Fiscal Year 2014

Budget in Brief

Strengthening Health and Opportunity for All Americans

U.S. Department of Health & Human Services

HHS.GOV

Department of Health and Human Services
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This document is also available at http://www.hhs.gov/budget/

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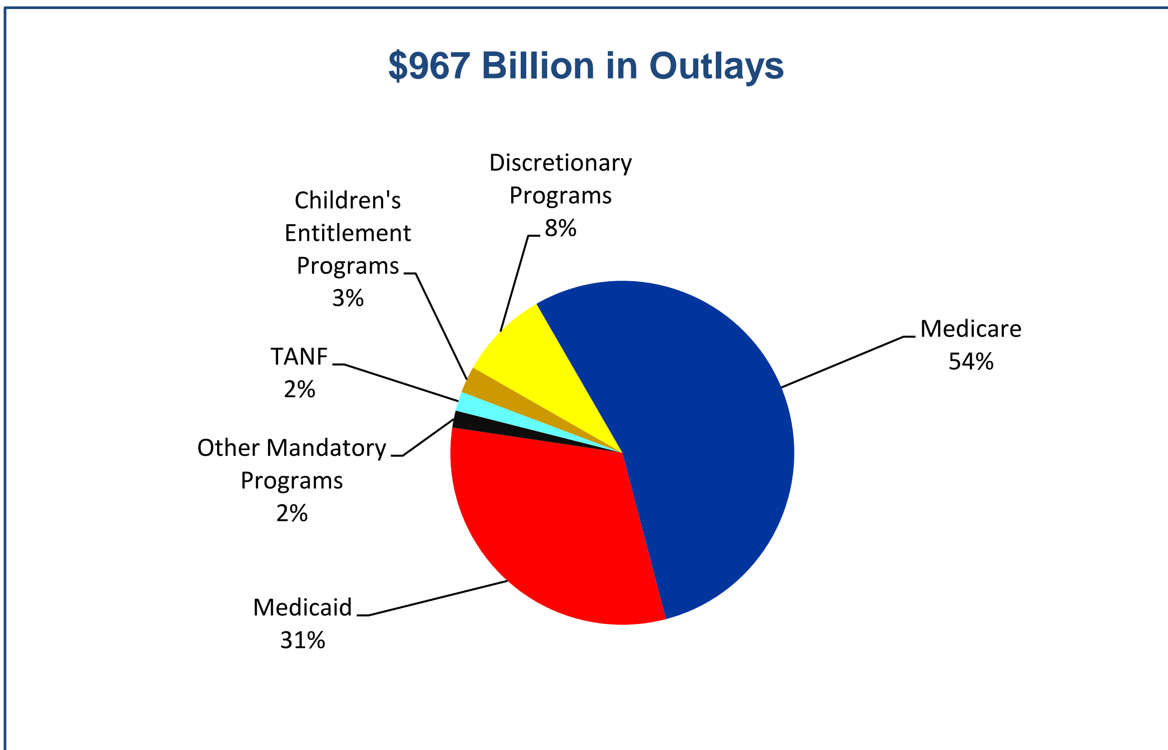
ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF THE NATION

FY 2014 President's Budget for HHS

dollars in millions	2012	2013	2014
Budget Authority	**873,872**	**909,524**	**974,594**
Total Outlays	**848,153**	**907,797**	**967,295**
Full-time Equivalents (FTE)	74,193	76,209	77,520



General Notes

Detail in this document may not add to the totals due to rounding. Budget data in this book are presented "comparably" to the FY 2014 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2014. This approach allows increases and decreases in this book to reflect true funding changes.

The FY 2012 figures herein reflect final enacted levels. The FY 2013 figures represent the annualized funding levels provided by the Continuing Appropriations Act through March 27, 2013 (P.L. 112-175), and do not reflect the cuts required by sequestration. The FY 2013 and FY 2014 mandatory figures reflect current law and mandatory proposals reflected in the Budget.

The Prevention and Public Health Fund (Prevention Fund) resources for FY 2013 are displayed in the Office of the Secretary. The FY 2012 and FY 2014 allocations of the Prevention Fund are included in the operating division totals.

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

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

The Budget for the Department of Health and Human Services (HHS) provides critical investments in health care, disease prevention, social services, and scientific research in order to create healthier and safer families, stronger communities, and a thriving America.

The President's fiscal year (FY) 2014 Budget for HHS includes investments needed to support the health and well-being of the nation, and legislative proposals that would save an estimated net $361.1 billion over 10 years. The Budget totals $967.3 billion in outlays and proposes $80.1 billion in discretionary budget authority. With this funding HHS will continue to improve health care and expand coverage, create opportunity and give kids the chance to succeed, protect vulnerable populations, promote science and innovation, protect the nation's public health and national security, and focus on responsible stewardship of taxpayer dollars.

Improving Health Care and Expanding Coverage

Expanding Health Insurance Coverage. Implementation of the Exchanges, also referred to as Marketplaces, will provide improved access to insurance coverage for more than 25 million Americans. Marketplaces make purchasing private health insurance easier by providing eligible consumers and small businesses with one-stop-shopping where they can compare across plans. New premium tax credits and rules ensuring fair premium rates improve affordability of private coverage. FY 2014 is the first operational year of the Marketplaces; open enrollment begins October 1, 2013 for the coverage year beginning January 1, 2014. The Budget supports operations in the Federal Marketplaces, as well as oversight and assistance to State-based and Partnership Marketplaces.

Beginning in January 2014, Medicaid coverage rules will be simplified and aligned with the Marketplaces, and millions of low-income people will gain coverage. The Centers for Medicare & Medicaid Services (CMS) is committed to working with states and other partners to advance state efforts that promote health, improve the quality of care, and lower health care costs.

Also beginning in 2014, consumers will benefit from a number of new protections in the private health insurance market. Most health insurers will no longer be allowed to charge more or deny coverage to people because of pre-existing conditions. These new protections will also prohibit most health insurers from putting annual dollar limits on benefits and from varying premiums based on gender or any factor other than age, tobacco use, family size, or geography. In addition, new plans in the individual and small group market will be required to cover a comprehensive package of items and services known as Essential Health Benefits, which must include items and services within ten benefit categories. Finally, most individuals choosing to participate in clinical trials will not face limits in health insurance coverage. This protection applies to all clinical trials that treat cancer or other life-threatening diseases.

Expanding Access to Care through Health Centers. The FY 2014 Budget includes $3.8 billion for the Health Centers program, including $2.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund. In FY 2014, 23 million patients will receive health care through more than 8,900 sites in medically underserved communities throughout the nation. The Budget funds 40 new health center sites for the provision of preventive health care services, expanding outreach and care to approximately 1.5 million additional patients.

Improving Patient Safety. HHS is committed to improving patient safety and reducing the risks and harm that patients can encounter. The Budget includes $63 million for patient safety research at the Agency for Healthcare Research and Quality (AHRQ). AHRQ's patient safety research focuses on the risks and harm inherent in the delivery of health care in order to understand the factors that can contribute to adverse events and how to prevent them. In FY 2014, AHRQ will fund projects to address the challenges of health care teamwork and coordination among providers. AHRQ will also support research on how to establish cultures conducive to patient safety in health care organizations. This research will serve as the foundational basis on which patient safety can be improved.

Helping Families and Children Succeed

In his State of the Union Address, the President proposed a series of new investments to create a continuum of high-quality early learning services for children beginning at birth through age five. As part of this initiative, HHS and the Department of Education are working together to make universal, high-quality preschool available to four-year olds from low- and moderate-income families through a partnership with states, expand the availability of high-quality care for infants and toddlers, and increase highly-effective, voluntary home visiting programs to provide health, social, and education supports to low-income families. Specifically, the FY 2014 HHS Budget includes:

Early Head Start—Child Care Partnerships. The Budget proposes $1.4 billion in FY 2014 for new Early Head Start – Child Care Partnerships that will expand the availability of early learning programs that meet the highest standards of quality for infants and toddlers, serving children from birth through age three. In addition to the new Partnerships, the Budget provides $222 million above FY 2012 to strengthen services for children currently enrolled in the program, avoid further enrollment reductions, and support the Head Start Designation Renewal System. Together, these investments total $9.6 billion, an increase of $1.7 billion over FY 2012.

Child Care Quality Fund. The request includes an additional $700 million above FY 2012 to expand early learning opportunities. Within this total, $200 million will help states raise the bar on quality by strengthening health and safety measures in child care settings, supporting professional development for providers, and promoting transparency and consumer education to help parents make informed child care choices. In addition to this funding, the Budget provides $500 million above FY 2012 to serve 1.4 million children, approximately 100,000 more than would otherwise be served.

Home Visiting. The Budget extends and expands this voluntary evidence-based program that has shown to be critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills; children's cognitive, language, and social-emotional development; and school readiness. The Budget proposes a long-term $15 billion investment beginning in FY 2015.

Child Support and Father Initiative. Additionally, the Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to Temporary Assistance for Needy Families recipients. Recognizing that healthy families need more than just financial support alone, the proposal requires states to include parenting time provisions in initial child support orders, to increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and to implement domestic violence safeguards. The Budget also includes new enforcement mechanisms that will enhance child support collections.

Protecting Vulnerable Populations

Programs that Serve American Indians and Alaska Natives. During the Tribal Nations Conference in December 2012, the President reiterated his commitment to improving the lives and well-being of American Indians and Alaska Natives. To reflect

this continued commitment, the Indian Health Service (IHS) discretionary budget has increased by 32 percent since FY 2008. The FY 2014 Budget funds IHS at $5.7 billion, an increase of $244 million over FY 2012. The Budget prioritizes funding to reduce health disparities in American Indian and Alaska Native communities by increasing resources for critical health services purchased outside of the IHS system and by providing staffing for new and replacement facilities that expand IHS's capacity to provide care at hospitals, outpatient facilities, and treatment clinics. Additionally, the Budget funds new construction at $85 million to work toward completion of several facilities that are projected to serve a population of approximately 32,200 patients collectively.

Increasing Access to Mental Health Services and Reducing Violence. While the vast majority of Americans with a mental illness are not violent, and are in fact more likely to be the victims of violence, recent tragedies have brought to light a hidden crisis in America's mental health system. The Budget addresses these issues by investing $130 million to make sure students and young adults get treatment for mental health issues. This funding supports a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) to increase the Behavioral Health Workforce by an additional 5,000 mental health professionals. This funding also supports Project AWARE (Advancing Wellness and Resilience in Education), an effort to reach 750,000 young people through programs to train teachers and other adults who work with youth to detect and respond to mental illness.

The Budget will incorporate lessons from the Youth Violence Prevention program and invest in state grants to help keep schools safe and get students with behavioral health issues referred to the services they need, and proposes a new Healthy Transitions program to support young people ages 16 to 25 and their families to access and navigate the behavioral health treatment systems. In addition, the Budget provides $30 million in new funding to the Centers for Disease Control and Prevention (CDC) to track gun violence and to research strategies to prevent it.

Addressing the Unique Needs of Communities. The Administration for Community Living (ACL) was formed in April 2012 as a single agency designed to help more people with disabilities and older adults have the option to live in their homes and participate fully in their communities. The FY 2014 Budget reflects the creation of ACL by bringing together the resources for the Administration on Aging, the Office on Disability, and the Administration on Intellectual and Developmental Disabilities, into a consolidated request. This newly organized agency works across HHS to harmonize efforts to promote community living, which can both save federal funds and allow people to choose to live with dignity in the communities they call home. ACL's Lifespan Respite Care program, as an example, focuses on providing a testbed for needed infrastructure changes and on filling gaps in service by putting in place coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs.

Ryan White. The Budget includes $2.4 billion for the Ryan White HIV/AIDS program to continue its critical role in support of patients across the HIV/AIDS continuum, by linking patients to care, prescribing and improving adherence to antiretroviral medicine, and achieving viral suppression. Included in this total is $943 million for the AIDS Drug Assistance Program (ADAP), an increase of $10 million over FY 2012 to provide life-saving and life-extending medications to 218,900 individuals, an additional 1,600 people living with HIV/AIDS. This investment will allow ADAP to serve an additional 1,600 people living with HIV/AIDS relative to the estimated number of clients served in FY 2012.

Promoting Science and Innovation

Advancing Scientific Knowledge. The FY 2014 Budget includes $31.3 billion for the National Institutes of Health (NIH), an increase of $471 million over the FY 2012 level, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that spurs economic growth while advancing medical science. In FY 2014, NIH will focus on investing in today's basic research for tomorrow's breakthroughs,

advancing translational sciences, and recruiting and retaining diverse scientific talent and creativity. Investment in NIH also helps drive the biotechnology sector and assure the nation's place as a leader in science and technology.

Alzheimer's Disease Initiatives. The Department continues to implement the National Plan to Address Alzheimer's Disease, as required by the National Alzheimer's Project Act. In FY 2014, the Budget includes a $100 million initiative targeted to expanding research, education, and outreach on Alzheimer's disease, and to improving patient, family, and caregiver support. Included in this initiative is $80 million within the NIH budget to be devoted to speeding drug development and testing new therapies. Also, the request for the Prevention and Public Health Fund (Prevention Fund) includes $20 million for the Alzheimer's Disease Initiative. Of this, ACL will use $15 million to strengthen state and local dementia intervention capabilities and for outreach to inform those who care for individuals with Alzheimer's disease about resources available to help them. HRSA will use the other $5 million to expand efforts to provide training to healthcare providers on Alzheimer's disease and related dementias.

Protecting the Nation's Public Health and National Security

Project BioShield and Advanced Development. In FY 2014, HHS will continue to support the development and procurement of medical countermeasures (MCMs) against chemical, biological, radiological, and nuclear (CBRN) threats. This funding includes $415 million to support advanced research and development of MCMs through the Biomedical Advanced Research and Development Authority. Additionally, the Budget includes $250 million as the first installment of a multi-year commitment to support Project BioShield, aimed to facilitate the procurement of these MCMs for the Strategic National Stockpile. Together, these efforts will enhance the nation's ability to acquire MCMs that will be vital to mitigating or preventing the effects of CBRN threats.

Strengthening the Nation's Food Supply. Ensuring the safety of the nation's food supply remains one of the Administration's top priorities. The Budget includes $1.5 billion, an increase of $312 million over FY 2012, to support the Food and Drug Administration (FDA) and CDC activities that will develop and strengthen an integrated and prevention-based food safety system. The Budget supports FDA's efforts to invest in system-wide domestic and foreign enhancements, such as improving import safety, risk analysis, and putting in place preventive controls to implement the FDA Food Safety and Modernization Act. The Budget proposes the food facility registration and inspection user fee and an importer user fee to support FDA's activities in FY 2014. The Budget also increases funding for CDC to enhance surveillance systems and continue support of Integrated Food Safety Centers of Excellence.

Medical Products. The Budget includes $2.6 billion, an increase of $456 million over FY 2012, for FDA to ensure the safety, effectiveness, and timely availability of medical products including prescription drugs, generic drugs, biologics, and devices. The FDA Safety and Innovation Act provided for the continuation of the prescription drug and medical device user fees. In addition, FDA may now collect fees from industry for two recently authorized programs to support generic drugs and biosimilar biological products. These resources are critical to strengthen the medical product review process. The Budget includes resources from these user fees and also proposes a medical product reinspection fee.

Infectious Disease Surveillance Modernization. The Budget invests $40 million to modernize CDC's surveillance technology and methods to better detect and track infectious disease. This investment will allow CDC to retool its national surveillance systems and detect and respond to emerging health threats in a timely manner. CDC's infectious disease surveillance technologies are becoming increasingly outdated and threaten the basic public health mission of the agency. In an effort to keep up with advances, CDC is making substantial investments in

bioinformatics, database development, data warehousing, and analytics. This initiative requires strategic and sustained investment in the following areas: pathogen identification and detection using genomics, adaptation of new diagnostics, state assistance and coordination, enhanced and integrated sustainable laboratory systems, and tool development to support prediction and modeling for early disease detection.

Focusing on Responsible Stewardship of Taxpayer Dollars

Contributing to Deficit Reduction while Maintaining Promises to all Americans. The Budget makes the investments the nation needs right now while reducing the deficit in the long term and ensuring the programs that millions of Americans rely on will be there for generations to come.

The Budget maintains ongoing investments in areas most central to advancing the HHS mission while making reductions to lower priority areas, reducing duplication, and increasing administrative efficiencies. Overall, the FY 2014 Budget includes nearly $2.3 billion in discretionary terminations and reductions.

The FY 2014 Medicare and Medicaid legislative proposals seek to reduce the deficit while encouraging economic growth and maintaining the promise of HHS programs. Medicare savings would total $371.0 billion over 10 years by encouraging beneficiaries to seek value in their health care choices, strengthening provider payment incentives to promote high-value, efficient care, and increasing the availability of generic drugs and biologics. The Budget includes $22.1 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the FY 2014 discretionary budget request and these legislative proposals allow HHS to support the Administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Combating Fraud, Waste, and Abuse in Health Care. The FY 2014 Budget makes cutting fraud, waste, and abuse a top Administration priority. In addition to the base discretionary Health Care Fraud and Abuse Control (HCFAC) funding in FY 2013 and FY 2014, the Budget seeks new mandatory funding. Starting in FY 2015, the Budget proposes all new HCFAC investments be mandatory, consistent with levels in the Budget Control Act. This investment supports fraud prevention initiatives like the Fraud Prevention System and provider screening; reducing improper payments in Medicare, Medicaid and CHIP; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team initiatives, including the Medicare Strike Force teams and the Fraud Prevention Partnership between the federal government, private insurers, and other key stakeholders.

From 1997 to 2012, HCFAC programs have returned over $23.0 billion to the Medicare Trust Funds, and the current three-year return-on-investment of 7.9 to 1 is the highest in the history of the HCFAC program. The Budget's 10-year HCFAC investment yields a conservative estimate of $6.7 billion in Medicare and Medicaid savings.

The Budget includes $389 million in discretionary and mandatory funding for the Office of Inspector General (OIG), an increase of $101 million above the FY 2012 level. This increase will enable OIG to expand CMS Program Integrity efforts for the Health Care Fraud Prevention and Enforcement Action Team and improper payments, and also enhance investigative efforts focused on civil fraud, oversight of grants, and the operation of Affordable Care Act programs.

The Budget also includes $82 million for the Office of Medicare Hearings and Appeals (OMHA), an increase of $10 million from FY 2012, to address OMHA's adjudicatory capacity and staffing levels and maintain quality and accuracy of its decisions. The increase allows OMHA to establish a new field office in the Central time zone supported by additional Administrative Law Judge teams, attorneys, and operational staff.

Performance, Evaluations and Effectiveness

Assessing the Impact of Health Insurance Coverage Expansions on Safety Net Programs. The Budget includes $3 million to the Assistant Secretary for Planning and Evaluation to evaluate the impact of health insurance coverage and benefit expansions among beneficiaries of HHS direct service programs. This request supports the continuation of research and evaluation studies, collection of data, and assessments of the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress.

Improving the Use of Evidence-Based Interventions. The Budget includes proposals to improve the use of evidence-based interventions in SAMHSA's Mental Health Block Grant to ensure that federal resources are invested in strategies that work. This proposal will require states to target resources, through their formula grant allocations, to evidence-based interventions.

The Budget will also substantially increase support for the National Registry of Evidence-based Programs and Practices. This searchable online system supports states, communities, and tribes in identifying and implementing evidence-based mental health and substance abuse prevention and treatment interventions. Additional funding will be used to ensure the registry includes cutting edge innovations that work.

HHS BUDGET BY OPERATING DIVISON

mandatory and discretionary dollars in millions /1	2012	2013	2014
Food and Drug Administration			
Budget Authority	2,572	2,523	2,560
Outlays	2,028	2,546	2,518
Health Resources and Services Administration			
Budget Authority	8,032	8,790	9,225
Outlays	8,892	9,155	8,734
Indian Health Service			
Budget Authority	4,464	4,491	4,588
Outlays	4,524	4,655	4,721
Centers for Disease Control and Prevention			
Budget Authority	6,804	6,028	6,372
Outlays	6,823	6,696	6,226
National Institutes of Health			
Budget Authority	30,852	31,049	31,323
Outlays	32,765	31,775	31,319
Substance Abuse and Mental Health Services Administration			
Budget Authority	3,439	3,368	3,406
Outlays	3,016	3,594	3,410
Agency for Healthcare Research and Quality			
Budget Authority	12	—	—
Program Level	405	432	434
Outlays	184	205	26
Centers for Medicare & Medicaid Services /2			
Budget Authority	765,208	798,811	861,433
Outlays	736,216	793,598	853,463
Administration for Children and Families /3			
Budget Authority	49,921	50,832	51,943
Outlays	49,368	50,604	51,437
Administration for Community Living			
Budget Authority	1,502	1,490	2,078
Outlays	1,465	1,470	1,826
Office of the National Coordinator			
Budget Authority	16	17	21
Outlays	570	580	376

1/ Figures in this table are not displayed comparably and may differ from agency totals listed elsewhere in this document.

2/ Budget Authority includes Non-CMS Budget Authority for Hospital Insurance and Supplementary Medical Insurance for the Social Security Administration and MedPAC.

3/ The FY 2014 Budget also includes General Provision language that would redirect $12 million from anticipated unobligated Abstinence Education funding in ACF to support a new program to prevent pregnancy among youth in Foster Care.

HHS BUDGET BY OPERATING DIVISON

mandatory and discretionary dollars in millions /1	2012	2013	2014
Medicare Hearings and Appeals			
Budget Authority	72	72	82
Outlays	64	58	82
Office for Civil Rights			
Budget Authority	41	41	42
Outlays	39	42	42
Departmental Management			
Budget Authority	529	502	431
Outlays	606	350	451
Prevention and Wellness			
Recovery Act Budget Authority	—	—	—
Outlays	+14	—	—
Prevention and Public Health Fund			
Budget Authority	—	1,000	—
Outlays	—	110	800
Health Insurance Reform Implementation Fund /4			
Budget Authority	—	—	—
Outlays	264	318	163
Public Health and Social Services Emergency Fund			
Budget Authority	568	767	1,290
Outlays	1,714	1,829	1,939
Office of Inspector General			
Budget Authority	50	58	69
Outlays	93	54	68
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)			
Budget Authority	654	642	667
Outlays	372	1,115	630
Offsetting Collections			
Budget Authority	-864	-957	-936
Outlays	-864	-957	-936
Total, Health and Human Services			
Budget Authority	**873,872**	**909,524**	**974,594**
Outlays	**848,153**	**907,797**	**967,295**
Full-time Equivalents	74,193	76,209	77,520
4/ Includes outlays for all agencies receiving resources from the fund.			

COMPOSITION OF THE HHS BUDGET
DISCRETIONARY PROGRAMS

dollars in millions	2012	2013 /1	2014	2014 +/-2012
Discretionary Programs (Budget Authority):				
Food and Drug Administration	2,506	2,521	2,558	+52
Program Level	*3,832*	*4,184*	*4,654*	*+821*
Health Resources and Services Administration /2	6,212	6,239	6,022	-191
Program Level	*8,202*	*8,547*	*9,043*	*+841*
Indian Health Service	4,307	4,333	4,431	+124
Program Level	*5,418*	*5,464*	*5,662*	*+244*
Centers for Disease Control and Prevention	5,725	5,762	5,293	-432
Program Level	*11,187*	*10,039*	*11,257*	*+71*
National Institutes of Health	30,702	30,899	31,173	+471
Program Level	*30,860*	*31,057*	*31,331*	*+471*
Substance Abuse and Mental Health Services Administration	3,347	3,368	3,348	+1
Program Level	*3,569*	*3,499*	*3,572*	*+4*
Agency for Healthcare Research and Quality	—	—	—	—
Program Level	*405*	*432*	*434*	*+29*
Centers for Medicare & Medicaid Service	3,820	3,843	5,217	+1,397
Program Level	*4,684*	*4,640*	*6,857*	*+2,174*
Administration for Children and Families /3	16,316	16,543	17,780	+1,464
Program Level	*16,322*	*16,549*	*17,786*	*+1,464*
ACF Discretionary Supplemental Funding (add-on) /4	—	100	—	—
Administration for Community Living	2,152	2,166	2,095	-58
Program Level	*2,185*	*2,201*	*2,129*	*-56*
Office of the Secretary:				
General Departmental Management	473	476	301	-172
Program Level	*597*	*571*	*551*	*-46*
Prevention and Public Health Fund (non-add)	—	*1,000*	—	—
Office of Medicare Hearing and Appeals	72	72	82	+10

COMPOSITION OF THE HHS BUDGET
DISCRETIONARY PROGRAMS

dollars in millions	2012	2013 /1	2014	2014 +/-2012
Office of the National Coordinator	16	17	21	+4
Program Level	*61*	*62*	*78*	*+17*
Office of Inspector General	50	50	69	+19
Program Level	*288*	*362*	*389*	*+101*
OIG Supplemental Funding (add-on) /4	—	5	—	—
Office for Civil Rights	41	41	42	+1
Public Health and Social Services Emergency Fund	568	572	1,290	+721
Program Level	*983*	*987*	*1,290*	*+306*
PHSSEF Supplemental Funding (add-on) /4	—	195	—	—
Discretionary HCFAC	310	312	311	+1
Accrual for Commissioned Corps Health Benefits	36	29	26	-10
Public Health and Prevention Fund (non-add)	—	*1,000*	—	—
Total, Discretionary Budget Authority	**76,655**	**77,543**	**80,058**	**+3,403**
Less Discretionary Supplemental Funding /4	—	*-300*	—	—
Less One-Time Rescissions /5	*-6,768*	*-6,578*	*-3,791*	*+2,977*
Revised, Discretionary Budget Authority	**69,887**	**70,665**	**76,267**	**+6,380**

1/ The FY 2013 figures represent the annualized funding levels provided by the Continuing Appropriations Act through March 27, 2013 (P.L. 112-175), and do not reflect the cuts required by sequestration. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

2/ The FY 2014 Budget includes General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding for the administration of the HEAL program is reflected in the Department of Education.

3/ The FY 2014 Budget also includes General Provision language that would redirect $12 million from anticipated unobligated Abstinence Education funding in ACF to support a new program to prevent pregnancy among youth in Foster Care.

4/ Reflects funding provided by the Disaster Assistance Supplemental for FY 2013 (P.L. 113-2). OMB reclassified the $500 provided to the Social Services Block Grant as mandatory funding.

5/ FY 2012 rescissions include $400 million from CO-OPs and $6.4 billion from CHIPRA performance bonuses. FY 2013 rescissions include $6.4 billion from CHIPRA performance bonuses, $200 million from CMS Community-base Care Transitions Program, and $10 million from the Independent Payment Advisory Board. The FY 2014 Budget proposes to rescind $3.8 billion from CHIPRA performance bonuses, and redirect $12 million from ACF as described above.

COMPOSITION OF THE HHS BUDGET
MANDATORY PROGRAMS

dollars in millions	2012	2013	2014	2014 +/- 2013
Mandatory Programs (Outlays):				
Medicare	466,242	505,052	524,162	+19,110
Medicaid	250,534	266,565	303,634	+37,069
Temporary Assistance for Needy Families /1	16,814	17,724	17,758	+34
Foster Care and Permanency	6,847	6,744	6,901	+157
Children's Health Insurance Program /2	9,065	10,022	10,092	+70
Child Support Enforcement	3,957	3,994	4,045	+51
Child Care	2,828	2,908	3,322	+414
Social Services Block Grant /3	1,715	1,964	2,062	+98
Other Mandatory Programs	9,007	11,447	15,031	+3,584
Offsetting Collections	-864	-957	-936	+21
Subtotal, Mandatory Outlays	**766,145**	**825,463**	**886,071**	**+60,608**
Total, HHS Outlays	**848,153**	**907,797**	**967,295**	**+59,498**

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

2/ Includes outlays for the Child Enrollment Contingency Fund.

3/ The increase in SSBG outlays in FY 2013 and FY 2014 are attributable to the funding provided by the Disaster Relief Appropriations Act (P.L. 113-2).

FOOD AND DRUG ADMINISTRATION

dollars in millions	2012	2013 /1	2014	2014 +/- 2012
Program				
Foods	875	880	1,107	+232
Human Drugs	979	1,268	1,292	+313
Biologics	329	334	338	+9
Animal Drugs and Feeds	165	166	191	+25
Medical Devices	376	378	435	+59
National Center for Toxicological Research	60	60	59	-1
Center for Tobacco Products	455	458	501	+47
Headquarters and Office of the Commissioner	232	260	298	+66
FDA Consolidation at White Oak	44	44	62	+18
GSA Rental Payment	205	211	228	+23
Other Rent and Rent Related Activities	88	102	121	+33
Export Certification Fund	3	5	5	+1
Color Certification Fund	8	8	8	—
Priority Review Voucher User Fee	5	—	—	-5
Buildings and Facilities	9	9	9	—
Total, Program Level	**3,832**	**4,184**	**4,654**	**+821**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA)	702	719	760	+58
Medical Device (MDUFA)	58	58	115	+57
Animal Drug (ADUFA) /2	22	22	24	+2
Animal Generic Drug (AGDUFA) /2	6	6	7	+2
Food Reinspection Fee	15	15	15	+1
Food Recall Fee	12	12	13	+1
Family Smoking Prevention and Tobacco Control Act	477	480	534	+57
Human Generic Drug	—	299	306	+306
Biosimilars	—	20	21	+21
Mammography Quality Standards Act (MQSA)	19	19	19	—
Export Certification Fund	3	5	5	+1
Color Certification Fund	8	8	8	—
Priority Review Voucher User Fee	5	—	—	-5
Subtotal, Current Law User Fees	**1,326**	**1,662**	**1,827**	**+500**
Proposed Law				
Food Facility Registration and Inspection Fee	—	—	59	+59
Food Import Fee	—	—	166	+166
Food Contact Notification Fee	—	—	5	+5
Cosmetics Fee	—	—	19	+19
Medical Products Reinspection Fee	—	—	15	+15
International Courier User Fee	—	—	6	+6
Subtotal, Proposed Law User Fees	—	—	**269**	**+269**
Total, User Fees	**1,326**	**1,662**	**2,096**	**+770**
Total, Discretionary Budget Authority	**2,506**	**2,521**	**2,558**	**+52**
Full-time Equivalents	13,538	14,572	15,580	+2,042

1/ Spending authority has been adjusted pursuant to P.L. 112-175, Section 101(c) for the applicable user fee programs.
2/ The Animal Drug User Fee Amendments of 2008 and the Animal Generic Drug User Fee Act of 2008 expire on October 1, 2013. HHS transmitted a legislative proposal to Congress on February 25, 2013.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, the nation's food supply, cosmetics, and products that emit radiation. FDA also advances the public health by helping to speed innovations that make medicines more effective, safer, and more affordable, and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. Furthermore, FDA has responsibility for regulating the manufacture, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, FDA plays a significant role in the nation's counterterrorism capability by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats.

The FY 2014 Budget includes $4.7 billion for the Food and Drug Administration (FDA), an increase of $821 million, or 21 percent, over FY 2012. Of the increase, $52 million is from budget authority. The FDA budget includes investments to continue implementation of the FDA Food Safety Modernization Act (FSMA); advance medical countermeasures; continue regulatory and public health activities to decrease initiation of tobacco use and encourage cessation; improve the safety of foods and medical products imported into the United States from China; strengthen regulatory science and better harness and use data to modernize FDA's decision-making process through the Administration's Big Data Initiative. In addition, the enactment of the FDA Safety and Innovation Act (FDASIA) in FY 2012 reauthorized and established key user fee programs that will advance the safety of the nation's drug and medical products supply.

Ensuring the Safety of Nation's Food Supply

FSMA was enacted to enhance the safety of the nation's food supply by shifting the focus from responding to food contamination to preventing outbreaks and illnesses. Since its enactment, FDA has taken steps to build the foundation for a prevention and risk-based food safety system:

- FDA created the Coordinated Outbreak Response and Evaluation network to streamline and strengthen its ability to prevent, detect, investigate, and respond to incidents and outbreaks which would inform preventive food safety practices.
- In January, FDA issued two significant proposed rules on produce safety standards and preventive controls for human food, which were informed by extensive outreach to federal and local government, industry, consumers, and research stakeholders.

In FY 2014, FDA will build on these accomplishments to continue implementation of FSMA activities.

Transforming the Food Safety System

FDA regulates more than $450 billion in foods; approximately 15 to 20 percent of foods consumed in the United States is imported from other countries. The impact of food and feed supply contamination can be costly to consumers, the food industry, and the health care system. The FY 2014 Budget includes a total program level of $1.5 billion, $296 million above the FY 2012 level, for FDA to protect the nation's food supply through implementation of FSMA. This total includes a total of $1.2 billion in budget authority. These investments will support integrating the food safety system, enhancing risk analytics, modernizing inspections, improving import safety, implementing preventive controls, and advancing food safety science. In addition, the Budget proposes a total of $225 million in resources through the food facility registration and inspection fee, and a food importer fee. These additional fee revenues are critical to implementing FSMA and would support activities such as developing new prevention standards, supporting education and outreach, enhancing inspection capacity, improving oversight, supporting risk-based technology, increasing border port coverage, and improving FDA's response capacity.

The Budget also proposes a $5 million food contact notification user fee that will support FDA activities, such as premarket notification, to ensure the safety of food contact substances. The fee will better position FDA to fulfill its public health mission by mitigating microbial food contamination.

Ensuring the Safety of Medical Products

FDA is the leader in global efforts for regulating medical products to ensure that Americans have access to timely, safe, and effective drugs and medical devices. The FY 2014 Budget includes $2.6 billion, $456 million above

the FY 2012 level, to support medical product safety activities across the agency which predominately includes the Human Drugs, Biologics, and Device programs at FDA. These programs protect the public by overseeing the safety, effectiveness, and quality of drugs, including generic and over-the-counter drugs, biologics, and medical devices. Through these programs, FDA evaluates the safety of products before they are marketed to the public, and ensures products meet FDA standards of quality, and continue to be safe and appropriately marketed once available to the public.

The enactment of FDASIA reauthorized the Prescription Drug User Fee and the Medical Device User Fee, which are critical to supporting medical product safety activities at FDA. In addition, FDASIA established the generic drug and biosimilars user fee. With these new generic drug user fee resources, FDA will review and act on 90 percent of original abbreviated new drug applications (ANDA) within 10 months of the date of submission by FY 2017. FDA will also review and act on 90 percent of all ANDA, amendments, and prior approval supplements regardless of current review status pending on October 1, 2012 by the end of FY 2017. The biosimilar user fee enables FDA to develop a pathway to approve biosimilars and biological products. The Congressional Budget Office has estimated that the use of biosimilars will save the federal health care system $7 billion during the next decade.

Finally, the Budget proposes a $15 million medical products reinspection user fee that would require manufacturers to pay the full costs of reinspections and associated follow-up work if they fail to meet FDA health and safety standards during an inspection.

Advancing Medical Countermeasures

The FDA Medical Countermeasure (MCM) Initiative helps accelerate MCM development, evaluation and approval, and establishes a clear regulatory, legal, and policy framework to support emergency preparedness and response. The FY 2014 Budget includes $24 million for the MCM initiative, which is $4 million above FY 2012. These resources will sustain the MCM initiative to ensure the nation has countermeasures in place to protect against chemical, biological, radiological, and nuclear threats, as well as emerging infection disease threats.

FDA Safety and Innovation Act

On July 9, 2012, the President signed into law the FDA Safety and Innovation Act (FDASIA), which reauthorized the prescription drugs and medical device user fees and authorized FDA to collect fees to support generic drugs and biologics. The newly authorized user fee programs are included in the FY 2014 President's Budget. These resources support stability in the review process of these products and enhance the timeliness in which FDA is able to make these products available to the public. FDASIA also permanently authorized the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act to ensure the safety of pediatric drug research and development. In addition, FDASIA provided FDA with other authorities to address drug shortages and drug supply chain safety.

Reducing Tobacco Use

Enacted in 2009, the Family Smoking Prevention and Tobacco Control Act provided FDA important new responsibilities for regulating the manufacture, marketing, and distribution of tobacco products, protecting public health, and reducing tobacco use by minors. The FY 2014 Budget includes $534 million in user fees for FDA to continue implementation of the Act by focusing on the following three strategic objectives:

- Reducing initiation of tobacco product use;
- Decreasing the harms of tobacco products; and,
- Encouraging cessation among tobacco users.

In FY 2014, FDA will support the Tobacco Retail Inspection program, which increases the efficiency of inspections through use of new technologies like mobile devices. In addition, FDA will expand advertising and labeling enforcement activities and support monitoring activities to ensure compliance with requirements in the Act. FDA will also invest in training and educational activities for tobacco product businesses, and outreach efforts to educate the public about the harms of tobacco products.

User Fees

The Budget proposes six new user fees across FDA, assumes the reauthorization of the animal drug and animal generic drug user fees that will expire on October 1, 2013, and reflects increases in existing user fees under current law. Resources from these user fees are critical to enable FDA to carry out its mission.

In addition to the food and medical product safety user fees described above, the FY 2014 Budget proposes two additional fees. The Budget continues to propose the international courier user fee, which would provide $6 million to support the activities related to the increased volume of FDA-regulated commodities, predominantly medical products, imported through express courier hubs. In addition, the proposed cosmetic user fee totaling $19 million will support FDA's role in ensuring the safety of cosmetic products in the United States. The volume of both domestic, and especially imported cosmetic products continues to grow and manufacturing technology and ingredients are becoming more complex. These user fee resources will build on activities currently supported by FDA to strengthen the cosmetics program.

FDA Facilities

The FY 2014 Budget includes resources to support and modernize FDA's infrastructure to keep up with the demands of the modern economy. A total of $62 million, $18 million above the FY 2012 level, is included to continue the consolidation of FDA headquarters to the White Oak campus in Maryland. This increase will support activities to prepare for occupation of the Life Sciences-Biodefense Complex in FY 2014. The complex will include state-of-the-art facilities that will support research to protect patients by better assessing the safety and effectiveness of medical products.

In addition, The Budget provides $9 million, the same as FY 2012, to fund repair and maintenance of FDA-owned facilities. Resources will be used for repairs at the Jefferson Laboratories Complex in Arkansas, which houses activities conducted by the National Center for Toxicological Research and other FDA field efforts.

Reauthorization of the Animal Drug and Animal Generic Drug User Fees

The Animal Drug User Fee Amendments (ADUFA) of 2008 and the Animal Generic Drug User Fee Act (AGDUFA) of 2008 expire on October 1, 2013. The enactment of ADUFA and AGDUFA allowed FDA to expedite the review process for new animal drugs and animal generic drugs, and to enhance the safety and effectiveness of products.

FDA published a notice in the Federal Register on December 5, 2012 to inform the public of recommendations and request input for the next authorization of ADUFA and AGDUFA. Public meetings were held on December 18, 2012 to discuss both programs and to provide an opportunity for public comments. HHS submitted legislative proposals for ADUFA and AGDUFA to Congress on February 25, 2013 that include recommendations developed through discussions with a wide range of stakeholders. The legislative proposals include a total of $24 million for ADUFA and $7 million for AGDUFA in FY 2014 to ensure FDA can continue to provide predictable and timely review processes to foster innovation.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

dollars in millions	2012	2013	2014	2014 +/- 2012
Primary Care				
Health Centers	2,672	2,992	3,672	+1,000
ACA Mandatory (non-add)	*1,200*	*1,500*	*2,200*	*+1,000*
Health Centers Tort Claims	95	95	95	—
ACA School Based Health Centers	50	50	—	-50
Free Clinics Medical Malpractice	.04	.04	.04	—
Subtotal, Primary Care	**2,817**	**3,137**	**3,767**	**+950**
Health Workforce				
ACA National Health Service Corps	295	300	305	+10
Training for Diversity	86	87	72	-15
Health Workforce Information and Analysis	3	3	5	+2
Primary Care Training and Enhancement	39	39	51	+12
Oral Health Training	32	33	32	—
Pediatric Loan Repayment	—	—	5	+5
Interdisciplinary, Community-Based Linkages	73	64	39	-34
Area Health Education Centers (non-add)	27	30	—	-27
Behavioral Health Education and Training (non-add)	*13*	*3*	*3*	*-10*
Public Health Workforce Development	33	8	8	-25
Prevention and Public Health Fund (non-add)	25	*N/A*	—	-25
Nursing Workforce Development	231	233	251	+20
Advanced Education Nursing (non-add)	*63*	*64*	*84*	*+20*
Children's Hospital Graduate Medical Ed. Payments	265	269	88	-177
Subtotal, Health Workforce	**1,058**	**1,037**	**856**	**-202**
Maternal and Child Health				
Maternal and Child Health Block Grant	639	649	639	—
Heritable Disorders	10	10	10	—
Prevention and Public Health Fund (non-add)	—	*N/A*	*10*	*+10*
Autism and Other Developmental Disorders	47	48	47	—
Traumatic Brain Injury	10	10	10	—
Sickle Cell Service Demonstrations	5	5	5	—
Universal Newborn Hearing Screening	19	19	19	—
Prevention and Public Health Fund (non-add)	—	*N/A*	*19*	*+19*
Emergency Medical Services for Children	21	21	21	—
Healthy Start	104	105	104	—
ACA Home Visiting	350	400	400	+50
ACA Family to Family Health Information Centers	5	5	--	-5
Subtotal, Maternal and Child Health	**1,208**	**1,272**	**1,253**	**+45**
Ryan White HIV/AIDS				
Emergency Relief - Part A	666	675	666	—
Comprehensive Care - Part B	1,361	1,329	1,371	+10
AIDS Drug Assistance Program (ADAP) (non-add)	*933*	*904*	*943*	*+10*
Early Intervention - Part C	215	206	225	+10
Children, Youth, Women, and Families - Part D	77	78	77	—
Education and Training Centers - Part F	35	35	35	—

HEALTH RESOURCES AND SERVICES ADMINISTRATION

dollars in millions	2012	2013	2014	2014 +/- 2012
Dental Services - Part F	13	14	13	—
PHS Evaluation Funds	25	25	25	—
Subtotal, HIV/AIDS	**2,392**	**2,361**	**2,412**	**+20**
Health Care Systems				
Organ Transplantation	24	25	26	+2
Cord Blood Stem Cell Bank	12	12	12	—
C.W. Bill Young Cell Transplantation Program	23	23	23	—
Poison Control Centers	19	19	19	—
Prevention and Public Health Fund (non-add)	—	*N/A*	*19*	*+19*
Hansen's Disease Programs	18	18	18	—
340B Drug Pricing Program	4	4	4	—
User Fee (non-add)	—	—	*6*	*+6*
Subtotal, Health Care Systems	**101**	**102**	**109**	**+8**
Rural Health				
Rural Health Outreach Grants	56	56	56	—
Rural Health Policy Development	10	10	10	—
Rural and Community Access to Emergency Devices	1	3	—	-1
Rural Hospital Flexibility Grants	41	41	26	-15
State Offices of Rural Health	10	10	10	—
Radiogenic Diseases	2	2	2	—
Black Lung	7	7	7	—
Telehealth	12	12	12	—
Subtotal, Rural Health	**138**	**140**	**122**	**-16**
Other Activities				
Family Planning	294	299	327	+34
Program Management	160	163	162	+2
Vaccine Injury Compensation Program Direct Operations	6	7	6	—
National Practitioner Data Bank (User Fees)	28	28	28	—
340B Drug Pricing Program (User Fees)		—	6	+6
Total, Program Level /1	**8,202**	**8,547**	**9,043**	**+841**
Less Funds From Other Sources				
PHS Evaluation Funds	-25	-25	-25	—
User Fees	-28	-28	-34	-6
Mandatory Funding	-1,900	-2,255	-2,905	-1,005
Prevention and Public Health Fund	-37	*N/A*	-57	-20
Total, Budget Authority	**6,212**	**6,239**	**6,022**	**-191**
Full-time Equivalents	1,894	1,894	1,872	-22

1/ The FY 2014 Budget includes General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding for the administration of the HEAL program is reflected in the Department of Education.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.

The FY 2014 Budget includes $9 billion for the Health Resources and Services Administration (HRSA), an increase of $841 million above FY 2012. HRSA is the principal federal agency charged with improving access to health care to those in medically underserved areas. The FY 2014 Budget prioritizes investments in HRSA that will improve access to quality health care services for people who are medically, geographically, or socioeconomically vulnerable; and assures the availability of quality health care to low income, isolated, vulnerable and special needs populations.

Improving Access to Health Care in Underserved Areas

Health Centers: Health centers are an essential primary care provider for America's most vulnerable populations and are a critical component of the healthcare system as more individuals gain insurance coverage and access health care services through the Affordable Care Act. The Budget includes $3.8 billion for the Health Center program, including $2.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund. In FY 2014, the Health Center Program will support more than 1,200 grantees, and serve approximately 23 million patients.

Improving Quality of Care

The Patient-Centered Medical Home (PCMH) Initiative was established to enhance the quality of care in health centers through enhanced access, planning, management, and monitoring of patient care. To become a nationally recognized patient-centered medical home, a health center needs to meet nationally qualified standards in services comprehensiveness, care coordination, enhanced access, and quality improvement.

In FY 2014, the quality of care provided by health centers will be improved by increasing the proportion of health centers that are nationally recognized as Patient Centered Medical Homes from 13% of health centers in FY 2012 to over 40% of health centers in FY 2014.

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

Improving Care for At-Risk Populations

HIV/AIDS: The Ryan White program annually serves over half a million low-income people with HIV/AIDS in the United States and is the federal government's largest investment in the well-being of people living with HIV/AIDS. The Ryan White program continues to be responsive to the needs of people living with HIV/AIDS and plays a critical role in supporting patients across the HIV/AIDS care continuum. This continuum, also referred to the HIV Treatment Cascade, includes linkage to care, engaging and retaining patients in care, prescribing and improving adherence to antiretroviral medications, and achieving viral suppression. Many of the services supported by the Ryan White program that are essential to people accessing care and remaining in care and on their medications are not covered by Medicaid or private insurance. By helping people stay in care and adhere to their antiretroviral treatments, the Ryan White program plays a critical role in preventing the spread of the HIV epidemic, as people living with HIV who are on drug treatment and virally suppressed are much less likely to transmit the infection.

The Budget includes $2.4 billion for the Ryan White program to improve and expand access to care for persons living with HIV/AIDS. The Budget includes $943 million to ensure that people living with HIV/AIDS have access to life-saving medications. In FY 2012, the Administration worked closely with states, local providers and industry to increase access to care, and to assist state AIDS Drug Assistance Programs (ADAP) with waiting lists or other cost containment measures. The FY 2014 investment is $10 million above FY 2012 and continues to support access to antiretroviral medications for the most vulnerable populations living with HIV/AIDS.

To ensure that community-based providers have the support they need, the Budget includes $225 million,

an increase of $10 million, to expand access to care for individuals with HIV/AIDS in high-need areas. The services supported by these resources include early intervention, core medical and support services, quality management, and care coordination .

Supporting Healthy Families

The Budget includes $1.6 billion to support investments that improve the health of mothers, children and their families as well as provide a broad range of family planning and related preventive health services for millions of low-income individuals.

Improving Maternal and Child Health: The FY 2014 Budget provides $1.3 billion to improve maternal and child health. This total includes $400 million to support evidence-based home visiting programs that have been shown to improve maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills; children's cognitive, language, and social-emotional development; and school readiness. The President has proposed to extend and expand the home visiting program beyond the $1.5 billion available since FY 2010**.** The request also includes $639 million, the same as FY 2012, for the Maternal and Child Health Block Grant. In addition, the Budget provides $47 million for research, screening and promoting evidence-based interventions for children with autism spectrum disorders and their families. No funding is provided for Family-to-Family Health Information Centers.

Expanding Access to Family Planning Services: The FY 2014 Budget includes $327 million, an increase of $34 million, to improve access to family planning centers and preventive health services for low-income individuals. This funding will allow clinics to provide access to reproductive and preventive services and other family planning activities at more than 4,000 clinics nationwide.

Building a Health Workforce for the 21st Century

In order to enable more Americans to get the quality care they need to stay healthy, it is critical to make targeted investments that promote a sufficient health workforce. HRSA health professions programs serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system. The Budget provides a total of $856 million, including $305 million in mandatory funding, to expand the nation's health workforce capacity. This total includes $144 million to support the continued distribution of primary care, dental and pediatric health providers, and advanced practice registered nurses and invest to train 2,800 new primary care providers over five years to expand the nation's workforce capacity. The Budget also provides $169 million to address the nurse shortage through strategies such as increasing the nursing faculty to provide training in nursing schools. A total of $39 million is provided to boost the number of social workers and psychologists who work in rural areas, and who serve military personnel, veterans and their families. Within the total provided for Health Workforce, $111 million continues activities that directly address the capacity of healthcare providers in oral health, behavioral health, and the public health workforce.

In addition, the Budget includes $35 million budgeted within SAMHSA for a collaboration with HRSA to increase the number of mental health professionals as part of the President's "Now is the Time" proposal responding to the recent tragedy at Sandy Hook Elementary School.

The Budget proposes $88 million, a decrease of $177 million below FY 2012, to support the direct costs associated with training physicians within freestanding children's hospitals. These costs include training pediatric residents, providing stipends and benefits, supporting supervisory physician salaries and paying administrative overhead expenses. No funds are requested for the Area Health Education Centers program or the Health Careers Opportunity Program.

Improving Rural Health: The HRSA rural health programs serve a policy and research resource for rural health issues as well as program grants that enhance health care delivery in rural communities. The FY 2014 Budget includes $122 million for targeted rural health programs. This investment includes $56 million to improve access to care, coordination of care, integration of services and to focus on quality improvement in health care for rural communities. In addition, the Budget provides $26 million to continue funding for all continuing Rural Hospital Flexibility grants; $20 million for research, technical assistance, and policy development to improve rural health outcomes; $12 million to expand access to quality care through telecommunications; and $9 million for

screening and care for coal miners and certain other individuals. No funds are requested for the Rural Access to Emergency Devices.

Making Prescription Drugs Affordable: The 340B program provides discounts on outpatient prescription drugs that serve a high number of low-income patients. The FY 2014 request includes $10 million to the 340B program – an increase of $6 million above FY 2012, through a new cost recovery fee. The user fee will help improve the program's operations, oversight and integrity. Participants in the 340B program include safety-net clinics and hospitals such as community health centers, Indian Health Service tribal clinics, children's hospitals, critical access hospitals, Federally Qualified Health Centers and look-a-likes, and programs that target sexually transmitted disease and tuberculosis prevention and treatment among others.

Other Public Health Activities

Supporting Transplantation: The Budget includes $26 million, an increase of $2 million, to coordinate organ donation activities and provide grants to states to develop and improve donor registries. In addition, the Budget includes $35 million to support patients who need a potentially life-saving marrow or cord blood transplant and to maintain the National Cord Blood Inventory.

Hansen's Disease Programs: The Budget maintains funding for the Hansen's Disease program that provides care to patients with leprosy, education of medical professionals about Hansen's Disease, and conducts biomedical research on Hansen's disease to advance treatment provided to patients.

Program Management

Program Management: The Budget requests $162 million, an increase of $2 million, to fund the infrastructure necessary to operate HRSA programs including rent, information technology, utilities, security, and agency oversight.

INDIAN HEALTH SERVICE

dollars in millions	2012	2013	2014	2014 +/- 2012
Services				
Clinical Services:	3,084	4,063	4,249	+224
Purchased/Referred Care (non-add)	*844*	*849*	*879*	*+35*
Medicaid (non-add)	*659*	*675*	*770*	*+112*
Preventive Health	147	148	152	+5
Tribal Management/Self-Governance	8.62	8.67	8.63	—
Urban Health	43	43	43	—
Indian Health Professions	41	41	41	—
Direct Operations	72	72	72	—
Diabetes Grants	150	150	150	—
Subtotal, Services	**4,486**	**4,526**	**4,716**	**+230**
Contract Support Costs /1	471	474	477	+6
Facilities				
Health Care Facilities Construction	85	86	85	—
Sanitation Facilities Construction	80	80	80	—
Facilities and Environmental Health Support	199	201	207	+8
Maintenance and Improvement	61	62	61	—
Medical Equipment	23	23	23	—
Subtotal, Facilities	**448**	**451**	**456**	**+8**
Total, Program Level	**5,418**	**5,464**	**5,662**	**+244**
Less Funds From Other Sources				
Health Insurance Collections	-954	-974	-1,074	-119
Rental of Staff Quarters	-8	-8	-8	—
Diabetes Grants /2	-150	-150	-150	—
Total, Budget Authority	**4,307**	**4,333**	**4,431**	**+124**
Full-time Equivalents	15,432	15,587	15,587	+155

1/ Contract Support Costs are requested as a separate appropriation in FY 2014. These funds were included in the Services appropriation in prior years.

2/ These mandatory funds were pre-appropriated in P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010, and P.L. 112-240, the American Taxpayer Relief Act of 2012.

INDIAN HEALTH SERVICE

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

The FY 2014 Budget requests $5.7 billion for the Indian Health Service (IHS), an increase of $244 million or 5 percent over FY 2012. The FY 2014 Budget continues to prioritize reducing health disparities in Indian Country though purchased care with the Purchased/Referred Care Program (formerly known as the Contract Health Service Program) and by providing staffing for new and replacement facilities. The Budget also encourages Indian self determination by supporting tribes that administer health programs and facilities in their areas. This increase reflects the Administration's commitment to fulfill the federal government's obligations to American Indians and Alaska Natives.

Fulfilling the Unique Role of the Indian Health Service

IHS partners with tribes to provide primary care, behavioral and community health, and sanitation services for a growing population of more than 2.2 million eligible American Indians and Alaska Natives. By partnering with tribes, IHS ensures maximum tribal participation in administering programs that impact tribal communities directly.

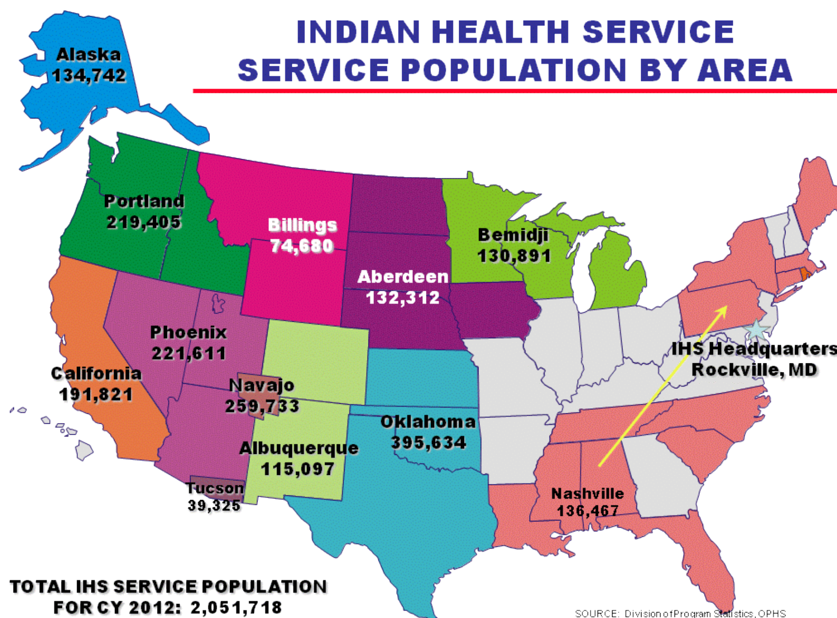
IHS and tribes deliver comprehensive health services to members of more than 566 federally recognized tribes through direct services in over 620 hospitals, clinics, and health stations on or near Indian reservations. Due to the unique relationship between the tribes and the federal government, IHS provides care in two ways: (1) preventive health care and direct medical care is provided through the IHS system, and (2) IHS contracts with hospitals and other health care providers to purchase care it is unable to provide through its own network.

Additionally, IHS provides a number of services beyond the provision of health care. IHS also builds sanitation systems to provide safe water and waste disposal for Indian homes, supports tribal self governance through contract funding, and provides scholarships and loan repayment awards to recruit health professionals to serve in areas with high provider vacancies.

Strengthening the Indian Health Service

The Budget includes an increase of $124 million to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives.

Purchased/Referred Care (formerly known as Contract Health Services): The Budget includes $879 million, an increase of $35 million or 4 percent over FY 2012, for the purchase of medical care from outside the IHS system. Care is purchased where no IHS facility is available or when the IHS facility cannot provide the services needed. The rising cost of health care continues to strain the IHS system, which uses medical priority criteria to determine priorities for purchasing care. Services in this program have expanded to more medical priorities in recent years and this increase ensures IHS can maintain that expansion.



Construction: The Budget includes $85 million for Health Care Facilities Construction to continue construction of healthcare facilities in San Carlos and Kayenta, Arizona and complete construction on the Southern California Regional Youth Treatment Center. Once completed, these facilities are projected to collectively serve a user population of 32,300 patients.

Staffing New and Replacement Health Facilities: The Budget includes an additional $77 million to support staffing and operating costs for ten new or replacement health facilities to be completed by FY 2014. Seven of the facilities are joint venture projects in which IHS is partnering with a tribal entity. IHS submits requests to Congress for funds for staffing, equipping, and operating the facility while the participating tribes fund the cost of design and construction. These joint venture projects demonstrate the shared commitment of the tribes and IHS to provide new facilities within the IHS system and the staff necessary to support the facilities' operations. This important partnership will continue to increase access to care and decrease health disparities faced by American Indians and Alaska Natives. When fully operational, these facilities are projected to collectively serve a user population of over 71,400 patients.

Health Insurance Reimbursements: In FY 2014, IHS estimates it will receive approximately $1 billion in health insurance reimbursements through Medicare, Medicaid, and private insurers. These funds are essential for maintaining accreditation standards by covering the costs of hiring additional medical staff, purchasing equipment, and making necessary building improvements.

The Affordable Care Act increases the potential that health insurance reimbursements to the IHS will grow by making additional American Indians and Alaska Natives eligible for Medicaid. In participating states, Medicaid coverage will expand to cover all individuals with incomes below 133 percent of the federal poverty level. The Act also subsidizes the cost of health insurance for American Indians and Alaska Natives with incomes up to 400 percent of the federal poverty level.

National Health Service Corps (NHSC)

IHS partners with HRSA to increase the number of IHS facilities eligible to participate in the NHSC. Participation in the NHSC helps IHS recruit and retain health providers. There are currently 588 active IHS sites eligible to participate in the program. The number of NHSC providers placed in IHS facilities currently stands at 305. To date, the NHSC has provided an additional 188,500 patient visits.

IHS estimates that the Affordable Care Act will increase health insurance reimbursements by $95 million in FY 2014. These resources will allow IHS to address the needs of its ever-expanding population and provide additional health care, further reducing health disparities in the American Indian and Alaska Native population. However, estimating the amount of the increase IHS will collect in FY 2014 is complicated both by a lack of information about which states will choose to expand Medicaid and uncertainty about the number of American Indians and Alaska Natives who will become eligible because of expansion and will continue to use IHS services.

Supporting Indian Self Determination

IHS understands that the tribes and tribal organizations are the most knowledgeable about what services are needed in their communities and that the planning and delivery of health services at the local level ensures effective, quality health care. About 55 percent of the IHS budget is administered by tribes through the authority provided to them under the

Ensuring Access to Care

In 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement. This Agreement will facilitate reimbursement by the VA to IHS for direct health care services provided to eligible American Indian and Alaska Native Veterans in IHS facilities. It is also a significant step forward in ensuring implementation of Section 405 of the Indian Health Care Improvement Act, passed as part of the Affordable Care Act, and represents a positive partnership to support improved coordination of care between IHS and the VA. Furthermore, this Agreement paves the way for future agreements negotiated between VA and tribal health programs.

Indian Self Determination and Education Assistance Act of 1975, as amended, which allows tribes to assume the administration of programs previously carried out by the federal government.

Contract Support Costs: The Budget funds contract support costs at $477 million, an increase of +$6 million above FY 2012. Contract support costs (CSC) funding enables tribes to support the infrastructure needed to administer federal programs. These funds provide tribes with additional support in the operation of their own health programs.

In its June 18, 2012 ruling in *Salazar v. Ramah Navajo Chapter*, the United States Supreme Court held that "not to exceed" language in past appropriations was not sufficient to limit contract support costs. The Court identified legislative remedies, ranging from amending the authorizing statute, to changing payments for contract support costs, to enacting line-item appropriations for each contract, to appropriating full funding for CSC. To balance the priorities of all tribes with the available appropriations, and in accordance with the Supreme Court's decision, the Administration proposes new appropriations language for both IHS and the Bureau of Indian Affairs to provide a specific amount for contract support costs funding for each Indian Self-Determination and Education Assistance Act contract. Due to fiscal constraints, funding for CSC must be balanced with funding for direct health care services for tribes. The Administration looks forward to working with tribes and Congress to develop a balanced, long-term solution.

Consultation: History has demonstrated the necessity of including the voices of tribal officials when formulating policies affecting their programs and communities. A key component of ensuring this inclusion is consultation, a process during which tribes play an integral role in the federal decision-making process. Tribal consultation is consistently an IHS top priority and continues to be one in FY 2014.

Special Diabetes Program for Indians

American Indian and Alaska Natives are substantially more likely to have diagnosed diabetes than the general population. The prevalence of this disease also comes with increased complications and health care costs for IHS and tribes. The Special Diabetes Program for Indians has changed the diabetes landscape across the IHS system, has resulted in improved access to quality diabetes care, and has helped drastically reduce diabetes complications such as end-stage renal disease.

To ensure sustained and additional improvements in the health of American Indian and Alaska Natives, the FY 2014 budget continues funding for this successful and essential program.

These funds allow IHS and tribes to continue to provide primary prevention awareness, education, and care, and to continue the efforts to eradicate and control this disease in tribes and tribal communities.

In addition to extensive solicitation of tribal input on local, area, and national level IHS operations and funding, HHS holds an annual department-wide tribal budget consultation. Tribal leaders are provided the opportunity to identify their budget priorities and, as possible, these are reflected in the FY 2014 Budget. IHS continues to work with tribes to improve consultation practices and has incorporated the implementation of tribal recommendations into the IHS portion of the HHS Strategic Plan.

The funding increases included in the FY 2014 Budget request, including additional purchased and referred care and staff for newly built health facilities, as well as the priorities expressed by tribes, reflect the Administration's commitment to provide health care to American Indians and Alaska Natives and to continue progress in changing and improving the IHS.

CENTERS FOR DISEASE CONTROL AND PREVENTION

dollars in millions	2012 /1	2013 /1	2014	2014 +/- 2012
Immunization and Respiratory Diseases	815	629	754	-61
Prevention and Public Health Fund (non-add)	*190*	*N/A*	*72*	*-118*
Vaccines For Children	4,006	3,607	4,293	+287
HIV/AIDS, Viral Hepatitis, STDs, and TB Prevention	1,163	1,160	1,177	+14
Prevention and Public Health Fund (non-add)	*10*	*N/A*	*—*	*-10*
Emerging and Zoonotic Infectious Diseases	362	312	432	70
Prevention and Public Health Fund (non-add)	*52*	*N/A*	*52*	*—*
Chronic Disease Prevention and Health Promotion	1,211	805	1,036	-175
Prevention and Public Health Fund (non-add)	*411*	*N/A*	*416*	*+5*
Birth Defects, Developmental Disabilities, Disability and Health	142	143	142	—
Prevention and Public Health Fund (non-add)	*—*	*N/A*	*75*	*+75*
Environmental Health	158	124	155	-3
Prevention and Public Health Fund (non-add)	*35*	*N/A*	*29*	*-6*
Injury Prevention and Control	146	147	182	+35
Public Health Scientific Services	517	450	539	+ 22
Prevention and Public Health Fund (non-add)	*70*	*N/A*	*70*	*—*
Occupational Safety and Health	325	327	272	-53
World Trade Center Health Program	188	239	241	+53
Energy Employee Occupational Illness Compensation Program	55	56	55	—
Global Health	377	379	393	+16
Public Health Preparedness and Response	1,382	1,360	1,334	-48
Balances from P.L. 111-32 Pandemic Flu (non-add)	*30*	*N/A*	*—*	*-30*
CDC-Wide Activities and Program Support	260	221	173	-88
Prevention and Public Health Fund (non-add)	41	*N/A*	41	—
Agency for Toxic Substances and Disease Registry	76	77	76	—
User Fees	2	2	2	—
Subtotal, Program Level	**11,187**	**10,039**	**11,257**	**+71**

CENTERS FOR DISEASE CONTROL AND PREVENTION

dollars in millions	2012 /1	2013 /1	2014	2014 +/- 2012
Less Funds Allocated from Other Sources				
Vaccines for Children	-4,006	-3,607	-4,293	-287
Energy Employee Occupational Injury Compensation Prog.	-55	-55	-55	—
World Trade Center Health Program	-188	-239	-241	-53
PHS Evaluation Fund Transfers	-371	-374	-618	-246
Balances from P.L. 111-32 Pandemic Flu	-30	—	—	30
Prevention and Public Health Fund	-809	N/A	-755	54
User Fees	-2	-2	-2	—
Total, Discretionary Budget Authority	**5,725**	**5,762**	**5,293**	**-432**
Total, Discretionary Program Level	**6,129**	**6,137**	**5,913**	**-216**
Full-time Equivalents	10,877	10,823	10,823	-54

1/ The FY 2012 and 2013 amounts have been made comparable to FY 2014 to reflect both the distribution of Business Support Services resources to other program budget lines and the proposed transfer of the Paralysis Resource Center to the Administration for Community Living.

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

The Centers for Disease Control and Prevention (CDC) works around the clock to keep Americans safe, healthy and secure and helps keep America competitive through improved health. The FY 2014 Budget request for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.3 billion. This total includes $755 million of the $1 billion available from the Prevention and Public Health Fund (Prevention Fund).

The Budget includes increases for a new investment in advanced molecular detection and response to infectious disease outbreaks, healthcare associated infections, food safety, injury prevention and control, and global health to continue to deliver world-class science and real-time health information. In addition, the Budget includes targeted reductions to specific immunization activities, preparedness and response activities, chronic disease prevention programs, occupational health activities, and direct medical services that are covered through insurance. A few of these targeted decreases, as well as some redirection of resources within programs, reflect the increased availability of preventive and direct health care services due to the implementation of the Affordable Care Act during FY 2014.

Protecting the Nation Against Infectious Disease

CDC saves lives from infectious diseases and protects people from emerging diseases. The Budget includes $6.7 billion for CDC's mission-critical efforts to prevent and control infectious diseases, of which $124 million is from the Prevention Fund and $4.3 billion is mandatory funding for the Vaccines for Children (VFC) program.

***Immunization and Respiratory Diseases*:**
Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age two, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as hepatitis B, influenza, and pneumococcal

disease. CDC works closely with public health agencies and private partners to improve and sustain immunization coverage and to monitor the safety and efficacy of vaccines. With increasing health coverage provided by the Affordable Care Act, CDC will focus on targeting the immunization program and resources to the uninsured, continuing to support the systems that make vaccine available nationwide and protecting public health's ability to respond to outbreaks.

CDC's $4.9 billion immunization program has two components: the mandatory VFC program and the discretionary Section 317 program. These two programs combined provide approximately 50 percent of the pediatric vaccines and 30 percent of the adolescent vaccines distributed in the United States each year. The Section 317 program provides funds to support state immunization infrastructure and operational costs and supplies many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2014 Budget includes $581 million for the Section 317 program, which is $61 million below FY 2012. Of this amount, $72 million is financed by the Prevention Fund. In FY 2014, $25 million of this amount will be available to continue projects to enable health departments to bill insurance for immunization services provided to covered patients.

HIV/AIDS, Viral Hepatitis, STD and TB Prevention: The Budget includes $1.2 billion for Domestic HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STDs) and Tuberculosis (TB), an increase of $14 million over FY 2012. The Budget proposes $40 million for the Community High-Impact Prevention Initiative, which will focus on implementing sustainable, high-impact HIV testing and screening programs; delivering comprehensive prevention for HIV-positive individuals, including linkage to and engagement in care and prevention services; using data to improve viral load suppression rates and other services; supporting scalable and effective behavioral interventions; and implementing public health strategies for at-risk populations. Additionally, the FY 2014 Budget includes $10 million to enable public health agencies to seek reimbursement from insurance companies for infectious disease testing covered because of the implementation of the Affordable Care Act.

Emerging and Zoonotic Infectious Disease: CDC detects and tracks a range of microbes, responds to outbreaks of known infectious threats, and uses surveillance systems to quickly identify new infectious threats as they emerge. The Budget includes $432 million for Emerging and Zoonotic Infectious Disease activities, a $70 million increase over FY 2012. This increase includes $40 million to begin significant investments aimed at modernizing CDC's technology and methods to better detect and track infectious diseases. The Advanced Molecular Detection and Response to Infectious Disease Outbreaks initiative represents a fundamental change and modernization in CDC's current public health microbiology and bioinformatics capabilities. The request will support investments in bioinformatics, database development, data warehousing and analytics to make use of recent technologic advances and allow CDC to derive information from increasingly complex data sets. The initiative is critical to maintain CDC's standing as the nation's premier public health agency and its mission to protect American's health.

Modernizing CDC's Infectious Disease Surveillance

The Budget includes $40 million to begin significant investments in modernizing infectious disease tracking at CDC – an effort critical to maintaining CDC as the global authority on infectious disease diagnosis and surveillance.

CDC's infectious disease surveillance technologies are becoming increasingly outdated and threaten the basic public health mission of the agency. In 2011, an external blue ribbon panel of experts identified a number of critical gaps in CDC's surveillance capabilities and starkly concluded that CDC was on the path to becoming obsolete, if not irrelevant.

The Advanced Molecular Detection and Response to Infectious Disease Outbreaks initiative begins investments to implement the recommendations of the external panel. In FY 2014, CDC will being investing in staff development, infrastructure improvement, partner laboratory development, and the planning necessary to disseminate these new approaches throughout CDC and its partner public health laboratories in a coordinated manner that advances public health.

Promoting Health and Disease Prevention

CDC also plays a critical role in protecting Americans from the leading causes of death and disability. CDC works to drive down the incidence of costly diseases, while helping Americans live longer, more productive lives to ensure the United States remains competitive through a healthy and productive population.

Chronic Disease Prevention and Health Promotion: Chronic diseases – such as heart disease, stroke, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the United States. Seven out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke alone account for more than 50 percent of all deaths each year. The Budget includes $1.0 billion, $175 million less than FY 2012, for Chronic Diseases Prevention and Health Promotion, of which $416 million is funded through the Prevention Fund. Grantees will benefit from being able to target resources to the areas of greatest burden. In FY 2014, CDC will allow states to reallocate up to 5 percent of grant funding from each chronic disease program to allow flexibility in making programmatic choices which best suit the needs of their state. The Budget continues to drive efficiencies across community grant programs and maximizes the impact and reach of the Community Transformation Grants. The Budget also includes $212 million, a $14 million increase over FY 2012, to increase support for effective evidenced-based programs intended to prevent or reduce tobacco use.

The Budget also proposes targeted reductions to select direct healthcare programs such as cancer screenings. In 2014, the Affordable Care Act's consumer protections and Medicaid expansion will promote coverage and use of new preventive services, such as screenings for populations formerly served through CDC grant programs.

Birth Defects, Developmental Disabilities, Disability, and Health: The Budget includes $142 million for Birth Defects, Developmental Disabilities, Disability, and Health, the same as FY 2012. CDC's programs provide credible, science-based public health information on the impact of birth defects, disabilities, and blood disorders on the American population; identify risk factors and causes of these conditions; and translate science into action to enhance the potential for full productive lives for many of these vulnerable populations. The Budget proposes to more closely align similar disability programs within the Department by requesting funding to support the Paralysis Resource Center program within the Administration for Community Living. The Budget maintains the remainder of CDC's activities in this area as discrete grant programs.

Ensuring Food Safety

The FY 2014 Budget includes $49 million for CDC's Food Safety activities, an increase of $17 million above FY 2012. Foodborne illnesses are common and costly—yet preventable. Each year, 1 in 6 Americans (or 48 million people) gets sick, and 3,000 die by consuming contaminated foods or beverages. CDC provides the link between illness in people and the food safety system, using strong partnerships with state and local public health agencies, FDA, and USDA to lead critical food safety networks and to drive improvements in foodborne outbreak detection and response. Reductions in human illness caused by 3 major foodborne pathogens, has accounted for over 500,000 averted illnesses and $100 million in direct medical costs saved in a single year. With increased funding, CDC will implement provisions of the Food Safety Modernization Act including critical upgrades to systems such as the National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet). Investments will help restore and improve state and local capacity to track foodborne illness and ensure faster outbreak responses.

Public Health Scientific Services

CDC provides scientific service, expertise, skills, and tools in support of its national efforts to promote health. The Budget includes $539 million, a $22 million increase over FY 2012, to support vital health statistics. Public Health Scientific Services, the foundation of CDC's efforts to protect the public's health, have led to the development, adoption, and integration of sound public health surveillance, epidemiological practices, and are based on advances in epidemiology, informatics, laboratory science, and surveillance. For FY 2014, the Budget includes $181 million for Health Statistics, a $22 million increase over FY 2012 to expand vital statistics by gradually phasing in electronic death records in the 21 remaining jurisdictions over four years, to continue to manage surveillance systems across the United States, and to provide statistical information that guides actions and policies to improve the health of the American people.

The Budget also includes $67 million to support Public Health Workforce and Career Development to continue to implement training to provide an effective, prepared and sustainable health workforce, including the Public Health Associate and the Applied Epidemiology Fellowship Programs, which provide frontline expertise to state and local public health departments while training tomorrow's public health leaders.

Keeping Americans Safe from Environmental and Work Hazards and Injuries

Environmental Health: Environmental factors contribute to more than 25 percent of diseases worldwide. CDC directs and coordinates a national program to maintain and improve the health of the American people by promoting a healthy environment. The Budget includes $155 million for Environmental Health, $3 million below FY 2012. Of that amount, $29 million is included for the Environmental Public Health Tracking System. The agency's long-established expertise in laboratory science, medical toxicology and environmental epidemiology, and environmental public health practice enable CDC to address complex public health threats and respond to natural and man-made disasters.

***Injury Prevention and Control*:** CDC helps protect people from violence and injury by researching the best ways to prevent violence and injuries and using that science to create solutions to keep people safe, healthy, and productive. The Budget includes $182 million for Injury Prevention and Control programs at CDC, an increase of $35 million over FY 2012. During FY 2013, the President directed CDC to conduct research into firearm violence and to expand its ability to better understand how and when firearms are used in violent death. Specifically, the Budget includes $10 million to conduct research on the causes and prevention of gun violence, including investigating links between video games, media images, and violence. The Budget also includes an additional $20 million to expand the National Violent Death Reporting System, which reports anonymous data on deaths associated with guns and violence, to all 50 states during FY 2014. The Budget also includes $5 million to fund evaluation activities with the goal of generating findings to improve sexual violence prevention nationwide.

National Healthcare Safety Network

The FY 2014 Budget includes an increase of $12 million for the National Healthcare Safety Network (NHSN) to allow CDC to reduce healthcare-associated infections (HAIs) in more than 1,800 additional facilities. Over the past decade, NHSN has saved 27,000 lives and $1.8 billion in excess medical costs. CDC will focus on two critical areas: (1) providing ward-specific and facility-wide data on highly antibiotic resistant infections to identify pathogens and transmission within and between facilities in a region, and (2) finding problem areas in high-use Medicaid facilities. To provide data on pathogens and transmission within and between facilities, CDC will use NHSN's Multi-Drug-Resistant Organism module and the new Antimicrobial Use and Resistance Module. The electronic data allow CDC to identify, analyze, and target areas that contribute to the spread of infections such as *Clostridium difficile* and other multi-drug resistant organisms. CDC will work with CMS under a new "Equality in Quality" prevention program to identify high-use Medicaid facilities that are outliers with high rates of HAIs. Together, CDC and CMS will work with state health departments to target prevention programs to improve the quality of care in these facilities and lower Medicaid spending for state and federal governments.

Occupational Safety and Health: The National Institute for Occupational Safety and Health (NIOSH) is the primary federal entity responsible for conducting research, making recommendations, and translating knowledge for the prevention of work-related illness and injury. The FY 2014 Budget provides $272 million for Occupational Safety and Health programs, $53 million below FY 2012. The Budget continues targeted reductions to programs such as the Education and Resource Centers and the Agriculture, Forestry, and Fishing Program within the National Occupational Research Agenda.

The Budget includes mandatory funding to support the administration of the World Trade Center Health Program to allow for treatment and monitoring for responders and other community members who were directly affected by the 9/11 attacks. A significant change to the program, the addition of certain types of cancers to the list of covered treatments, was implemented during FY 2012.

Within the total for NIOSH, the Budget also includes $55 million in mandatory funding to continue CDC's role in the Energy Employees Occupational Illness Compensation Program.

Protecting Americans from Threats 24/7

CDC works around the clock to ensure the security, safety, and health of Americans from threats foreign and domestic, as well as intentional or naturally occurring. The FY 2014 Budget provides $1.3 billion for biodefense and emergency preparedness activities in CDC, a decrease of $48 million below FY 2012. Within that total, $658 million is requested for Public Health and Emergency Preparedness (PHEP) grants, $8 million below FY 2012. The PHEP program will provide nearly $11 billion in funding from 2001 to 2014 for these efforts. These grants support local public health preparedness efforts and are coordinated with the Hospital Preparedness grants administered by the Assistant Secretary for Preparedness and Response (ASPR). In March 2012, CDC and ASPR released a joint funding opportunity announcement that aligns to PHEP's 15 public health preparedness and HPP's eight healthcare preparedness capabilities and implements two joint preparedness measures to promote program improvements at the state, local and territorial levels.

In FY 2014, $166 million is provided to improve the CDC Preparedness and Response Capability, $1 million below FY 2012. This funding supports CDC's core capabilities in epidemiology, laboratory, and surveillance to respond to public health emergencies. These core functions protect Americans against public health emergencies and help prepare for, respond to, investigate, and recover from public health security threats.

The Strategic National Stockpile request is $510 million, a decrease of $38 million below FY 2012, to support product replacement costs, acquire new products, and support security and management costs.

Keeping Americans Safe Through Global Health Security

CDC is continuously vigilant against outbreaks that start in remote corners of the world and can spread quickly. The FY 2014 Budget includes $393 million for Global Health programs, a $16 million increase over FY 2012. CDC's Global Health programs are run by world leaders in epidemiology, surveillance, informatics, laboratory systems, and other essential disciplines. Through partnerships with other countries' ministries of health, CDC is improving global public health by reducing the risk of infectious diseases reaching the nation's borders. Currently, CDC's Global Health activities address over 400 diseases, health threats, and conditions that are major causes of death, disease, and disability. These programs provide a strong foundation for protecting Americans from major health threats, wherever they arise.

The Budget includes an additional $15 million to enhance CDC's effort to eradicate polio worldwide. CDC has contributed significantly to the more than 99 percent decline in global polio cases: from more than 350,000 cases reported annually in 1998 to 650 cases reported in 2011. The Budget also supports CDC as a principal United States government agency implementing the President's Emergency Plan for AIDS Relief (PEPFAR). CDC applies scientific evidence and extensive programmatic experience to support the highest impact interventions to reduce HIV transmission.

Managing CDC Infrastructure and Human Capital

The Budget includes $173 million in administrative and infrastructure activities to support CDC's mission critical efforts. The Business Services Support budget line is proposed for elimination in FY 2014. The funds will be distributed within CDC's program budget lines to give program managers enhanced ownership and control over these expenses. The newly established Working Capital Fund will support agency business services.

***Public Health Leadership and Support*:** The Budget includes $117 million, $2 million above FY 2012, to support CDC's cross-cutting areas that seek to ensure the effectiveness of public health programs and science. The Budget request continues support for the Office of State, Tribal, Local and Territorial Support, which provides guidance and oversight for CDC's resources and assets invested in health departments and other partner agencies.

Buildings and Facilities: The Buildings and Facilities program provides critical support to CDC's mission. The Budget includes nearly $15 million in Repairs and Improvements projects to restore or improve failed or failing primary building systems or real property components to effective use.

Agency for Toxic Substances and Disease Registry (ATSDR)

Managed as part of CDC, ATSDR protects the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and diseases related to toxic substances. The Budget request for ATSDR is $76 million, the same as FY 2012. The agency will continue to support healthy, sustainable environments in communities by identifying chemical exposures, educating the public and health care providers, and conducting exposure investigations and health studies. Over the past three decades, ATSDR scientists have worked in 8,000 communities in the United States. In FY 2014, ATSDR expects to support assessments of possible hazards at more than 500 sites.

NATIONAL INSTITUTES OF HEALTH

dollars in millions	2012	2013	2014	2014 +/- 2012
Institutes				
National Cancer Institute	5,063	5,097	5,126	+63
National Heart, Lung and Blood Institute	3,073	3,094	3,099	+25
National Institute of Dental and Craniofacial Research	410	413	412	+2
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,944	1,956	1,962	+18
National Institute of Neurological Disorders and Stroke	1,623	1,634	1,643	+19
National Institute of Allergy and Infectious Diseases	4,482	4,513	4,579	+96
National Institute of General Medical Sciences	2,426	2,442	2,401	-25
Eunice K. Shriver Natl Inst. of Child Health & Human Dev	1,319	1,328	1,339	+20
National Eye Institute	701	706	699	-2
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	684	689	691	+7
Interior Appropriation	79	79	79	—
National Institute on Aging	1,120	1,109	1,193	+73
Natl Inst. of Arthritis & Musculoskeletal & Skin Diseases	535	538	541	+6
Natl Inst. on Deafness and Communication Disorders	416	418	423	+7
National Institute of Mental Health	1,478	1,488	1,466	-12
National Institute on Drug Abuse	1,051	1,059	1,072	+20
National Institute on Alcohol Abuse and Alcoholism	459	462	464	+5
National Institute of Nursing Research	145	145	146	+2
National Human Genome Research Institute	512	515	517	+5
Natl Institute of Biomedical Imaging and Bioengineering	338	340	339	+1
Natl Institute on Minority Health and Health Disparities	276	278	283	+7
Natl Center for Complementary and Alternative Medicine	128	129	129	+1
National Center for Advancing Translational Sciences	574	578	666	+91
Fogarty International Center	69	70	73	+3
National Library of Medicine	373	384	390	+17
Office of the Director	1,457	1,466	1,473	+16
Buildings and Facilities	125	126	126	+1
Total, Program Level	**30,860**	**31,057**	**31,331**	**+471**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	—
Type 1 Diabetes Research (NIDDK) /1	-150	-150	-150	—
Total, Discretionary Budget Authority	**30,702**	**30,899**	**31,173**	**+471**
Labor/HHS Appropriation	30,623	30,819	31,094	+471
Interior Appropriation	79	79	79	—
Full-time Equivalents	18,497	18,497	18,497	—

1/ These mandatory funds were pre-appropriated in P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010, and P.L. 112-240, the American Taxpayer Relief Act of 2012.

NATIONAL INSTITUTES OF HEALTH

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

The FY 2014 Budget requests $31.3 billion for the National Institutes of Health (NIH), an increase of $471 million, or 1.5 percent, over the FY 2012 level, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that advances medical science while spurring economic growth. In FY 2014, NIH estimates it will support a total of 36,610 research project grants, including 10,269 new and competing awards.

Investment in NIH enhances understanding of the fundamental underpinnings of human health and disease and creates an evidence base to transform health care, from introducing innovative approaches to prevent disease and disability, to increasing the arsenal of tools and techniques used to identify and treat them. It also helps drive the biotechnology sector and assure the nation's place as a leader in science and technology.

NIH's budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2014, about 83 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 300,000 research positions at over 2,500 organizations, including universities, medical schools, hospitals, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research and training activities managed by world class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives the nation the unparalleled ability to respond immediately to national and global health challenges. Another six percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

Research Priorities in FY 2014

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. In FY 2014, with the $31.3 billion requested, NIH will focus on generating the basic science findings of today to fuel tomorrow's breakthroughs in health. At the same time, NIH will continue its investment in translating basic discoveries into improvements in public health, including the delivery of more effective health care. Since this entire endeavor depends upon a robust and exceptional workforce now and in the future, NIH will further enhance efforts to recruit and retain diverse scientific talent and creativity.

Investing in Today's Basic Research for Tomorrow's Breakthroughs: Approximately 53 percent of the NIH budget is devoted to basic biomedical and behavioral research that makes it possible to understand the causes of disease onset and progression. As an

NIH Disease Accomplishments

NIH is continuing to make progress in combating major diseases. A few examples of accomplishments made recently by NIH-supported scientists include:

Cancer researchers continue to make progress in uncovering the genomic basis of cancer. The Cancer Genome Atlas project recently provided a comprehensive characterization of a type of lung cancer, found genomic similarities between breast and ovarian cancer, and identified a number of promising drug targets.

Using a brain-computer interface called BrainGate, researchers taught two patients who were paralyzed by stroke to reach and grasp objects by controlling a robotic arm with their thoughts, a promising step toward greater independence and quality of life for people who have lost the use of their limbs.

Researchers discovered that, in addition to food intake, the microbial inhabitants of the gastrointestinal tract also make a major contribution to either causing or preventing malnutrition.

example, in FY 2014, NIH plans to spend about $40 million on research collaborations with academic institutions, the private sector, and other government agencies on the new Brain Research through Application of Innovative Neurotechnologies (BRAIN) Initiative. This ambitious project will develop new tools for comprehensively and precisely examining the activity of the millions of nerve cells, networks, and pathways in the brain in real time to gain revolutionary understanding of complex brain functions. This knowledge will help answer fundamental questions regarding the complex links between brain function and behavior, and ultimately, help develop new tools to treat such devastating conditions as Alzheimer's disease, autism, and schizophrenia.

Another basic research opportunity to be pursued in FY 2014 is to improve NIH's ability to visualize, manipulate and mine many of the large and complex digital datasets of information, known as "Big Data," that are currently being produced, such as high-resolution medical images, recorded physiological signals, and complete DNA sequences of large numbers of individuals. Improving the ability to use and responsibly share such data, including the development of a well-trained workforce, represents a critical link in translating new research discoveries into clinical applications.

Advancing Translational Sciences: Recent insights into the molecular basis of disease have identified many promising new targets for therapeutic intervention and yielded a vast potential for developing more effective diagnostics and therapeutics. In FY 2014, through the newly established National Center for Advancing Translational Sciences (NCATS), NIH will continue efforts to re-engineer the process of translating such scientific discoveries into new diagnostics and therapeutics. Within NCATS, the Budget proposes $50 million, an increase of $40 million over FY 2012, for the Cures Acceleration Network to accelerate the development of "high need cures" by reducing barriers between research discovery and clinical trials.
In FY 2014, NIH will also be engaged in planning for the development of a national clinical research network that would bring together tens of millions of patients who agree to participate in a broad range of clinical research studies. This network, to be assembled in collaboration with the Agency for Healthcare Research and Quality and the Patient-Centered Outcomes Research Institute, would enable research trials to be initiated quickly, completed more efficiently and cost-effectively, and produce results that are generalizable and relevant to clinical practice. NIH envisions that this network would use information technologies such as electronic health records, standardized, interoperable data frameworks, a biobank, and large-scale data repositories to integrate clinical data and enable reliable longitudinal follow-up and data sharing at low cost.

Molecular Libraries Program

NIH's Molecular Libraries Program (MLP) has made exceptional progress toward its performance goal of making freely available to researchers the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds. The MLP exceeded the FY 2012 performance target by depositing chemical structure and biological data for 294 small molecule probes in PubChem (a database of chemical molecules) since the program began. By disseminating this data in PubChem, the MLP has enabled mining of one of the largest sets of publicly available chemical biological information, providing a scientific resource that will accelerate the discovery of protein functions that control critical biological processes such as development, aging, and disease.

Recruiting and Retaining Diverse Scientific Talent and Creativity: The future vitality of biomedical science in the United States depends upon the NIH and its support for young scientists. NIH has recently conducted an assessment of the staffing and training needed to institute more effective mechanisms and policies for a 21st century biomedical workforce. In FY 2014, to encourage exceptionally promising new investigators and to speed the transition of talented trainees to independent researcher positions, NIH will continue to emphasize programs such as the NIH Director's Early Independence Award, Transformative Research Award, and New Innovator Award, as well as the Pathway to Independence Award and the Lasker Clinical Research Scholars Program. NIH is also planning a series of steps to enhance its effort to recruit and advance the careers of people traditionally underrepresented in the biomedical and behavioral research workforce. Such steps include creating a new program to provide relatively under-resourced institutions with opportunities to provide mentorship and resources to undergraduate students interested in pursuing a biomedical research career. Other efforts include building a nationwide consortium that will

connect students, postdoctoral fellows, and faculty to experienced mentors, and improving upon data collection and evaluation efforts to determine the most effective approaches.

A total of $776 million is requested in FY 2014 to support training 16,197 of the next generation of research scientists through the Ruth L. Kirschstein National Research Service Awards program. The Budget proposes a two percent stipend increase for predoctoral research trainees and an average four percent increase for postdoctoral trainees.

HIV/AIDS: NIH estimates it will devote more than $3.1 billion for research on HIV/AIDS in FY 2014. With newly discovered ways of identifying and treating HIV infection and preventing HIV transmission, coupled with the promise of safe, effective, and affordable vaccines, the world can, for the first time, imagine achieving an AIDS-free generation. To ensure that HIV/AIDS funds support research in the highest priority areas of scientific opportunity and public health challenges that require focused attention, NIH reallocates these funds among its Institutes and Centers in each year's Budget requests.

Research Project Grants: NIH estimates that it will devote $16.9 billion, or 54 percent of its total budget, to finance a total of 36,610 competitive, peer-reviewed, and largely investigator-initiated research project grants (RPGs) in FY 2014. This is a net increase of $382 million and 351 grants more than FY 2012. Within this total, NIH anticipates supporting 10,269 new and competing RPGs, an increase of 1,283 grants over FY 2012 levels. In total, the average cost of a new and competing RPG in FY 2014 is expected to be about $456,000. However, excluding the large cohort of expensive HIV/AIDS clinical trials that are due to cycle into competing status or be initiated in FY 2014, the NIH-wide average cost of a new and competing RPG in FY 2014 is estimated to be about $420,000, or approximately the same as in FY 2012. In addition, the statutory set-aside for the Small Business Innovation Research grant and contract program is scheduled to rise from 2.6 percent in FY 2012 to 2.8 percent in FY 2014, and from 0.35 percent to 0.4 percent for the Small Business Technology Transfer program.

Science, Technology, Engineering, and Mathematics (STEM) Education: The FY 2014 Budget proposes a major reorganization of government-wide STEM programs in order to improve STEM education outcomes and generate many more STEM teachers and graduates. Fragmentation of 220 STEM education programs across 13 agencies throughout the government is a barrier to more robust and more effective investments. Led by the Department of Education and the National Science Foundation, the STEM reorganization will create core initiatives centered around improving K-12 instruction, reforming undergraduate education, consolidating the administration of fellowships to better meet national STEM goals, and supporting programs to engage the public, students, and teachers in STEM education. Nine of

Alzheimer's Disease Research

NIH is continuing to implement the research components of the National Plan to Address Alzheimer's Disease (AD), a roadmap to help us meet the goal to prevent and effectively treat AD by 2025. Recent advances, such as the discovery that misfolded tau proteins progressively spread across the synapses of neurons, that common variants of the ApoE gene are strongly associated with the risk of late-onset AD, and that the skin cancer drug bexarotene may have potential to promote clearance of beta-amyloid and reverse cognitive deficits, are providing new avenues in AD research.

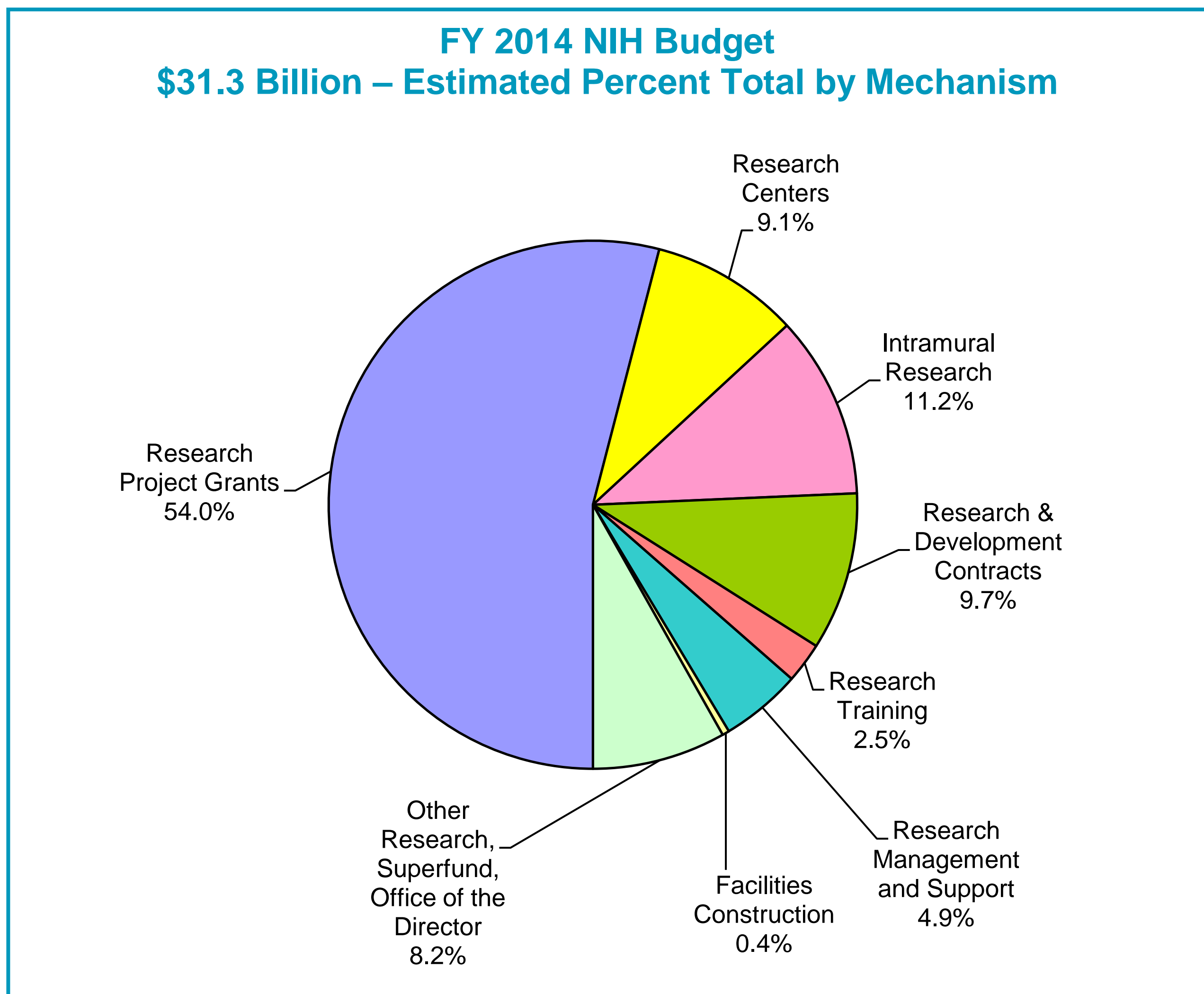
NIH currently supports over 35 clinical trials investigating a wide range of interventions to prevent, slow, or treat AD and/or cognitive decline. Examples of highly promising studies include a pilot trial on a nasal-spray form of insulin to delay memory loss and preserve cognition; a study of brain amyloid deposits in healthy people as a predictor of AD risk; and a cerebrospinal fluid biomarker study, which may aid the development of a diagnostic test for the early stages of AD.

In FY 2014, NIH estimates it will spend $562 million on AD research. Within this total, the National Institute on Aging (NIA) plans to devote an additional $80 million in research grants aimed at speeding drug development and testing new therapies. Building on the recommendations of the Alzheimer's Disease Research Summit held in May 2012, NIA will seek to enable rapid sharing of data, disease models, and biological specimens; and will promote the building of new multidisciplinary translational research teams devoted to AD. NIA will also establish new public-private partnerships to speed drug development by identifying novel therapeutic targets, including repurposing abandoned compounds.

NIH's STEM education programs, including the Science Education Partnership Awards, will be included in this reorganization and consolidation.

Intramural Buildings and Facilities

A total of $134 million is requested for NIH intramural Buildings and Facilities (B&F) in FY 2014, about $1 million above FY 2012, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2014, NIH will devote $75 million of its B&F resources as a one-time expense to add three new water chillers on the Bethesda campus in order to improve the capacity and reliability of this critical campus-wide utility for cooling. Most of the remaining funds will be used for facility repairs and improvements. The B&F mechanism total also includes about $8 million requested within the National Cancer Institute budget for facilities projects at its Frederick, Maryland campus.



NATIONAL INSTITUTES OF HEALTH OVERVIEW BY MECHANISM

dollars in millions	2012	2013	2014	2014 +/- 2012
Mechanism				
Research Project Grants (dollars)	16,550	16,691	16,932	+382
[# of Non-Competing Grants]	*[25,631]*	*[25,052]*	*[24,566]*	*[-1,065]*
[# of New/Competing Grants]	*[8,986]*	*[9,600]*	*[10,269]*	*[+1,283]*
[# of Small Business Grants]	*[1,642]*	*[1,691]*	*[1,775]*	*[+133]*
[Total # of Grants]	*[36,259]*	*[36,343]*	*[36,610]*	*[+351]*
Research Centers	3,040	2,952	2,846	-195
Other Research	1,808	1,863	1,866	+58
Research Training	762	766	776	+14
Research and Development Contracts	2,911	2,953	3,030	+119
Intramural Research	3,437	3,465	3,503	+66
Research Management and Support	1,530	1,541	1,550	+20
Office of the Director	609	613	614	+5
NIH Common Fund (non-add)	*[545]*	*[548]*	*[573]*	*[+28]*
Buildings and Facilities	133	134	134	+1
NIEHS Interior Appropriation (Superfund)	79	79	79	—
Total, Program Level	**30,860**	**31,057**	**31,331**	**+471**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	—
Type 1 Diabetes Research (NIDDK) /1	-150	-150	-150	—
Total, Budget Authority	**30,702**	**30,899**	**31,173**	**+471**
Labor/HHS Appropriation	30,623	30,819	31,094	+471
Interior Appropriation	79	79	79	—
Full-time Equivalents	18,497	18,497	18,497	—

1/ These mandatory funds were pre-appropriated in P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010, and P.L. 112-240, the American Taxpayer Relief Act of 2012.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

dollars in millions	2012	2013	2014	2014 +/- 2012
Now is the Time Presidential Initiatives				
Within Mental Health:				
Project AWARE	—	—	55	+55
Project AWARE State Grants (non-add)	—	—	*40*	*+40*
Mental Health First Aid (non-add)	—	—	*15*	*+15*
Healthy Transitions	—	—	25	+25
Within Health Surveillance and Program Support:				
Workforce	—	—	50	+50
Mental Health Workforce Expansion (non-add)	—	—	*35*	*+35*
Peer Professionals (non-add)	—	—	*10*	*+10*
Minority Fellowship Program Expansion (non-add)	—	—	*5*	*+5*
Total, Now is the Time Presidential Initiatives	—	—	**130**	**+130**
Mental Health				
Community Mental Health Services Block Grant	460	463	460	—
PHS Evaluation Funds (non-add)	*21*	*21*	*21*	—
Programs of Regional and National Significance	316	272	361	+46
Prevention and Public Health Fund (non-add)	*45*	*N/A*	*28*	*-17*
Project AWARE (non-add)	—	—	*55*	*+55*
Healthy Transitions (non-add)	—	—	*25*	*+25*
Children's Mental Health Services	117	118	117	—
Projects for Assistance in Transition from Homelessness	65	65	65	—
Protection and Advocacy for Individuals with Mental Illness	36	36	36	—
Subtotal, Mental Health	**994**	**955**	**1,039**	**+46**
Substance Abuse Treatment				
Substance Abuse Prevention and Treatment Block Grant	1,800	1,811	1,820	+20
PHS Evaluation Funds (non-add)	*79*	*80*	*72*	*-7*
Programs of Regional and National Significance	429	403	335	-94
PHS Evaluation Funds (non-add)	*2*	*2*	—	*-2*
Prevention and Public Health Fund (non-add)	*29*	*N/A*	*30*	*+1*
Subtotal, Substance Abuse Treatment	**2,229**	**2,214**	**2,155**	**-74**
Substance Abuse Prevention				
Programs of Regional and National Significance	186	187	176	-10
Subtotal, Substance Abuse Prevention	**186**	**187**	**176**	**-10**
Health Surveillance and Program Support				
Program Support	77	77	73	-4
Health Surveillance	47	30	47	—
PHS Evaluation Funds (non-add)	*27*	*28*	*45*	*+18*
Prevention and Public Health Fund (non-add)	*18*	*N/A*	—	*-18*
Data Request and Publications User Fees	—	—	2	+2
Public Awareness and Support	14	14	14	—
PHS Evaluation Funds (non-add)	—	—	*14*	*+14*
Performance and Quality Information Systems	13	13	13	—
PHS Evaluation Funds (non-add)	—	—	*13*	*+13*

Substance Abuse and Mental Health Services Administration
SAMHSA

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

dollars in millions	2012	2013	2014	2014 +/- 2012
Agency-Wide Initiatives	9	9	54	+45
Workforce Expansion (non-add)	—	—	*50*	*+50*
Subtotal, Health Surveillance and Program Support	**160**	**143**	**203**	**+43**
Total, Program Level	**3,569**	**3,499**	**3,572**	**+4**
Less Funds From Other Sources:				
PHS Evaluation Funds	-130	-130	-165	-35
Prevention and Public Health Fund	-92	*N/A*	-58	+34
User Fees	—	—	-2	-2
Total, Discretionary Budget Authority	**3,347**	**3,368**	**3,348**	**+1**
Full-time Equivalents	590	631	655	+65

The Substance Abuse and Mental Health Services Administration reduces the impact of substance abuse and mental illness on America's communities.

The FY 2014 Budget requests $3.6 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), an increase of $4 million above FY 2012. The Budget includes new efforts to increase access to mental health services to protect children and communities. Consistent with the President's charge after the tragedy at Sandy Hook Elementary School, SAMHSA is working to ensure mental health care is accessible to all Americans in need of assistance. To this end and to ensure coordination throughout the United States, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more strategically by:

- Targeting resources to evidence-based prevention and treatment interventions;
- Improving providers' capacity to bill insurance to increase access; and
- Issuing additional guidance to states to ensure that existing programs support, but do not supplant, insurance coverage.

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

Now is the Time – Protecting Young People from Violence

On January 16, the President announced a plan to protect children and communities in response to recent tragedies. For HHS, his plan calls for new investments totaling $160 million for Project AWARE (Advancing Wellness and Resilience in Education), a workforce initiative to ensure there are trained mental health providers ready to provide help in a crisis, Healthy Transitions to support young people with mental health or substance abuse issues, and Workforce investments to train 5,000 additional mental health professionals. This total also includes $30 million for the Centers for Disease Control and Prevention to support a nationwide violent deaths surveillance system and additional research on the causes and impact of gun violence in FY 2014.

Responding to National Mental Health Needs

Increasing Access to Mental Health Services to Protect Children and Communities: While the vast majority of Americans with a mental illness are not violent, several recent mass shootings have brought to light a hidden crisis in America's mental health system. Today, less than half of children and adults with diagnosable mental health problems receive the treatment they need.

Consistent with the President's "Now is the Time" proposal, the Budget will begin to address these issues by investing $130 million in new SAMHSA funding to make sure students and young adults get treatment for mental health issues. These efforts will reach 750,000 young people every year through programs to promote mental health, prevent violence, identify mental illness early and create a clear pathway to treatment for those in need. This objective will be accomplished by providing:

- $55 million for Project AWARE (Advancing Wellness and Resilience in Education) composed of: $40 million for State grants to help states and communities keep schools safe and get students with behavioral health issues referred to the services they need and $15 million for Mental Health First Aid training for teachers and other adults who work with youth to detect and respond to mental illness, including how to encourage adolescents and families to seek treatment; and a;
- $50 million to train 5,000 new social workers, counselors, psychologists, peer professionals and other mental health professionals to serve students and young adults, $35 million of which will be co-administered with HRSA; and
- $25 million for Healthy Transitions, innovative state-based strategies supporting young people ages 16 to 25 and their families to access and navigate the behavioral health treatment systems.

Improving Children's Mental Health: Coordinated systems of mental health care for children have proven to be effective in producing sustained improvement of school attendance and achievement, reductions of suicide-related behaviors, decreased utilization of inpatient hospital care, and significantly reduced contacts with law enforcement. The Budget includes $117 million, the same level as FY 2012, for Children's Mental Health Services for the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders and their families.

SAMHSA Leverages Partnerships to Prevent Suicides

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

Preventing Suicide: The Budget provides $50 million to prevent suicide. First time funding is provided to implement the National Strategy for Suicide Prevention, the nation's blueprint for reducing suicide over the next decade. The strategy is a public-private partnership between federal agencies and a broad national coalition of experts in suicide prevention. SAMHSA will use this funding to develop and test nationwide efforts such as suicide awareness, provider credentialing changes, emergency room referral processes, clinical care practice standards, and other activities.

SAMHSA's suicide prevention programs support intervention and prevention strategies in states to develop and implement youth suicide prevention and early intervention strategies involving public-private collaborations, as well as interventions in schools, institutions of higher education, juvenile justice systems, and other youth support organizations. The Budget sustains the capacity of the National Suicide Prevention Lifeline, a national hotline that routes calls across the country to a network of certified local crisis centers that can connect callers to local emergency, mental health, and social service resources.

Protecting Individuals With Mental Illness: Individuals with mental illness and serious emotional disturbances who reside in treatment facilities are vulnerable to neglect and abuse. The Budget provides $36 million, the same level as FY 2012, to support state protection and advocacy systems to monitor residential treatment facilities. In 2011, more than 92 percent of substantiated complaints handled through these systems resulted in positive changes for clients.

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

Ensuring Substance Abuse Treatment and Prevention and Mental Health Services

The Budget includes $1.8 billion for the Substance Abuse Prevention and Treatment Block Grant, an increase of $20 million over FY 2012, and $460 million for the Community Services Mental Health Block Grant, the same level as FY 2012, to implement evidence-based treatment and prevention strategies nationwide and maintain the nation's public behavioral health infrastructure. These flexible sources of funding represent 32 percent of state substance abuse agency funding, and approximately 1 percent of all public spending on mental health care in the United States, respectively.

This funding can be used by states for many purposes related to mental health and substance abuse. These purposes can include medical treatment, prevention efforts, testing, case management, as well as supportive services such as provider or patient education, employment or housing supports, outpatient counseling for family members of those with substance use disorders, and residential detoxification.

States are encouraged to use these funds for services not covered by other public or private insurance. Treatment infrastructure funding has declined in recent years as many states have scaled back their investments in behavioral health in the face of budget shortfalls. This Budget's block grant funding is anticipated to contribute to services to over 9 million individuals. As access to health coverage expands through the implementation of the Affordable Care Act, SAMHSA will work with states to leverage these resources, ensuring that the millions of newly covered individuals will benefit from the services necessary for care but not covered by insurance.

The Budget proposes funding within the block grants to encourage states to build providers' capacity to bill public and private insurance, and to facilitate enrollment in insurance, and to promote the adoption evidence-based interventions. States will receive the same formula amount as determined by statute and will be encouraged to award these incentive funds through competitive grant programs at the state level.

Disaster Response

The Budget includes $3 million for SAMHSA's disaster response activities, including its Disaster Distress Helpline. Begun in 2010 to help individuals in the Gulf Coast cope with the stresses of the Deepwater Horizon oil spill, the Helpline is a nationally available crisis counseling line available in the wake of international, national, and local disasters. Callers and texters are connected to trained and caring professionals from the closest crisis counseling center in the network. Helpline staff provide counseling and support, including information on common stress reactions and healthy coping, as well as referrals to local disaster-related resources for follow-up care and more intensive support. As of February 2013, the helpline had responded to 2,567 calls in the response to Hurricane Sandy.

Testing and Delivering Targeted Interventions

SAMHSA's Programs of Regional and National Significance have long fostered innovative solutions to emerging issues in substance abuse and mental health services. SAMHSA will continue testing and evaluating promising approaches to the nation's most challenging behavioral health concerns. The Budget includes $872 million, $59 million below FY 2012, for Programs of Regional and National Significance and other competitive and targeted grant activities within SAMHSA's three programmatic centers. The Budget discontinues funding for new awards in a number of well-established program areas. Resources are targeted to the testing of new practices and to maintaining and bolstering the state and tribal efforts necessary to implement and sustain evidence-based strategies nationwide.

For example, the Budget includes savings of $33 million from grants coming to a natural end in the Access to Recovery program. SAMHSA will work closely with grantees to improve the successful voucher system already in place to ensure both that

the traditional provider network is expanded to those who typically do not bill insurance, such as faith-based organizations, and to fund recovery support services typically not covered by insurance, such as transportation, housing, and employment support.

Ensuring Informed and Responsible Management

Health Surveillance and Program Support:
The Budget includes a decrease of $4 million below FY 2012, for the support of national survey efforts, the administration and monitoring of SAMHSA programs and grantees, and public awareness activities. Within this total are continued savings generated from efficiencies, consolidations, and the in-sourcing of select activities previously performed under contracts. Analyses conducted through SAMHSA's national surveys are used by federal, state, and local authorities, as well as by health care providers, to inform policymakers about substance use and mental disorders, the impact and treatment of these disorders, and the recovery process.

Data and Publication User Fees: The Budget includes a user fee to enable SAMHSA to fulfill requests for special data analyses and bulk publications of an extraordinary nature. While the vast majority of data and publications will remain free, costs for the most expensive requests will now be borne by the requestor.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

dollars in millions	2012	2013	2014	2014 +/- 2012
Health Costs, Quality and Outcomes Research (HCQO)				
Health Information Technology	26	26	26	—
Patient Safety Research	66	66	63	-3
Patient-Centered Health Research	41	77	100	+59
PCORTF Transfer (non-add) /1	*24*	*61*	*100*	*+76*
PHS Evaluation Fund (non-add)	*17*	*17*	—	*-17*
Research Innovations	108	109	89	*-19*
Value	4	4	3	*-0.5*
Prevention/Care Management	28	16	21	-7
PHS Evaluation Funds (non-add)	*16*	*16*	*21*	*+5*
Prevention and Public Health Fund (non-add) /2	*12*	*N/A*	—	*-12*
Subtotal, Program Level, HCQO	272	298	301	+29
Subtotal, PHS Evaluation Funds, HCQO (non-add)	*236*	*237*	*201*	*-35*
Medical Expenditure Panel Surveys	59	60	64	+5
Program Support	74	74	69	-5
Total, Program Level	**405**	**432**	**434**	**+29**
Less Funds From Other Sources				
PHS Evaluation Funds	-369	-371	-334	-35
Patient-Centered Outcomes Research Trust Fund	-24	-61	-100	+76
Prevention and Public Health Fund	-12	*N/A*	—	-12
Total, Discretionary Budget Authority	—	—	—	—
Full-time Equivalents /2	308	320	323	+15

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

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

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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

The FY 2014 Budget includes a total program level of $434 million for the Agency for Healthcare Research and Quality (AHRQ), $29 million above the FY 2012 level. This total includes $334 million in Public Health Service (PHS) Evaluation Funds, a decrease of $35 million below FY 2012, and $100 million from the Patient-Centered Outcomes Research Trust Fund.

AHRQ's efforts are focused on improving the quality of the health care system through health services research, data collection, and dissemination of evidence and evidence-based tools. AHRQ has been charged with discovering how to ensure that America's annual investment in health care can be the most effective, highest value, and best aligned with the needs of all Americans. The FY 2014 Budget continues support for core health services research on delivery system cost, quality, and outcomes. The Budget also supports the collection of information on health care expenditures and use.

Health Costs, Quality, and Outcomes

The FY 2014 Budget includes a program level of $301 million, $29 million above FY 2012, to support research on issues affecting the cost, quality, and effectiveness of health care. AHRQ's research on health costs, quality, and outcomes is organized by six main research portfolios: health information technology; patient-centered health research; patient safety; prevention and care management; value; and research innovations.

Health Information Technology: The Budget includes $26 million, the same level as FY 2012, for the AHRQ health information technology (health IT) research portfolio. This investment includes $20 million to support approximately 44 research grants that will generate foundational health IT research to improve the quality, safety, effectiveness, and efficiency of health care in the United States. In addition, $6 million will support contract activities related to synthesizing and disseminating evidence on meaningful use of health IT and developing the tools and resources for various stakeholders to implement best practices.

AHRQ coordinates with other federal health IT programs in order to leverage resources and maximize their impact. AHRQ's health IT research, which focuses on whether and how health IT improves health care quality, creates the evidence base and resources that are utilized by the HHS Office of the National Coordinator for Health Information Technology (ONC) and other stakeholders. In FY 2014, AHRQ will increase its support for research grants, while decreasing support for developing implementation tools, which are increasingly funded by ONC.

Patient-Centered Health Research: The Budget includes a total of $100 million for Patient-Centered Health Research (also known as Patient-Centered Outcomes Research or Comparative Effectiveness Research), provided through the Patient-Centered Outcomes Research Trust Fund (PCORTF). The PCORTF, established by the Affordable Care Act, transfers funding to HHS to build research capacity, translate and disseminate comparative clinical effectiveness research, and establish grants to train researchers. In FY 2014, investments will build on current AHRQ efforts, such as programs to train researchers in methods and standards for conducting patient-centered outcomes research and dissemination and translation efforts.

Enhancing Patient Safety: The Budget includes $63 million, a decrease of $3 million below FY 2012, for the AHRQ patient safety research portfolio. This portfolio supports activities which aim to prevent, mitigate, and decrease the number of medical errors, patient safety risks and hazards, and quality gaps. In order to make demonstrable improvements in patient safety, AHRQ focuses on measurement, reporting, dissemination, and implementation, while also funding fundamental research. These activities support ongoing evidence generation and a continuous cycle of improvement that encompasses both the discovery and application of safe health care practices.

In FY 2014, AHRQ will provide $34 million, the same level as FY 2012, to support the generation of new knowledge and promote the application of proven methods for preventing healthcare-associated infections (HAIs). Of this total, $14 million will support the ongoing expansion of the nationwide implementation of the Comprehensive Unit-based Safety Program (CUSP) to reduce HAIs. CUSP implements evidence-based practices in various health care settings in order to prevent common HAIs, including central line-associated blood stream and catheter-associated urinary tract infections, surgical site infections, and ventilator-associated pneumonia. This work complements and contributes to the goals of the HHS National Action Plan to Prevent HAIs and the CMS Innovation Center's Partnership for Patients.

Improving Patient Safety

Improving the safety of health care remains a high priority for HHS. AHRQ contributes to this important objective by making available a broad range of evidence-based resources for use by health care organizations to improve patient safety and reduce the risk of patient harm. An expanding set of evidence-based tools is available as a result of ongoing investments in research, including optimal ways to synthesize and disseminate research findings. In FY 2012, a total of 106 evidence-based tools, information, and products were available to health care providers. AHRQ aims to continue to increase the number of resources available to 116 in FY 2014.

Prevention and Care Management: The Budget includes $21 million, $7 million below FY 2012, for the AHRQ Prevention and Care Management research portfolio which supports health system redesign activities to improve primary health care services delivery for high-quality, safe, and effective clinical prevention and chronic disease care. For example, in FY 2014, AHRQ will support research, technical assistance, and tool and resource development in areas of primary care redesign.

Of the total requested in FY 2014 for the Prevention and Care Management research portfolio, $11 million will support the U.S. Preventive Services Task Force (Task Force). The Task Force is an independent non-governmental panel focused on evaluating risks and benefits of clinical preventive services, making recommendations about which services should be incorporated into primary medical care, and identifying research priorities. AHRQ provides scientific and administrative support to the Task Force, including topic selection, methods development, systematic evidence review, and dissemination. In FY 2014, AHRQ will continue to focus on enhancing the quality of scientific support provided, as well as continue efforts to improve public engagement and transparency.

Increasing Health Care Value and Other Research and Dissemination Activities: The Budget includes a total of $92 million, a decrease of $20 million below FY 2012, for AHRQ research focused on health care value and research innovations. Of this total, the Budget includes $3 million to achieve greater value in health care by reducing unnecessary costs and waste while also improving quality, enhancing transparency of information, and measuring and tracking useful information.

In FY 2014, AHRQ will continue high-impact and successful programs such as My Own Network powered by AHRQ, also known as MONAHRQ, which is advancing quality improvement reporting. MONAHRQ is a tool that gives states, communities, and others the software they need to build their own websites for public reporting and quality improvement. AHRQ will continue to enhance MONAHRQ in FY 2014, by adding new Hospital Compare measures, more Quality Improvement Guides, and greater capacity to report other information and data needed by state and local policymakers in order to improve public reporting and the quality and value of care.

AHRQ's research innovations portfolio will support projects that are crosscutting within all of the Health Costs, Quality, and Outcomes portfolios. AHRQ will fund $29 million in investigator-initiated research grants, of which $9 million will be used to fund new grants. New investigator-initiated research grants ensure that an adequate number of new ideas are created each year. Topics addressed by investigator-initiated research proposals reflect timely issues and innovative ideas and approaches in health costs, quality, and outcomes research to improve health care delivery.

In addition, AHRQ will continue to support measurement and data collection activities, including the Healthcare Cost and Utilization Project (HCUP), the largest collection of all-payer, longitudinal hospital

discharge data in the United States. HCUP data supports many efforts, including the Partnership for Patients initiative to track and reduce injuries a mother may suffer during childbirth. HCUP data provide national estimates for two Quality Indicators that measure this kind of trauma. HCUP also contributes to the national benchmark for readmissions to community hospitals, so that clinicians and policymakers can accurately measure improvements in the rate of readmissions for patients as interventions are implemented under the Partnership for Patients.

Medical Expenditure Panel Survey (MEPS)

The FY 2014 Budget includes $64 million, $5 million above FY 2012, for MEPS in order to maintain sample size and ensure the timeliness and comphrensiveness of core data products. MEPS includes three interrelated survey components: household, medical provider, and insurance. These three surveys provide the only national source of annual data on how Americans, including the uninsured, use and pay for health care. MEPS data have become the linchpin for public and private economic models of health care utilization and expenditures. These data continue to be key for the evaluation of health reform policies and analyzing the effect of tax code changes on health expenditures andtax revenue. In addition, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care, and health care quality. In FY 2014, MEPS will maintain the precision and analytical capacity in all three surveys to continue providing valuable data on health status, demographics, employment, and health care access and quality.

Program Support

The FY 2014 Budget includes $69 million, a decrease of $5 million below the FY 2012 level, to support agency-wide operational and administrative costs. A total of $4 million of this reduction is associated with AHRQ's recent building move and lease renegotiation.

Improving the Quality of Care

Inpatient hospital costs represent the largest component of health care expenditures in the United States. The Healthcare Cost and Utilization Project (HCUP) is the largest collection of all-payer, longitudinal hospital care databases in the United States, with encounter-level information beginning in 1998. HCUP provides a unique data resource to enable the study of health care delivery at the discharge, physician, market, and state levels. Currently, 97 percent of all hospital discharge records are in HCUP, with 46 states participating. In addition, over 60 percent of all emergency department records are also included, as well as ambulatory surgery data from 30 states. HCUP's large databases allow study of rare conditions and uncommon procedures. HCUP also provides information on readmissions for all payers and age groups, and is the only national all-payer data source on charges and costs, including the uninsured. HCUP is able to make these valuable contributions because it leverages investments in data made by states as the foundation to build nationwide databases and comparable state-wide databases for policy analysis, research, and trends.

CENTERS FOR MEDICARE & MEDICAID SERVICES
OVERVIEW

dollars in millions	2012	2013	2014	2014 +/-2013
Current Law:				
Medicare /1	472,017	511,466	522,130	+10,664
Medicaid /2	250,534	266,586	303,791	+37,206
CHIP /3	9,065	10,022	10,092	+70
State Grants and Demonstrations	477	788	749	-39
Health Insurance Programs	3,700	4,144	7,309	+3,165
Center for Medicare and Medicaid Innovation	781	1,313	1,413	+100
Total Net Outlays, Current Law	**736,574**	**794,319**	**845,484**	**+51,165**
Adjusted Baseline:				
Prevent Reduction in Medicare Physician Payments	—	—	15,399	+15,399
Total Net Outlays, Adjusted Baseline	**736,574**	**794,319**	**860,883**	**+66,564**
Proposed Law:				
Medicare /4	—	—	-6,155	-6,155
Medicaid /4	—	—	-126	-126
Health Insurance Programs	—	—	—	—
Program Management	—	—	110	+110
HCFAC Investment /5	—	303	329	+26
Total Proposed Law	**—**	**303**	**-5,842**	**-6,145**
Total Net Outlays, Proposed Law /6	**736,574**	**794,622**	**855,041**	**+60,419**
Savings from Program Integrity Investments /7	—	-494	-716	-222
Total Net Outlays, Proposed Policy	**736,574**	**794,128**	**854,325**	**+60,197**

1/ Current law Medicare outlays net of offsetting receipts.

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

3/ Includes the Child Enrollment Contingency Fund.

4/ Includes a proposal to extend the QI program through CY 2014; it is currently authorized through December 31, 2013. Costs of this proposal are reflected in Medicare.

5/ Totals reflect additional HCFAC mandatory investments proposed in the President's Budget, above FY 2013 and 2014 discretionary HCFAC levels.

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

7/ Includes non-PAYGO scorecard savings from additional investments in HCFAC and Social Security disability reviews, above savings already assumed in current law.

CENTERS FOR MEDICARE & MEDICAID SERVICES OVERVIEW

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

The FY 2014 Budget estimate for the Centers for Medicare & Medicaid Services (CMS) is $854.3 billion in mandatory and discretionary outlays, a net increase of $60.2 billion above the FY 2013 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), private health insurance programs and oversight, program integrity efforts, and operating costs.

The Budget supports CMS's work to continue implementing key provisions of the Affordable Care Act which continues to bring comprehensive insurance reforms, expanded coverage, and enhanced quality of health care to tens of millions of Americans. The Budget proposes additional targeted reforms to Medicare and Medicaid that are projected to save $393.2 billion over the next decade. These reforms will strengthen the long-term sustainability of Medicare and Medicaid and increase the efficiency of the programs, while continuing to provide essential and appropriate care for the elderly, children, low-income families, and people with disabilities.

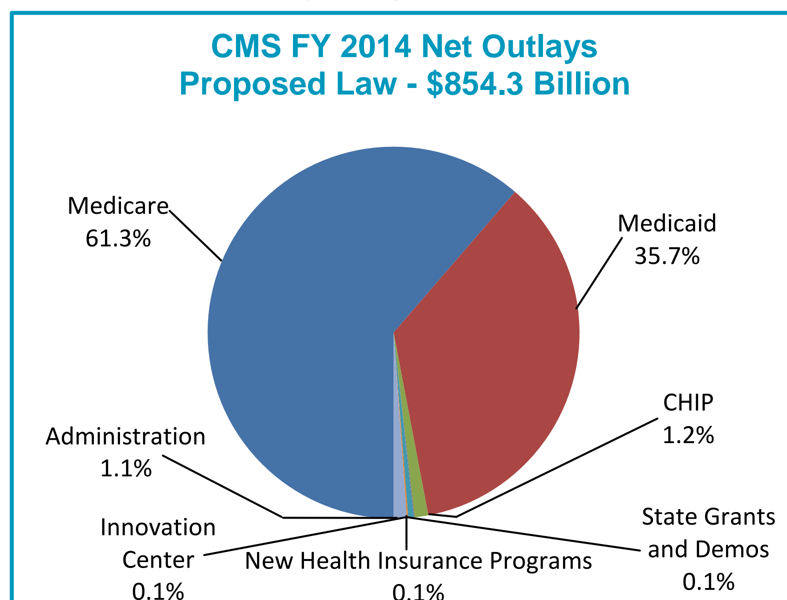
Budgetary Request

Medicare: The Budget includes projected Medicare savings of $371.0 billion over 10 years, including proposals to better align payments with costs and strengthen incentives for providers to deliver high-quality care.

Medicaid: The Budget includes $22.1 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable. The Budget extends two important programs within Medicaid: the Transitional Medical Assistance program and Medicare Part B premium assistance for low-income Medicare beneficiaries.

Program Integrity: The Budget includes $311 million in discretionary program integrity resources and an additional $329 million mandatory investment, as part of a multi-year investment to enable HHS and the Department of Justice to detect, prevent, and prosecute health care fraud. These targeted efforts will save $6.7 billion over 10 years. The Budget also proposes a series of new authorities to strengthen program integrity oversight for Medicare, Medicaid, and CHIP. Of the total Medicare and Medicaid savings, Program Integrity legislative proposals yield $4.1 billion in savings over 10 years.

Discretionary Program Management: The Budget for Program Management enables reforms in health care delivery while continuing to support ongoing activities in CMS. The Budget supports the operation of the Health Insurance Marketplaces, also known as Exchanges, scheduled to begin enrollment in October of 2013. The request also accommodates substantial increases in CMS workload because of demographic trends driving higher Medicare enrollment and implements responsibilities assigned in the Affordable Care Act and other legislation related to Medicare. At the same time, the Budget reflects significant operational savings which result from CMS more efficiently serving beneficiaries.



MEDICARE

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law:				
Outlays				
Benefits Spending (gross) /1	541,404	585,158	599,883	+14,725
Less: Premiums Paid Directly to Part D Plans /2	-5,222	-5,969	-6,934	-965
Subtotal, Benefits Net of Direct Part D Premium Payments	**536,182**	**579,189**	**592,949**	**+13,760**
Related-Benefit Expenses /3	13,130	10,963	10,899	-64
Administration /4	7,819	9,920	9,686	-234
Total Outlays, Current Law	**557,131**	**600,072**	**613,534**	**+13,462**
Offsetting Receipts				
Premiums and Offsetting Receipts /5	-85,114	-88,606	-91,404	-2,778
Current Law Outlays, Net of Offsetting Receipts	**472,017**	**511,466**	**522,130**	**+10,664**
Adjusted Baseline				
Prevent Reduction in Medicare Physician Payments	—	—	15,399	+15,399
Adjusted Baseline Outlays, Net of Offsetting Receipts	**472,017**	**511,466**	**537,529**	**+26,063**
Proposed Law:				
Medicare Proposals /6	—	—	-6,155	-6,155
Program Management /7	—	—	110	+110
HCFAC Investment /8	—	303	329	+26
Total Medicare Proposals, Net of Offsetting Receipts	**—**	**303**	**-5,716**	**-6,019**
Savings from Program Integrity Investments /9	—	-473	-685	-212
Total Net Outlays, Proposed Policy	**472,017**	**511,296**	**531,128**	**+19,832**
Mandatory Proposed Law:				
Mandatory Total Net Outlays, Proposed Policy /10	**466,242**	**505,052**	**524,162**	**+19,110**

1/ Represents all spending on Medicare benefits by either the federal government or beneficiaries, not including cost-sharing or deductibles. Includes Medicare Health Information Technology Incentives under both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI).

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

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

4/ Includes CMS Program Management, non-CMS administration, HCFAC, and QIOs. Includes CMS Program Management non-trust fund outlays of $225 million in FY 2012, $1,303 million in FY 2013, and $325 million in FY 2014.

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

6/ Includes SMI transfers to Medicaid of $405 million in FY 2014, to extend the Qualified Individuals (QI) Program.

7/ The Program Management proposals are funded from the Trust Funds.

8/ Totals reflect additional HCFAC mandatory investments proposed in the President's Budget, above FY 2013 and 2014 discretionary HCFAC levels.

9/ Includes non-PAYGO scorecard savings from additional investments in HCFAC and Social Security disability reviews, above savings already assumed in current law.

10/ Removes total Medicare discretionary amount: FY 2012- $5,775 million; FY 2013- $6,244 million; and FY 2014- $6,966 million.

In FY 2014, gross current law spending on Medicare benefits will total $600 billion. Medicare will provide health insurance to 54 million individuals who are 65 or older, disabled, or have end-stage renal disease (ESRD).

The Four Parts of Medicare

Part A ($200.5 billion gross fee-for-service spending in 2014): Medicare Part A pays for inpatient hospital, skilled nursing facility (SNF), home health related to a hospital stay, and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax paid by both employees and employers.

Generally, individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most services require a beneficiary co-payment or coinsurance. In 2013, beneficiaries pay a $1,184 deductible for a hospital stay of 1-60 days, and $148 daily coinsurance for days 21-100 in a SNF.

Part B ($172.8 billion gross fee-for-service spending in 2014): Medicare Part B pays for physician, outpatient hospital, ESRD, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 91 percent of all Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

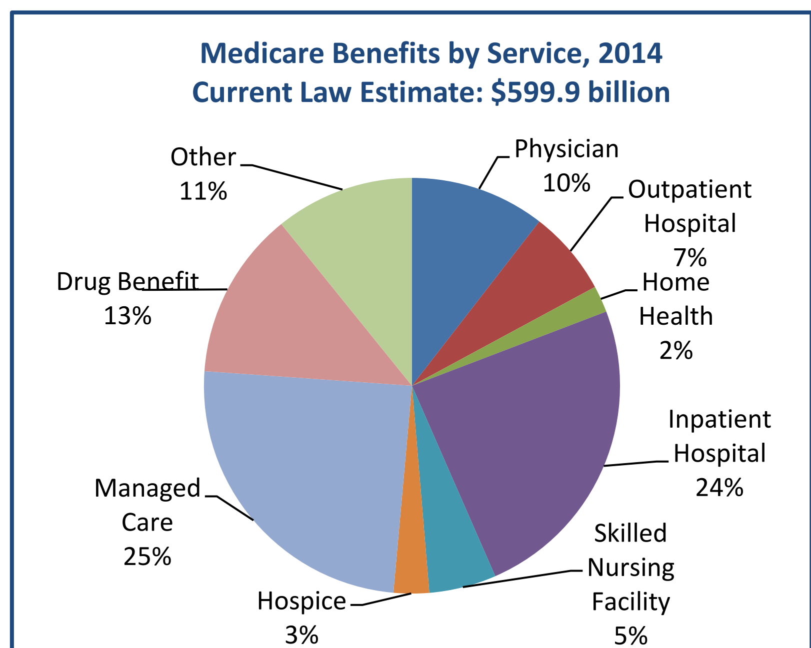
The standard monthly Part B premium is $104.90 in 2013, $5.00 higher than the 2012 premium. Over the last five years, the Part B premium has gone up slowly, averaging less than two percent a year. The Part B deductible is $147.

Some beneficiaries pay a higher Part B premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married) will pay from $146.90 to $335.70 per month in 2013.

Part C ($148.1 billion in 2014): Medicare Part C, the Medicare Advantage (MA) program, pays MA plans a capitated monthly payment to provide all Part A and B services, and also Part D services, if offered by the plan. Plans can offer additional benefits or alternative cost sharing arrangements that are at least as generous as the standard Part A and B benefits under traditional Medicare. In addition to the regular Part B premium, beneficiaries who choose to participate in Part C may pay monthly plan premiums which vary based on the services offered by the plan and the efficiency of the plan.

In 2014, MA enrollment will total approximately 15 million. CMS data confirm that Medicare beneficiary access to an MA plan remains strong and stable at 99.6 percent in 2013, premiums have remained stable, MA supplemental benefits remain largely unchanged, and enrollment is growing.

Part D ($78.4 billion projected gross spending in 2014): Medicare Part D offers a standard prescription drug benefit with a 2012 deductible of $325 and an average estimated monthly premium of $31. Enhanced and alternative benefits are also available with varying deductibles and premiums. Beneficiaries who choose to participate are responsible for covering



a portion of the cost of their prescription drugs. This portion may vary depending on whether the medication is generic or a brand name and how much the beneficiary has already spent on medications that year. Low-income beneficiaries are responsible for varying degrees of cost sharing, with co-payments ranging from $0 to $6.60 in 2013 and low or no monthly premiums.

For 2014, the number of beneficiaries enrolled in Medicare Part D is expected to increase by about 3 percent to 39 million, including about 12 million beneficiaries who receive the low-income subsidy. In 2013, approximately 55 percent of those with Part D coverage are enrolled in a stand-alone Part D prescription drug plan, 31 percent are enrolled in a Medicare Advantage Prescription Drug Plan, and the remainder receives the Retiree Drug Subsidy. Overall, approximately 90 percent of all Medicare beneficiaries receive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage.

The Affordable Care Act established a discount program for Medicare beneficiaries who reach the Part D coverage gap, or "donut hole." Beneficiaries fall into the coverage gap once their total drug spending exceeds an initial coverage limit ($2,970 in 2013), until they reach the threshold for qualified out-of-pocket spending ($4,750 in 2013), at which point they are generally responsible for five percent of their drug costs. Prior to the Affordable Care Act, beneficiaries were responsible for 100 percent of their drug costs in the coverage gap. Under the discount program, in 2014, non-LIS beneficiaries who reach the coverage gap will pay 47.5 percent of the cost of covered Part D brand drugs and biologics, and 72 percent of the costs for all generic drugs in the coverage gap. Cost-sharing in the coverage gap will continue to decrease each year until beneficiaries are required to pay only 25 percent of the costs of covered Part D drugs in 2020 and beyond.

In 2012, approximately 3.7 million beneficiaries reached the coverage gap and saved more than $2.7 billion on their medications due to the prescription drug discount program. These savings averaged about $724 per person.

Medicare Enrollment
(Enrollees in millions)

	2012	2013	2014	2014 +/-2013
Aged	41.9	43.3	44.7	+1.4
Disabled	8.5	8.7	9.0	+0.2
Total Beneficiaries	50.4	52.0	53.6	+1.6

2014 Legislative Proposals

The FY 2014 Budget includes a package of Medicare legislative proposals that will save $371.0 billion over 10 years by aligning payments with costs of care, strengthening provider payment incentives to promote high-quality efficient care, and making structural changes that will reduce federal subsidies to high-income beneficiaries and create incentives for beneficiaries to seek high-value services. Together, these measures will extend the Hospital Insurance Trust Fund solvency by approximately four years.

Align Medicare Drug Payments with Medicaid Policies for Low-Income Beneficiaries: Currently, drug manufacturers are required to pay specified rebates for drugs dispensed to Medicaid beneficiaries. In contrast, Medicare Part D plan sponsors negotiate with manufacturers to obtain plan-specific rebates at unspecified levels. Analysis has found substantial differences in rebate amounts and prices paid for brand name drugs under the two programs, with Medicare receiving significantly lower rebates and paying higher prices than Medicaid. Prior to the establishment of Medicare Part D, manufacturers paid Medicaid rebates for drugs provided to the dual eligible population. This proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy, beginning in 2014. The proposal would require manufacturers to pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels. [$123.2 billion in savings over 10 years]

Closing the Coverage Gap

The following table displays Part D beneficiary cost savings for brand and generic drugs in the Part D coverage gap by year, until 2020.

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

Year	Percent Cost Sharing Paid by Enrollee for Branded Drugs (Current Law)	Percent Cost Sharing Paid by Enrollee for Branded Drugs (Proposed Law)	Percent Cost Sharing Paid by Enrollee for Generic Drugs (Proposed and Current Law)	Average Amount Saved per Enrollee who Reaches the Coverage Gap (Current Law) /3
2010 /2	100%	100%	100%	$250
2011	50%	50%	93%	$604
2012	50%	50%	86%	$714
2013	47.5%	47.5%	79%	$723
2014	47.5%	47.5%	72%	$780
2015	45%	25%	65%	$879
2016	45%	25%	58%	$840
2017	40%	25%	51%	$1,114
2018	35%	25%	44%	$1,293
2019	30%	25%	37%	$1,492
2020	25%	25%	25%	$1,734
2021	25%	25%	25%	$1,847
2022	25%	25%	25%	$1,969

1/ Savings only apply to applicable beneficiaries who do not receive the low-income subsidy.
2/ Percent cost sharing does not include $250 rebate for each beneficiary who hit the coverage gap in 2010.
3/ Source for 2010-2012: CMS data. Source for 2013-2022: ASPE Issue Brief "Estimated Savings of $5,000 to Each Medicare Beneficiary From Enactment Through 2022 Under the Affordable Care Act" released Sept 21, 2012.

Reduce Medicare Coverage of Bad Debts: For most hospitals and SNFs, Medicare currently pays 65 percent of bad debts resulting from beneficiaries' non-payment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. Starting in 2014, this proposal would reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments. This proposal would more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. [$25.5 billion in savings over 10 years]

Better Align Graduate Medical Education Payments with Patient Care Costs: The Medicare Payment Advisory Commission (MedPAC) has found that existing Medicare add on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal would partially correct this imbalance by reducing these payments by ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high-value health care delivery. [$11.0 billion in savings over 10 years]

Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap: Currently, beneficiaries in the Medicare Part D coverage gap receive a 50 percent discount from pharmaceutical manufacturers on their brand drugs. The Affordable Care Act closes this gap by 2020 through a combination of manufacturer discounts and federal subsidies. Beginning in plan year 2015, this proposal would increase manufacturer discounts to 75 percent, effectively closing the coverage gap for brand drugs in 2015. The phase-out for generic drugs would continue through 2020. [$11.2 billion in savings over 10 years]

Reduce Critical Access Hospital Reimbursements to 100% of Costs: Critical Access Hospitals (CAHs) are small, rural hospitals that provide their communities with access to basic emergency and inpatient care.

CAHs receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently reimburses CAHs at 101 percent of reasonable costs. This proposal would reduce this rate to 100 percent beginning in 2014. [$1.4 billion in savings over 10 years]

Prohibit Critical Access Hospital Designation for Facilities that are Less Than 10 Miles from the Nearest Hospital: Beginning in 2014, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced rate. [$690 million in savings over 10 years]

Increase the Minimum Medicare Advantage Coding Intensity Adjustment: Starting in 2015, this proposal changes the yearly increase to the minimum coding intensity adjustment from 0.25 percentage points to 0.67 percentage points until the minimum adjustment plateaus at 7.59 percent in 2018 and thereafter. [$15.3 billion in savings over 10 years]

Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids: Beginning in payment year 2015, this proposal would establish payment amounts for Employer Group Waiver Plans (EGWPs) based on the average MA plan bid in each individual market. [$4.1 billion in savings over 10 years]

Adjust Payment Updates for Certain Post-Acute Care Providers: This proposal would gradually realign payments with costs by reducing the market basket updates for Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals, SNFs and Home Health agencies, by 1.1 percentage points beginning in 2014 through 2023. These adjustments build on recommendations from MedPAC that Congress eliminate the payment updates for each of these provider types. Payment updates for these providers would not drop below zero under this provision. [$79.0 billion in savings over 10 years]

Encourage Appropriate Use of Inpatient Rehabilitation Facilities: This proposal would adjust the standard for classifying a facility as an IRF. Under current law, at least 60 percent of patient cases admitted to an IRF must meet one or more of 13 designated severity conditions. This standard was changed to 60 percent from 75 percent in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Beginning in 2014, this proposal would reinstitute the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.5 billion in savings over 10 years]

Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities: This proposal would adjust payments for three conditions involving hips and knees, pulmonary conditions, as well as other conditions selected by the Secretary. While these conditions are commonly treated at both IRFs and SNFs, Medicare payments are significantly higher when services are provided in an IRF. Beginning in 2014, this proposal would improve financial incentives to encourage efficient and appropriate provision of care by reducing the disparity in Medicare payments between the settings. IRFs provide intensive inpatient rehabilitation that may not be appropriate for patients with relatively uncomplicated conditions that could be treated in a SNF. [$2.0 billion in savings over 10 years]

Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions: The Affordable Care Act requires payment reductions starting in 2013 for hospitals with high rates of readmissions, many of which could have been avoided with better care. MedPAC analysis indicates that nearly 14 percent of Medicare patients discharged from a hospital to a SNF are readmitted to the hospital for conditions that could potentially have been avoided. To promote similar high-quality care in SNFs, this proposal reduces payments by up to three percent for SNFs with high rates of care-sensitive, preventable hospital readmissions, beginning in 2017. [$2.2 billion in savings over 10 years]

Implement Bundled Payment for Post-Acute Care Providers: Beginning in 2018, this proposal would implement bundled payment for post-acute care providers, including long term care hospitals (LTCHs), IRFs, SNFs, and home health providers. Payments would be bundled for at least half of the total payments for post-acute care providers. Rates based on patient characteristics and other factors will be set to produce a permanent and total cumulative adjustment of -2.85% by 2020. Beneficiary coinsurance would equal levels under current law. [$8.2 billion in savings over 10 years]

Reduce Overpayment of Part B Drugs: To reduce overpayment of Part B drugs administered in the physician office setting, this proposal lowers reimbursement from 106 percent of the Average Sales Price (ASP) to 103 percent of ASP. In order to preserve access to care, manufacturers would be required to provide a specified rebate in certain instances as determined by the Secretary. [$4.5 billion in savings over 10 years]

Modernize Payments for Clinical Laboratory Services: This proposal would lower the payment rates under the Clinical Laboratory Fee Schedule (CLFS) by -1.75 percent every year from 2016 through 2023 to better align Medicare payments with private sector rates and would also provide the Secretary the authority to adjust payment rates under the CLFS in a budget-neutral manner, precluding administrative or judicial review of these adjustments. Additionally, the Budget supports policies to encourage electronic reporting of laboratory results. [$9.5 billion in savings over 10 years]

Exclude Certain Services from the In-Office Ancillary Services Exception: The in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely performed on the same day as the related physician office visit. Additionally, evidence suggests that this exception may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2015, this proposal would seek to encourage more appropriate use of select services by excluding radiation therapy, therapy services, and advanced imaging from the in-office ancillary services exception to the prohibition against physician self-referrals (Stark law), except in cases where a practice meets certain accountability standards, as defined by the Secretary. [$6.1 billion in savings over 10 years]

Expand Medicare Data Sharing with Qualified Entities: The Affordable Care Act includes a provision which allows CMS to make Medicare Part A, B, or D claims data available to qualified entities for the purpose of publishing reports evaluating the performance of providers and suppliers. This proposal would expand the scope of how qualified entities can use Medicare data beyond simply performance measurement. For example, entities would be allowed to use the data for fraud prevention activities and value-added analysis for physicians. In addition, qualified entities would be able to release raw claims data, instead of simply summary reports, to interested Medicare providers for care coordination and practice improvement. This proposal includes additional resources for CMS by making claims data available to a qualified entity for a fee equal to Medicare's cost of providing the data. [No budget impact]

Clarify the Medicare DSH Statute: This proposal would clarify that individuals who have exhausted inpatient benefits under Part A or who have elected to enroll in Part C plan should be included in the calculation of the Medicare fraction of hospitals' Disproportionate Share Hospital (DSH) patient percentages. [No budget impact]

Increase Income-Related Premiums under Medicare Part B and Part D: Under Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2017, this proposal would restructure income-related premiums under Medicare Parts B and D by increasing the lowest income-related premium five percentage points, from 35 percent to 40 percent, and also increasing other income brackets until capping the highest tier at 90 percent. The proposal maintains the income thresholds associated with these premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. This proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those beneficiaries who can most afford them. [$50.0 billion in savings over 10 years]

Modify Part B Deductible for New Enrollees: Beneficiaries who are enrolled in Medicare Part B are required to pay an annual deductible ($147 in CY 2013). This deductible helps to share responsibility for payment of Medicare services between Medicare and beneficiaries. To strengthen program financing and encourage beneficiaries to seek high-value health care services, this proposal would apply a $25 increase to the Part B deductible in 2017, 2019, and 2021 respectively for new beneficiaries beginning in 2017. [$3.3 billion in savings over 10 years]

Introduce Home Health Copayments for New Beneficiaries: This proposal would create a co-payment for new beneficiaries of $100 per home health episode, starting in 2017. Consistent with MedPAC recommendations, this co-payment would

Healthcare Associated Infections

CMS is the lead agency partnering with the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the Secretary in working to improve patient safety and reduce the national rate of healthcare-associated infections (HAIs) by reducing hospital-acquired central-line associated bloodstream infections by 25 percent and hospital-acquired catheter-associated urinary tract infections by 20 percent by the end of FY 2013. HAIs are among the leading cause of morbidity and mortality in the United States.

As of March 2012, HHS reduced hospital-acquired central-line associated bloodstream infections by 18% from baseline. Less progress has been observed for hospital-acquired catheter-associated urinary tract infections, which can be attributed at least partially to a change in measurement strategy. The Department will continue to work towards these goals, using CDC's National Healthcare Safety Network as a data source, AHRQ's Comprehensive Unit-based Safety Program, and the Office of the Assistant Secretary for Health's "National Action Plan to Prevent HAIs: Roadmap to Elimination" for strategic direction, as well as leveraging the work of CMS' Quality Improvement Organizations and CMS' Innovation Center Partnership for Patients project.

apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. Home health services represent one of the few areas in Medicare that do not currently include some beneficiary cost-sharing. This proposal aims to encourage appropriate use of home health services while protecting beneficiary access. [$730 million in savings over 10 years]

Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth: Created by the Affordable Care Act, the Independent Payment Advisory Board (IPAB) has been highlighted by economists and health policy experts as a key contributor to Medicare's long-term solvency. Under current law, if the projected Medicare per capita growth rate exceeds a predetermined target growth rate, IPAB will recommend policies to Congress to reduce the Medicare growth rate to meet the target. To further moderate Medicare cost growth, this proposal would lower the target rate applicable for 2020 and after from gross domestic product (GDP) per capita growth plus 1 percentage point to GDP per capita growth plus 0.5 percentage points. [$4.1 billion in savings over 10 years]

Introduce Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap Coverage: Medicare requires cost-sharing for various services, but Medigap policies sold by private insurance companies provide beneficiaries with additional coverage for these out-of-pocket expenses. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare costs and Part B premiums. This proposal would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, effective in 2017. Other Medigap plans that meet minimum cost- sharing requirements would be exempt from the surcharge. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium (or about 30 percent of the Part B premium). [$2.9 billion in savings over 10 years]

Encourage the Use of Generic Drugs by Low Income Beneficiaries: Beginning in plan year 2014, this proposal would encourage greater generic utilization by lowering copayments for generic drugs by more than 15 percent, to 90 cents for beneficiaries with income below 100 percent of the federal poverty level, and $1.80 for beneficiaries with incomes below 135 percent of the federal poverty level. Brand drug copayments would increase to twice the level required under current law. The Secretary would have new authority to exclude therapeutic classes from this policy if therapeutic substitution is determined not to be clinically appropriate or a generic is not available. Beneficiaries could also obtain brand drugs at current law cost-sharing levels with a successful appeal of a coverage determination. In addition, the change in cost-sharing would apply to beneficiaries with incomes between 135 and 150 percent of the poverty level only upon reaching the catastrophic coverage level. Low-income beneficiaries qualifying for institutional care would be excluded from this policy. [$6.7 billion in savings over 10 years]

Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics: Beginning in 2014, this proposal would increase the availability of generic drugs and biologics

by authorizing the Federal Trade Commission (FTC) to prohibit pay-for-delay agreements between brand and generic pharmaceutical companies that delay entry of generic drugs and biologics into the market. In these agreements, a brand name company settles its patent lawsuit by paying the generic firm to delay entering the market. This proposal will save money in Medicare and Medicaid. [$8.6 billion in Medicare savings over 10 years]

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics: This proposal would reduce the length of exclusivity on brand name biologics to encourage faster development of generic biologics while retaining appropriate incentives for research and development for the innovation of breakthrough products. Effective in 2014, the proposal would award brand biologic manufacturers 7 years of exclusivity rather than 12 years under current law and prohibit additional periods of exclusivity for brand biologics due to minor changes in product formulations, a practice often referred to as ever-greening. This proposal will save money in Medicare and Medicaid. [$3.1 billion in Medicare savings over 10 years]

The Affordable Care Act Highlights Strengthening Medicare

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

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

Medicare Shared Savings Program: This initiative is a fee-for-service program established by the Affordable Care Act designed to improve beneficiary outcomes and increase value of care. ACOs that meet certain quality objectives and reduce overall expenditures get to share in the savings with Medicare and may be subject to losses. The final rule that implements this program was published on November 2, 2011. There were two start dates in 2012 and one in January 2013. A total of 114 organizations began participating in the program in 2012 and 106 were selected to participate in 2013. This program is estimated to save Medicare up to $940 million over 4 years.

Advance Payment ACO Model**:** With 35 ACOs currently participating, this initiative, sponsored by the CMS Innovation Center, tests whether pre-paying a portion of future shared savings could increase participation in the Medicare Shared Savings Program.

Pioneer ACO Model: Also sponsored by the Innovation Center, this model includes 32 health care organizations and providers that already have experience coordinating care for patients across care settings.

Primary Care and Prevention: Beginning in 2011, primary care providers and surgeons in health professional shortage areas started receiving an additional 10 percent payment for primary care services or major surgical procedures, respectively. In addition, approximately 34.1 million people with Medicare reviewed their health status at a free Annual Wellness Visit or received other preventive services without cost sharing in 2012.

Improving Quality and Value: Medicare continues its transformation from a passive payer to an effective purchaser of high-quality, efficient care. The Affordable Care Act established a value-based purchasing program for hospitals, and required CMS to develop plans to implement value-based purchasing for SNFs, home health agencies, and ambulatory surgical centers. Implementing these provisions will continue to be a high priority for CMS in FY 2014, which will be the second year of quality-based payment adjustments for hospitals, and will include patient mortality measures for the first time.

The Affordable Care Act also required CMS to implement a quality-based bonus payment for MA plans based on a 5-star rating system beginning in 2012. In 2013, the number and market share of four or five star plans each increased significantly, suggesting that the rating system has begun to encourage quality improvement.

Reducing Costs: The Affordable Care Act includes numerous changes designed to control the growth in

Medicare spending. These changes include small adjustments to certain provider payment updates, more closely aligning Medicare Advantage payments with those under traditional Medicare, program integrity enhancements, and creation of payment incentives to provide high-quality care.

CMS published four final Health Insurance Portability and Accountability Act Administrative Simplification regulations required by the Affordable Care Act which will save approximately $26 billion for the health care industry over ten years. The regulations: adopt operating rules for health plan eligibility and health care claims; set standards to change the way the health care industry pays bills—from paper checks to electronic payments; and set a standard identifier for health plans.

Additionally, the Affordable Care Act expands the Durable Medical Equipment (DME) Competitive Bidding program from 79 to 100 metropolitan statistical areas. The American Taxpayer Relief Act further expanded the program by setting all retail diabetic testing supplies prices at national mail-order competition levels starting in July 2013. The program will soon expand operations to an additional 91 metropolitan statistical areas and institute prices based on a national mail-order competition for diabetic testing supplies. As a result, millions of Medicare beneficiaries across the country will save money from competitive pricing while continuing to have access to quality medical equipment from accredited suppliers. CMS expects to save $25.8 billion over 10 years as a result of the DME Competitive Bidding program. Additionally, CMS expects beneficiaries will save $17.2 billion over 10 years in lower premiums and reduced co-payments as a result of this program.

Highlights from the American Taxpayer Relief Act of 2012

The American Taxpayer Relief Act of 2012 included multiple provisions that affect Medicare.

Medicare Physician Update: The Act averted a 26.5 percent reduction to physician payment rates and provided a zero percent update to rates in 2013. CBO estimated the cost of this one-year "doc fix" to be $25.2 billion over 10 years (FY 2013-2022).

Medicare Extenders: The Act included eight provisions that extend current Medicare payment policies through 2013. Some examples of these policies include extending: the exceptions process for outpatient therapy caps; the work Medicare physician fee schedule geographic practice cost index floor at 1.0; and the add-on payments for ambulance services. CBO estimated the cost of these Medicare "extenders" to be approximately $2.3 billion over 10 years (2013-2022).

Medicare Savings: The Act also included numerous provisions that reduced Medicare expenditures. CBO estimated the total savings from these provisions at $24.1 billion over ten years. Major savers include:

- *Inpatient Hospital Documentation and Coding Adjustment*: Granted CMS authority to recover hospital overpayments that resulted from the transition to a new coding system in FY 2008. (Savings: $10.5 billion)
- *Rebased End Stage Renal Disease Payments*: Changed ESRD reimbursement rates to better reflect market conditions, following a recommendation by the Government Accountability Office. (Savings: $4.9 billion)
- *Medicare Advantage Coding Intensity Adjustment*: Increased downward adjustments to Medicare Advantage plan payments to reflect differences in coding practices between Medicare fee-for-service and Medicare Advantage. (Savings: $2.5 billion)
- *Therapy Multiple Procedure Payment Reduction*: Reduced Medicare payments to physicians when multiple therapies are provided to the same patient on the same day. (Savings: $1.8 billion)

Medicare Quality Improvement Organizations

The mission of the Quality Improvement Organization (QIO) Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The current three year contract cycle, or 10th Statement of Work (SOW), was launched on August 1, 2011 and provides approximately $1.6 billion in funding through July 31, 2014. Through partnership and collaboration, the 10th SOW aligns the strengths of the QIO program with national quality goals that seek to continually improve health and health care for all Americans.

QIOs are the boots-on-the ground experts to drive local change and achieve national goals which can translate into national quality improvement.

Major 10th SOW activities are organized around four priorities:

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

Improve Individual Patient Care: Focus on patient safety to reduce health care associated infections; eliminate unnecessary physical restraints and reduce pressure ulcers in nursing homes; and improve the quality of care provided through value based purchasing.

Estimated QIO Funding 10th SOW (2011-2014) (dollars in millions)	
QIO Clinical Quality Improvement	
Improving Individual Patient Care	$223.1
Integrated Care for Populations .	$93.9
Improving Health for Populations and Communities	$101.7
Care Reinvention through Innovative Spread	$30.6
Subtotal, Clinical Quality Improvement	**$449.3**
Infrastructure, Staff, and Special Initiatives	**$405.4**
Other Support Contracts	**$207.6**
Beneficiary Centered Care	**$181.0**
Value Based Purchasing Support	**$404.2**
Subtotal 10th SOW Funding	**$1,647.5**

Integrate Care for Populations: Improve care transitions by working to reduce hospital readmissions and assisting care transition programs.

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

QIO 10th Statement of Work Success Stories: Many QIOs have identified best practices worthy of national adoption. For example, one nursing home demonstrated a best practice for the medication reconciliation discharge hand-off process. Their process has proven that communication of medication reconciliation reduces and prevents adverse drug events, as evidenced by a reduction of hospital readmission rates and improved patient safety.

In addition, as of December 31, 2012, recruited communities across the country doing care transition work include: 844 hospitals, 1,458 SNFs, 852 home health agencies, 97 dialysis facilities, and 324 hospice programs.

QIO 11th Statement of Work: The 11th SOW begins August 1, 2014, and its development is currently underway. The next SOW will implement several changes to the program enacted in the Trade Adjustment Assistance Extension Act of 2011, which provided the Secretary authority to:

- Determine the geographic scope of QIO contracts;
- Extend the length of QIO contracts from three years to five years;
- Contract with a broader range of entities to perform QIO functions;
- Award certain QIO tasks to specialty contractors; and
- More easily terminate QIO contracts for poor performance.

FY 2014 Medicare Legislative Proposals

dollars in millions (Negative numbers reflect savings and positive numbers reflect costs)	2014	2014 -2018	2014 -2023
Increase Value in Medicare Provider Payments			
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	-3,140	-40,290	-123,170
Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap	—	-1,580	-11,210
Reduce Medicare Coverage of Bad Debts	-200	-8,360	-25,490
Better Align Graduate Medical Education Payments with Patient Care Costs	-780	-4,710	-10,980
Reduce Critical Access Hospital Reimbursements to 100% of Costs	-90	-570	-1,430
Prohibit Critical Access Hospital Designation for Facilities that are less than 10 Miles from the Nearest Hospital	-40	-280	-690
Increase the Minimum Medicare Advantage Coding Intensity Adjustment	—	-3,910	-15,340
Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids	—	-1,380	-4,050
Adjust Payment Updates for Certain Post-Acute Care Providers	-830	-16,540	-79,040
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-190	-1,140	-2,520
Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	-140	-850	-1,950
Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions	—	-500	-2,210
Implement Bundled Payment for Post-Acute Care Providers		-290	-8,160
Reduce Overpayment of Part B Drugs	-220	-1,840	-4,480
Modernize Payments for Clinical Laboratory Services	—	-1,080	-9,460
Exclude Certain Services from the In-Office Ancillary Services Exception	—	-2,140	-6,050
Expand Medicare Data Sharing with Qualified Entities	—	—	—
Clarify the Medicare DSH Statute	—	—	—
Medicare Structural Reforms			
Increase Income-Related Premiums Under Part B and Part D	—	-6,000	-50,000
Modify Part B Deductible for New Enrollees	—	-110	-3,320
Introduce Home Health Copayments for New Beneficiaries	—	-60	-730
Strengthen IPAB to Reduce Long-Term Drivers of Medicare Cost Growth	—	—	-4,100
Introduce Part B Premium Surcharge for New Beneficiaries that Purchase Near First-Dollar Medigap Coverage	—	-250	-2,910
Encourage the Use of Generic Drugs by Low Income Beneficiaries	-350	-2,600	-6,730
Increase the Availability of Generic Drugs and Biologics			
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics (Medicare Impact)	-580	-3,410	-8,570
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare Impact)	—	-590	-3,090
Reduce Fraud, Waste, and Abuse in Medicare (See Prog. Integrity Section)	—	-120	-400
Other Proposals			
Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries	—	—	—
Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Extend the Qualified Individuals Program /1	405	590	590
Interactions /2	—	100	14,470
Total, Medicare Legislative Proposals	**-6,155**	**-97,910**	**-371,020**

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

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

PROGRAM INTEGRITY

dollars in millions	2012	2013	2014	2014 +/- 2013
Budget Authority:				
HCFAC Discretionary /1	310	312	311	-1
HCFAC Mandatory /2	1,290	1,597	1,650	+53
Affordable Care Act (non-add) /3	*117*	*122*	*148*	*+26*
Total, Budget Authority	**1,600**	**1,909**	**1,961**	**+52**

1/ For FY 2014, the Budget provides $311 million for HCFAC through discretionary appropriations. The Budget also proposes additional mandatory funding beginning in FY 2013.

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

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

The FY 2014 Budget supports fraud prevention and the reduction of improper payments as top priorities of the Administration. The Budget invests $640 million in additional HCFAC funding in FY 2014, $311 million in base discretionary funding and $329 million in proposed mandatory funding. Additional mandatory HCFAC funding above the discretionary base is also proposed for FY 2013. Starting in FY 2015, the Budget requests all additional HCFAC funds as mandatory, instead of through the discretionary cap adjustment included in the Budget Control Act (BCA). This approach will provide a dedicated, dependable source of additional resources to perform program integrity activities and make certain that only the right people receive the right payment for the right reason at the right time. All proposed Health Care Fraud and Abuse Control (HCFAC) program investments, including gradual growth over time, are consistent with BCA levels and save $6.7 billion over 10 years in gross savings. The Budget also proposes legislative changes that give HHS important new tools to enhance program integrity oversight; cut waste, fraud, and abuse in Medicare, Medicaid, and CHIP; and generate an additional $4.1 billion in program savings over 10 years.

HCFAC Multi-Year Investment and Savings

(in millions)	2013 Base	2014	2015	2016	2017	2018	2014 2018	2014 -2023
Mandatory Base Funding /1	1,294	1,321	1,339	1,368	1,377	1,407	6,812	14,292
Proposed Mandatory Funding /2	303	329	672	706	725	745	3,177	7,216
Discretionary Funding /2	312	311	—	—	—	—	311	311
Total Program Level	**1,909**	**1,961**	**2,011**	**2,074**	**2,102**	**2,152**	**10,300**	**21,819**
Savings from HCFAC Investment /3:	**-450**	**-496**	**-546**	**-599**	**-628**	**-659**	**-2,928**	**-6,708**

1/ Totals do not include Deficit Reduction Act of 2005 funding for the Medicaid Integrity Program, which is discussed separately under State Grants and Demonstrations.
2/ Totals reflect additional HCFAC mandatory investments proposed in the President's Budget, above FY 2013 and 2014 discretionary HCFAC levels.
3/ Savings are attributable only to the incremental increase in the HCFAC investment. Savings are not scored under PAYGO.

Health Care Fraud and Abuse Control Funding

The FY 2014 Budget proposes to build on recent progress by increasing support for the HCFAC program through both mandatory and discretionary funding streams. The FY 2014 HCFAC program level is $2.0 billion. Of the total FY 2014 program level, $1.7 billion is mandatory funding and $311 million is requested in discretionary funding.

The $1.3 billion in mandatory base funds for FY 2014 are financed from the Medicare Part A Trust Fund. This funding is allocated to: the Medicare Integrity Program (MIP) and the HCFAC Account, which is divided annually among the HHS Office of Inspector General (OIG), other HHS agencies, and law enforcement partners at the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). These dollars fund comprehensive efforts to combat health care fraud, waste, and abuse, including prevention focused activities, improper payment reductions, provider education, data analysis, audits, investigations, and enforcement.

The additional FY 2014 Budget request of $640 million of discretionary and additional mandatory funding is allocated between CMS ($429.9 million), OIG ($107.5 million), and DOJ ($102.6 million). It is part of a multi-year program integrity investment of new mandatory funding to combat health care fraud in Medicare, Medicaid, and CHIP.
Despite enactment of multi-year discretionary cap adjustments, annual appropriations bills have not provided the full amount of program integrity funding authorized in the BCA. Billions of dollars in savings over the next ten years from curtailing improper payments will not be realized if consistent, additional funding for program integrity is not provided.

The HCFAC investment supports efforts to reduce the Medicare fee-for-service (FFS) improper payment rate and initiatives of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) task force, including Strike Force teams in cities where intelligence and data analysis suggest high levels of fraud, and the new Health Care Fraud Prevention Partnership between the federal government, private insurers, and other stakeholders. CMS will also make further investments in innovative prevention initiatives, such as the Fraud Prevention System to analyze all Medicare FFS claims using sophisticated algorithms to identify suspicious behavior. See "Fraud Prevention System" for additional details. In FY 2014 and beyond, CMS will continuously refine these technologies to better combat fraud, waste, and abuse in Medicare, Medicaid, and CHIP.

Finally, these funds will support more rigorous data analysis and an increased focus on civil fraud, such as off-label marketing and pharmaceutical fraud.

Return on Investment: Programs supported by HCFAC mandatory funds have a proven record of returning far more money to the Medicare Trust Funds than the dollars spent. The MIP return on investment averaged 14 to 1 in 2011, and MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade.

The HCFAC 3-year rolling average return on investment is now a record 7.9 to 1. From 1997 to 2012, programs supported by HCFAC have returned over $23 billion to the Medicare Trust Funds. In FY 2012 alone, $4.2 billion was recovered, including $2.4 billion returned to the Medicare Trust Funds and $835.7 million in federal Medicaid recoveries returned to the Treasury. CMS actuaries conservatively project that for every new dollar spent by HHS to combat

Fraud Prevention System

In 2012, CMS completed its first year of implementation of the Fraud Prevention System, marking a significant shift from a pay and chase model to a predictive modeling and claims screening model similar to technology used by the credit card industry. This approach screens all Medicare Part A, Part B, and Durable Medical Equipment (DME) claims through a series of predictive models to identify suspicious billing activity and emerging fraud trends. The system prioritizes leads for CMS's program integrity contractors to investigate and determine whether to stop payment or make a referral to law enforcement.

- In its first year the Fraud Prevention System prevented or identified $115.4 million in inappropriate payments, generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations, and triggered thousands of provider and beneficiary interviews to verify legitimate items and services were provided to beneficiaries.

Medicaid and CHIP Business Information and Solutions

Transforming the Medicaid and CHIP data enterprise is necessary to meet the requirements of the Affordable Care Act, improve program integrity efforts, and improve performance and accountability of the Medicaid and CHIP programs. This effort is making this transformation possible in two ways:

- Updating the operational claims, provider, and enrollment data needed for claims review and program oversight through the Transformed Medicaid and CHIP Statistical Information System.
- Developing a system for aggregate level Medicaid and CHIP program data to facilitate efficient adjudication of the state plan, waiver, and other administrative actions submitted to CMS by states for approval.

health care fraud; about $1.50 is saved or averted. Based on these projections, the $640 million in HCFAC funding, as part of a multi-year investment, will yield additional Medicare and Medicaid savings of $6.7 billion over 10 years. Further, the HCFAC ROI demonstrates that in recent years the actual recoveries from HCFAC law enforcement efforts have far exceeded the projected savings.

New Affordable Care Act Authorities

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

CMS began implementing its new Affordable Care Act authorities in 2011. New authorities include enhanced provider screening that is applying a rigorous risk-based screening process for all new and re-enrolling providers and suppliers and suspending payments to a provider or supplier pending the investigation of a credible allegation of fraud. The Affordable Care Act also requires a face-to-face encounter between patient and doctor prior to certifying Medicare and Medicaid eligibility for the home health, hospice, and durable medical equipment (DME) benefits.

Additionally, CMS must include national provider identifiers on all provider enrollment applications and claims and requires physicians and suppliers to maintain documentation of written orders for DME, home health, or other referrals upon request. Also, CMS issued rules under the Affordable Care Act requiring states to implement Medicaid Recovery Audit Contractor (RAC) programs by January 1, 2012. As of January 15, 2013, 42 states have implemented Medicaid RAC programs.

Finally, on February 1, 2013, CMS issued a final regulation implementing a national provider payment transparency program, also known as the Sunshine Rule. This program increases public awareness of financial relationships between drug and device manufacturers and health care providers by requiring manufacturers of certain drug products covered by Medicare, Medicaid, and CHIP to report payments or other transfers of value they make to physicians and teaching hospitals. CMS will then post that data to a public website. The final rule also requires the disclosure of physician ownership or investment interests. CMS will release the data on a public website beginning September 30, 2014.

Program Integrity Legislative Proposals

The Budget includes 17 legislative proposals to further strengthen program integrity for Medicare, Medicaid, and CHIP, saving $4.1 billion over 10 years.

Medicare Fraud Strike Force Successes

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

In the 5 ½ years since its inception, Strike Force prosecutors filed more than 724 cases charging more than 1,476 defendants who collectively billed the Medicare program more than $4.6 billion. Strike Force prosecutors secured 918 guilty pleas and 105 others were convicted in jury trials. Additionally, 745 defendants were sentenced to imprisonment for an average term of nearly 4 years.

Medicare:

Require Prepayment Review or Prior Authorization for Power Mobility Devices: Historically, due to high payment rates, Power Mobility Devices (PMDs) have a high incidence of fraud and abuse. Pre-payment or earlier review of claims will deter fraud and prevent improper payments by validating medical necessity. CMS is currently testing the effectiveness of using prior-authorization on some PMDs through a demonstration. [$90 million in savings over 10 years]

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

> **Strengthening Program Integrity Tools**
>
> The FY 2014 Budget builds on the Affordable Care Act's unprecedented fraud-fighting authorities with 17 program integrity legislative proposals. These proposals enhance pre-payment scrutiny, increase penalties for improper actions, strengthen CMS's ability to implement corrective actions, and promote integrity in federal-state financing while saving Medicare, Medicaid, and CHIP $4.1 billion over 10 years.

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

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

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

Medicaid:

Expand Medicaid Fraud Control Unit (MFCU) Review to Additional Care Settings: A MFCU's investigation or prosecution of abuse and neglect does not always qualify for federal matching funds in a variety of settings in which a beneficiary may be victimized in the course of receiving health care services. This limitation was logical when the MFCU program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting, but has become outmoded as the delivery and payment for health services has shifted to in-home and community-based settings. [$73 million in savings over 10 years]

Strengthen Medicaid Third-Party Liability: Medicaid is the payer of last resort, and this proposal would affirm Medicaid's position by strengthening third-party liability under Medicaid to improve states' and providers' abilities to receive third-party payments for beneficiary services, as appropriate. This proposal allows states to delay payment of costs for prenatal and preventive pediatric claims when third parties are responsible to the extent beneficiary access to care is not negatively impacted; allows states to collect medical child support where health insurance is available from a non-custodial parent, and allows Medicaid to recover costs from beneficiary liability settlements. [$1.7 billion in savings over 10 years]

Improvements to Program Integrity for Medicaid Drug Coverage: The President's Budget includes five related proposals to enhance program integrity for the Medicaid prescription drug program. The first proposal would track high prescribers and utilizers of prescription drugs in Medicaid. States are currently authorized to implement prescription drug monitoring activities, but not all states have adopted such activities. Under this proposal, states will be required to monitor high risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care. [$1.8 billion in savings over 10 years]

The second proposal would require manufacturers that improperly report items for Medicaid drug coverage to repay the full amount. Manufacturers are required to report a list of their covered outpatient drugs to CMS for Medicaid prescription drug coverage under current federal law. Some manufacturers improperly report items that are not covered by Medicaid. This proposal requires full restitution to states for any covered drug improperly reported by the manufacturer on the Medicaid drug coverage list. [$18 million in savings over 10 years]

The third proposal would enhance existing enforcement of manufacturer compliance with drug rebate requirements. Under current law, CMS has authority to survey drug manufacturers, and OIG has authority to audit drug manufacturers. This proposal would allow more regular audits and surveys of drug manufacturers to ensure compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective. [No budget impact]

The fourth proposal would require drugs to be electronically listed with the Food and Drug Administration (FDA) to receive Medicaid coverage. Current law requires manufacturers to list their prescription drugs with the FDA, but not all drugs on the market are properly listed. This proposal would require electronic listing of drugs with the FDA in order to receive Medicaid coverage and thereby align Medicaid drug coverage requirements with Medicare drug coverage requirements. [No budget impact]

Finally, the President's Budget proposes to increase penalties for fraudulent noncompliance on rebate agreements. Under Medicaid drug rebate agreements, drug manufacturers are required to report accurate information. This proposal would increase penalties collected from drug manufacturers that knowingly report false information under their drug rebate agreements for the calculation of Medicaid rebates. [No budget impact]

Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP: Federal regulations prohibit federal funds from being used as the state share for Medicaid unless authorized in federal law. By codifying this principle in statute, this proposal would prevent states from using federal funds to pay the state share of Medicaid or CHIP, unless specifically authorized under law. [No budget impact]

Consolidate Redundant Error Rate Measurement Programs: This proposal would alleviate state program integrity reporting requirements and create a streamlined audit program by consolidating the

Partnership Fund Pilots

CMS has joined with OMB's Partnership Fund for Program Integrity Innovation in two pilot projects:

- Automating the Provider Enrollment Process for Risk Assessment and Comparative Analysis— CMS is testing an automated tool to screen Medicaid providers for potential fraud by cross-checking their credentials, background, and history among states and with Federal Medicare data.
- Provider Screening Innovator Challenge — CMS has partnered with the National Aeronautics and Space Administration, Harvard Business School, TopCoder, and the State of Minnesota to help execute a series of challenge contests to develop a shared service solution that can be provided to States to assist in their provider screening efforts.

Medicaid Eligibility Quality Control and Medicaid Payment Error Rate Measurement programs. [No budget impact]

Medicare and Medicaid:

Retain a Portion of Recovery Audit Contractor Recoveries to Implement Actions That Prevent Fraud and Abuse: Under current law, CMS can use the Recovery Audit Contractor (RAC) program recovery funds to administer the RAC program but cannot use these funds to implement corrective actions, such as new processing edits and provider education and training, to prevent future improper payments. This proposal addresses this funding restriction. [$250 million in savings over 10 years]

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

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

FY 2014 Program Integrity Legislative Proposals

dollars in millions	2014	2014 -2018	2014 -2023
Legislative Savings:			
Medicare			
Require Prepayment Review or Prior Authorization for Power Mobility Devices	—	-40	-90
Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records	—	-40	-90
Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High Risk Items and Services.	—	—	—
Increase Scrutiny of Providers Using Higher-Risk Banking Arrangements to Receive Medicare Payments	—	—	—
Require Prior Authorization for Advanced Imaging	—	—	—
Medicaid			
Expand Medicaid Fraud Control Unit (MFCU) Review to Additional Care Settings	-5	-30	-73
Strengthen Medicaid Third-Party Liability	-100	-680	-1,690
Improvements to Program Integrity for Medicaid Drug Coverage	-51	-728	-1,838
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid [non-add]	*-50*	*-720*	*-1,820*
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States [non-add]	*-1*	*-8*	*-18*
Enforce Manufacturer Compliance with Drug Rebate Requirements [non-add]	—	—	—
Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage [non-add]	—	—	—
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements [non-add]	—	—	—
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	—	—	—
Consolidate Redundant Error Rate Measurement Programs	—	—	—
Medicare & Medicaid			
Retain a Portion of RAC Recoveries to Implement Actions That Prevent Fraud and Abuse	—	-70	-250
Medicare [non-add]	—	*-30*	*-160*
Medicaid [non-add]	—	*-40*	*-90*
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	—	-10	-60
Medicare [non-add]	—	*-10*	*-60*
Medicaid [non-add]	—	—	—
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	—	—	—
Medicare [non-add]	—	—	—
Medicaid [non-add]	—	—	—
Improve Prisoner Database to Determine Eligibility for Improper Payments /1	—	—	—
Subtotal, Medicare Impact	**—**	**-120**	**-400**
Subtotal, Medicaid Impact	**-156**	**-1,478**	**-3,691**
Subtotal, Program Integrity Savings	**-156**	**-1,598**	**-4,091**

FY 2014 Program Integrity Legislative Proposals

dollars in millions	2014	2014 -2018	2014 -2023
Legislative Costs: /2			
HCFAC Mandatory Investment	**329**	**3,177**	**7,216**
HCFAC Discretionary Savings (non-add)	—	*-1,244*	*-2,799*
Net HCFAC Mandatory Investment (non-add)	*329*	*1,933*	*4,417*
Savings from Program Integrity Investments /3			
Savings from Additional HCFAC Investment	-496	-2,928	-6,708
Savings from Social Security Disability Review Investment	-220	-2,086	-7,870
Subtotal, Medicare and Medicaid Savings from Program Integrity Investment	**-716**	**-5,014**	**-14,578**
Total, Net Savings Program Integrity Proposed Policy	**-543**	**-3,435**	**-11,453**
Impact Net of Discretionary Savings (non-add)	*-543*	*-4,679*	*-14,252*

1/ This proposal is a multi-agency proposal with savings to Medicare and Medicaid.

2/ Totals reflect additional HCFAC mandatory investments proposed in the President's Budget, above the FY 2013 and 2014 discretionary HCFAC levels. The Budget no longer proposes discretionary HCFAC funding after FY 2014, and instead requests mandatory HCFAC funding.

3/ Includes non-PAYGO Scorecard savings from additional investments in HCFAC and Social Security disability reviews above savings already assumed in current law.

MEDICAID

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law:				
Benefits /1	236,670	250,404	287,338	+36,934
State Administration	13,864	16,182	16,453	+272
Total Net Outlays, Current Law	**250,534**	**266,586**	**303,791**	**+37,206**
Proposed Law:				
Legislative Proposals /2	—	—	-126	-126
Extend Qualified Individual (QI) Program /3	—	—	+405	+405
Adjustment for QI Transfer from Medicare /3	—	—	-405	-405
Total Net Outlays, Proposed Law	**250,534**	**266,586**	**303,665**	**+37,080**
Savings from Program Integrity Investments /4	—	-21	-31	-10
Total Net Outlays, Proposed Policy	**250,534**	**266,565**	**303,634**	**+37,070**

1/ Includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention.
2/ Includes proposal to extend Transitional Medical Assistance (TMA) currently authorized through December 31, 2013.
3/ States pay the Medicare Part B premium costs for Qualified Individuals (QIs) that are in turn offset by a 100 percent reimbursement from Medicare Part B. Costs of the proposal to extend the QI program through CY 2014 are reflected in Medicare outlays. The QI program is currently authorized through December 31, 2013.
4/ Includes non-PAYGO scorecard savings from additional investments in HCFAC and Social Security disability reviews, above savings already assumed in current law.

As a central component of the nation's medical safety net, Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In FY 2011, more than 1 in 5 individuals were enrolled in Medicaid for at least one month during the year, and in FY 2013, an estimated 57 million people on average will receive health care coverage through Medicaid.

How Medicaid Works

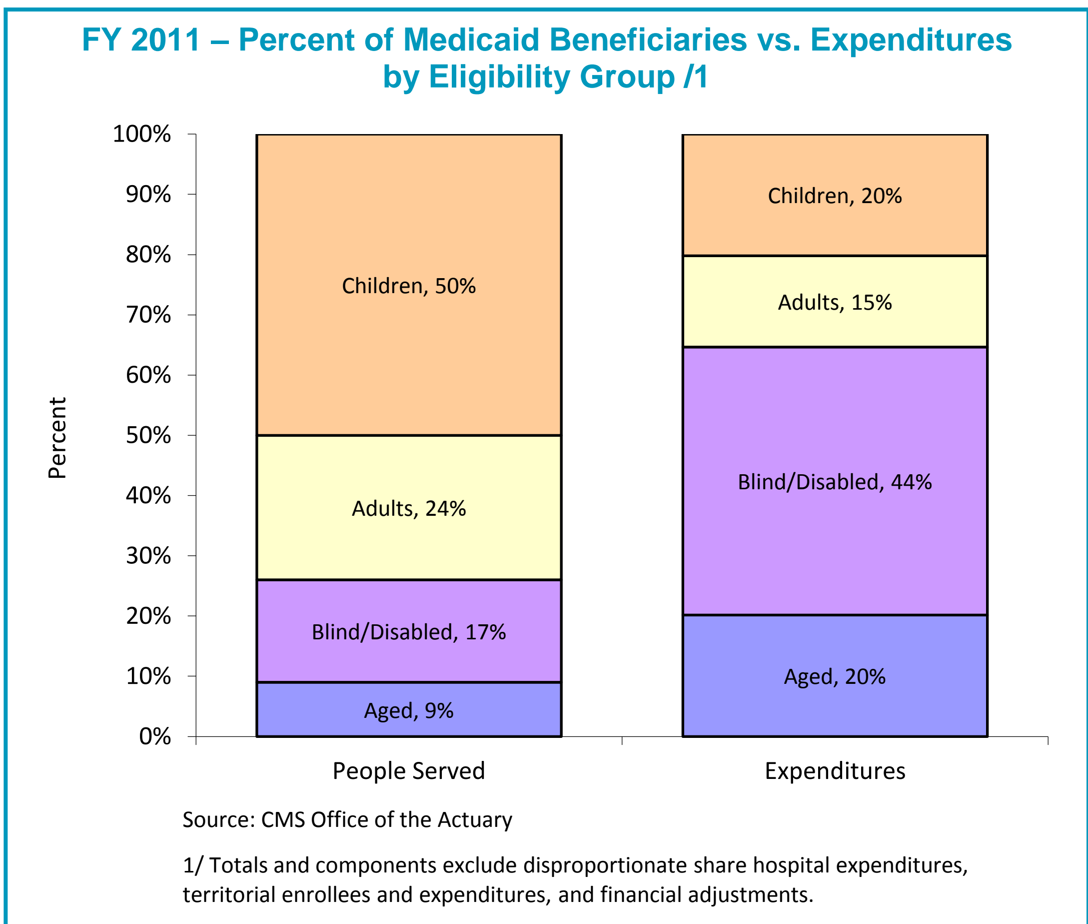
Although the federal government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. The federal government matches state expenditures on medical assistance based on the federal medical assistance percentage, which can be no lower than 50 percent. In FY 2014, the federal share of current law Medicaid outlays is expected to be nearly $303.8 billion.

States are currently required to cover individuals who meet certain minimum categorical and financial eligibility standards. Medicaid beneficiaries include children, pregnant women, adults in families with dependent children, the aged, blind and/or disabled, and individuals who meet certain minimum income eligibility criteria that vary by category. States also have the flexibility to extend coverage to higher

Medicaid Enrollment (person-years in millions)

	2012	2013	2014
Aged 65 and Over	5.1	5.2	5.4
Blind and Disabled	9.5	9.6	9.7
Children	28.2	27.9	29.4
Adults	13.7	13.7	20.2
Territories	1.0	1.0	1.0
Total	**57.5**	**57.4**	**65.7**

Source: CMS Office of the Actuary estimates.



income groups, including medically needy individuals through waivers and amended state plans. Medically needy individuals are those individuals who do not meet the income standards of the categorical eligibility groups, but incur large medical expenses such that when subtracted from their income, they fall within the financial eligibility standards.

Beginning in 2014, the Affordable Care Act expands Medicaid eligibility at the state's option to individuals under age 65 with family incomes up to 133 percent of the federal poverty level (or $31,322 for a family of four in 2013).

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

Recent Program Developments

Affordable Care Act (P.L. 111-148 and P.L. 111-152): Beginning in 2014, the Affordable Care Act expands Medicaid eligibility at the state's option to individuals with family incomes up to 133 percent of the federal poverty level. The federal government will pay 100 percent of state expenditures related to newly eligible individuals for the next three years. In addition to strengthening Medicaid program integrity efforts, the Affordable Care Act also improves services to Medicaid beneficiaries by increasing emphasis on providing long-term services and supports in home and community-based settings rather than institutions.

Middle Class Tax Relief and Job Creation Act (P.L. 112-96): This law amended the formula in the Affordable Care Act for providing increased federal funding to states experiencing a statewide disaster. Additionally, this law extended the reductions to Medicaid disproportionate share hospital (DSH) allotments from the Affordable Care Act.

American Taxpayer Relief Act of 2012 (P.L. 112-240): This law extended the Qualified Individual program and Transitional Medical Assistance program through December 31, 2013. This law also made technical adjustments to the calculation of Medicaid DSH allotments.

Medicaid Legislative Proposals

Rebase Future Disproportionate Share Hospital (DSH) Allotments: As the number of uninsured people decreases due to the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of DSH funding needed. Legislation has extended DSH reductions through FY 2022, but in FY 2023, allotments revert to levels that had been in effect prior to the Affordable Care Act. This proposal would determine future state DSH allotments based on states' actual DSH allotments as reduced by the Affordable Care Act. [$3.6 billion in savings over 10 years]

Begin Affordable Care Act Disproportionate Share Hospital (DSH) Reductions, One Year Later, in FY 2015: As states continue working to reduce their uninsured populations, this proposal begins the DSH payment reductions one year later, in FY 2015. Instead, the payment reductions currently scheduled for FY 2014 would be spread over FY 2016 and FY 2017. [No budget impact]

Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates: Through the DME Competitive Bidding Program, Medicare is in the process of implementing innovative ways to increase efficiency for DME payments, expected to save Medicare more than $25.8 billion, and Medicare beneficiaries approximately $17.2 billion, over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting federal reimbursement for a state's Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services. [$4.5 billion in savings over 10 years]

Clarify Medicaid Drug Rebate and Payment Definitions and Calculations: The Budget includes a number of proposals that clarify and improve the way Medicaid determines the Average Manufacturer Price (AMP) and Federal Upper Limits (FUL). These proposals clarify the definition of brand drugs, remove brand-name and authorized generic drug prices from the FUL and brand rebate calculations, and correct the rebate formula for new drug formulations. [$8.8 billion in savings over 10 years]

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

Extend Transitional Medical Assistance (TMA) through CY 2014: The TMA program extends Medicaid coverage for at least 6 months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. This proposal extends authorization and funding of the TMA program through December 31, 2014. States that adopt the Medicaid expansion will be able to opt out of TMA, consistent with a Medicaid and CHIP Payment and Access Commission recommendation. Current law extends this program through December 31, 2013. [$1.1 billion in costs over 10 years]

Modified Adjusted Gross Income

To promote administrative simplicity and seamless coordination between Medicaid, CHIP, and the Marketplaces, states will determine eligibility for all three programs using a methodology based on Modified Adjusted Gross Income (MAGI) for most enrollees. Effective January 1, 2014, MAGI-based methodology will apply to pregnant women, children, parents and other caretaker relatives, and the new adult group. MAGI-based methodology will standardize eligibility determination systems, replacing states' use of various and disparate income counting methods and disregards that historically have been used to determine income and eligibility. MAGI-based methodology will not be used to determine eligibility for elderly and disabled populations. On December 28, 2012, CMS provided guidance regarding MAGI. States have the option of converting income standards using options put forth by CMS, or proposing their own alternative methodologies and processes, with federal approval.

Extend the Qualified Individual (QI) Program through CY 2014: The QI program provides states 100 percent federal funding to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. This proposal extends authorization and funding of the QI program through December 31, 2014. Current law extends this program through December 31, 2013. [$590 million in costs over 10 years]

***Medicaid Program Integrity Proposals*:** The Budget includes a number of Medicaid program integrity proposals that strengthen the Department's ability to fight fraud, waste, and abuse in the Medicaid program. See Program Integrity section for proposal descriptions. [$3.7 billion in savings over 10 years]

Establish Hold Harmless for Federal Poverty Guidelines: To protect access to programs, including Medicaid, for low-income families and individuals, this proposal would treat the Consumer Price Index for All Urban Consumers (CPI-U) adjustment for the poverty guidelines consistent with the treatment of the annual cost of living adjustments for Social Security Benefits. The poverty guidelines would only be adjusted when there is an increase in the CPI-U, not a decrease in CPI-U. [No budget impact]

Improve Adult Health Care Quality in Medicaid

The Affordable Care Act established a quality measurement program for adults enrolled in the Medicaid program, building a foundation for tracking and improving the quality of care in Medicaid as coverage expands in 2014. In January 2012, CMS finalized the initial core set of 26 quality measures and has a target of 65 percent of states reporting on at least five of these measures in FY 2014.

Legislative Proposals for Dually Eligible Beneficiaries

The Budget includes two proposals to improve the quality and efficiency of care for Medicare-Medicaid beneficiaries.

Integrate the Appeals Process for Medicare-Medicaid Enrollees: Different provisions of the Social Security Act govern the Medicare and Medicaid appeals processes; therefore, each program has different requirements related to timeframes and limits, amounts in controversy, and levels of appeals. These sometimes conflicting requirements can result in confusion for beneficiaries and inefficiencies and administrative burdens for states and providers. This proposal provides the Secretary the authority to implement a streamlined appeals process for Medicare-Medicaid beneficiaries by allowing for more efficient integration of program rules and requirements. [No budget impact]

Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries:
This proposal would allow CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed. This plan would serve as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. Under current law, these beneficiaries are assigned at random to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under this proposal, the plan would be paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. A current demonstration has shown the proposed approach to be more efficient and less disruptive to beneficiaries, but is set to expire at the end of calendar year 2014. [No budget impact]

MEDICAID PROPOSALS

FY 2014 Medicaid Legislative Proposals

dollars in millions *(negative numbers reflect savings and positive numbers reflect costs)*	2014	2014 -2018	2014 -2023
Medicaid Proposals			
Rebase Future Disproportionate Share Hospital (DSH) Allotments	—	—	-3,630
Begin ACA DSH Reductions, One Year Later, in FY 2015 /1	360	—	—
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	-250	-1,750	-4,483
Clarify the Medicaid Definition of Brand Drugs	-21	-116	-256
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits	-90	-740	-1,740
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations	-30	-160	-355
Correct the ACA Medicaid Rebate Formula for New Drug Formulations	-270	-2,700	-6,450
Expand State Flexibility to Provide Benchmark Benefit Packages	—	—	—
Extend the Transitional Medical Assistance (TMA) Program through CY 2014 /2	480	1,055	1,055
Extend the Qualified Individual (QI) Program through CY 2014 /3	405	590	590
Adjustment for QI Transfer from Medicare /3	-405	-590	-590
Medicaid Program Integrity Proposals /4	-156	-1,478	-3,691
Total Outlays, Medicaid Proposals	**23**	**-5,889**	**-19,550**
Dually Eligible Beneficiary Proposals			
Integrate Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries	—	—	—
Total Outlays, Dually Eligible Beneficiary Proposals	—	—	—
Medicaid Interactions			
Establish Hold-Harmless for Federal Poverty Guidelines	—	—	—
Extend Supplemental Security Income Time Limits for Qualified Refugees /5	11	24	24
Eliminate Medicaid Recoupment of Birthing Costs from Child Support /6	—	—	—
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /7	10	-50	-190
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics /7	-170	-1,040	-2,430
Total Outlays, Medicaid Interactions	**-149**	**-1,066**	**-2,596**
Total Outlays, Medicaid Legislative Proposals	**-126**	**-6,955**	**-22,146**

1/ CMS Office of the Actuary projects that postponing the DSH reductions will increase outlays by $360 million in FY 2014. This proposal is budget neutral over 5- and 10-year windows because the scheduled cuts are redistributed to FY 2016 and FY 2017.
2/ Currently authorized through December 31, 2013.
3/ States pay the Medicare Part B premium costs for Qualified Individuals (QIs) that are in turn offset by a reimbursement from Medicare Part B. Costs of the proposal to extend the QI program through CY 2014 are reflected in Medicare outlays. The QI program is currently authorized through December 31, 2013.
4/ See Program Integrity chapter for proposal descriptions.
5/ This proposal is included in the Social Security Administration's FY 2014 Budget Request.
6/ This proposal is included in the Administration for Children and Families' FY 2014 Budget Request.
7/ This proposal is a multi-agency proposal with savings to Medicaid. See Medicare chapter for proposal descriptions.

CHILDREN'S HEALTH INSURANCE PROGRAM

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law:				
Children's Health Insurance Program	9,065	9,897	9,992	+95
Child Enrollment Contingency Fund	—	125	100	-25
Total, Outlays	**9,065**	**10,022**	**10,092**	**+70**

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

How CHIP Works

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

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

States have a high degree of flexibility in designing their programs. They can implement CHIP by expanding Medicaid, creating a separate program, or a combination of both approaches. As of January 1, 2013, there were 13 Medicaid expansion programs, 17 separate programs, and 26 combination programs among the states, District of Columbia, and territories.

In FY 2012, the CMS Office of the Actuary estimated that 8.3 million individuals received health insurance funded through CHIP allotments at some point during the year, an increase of 1.2 percent over FY 2011.

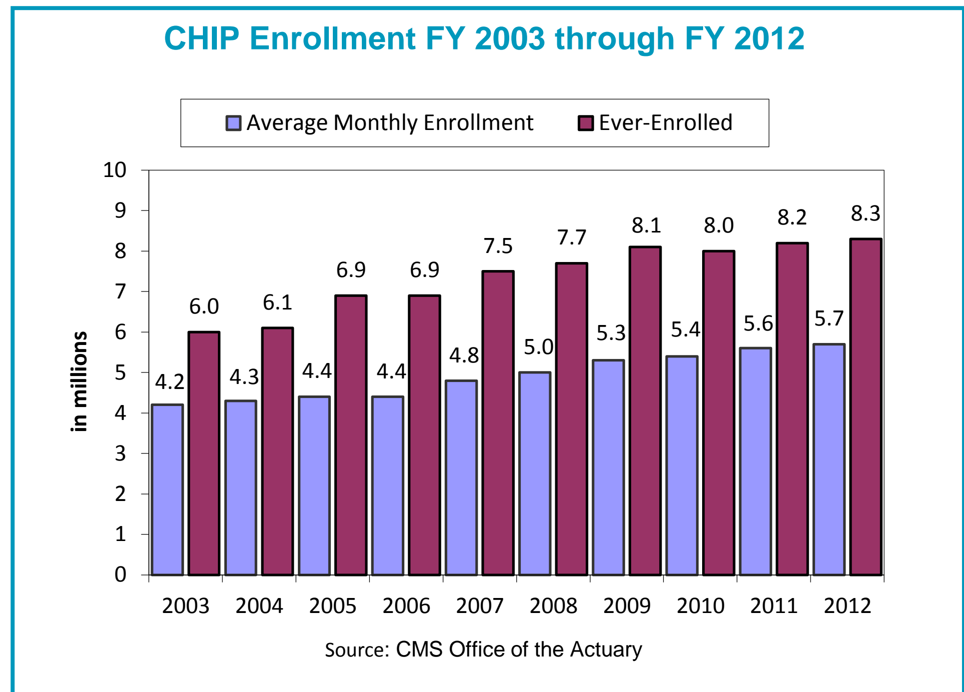
Funding for CHIP allotments to states increased under CHIPRA by $44 billion over the baseline for 5 years (FY 2009-FY 2013). The Affordable Care Act extended funding for CHIP, providing $19.1 billion for FY 2014 CHIP allotments and $21.1 billion for FY 2015 CHIP allotments. This expansion allowed for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

Increasing Enrollment of Eligible Children

CMS' goal is to improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.

FY 2011 actual: +17 percent over 2008 (43.5 million children)
FY 2013 target: +22 percent over 2008 (45.6 million children)
FY 2014 target: +25 percent over 2008 (46.6 million children)

Recent Program Developments



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

Eligibility and Coverage: Under the Affordable Care Act, states will use simplified procedures to determine eligibility for coverage under a state's CHIP program. CHIPRA provides states the option to offer CHIP coverage to children eligible for family coverage under a state health care employee plan, if the state meets certain conditions.

Enrollment and Retention Outreach: The Affordable Care Act also increased funding originally provided in CHIPRA for grants and a national campaign to improve outreach and enrollment from $100 million to $140 million and extended its availability through FY 2015. Of this amount, 10 percent is set aside for a national enrollment campaign, and an additional 10 percent is set aside to increase enrollment of Native Americans and Alaska Natives. In FY 2011, $40 million in grants were awarded with a renewed focus on advancing coverage among the hardest to reach children and in FY 2013 CMS announced plans to award an additional $32 million. These grants support the Secretary's "Connecting Kids to Coverage Challenge," calling on leaders at every level of government and the private sector to find and enroll the nearly 5 million uninsured children who are eligible for Medicaid and CHIP. Since 2009, 46 states and the District of Columbia have taken up new options for improving retention and enrollment. Outlay totals for Outreach and Enrollment Grants are reflected in the State Grants and Demonstrations chapter.

Improving Quality: CHIPRA provided $225 million over 5 years for activities that improve child health quality in Medicaid and CHIP, and in FY 2012, 18 states (across 10 grants) continued CHIPRA Quality Demonstrations that build a framework for measuring and improving the quality of care. CMS activities included providing significant technical assistance to states on measurement of child health quality, partnering with the Agency for Healthcare Research and Quality to administer grants to seven Centers of Excellence in Pediatric Quality Measures, and working with the Office of the National Coordinator for Health Information Technology to develop children's health care quality measures and to electronically specify the Children's Core Set measures.

Performance Bonus Payments

In December 2012, CMS awarded $306 million to 23 states that made significant improvement in enrolling children in the Medicaid and CHIP programs in FY 2012.

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

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

STATE GRANTS AND DEMONSTRATIONS

dollars in millions	2012	2013	2014	2014 +/- 2013
<u>Current Law Budget Authority:</u>				
Medicaid Integrity Program	78	80	82	+2
Money Follows the Person Demonstration	449	449	449	—
Money Follows the Person Evaluations	1	1	1	—
Total, Current Law Budget Authority	**528**	**530**	**532**	**+2**
<u>Current Law Outlays:</u>				
Incentives for Prevention of Chronic Diseases in Medicaid /1	2	35	27	-8
Medicaid Emergency Psychiatric Demonstration	— *	13	17	4
CHIP Outreach and Enrollment Grants /1	18	18	20	+2
CHIP Grants for Prospective Payment System Transition /1	— *	1	—	-1
Medicaid Integrity Program	63	96	86	-10
Psychiatric Residential Treatment Demo and Evaluation	40	50	50	—
Money Follows the Person Demonstration	255	525	531	+6
Money Follows the Person Evaluations	2	2	2	—
Expansion of State Long-Term Care Partnership Program /1/2	12	3	—	-3
Ticket to Work Grant Programs /1	31	23	— *	-23
Medicaid Transformation Grants /1	3	5	—	-5
Emergency Services for Undocumented Aliens /1	50	16	16	—
Katrina/Rita Hurricane Support /1	—	— *	—	—
Katrina Hurricane Relief /3	3	— *	—	—
PACE Funds for Outlier Costs /1	— *	—	—	—
Alternate Non-Emergency Network Providers /1	— *	— *	—	—
Total, Current Law Outlays	**477**	**788**	**749**	**-39**

1/ Outlays are from prior year budget authority.

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

3/ FY 2012 outlays are from FY 2006 budget authority.

* Outlays are less than $1,000,000.

STATE GRANTS AND DEMONSTRATIONS

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

Affordable Care Act

Incentives for Prevention of Chronic Diseases in Medicaid: The Affordable Care Act provides $100 million for states to award incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes related to chronic disease, including by adopting healthy behaviors. Funds are available for a five-year period, and states must commit to operating prevention programs for a minimum of three years. Grants must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition.

CMS awarded the first year of grants to 10 states in September 2011, and the second year in September 2012. CMS also awarded an implementation contract in September 2011. The implementation contractor provides technical assistance to grantees on implementation and operation of the program; monitors implementation and reports to CMS on grantee progress; facilitates collaboration and learning among grantees; and supports the federal evaluation contractor's efforts to assess the outcomes of the program. CMS awarded an evaluation contract in May 2012.

Medicaid Emergency Psychiatric Demonstration: The Affordable Care Act provides up to $75 million for a 3-year demonstration to provide Federal matching funds to states to provide inpatient emergency psychiatric care to Medicaid beneficiaries ages 21 to 64 in private psychiatric hospitals. Funding for this demonstration is available through December 31, 2015. In March 2012, CMS announced the 11 states and the District of Columbia as participants.

Extension of Existing Programs: The Affordable Care Act also extends the Money Follows the Person demonstration and increases funding for the Medicaid Integrity Program by providing an inflation adjustment. Both of these programs are described in more detail below.

Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009

Outreach and Enrollment Grants: See the CHIP chapter for additional details.

Deficit Reduction Act (DRA) of 2005

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

Money Follows the Person Demonstration: This demonstration helps states to sustain their Medicaid programs while helping individuals achieve independence. States that are awarded competitive grants receive an enhanced Medicaid matching rate to help eligible individuals transition from a qualified institutional setting to a qualified home or community-based setting. Approximately $3.5 billion has been awarded to 43 states and the District of Columbia, including the addition of 13 new state grantees in FY 2011. The DRA established this demonstration and appropriated $1.75 billion through FY 2011. The Affordable Care Act provided an additional $2.25 billion, $450 million for each fiscal year starting in FY 2012 through FY 2016. Funding awarded to states in FY 2016 is available to states for expenditures through FY 2020. These additional appropriations will enable state grantees to continue to develop their home and community-based programs and increase the number of beneficiaries served while continuing to rebalance their long-term care systems between institutional and community settings. As of June 30, 2011, 16,600 individuals have transitioned to community services and supports through this effort. In 2013, CMS issued a funding opportunity announcement to offer states and tribes the resources to build sustainable community-based long-term services and supports specifically for Indian country through the Tribal Initiative.

Medicaid Emergency Psychiatric Demonstration

In March 2012, CMS announced that it will provide up to $75 million over three years to 11 states—Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, West Virginia and the District of Columbia — to participate in the Medicaid Emergency Psychiatric Demonstration created by the Affordable Care Act. This demonstration will test whether Medicaid can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable.

Participating States will provide Medicaid payments to private psychiatric hospitals that are subject to the Emergency Medical Treatment and Labor Act and that have 17 or more inpatient beds for inpatient services provided to individuals between 21 and 64 years of age in need of acute psychiatric care. In return, states are required to participate in an evaluation of whether Medicaid reimbursement for institutions for mental disease improves psychiatric care for people with mental illness and lowers State Medicaid program costs.

CMS worked collaboratively with private non-profit organizations and across the Department of Health and Human Services to develop this demonstration. Partners included the National Association of Psychiatric Health Systems, and, within HHS, the Office of the Assistant Secretary for Planning & Evaluation (ASPE) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

PRIVATE HEALTH INSURANCE PROTECTIONS AND PROGRAMS

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law:				
Affordable Insurance Exchange Grants /1	167	1,457	2,061	+604
Pre-Existing Condition Insurance Plan Program	1,501	2,156	937	-1,219
Early Retiree Reinsurance Program	1,950	147	23	-124
Consumer Operated and Oriented Plan (CO-OP) Program	38	284	230	-54
Rate Review Grants to States	22	100	80	-20
Consumer Assistance Grants to States	22	—	—	—
Reduced Cost-sharing	—	—	3,978	+3,978
Total Outlays, Current Law	**3,700**	**4,144**	**7,309**	**+3,165**
Proposed Law:				
Accelerate Issuance of State Innovation Waivers	—	—	—	—
Total Outlays, Proposed Law	**3,700**	**4,144**	**7,309**	**+3,165**

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

The Affordable Care Act provides critical new protections for consumers with private health insurance, putting patients and consumers back in charge of their health care. Several vital consumer protections have already been implemented, providing more benefits and protections for patients and employers. Implemented protections include expanding access to affordable coverage for high-risk, high-cost individuals; encouraging employers to continue retiree insurance programs; and strengthening insurer accountability. Furthermore, beginning in 2014, millions of Americans will gain access to affordable coverage through the establishment of Health Insurance Marketplaces (Marketplaces), also known as Exchanges, and the expansion of Medicaid.

Insurance Market Reforms for Consumer Protection

Private Insurance Market Reforms: Many important Affordable Care Act protections are already in effect, providing an array of new rights and benefits to patients and consumers with private health insurance. For example, 3.1 million young adults who were uninsured have gained coverage by being able to stay on their parents' health plans until age 26.

Consumer Protections

Consumer Protection	Consumers Benefiting
Adult Child Coverage to Age 26	3,100,000
Elimination of Lifetime Limits	105,000,00
Prohibition on Insurance Rescissions	10,700
Elimination of Pre-Existing Condition Exclusions for Children Under Age 19	17,600,000
Free Preventive Services	54,000,000
Establishment of Internal and External Appeals Rights	41,000,000
Restrictions on Cost Sharing for Out of Network Emergency Rooms	41,000,000
Choice of Health Care Professional	41,000,000

Due to the Affordable Care Act's Patient's Bill of Rights, health plans—including grandfathered

plans—are prohibited from denying coverage to children because of a pre-existing condition. Consequently, the parents of over 17 million children no longer have to worry that their child will be denied coverage. This protection will extend to most Americans in 2014. Additionally, more than 105 million consumers no longer have a lifetime limit on benefits, ensuring that patients can use their insurance coverage when they are sick and need it most. Annual dollar limits on benefits are set at increasingly higher amounts until January 1, 2014, when most plans will be banned from having an annual dollar limit on coverage.

Furthermore, 41 million Americans in new plans can now appeal insurance company decisions to an independent reviewer and use the nearest emergency room without higher cost sharing, regardless of whether it is in network. In addition, 54 million Americans now receive coverage through their private health insurance plan for many preventive services without cost sharing such as copays or deductibles, including colonoscopy screenings, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets will have to offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Essential health benefits ensure that plans cover a core set of items and services, giving consumers a consistent way to compare plans.

Medical Loss Ratio (MLR): The Affordable Care Act increases healthcare efficiency by requiring insurance plans to spend at least 80 to 85 percent of collected premium revenue annually on health care benefits or quality improving activities, depending on the market. States have the option to require a higher MLR than the federal standard. Insurers must inform consumers of their compliance with the MLR and issue rebates to consumers if they do not meet the requirement. The first round of rebates was issued in August 2012 for the prior reporting year, when consumers nationwide received rebates totaling $1.1 billion. Insurers must continue to submit their MLR information to CMS annually, and consumers will receive rebates annually for plans that do not comply with the MLR.

Rebates to Consumers

In accordance with the ACA, insurance plans issued rebates to consumers if they did not spend 80 to 85 percent of collected premiums on health expenses.

- Nationally, 13.1 million consumers received a total of $1.1 billion in rebates due to the Medical Loss Ratio (MLR) in August 2012.
- 24.5% of health insurance companies owed rebates to consumers in at least one market.
- 66.9 million Americans were insured in 2011 by plans that met the MLR requirement.

Insurance Premium Rate Review: Insurers must submit to the Secretary and relevant state offices a justification for any premium increase greater than 10 percent prior to implementation of the increase. To date, state and national premium rate review programs have saved consumers approximately $1 billion by lowering health insurance premiums.

Through the end of 2012, HHS has awarded over $162 million to states, territories and the District of Columbia to support their premium rate review programs. These grants support the hiring of new staff, improved communication with consumers about rate review, and the enhancement of existing infrastructure required to operate an effective rate review program. Further awards are currently planned for 2013.

HealthCare.gov: HealthCare.gov increases transparency by bringing information and links to health insurance plans together, in one place, to make it easy for consumers and small businesses to learn about and compare their insurance options. As of February, 2013, the HealthCare.gov plan finder included over 13,000 individual and family insurance

plans, as well as over 1,500 product lines available to small employers. These offerings are made available

from over 550 insurance issuers. Additionally, of the approximately 16.5 million unique visitors to the HealthCare.gov website in 2012, about 1.5 million used the Insurance Finder tool.

Starting in October 2013 consumers will be able to enroll for coverage in the new Marketplaces on HealthCare.gov. This effort expands on the website's existing features that provide information about rate increases to enhance consumers' purchasing and decision making abilities. The website also provides information on medical loss ratio percentages and rate review by plan, health plan quality and performance metrics, and appeals and complaints data. HealthCare.gov will continue to include information for all health plans regardless of whether they are offered in a Marketplace. As a result, the site is and will continue to be an essential tool for consumers researching their best health insurance plan options.

Private Health Insurance Programs

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

State Work to Implement Marketplaces: States may establish their own Marketplaces or HHS will operate a Federally-facilitated Marketplace (FFM) in states that choose not to implement their own. In some cases, states may partner with HHS to operate some functions through in a State Partnership Marketplace (SPM). In addition to enrolling individuals and employees of small businesses in insurance coverage, Marketplaces must also determine eligibility for premium tax credits and cost sharing reductions, or Medicaid and CHIP; ensure health plans meet certain standards; operate a hotline and website to provide consumer assistance; and assist individuals in locating and obtaining affordable health coverage. In FY 2014, as many as 17 states and the District of Columbia will begin full operations of their Marketplaces, and 7 are currently conditionally-approved to partner with HHS. States with FFMs or SPMs may continue implementation activities in FY 2014, working toward establishment of State-based Marketplaces (SBM) in future years.

Marketplace Establishment Grants: The Affordable Care Act provides grant funding to enable states to plan for and establish Marketplaces. Since 2011, 37 states and the District of Columbia received over $3.4 billion in grants to operate Marketplaces. States may use Establishment grants to fund their costs, whether for SBM or SPM functions, or to support the FFM. Marketplace grants fund the first operational year of activities when system testing and process development will still be underway. Thus far, 11 states and the District of Columbia have received Level II Establishment funding to establish a SBM, and grants will continue to be awarded through December 2014 to states working toward establishing SBMs in future years. After their initial establishment, Marketplaces will be self-funded through user fees or other funding to support ongoing operations.

Payments for Reduced Cost-Sharing: Individuals who enroll in qualified health plans through the Marketplaces beginning in 2014 may qualify to have their out-of-pocket health care costs reduced. Individuals with incomes below 250 percent of the federal poverty level may have lower deductibles, coinsurance, co-pays and out of pocket limits. These same individuals will receive assistance with premium costs through the premium tax credit administered by the Department of Treasury. CMS will pay health insurance issuers for the value of the cost sharing that would otherwise have come from enrollees. In FY 2014 these amounts are estimated to total $4 billion.

Pre-Existing Condition Insurance Plan (PCIP) Program: The Affordable Care Act created the PCIP program to

State Marketplace Progress

Seventeen states and DC have been conditionally approved to operate State-based Marketplaces in 2014. Between now and January 1, 2014, these states will continue development and testing of IT systems, certify qualified health plans to be offered in the Marketplace, implement outreach campaigns to inform consumers of their options for coverage, and begin eligibility and enrollment processes. The work of these ground-breaking states will pave the way for other states hoping to operate their own Marketplaces in future years.

make health insurance available to uninsured Americans without access to affordable private insurance due to a pre-existing condition. This temporary program was launched on July 1, 2010, just 90 days after the law's enactment and currently provides covered services to over 100,000 enrollees in the PCIP program. Twenty-seven states administer their own PCIP programs, while CMS operates the program in the remaining states and the District of Columbia. Funding for this program is limited to $5 billion to pay claims and administrative costs that are in excess of the premiums collected from enrollees in the program.

Individuals are eligible for the PCIP program if they have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of a health condition, and are U.S. citizens or residing in the United States legally. Eligibility is not based on an individual's income level.

In February and March 2013, the PCIP program suspended enrollment and made adjustments to benefit coverage to manage costs within the last year of the program. Experience shows that PCIP enrollees have some of the most expensive medical conditions. The average cost per enrollee in 2012 was $32,108 per year, and in one year, four percent of PCIP enrollees accounted for over 50 percent of costs. Individuals incurring high annual costs tend to present with multiple, complex diagnoses, including cancer, heart disease, and degenerative bone diseases.

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

Congress appropriated $5 billion for this temporary program, and to date nearly all of the funding has been paid to over 2,850 plan sponsors spanning every state in the nation to help over 5 million individuals maintain coverage. Both large and small plan sponsors have benefited from the program, with one third of participating plans receiving $100,000 or less in total reinsurance payments from ERRP. As a result, in December 2011, CMS notified plan sponsors that claims incurred after December 31, 2011 would not be accepted.

Starting in FY 2012 the CMS program integrity contractor began conducting audits of plan sponsors, including the examination of the validity of claims submitted and the use of program funds. Additional funds have become available as CMS recoups overpayments due to price concessions, audits, and other activities; recoveries made in 2012 and 2013 will be used to reimburse pending requests. Payments to plans from recovered funds will continue until the program sunsets on January 1, 2014.

Consumer Operated and Oriented Plans (CO-OPs):
The CO-OP loan program fosters the creation of new, private, nonprofit, member-governed health insurance plans. The Affordable Care Act required that any profits the CO-OP makes must be used to lower premiums, improve benefits, or improve the quality of health care delivered to plan members. CO-OPs will contribute to the success of the Marketplaces by increasing competition in state insurance markets and by offering more choices to consumers.

CO-OP loans have been awarded in 24 states, nearly half of the country. Loan awards total $1.98 billion. The American Taxpayer Relief Act rescinded $2.3 billion of the appropriation, leaving $253 million in a contingency fund for oversight and assistance to existing loan entities.

Each of the 24 CO-OP awardees has undergone a thorough application review process and extensive loan negotiations. Loans have been made only to entities demonstrating a high probability of financial viability, and CMS expects that these CO-OPs will become active participants in the new health insurance Marketplaces. CMS closely monitors CO-OPs to ensure they are meeting program goals and will be able to repay loans.

Premium Stabilization Programs: The Affordable Care Act included two temporary and one permanent program to mitigate volatility of insurance premiums in the individual and small group markets beginning in 2014 when Marketplaces and new market rules take effect. The transitional reinsurance program will provide protection to plans in the individual market

when enrollees experience high claims costs for plan years 2014 through 2016. The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 through shared risk in losses and gains. The permanent risk adjustment program transfers funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees to protect against potential effects of adverse selection. The Notice of Benefit and Payment Parameters published each year will outline specifications for these programs, and transfers resulting from these programs will not occur until FY 2015.

Legislative Proposals

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

CENTER FOR MEDICARE AND MEDICAID INNOVATION

dollars in millions	2012	2013	2014	2014 +/- 2013
Obligations:				
Innovation Activities	713	1,162	1,257	+95
Innovation Supports	41	75	75	—
Administrative Expenses	26	76	81	+5
Total, Innovation Center Obligations	**781**	**1,313**	**1,412**	**+100**
Total, Outlays	**218**	**993**	**1,339**	**+346**

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

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

In its first two plus years of operation (FY 2010 – FY 2012), the Innovation Center obligated approximately $875 million. Cumulative obligations are projected to increase to $2.2 billion by the end of FY 2013 and to $3.6 billion by the end of FY 2014 as the portfolio of models being tested continues to expand. In FY 2013 and FY 2014, roughly 94 percent of spending is projected to be on specific models and initiatives, as well as necessary innovation supports, with the remainder dedicated to administrative expenses.

Innovation Center Models

As of January 2013, the Innovation Center is testing over a dozen major payment and service delivery models. Each of these models will be comprehensively evaluated with the potential for expansion if they are shown to be effective at improving quality without increasing costs or reducing costs while maintaining quality.

Partnership for Patients: The Partnership for Patients is a collaborative effort by CMS and more than 8,400 stakeholders across the nation (including over 3,700 hospitals) to improve patient safety. The Partnership has set ambitious targets of reducing hospital acquired conditions by 40 percent by 2013 (compared to a 2010 baseline) and hospital readmissions by 20 percent over the same time period. Meeting these targets could save the health care system, including Medicare and Medicaid, tens of billions of dollars over the next several years.

In December 2011, the Innovation Center awarded $218 million to 26 regional hospital engagement networks. In their first year of operation, these engagement networks have worked with partner hospitals to disseminate proven approaches to improving patient safety.

Health Care Innovation Awards: In 2012, the Innovation Center announced 107 recipients of Health Care Innovation Awards. These awardees, who include providers, payers, local governments, and other partners, will be provided with up to $900 million in total funding via cooperative agreements with CMS. Awardees were chosen based on the strength of their proposals to implement or expand compelling new models to improve care and reduce costs, with a particular focus on high need populations and workforce development. Awards span a three year time period.

Bundled Payments: The Bundled Payments for Care Improvement initiative seeks to better coordinate care by providing a single, bundled Medicare payment for an episode of care involving multiple providers. Providers paid through the bundle may include (among others) hospitals, physicians, and skilled nursing facilities. The Innovation Center has proposed four initial models as part of the broader Bundled Payments initiative – each model incorporates a somewhat different set of services and payment arrangements. However, within each model, providers must offer a discount to Medicare as a condition of participation in the initiative. To date, CMS has announced potential provider participants in all four models. Participant lists will be finalized and implementation will begin later in 2013.

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

The Pioneer ACO Model allows health care organizations and providers that are already experienced in coordinating care for patients across care settings to move more rapidly to a population based Medicare payment model. Pioneer ACOs assume more risk than participants in the Shared Savings Program and must commit to having the majority of their revenues (across all payers) come from performance based contracts in which payment depends on quality of care by the end of the second performance year. In January 2012, 32 organizations began participating in the model.

The Advance Payment ACO Model tests whether pre paying a portion of future shared savings can increase participation in the Medicare Shared Savings Program. Providing up front payments to certain physician led and rural organizations in the Shared Savings Program will allow these ACOs to make investments in infrastructure and staff in order to improve patient care and reduce costs. Advance payments will be recouped from the actual shared savings payments that ACOs earn. There are currently 35 ACOs participating in the Advance Payment Model.

FQHC Advanced Primary Care Demonstration: In 2011, the Innovation Center selected 491 federally qualified health centers (FQHC) to participate in a three year demonstration to evaluate the effect of an advanced primary care practice model (also known as a patient centered medical home) on the quality and cost of care provided to Medicare beneficiaries. Participating health centers that pursue Level 3 status as a patient centered medical home (as defined by the National Committee for Quality Assurance) are eligible for additional Medicare care management payments. This demonstration has the potential to improve quality and reduce costs for approximately 215,000 Medicare beneficiaries.

Comprehensive Primary Care Initiative: In October 2011, the Innovation Center announced the Comprehensive Primary Care Initiative. In this initiative, private payers and state Medicaid programs partner with Medicare to invest in primary care, which has been historically under-funded and under-valued in the United States. The Initiative was rolled out in two phases. The Innovation Center first selected seven markets with significant payer interest to participate in this demonstration. The markets include Arkansas, Colorado, New Jersey, Oregon, New York's Capital District Hudson Valley region, Ohio and Kentucky's Cincinnati Dayton region, and the Greater Tulsa region of Oklahoma. In August 2012 CMS selected approximately 500 primary care practices within these markets to participate in the Initiative, serving an estimated 315,000 Medicare beneficiaries. The selected practices receive additional care coordination or similar payments from all participating payers, allowing them to transform their practices and make expanded services available to all patients.

Strong Start for Mothers and Newborns: In February 2012, the Innovation Center announced the Strong Start initiative, which supports reducing the risk of significant complications and long term health problems for both expectant mothers and newborns. Experts at the Centers for Disease Control and Prevention, National Institutes of Health, Administration for Children and Families, and the Health Resources and Services Administration worked with the Innovation Center to identify the goals and shape the direction of Strong Start.

Strong Start contains two strategies: 1) a public private partnership, building on the work of Partnership for Patients to test ways to encourage best practices and supports providers in reducing early elective deliveries prior to 39 weeks; and 2) a four-year initiative to test the effectiveness of specific enhanced prenatal care

approaches to reduce the frequency of premature births in pregnant Medicaid or CHIP beneficiaries.

State Innovation Models: This model provides up to $300 million to assist states in transforming their health care payment and delivery systems. In order to qualify for awards states must propose reforms that incorporate multiple payers and that are expected to improve quality of care, while reducing costs. Some states will receive funding to support the design of new payment and delivery models, while other (more advanced) states will receive funding to support the testing of such models. State awardees were announced in February 2013.

Comprehensive ESRD Care Initiative: In February 2013, the Innovation Center announced the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative, which will incentivize providers to provide high quality, efficient, and coordinated care to Medicare beneficiaries who require dialysis. In order to participate, groups of providers (including dialysis facilities, nephrologists, and others) must form ESRD Seamless Care Organizations, or ESCOs, which assume full clinical and financial accountability for assigned beneficiaries. ESCOs will be eligible to share in any model savings with Medicare. Applications from providers to participate in this model are due in July 2013.

Initiatives Supporting Dually Eligible Beneficiaries

More than 10 million Americans are enrolled in both the Medicare and Medicaid programs. Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, to promote access to care, improve the overall beneficiary experience, and coordinate services for Medicare-Medicaid enrollees. This office also provides technical assistance to support states' efforts toward innovative service delivery for dually eligible beneficiaries.

The Medicare-Medicaid Coordination Office has partnered with the Innovation Center to pursue several promising approaches to address the needs of these beneficiaries.

Medicare-Medicaid Financial Alignment Initiative: To incentivize high quality, coordinated care, CMS has partnered with states to design person centered approaches to coordinating care across primary, acute, and behavioral health and long term supports and services. In 2011, CMS awarded contracts of $1 million each to 15 states to support the planning and design of state-based care models. States plan to implement these demonstration models beginning in 2013. See “Medicare-Medicaid Financial Alignment Initiative” for additional details.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Nursing facility residents often experience potentially avoidable inpatient hospitalizations, which are expensive, disruptive, and disorienting for the frail elderly and people with disabilities. Through this initiative, CMS has partnered with seven organizations to implement evidence based interventions that both improve care and lower costs, focusing on reducing preventable inpatient hospitalizations among long term residents of nursing facilities. This initiative supports the Partnership for Patients’ goal of reducing hospital readmission rates by 20% by the end of 2013.

Medicare-Medicaid Financial Alignment Initiative

A longstanding barrier to coordinating care for dually eligible beneficiaries has been the financial misalignment and lack of service delivery coordination between Medicare and Medicaid. The Medicare-Medicaid Financial Alignment Initiative provides an opportunity for states and CMS to integrate care for Medicare and Medicaid beneficiaries through targeted demonstrations. Twenty-six states have submitted proposals to pursue one of two models: (1) a capitated managed care model or (2) a managed fee-for-service model. Currently, the Medicare-Medicaid Coordination Office continues to work with over 20 states to develop and test unique demonstrations, and as of March 27, 2013, CMS had signed Memorandum of Understanding agreements with California, Illinois, Massachusetts, Ohio, and Washington. The first state demonstration will begin in 2013.

PROGRAM MANAGEMENT

dollars in millions	2012	2013	2014	2014 +/- 2012
Discretionary Administration				
Medicare/Program Operations	2,608	2,624	4,011	+1,403
Federal Administration	772	776	772	—
Survey and Certification	375	378	412	+37
Research	21	21	—	-21
State High-Risk Pools	44	44	22	-22
Total, Discretionary Budget Authority /1 /2	**3,820**	**3,843**	**5,217**	**+1,397**
Mandatory Administration				
Affordable Care Act	135	136	136	+1
American Recovery and Investment Act	140	140	140	—
Medicare Improvements for Patients and Providers Act	38	3	3	-35
American Taxpayers Relief Act	—	18	—	—
Total, Mandatory	**313**	**297**	**279**	**-34**
Reimbursable Administration /3	550	500	951	+401
Subtotal, Discretionary and Mandatory	**4,684**	**4,640**	**6,447**	**+1,764**
Proposed Law (Mandatory)				
Program Management (mandatory)	—	—	400	+400
Survey Revisit User Fee	—	—	—	—
Extension of CMS Quality Measurement	—	—	10	+10
Subtotal, Proposed Law	**—**	**—**	**410**	**+410**
Total, Program Level, Proposed Law	**4,684**	**4,640**	**6,857**	**+2,174**
Full-time Equivalents /4	5,400	6,160	6,112	+712

1/ FY 2012 and FY 2013 levels have been comparably adjusted each year for the SHIP transfer to ACL as follows: Program Operations -$51 million, Federal Administration -$1 million.

2/ State High Risk Pools are classified as a mandatory activity in FY 2012, but are comparably adjusted for the President's Budget.

3/ Includes the following user fees: Federal Marketplaces (FY 2014), Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program education campaign, recovery audit contractors, provider enrollment fees., and other reimbursable activities.

4/ FTE totals include FTE from other funding sources: HCFAC, State Grants, reimbursables, and mandatory appropriations. CMS will fund the following FTE from other sources: FY 2012 = 1,045; FY 2013 = 1,414; and FY 2014=1,477.

PROGRAM MANAGEMENT

The FY 2014 discretionary budget request for CMS Program Management is $5.2 billion, an increase of $1.4 billion above a comparable FY 2012 enacted level. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and to implement new health insurance reforms contained in the Affordable Care Act. Of the total request, $1.5 billion will support operation of Health Insurance Marketplaces, also referred to as Exchanges.

Budget Account Summaries

Program Operations: The Program Operations request is $4.0 billion, an increase of $1.4 billion above a comparable FY 2012 enacted level. The Program Operations account funds mission-critical contractor and IT activities necessary to administer Medicare, Medicaid, and CHIP, the implementation of new private health insurance protections created by the Affordable Care Act, and additional activities required by legislation. Top priority activities for FY 2014 include:

- *Ongoing Medicare Contractor Operations:* Approximately 26 percent, or $1.0 billion, of the FY 2014 Program Operations request supports ongoing contractor operations such as Medicare claims processing, an 8 percent increase from the FY 2012 level.

- *Marketplace Operations:* Open enrollment for Marketplaces begins October 1, 2013. CMS will operate some or all Marketplace functions in over 30 states in 2014, through the Federally-facilitated Marketplaces (FFM) or State Partnership Marketplaces (SPM). In all of these states, CMS will perform eligibility and appeals work, payment functions, and operation of the Small Business Health Options Program (SHOP). SPMs will assist with plan management and consumer outreach.

  Additionally, CMS will oversee operations of State-based Marketplaces (SBMs) and provide technical assistance in their first year of operations. Work for the 2015 benefit year will also occur in FY 2014, including receiving and evaluating submissions from issuers for qualified health plans in the FFM.

  The Budget requests $803.5 million for CMS activities to support Marketplace operations in FY 2014. CMS will also collect user fees from issuers participating in the FFMs and SPMs beginning in January 2014 to support Marketplace operations.

- *Consumer and Beneficiary Education and Outreach:* The Budget includes $837 million in discretionary funding for beneficiary education and outreach activities through the National Medicare Education Program and consumer support in the private insurance marketplace, including $554 million for the Marketplaces. CMS will also collect user fees from issuers participating in the FFMs and SPMs beginning in January 2014 to support Marketplace outreach and education. CMS will operate a call center and website for the FFM, as well as develop and disseminate outreach materials to inform consumers of their insurance options. CMS will provide in-person assistance to consumers and small businesses through Navigators. Private insurance consumer support activities include funding independent review organization contractors to externally review adverse benefit decisions for consumers and updating coverage fact labels to help consumers compare potential out-of-pocket costs for various coverage options.

- *Insurance Oversight:* The Budget requests $18.4 million for CMS contracts to ensure compliance with the private insurance provisions contained in the Affordable Care Act, notably the Medical Loss Ratio and Rate Review Premium provisions.

- *IT Systems and Support:* The Budget includes $519 million for general IT systems and other support, such as systems to manage and administer Medicare Advantage and the Part D benefit, the FFM IT systems and Marketplace data services hub, and CMS's data center and telecommunications infrastructure. This request

includes $222.9 million to modernize and transform CMS's enterprise-wide IT systems, a critical investment to support value-based purchasing payment reforms.

- *Medicaid and CHIP Operations:* The Budget requests $24 million to fund administrative activities to improve Medicaid and CHIP program operations and implement new responsibilities under the Affordable Care Act. Some of these activities include initiatives to improve enrollment of eligible individuals into Medicaid and CHIP and modernize data systems.

- *HealthCare.gov:* The Budget requests $3.8 million for updates to HealthCare.gov, a one-stop website that provides information, including health plan data and rate information, to enhance consumers' and small businesses' purchasing and decision making abilities. Starting in October 2013 consumers will be able to apply for insurance through the new Marketplaces directly on HealthCare.gov. Funding in FY 2014 will support the maintenance and quality reviews of the data posted on HealthCare.gov.

Federal Administration: For FY 2014, the Budget requests $772 million for CMS federal administrative costs, approximately the same as the comparable FY 2012 enacted level.

Meaningful Use of Electronic Health Records

CMS and the Office of the National Coordinator for Health IT are working together to improve quality, reduce costs, decrease paperwork, and expand access to care through increased adoption and meaningful use of electronic health records (EHRs). At the end of FY 2012, 156,758 providers had been paid EHR incentives. HHS aims to increase the number of eligible providers who receive an incentive payment from the Medicare and Medicaid EHR Incentive Programs from 230,000 by the end of FY 2013 to 314,000 by the end of FY 2014.

Survey and Certification Frequencies

Type of Facility	2012 Enacted	2014
Long-Term Care Facilities /1	Every Year	Every Year
Home Health Agencies /1	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 4 Years	Every 3.4 Years
Accredited Hospitals	2% Per Year	2.5% Per Year
Organ Transplant Facilities	Every 6.1 Years	Every 6 Years
ESRD Facilities	Every 4.3 Years	Every 3.5 Years
Ambulatory Surgical Centers	Every 4.5 Years	Every 4 Years
Community Mental Health Centers	Not Funded	Every 6 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Rural Health Clinics, Portable X-Ray	Every 7 Years	Every 6 Years

1/ Legislatively mandated.

Of this total, $634 million will support a full-time equivalent (FTE) level of 4,635, an increase of 280 FTEs over FY 2012. This staffing increase will enable CMS to address the needs of a growing Medicare population, as well as oversee expanded responsibilities resulting from the Affordable Care Act and other legislation passed in recent years.

Survey and Certification: The FY 2014 Survey and Certification request is $412 million, a $37 million increase over FY 2012. This increase from FY 2012 is needed to complete surveys at frequencies consistent with statutory and policy requirements, given continued growth in the number of participating facilities, increased survey responsibility, and inflation. Between FY 2012 and FY 2014 the number of Medicare-certified facilities is expected to grow by 4.3% percent, from 55,808 to 58,202 facilities. CMS expects states to complete over 24,000 initial surveys and re-certifications and over 55,000 visits in response to complaints in FY 2014.

Approximately 92 percent of the request will go to state survey agencies. Surveys include mandated federal inspections of long-term care facilities (i.e.,

nursing homes) and home health agencies, as well as federal inspections of other key facilities. All facilities participating in the Medicare and Medicaid programs must undergo inspection when entering the program and on a regular basis thereafter. CMS expects to finalize the first conditions of participation for community mental health centers (CMHCs) by FY 2014, which will promote quality improvement by setting minimum quality and safety standards that these facilities will have to meet to remain a Medicare provider. The FY 2014 Budget is the first to include CMHC survey funds. CMS is currently engaged in an effectiveness and efficiency strategy aimed at quality improvement while identifying risk-based approaches to surveying.

National Medicare & You Education Program (NMEP)
FY 2014 Program Level Request in Millions

Activity	2012	2014
Beneficiary Materials (e.g. Handbook)	52	48
1-800-MEDICARE Toll Free Line	220	233
Internet	27	31
Community-Based Outreach /1	3	5
Program Support Services /2	21	23
Total, NMEP Program Level /3	**322**	**340**

1/ FY 2012 level includes a comparability adjustment of -$50 million to reflect the FY 2014 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration for Community Living.

2/ Includes multi-media campaign and consumer research.

3/ Includes funding from Program Management ($249 million for FY 2012; $269 million for FY 2014), user fees ($70 million for FY 2012; $71 million for FY 2014), and QIOs ($3 million in 2012; 2014 QIO funding is TBD).

Research, Demonstrations, and Evaluation: Beginning in FY 2014, ongoing research activities will be funded from Program Operations.

State High Risk Pools: The Budget requests $22 million for the State High Risk Pools. Consistent with regulations, the FY 2014 request provides funding for losses incurred in the prior year.

National Medicare Education Program (NMEP): The total FY 2014 program level for NMEP is $340.1 million, an increase of approximately $17.8 million from the FY 2012 level. The NMEP program level includes funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and Quality Improvement Organizations. In order to ensure that beneficiaries have accurate and up-to-date information on their coverage options and covered benefits, beneficiary education remains a top priority for CMS.

Of the total, $233.1 million, or 69 percent, supports the 1-800-MEDICARE call center which provides beneficiaries with access to customer service representatives who are trained to answer questions regarding the Medicare program. The request will support approximately 27 million calls with an average-speed-to-answer of 5 minutes. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations. CMS is using information from beneficiary fraud allegations in new ways, to compile provider-specific complaints, flag providers who have been the subject of multiple fraud complaints, and map shifts and trends in fraud allegations over time.

2014 Legislative Proposals

Provide Mandatory Administrative Resources for Implementation: The President's Budget includes $400 million in mandatory Program Management funds to implement the mandatory health care proposals accompanying this submission. These health care proposals will allow the Administration to realize additional cost efficiencies and further root out waste and abuse in Medicare and Medicaid. CMS estimates the savings from these proposals to be $393 billion over the next ten years. [$400 million in costs over 10 years]

Survey Revisit User Fee: The Budget proposes a survey and certification revisit user fee which would provide CMS an increased ability to revisit poor performers, while creating an incentive for facilities to correct deficiencies and ensure quality of care. It is assumed that no savings will be realized in the FY 2014 year of implementation. [No budget impact]

Extension of CMS Quality Measurement: The Budget proposes to extend funding for a consensus-based entity focused on performance measurement through 2017. The duties for a consensus-based entity are divided between those originally authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and those that are new or amended by the Affordable Care Act and the American Taxpayer Relief Act of 2012. Under current law, MIPPA funding is set to expire at the end of 2013 and funding appropriated in the Affordable Care Act at the end of 2014. Continued funding for performance measurement is essential as CMS continues to implement valued-based purchasing initiatives and other models which focus on performance-based payments. [$100 million in costs over 10 years].

ADMINISTRATION FOR CHILDREN AND FAMILIES

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

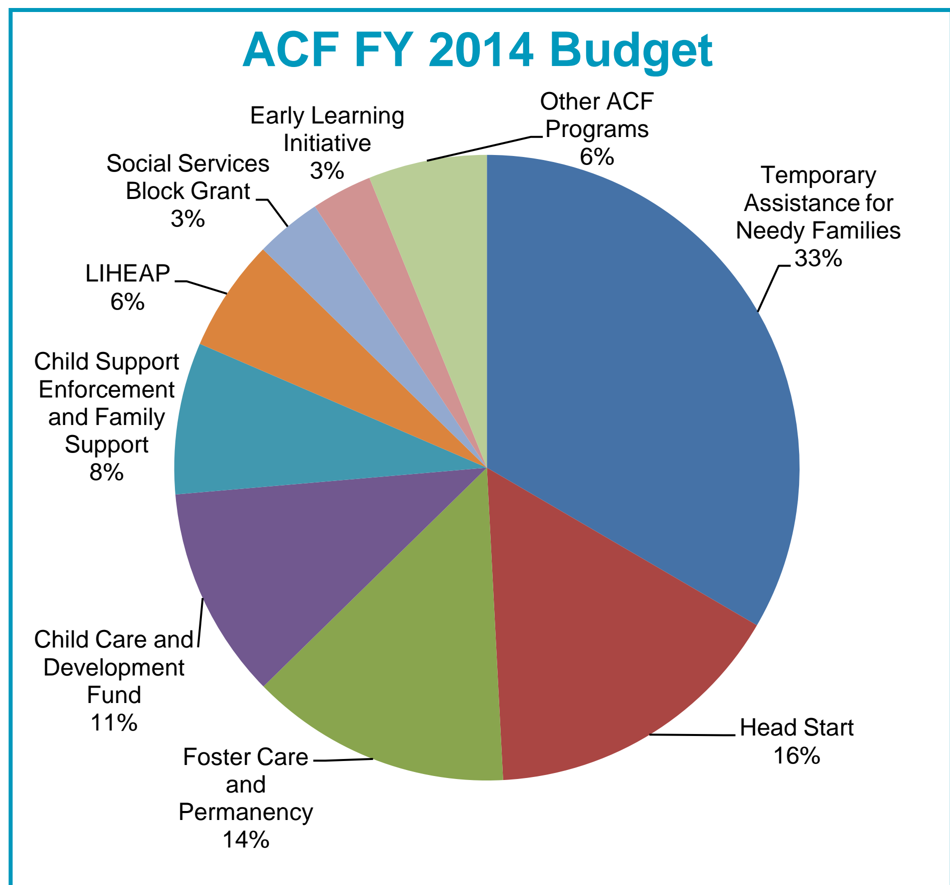
The Administration for Children and Families promotes the economic and social well-being of children, youth, families, and communities, focusing particular attention on vulnerable populations such as children in low-income families, refugees, and Native Americans.

dollars in millions	2012	2013	2014
Mandatory			
Budget Authority	33,432	34,015	34,176
Discretionary			
Budget Authority	16,316	16,543	17,780
Change in Mandatory Programs /1	—	—	-12
Total, ACF Budget Authority	**49,748**	**50,558**	**51,944**

1/ The FY 2014 Budget includes General Provision language that would redirect $12 million from anticipated unobligated Abstinence Education funding in ACF to support a new program to prevent pregnancy among youth in Foster Care.

The FY 2014 Budget request for the Administration for Children and Families (ACF) is $51.9 billion. ACF works in partnership with states and communities to provide critical assistance to vulnerable families while helping families and children achieve a path to success. ACF programs find safe and supportive families for abused children, work with newly-arrived refugees as they start their new lives in America, and work with troubled teens to leave the streets and find opportunity. The Budget includes additional funding for Head Start, Child Care, and Refugee programs and supports important reforms in Head Start, Child Care, and Child Support. The Budget also creates a new program to reduce teen pregnancy among youth in foster care.

The mandatory Budget includes $17.4 billion for Temporary Assistance for Needy Families, $7.0 billion for Foster Care and related programs, $4.1 billion for Child Support Enforcement and Family Support, and $3.4 billion for the Child Care Entitlement to States for FY 2014.



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

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

dollars in millions	2012	2013	2014	2014 +/- 2012
Head Start	7,969	8,017	9,621	+1,653
Child Care & Development Block Grant (discretionary)	2,278	2,292	2,478	+200
Refugee Programs /1				
Transitional and Medical Services	323	384	391	+68
Unaccompanied Alien Children	267	302	495	+227
Other Refugee Programs	178	213	237	+59
Subtotal, Refugee Programs	**768**	**900**	**1,123**	**+355**
Child Welfare/Adoption Assistance	357	360	357	—
Chafee Education & Training for Foster Youth	45	45	45	—
Family Violence Prevention	133	134	140	+7
Adoption Incentives	39	40	39	—
Runaway and Homeless Youth Programs	115	116	118	+3
Child Abuse	94	94	94	—
Promoting Safe and Stable Families (discretionary)	63	63	75	+12
LIHEAP				
Formula Grants	3,472	3,493	2,820	-652
Contingency Fund	—	—	150	+150
Energy Burden Reduction Grants	—	—	50	+50
Subtotal, LIHEAP Budget Authority	**3,472**	**3,493**	**3,020**	**-452**
Native Americans	49	49	49	—
Community Services Block Grant	677	682	350	-327
Other Community Services Programs	55	55	19	-35
Subtotal, Community Service Programs	**732**	**737**	**369**	**-363**
Disaster Human Services Case Management	2	2	2	—
Social Services Research & Demonstration	6	6	50	+44
National Survey of Child and Adolescent Well-Being	—	—	*6*	*+6*
Early Childhood Evaluation	—	—	*3*	*+3*
Family Strengthening Initiative	—	—	*35*	*+35*
PHS Evaluation Funds (non-add)	*6*	*6*	*6*	—
Federal Administration	200	201	205	+5
Center, Faith Based/Community Initiatives (non-add)	*1*	*1*	*1*	—
Total, Program Level	**16,322**	**16,549**	**17,786**	**+1,464**
Less Funds From Other Sources				
PHS Evaluation Funds	6	6	6	—
Total, Discretionary Budget Authority /2	**16,316**	**16,543**	**17,780**	**+1,464**
Full-time Equivalents (including those financed with mandatory funds)	1,302	1,379	1,429	+127

1/ FY 2012 figures reflect reallocation of $98 million from refugee activities to Unaccompanied Alien Children.

2/ The FY 2014 Budget also includes General Provision language that would redirect $12 million from anticipated unobligated Abstinence Education funding in ACF to support a new program to prevent pregnancy among youth in Foster Care.

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

The FY 2014 discretionary request for the Administration for Children and Families (ACF) is $17.8 billion, an increase of $1.5 billion above FY 2012. The Budget invests in high quality infant and toddler care as part of the President's plan to expand access to high-quality early education, to help prepare America's children for success in life. Additional funding is also included for programs that protect the country's most vulnerable children and families, including unaccompanied alien children, victims of domestic trafficking and domestic violence, as well as runaway and homeless youth.

Early Childhood Development

The President has proposed a series of new investments that will create a continuum of high-quality early learning services for children beginning at birth and through age five. This initiative would provide high-quality preschool for all four year olds in low- and moderate-income families through a new federal-state partnership at the Department of Education, as well as $1.6 billion in FY 2014 for expanded high-quality care for infants and toddlers through HHS' Early Head Start and Child Care programs and additional mandatory funding to extend and expand current federal investments in voluntary home visiting programs.

Early Head Start – Child Care Partnerships: The Budget requests $1.4 billion to create Early Head Start – Child Care Partnerships that will help states and communities to expand the availability of early learning programs that meet the highest standards of quality for infants and toddlers, serving children from birth through age three. Funds will be competitively awarded to new and existing Early Head Start programs that will partner with child care providers that serve a high number of children with child care subsidies. Through these partnerships, the Early Head Start program will work with child care providers to create high-quality slots that are full-day, offer comprehensive services that meet the needs of working families, and prepare children for the transition to preschool. The President has also proposed extending and expanding the evidence-based home visiting program, which is implemented through a partnership with the Health Resources and Services Administration. HHS will collaborate with the Department of Education to ensure that the investments at both agencies together will build a cohesive and well-aligned system of early learning from birth to age five.

Child Care: The FY 2014 request for the Child Care and Development Fund is $5.9 billion, which includes $3.4 billion for the Child Care Entitlement (CCE) and $2.5 billion for the Child Care and Development Block Grant (CCDBG). The funding level represents a total increase of $700 million over FY 2012 in combined discretionary and mandatory funds, and will support subsidies for 1.4 million children – 100,000 more children than would otherwise be served.

Of the $2.5 billion available in discretionary funds for child care, $200 million is proposed to help states raise the bar on quality by developing higher standards, improving monitoring, investing in evidence-based professional development, and improving information available for parents selecting a child care provider.

Child Care Quality Rating & Improvement Systems

As part of the HHS High Priority Goal to improve the quality of early care and education programs for low-income children, ACF is working to expand the number of states with Quality Rating and Improvement Systems (QRIS) that meet high quality benchmarks developed by HHS in coordination with the Department of Education. QRIS is a mechanism to improve the overall quality of child care and potentially improve child outcomes by providing pathways and support for child care providers, while also increasing parents' understanding of available child care options. As of FY 2012, 19 states implemented a QRIS that met high-quality benchmarks, an increase of 2 states over the FY 2011 baseline. ACF continues to provide technical assistance and support to states as they implement high quality QRIS.

Head Start: In addition to launching the new $1.4 billion for Early Head Start-Child Care Partnerships, the President remains firmly committed to serving children through the existing Head Start program. The FY 2014 request includes an additional $197 million to strengthen services for children currently enrolled in Head Start, and avoid further enrollment reductions.

In FY 2014, ACF will continue to require grantees that do not meet rigorous quality benchmarks to compete for ongoing federal funding. The Budget requests $25 million above FY 2012 in support of this effort to minimize the potential for service disruptions in the transition between incumbent and new grantees.

Protecting Vulnerable Individuals

Refugee-Related Programs: Among the most vulnerable populations served by ACF are refugees coming to the United States in search of a better life and unaccompanied alien children (UAC) apprehended by law enforcement crossing the Southwest Border. Refugees, and other eligible populations, come to the United States fleeing violence, persecution and even torture. ACF is a key partner in the Administration's efforts to increase refugee arrivals, helping them begin new lives by providing time-limited cash and medical assistance and social services – job training and English instruction – so they can become self-sufficient as quickly as possible.

ACF provides a safe environment for UAC until their claims to remain in the United States are adjudicated or ACF can identify a family member or guardian who can take custody of the child. In FY 2012, the number of UAC that entered ACF's custody doubled to nearly 14,000. ACF was able to accommodate the additional children because of one-time savings it realized in its refugee programs and by re-programming funds within the refugee account. In FY 2013, ACF anticipates (in consultation with the Department of Homeland Security) it will need to serve approximately 23,500 UAC. ACF has reduced its per child cost by negotiating lower daily rates for most children and speeding the family reunification process to reduce the length of time children remain in care. Despite these efforts, overall UAC costs rise because of the increased number of children. To provide services for the projected numbers of both UAC and refugees, Congress provided a FY 2013 refugee appropriation of $1 billion, an increase of $248 million above the FY 2012 appropriation.

Based on the significant increases in UAC arrivals that have continued for the past eighteen months, the FY 2014 Budget requests $1.1 billion for the Office of Refugee Resettlement, including $495 million to provide shelter to an estimated 26,000 UAC. Funds are also included to provide eight months of cash and medical services for 70,000 refugees and 55,000 other arrivals, and to maintain refugee social services, and assistance to victims of trafficking and torture.

Victims of Human Trafficking: ACF aids in the fight against international human trafficking by identifying victims in the United States and certifying them as eligible to receive federal benefits and services in the same way that refugees are supported. The ACF budget also includes an increase of $10 million for a new initiative to prevent and address domestic human trafficking. This proposal will provide direct services to domestic victims of human trafficking, including case management services for victims of all ages, and a housing pilot targeted to minors. Funds will also support training for service providers, as well as research and evaluation to ensure that the lessons learned from this initiative can be widely disseminated through existing service systems for vulnerable groups.

Runaway and Homeless Youth: To support the President's Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, the Budget requests an additional $3 million to develop a national count and an improved understanding of the needs of runaway and homeless youth. The information collected through this national effort will assist in the implementation of more effective and efficient strategies for preventing and addressing youth homelessness.

Family Violence Prevention: The Budget includes $140 million, an increase of $7 million, for Family Violence Prevention and Services programs. These programs are the primary federal funding stream dedicated to the support of domestic violence shelters and services for victims of domestic violence and their children. The increased funding will help to serve an additional 27,000 victims, and support increased call volume to and enhanced technology and services for the National Domestic Violence Hotline.

Family Strengthening Initiative: The Budget includes $35 million for a new initiative to identify and address marriage disincentives that result from benefit program regulations. This initiative will include a multi-faceted strategy to help states identify possible marriage disincentives and design strategies to reduce instances where government regulations may interfere with or penalize unmarried families looking to transition into married households.

Low Income Home Energy Assistance Program (LIHEAP): The Budget includes $3 billion for LIHEAP, the same amount as the FY 2013 President's Budget and $452 million below the FY 2012 level. The request targets $2.8 billion in formula grants using the state allocation Congress enacted for FY 2012. It also includes $150 million in contingency funds to respond to home-energy related emergencies such as extreme weather and high fuel prices.

The Budget includes $50 million for new competitive energy burden reduction grants to support replacement of inefficient home heating systems and other energy conservation measures. Heating systems used by LIHEAP-eligible households tend to be older, and therefore less efficient than heating systems used by other households. The inefficiency of some of these high-burden systems, coupled with their use of more expensive fuels such as heating oil and propane, makes replacing them a cost-effective use of LIHEAP funds that can improve the impact of future LIHEAP funding. Grants will be awarded to states that analyze local conditions and design evidenced-informed projects to reduce the energy burden of LIHEAP-eligible households by increasing the energy efficiency of their homes.

Reducing the Energy Burden of LIHEAP Homes

In his State of the Union address, President Obama urged that rebates be given to Americans who make their homes more energy-efficient. LIHEAP-eligible households typically spend a greater portion of their incomes on heating and cooling their homes than other households. To improve the energy efficiency of the homes of LIHEAP-eligible households, and help these households switch to less costly fuels, the Budget includes $50 million for new energy burden reduction grants.

Strengthening Communities

Native Americans: As part of its efforts to strengthen vulnerable Native American communities, ACF promotes self-sufficiency by funding community-based projects and training and technical assistance for eligible tribes and native organizations including American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders. Funds are used primarily to strengthen community economic development by providing job training and supporting business expansion, financial literacy, and home ownership. Funds also support the preservation of Native languages and the protection of natural and cultural resources for current and future generations. The Administration for Native Americans includes $49 million for these efforts, the same level as FY 2012.

Community Services Programs: The Budget includes $350 million for the Community Services Block Grant. The Budget proposes to target funds to grantees that successfully meet community needs through a system of competition based on core standards. Funding is not requested for the Community Economic Development (CED) program. Funding for the Healthy Food Financing Initiative, which CED funds currently support, is being consolidated with the Department of Treasury's Community Development Financial Institutions Fund (CDFI). The President's Budget request maintains the current level of government-wide investments to increase the availability of affordable, healthy foods in underserved urban and rural communities. ACF will continue to collaborate with the Department of Treasury on this important initiative.

Ensuring Program Effectiveness

ACF must have a rigorous program evaluation capacity to ensure that its programs are effective. The Budget includes $15 million, an increase of $9 million over FY 2012, for research and evaluation activities. This additional funding includes $6 million to continue the National Survey of Child and Adolescent Well-Being, which provides critical information that is foundational to ACF's efforts to improve the social and emotional welfare of children in and out of foster care. The remaining $3 million is requested to help identify the features of early care and education that are most important in supporting early cognitive development.

Federal Administration: The Budget includes $205 million for ACF program administration, including pay and benefits for the majority of agency staff, an increase of $5 million over FY 2012. Additional funding will cover increased operating costs and staff that are implementing critical Head Start reforms. Almost 1,700 grantees will be evaluated over the next three years and, for the first time in the history of this program, those that fall short of quality benchmarks, including classroom instruction, health and safety, and management, will have to compete for continued funding against other organizations in their communities.

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

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	2,917	—
Child Care and Development Fund (non-add) /1	*5,195*	*5,209*	*5,195*	*-14*
Child Support Enforcement and Family Support	3,836	4,004	4,065	+61
Foster Care and Permanency	7,006	6,921	7,009	+88
Promoting Safe and Stable Families (mandatory only) /2	485	485	470	-15
Temporary Assistance for Needy Families (TANF)	16,739	16,739	16,739	—
TANF Contingency Fund /3	612	612	612	—
Subtotal, TANF (non-add)	*17,351*	*17,351*	*17,351*	—
Children's Research and Technical Assistance	52	52	52	—
Social Services Block Grant	1,785	1,785	1,785	—
Sandy Supplemental /4	—	500	—	-500
Total, Current Law Budget Authority	**33,432**	**34,015**	**33,649**	**-366**
Proposed Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	3,417	+500
Child Care and Development Fund (non-add)	*5,195*	*5,209*	*5,895*	*+686*
Child Support Enforcement and Family Support	3,836	4,004	4,075	+71
Foster Care and Permanency	7,006	6,921	7,011	+90
Promoting Safe and Stable Families (mandatory only)	485	485	485	—
TANF	16,739	16,739	17,058	+319
TANF Contingency Fund	612	612	293	-319
Subtotal, TANF (non-add)	*17,351*	*17,351*	*17,351*	—
Children's Research and Technical Assistance	52	52	52	—
Social Services Block Grant	1,785	1,785	1,785	—
Sandy Supplemental	—	500	—	-500
Total, Proposed Law Budget Authority	**33,432**	**34,015**	**34,176**	**+161**

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

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

3/ The Protect Our Kids Act of 2012 (P.L. 112-275) extended the Contingency Fund through the end of FY 2014, and targeted $2 million of the $612 million for the Contingency Fund for each of fiscal years 2013 and 2014 to establish the Commission to Eliminate Child Abuse and Neglect Fatalities.

4/ The Disaster Relief Appropriations Act (P.L. 113-2) provided $500 million in mandatory funding for SSBG to aid in the recovery from Hurricane Sandy.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

The FY 2014 Budget request for ACF Mandatory programs is $34.2 billion. ACF serves the nation's most vulnerable populations through mandatory programs such as Temporary Assistance for Needy Families (TANF), Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

The Budget supports improved access to high-quality child care for low-income children, increases the child support that is paid to families, and promotes fathers' involvement in the lives of their children. The Budget continues existing funding for the TANF program and proposes to restructure the contingency fund to make it more effective.

Child Care Entitlement to States

The Budget supports important reforms in the Child Care and Development Block Grant and the Child Care Entitlement to States. The Budget request for the Child Care Entitlement is an increase of $7 billion over 10 years, including an increase of $500 million in FY 2014. Total child care funding for the Child Care and Development Fund is $5.9 billion in FY 2014. The Budget request includes $200 million in discretionary funding for competitive grants to help states raise the bar on the quality of child care through improved regulation, monitoring, and transparency for parents, while providing sufficient mandatory funds to continue providing access to child care subsidies for low-income families. In FY 2014, the request would enable 1.4 million children to receive child care assistance – approximately 100,000 more children than could be served without the additional funding requested. These improvements, along with a new preschool program in the Department of Education and $1.4 billion in discretionary funds for new Early Head Start-Child Care Partnerships to support states and communities in expanding the availability of high-quality learning opportunities for infants and toddlers, are key elements of the Administration's broader education agenda designed to help every child reach his or her academic potential and improve the nation's competitiveness.

Partnership Fund Pilots

ACF has joined with OMB's Partnership Fund for Program Integrity Innovation in three pilot projects:

- Integration and Interoperability in Health and Human Services: ACF is administering a competitive grant program for state projects designed to explore improved systems interoperability and integration in eligibility and enrollment systems, case management systems, and other related systems. States are using these grants to explore system design and implementation options focused on interoperability issues ranging from common client databases to data governance issues.
- TANF Program Integrity: ACF will award competitive grants to states to test innovative ways to identify improper payments in the TANF program while also identifying strategies to target benefits to the neediest families.
- Automation of Foster Care Transfer Records: ACF will work with states to test a web-based system for exchange of foster care information with the goal of expeditious exchange of case documentation and timeliness of communication and case assignment. Results will guide and support continuous quality improvement.

Child Support Enforcement and Family Support Programs

The Budget request is $4.1 billion in budget authority in FY 2014 for Child Support Enforcement and Family Support Programs.

The Budget includes $2.0 billion over 10 years for an initiative to modernize the Child Support system and promote responsible fatherhood. Of those costs, $1.8 billion impacts the Child Support program and $254 million impacts Foster Care. Child Support

Enforcement is a joint federal, state, tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The proposal promotes strong families and responsible fatherhood by ensuring that children benefit when parents pay support, promoting parenting time arrangements, and improving enforcement tools. This proposal also includes funding specifically to encourage states to pass through child support payments to families.

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

Child Support Enforcement

The Child Support Enforcement program continues to make strong gains in support orders and paternity establishment. In FY 2011:

- Child support collections increased by 3 percent to $27.3 billion.
- 1.7 million paternities were established and acknowledged.
- Paternity was established for 96 percent of all child support cases, exceeding the target of 93 percent.
- Child support orders were established for 81 percent of child support cases, which surpassed the target of 77 percent.
- For every dollar invested in the program, $5.12 in child support was collected, which exceeded the Agency's target of $4.80.
- Three tribal programs became comprehensive, fully operational program service providers, bringing the total number of comprehensive Tribal Child Support Enforcement Programs to 42.

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

Children's Research and Technical Assistance

The Budget request includes $52 million for activities in three areas: child support enforcement training and technical assistance; operation of the Federal Parent Locator Service (FPLS) which assists states in locating absent parents; and research on welfare and child well-being. Of the total, $12 million will fund child support enforcement training and technical assistance, $25 million will support the FPLS operations, and $15 million will fund welfare research. Support for the National Survey of Child and Adolescent Well-Being, previously funded in this account, is requested in ACF's discretionary budget.

Foster Care and Permanency

The Budget request for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs is $7.0 billion in FY 2014 budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence. The Budget includes $2 million in FY 2014 and $254 million over ten years to require that child support payments made on behalf of children in foster care are used in the best interests of the child.

The FY 2014 Budget includes $4.3 billion in budget authority to support the Foster Care program, including maintenance payments to children. This amount is a $5 million decrease below FY 2013. The proposed level of funding will provide assistance and support to an estimated 147,000 children each month, which is approximately 3,000 fewer children than in FY 2013. This decrease is partially due to placement of more children in permanent settings. Some of the decline can be attributed to the erosion of eligibility under statute, as children's eligibility for federal foster care is tied to the former Aid to Families with Dependent Children income eligibility standards, which are increasingly outdated as they were not indexed to account for inflation.

The Budget also includes $2.5 billion in budget authority for the Adoption Assistance program, an increase of $94 million above FY 2013. An estimated

average 451,000 children per month, an increase of 12,000 over FY 2013, will qualify for this assistance in FY 2014.

The Budget includes $124 million for the Guardianship Assistance program, an increase of $1 million above FY 2013, reflecting an increase in the number of children participating in Guardianship Assistance programs. Under this program, state title IV-E agencies provide a subsidy on behalf of a child to a relative who has been granted legal guardianship of that child. An estimated average 24,000 children per month, an increase of 4,000 over FY 2013, will participate in FY 2014.

The Budget also includes $140 million for the Chafee Foster Care Independence Program, the same level as in FY 2013. This program funds services for youth who will likely remain in foster care until they turn 18 and current or former foster children between the ages of 18 and 21.

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

Promoting Safe and Stable Families

The Budget includes $485 million for Promoting Safe and Stable Families (PSSF). Of this amount, $345 million supports the mandatory portion of PSSF, $75 million supports the Personal Responsibility Education Program, $50 million supports Abstinence Education and a new Pregnancy Prevention Program for Foster Care Youth proposal, and $15 million supports the reauthorization of the Family Connection Grants. The Budget proposes to reauthorize the Family Connection Grants through FY 2016.

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

Child Welfare Demonstrations

The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) provided HHS with authority to approve up to 10 child welfare waivers in each of fiscal years 2012–2014. These cost-neutral demonstrations allow for more flexible use of federal funds in testing new approaches to service delivery and financing structures with the aim of improving outcomes for children and families involved in the child welfare system. The demonstrations are required to have one or more of the following goals:

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth;
- Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth; and/or
- Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

HHS established priority consideration for applicants focusing on promoting social and emotional well-being and addressing trauma.

- In September 2012, nine waiver demonstrations were approved for the following states: Arkansas, Colorado, Illinois, Massachusetts, Michigan, Pennsylvania, Utah, Washington and Wisconsin.

Social Services Block Grant Aid for Hurricane Sandy Recovery

The Disaster Relief Appropriations Act of 2013 (P.L 113-2) provided $500 million, which does not reflect the impact of sequestration, in Social Services Block Grant funding to aid in the recovery efforts from Hurricane Sandy. In order to direct funding to those most in need, ACF has allocated supplemental grants based on the number of FEMA Individual Assistance registrants in affected states (New York, New Jersey, Connecticut, Maryland, and Rhode Island). In addition to the range of social services allowed under the regular block grant, funds may be used for health services (including mental health services), and for costs of renovating, repairing, or rebuilding health care facilities (including mental health facilities), child care facilities, or other social services facilities.

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

Temporary Assistance for Needy Families (TANF)

TANF provides $17.4 billion annually to states, territories, and eligible tribes to assist low-income families and improve employment and other outcomes. For FY 2013, the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6) extended all TANF grants except the Supplemental Grants through September 30, 2013. The Protect Our Kids Act of 2012 (P.L. 112-275) extended the $612 million for the Contingency Fund through the end of FY 2014 and targeted $2 million for each of fiscal years 2013 and 2014 to establish the Commission to Eliminate Child Abuse and Neglect Fatalities. The Budget continues existing funding for the TANF program.

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

Social Services Block Grant(SSBG)

SSBG is a capped entitlement which provides flexible grants to states according to population size for the provision of social services ranging from child care to residential treatment. States have broad discretion over the use of these funds. SSGB funds a variety of initiatives to support high priority service needs in areas such as daycare, protective services, special services to persons with disabilities, adoption services, case management, health-related services, transportation support, foster care, substance abuse services, home-delivered meals, independent/transitional living, and employment-related services.

SSBG is funded at $1.7 billion for FY 2014, the same as FY 2013. An additional $85 million per year funds the Health Professions Opportunity Grants.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

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

Outlays Overview

dollars in millions	2012	2013	2014	2014 +/- 2013
Current Law Outlays:				
Child Care Entitlement to States	2,828	2,908	2,916	+8
Child Care and Development Fund (non-add) /1	*5,028*	*5,194*	*5,243*	*+49*
Child Support Enforcement and Family Support	3,957	3,994	4,035	+41
Foster Care and Permanency	6,847	6,744	6,899	+155
Promoting Safe and Stable Families (mandatory only) /2	419	448	457	+9
Temporary Assistance for Needy Families (TANF)	16,136	16,848	16,982	+134
TANF Contingency Fund /3	678	876	776	-100
TANF Emergency Fund (Recovery Act) /4	118	200	100	-100
Subtotal, TANF (non-add)	*16,932*	*17,924*	*17,858*	*-66*
Children's Research and Technical Assistance	53	60	58	-2
Social Services Block Grant	1,715	1,864	1,762	-102
Sandy Supplemental /5	—	100	300	+200
Total, Current Law Outlays	**32,751**	**34,042**	**34,285**	**+243**
Proposed Law Outlays:				
Child Care Entitlement to States	2,828	2,908	3,322	+414
Child Care and Development Fund (non-add)	*5,028*	*5,194*	*5,764*	*+570*
Child Support Enforcement and Family Support	3,957	3,994	4,045	+51
Foster Care and Permanency	6,847	6,744	6,901	+157
Promoting Safe and Stable Families (mandatory only)	419	448	457	+9
Temporary Assistance for Needy Families (TANF)	16,136	16,848	17,271	+423
TANF Contingency Fund	678	876	487	-389
TANF Emergency Fund	118	200	100	-100
Subtotal, TANF (non-add)	*16,932*	*17,924*	*17,858*	*-66*
Children's Research and Technical Assistance	53	60	58	-2
Social Services Block Grant	1,715	1,864	1,762	-102
Sandy Supplemental	—	100	300	+200
Total, Proposed Law Outlays	**32,751**	**34,042**	**34,703**	**+661**

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

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

3/ The Protect Our Kids Act of 2012 (P.L. 112-275) extended the Contingency Fund through the end of FY 2014, and targeted $2 million of the $612 million for the Contingency Fund for each of fiscal years 2013 and 2014 to establish the Commission to Eliminate Child Abuse and Neglect Fatalities.

4/ The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) appropriated $5 billion for FY 2009 and FY 2010 for the TANF Emergency Contingency Fund.

5/ The Disaster Relief Appropriations Act (P.L. 113-2) provided $500 million in funding for SSBG to aid in the recovery from Hurricane Sandy.

FY 2014 ACF Mandatory Legislative Proposals

Dollars in millions	2014	2014 -2018	2014 -2023
Child Care Entitlement	406	3,318	7,068
Child Support Enforcement and Family Support Programs /1	6	510	1,763
Foster Care and Permanency /2	2	133	254
Promoting Safe and Stable Families	—	43	45
Temporary Assistance for Needy Families (TANF)	—	—	—
Total, ACF Legislative Proposals	**414**	**4,004**	**9,130**

1/ The Child Support Enforcement (CSE) outlays in this table are net of estimated savings in the Supplemental Nutrition Assistance Program ($544 million) and the Supplemental Security Income program ($53 million), which would result from this proposal. These outlays include the impact on federal offsetting collections.

2/ The Foster Care and Permanency outlays reflect the impact of a Child Support Enforcement (CSE) proposal to require states to use the collections received on behalf of IV-E children in the best interest of the child. This proposal costs $254 million over ten years.

ADMINISTRATION FOR COMMUNITY LIVING

dollars in millions	2012	2013	2014	2014 +/- 2012
Health and Independence				
Home and Community-Based Supportive Services	367	369	367	—
Nutrition Services	816	821	816	—
Native American Nutrition & Supportive Services	28	28	28	—
Preventive Health Services	21	21	21	—
Senior Community Service Employment Program /1	448	451	380	-68
Aging Network Support Activities	8	8	8	—
Subtotal, Health and Independence	**1,688**	**1,698**	**1,620**	**-68**
Caregiver Services				
Family Caregiver Support Services	154	155	154	—
Native American Caregiver Support Services	6	6	6	—
Alzheimer's Disease Demonstration Grants	4	4	10	+6
Lifespan Respite Care	2	3	2	—
Subtotal, Caregiver Services	**166**	**168**	**172**	**+6**
Protection of Vulnerable Older Adults				
Adult Protective Services (Discretionary)	—	—	8	+8
Long Term Care Ombudsman Program	17	17	17	—
Prevention of Elder Abuse & Neglect	5	5	5	—
Senior Medicare Patrol Program	9	9	9	—
Elder Rights Support Activities	4	4	4	—
Subtotal, Protection of Vulnerable Older Adults	**35**	**36**	**43**	**+8**
Programs for People With Developmental Disabilities				
State Councils on Developmental Disabilities	75	75	75	—
Protection and Advocacy	41	41	41	—
Projects of National Significance	8	8	8	—
Univ. Centers for Excellence in Developmental Disabilities	39	39	39	—
Subtotal, Developmental Disabilities Programs	**163**	**164**	**163**	**—**
Consumer Information, Access and Outreach				
Voting Access for People With Disabilities (HAVA)	5	5	5	—
Aging and Disability Resource Centers	6	6	—	-6
State Health Insurance and Assistance Programs	52	52	52	—
Subtotal, Consumer Information, Access and Outreach	**64**	**64**	**57**	**-6**
Paralysis Resource Center	7	7	7	—
Chronic Disease Self Management	10	*N/A*	10	—
Adult Protective Services	6	*N/A*	—	-6
Alzheimer's Disease Initiative	4	*N/A*	15	+11
Long-Term Care Clearinghouse	3	—	3	—
American Taxpayer Relief Act	—	25	—	—
ACL Program Administration	30	30	30	—
Total, Program Level	**2,185**	**2,201**	**2,129**	**-56**
Less Funds from Other Sources				
Prevention and Public Health Fund	-20	*N/A*	-25	-5
Mandatory Funding	-13	-38	-10	+3
Total, Budget Authority	**2,152**	**2,166**	**2,095**	**-58**
Full-time Equivalents /2	119	119	196	+77

1/ The Budget proposes a transfer from the Dept. of Labor to HHS in FY 2014. The FY 2012 and FY 2013 columns are displayed comparably.

2/ The FTE totals for FY 2012 and FY 2013 represent AoA FTEs only. The FTE total for FY 2014 reflects the reorganization of ACL, including FTEs from AoA, AIDD, and the Office on Disability, as well as from requested transfers.

ADMINISTRATION FOR COMMUNITY LIVING

The Administration for Community Living works to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

The FY 2014 Budget requests $2.1 billion for the Administration for Community Living (ACL). ACL focuses on ensuring that both older adults and people with disabilities are able to live at home with the supports they need while participating in communities that value their contributions. The Budget prioritizes efforts to address Alzheimer's disease, protects critical programs like nutrition, protection and advocacy, and caregiving support, and includes transfers of programs currently administered by other federal organizations to better coordinate activities that impact older adults as well as people with disabilities.

Addressing the Challenges Posed by Alzheimer's Disease

The nature of Alzheimer's disease—a slow loss of cognitive and functional/physical independence—means that most people with Alzheimer's disease are cared for in the community for years. People with Down's syndrome are at greater risk of developing Alzheimer's, as are older adults. The ACL Budget funds a three-pronged approach for addressing the challenges posed by the effects of Alzheimer's disease, including the impact on caregivers and families:

- Alzheimer's Disease Supportive Services Program: $9 million to fund competitive grants to States that expand the availability of evidence-based interventions designed to assist persons with dementia and their caregivers;
- Alzheimer's Disease Initiative: $11 million to strengthen the dementia capabilities of States, tribes, and localities, enabling these entities to enact permanent systems change; and
- Outreach: $4 million to inform those who care for individuals with Alzheimer's disease about resources available to help them. This campaign supports www.alzheimers.gov and promotes the website through social media, television, radio, and print advertisements.

The Creation of ACL

ACL was formed in April 2012 as a single agency charged with helping more people with disabilities and older adults have the option to live in their homes and participate fully in their communities. The creation of ACL brought together the Administration on Aging, the Office on Disability, and the Administration on Intellectual and Developmental Disabilities (AIDD), which had previously been separate entities within the broader U.S. Department of Health and Human Services. This newly organized agency is designed to support initiatives to increase access to community supports and maximize full community participation for seniors and people with disabilities. ACL works across HHS to harmonize efforts to promote community living, which can both save federal funds and allow people who choose to live with dignity in the communities they call home.

Helping Seniors Maintain Their Health and Independence

The Budget requests a total of $816 million for nutrition services, the same as FY 2012, to ensure that millions of older adults have access to the nutritious food needed they need to stay healthy. Some meals supported by ACL grants are delivered to the doors of seniors unable to leave their homes, providing nutrition support for some of the frailest, yet nevertheless independent, members of the community. Other meals funded by ACL are served in congregate settings such as community senior centers, which give seniors the opportunity for vital social contact. In combination with state and local contributions, the Budget will support 214 million congregate and home-delivered meals for approximately 2.3 million older individuals nationwide.

The Budget also includes a total of $367 million to fund in-home and community-based services to help older adults live independently and with dignity. These services include transportation assistance; case management; information and referral; help with personal care, including eating, dressing, and bathing; and adult day care and physical fitness programs. In combination with state and local funding, the Budget will support more than 21 million rides for critical daily activities, such as visiting the doctor, pharmacy, or

grocery stores; over 24 million hours of assistance to seniors unable to perform daily activities; and over 8 million hours of adult day care. In addition to directly helping seniors, these efforts also assist the caregiving friends and family members of seniors by providing them with relief and flexibility.

Supporting Caregivers

The Budget request includes $172 million for four programs that support family and informal caregivers by providing them with information, counseling, training, respite, and other services. These caregiver programs enable seniors to stay at home longer and enjoy greater independence, which can—when institutional care is avoided—translate into lower overall costs. Through this investment, ACL supports the many caregivers nationwide who provide hundreds of billions of dollars in care annually, care that might otherwise be billed to Medicare or Medicaid. The Budget will support approximately 790,000 caregivers, including more than 122,000 caregivers who will have the opportunity to participate specifically in counseling, peer support groups, and training to help them manage the stresses associated with caregiving.

Protecting Vulnerable Older Americans

The results of a national survey conducted by the National Center on Elder Abuse (NCEA)—in combination with the results of a national incidence study conducted by NCEA—suggest that more than 10 percent, or 5 million older Americans, suffer from elder abuse, neglect, and exploitation annually. The Budget includes $43 million for programs that provide a range of services designed to ensure the safety and well-being of seniors who are in danger of being mistreated or neglected.

These elder rights programs work to protect seniors in a number of ways. ACL's Adult Protective Services Program helps states test methods to detect, prevent, and address elder abuse. The Long-Term Care Ombudsman Program provides state support for ombudsmen who advocate on behalf of residents of long-term care facilities to ensure the protection of their rights and welfare. The Senior Medicare Patrol Program trains retired professionals to educate seniors on how to prevent, detect, and report Medicare fraud and abuse. Other ACL programs address elder abuse prevention and elder rights issues. Together, these distinct but complementary programs help prevent, detect, and respond to elder abuse, neglect, and exploitation in both at-home and institutional settings.

Preventing, Detecting, and Responding to Elder Abuse

Even modest forms of elder abuse, neglect, and exploitation can lead to dramatically higher (300 percent) morbidity and mortality rates for seniors relative to non-abused older people, as well as an increased likelihood of heart attacks, dementia, depression, chronic diseases, and psychological distress. As a result of this abuse, a growing number of seniors access the health care system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.

The Budget includes $8 million for the Adult Protective Services Demonstration Program to provide competitive grants to States to test and evaluate innovative approaches to preventing elder abuse, neglect, and exploitation. The program will expand the number of states that are currently working to translate and evaluate promising elder abuse prevention interventions from promising violence prevention efforts in related fields such as interpersonal violence and child maltreatment.

Improving the Lives of Individuals with Disabilities

ACL is dedicated to ensuring that individuals with disabilities and their families are able to fully participate in and contribute to all aspects of community life. The primary way in which ACL works toward accomplishing this goal is through a variety of partnerships with states and territories, including State Councils on Developmental Disabilities, Developmental Disabilities Protection and Advocacy programs, University Centers for Excellence in Developmental Disabilities, and Projects of National Significance.

The Budget requests $75 million to continue funding for State Councils on Developmental Disabilities, which operate in each state and territory, to promote systems change efforts aimed at increasing self-determination, integration, and inclusion for people with developmental disabilities. These Councils examine and conduct in-depth analysis of the quantity and quality of services and supports that are provided at the state and local level in order to identify the most

pressing needs of people with developmental disabilities and their families. The goal of the Councils is to help improve these services through the creation and implementation of strategic plans that help move states toward effective, coordinated systems of support and services for individuals with disabilities.

The Budget also requests $41 million to continue funding for the Developmental Disabilities Protection and Advocacy (P&A) programs, which provides formula grants to establish and maintain a P&A system for each state and territory. These P&A systems protect the legal and human rights of all people with developmental disabilities, as they are equipped with the authority to investigate incidents of abuse and neglect against individuals with developmental disabilities, and to pursue legal, administrative, or other appropriate remedies.

The Budget request also includes $39 million for University Centers for Excellence in Developmental Disabilities. These Centers advise federal, state, and community policymakers about opportunities for individuals with developmental disabilities to exercise self-determination, be independent, productive, and integrated and included in all facets of community life. In addition, the Centers provide an array of interdisciplinary programs to improve the quality of services and supports for individuals with developmental disabilities and training for professionals. On average, the Centers train close to 2,800 professionals each year.

The Budget requests $8 million for Projects of National Significance, which focus on the most pressing issues affecting people with disabilities and their families. These funds support the development of national and state policy as well as the awarding of grants and contracts, efforts that include the collection and analysis of longitudinal data that will allow ACL to enhance the independence, productivity, inclusion, and integration of people with developmental disabilities.

Additionally, the Budget requests $5 million for the Help America Vote Act protection and advocacy program. In each eligible state and territory, these protection and advocacy programs works to ensure that individuals with disabilities have the opportunity to fully participate in every step of the voting process. These programs educate individuals about voter registration and their legal voting rights, provide voter registration opportunities, and help individuals access the polls on election day.

Finally, the Budget proposes to transfer the Paralysis Resource Center from the Centers for Disease Control and Prevention to ACL at the FY 2014 funding level of $7 million. The Paralysis Resource Center promotes the health and well-being of individuals living with spinal cord injury, mobility impairment, and paralysis by providing resources and referral services. The Paralysis Resource Center focuses on health promotion after paralysis resulting from any disease, injury, or birth condition.

Promoting Efficiency in Community Based Service Delivery

The Budget requests $52 million, the same level as FY 2012, to fund more than 12,000 counselors in more than 1,300 community-based organizations through the State Health Insurance Assistance Program. These individuals and groups provide one-on-one outreach and counseling for Medicare beneficiaries who have a disability and/or who are elderly, as well as those nearing Medicare eligibility. Beneficiaries receive assistance in navigating the complexities of health and long-term care systems.

This funding is currently administered at the federal level by the Centers for Medicare & Medicaid Services, but activities at the state level are closely integrated with ACL's existing programs. Moving this program to ACL will enable grantees, about two-thirds of which are already state units on aging funded in part by ACL, to streamline their interaction with the federal government, with the goal of producing administrative efficiencies and improving coordination.

The Budget also includes funding for the Senior Community Service Employment Program (SCSEP), and proposes to move it from the Department of Labor to ACL at a reduced level of $380 million, $68 million below the FY 2012 funding level. As part of the proposed transfer to ACL's administration, ACL will make improving program performance, including targeting the SCSEP program to people with the greatest need, a priority by considering all sources of income. This action provides unemployed older adults with opportunities for community service training and

employment in non-profits and government agencies such as schools, libraries, and senior citizens programs. Supported participants are low-income older individuals with low to limited prospects for employment who can benefit from the social and supportive services provided by the ACL aging network.

Supporting Evidence-Based Initiatives and Access to Services

To ensure the continuation of a vibrant aging services network, ACL identifies, evaluates, and replicates the best models and practices nationwide across this network, funding lower-cost, non-medical services and supports. The Budget includes $10 million for Aging and Disability Resource Centers, "one-stop shop" entry points into long-term care at the community level where individuals of all ages may turn for objective information on their long-term services and support options.

The Budget also includes $10 million for Chronic Disease Self-Management Education programs that help individuals to better manage their own chronic diseases. These programs teach individuals with chronic diseases such as diabetes to manage their illnesses, help them adopt healthy behaviors, improve their health status, and reduce their hospital stays and emergency room visits. These programs represent two examples of state-of-the-art approaches that ACL is continuing to replicate and evaluate in support of its core programs.

Federal Administration

The Budget includes $30 million for program management and support activities. Funds support staff, rent and other administrative needs, and include funding for a planned ACL headquarters relocation. ACL administration funding will also be used to support staff in ACL's regional offices.

OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT

dollars in millions	2012	2013	2014	2014 +/- 2012
Budget Authority	473	476	301	-172
Prevention and Public Health Fund	30	*N/A*	105	+75
PHS Evaluation Funds	69	70	120	+51
Pregnancy Assistance Fund	25	25	25	—
Total, Program Level	**597**	**571**	**551**	**-46**
Prevention and Public Health Fund (non-add) /1	—	*1,000*	—	—
Full-time Equivalents	1,595	1,526	1,523	-72

1/ The FY 2013 Prevention and Public Health Fund resources are reflected in the Office of the Secretary. In 2012 and 2014, the Prevention Fund resources are allocated within the operating divisions.

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

The FY 2014 Budget for General Departmental Management (GDM) is $551 million in program level funding, a decrease of $46 million below the FY 2012 level. This Budget supports grant programs as well as those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 11 Staff Divisions and Offices in GDM.

Teen Pregnancy Prevention: The FY 2014 Budget includes $105 million from the Prevention and Public Health Fund to support community efforts to reduce teen pregnancy. In addition, $4 million in Public Health Service Act evaluation funding is included for the evaluation of teen pregnancy prevention activities. Teen pregnancy prevention funds will be used for replicating programs that have proven effective through rigorous evaluation to reduce teenage pregnancy; for research and demonstration grants to develop, replicate, refine and test additional models and innovative strategies; and for training, technical assistance, and outreach. Collaborative efforts in teen pregnancy prevention will support innovative youth pregnancy prevention strategies which are medically accurate and age appropriate.

Office of Minority Health: The Budget includes $41 million for the Office of Minority Health in FY 2014. The Office of Minority Health will lead, coordinate and collaborate minority health activities in HHS, and place less emphasis on program development and grant-making. This funding will enable the Office of Minority Health to continue health promotion, service demonstration, and educational efforts to prevent disease and reduce and ultimately eliminate disparities in racial and ethnic minority populations across the country.

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

Office on Women's Health: The Budget includes $27 million for the Office on Women's Health in FY 2014. The Office on Women's Health will lead, coordinate, and collaborate women's health activities in HHS, and place less emphasis on program development and grant-making. This funding will allow the Office on Women's Health to continue to support the advancement of women's health programs through promoting and coordinating research, service delivery, and education. These programs are carried out throughout the agencies and

offices of HHS, with other government organizations, and with consumer and health professional groups.

Acquisition Reform: An additional $2 million is included for the HHS portion of a government-wide initiative in contract and acquisition reform. Funding will be used to increase the capacity and capabilities of the Department's acquisition workforce.

Other General Departmental Management: The FY 2014 Budget includes $318 million for the remainder of the GDM program level. The Budget funds leadership, policy, legal, and administrative guidance to HHS components and also includes funding to continue ongoing programmatic activities. In addition, the Budget will strengthen program integrity by reducing fraud, waste, and abuse while increasing accountability.

OFFICE OF THE SECRETARY
OFFICE OF MEDICARE HEARINGS AND APPEALS

dollars in millions	2012	2013	2014	2014 +/- 2012
Program Level	72	72	82	+10
Full-time Equivalents	466	490	514	+48

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

The FY 2014 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $82 million, an increase of $10 million over the FY 2012 enacted level. To hear cases under Title XVIII of the Social Security Act and related provisions in Title XI of the Act, OMHA requests funds from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Fund. By statute, Level III Medicare appeals are to be heard within 90 days after receipt of a request for a hearing from a Medicare appellant.

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

OMHA began processing cases on July 1, 2005; since then, it has received more than one million claims nationwide for Medicare Parts A, B, C, and D appeals, as well as for Medicare entitlement and eligibility appeals. In FY 2011, OMHA began receiving additional claims resulting from the permanent expansion of the Recovery Audit Contractor program, administered by the Centers for Medicare & Medicaid Services, to all 50 states. OMHA received 234,000 total claims in FY 2011 and 313,000 claims in FY 2012, and expects to receive 368,000 claims in FY 2013. OMHA projects that its FY 2014 caseload will increase to approximately 392,000 total claims (a sixty-eight percent increase over FY 2011).

With the requested funding level of $82 million, OMHA will strive to process the increasing number of Medicare appeals while maintaining the quality and accuracy of its decisions. OMHA will continue to utilize technology to offer appellants access to multiple hearing venues and services.

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

dollars in millions	2012	2013	2014	2014 +/- 2012
Budget Authority	16	16	20	+4
PHS Evaluation Funds	45	45	56	+11
User Fee	—	—	1	+1
Total, Program Level	**61**	**61**	**78**	**+17**
Full-time Equivalents	159	191	191	+32

The Office of the National Coordinator for Health Information Technology pursues the modernization of the American health care system through the adoption and meaningful use of health IT. These efforts will make health information available for better decision-making by consumers, clinicians, health care managers, and policy-makers at all levels of the health care system.

The FY 2014 Budget for the Office of the National Coordinator for Health Information Technology (ONC) is $78 million, $17 million above FY 2012. The Budget builds upon the investment of health information technology (IT) resources authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. It also strengthens ONC's expertise on activities related to ONC's core mission including adoption and meaningful use; policy development; standards development; certification; information exchange and interoperability.

With the end of Recovery Act funding in FY 2013, the FY 2014 Budget allows ONC to leverage critical investments to further accelerate the nationwide implementation and meaningful use of health IT. ONC will continue to develop and coordinate policies and standards that advance the goals of health IT while protecting the privacy and security of health information. ONC will also provide continued leadership and expertise to implementers and consumers of health IT as they adopt and seek to realize the benefits of health IT and health information exchange (HIE). As health IT advances, the health IT community will look to ONC for leadership on a wide range of issues and challenges. To meet this demand, the FY 2014 Budget strengthens ONC's core standards development capacity and its Health IT Certification Program.

Standards, Interoperability, and Certification

ONC leads a variety of efforts designed to accelerate progress towards the interoperability of health IT systems. ONC engages health care, technology, and standards stakeholders to accelerate industry consensus on the standardization of health data and HIE and establish core standards and policies that enable the electronic exchange and meaningful use of health information. ONC supports these efforts by convening federal agencies and other partners to implement nationwide solutions to HIE and providing technical assistance and resources to states and communities who have committed to developing interoperable health IT infrastructures that support national priorities. ONC also

Standards and Interoperability Framework

Through the Standards and Interoperability (S&I) Framework, ONC regularly convenes a broad community of almost 1,000 stakeholders from across the United States who are working to accelerate industry consensus on the standardization of health IT and HIE. Each year, a number of critical standards and interoperability challenges are resolved through a rigorous process of use case development, harmonization of technical specifications and implementation guides, and real-world testing and feedback.

Through the S&I Framework, ONC has successfully reduced the timeframe for developing standards from three years to under one year. This accelerated timeline has led to rapid gains in health IT interoperability and functionality, paving the way for health IT-enabled care transformation and new payment models.

administers a reliable Health IT Certification Program that builds trust in the health IT marketplace and encourages the development and adoption of standards-based technologies that support national priorities, including meaningful use.

Adoption, Utilization, and Meaningful Use of Health IT

As the number of providers using EHRs increase, there is an ongoing need to provide technical assistance in support of meaningful use. In 2012, ONC supported over 140,000 providers through the Regional Extension Center program, of which over 100,000 providers were live on an EHR system, capable of e-prescribing and producing quality measures, and almost 34,000 providers have demonstrated meaningful use.

The FY 2014 Budget will allow ONC to provide ongoing leadership and implementation assistance in support of meaningful use. ONC will continue to enhance the National Learning Consortium (NLC) where adopters and implementers can share knowledge and address barriers. Through the NLC, ONC will publish tools and resources developed under its HITECH Act programs, including health IT workforce curricula, training materials, and workflow and implementation guides.

Promoting the Meaningful Use of Health IT

ONC works closely with the Centers for Medicare & Medicaid Services to refine and expand the criteria governing the Medicare and Medicaid EHR Incentive Programs. These programs provide incentive payments to eligible providers who adopt and meaningfully use certified EHR technology to improve health care.

In FY 2014, eligible providers will begin to attest to Stage 2 of the EHR Incentive Programs. Stage 2 represents a major step towards leveraging health IT to support patient centered, value driven, health care across the nation.

Highlights include:

- Standards and specifications that will support HIE across vendor boundaries and with patients.
- New and enhanced measures for capturing and reporting clinical quality measure data.
- A new focus on patient safety.
- Enhanced privacy and security protections for mobile devices.

ONC remains committed to increasing consumers' access to and engagement with their electronic health information. ONC continues to promote the "Blue Button" program and related technologies that allow consumers to download their health information securely and privately. ONC will continue to convene stakeholders and develop strategies to increase consumer adoption and utilization of health IT.

Governance of Health Information Exchange

As providers and patients increasingly engage and seek benefit from interoperable health IT, governance and oversight entities will have a critical role in establishing policies and business practices that allow information to follow patients whenever and wherever they seek care. ONC is committed to advancing the governance goals of nationwide HIE through leadership, guidance, engagement, and monitoring. In FY 2014, ONC will work with governance and oversight entities to develop and promote policies and practices that support robust, secure, and interoperable exchange.

Patient Safety and Health IT Usability

Patient safety and usability continue to be a focus for ONC. Working with federal partners AHRQ and FDA, ONC will create the foundation for a patient safety program that will be launched in FY 2014 called "The Patient Safety Plan". The Plan seeks to ensure that health IT is safely designed and implemented, medical staff are properly informed and trained to use their health IT systems, and a surveillance system is established to monitor health IT related patient safety events and ensure that unsafe conditions are corrected.

Privacy and Security

The Budget will enable ONC to address new privacy and security policy issues. ONC will continue to work alongside industry partners to construct and support innovative frameworks in support of a national Cybersecurity program. Recognizing that privacy and security are critical factors in moving health IT forward, ONC provides policy guidance to internal and external stakeholders to promote confidence and trust in health IT. ONC also explores privacy and security issues arising from new technologies and increased participation in HIE.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

dollars in millions	2012	2013	2014	2014 +/- 2012
Program Level	41	41	42	+1
Full-time Equivalents	226	225	233	+7

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

The FY 2014 request for the Office for Civil Rights (OCR) is $42 million, an increase of $1 million over the FY 2012 enacted level. The increase will support enforcement of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The HHS Secretary delegated authority for the administration and enforcement of the Security Standards for the electronic protected health information (HIPAA Security Rule) to the Director of OCR. Providing OCR with the authority to administer and enforce federal HIPAA standards for health information privacy and security, has helped streamline HIPAA oversight and improved HHS' ability to protect individuals' health information.

The Budget continues to support OCR's activities as the primary defender of the public's right to nondiscriminatory access to the receipt of federally-funded health and human services. In addition, the Budget supports OCR's expanded responsibilities under the Privacy and Security Rules issued pursuant to HIPAA. OCR assesses compliance through complaint investigations, violation findings, resolution agreements, enforcement actions and monitoring, public education, technical assistance, civil rights compliance reviews, and HIPAA audits. The Budget maintains this current programmatic focus and also supports an initiative of enhanced enforcement of the HIPAA Security Rule.

Civil Rights

OCR receives and resolves nearly 3,000 discrimination complaints annually. The wide array of federal civil rights laws and regulations that OCR enforces range from non-discrimination on the basis of race, color, national origin, disability, age, sex and religion in HHS funded health and human service programs to federal health care provider conscience protections and protections against discrimination on the basis of disability in health care and social service programs of state and local governments. Under Section 1557 of the Affordable Care Act, OCR also has enforcement authority with respect to race, color, national origin, sex, age and disability discrimination in health programs and activities that receive financial assistance from HHS or are administered by HHS or any entity established under Title I of the Affordable Care Act.

Resolution Agreements and Compliance Activities:

- OCR continues to review nearly 3,000 new Medicare applicants each year to ensure their compliance with federal civil rights requirements. Through formal agreements with 52 health care corporations, OCR ensures ongoing civil rights compliance in more than 4,500 health care facilities that serve over 10 million patients annually.

- Through its Advancing Effective Communication in Critical Access Hospitals Initiative, OCR conducts compliance reviews and provides technical assistance to Critical Access Hospitals, which serve rural and isolated areas, to ensure that they provide language assistance services to limited English proficient individuals. To date, OCR has completed compliance reviews and provided technical assistance to Critical Access Hospitals in California, Colorado, Florida, Illinois, Massachusetts, Nebraska, New York,

Texas, Virginia and Washington. The second phase of this Initiative includes compliance reviews of Critical Access Hospitals in all 45 states which have such Hospitals.

- OCR also has provided technical assistance and education to states to assist them in complying with their obligations under the Americans with Disabilities Act. OCR is disseminating information from a Substance Abuse and Mental Health Services Administration-sponsored *Olmstead* policy academy, creating virtual learning communities, and providing webinars on topics such as housing and Medicaid services that provide individuals with disabilities opportunities to live in their communities.

Health Information Privacy and Security

OCR received and resolved more than 9,500 complaints of alleged HIPAA violations in FY 2012 and OCR's compliance responsibilities under the Privacy and Security Rules issued pursuant to HIPAA continue to expand. OCR enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Omnibus Rule: HHS recently strengthened the privacy and security protections for health information established under the HIPAA Act of 1996. The final rule implements a number of provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. The final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law. The changes in the final rulemaking provide the public with increased protection and control of personal health information. The HIPAA Privacy and Security Rules have focused on health care providers, health plans and other entities that process health insurance claims. The changes expand many of the requirements to business associates of these entities that receive protected health information, such as contractors and subcontractors. Some of the largest breaches reported to HHS have involved business associates. Penalties are increased for noncompliance based on the level of negligence with a maximum penalty of $1.5 million per violation. The changes also strengthen the HITECH Breach Notification requirements by clarifying when breaches of unsecured health information must be reported to HHS.

Monetary Settlements: The HITECH Act authorized OCR to levy monetary settlements and impose civil monetary penalties. OCR received almost $4.0 million in settlements in FY 2012 and anticipates $5.5 million in FY 2013. OCR uses funding received through civil monetary penalties and settlements to support HIPAA enforcement activities.

A noteworthy example of OCR enforcement action was a 2012 settlement agreement entered into between Citizen's Medical Center (CMC) in Victoria, Texas and OCR (Region VI). As a result of OCR's enforcement, children with disabilities will now have the same rights as other American children to access child care programs. The settlement followed an OCR investigation into a complaint filed on behalf of a complainant's child who was denied an opportunity to participate in a CMC child care program, based on the child's disability, autism spectrum disorder. OCR's investigation into the complaint revealed that CMC violated Section 504 and the ADA when it rejected the child for enrollment based on its perception that the child would need one-on-one care as a reasonable modification. The settlement agreement required CMC to establish a non-discrimination policy and provide notice to its staff and program participants of the policy. In addition, CMC agreed to staff receiving comprehensive training concerning their obligations to provide services without discrimination to qualified persons with disabilities and specific training on autism spectrum disorder; implement a patient grievance procedure; inform patients of their right to file a complaint with OCR; appoint a Section 504 Coordinator who will be responsible for CMC's efforts to comply with Section 504 and Title II of the ADA; and report to OCR for an 18 month period.

OFFICE OF INSPECTOR GENERAL

dollars in millions	2012	2013	2014	2014 +/- 2012
Discretionary Appropriation	50	50	69	+19
Disaster Relief Appropriations Act of 2013	—	5	—	—
HCFAC Collections	12	12	12	—
Discretionary HCFAC /1	30	30	30	—
Mandatory HCFAC /1	196	270	278	+82
Total, Program Level	**288**	**367**	**389**	**+101**
Full-time Equivalents	1,773	1,883	2,030	+257

1/ For FY 2014, the Budget provides $311 million for HCFAC through discretionary appropriations. The Budget also proposes additional mandatory funding beginning in FY 2013. OIG's allocation of this adjustment is displayed above.

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

The FY 2014 Budget request for OIG is $389 million, an increase of $101 million above FY 2012 enacted level. OIG is a key partner in the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, and the President's Budget includes $320 million in support of HEAT and other program integrity efforts aimed at reducing fraud, waste and abuse in the Medicare and Medicaid programs. In addition to maintaining the efforts and success of the Medicare Fraud Strike Forces, HEAT activities in FY 2014 include enhancing investigative efforts focused on civil enforcement and complex fraud schemes that require long-term investigations and identifying and recommending solutions to reduce improper payments. The request also includes $69 million, an increase of $19 million for oversight of HHS's more than 300 non-Medicare/Medicaid programs, which have grown significantly in scope and complexity during the last decade. These funds will enable OIG to expand existing HHS oversight efforts and to monitor the implementation of the Affordable Care Act and the operation of Affordable Care Act programs.

While specific activities in FY 2014 will be determined through OIG's work planning process, areas of potential oversight as reflected in OIG's assessment of the top management and performance challenges facing HHS follow.

Integrity of Medicare and Medicaid

Preventing and Detecting Medicare and Medicaid Fraud: Medicare and Medicaid fraud continue to be significant challenges facing HHS. Perpetrators of fraud range from criminals who masquerade as bona fide health care providers and suppliers but who do not provide legitimate services to companies that pay kickbacks in return for referrals. Fraud is a crime of deception, and perpetrators design their schemes to avoid detection. OIG has set the following strategic priorities for protecting the integrity of Medicare and Medicaid and the well being of beneficiaries in FY 2014:

- Investigating suspected fraud to hold accountable perpetrators of Medicare and Medicaid fraud;
- Assessing program vulnerabilities and recommending actions to reduce improper payments and prevent fraud;
- Fostering a culture of compliance and effective fraud prevention and detection mechanisms within the health care industry both by issuing formal guidance and reaching out to other federal and state agencies, stakeholder organizations, providers, and the public; and

- Increasing OIG's capacity to effectively utilize data to identify fraud "hot spots," trends, and suspected perpetrators of fraud.

Identifying and Reducing Improper Payments: Improper payments cost more than $100 billion across federal programs in FY 2012. In FY 2014, OIG will continue to identify HHS overpayments for recovery, assess the vulnerabilities contributing to improper payments, and recommend actions to prevent future improper payments.

Ensuring Patient Safety and Quality of Care: As a purchaser of health care for over 100 million Americans, the Department faces challenges in ensuring the quality of care rendered. OIG continues to assess quality of care and patient safety across a variety of health care settings and recommend improvements to oversight and safeguards. OIG also investigates the provision of substandard and deficient care in cases so egregious that they constitute health care fraud.

Additional Areas of Potential CMS Oversight:

- Integrity and security of information systems and data;
- Avoiding waste and promoting value in health care; and
- Ensuring efficiency and effectiveness of Medicare and Medicaid Program Integrity Contactors.

Integrity of the Department's Public Health and Human Services (PHHS) Programs

Grants Management and Administration of Contract Funds: HHS is the largest grant-making organization in the federal government, awarding over $347 billion in grants in FY 2012, of which approximately $90 billion were for PHHS programs. With the passage of the Recovery Act and Affordable Care Act, the Department's grant portfolio has expanded in size, scope, and complexity. In FY 2014, OIG will provide the Department with vital information that will help hold accountable grantees and contractors that manage large grant awards and contracts, and ensure the integrity of these significant expenditures.

Protecting Consumers of Food, Drugs, and Medical Devices: OIG will continue to evaluate the Department's management of food safety issues. In addition, OIG continues to work closely with the Food and Drug Administration and the Justice Department to investigate illegal marketing practices by drug and devise manufacturers.

Fostering an Ethical and Transparent Environment: OIG has long been involved in oversight and enforcement related to conflicts of interest and financial relationships with respect to Department employees, grantees, and contractors and within the health care industry. OIG has recommended increased transparency and accountability in all of these contexts. OIG will continue to monitor these issues in FY 2014.

Integrity of Health Care Reform Implementation

In FY 2014, OIG will continue to focus on the implementation and operation of ACA programs. Ongoing challenges include the magnitude, complexity, and novelty of programs; compressed implementation timelines; and marketplace dynamics. In addition, ensuring the integrity, privacy, and security of sensitive data will be critical to the successful administration of the Federally-facilitated Marketplaces and related programs, including the premium tax credit program. Assessing the integrity of these programs is essential to ensuring that they operate with economy and efficiency and are protected from fraud, waste, and abuse.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

dollars in millions	2012	2013	2014	2014 +/- 2012
Office of the Secretary, ASPR				
Preparedness and Emergency Operations	30	30	25	-5
National Disaster Medical System (NDMS)	53	53	53	—
Hospital Preparedness	375	377	255	-125
ESAR-VHP	5	5	1	-4
Medical Countermeasure Dispensing	—	—	5	+5
BARDA	415	415	415	—
Strategic Investor (non-add)	—	—	*20*	*+20*
Project BioShield	—	—	250	+250
Policy and Planning	16	16	15	—
Operations	33	33	33	—
Subtotal, ASPR	**926**	**929**	**1,051**	**+126**
Other Office of the Secretary:				
Security and Strategic Information	6	6	7	+1
Cybersecurity	40	40	41	+1
Medical Reserve Corps	11	11	9	-2
HHS Lease Replacement	—	—	41	+41
Subtotal, Other Office of the Secretary	**58**	**58**	**99**	**+41**
Pandemic Influenza:				
No-Year Funding	—	—	108	+108
Annual Funding	—	—	32	+32
Subtotal, Pandemic Influenza	—	—	**140**	**+140**
Total, Program Level	**983**	**987**	**1,290**	**+307**
Less Funds From Other Sources:				
Use of BioShield Balances	-415	-415	—	—
Total, Discretionary Budget Authority	**568**	**572**	**1,290**	**+722**
Full-time Equivalents	626	650	691	+90

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

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

To enhance the nation's preparedness against bioterrorism and other public health threats, the FY 2014 Budget includes $1.3 billion for the Public Health and Social Services Emergency Fund (PHSSEF) in the Office of the Secretary. This request reflects the ongoing commitment to the medical countermeasure enterprise, including a funding request for the first year of continuing procurements through Project BioShield. In addition, the Budget provides funding to support advanced development of medical countermeasures and pandemic influenza preparedness activities. The Budget includes over $4.8 billion to combat bioterrorism and pandemic influenza, and to support emergency preparedness activities across the Department.

Bioterrorism and Emergency Preparedness

The FY 2014 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $1.29 billion, an increase of $722 million above FY 2012 budget authority. Many activities in recent years have been supported by balances from Project BioShield and pandemic influenza supplemental funding, which will no longer be available in FY 2014. The Budget will support coordination of preparedness and response activities across HHS to improve the nation's ability to prepare for, respond to, and recover from the adverse health effects of public health emergencies and disasters.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) is the lead for the federal government for public health and medical services response efforts under the National Response Framework. ASPR coordinates the bioterrorism and emergency preparedness activities of HHS agencies, develops and coordinates national policies and plans, provides program oversight, and serves as the Secretary's public health emergency representative to other federal, state, and local agencies. The FY 2014 Budget provides $1.051 billion for ASPR; an increase of $540 million over FY 2012.

ASPR has improved the nation's ability to respond to natural and man-made threats including anthrax, smallpox, botulism, and a pandemic influenza virus. To continue fostering improvements in emergency response, the FY 2014 Budget requests $250 million to support a renewed multi-year commitment to Project BioShield (BioShield). BioShield was originally authorized in 2004 to support the development and procurement of novel medical countermeasures to protect the nation against chemical, biological, radiological, and nuclear threats. To enhance the BioShield program, the Budget includes a proposal for multi-year contract authority. This authority allows BioShield to retain its long-term commitment to the procurement of medical countermeasures within fiscal constraints.

The Budget also includes $415 million in new resources for the Biomedical Advanced Research and Development Authority (BARDA), which had previously been funded from Project BioShield balances. In FY 2014, BARDA will support the Strategic Investor program, an independent, not-for-profit entity that will provide capital and business support to new and small companies conducting research on medical countermeasures. This investment is aimed to encourage promising new private sector developments in medical countermeasures in hopes of mitigating the health consequences of potential chemical, biological, radiological, and nuclear threat events. Additionally, BARDA funds will support the first full year of operation costs for the Centers of Innovation for Advanced Development and Manufacturing. Awarded in 2012, the Centers will provide core capabilities for advanced development and manufacturing of chemical, biological, radiological, and nuclear medical countermeasures, as well as the development and manufacturing of pandemic influenza vaccine in the event of an emergency.

In FY 2014, $255 million is requested for the Hospital Preparedness Program (HPP), a reduction of $125 million from FY 2012. Funds will support grants to states and other entities for healthcare coalitions to improve surge capacity and enhance community and hospital preparedness for public health emergencies. Additionally, the Centers for Disease Control and Prevention (CDC) will provide $658 million to state and local public health departments to support public health preparedness activities. Between FY 2003 and FY 2014, these programs will have provided nearly $11 billion for cooperative agreements to states, cities, and territories to strengthen the capability of health departments, hospitals, and health care systems to plan for, respond to, and recover from all hazards events. Recently, these two programs underwent a strategic process to re-align along 15 key response capabilities. This process is expected to support whole community preparedness planning and encourage greater collaboration across the health spectrum. The enhanced alignment is also expected to increase administrative efficiencies for grantees and program administrators.

The Budget provides $82 million to support the Department's direct emergency preparedness, response, and recovery efforts. This request includes the National Disaster Medical System (NDMS), which is a nationwide partnership designed to deliver quality medical care to the victims of, and responders to, a domestic disaster. This funding also supports ASPR's emergency operations, which are activated during support of federal governmentwide events and provide expertise and coordination to agencies across HHS. The Budget also provides $5 million to support medical countermeasure dispensing pilot programs in partnership with the United States Postal Service.

Additionally, the Budget proposes an emergency transfer authority to assist in the rapid response to public health emergencies. This authority will provide flexibility to redirect resources quickly to programs providing immediate disaster response.

Hurricane Sandy Response and Recovery

Under the National Response Framework, HHS leads Emergency Support Function (ESF) 8—Public Health and Medical Services; and under the National Disaster Recovery Framework, HHS leads the Health and Social Services Recovery Support Function. The ASPR coordinates these activities with agencies across the Department. During Hurricane Sandy response, HHS deployed nearly 2,300 personnel and engaged in a wide range of life-preserving activities. For example, HHS:

- Stationed 26 50-person medical teams in the affected areas to support hospital decompression, respond to medical needs at shelters, and conduct door-to-door wellness checks;
- Deployed 791 tons of medical materiel including 7 Federal Medical Stations from the Strategic National Stockpile;
- Deployed Field Coordinators for recovery to the New Jersey and New York Joint Field Offices;
- Coordinated civilian volunteers, trained by the Office of the Civilian Volunteer Medical Reserve Corps Program;
- Enhanced food safety and water testing by the Food and Drug Administration,
- Provided Crisis Counseling and other mental health services by the Substance Abuse and Mental Health Administration,
- Issued waivers from the Centers for Medicare & Medicaid Services, to better enable healthcare providers to meet heightened demand, and
- Helped communities implement disaster plans – including for patient evacuation and sheltering in place – developed through the Hospital Preparedness and Public Health Emergency Preparedness programs.

Pandemic Influenza

The impact and severity of recent flu seasons have demonstrated the need for ongoing influenza preparedness activities. While HHS has made tremendous progress in achieving the goals of its pandemic influenza plans, additional resources are needed for continued support of its efforts to protect Americans in the event of an influenza pandemic. The FY 2014 Budget requests $140 million to counter the continuing threat of a global influenza pandemic. This funding includes $108 million to support: the development of next generation recombinant and molecular influenza vaccines; the advanced development of respiratory devices; readiness activities associated with manufacturing of vaccines

and biological products; maintenance of the egg supply program; and new methods for extending the usable life of various vaccine products in the Strategic National Stockpile.

The Budget also includes $10 million to support the development of rapid diagnostics, which can help clinicians identify at-risk influenza patients early for antiviral intervention and rapidly detect the emergence of drug resistant virus strains, alert health departments of the real-time rate of influenza in their community, and provide necessary data to efficiently control the spread of influenza. Funds will also support the advancement of vaccine capability in other countries and HHS's diplomatic efforts to improve the global response to and prevention of pandemics. In recent years, the Department's pandemic influenza activities were supported by supplemental funding appropriated in FY 2009.

Cybersecurity: The Budget provides $41 million to support and protect the Department's information technology systems and to safeguard personally identifiable information, commercial proprietary data, and scientific research of national importance. As health information increasingly shifts to online environments, the Cybersecurity program works to maintain the public trust and engages in system risk analysis and testing and continuous security monitoring. The Security Incident Response Center supports the enterprise-wide capabilities to detect and identify intrusions through security forensics, and monitor secure internet connections. In FY 2014, Cybersecurity funding will also support implementation of the DHS Trusted Internet Connections (TIC), which is a top priority for the Department.

Security and Strategic Information: The Budget includes $7.5 million, $1 million above FY 2012, for Security and Strategic Information, which in part enables the Department to translate and respond to secure information and fulfill its role as an interagency actor in health defense. This funding supports clearance information for international visitors and provides security information for HHS employees travelling abroad. Funds also support the formulation and oversight of the Department's physical and information security standards.

Medical Reserve Corps: The Civilian Volunteer Medical Reserve Corps are local units trained and available to respond to public health emergencies. The Budget request includes $9 million for the Medical Reserve Corps in FY 2014, which is $2 million below FY 2012, to maintain training with current units.

Highlighted Bioterrorism Preparedness Activities: In addition to agencies funded through the PHSSEF, many of the agencies and offices across HHS play important roles in ensuring that the country is prepared for and able to respond to a bioterrorist attack or significant public health emergency. In addition to funding in the PHSSEF, another $3.6 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for the Centers of Disease Control and Prevention, the Food and Drug Administration, the National Institutes of Health, the Administration for Children and Families, and the Office of the Secretary.

Other PHSSEF Activities: The Budget includes $41 million for centrally managed HHS lease replacement costs, $41 million above FY 2012. These funds will support space consolidation for several agencies within HHS, and for costs related to fit-out of properties for lease replacement. The consolidated lease replacement fund allows the Department to more effectively and efficiently manage these resources and allocate them to property management needs across the Department. This approach also helps to prevent higher priced hold-over and short term lease extensions.

First Cell- and Recombinant-Based Influenza Vaccines Approved

In November 2012, the Food and Drug Administration (FDA) announced approval of the first seasonal flu vaccine made using cell-based technology. This technological breakthrough allows HHS to maintain an adequate supply of readily available, previously tested cells for use in influenza vaccine production. Ultimately, this change in production will reduce time required for start-up of the vaccine manufacturing process in the event of a pandemic. Additionally, in January 2013, FDA approved the first recombinant-based seasonal influenza vaccine. This technology does not depend on growing influenza viruses in the vaccine manufacturing process, and instead uses the virus's gene sequence in insect cells. Because this technology does not depend on egg supply or availability of influenza virus for vaccine production, FDA anticipates less start-up time be needed to manufacture in the event of a pandemic.

ABBREVIATIONS AND ACRONYMS

A

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ACF	Administration for Children and Families
AD	Alzheimer's Disease
ACL	Administration for Community Living
ADAP	AIDS Drug Assistance Program
ADUFA	Animal Drug User Fee Amendments
AHRQ	Agency for Healthcare Research and Quality
AGDUFA	Animal Generic Drug User Fee Act
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AMP	Average Manufacturer Price
ANDA	Abbreviated New Drug Application
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
AWARE	Advancing Wellness and Resilience in Education

B

BA	Budget Authority
B&F	Buildings and Facilities
BARDA	Biomedical Advanced Research and Development Authority
BBA	Balanced Budget Act of 1997
BCA	Budget Control Act of 2011
BRAIN	Brain Research through Application of Innovative Neurotechnologies

C

CAH	Critical Access Hospital
CAN	Cures Acceleration Network
CBRN	Chemical, Biological, Radiological, and Nuclear
CCDBG	Child Care and Development Block Grant
CCE	Child Care Entitlement
CDC	Centers for Disease Control and Prevention
CDFI	Community Development Financial Institutions
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMHC	Community Mental Health Centers
CMS	Centers for Medicare & Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
CPI-U	Consumer Price Index for All Urban Consumers
CSE	Child Support Enforcement
CUSP	Comprehensive Unit-based Safety Program
CY	Calendar Year

D

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

E

EGWP	Employer Group Waiver Plan
EHR	Electronic Health Record
ERRP	Early Retiree Reinsurance Program
ESRD	End Stage Renal Disease

F

FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FDASIA	FDA Safety and Innovation Act
FFM	Federally-Facilitated Marketplace
FFS	Fee-For-Service
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FQHC	Federally-Qualified Health Center
FSMA	Food Safety Modernization Act
FTE	Full-Time Equivalent
FUL	Federal Upper Limits
FY	Fiscal Year

G

GAO	Government Accountability Office
GDM	General Departmental Management
GDP	Gross Domestic Product
GME	Graduate Medical Education

ABBREVIATIONS AND ACRONYMS

H

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

I

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

L

LTCH	Long Term Care Hospital
LIHEAP	Low Income Home Energy Assistance Program

M

MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MCM	Medical Countermeasures
MDUFA	Medical Device User Fee Act
MedPAC	Medicare Payment Advisory Commission
MEPS	Medical Expenditure Panel Survey
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MIP	Medicaid Integrity Program
MLR	Medical Loss Ratio
MQSA	Mammography Quality Standards Act

N

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

O

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

P

P&A	Protection and Advocacy
PAYGO	Pay-As-You-Go Act of 2010
PCIP	Pre-Existing Condition Insurance Plan
PCORTF	Patient-Centered Outcomes Research Trust Fund
PDUFA	Prescription Drug User Fee Act
PHEP	Public Health and Emergency Preparedness
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PMD	Power Mobility Devices

Q

QI	Qualified Individual
QIO	Quality Improvement Organization

ABBREVIATIONS AND ACRONYMS

R

RAC Recovery Audit Contractor
REC Regional Extension Center
RDS Retiree Drug Subsidy
RPG Research Project Grant

S

SAMHSA Substance Abuse and Mental Health Services Administration
SBM State-based Marketplace
SCSEP Senior Community Service Employment Program
SHOP Small Business Health Options Program
SNF Skilled Nursing Facilities
SPM State Partnership Marketplace
SOW Statement of Work
SSBG Social Services Block Grant
SSI Supplemental Security Income
StaffDiv Staff Division
STD Sexually Transmitted Diseases
STEM Science, Technology, Engineering, and Mathematics

T

TANF Temporary Assistance for Needy Families
TB Tuberculosis
TIC Trusted Internet Connections
TMA Transitional Medical Assistance

U

UAC Unaccompanied Alien Children

V

VFC Vaccines for Children
VTC Video Teleconference

W

WTC World Trade Center