic levels of Title IV-A child care expenditures. Two percent of the total appropriation (both mandatory and discretionary) is set aside for Tribes.

- Matching Child Care - This is the total allocation, less the mandatory child care allocations and the two percent tribal set-aside. Matching funds are matched at the FY 1995 Federal matching rates (FMAP) and allocated using the at-risk child care formula.

- Training and Technical Assistance Program - These amounts are set aside for training and technical assistance to States and Tribes.

CHILD CARE INITIATIVE

Studies indicate that working families across the country are struggling to find safe and affordable child care for their children. Of the 10 million children in working families with incomes below 200 percent of poverty, funds from the Child Care and Development Block Grant Act served only 1.25 million in 1997, approximately 10 percent of those eligible. The children of these working parents often spend their days in settings that do not promote healthy child development and the quality of care is often quite poor. Even low quality care can be extremely

expensive. For families with children between three and five, child care is the third greatest expense after housing and food.

The problem is just as severe for older children. Experts estimate that nearly five million school-age children spend time without adult supervision during a typical week. The Administration seeks to address this situation and help parents find affordable, high quality child care that will support and nurture the development of their children.

Following the White House Child Care Conference in October of 1997, the Administration proposed a comprehensive, initiative to improve child care for America's working families, including increased funding for child care programs in several Departments. In response to last year's request for funds to improve quality and research in child care, the FY 1999 appropriation for HHS forward funded (for FY 2000) an additional $173 million for improvement in child care quality and $10 million dedicated to child care research. Additional details on these programs can be found in the discretionary section of the budget.

CHILD CARE LEGISLATIVE PROPOSALS

As was the case in last year's budget, the President has included comprehensive increases in child care funding to help working families. Beyond the tax credits and school-age child care funding in the Departments of Treasury and Education, $10.5 billion over 5 years in additional funding is targeted for HHS child care programs. This funding includes:

SUBSIDY INCREASE:

A five year $7.5 billion increase in the entitlement funding for child care which, when combined with funds from welfare reform, will increase the number of children receiving child care subsidies by more than 1 million to a total of 2.4 million by 2004.

EARLY LEARNING FUND:

The budget includes $3 billion over five years in entitlement funds for an Early Learning Fund to improve child care safety and quality and enhance early childhood development, emergent literacy, and school readiness. The Fund will provide States with dollars for community level challenge grants to support programs that improve early learning and the quality and safety of child care for children up to age five.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES

Welfare reform dramatically changed the nation's welfare system by replacing AFDC, AFDC Child Care, Emergency Assistance and JOBS programs with the State TANF block grant, a single capped entitlement of approximately $17 billion annually. Under TANF, recipients must engage in work activities to receive time-limited assistance. Over the past five years, the number of families on welfare has dropped by almost 40 percent, to under 3 million families.

Welfare reform promotes work by imposing stringent work requirements upon families and States. Adult recipients must be engaged in work activities after receiving assistance for 24 months or less, with few exceptions. States must also meet minimum work participation rate requirements; in FY 2000, 40 percent of all families and 90 percent of two-parent families must be engaged in work activities. In addition, TANF is time-limited so that families may not receive Federal assistance for more than five cumulative years, or less at State option.

To meet the above work requirements, welfare reform gives States wide flexibility to design State TANF programs. Welfare reform broadly defines eligibility criteria as a "needy"(as defined by the State) family that includes or is expecting a child. States are required to provide TANF recipients with job skills assessments, job preparation, and

job search services. However, States determine their own eligibility criteria and benefit levels, as well as the type of services available to TANF recipients. All States implemented their State TANF programs by the July 1, 1997 deadline.

Welfare reform authorizes and pre-appropriates about $17 billion annually to States for the following activities:

- Family Assistance Grants to States, Tribes and Territories;
- Matching Grants to Territories;
- Bonus to Reward Decrease in Out-of-Wedlock Births;
- Supplemental Grants for Population Increases;
- Bonus to Reward High Performance States;
- Tribal Work Programs; and,
- Loans for State Welfare Programs.

TANF Legislative Proposals

The FY 2000 President's Budget includes the following two TANF legislative proposals.

Supplemental Grants for Population Increases:

With the rapid decline in welfare caseloads, the budget proposes to freeze the Supplemental Grants for Population Increases at the FY 1999 level. In FY 2000, seventeen States are eligible for this grant. These States qualify based on population growth and/or lower than average State welfare spending per low-income person. This proposal will save $83 million in FY2000, and $241 million over the next five years.

Accelerate by One Year the Cap Reduction on Transfers to SSBG:

Under current law, in FY 2000, States may transfer up to 10 percent of TANF funds to the Social Services Block Grant (SSBG) program, and in FY 2001, the transfer cap is reduced to 4.25 percent. In light of the SSBG proposed (see below) increase of $471 million above the FY 1999 level, the President's Budget proposes to reduce the transfer cap amount to 4.25 percent beginning in FY 2000, rather than FY 2001. This proposal will save $600 million in FY2000.

Contingency Fund for State Welfare Programs

Welfare reform established a Contingency Fund to assist States that, due to economic hardship, need additional funds above their TANF grant to provide assistance to needy families. States are eligible for these matching funds during periods of high unemployment or rising Food Stamp caseloads. The total amount of Contingency Funds pre-appropriated for FYs 1997 through 2001 is $1.96 billion.

Contingency Fund Legislative Proposal

The FY 2000 President's Budget proposes to replace the current capped Contingency Fund with a new uncapped fund that could more effectively respond to State needs in the event of an unforeseen economic downturn. This proposal would save $1.6 billion in Budget Authority in FY 2000, and would have no effects on outlays.

Children's Research and Technical Assistance (CRTA)

Welfare reform authorizes and appropriates funds for welfare research and technical assistance for States. The FY 2000 total is $62 million.

Of this, $41 million includes two child support set-asides: one for training and technical assistance and the other to assist in operating the Federal Parent Locator Service (FPLS). The funds appropriated for these activities are equal to one and two percent

respectively of the amount paid to the Federal government for its share of child support collections during the preceding fiscal year.

Also included is $21 million in pre-appropriated mandatory funds for the following activities: $15 million for welfare research, and $6 million for a longitudinal child welfare study. These funds will also focus on welfare research activities such as studying the effects of welfare reform and identifying ways to improve the welfare system.

CHILD SUPPORT ENFORCEMENT

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The program provides critical support for working families and assists in the transition to self-sufficiency. In FY 2000, an estimated total of $4.4 billion in Federal and State dollars will be spent in order to collect over $17.6 billion in payments. This represents a 9 percent gain in collections over FY 1999 and a total return of more than $4 for every $1 invested in the administration of the program. Since the inception of the program in FY 1975, over $100 billion has been collected.

The Federal government shares in the financing of this program by providing incentive payments, a 66 percent match rate for general State administrative costs, and an enhanced match rate for paternity testing and specified automated systems requirements. The CSE program also includes a capped entitlement of $10 million annually for grants to States to facilitate noncustodial parents' access and visitation of their children.

The CSE program strengthens families by helping children get the support they are owed from non-custodial parents. In non-TANF cases, child support collections are forwarded to the custodial family. By securing support on a consistent and continuing basis, non-welfare families may avoid the need for public assistance, thus potentially reducing future welfare spending. Applicants for TANF assign their rights to support payments to the State as a condition of receipt of assistance. TANF child support collections are shared between the State and Federal government.

As noted above, a portion of the Federal share of child support collections is paid to the States as incentive payments. Previously, Federal incentive payments to States were based on the State's cost effectiveness in operating the program and the amount of payments collected. Following passage of the Child Support Performance and Incentive Act of 1998, a new incentives structure will be put into place using five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. This new system will be phased in starting in FY 2000.

CHILD SUPPORT LEGISLATIVE PROPOSALS

The budget proposes three legislative changes in the child support program: (1) reducing the match rate for paternity establishment laboratory tests; (2) repealing the hold harmless provision; and, (3) beginning in FY 2001, a proposal to return to the pre-welfare reform policy of mandatory review and adjustment of child support TANF assistance cases. The first two proposals were included in the FY 1999 President's Budget.

ADJUSTING THE MATCH RATE:

Currently, there is a 90 percent Federal match for laboratory tests to establish paternity. However, the financing structure for child support is very complex with various levels of match rates and the cost of paternity establishment testing has been

decreasing. Therefore, the Administration proposes that starting in FY 2000, laboratory tests for paternity establishment be matched at the regular 66 percent administrative match rate. This change simplifies the child support funding structure, increases incentives to control costs, and saves approximately $9 million in FY 2000 and $45 million over 5 years.

HOLD HARMLESS:

The Administration proposes, starting in FY 2000, to repeal the "hold harmless" provision that was put into place in welfare reform. Hold harmless ensured that if States did not reach their 1995 level of collections, they would receive recoupment payments from the Federal government. This provision was put into place largely to protect States from any loss resulting from new distribution rules. However, this provision is not working as intended. Since TANF collections are declining for a variety of reasons, many States are receiving these payments before distribution changes have taken place. Further, there is no way to separate out the effect of distribution changes when they do occur. Therefore, we propose that hold harmless be repealed, saving approximately $65 million in FY 2000 and $279 million over 5 years.

REVIEW AND ADJUSTMENT:

Under welfare reform, periodic reviews of child support orders are no longer required. This proposal returns to pre-welfare reform policy and requires States to conduct reviews in TANF assistance cases at least every 3 years and to adjust appropriately. This change will likely help families and/or reduce reliance on Food Stamps, medical, emergency or other public benefits. This proposal will start in FY 2001, with savings in Medicaid and Child Support totaling approximately $85 million by FY2004. Child Support savings total over $25 million during this time period.

FOSTER CARE, ADOPTION ASSISTANCE AND INDEPENDENT LIVING PROGRAM

The FY 2000 budget requests $5.6 billion in Budget Authority for the Foster Care, Adoption Assistance and Independent Living programs. This request represents an increase of $706 million over the FY 1999 appropriation. About $600 million of this increase is due to: (1) projections that average Foster Care payments and caseloads will continue to grow in FY 2000 at a rate consistent with the past five years, and (2) prior year claims that exceeded FY 1999 funding levels.

Of the total request, $4.5 billion will provide Foster Care payments on behalf of about 338,700 children each month. This request will also fund State administration, including child welfare information systems, training, and State data systems.

For the Adoption Assistance program, about $1 billion will provide payments for families who adopt special needs children. Monthly payments are made on behalf of adopted children until their 18th birthday. The proposed level of funding will support approximately 217,100 children each month.

FOSTER CARE-RELATED LEGISLATIVE PROPOSALS

Foster care youths become ineligible for maintenance payments at age 18. Each year, approximately 16,000 youths age out of foster care and 9,000 youths leave the foster care system by running away. These youths often lack the resources or supports needed to maintain a self-sufficient lifestyle. Consistent with the Department's efforts to move families from welfare to work, the FY 2000 President's Budget includes a package of legislative proposals aimed at assisting these former foster youths in making the transition to living on their own. In sum, this package would cost $50 million in FY 2000, and $275 million over the next five years. The proposals include:

INCREASE INDEPENDENT LIVING PROGRAM (ILP) FUNDING:

Increasing the ILP funding level from $70 million to $105 million would allow States to provide basic skills, employment and education training to an additional 17,500 foster youths aged 16 through 18, and at State option, to age 21. This proposal will cost $35 million in FY 2000, and $175 million over the next five years.

SUPPORT THE LIVING EXPENSES OF YOUTHS IN TRANSITIONAL LIVING PROGRAMS:

Through ILP, this proposal would grant $5 million for States to support the living expenses of approximately 1,750 youths participating in transitional living programs. Funding for these activities would slightly increase by $5 million each year, for a total cost of $50 million over four years.

INCREASE RUNAWAY AND HOMELESS YOUTH TRANSITIONAL LIVING PROGRAM FUNDING:

Increasing the funding for this discretionary grant program by $5 million would allow States to provide services to an additional 600 runaway or homeless youth who may no longer be eligible for foster care. (See ACF Discretionary section for more details regarding this program.)

MEDICAID COVERAGE FOR EMANCIPATED YOUTHS UP TO 21:

This proposal would allow States to expand Medicaid eligibility to youths up to age 21 who were eligible for foster care at age 18. This proposal will cost $5 million in FY 2000, and $45 million over the next five years. (See HCFA Medicaid section for more details regarding this program.)

PROMOTING SAFE AND STABLE FAMILIES

The Adoption and Safe Families Act of 1997 reauthorizes and expands the Promoting Safe and Stable Families program (formerly known as the Family Preservation and Support program). The request includes $295 million in FY 2000 for States and eligible Indian tribes.

The Promoting Safe and Stable Families program supports State child welfare agencies and tribes in providing: family preservation services, family support services, time-limited family reunification services, and adoption promotion and support services.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG) allows States the flexibility to provide or supplement social services at the State and local levels. SSBG funding provides direct social services and resources that link human service delivery systems together. Programs or services most frequently supported by SSBG include child care, child welfare (foster care, adoption and protective services), elder care, drug abuse prevention and treatment activities, home based services, employment services, prevention and intervention programs, and services for the disabled.

The FY 2000 President's Budget requests funding at the full authorization level of $2.38 billion for this program. This is an increase of $471 million above FY 1999 levels. The Department has taken steps in the past year to improve the quality of program information, and will continue to work with States to improve reporting and accountability for services provided with these funds.

AFDC AND RELATED PROGRAMS

Welfare reform replaced the Aid to Families with Dependent Children (AFDC) Benefits, State and local Administration,

Emergency Assistance, AFDC Child Care, and Job Opportunities and Basic Skills Training (JOBS) programs with TANF and the Child Care Entitlement programs.

During FY 2000, we expect to completely phase out funding for the repealed programs. Estimates for FY 1999 and 2000 represent claims for expenditures incurred before these programs were repealed. These claims will be funded by carry over balances from prior years.

FY 2000 PROPOSED ACF LEGISLATION

(dollars in millions /1)

PROPOSAL	1-YEAR FY 2000	5-YEARS FY 00-04
CHILD SUPPORT ENFORCEMENT:		
Eliminate Hold Harmless Provision /2	-$65	-$279
Reduce Match of Paternity Laboratory Tests from 90 to 66 Percent	-9	-45
Mandatory Review of Child Support Orders/3	0	-25
Subtotal, Child Support Enforcement	-74	-349
CHILD CARE:		
Subsidy at Special Match Rate	+1,155	+7,500
Early Learning Fund	+600	+3,000
Subtotal, Child Care	+1,755	+10,500
TANF:		
Freeze Supplemental Grants at FY 1999 Level	-83	-241
Reduce Cap on Transfers to SSBG from 10 to 4.25 Percent /4	-600	-500
Subtotal, TANF	-683	-741
CONTINGENCY FUND:		
Eliminate Budget Authority Cap	-1,644	-1,644
INDEPENDENT LIVING PROGRAM:		
Increase Authorization Level	+35	+175
Support Living Expenses of Youth in Transitional Living Programs	+5	+50
Subtotal, ILP	+40	+225
TOTAL ACF PROPOSED LAW IMPACT	**-$606**	**$7,991**

/1 Negative numbers are savings, positive numbers are costs. Except where noted, all figures represent Budget Authority.

/2 Elimination of the hold harmless provision results in a $65 million reduction in spending authority from offsetting collections.

/3 This proposal begins in FY 2001 and has additional savings in Medicaid totaling $60 million by FY 2004 Child support totals combine increased administrative costs and savings due to increased collections.

/4 This proposal effects outlays, but has no impact on Budget Authority.

CHILD SUPPORT ENFORCEMENT OVERVIEW: Collections and Costs

(dollars in millions) /1

	1998 Actual	1999 Enacted	2000 Request/2	Request +/- Enacted
Total Collections Distributed:				
Non-TANF Families	$11,243	$12,931	$14,449	+$1,518
TANF/FC families	152	153	154	+1
TANF program	2,433	2,446	2,470	+24
FC program	32	34	36	+2
Total	**$13,860**	**$15,564**	**$17,109**	**+$1,545**
Distributed to TANF Program:				
Net Federal Share	$945	$945	$1,030	$85
State Share (includes incentives and hold harmless payments)	1488	1501	1440	-61
Total	**$2,433**	**$2,446**	**$2,470**	**+$24**
Administrative Costs (Outlays):				
Federal Share	$2,110	$2,593	$2,840	$247
State Share	1196	1389	1498	+109
Costs	**$3,306**	**$3,982**	**$4,338**	**+$356**
Program Saving and Costs (Collections: minus Costs):				
Federal Costs	$1,165	$1,648	$1,810	+$162
State Savings	292	112	58	+170
Net Costs	**$873**	**$1,536**	**$1,868**	**+$332**

/1 Numbers may not add due to rounding.
/2 Numbers include legislative proposals.

ACF OVERVIEW: ENTITLEMENT SPENDING

(dollars in millions) /1

PROGRAM	1998 Actual	1999 Enacted	2000 Request /2	Request +/- Enacted
TANF /3	$16,672	$17,053	$17,003	-$50
Contingency Fund /3	1,960	0	-1,644	-1,644
Child Care Entitlement /3	2,070	2,167	4,122	+1,955
Child Support Enforcement(obligations) /4	2,153	2,583	2,824	+241
Foster Care/Adoption Assistance	4,311	4,922	5,667	+745
Children's Research & Technical Assist (net BA) /3	$53	$52	$62	+10
Promoting Safe and Stable Families	255	275	295	+20
Social Service Block Grant	2,299	1,909	2,380	+471
AFDC/EA/JOBS/Related /5, /6	-1,546	66	-2,074	-$2,140
Total, Program Level/BA	**$28,227**	**$29,027**	**$28,635**	**-$392**

/1 Numbers may not add due to rounding.
/2 Numbers include legislative proposals.
/3 Programs are preappropriated.
/4 Child Support Enforcement (CSE) spending reflects the legislative proposal to reduce the federal match on paternity testing. CSE also has two other legislative proposals to: (1) repeal the hold harmless provision, reducing spending authority in offsetting collections by $65,000,000 in FY 2000 and, (2) institute mandatory review and adjustment beginning in FY 2001.
/5 AFDC and related assistance is shown net of child support collections.
/6 The negative budget authority shown for FY 1998 and FY 2000 represents the use of funds carried over from prior years.

ADMINISTRATION ON AGING

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$871	$882	$1,048	+$166
Program Level	872	883	1,050	+167
Outlays	834	864	971	+107
FTE	121	134	155	+21

SUMMARY

The FY 2000 budget for the Administration on Aging (AoA) is $1.0 billion, an increase of $167 million, or 19 percent, over FY 1999. This increase will allow the Agency to better respond to the increasing longevity of our older population. There are 45 million Americans 60 years of age and over. The Census Bureau projects that by 2030 these numbers will almost double to 88 million.

Additional funds requested will be used primarily for the new National Family Caregiver Support Program — a vital piece of the Administration's Long-Term Care initiative that will provide essential assistance to families caring for older relatives. The increase will also be used to serve more home-delivered meals and to reduce the high levels of disability and rates of disease among minority elders.

AoA serves older persons and their families through the administration of the Older Americans Act as well as through aging-related applied research and education projects. AoA's goal is to improve the quality of life for older Americans, primarily by helping them to remain independent and productive.

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

AoA is proposing a new $125 million National Family Caregiver Support Program that will offer a range of critical services for caregivers including respite care, information, assistance in locating services, and home care services. Some 3 to 4 million older individuals rely on care from family and close friends, enabling them to remain at home instead of entering a nursing home or other institutional setting. The role of the caregiver is difficult. Half are themselves over the age of 65, the majority are women, and one third have full-time jobs. Research shows that their rates of depression are significantly higher than non-caregivers of the same age.

The National Family Caregiver Support Program reflects the Administration's conviction that the nation's millions of caregivers need help and that such help will pay great dividends. Recent studies have found that respite care and other services not only relieve caregiver stress, but also delay nursing home entry. Support for families of persons with Alzheimer's disease has demonstrated that institutionalization can be delayed for as long as a year.

AoA's National Family Caregiver Support Program is a key component of the Administration's Long-Term Care proposal

to support Americans with long-term care needs and the millions of family members who care for them. (Other parts of the new initiative include a $1,000 tax credit for disabled individuals and caregivers; a national campaign to educate Medicare beneficiaries about that program's limited long-term care coverage and how best to evaluate long-term care options; and having a proposal for the Federal government to offer insurance to its employees at group rates. As the nation's largest employer, the market leverage of the Federal government will influence the private sector to develop better long-term care insurance).

As with most of its existing programs, AoA will distribute funds via state formula grants. This will allow states to create caregiver support infrastructure networks that provide quality respite care; critical information about community long-term care services that best meet a families' needs; and counseling and other assistance.

NUTRITION SERVICES

The FY 2000 budget includes $522 million for all meals. Of this amount, $147 million is for Home-Delivered Meals, an increase of $35 million over FY 1999. AoA will support the delivery of some 146 million meals in FY 2000 (a 23 percent increase over FY 1999) and increase the number of high-risk older adults served. Like the National Family Caregiver Support Program, the increase for home-delivered meals will assist more older persons to remain in their homes and communities. A national evaluation indicated that for many, the availability of a home-delivered meal is crucial to their ability to function at home. According to this same evaluation, meal preparation is difficult or impossible for 41 percent of program recipients and 77 percent have difficulty with one or more daily activity.

Support for Congregate Meals remains at the FY 1999 level of $375 million, maintaining current service levels; i.e. 119 million meals served to 2.1 million at-risk older adults. Adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and disease-related disabilities. Congregate nutrition services present opportunities for active social engagement the reduction of isolation, and for encouraging improved physical and mental functioning. The budget also includes $18 million for grants to Indian tribes and Native Hawaiian organizations, the same as in FY 1999.

HEALTH DISPARITY INTERVENTIONS

The FY 2000 budget requests a new $4 million program to assist in reducing higher incidence rates of disability and disease among minority elders. AoA will provide intervention grants to State Agencies on Aging to partner with State health departments, local health associations and Area Agencies on Aging to target three areas of concern: cardiovascular disease, diabetes, and adult immunizations. These focused efforts will complement a broader emphasis throughout the Department to address racial health disparities. Grantees will implement public health education programs and design culturally appropriate interventions and outreach efforts for minority communities. AoA is uniquely positioned to address these concerns because its network of service providers is in daily contact with millions of older persons, 20 percent of the people served by community services are minority as are 27 percent of those served by the meals programs.

SUPPORTIVE SERVICES AND CENTERS

Supportive services represents the cornerstone of AoA's comprehensive system of home and community-based services for older Americans. The budget request is for $310 million which includes $10 million that currently supports in-home services for the frail elderly. Support Services are administered through 57 State Agencies on

aging, 655 Area Agencies on Aging, 6,400 senior centers and more than 27,000 service providers throughout the country. On an annual basis, supportive services and centers provide homemaker services to 160,000 elders, chore services to 54,000, case management services to 401,000, adult day care to 27,000 and personal care to 86,000. Of these recipients, 38 percent were at or below the poverty level. The Older Americans Act gives priority to those who are in greatest economic and social need, with particular attention to low-income, minority older persons.

OTHER AOA PROGRAMS

A total of $17 million is proposed for Program Administration, an increase of $2 million compared to FY 1999. The additional $2 million will allow AoA to hire 12 additional staff to implement the results of a workforce plan to provide the agency with the competencies and skills required for the future. Further, the increase will cover pay costs for existing staff, and fund the administrative and support service costs. In addition, 9 added staff will be funded from amounts provided under the Operation Restore Trust program in order to implement increased responsibilities in detecting health care fraud and abuse against seniors.

AoA will operate the Alzheimer's Disease Demonstration Grants to States Program which was transferred from the Health Resources and Services Administration in FY 1999. Funding for this program is $6 million, the same as in FY 1999. The budget request also includes $16 million for Preventive Health Services, $18 million for State and local Innovations, and $12 million for Grants to States for Protection of Vulnerable Americans– all continuation activities funded at the same level as in the previous year.

AoA OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
National Family Caregiver Support Program.....	$0	$0	$125	+$125
Meals:				
Home-Delivered Meals.....	$112	$112	$147	+$35
Congregate Meals.....	375	375	375	0
Subtotal, Meals**.....	**$487**	**$487**	**$522**	**+$35**
Health Disparities Interventions.....	$0	$0	$4	+$4
Supportive Services & Centers.....	310	310	310	0
Grants to Indian Tribes & Native Hawaiians.....	18	18	18	0
Alzheimer's Disease.....	6	6	6	0
Program Administration.....	15	15	17	+2
Preventive Health Services.....	16	16	16	0
State and Local Innovations.....	10	18	18	0
Vulnerable Older Americans.....	9	12	12	0
Operation Restore Trust (HCFAC).....	1	1	2	+1
Total, Program Level	**$872**	**$883**	**$1,050**	**$167**
Reimbursements:				
Operation Restore Trust (HCFAC).....	-$1	-$1	-$2	-$1
Subtotal, Reimbursements.....	**-$1**	**-$1**	**-$2**	**$0**
Total, Budget Authority	**$871**	**$882**	**$1,048**	**$166**
FTE.....	121	134	155	+21

DEPARTMENTAL MANAGEMENT

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$191	$199	$206	+$7
Program Level	$212	$231	$282	+$51
Outlays	$181	$200	$211	+$11
FTE	1,236	1,353	1,457	+104

SUMMARY

Departmental Management (DM) is a consolidated display which includes those activities funded under two appropriation accounts in the Office of the Secretary: General Departmental Management (GDM) and Policy Research. The FY 2000 budget request provides a program level of $282 million for Departmental Management, including an appropriation of $206 million, intra-agency transfers of $21 million in one-percent evaluation funds and $55 million in bioterrorism funds.

GENERAL DEPARTMENTAL MANAGEMENT

The GDM account supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department, through nine Staff Divisions (STAFFDIVs): the Immediate Office of the Secretary, the Departmental Appeals Board (DAB), and the Offices of Public Affairs, Legislation, Planning and Evaluation, Management and Budget, Intergovernmental Affairs, General Counsel (OGC), and Public Health and Science (OPHS). The GDM budget request for FY 2000 totals $192 million, a net increase of $7 million.

The largest part of this increase is a total of $9.5 million for OGC and DAB, as part of the President's Nursing Home Initiative to improve the quality of nursing home care in this country. Working with the Health Care Financing Administration (HCFA), OGC has significantly increased the number of sanctions against nursing homes that violate patient health and safety rules. As a result of appeals by the homes against these sanctions, both DAB's judicial hearings caseload and OGC's administrative and court litigation workloads have expanded dramatically. The requested funding increase will ensure adequate OGC and DAB staff to handle these workloads in a timely and efficient manner, and to decrease current caseload backlogs.

The Office of Public Health and Science (OPHS), the largest of the GDM STAFFDIVs, is headed by the Assistant Secretary for Health/Surgeon General, who serves as senior advisor to the Secretary on public health and science issues and exercises management responsibility for ten OPHS operational programs, including the following:

OFFICE OF MINORITY HEALTH

The request includes $28 million to improve disease prevention, health promotion, and health service delivery for disadvantaged and minority individuals. This funding also supports research to improve the health status of racial and ethnic minority populations in the United States, which continues to lag behind the health status of the American population as a whole.

OFFICE ON WOMEN'S HEALTH

The request of $18 million provides funding to advance women's health programs through the promotion and coordination of research, service delivery, and education throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups. This request includes a $2 million (13 percent) increase over the FY 1999 enacted level. The increased funds will provide: additional funding for the existing 18 National Centers of Excellence in Women's Health; support for the new Community Centers of Excellence in Women's Health; and support to coordinate HHS activities on domestic violence.

OFFICE OF EMERGENCY PREPAREDNESS

The budget request of $10 million will be used to manage and coordinate the health, medical and health-related social services that are provided by the Federal Government to victims of catastrophic disasters through the Federal Response Plan's Emergency Support Function (ESF) #8. Under ESF #8, HHS coordinates the support of twelve Federal agencies in the preparedness for, response to, and recovery from natural and man-made disasters.

Also in FY 2000, OEP will continue to carry out tasks from the National Security Council to assess and remedy any shortfalls in the health and medical consequence response capabilities that will be necessary in the event of a terrorist use of a weapon of mass destruction, whether chemical, biological or nuclear. Funding for these bioterrorism activities are included in the Public Health and Social Services Emergency Fund.

OFFICE OF POPULATION AFFAIRS

The request of $9 million provides support for the Adolescent Family Life (AFL) Demonstration and Research program authorized under Title XX of the Public Health Service Act. Through these grants, AFL provides funding for three areas: care demonstration projects, prevention projects, and research projects. In addition, OPA administers the Family Planning program under Title X of the Public Health Service Act (this program is funded though the Health Resources and Services Administration).

POLICY RESEARCH

The FY 2000 budget request for DM also includes $14 million for the Policy Research account, to support research on issues of national significance. Policy Research examines broad issues that cut across agency and subject lines, as well as new policy approaches developed outside the context of existing programs.

Priority issues that will be examined are those related to welfare reform, health care insurance reform, family support and independence, poverty, at-risk children and youth, aging and disability, science policy, and improved access to health care and support services.

As part of a multi-agency initiative, the Department will explore means by which discrimination in the health sector can be managed and reported. HHS will seek to implement a research plan for distinguishing between discriminatory behavior and practices and other differences that may affect health care outcomes.

DEPARTMENTAL MANAGEMENT OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
General Departmental Management:				
GDM Staff Divisions	$105	$110	$125	+$15
OPHS Program Offices				
Minority Health	29	28	28	0
Women's Health	12	15	17	+2
Emergency Preparedness	10	10	10	0
Council on Physical Fitness & Sports	1	1	1	0
Adolescent Family Life	17	18	9	-9
Congressional Earmarks	3	3	2	-1
Total, GDM	**$177**	**$185**	**$192**	**$7**
Policy Research	14	14	14	0
Total, DM Budget Authority	**$191**	**$199**	**$206**	**+$7**
One-Percent Evaluation Funds	21	22	21	-1
Bioterrorism		10	55	+45
Total, DM Program Level	**$212**	**$231**	**$282**	**+$51**
FTE	1,236	1,353	1,457	+104

HEALTH CARE ACCESS FOR THE UNINSURED

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$0	$0	$25	+$25
Program Level	$0	$0	$25	+$25
Outlays	$0	$0	$4	+$4
FTE	0	0	0	

SUMMARY

It is estimated that 43 million people in the U.S. lack health insurance. Of these, 24.6 million are working people (5.9 million work part time and 18.7 million work full time). These uninsured often remain outside organized systems of care. They often have complex medical needs and insufficient resources to obtain care. They may defer care or not receive needed services and are about half as likely to receive a routine check-up as insured adults. They rely heavily on expensive emergency rooms, and because they lack a routine source of care, often may not receive needed follow-up services.

Many of the uninsured, especially those with low incomes, rely on "safety net" providers—those hospitals, clinics and other providers who offer a significant volume of health care services either for free or with reduced fees. These providers had to adjust to the rapid growth of managed care in both private and public insurance programs, but often lack the resources required to make the changes needed to become efficient, effective providers of care in the changing health care environment.

Therefore, a new program is included in the FY 2000 budget at $25 million. This competitive grant program is the cornerstone of a multi-year initiative designed to increase the capacity and effectiveness of the nation's health care safety-net. Funds in this initiative total $1 billion over five years. The goal is to assure that more uninsured people receive needed care, that the care received is of higher quality, and that the uninsured are served by providers who participate in integrated health systems.

Funds will be available to: (1) assist eligible providers to develop and expand integrated systems of care; and (2) address service gaps within such integrated systems, with a focus on primary care, mental health services and substance abuse services. The result will be that more uninsured individuals will have access to a continuum of core services.

During FY 2000, the program's first year, funds will be used for 10-20 grants for infrastructure development, primarily in locations which have already begun organized community-based efforts to coordinate services provided to the uninsured. A small percentage of funding may be devoted to service delivery at these or other sites where coordinated systems are being developed. In the following years, when more funds are available, the percentage of funds devoted to filling service gaps within coordinated systems will increase, and additional new sites will be selected.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$20	$21	$22	+$1
Program Level	$20	$21	$22	+$1
Outlays	$18	$21	$22	+$1
FTE	216	225	225	0

SUMMARY

The FY 2000 budget request for the Office of Civil Rights (OCR) is $22 million, an increase of $2 million over the FY 1998 level and an increase of $1 million over the FY 1999 level. OCR is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes cover nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion. OCR coordinates implementation of the Section 504 regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS. OCR also coordinates government-wide enforcement of the Age Discrimination Act. OCR implements the civil rights requirements under the inter-ethnic adoption provisions of the Small Business Job Protection Act of 1996 (SBJPA) intended to prevent racial and national origin discrimination in foster care and adoption placements.

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

OCR continues to address issues such as race discrimination in access to health and human services and discrimination against persons with disabilities. In 1998, OCR completed 4,899 discrimination complaint and review cases, with nearly 43 percent of investigations and post-grant reviews resulting in changes in policies and practices.

This budget request supports an enhanced compliance program focused on implementing the adoption and foster care nondiscrimination provisions of the Small Business Job Protection Act of 1996, ensuring nondiscrimination in the Temporary Assistance to Needy Families (TANF) program, and supporting quality health care by ensuring access for racial and national origin minorities and persons with disabilities to managed care plan services, children's health programs, HIV/AIDs services and home health care services.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority 1/	$0	$373	$386	+$13
Program Level 1/	$0	$397	$430	+$33
Outlays 1/	$1	$221	$301	+$80
FTE	0	0	0	0

1/ FY 1999 Enacted reflects a comparable transfer to CDC of $33 million for polio and measles ($28 million) and the environmental health laboratory ($5 million).

SUMMARY

The FY 2000 President's Budget request provides a budget authority of $386 million for the Public Health and Social Services Emergency Fund (PHSSEF). In FY 1999, Congress appropriated a total of $373 million (comparable) to the PHSSEF, composed of earmarks for: anti-bioterrorism ($134 million); AIDS prevention and treatment in minority communities ($50 million); and Year 2000 conversion of computer systems ($189 million). Also in FY 1999, Congress designated these funds as an emergency requirement as defined in the Balance Budget and Emergency Deficit Control Act of 1985, as amended.

The FY 2000 President's Budget is the first to include a request for the PHSSEF appropriation. This request assumes that the funds are not required for emergency purposes, as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

RESPONDING TO BIOTERRORISM

Because terrorism is a nationwide threat, programs and activities to address and respond to this threat are a part of a government-wide effort. Within the Federal government's initiative, HHS has the responsibility to meet the public and medical needs associated with terrorist events.

The FY 2000 President's Budget request for the PHSSEF includes a total of $230.4 million in program level for the continuation of HHS anti-bioterrorism efforts. These funds are intended to:

- improve and enhance the nation's public surveillance network – by strengthening our detection, epidemiological, laboratory and electronic communication capacities;
- strengthen capabilities to provide a medical and public health response to chemical and biological weapons attacks;

- create and maintain a stockpile of pharmaceuticals, vaccines and other materials for civilian use if massive treatment is needed; and

- accelerate research, development and regulatory review/approval of rapid diagnostics, antibiotics/ antivirals and vaccines.

AIDS IN MINORITY COMMUNITIES

The FY 2000 President's Budget request for the PHSSEF also includes $50 million to continue to address the AIDS crisis facing minority communities. These funds are specifically targeted to address HIV/AIDS prevention, treatment and infrastructure/ capacity development needs within the African-American and other racial and ethic minority communities.

YEAR 2000 COMPUTER CONVERSION

Finally, the FY 2000 President's Budget request for the PHSSEF includes $150 million to continue the Department's efforts towards achieving millennium compliance. Achieving Year 2000 (Y2K) compliance is HHS's highest priority, and the Department is making substantial progress in its system compliance. In its Year 2000 work, the Department is chairing Y2K outreach efforts in the health care and human services communities, and has expanded outreach activities in these sectors. The Department is also committed to ensuring that the Y2K date problem does not disrupt services or impair our mission.

PHSSEF OVERVIEW

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
BIOTERRORISM:				
PHSSEF:				
Centers for Disease Control and Prevention.....		$124	$118	-$6
Office of Emergency Preparedness.....		10	55	+45
Food and Drug Administration.....		0	13	+13
Subtotal, PHSSEF Budget Authority.....		**$134**	**$186**	**+$52**
Direct Appropriations:				
Centers for Disease Control and Prevention			20	+20
National Institutes of Health.....	14	24	24	0
Total, Bioterrorism Program Level	**$14**	**$158**	**$230**	**+$72**
AIDS/HIV FUNDING.....		**$50**	**$50**	**$0**
YEAR 2000 COMPUTER CONVERSION.....		**$189**	**$150**	**-$39**
Total, PHSSEF Budget Authority.....	**$0**	**$373**	**$386**	**+$13**
Total, Program Level.....	**$14**	**$397**	**$430**	**+$33**
FTE.....	0	0	0	0

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Budget Authority	$32	$29	$32	+$3
Program Level	$118	$129	$152	+$23
Outlays	$127	$128	$152	+$24
FTE	1,166	1,305	1,408	+103

SUMMARY

For FY 2000, the Office of Inspector General (OIG) requests a discretionary appropriation of $32 million, an increase of $3 million above the FY 1999 discretionary level. The OIG will also receive between $110 and $120 million in FY 2000 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare related fraud and abuse activities.

The OIG's statutory mission is to: improve HHS programs and operations and protect them against fraud, waste and abuse. By conducting independent and objective audits, evaluations, and investigations, OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress and the public.

In the FY 1999-2000 time frame, the OIG will focus on such program areas as:

INCREASING COLLECTIONS IN THE CHILD SUPPORT ENFORCEMENT PROGRAM

OIG will expand its multi-agency task forces to identify, investigate, and prosecute individuals who willfully avoid their payment of their child support obligations under the Child Support Recovery Act. These task forces will bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, Marshall Services personnel, the FBI, State and county child support office resources, and all other interested parties from the 18 states covered by the task forces.

CHILD SUPPORT

OIG will examine a wide range of child support issues, including client cooperation, paternity establishment, review and adjustment of support orders, child support enforcement coordination with foster care and with welfare offices, medical insurance coverage under Medicaid and under managed care, interstate case collections, earnings of noncustodial parents, use of license revocation, wage withholding, data systems, incentive funding, and the Federal Parent Locator Service.

SAFE, AVAILABLE AND AFFORDABLE CHILD CARE

OIG will examine subsidy systems for child care, focusing on issues such as health and safety, licensing standards and fraud and abuse potential. OIG will also assess the success of technical assistance provided to States on child care issues.

TANF PROGRAM

OIG will work with Federal and State offices in their implementation of welfare reform. OIG will focus on reviewing how Federal and state offices are achieving successful outcomes and performance in welfare programs.

POST-MARKET DRUG SURVEILLANCE BY FDA

As FDA more quickly approves new drugs, the OIG will continue to review how the agency is carrying out the post-marketing surveillance responsibilities, to ensure that the over 9,000 marketed drugs are safe and effective. OIG review efforts will focus on two critical areas: (1) ensuring that FDA is adequately dealing with the problems of adverse drug reactions, which was recently reporting in medical literature as a leading cause of death in the U.S. and (2) monitoring FDA statutory compliance to inspect drug manufacturers every 2 years.

NIH CONTROLS OVER TECHNOLOGY TRANSFER

OIG will determine whether grantees are complying with the provisions of the Bayh-Dole Act regarding the disclosure, reporting, and licensing of inventions developed under Federally sponsored projects. The OIG will also determine whether the Government is using royalty-free licenses for inventions when making purchases under Federal programs.

PREVENT YOUTH SUBSTANCE ABUSE

OIG will update its 1991 study on youth use of alcohol, "Youth and Alcohol: A National Survey – Drinking Habits, Access, Attitudes and Knowledge," to identify changes in youth patterns of alcohol use and/or abuse. OIG will also examine HHS prevention and cessation programs specifically aimed at youth.

FOOD SAFETY

OIG will examine FDA's efforts to develop an integrated food safety inspection system with the States to ensure appropriate inspections coverage, including the development of shared data systems. OIG will also identify and describe existing models of equivalency which FDA could use as it develops equivalency agreements with our international trading partners for importing and exporting food products.

ELDERLY PROTECTION

OIG will conduct reviews to determine the adequacy of services and programs for investigating elderly abuse. OIG will identify innovative methods to strengthen programs to protect elderly persons.

PUBLIC HEALTH FRAUD

Investigations of fraud in public health programs are diverse, complex, and often critical to protecting the health of the American people. These investigations will address grant and contract fraud, research fraud, and other allegations of wrongdoing. This area is of particular interest in view of expected increases in program grant funding.

EDP AUDITING

OIG will continue to assist the Department in assessing the programs in making all mission critical systems Year 2000 (Y2K) compliant, including reviewing contingency planning.

FINANCIAL STATEMENTS

OIG will perform audits for the purpose of expressing opinions on the financial statements of certain reporting entities in the Department, as identified under the CFO Act of 1990 and the Government Management Reform Act of 1994.

The OIG has strengthened its partnerships with other Federal Agencies, such as the Department of Justice and the Internal Revenue Service. Also, included in these relationships are State Governments, ombudsmen, and the private sector including local aging organizations, all of whom are

working toward similar goals. OIG continues to form partnerships with the health care industry to publicize “best practices,” promote voluntary compliance plans, establish an adverse action data bank, and consult on broad program integrity strategies. This multi-disciplinary approach will continue to enhance the office’s ability to carry out its mission.

PROGRAM SUPPORT CENTER

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Expenses.....	$259	$271	$282	+$11
FTE.....	1,069	1,085	1,085	0

SUMMARY

The Program Support Center (PSC) became operational in FY 1996 and was formed by combining administrative activities formerly located in the Office of the Secretary (OS), and funded by the OS Working Capital Fund (WCF), with activities from the former Office of the Assistant Secretary for Health (OASH), and funded by the Public Health Service (PHS) Service and Supply Fund (SSF). The formation of the PSC resulted from the Department's REGO II analysis with a goal of further streamlining and minimizing duplication of functions in the provision of cost effective administrative services to components of the Department and other Federal agencies on a service-for-fee basis. Services are provided in three broad areas: human resources, financial management, and administrative operations.

HUMAN RESOURCES SERVICE

The FY 2000 estimated expenses for the Human Resources Service (HRS) are $42 million, which is the same as the FY 1999 level. HRS provides a full range of personnel management services including personnel and payroll systems support; personnel operations services for civilian and commissioned personnel; training and career development; employee and labor relations; and administration of the Board for Corrections of PHS Commissioned Corps personnel records.

FINANCIAL MANAGEMENT SERVICE

The FY 2000 estimated expenses for the Financial Management Service (FMS) are $44 million, an increase of $1 million above the FY 1999 level. FMS supports the financial operations of HHS and other departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates.

ADMINISTRATION OPERATIONS SERVICE

The FY 2000 estimated expenses for the Administrative Operations Services (AOS) are $196 million, an increase of $10 million above the FY 1999 level. AOS supports the administrative management functions within the Department in the areas of property and material management, and support services ranging from commercial graphics to mail distribution and telecommunications services. The Telecommunications Improvement Project consolidates telephone services under one contract with substantial savings in telephone bills to agencies located in Maryland.

PROGRAM SUPPORT CENTER ENTITLEMENT SPENDING

(dollars in millions)

	1998 Actual	1999 Enacted	2000 Request	Request +/- Enacted
Retirement Pay and Medical Benefits for Commissioned Officers:				
Retirement Payments	$150	$159	$172	+$13
Survivor's Benefits	11	12	12	0
Medical Care	28	29	30	+1
Military Service credits	2	2	1	-1
Total	**$191**	**$202**	**$215**	**+$13**
Outlays	**$186**	**$199**	**$213**	**+$14**

SUMMARY

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payment to survivors of deceased retired officers. This account also funds the provision of medical care to active duty and retired members and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps. In addition, this account includes amounts to be paid to the Social Security Administration (SSA) for military service credits which are earned by active duty Commissioned Officers for non-wage income.