Fiscal Year 2015

Budget in Brief

Strengthening Health and Opportunity for All Americans

U.S. Department of Health & Human Services

HHS.GOV

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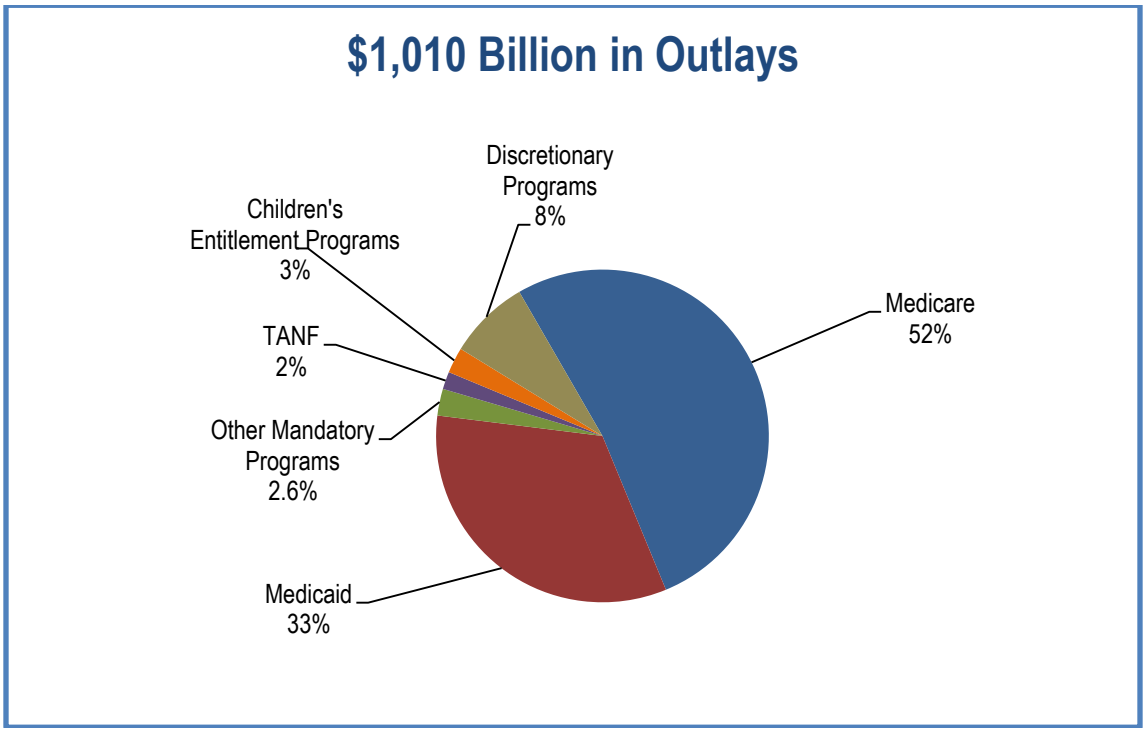
ADVANCING THE HEALTH, SAFETY, AND WELL–BEING OF THE NATION

FY 2015 President's Budget for HHS

dollars in millions	2013	2014	2015
Budget Authority	**873,535**	**962,554**	**1,020,284**
Total Outlays	**886,472**	**958,077**	**1,010,479**
Full-time Equivalents (FTE)	74,992	77,457	79,540



General Notes

Detail in this document may not add to the totals due to rounding. Budget data in this book is presented "comparably" to the Fiscal Year (FY) 2015 Budget, since the location of programs may have changed from prior years or may be proposed for change in FY 2015. This approach allows increases and decreases in this book to reflect true funding changes.

The FY 2013 figures herein reflect final levels post sequestration and transfers. The FY 2014 and FY 2015 mandatory figures reflect current law and mandatory proposals reflected in the Budget.

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) improves the economic opportunity of all Americans by providing critical investments in scientific research, health care, disease prevention, social services, and children's well-being, to support healthier families, stronger communities, and a thriving America.

The President's fiscal year (FY) 2015 Budget for HHS includes investments needed to support the health and well-being of the nation, and legislative proposals that taken together would save an estimated $355.6 billion over 10 years. The Budget totals $1 trillion in outlays and proposes $77.1 billion in discretionary budget authority, a reduction of $1.3 billion from FY 2014. With this funding HHS will continue to improve health care and expand coverage, create opportunity, give children 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.

Strengthening Health Care

Continuing Effective Implementation of the Affordable Care Act

Expanding Health Insurance Coverage. As of January 1, 2014, millions of Americans gained access to new health insurance options previously not available to them. The Marketplaces provide improved access to insurance coverage, creating a new private health insurance market in which those in need of coverage are more easily able to purchase health insurance. The Marketplaces have enrolled 4 million individuals. New premium tax credits and rules ensuring fair premium rates are making private coverage more affordable for consumers. The Budget supports continued operations in the federally-facilitated Marketplaces, as well as oversight and assistance to state-based and Partnership Marketplaces.

The Affordable Care Act provides full federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the federal poverty level for three years starting in 2014 and covers no less than 90 percent thereafter. The Affordable Care Act also simplified Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment processes and aligned them with Marketplaces. As a result, millions more low-income people have been determined eligible for Medicaid or CHIP. The Centers for Medicare & Medicaid Services (CMS) continues to work 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. Non-grandfathered health plans will no longer be allowed to charge more or deny coverage to people because of pre-existing conditions. These new protections will also prohibit non-grandfathered plans 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 that 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.

Health Centers. Health centers will continue to be a vital source of primary care for uninsured and medically underserved patients seeking a quality source of care in FY 2015. The Budget requests $4.6 billion for health centers, of which $3.6 billion is funded by the Affordable Care Act's Community Health Center Fund, to serve approximately 31 million patients in FY 2015. These resources will support the establishment of 150 new health

centers in areas of the country where they do not currently exist, enhance quality, and support capital development and facility improvements at currently existing health centers, all of which will improve health center capacity to provide quality primary and preventive-health services to existing patients and expand access to new patients.

Health Care Workforce. The Budget makes new and strategic investments in our nation's health care workforce to ensure rural communities and other underserved populations have access to doctors and other providers. In total, $14.6 billion will be invested in three key initiatives: $4 billion in expanded funding for the National Health Service Corps, $5.2 billion for a new Targeted Support for Graduate Medical Education program, and $5.4 billion for enhanced Medicaid reimbursements for primary care.

The $4 billion in new mandatory resources from FY 2015 through FY 2020 is in addition to $100 million in discretionary funding and $310 million in current law funding for FY 2015 for the National Health Service Corps. Corps clinicians serve in medical facilities in high-need areas of the country, including rural areas and federally-funded health centers, where access to care is limited and where shortages of health care professionals often persist. The proposed investment by the Health Resources and Services Administration (HRSA) is projected to support a field strength of 15,000 providers in FYs 2015–2020 and serve the primary care needs of more than 16 million patients.

HRSA will also invest in our nation's health workforce through the new Targeted Support for Graduate Medical Education program. Between FY 2015 and FY 2024, $5.2 billion in total mandatory funding is requested for this effort, to be distributed through a new competitive grant program to teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals or other health care entities. The focus of the targeted support program will be to support ambulatory and preventive care, in order to advance the Administration's goals of higher-value health care that reduces long-term costs. This investment will support 13,000 residents over 10 years.

Concurrent with these efforts at HRSA, CMS will devote $5.4 billion to extend enhanced reimbursements to states for primary care through the end of calendar year 2015, expand eligibility for reimbursements to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care.

Protecting Vulnerable Populations

Programs that Serve American Indians and Alaska Natives. Over the past year, the Indian Health Service (IHS) has actively consulted with tribes and engaged with the White House Council on Native American Affairs to ensure IHS is providing services that both align with tribal priorities and are coordinated with other agencies within the federal government. The FY 2015 Budget funds IHS at $6 billion, an increase of $228 million over FY 2014. The Budget prioritizes funding to reduce health disparities in tribal communities by increasing resources for health care services provided by both IHS and tribes and for critical health services purchased outside of these health systems. It also provides staffing and operating costs for new and replacement facilities that expand both IHS and tribal capacity to provide health care services to American Indians and Alaska Natives. Additionally, the Budget fully funds estimated contract support costs, which assist tribes in administering their own health plans to ensure appropriate decisions about local health care needs are made by those in the best position to make those decisions.

Elder Justice. The FY 2015 Budget proposes $25 million in the Administration for Community Living (ACL) to protect vulnerable older adults by combating the rising scourge of elder abuse, neglect, and exploitation in America. This effort builds on the findings and recommendations of the Elder Justice Coordinating Council, a consortium of federal partners established by the Elder Justice Act of 2009 and led by the HHS Secretary. In response to the recommendations of the Council, ACL will begin developing a national Adult Protective Services data system and provide funding for key research. This investment will help states improve the quality and consistency of their Adult Protective Services programs.

Ryan White HIV/AIDS Program. Serving over half a million low-income people with HIV/AIDS annually, the Ryan White HIV/AIDS Program plays a critical role in supporting patients across the HIV/AIDS continuum and ensuring care across all life stages, genders, and ages. The Budget requests $2.3 billion in FY 2015 to continue linking patients to care, engaging and retaining patients, prescribing and improving adherence to antiretroviral medicine, and achieving viral suppression. The Administration is committed to working with state and local governments, grantees, clients, and other key stakeholders to implement the program in a manner that is responsive both to the impact of expanded insurance coverage and the current demands of the epidemic.

Advancing Scientific Knowledge and Innovation

Promoting Global Health Security. Epidemic threats to national security arise at unpredictable intervals and from unexpected sources. Because these threats do not recognize national borders, the health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, the stability of foreign governments, and the well-being of United States citizens at home. The FY 2015 Budget includes an increase of $45 million for global health security activities in the Centers for Disease Control and Prevention (CDC) to strengthen the capacity to prevent the introduction and spread of global health threats. CDC will help other nations build capacity to manage emerging threats, enhance early disease detection, improve disease confirmation, and effectively respond to epidemics and other public health catastrophes before they reach our borders.

Combating Antibiotic Resistance. While antibiotic resistance is not a new phenomenon, the current magnitude of the problem and the speed in which new resistance is developing pose the possibility of a future without effective treatment options. The Budget includes an increase of $30 million for CDC's Detect and Protect Against Antibiotic Resistance initiative, which will enhance surveillance and laboratory capacity at local, state, and national levels to characterize domestic threats and protect patients from imminent danger.

In FY 2015, the Budget also includes $29 million for the Food and Drug Administration (FDA) to advance the protection of human and animal health through integrated monitoring of antimicrobial resistance. The Budget supports an increase within the FDA food safety program specifically to conduct research to better understand antimicrobial drug use practices in animals and the public health impacts of bacteria.

In addition, the Biomedical Advanced Research and Development Authority (BARDA) anticipates spending $79 million on its Broad Spectrum Antimicrobials program in FY 2015. Throughout the next several years, BARDA plans to build a portfolio in this area of candidate countermeasures, focus on developing applicable drugs, and obtain regulatory approval for use within hospital and community-based settings.

Protect Patients from Healthcare-Associated Infections. CDC estimates that 1 in 20 hospitalized patients acquires a healthcare-associated infection (HAI), and over 1 million HAIs occur across the healthcare spectrum each year at a cost of over $30 billion. HHS is committed to reducing the national rate of HAIs. The Budget includes $44 million for HAI prevention activities at CDC, which include identifying emerging threats and protecting patients across healthcare through outbreak detection and control, gold-standard laboratory testing of the health care environment and contaminated products, and guideline development.

Complementing CDC's efforts, the Agency for Healthcare Research and Quality (AHRQ) focuses on conducting research to develop new methods of preventing and reducing HAIs and disseminates these research findings to clinicians. AHRQ's Comprehensive Unit-based Safety Program accelerates the widespread adoption of evidence-based interventions to prevent HAIs. For example, this effort reduced the rate of central line-associated blood stream infections by 41 percent when implemented in over 1,000 intensive care units. The request includes $34 million for AHRQ's efforts to protect patients from HAIs.

Advancing Biomedical Research. The FY 2015 Budget includes $30.4 billion for the National Institutes of Health (NIH), an increase of $211 million over FY 2014, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that advances medical science while stimulating economic growth. In FY 2015, NIH will focus on generating the basic science for tomorrow's health breakthroughs, translating these basic discoveries into tailored and more effective health interventions, and nurturing 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.

BRAIN Initiative. In FY 2015, NIH plans to spend $100 million on research collaborations with academic institutions, the private sector, and other government agencies on the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. This project will develop new tools to comprehensively and precisely examine 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 and their links to behavior and disease. The NIH contribution is part of a $200 million planned investment in FY 2015 by three government agencies (NIH, the National Science Foundation, and the Defense Advanced Research Project Agency) along with private sector partners.

Big Data. NIH will continue to ramp up efforts in FY 2015 to improve its ability to analyze many of the large and complex digital datasets of information, known as "Big Data," that biomedical researchers are currently generating, such as high-resolution medical images, recorded physiological signals, and complete DNA sequences of large numbers of individuals. Improving the ability to use, protect, 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.

Improving Healthcare through Meaningful Use of Health IT. Health information technology (IT) is essential to improving our nation's health care by moving from a transaction-based system to one that emphasizes quality and value. The Budget includes $75 million for the Office of the National Coordinator for Health Information Technology (ONC) to coordinate and support investments in policies, standards, testing tools, and implementation guides that have dramatically accelerated the adoption and meaningful use of certified Electronic Health Record technologies. Within this total, ONC will begin to address health IT-related patient safety issues under the Health IT Safety Center (Center). In FY 2015, the Center will begin a robust collection and analysis of health IT-related adverse events, which will facilitate benchmark data on the types and frequencies of events. The Center will monitor and analyze data on patient-safety events, potentially unsafe conditions associated with health IT, and patient-safety events that could be prevented by health IT. ONC will work closely with AHRQ, Patient Safety Organizations, the Joint Commission, and FDA on this effort.

Advancing the Health, Safety, and Well-Being of the American People

Supporting Families

Early Head Start—Child Care Partnerships. The Budget proposes $650 million in FY 2015 for Early Head Start – Child Care Partnerships, an increase of $150 million above FY 2014. These funds will support and expand the availability of high quality early learning programs for tens of thousands of infants and toddlers through competitive grants to new and existing Early Head Start programs that partner with child care providers, especially those receiving federal child care subsidies. In addition, the Budget provides $120 million above FY 2014 to strengthen services for children served by the Head Start program. Together, these investments total $8.9 billion, an increase of $270 million over FY 2014.

Unaccompanied Alien Children (UAC). By law, the Administration for Children and Families (ACF) must assume custody of all unaccompanied alien children apprehended by law enforcement who file claims to remain in the United States. ACF provides support to state-licensed group homes to care for these children until ACF can place the children with sponsors. Since FY 2011, the annual number of

arriving UAC has increased from 6,560 to an estimated 60,000 for FY 2014. ACF has implemented strategies to reduce the cost per child, but total costs have risen dramatically as the number of UAC has increased. Due to the volatile nature of this program, the Administration is not able to reliably predict the number of UAC who will arrive in FY 2015 at this time. The FY 2015 Budget for the UAC program is therefore $868 million, the same as FY 2014.

Child Support and Fatherhood Initiative. The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to Temporary Assistance for Needy Families (TANF) recipients. Recognizing that healthy families need more than just financial support alone, the proposal requires states to include provisions in initial child support orders addressing parenting time responsibilities, 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 such as requiring states to implement electronic income withholding orders that will enhance child support collections. The Budget proposes an investment of $1.8 billion over 10 years for these initiatives.

Facilitating Transitions to Adulthood

Youth Transitions. The FY 2015 Budget proposes to better serve the most vulnerable youth. The consequences of not doing so are serious for both individuals and society as a whole. When youth are disconnected from school, work, or family, they cost the nation billions of dollars every year in lost earnings, welfare and medical costs, and unmet personal potential.

The Budget includes $130 million within the Substance Abuse and Mental Health Services Administration (SAMHSA) for the President's *Now is the Time* initiative. This investment provides $20 million to continue the Healthy Transitions program, which will assist 16 to 25 year-olds with mental illnesses and their families in accessing and navigating behavioral health treatment systems to ensure their vulnerability does not hinder their treatment. Youths with mental health conditions are less likely than similar adults to receive care. It is important to ensure these vulnerable youth do not fall through the cracks during this period because having an untreated mental health condition makes young adults more likely to experience homelessness, be arrested, drop out of school, or experience underemployment.

The Budget also provides $5 million within the Administration for Community Living to develop best practices and an evidence base to better support young people with intellectual and developmental disabilities as they transition from adolescence into young adulthood across all systems—health, education, employment, human services, and community living. This initiative stems in part from the findings of a July 2012 GAO Report, *Students with Disabilities: Better Federal Coordination Could Lessen Challenges in the Transition from High School*. GAO's report builds on a growing body of evidence that the success of youth with disabilities exiting high school could be dramatically improved through better coordination across the systems that serve them. The goals of this investment are to increase coordination between federal agencies serving these youth in order to reduce unnecessary institutionalization and to help transitioning youth with intellectual and developmental disabilities become active participants in their communities.

Demonstration to Address the Over-Prescription of Psychotropic Medications for Children in Foster Care. The Budget includes $500 million for a new Medicaid demonstration in partnership with ACF to provide performance-based incentive payments to states through Medicaid, coupled with $250 million in mandatory child welfare funding to support state infrastructure and capacity building. This transformational approach will encourage the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders among children and youth in foster care in order to reduce the over-prescription of psychotropic medications. This new investment and continued collaboration will improve the social and emotional

outcomes for some of America's most vulnerable children.

Strengthening Public Health and Medical Preparedness and Response

Protecting the Public's Health

Modernizing the Nation's Food Safety System. Approximately 15 percent of food consumed in the United States is imported from another country. The increasing globalization of the American food supply is even more prominent within specific products, for example, nearly 50 percent of fresh fruit, 20 percent of fresh vegetables, and 80 percent of seafood are imported. The Administration continues its commitment to transforming the nation's food safety system to one that is prevention based and ready to address today's global challenges. The FY 2015 Budget includes $1.5 billion, an increase of $273 million above FY 2014, to enhance efforts within FDA and CDC to advance implementation of the Food Safety and Modernization Act. The Budget includes an increase of $263 million for FDA to implement regulatory action; enhance technical expertise, including training for federal, state, and tribal partners; improve the safety of imported products; and improve domestic and foreign inspection capacity. The Budget also includes an increase of $10 million for CDC's food safety activities to support and enhance three priorities, all of which are integral provisions of the legislation: providing information to help guide food safety policy; detecting, investigating and stopping foodborne outbreaks; and advancing technology for faster, better foodborne disease control and prevention.

Improving Oversight of Compounding Pharmacies. Ensuring the safety, quality, and availability of medical products available to Americans in the face of increasing complexity in the context of a global market is a critical priority and responsibility for FDA. The recent enactment of the Drug Quality and Security Act expands FDA authorities related to compounding facilities. In order to address this critical area of concern, the Budget invests $25 million for FDA to develop a more robust oversight program in three primary areas: inspections and enforcement activities, policy development, and improved coordination with partners.

Project BioShield and Advanced Development. In FY 2015, HHS will continue to support the development and procurement of medical countermeasures against chemical, biological, radiological, and nuclear threats. The Budget includes $415 million to support advanced research and development through the BARDA and $415 million to develop and procure new measures through Project BioShield. Together, these efforts will improve the nation's ability to prepare for and respond to the most pressing threats.

Pandemic Influenza. The 2013 outbreak of the novel avian influenza virus, H7N9, demonstrated the critical need for sustaining and enhancing the nation's influenza preparedness and response capabilities. Recent advances in science provide the momentum for investments in new strategies in vaccine development. The Budget includes a total investment of $170 million in the Public Health and Social Services Emergency Fund to support pandemic flu activities. Of this amount, $73 million supports the advanced development of a universal influenza vaccine designed to be effective against all strains of flu to protect Americans from an influenza pandemic. The Budget also supports the advanced development of a new class of antivirals to improve effectiveness against virus mutation and drug resistance and supports activities to improve vaccine manufacturing and production efficiency. These efforts, together with the pandemic influenza activities in CDC, NIH, and FDA, will improve the nation's protection against future novel influenza strain outbreaks.

Supporting Prevention

Reducing Tobacco Use. Having set a priority goal to reduce annual combustible tobacco use in the United States, HHS continues to make progress in reducing tobacco consumption and encouraging cessation among current users. The FY 2015 Budget includes $1.1 billion to support tobacco efforts across HHS, an increase of $33 million above FY 2014. FDA will implement the Family Smoking Prevention and Tobacco Control Act through expansions of inspection programs, compliance,

advertising campaigns, and monitoring activities. Of the total in FY 2015, $211 million is for CDC to implement comprehensive tobacco control and prevention activities, enhance educational efforts, expand the Tips from Former Smokers national mass-media campaign, and increase tobacco cessation quitline capacity. HHS will continue work through the Tobacco Control Implementation Committee to align Departmental strategies with the Healthy People 2020 objective and the HHS Tobacco Control Strategic Plan in order to most effectively lead the nation toward a tobacco-free generation. The Budget also proposes to increase the tax on cigarettes to $97.65 per 1,000 cigarettes (or about $1.95 per pack) increase all other tobacco taxes by about the same proportion, and index the taxes for inflation after 2014.

Preventing Prescription Drug Overdose. The Budget includes $26 million for new interventions to fight prescription drug misuse, abuse, and overdose. This investment includes a $16 million increase for CDC to expand the existing State Core Violence and Injury Prevention Program to additional states with a high burden of prescription drug overdose. This investment will help state health departments enhance their infrastructure and implement a structured set of interventions to understand the nature of the epidemic unique in each state, leverage the best available evidence to save lives, and adopt foundational overdose prevention practices. Also within the total, the Budget includes a $10 million increase for SAMHSA to help state substance abuse authorities develop comprehensive prevention approaches through collaboration with state partners and integration of health information exchange systems with strategic plans.

Ensuring Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Continuing Program Integrity and Oversight

Combating Fraud, Waste, and Abuse in Health Care. The FY 2015 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 2015, the Budget seeks new mandatory funding. Starting in FY 2016, the Budget proposes that 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; reducing improper payments in Medicare, Medicaid, and CHIP; and HHS–Department of Justice Health Care Fraud Prevention and Enforcement Action Team initiatives, including the Fraud Prevention Partnership between the federal government, private insurers, and other key stakeholders. The Budget's 10-year investment in HCFAC yields a conservative estimate of $7.4 billion in Medicare and Medicaid savings.

To help ensure the prudent use of federal funds, the Budget also includes $25 million in discretionary HCFAC funding for program integrity activities in private insurance, including the Marketplaces.

The Budget includes $400 million in discretionary and mandatory funding for the Office of Inspector General (OIG), an increase of $105 million above FY 2014. 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 will enhance investigative efforts focused on civil fraud, oversight of grants, and the operation of Affordable Care Act programs.

The Budget also includes $100 million for the Office of Medicare Hearings and Appeals (OMHA), an increase of $18 million above FY 2014. OMHA received over 600,000 claims in FY 2013 compared to 313,000 received in FY 2012. The Budget will support adjudicatory capacity and central operations case processing in order to address a critical backlog in the number of appeals and maintain the quality and accuracy of its decisions.

Medicaid Program Integrity. States have the primary responsibility for combating fraud and abuse in the Medicaid program. CMS supports this effort through technical assistance and by contracting with eligible entities to carry out reviews, audits, identification of overpayments, education activities, and technical support. Other key CMS efforts include measuring Medicaid improper payments and efforts to transform the Medicaid data enterprise through the Medicaid and

CHIP Business Information and Solutions program to provide states, auditors, and reviewers timely access to more complete encounter data and other claims information. The Budget includes an additional $25 million for the Medicaid Integrity Program.

340B Prescription Drug Discount Program. The 340B prescription drug program facilitates discounts on outpatient prescription drugs to safety-net clinics and hospitals. The Budget includes $17 million for the program, an increase of $7 million, to establish a cost recovery fee to improve program integrity and oversight.

Ensuring Responsible Stewardship of Taxpayer Dollars

Contributing to Deficit Reductions while Maintaining Promises to all Americans. The FY 2015 Medicare and Medicaid legislative proposals seek to strengthen these programs through payment innovations and other reforms that encourage high-quality and efficient care while continuing to reduce health care cost growth. Medicare savings would total $407 billion over 10 years by encouraging beneficiaries to seek value in their health care choices, strengthening provider payment incentives to promote high-value and efficient care, and lowering drug costs. The Budget includes $7.3 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable. Together, the FY 2015 legislative proposals allow HHS to support the Administration's complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Opportunity, Growth, and Security Initiative

The Budget proposes a $56 billion, government-wide initiative to support both domestic and security expenditures that reflect the President's priorities to grow the economy and create opportunities. Resources for the initiative would be offset with a balanced package of spending reductions and the closing of tax loopholes. Multiple, specific HHS programs would benefit from the initiative.

National Institutes of Health. An additional $970 million would be provided by the initiative to increase the NIH budget to $31.3 billion. Funds would be used to increase the number of new grants funded by 650, and provide additional resources for signature activities such as the BRAIN Initiative, improving the sharing and analysis of complex biomedical data sets, expanding research on Alzheimer's disease and vaccine development, further accelerating partnership efforts to identify and develop new therapeutic drug targets, and other innovative projects. These investments would allow NIH to accelerate progress in areas that are priority public health concerns, deepen our understanding of disease, and establish a stronger foundation for entirely new approaches to the development of the next generation of treatments.

Universal Influenza Vaccine Development. The initiative would provide an additional $50 million to support the advanced development of vaccine candidates for a universal influenza vaccine and to support activities to improve the basic effectiveness of existing vaccines. Successful development of a universal influenza vaccine would provide individuals with immunity across influenza strain types, providing the nation with more security against the threat of an annual influenza pandemic. Within the Public Health and Social Services Emergency Fund, this investment would bring total funding for universal influenza vaccine development to $123 million in FY 2015.

Investing in Health Care Facilities Construction within IHS. The initiative would provide an additional $200 million for projects on the IHS health care facilities construction priority list. This funding would build upon the FY 2015 request of $85 million to IHS to ensure that IHS could continue to provide appropriate, state-of-the-art care to American Indians and Alaska Natives in the future. IHS would be able to build two to three additional health care facilities with this additional funding.

Head Start. The initiative would also provide an additional $800 million to further expand Early Head Start – Child Care Partnerships. This investment would bring total funding for Early Head Start – Child Care Partnerships to $1.5 billion in FY 2015, and serve over 100,000 children in high-quality early learning programs. The initiative would also provide additional resources to support Head Start programs that expand program duration and invest in teacher quality.

HHS BUDGET BY OPERATING DIVISION

mandatory and discretionary dollars in millions	2013	2014	2015
Food and Drug Administration /1			
Budget Authority	2,073	2,642	2,586
Outlays	1,537	2,668	2,877
Health Resources and Services Administration			
Budget Authority	8,370	9,142	10,404
Outlays	8,645	9,121	9,514
Indian Health Service			
Budget Authority	4,287	4,590	4,792
Outlays	4,274	4,607	4,883
Centers for Disease Control and Prevention			
Budget Authority	6,273	7,170	6,674
Outlays	6,617	6,783	6,624
National Institutes of Health			
Budget Authority	29,291	30,142	30,353
Outlays	30,976	31,124	29,705
Substance Abuse and Mental Health Services Administratior			
Budget Authority	3,226	3,497	3,356
Outlays	3,225	3,701	3,409
Agency for Healthcare Research and Quality			
Budget Authority	6	7	—
Program Level	430	464	440
Outlays	319	343	113
Centers for Medicare & Medicaid Services /2			
Budget Authority	769,182	850,810	906,799
Outlays	777,258	844,379	897,235
Administration for Children and Families			
Budget Authority	49,592	51,158	51,316
Outlays	50,430	50,072	51,490
Administration for Community Living			
Budget Authority	1,407	1,647	2,058
Outlays	1,440	1,563	1,903
Office of the National Coordinator			
Budget Authority	15	16	—
Outlays	551	414	53

1/ The Budget Authority levels for FDA are based on the Appendix and will differ from levels displayed in the FDA section. In FY 2013, the difference is due to the timing and availability of user fee collections, and in FY 2014, the inclusion of sequestered user fees made available in FY 2014.

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

HHS BUDGET BY OPERATING DIVISION

mandatory and discretionary dollars in millions	2013	2014	2015
Office of Medicare Hearings and Appeals			
Budget Authority	69	82	100
Outlays	73	91	100
Office for Civil Rights			
Budget Authority	39	39	41
Outlays	40	39	41
General Departmental Management			
Budget Authority	470	481	416
Outlays	582	855	590
Health Insurance Reform Implementation Fund /3			
Budget Authority	—	—	—
Outlays	221	163	100
Public Health and Social Services Emergency Fund			
Budget Authority	588	1,243	1,423
Outlays	1,769	1,784	1,905
Office of Inspector General			
Budget Authority	52	71	75
Outlays	41	66	81
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)			
Budget Authority	636	658	678
Outlays	515	1,145	643
Offsetting Collections			
Budget Authority	-2,041	-841	-787
Outlays	-2041	-841	-787
Total, Health and Human Services			
Budget Authority	**873,535**	**962,554**	**1,020,284**
Outlays	**886,472**	**958,077**	**1,010,479**
Full-time Equivalents	74,992	77,457	79,540
3/ Includes outlays for all agencies receiving resources from the fund.			

COMPOSITION OF THE HHS BUDGET
DISCRETIONARY PROGRAMS

dollars in millions	2013 /1	2014	2015	2015 +/-2014
Discretionary Programs (Budget Authority):				
Food and Drug Administration	2,386	2,561	2,584	+23
Program Level	*4,031*	*4,387*	*4,745*	*+358*
Health Resources and Services Administration	5,861	6,061	5,300	-761
Program Level	*8,097*	*8,915*	*10,753*	*+1,838*
Indian Health Service	4,131	4,435	4,634	+200
Program Level	*5,307*	*5,761*	*5,989*	*+228*
Centers for Disease Control and Prevention	5,503	5,882	5,474	-407
Program Level	*10,243*	*10,806*	*11,117*	*+311*
National Institutes of Health	29,001	30,003	30,203	+200
Program Level	*29,151*	*30,151*	*30,362*	*+211*
Substance Abuse and Mental Health Services Administration	3,210	3,435	3,298	-137
Program Level	*3,354*	*3,631*	*3,568*	*-63*
Agency for Healthcare Research and Quality	—	—	—	—
Program Level	*430*	*464*	*440*	*-24*
Centers for Medicare & Medicaid Service	3,737	3,973	4,200	+227
Program Level	*5,154*	*5,344*	*12,398*	*+7,054*
Administration for Children and Families	15,759	17,677	17,040	-637
Program Level	*15,765*	*17,683*	*17,046*	*-637*
Administration for Community Living	2,031	2,097	2,062	-34
Program Level	*2,074*	*2,147*	*2,123*	*-24*
Office of the Secretary:				
General Departmental Management	447	458	286	-172
Program Level	*540*	*550*	*535*	*-16*
Office of Medicare Hearings and Appeals	69	82	100	+18

COMPOSITION OF THE HHS BUDGET
DISCRETIONARY PROGRAMS

dollars in millions	2013	2014	2015	2015 +/-2014
Office of the National Coordinator	15	16	—	-16
Program Level	*60*	*60*	*75*	*+14*
Office of Inspector General	47	71	75	+4
Program Level	*276*	*295*	*400*	*+105*
Office for Civil Rights	39	39	41	+2
Public Health and Social Services Emergency Fund	553	1,243	1,423	+180
Program Level	*968*	*1,243*	*1,438*	*+194*
Discretionary HCFAC	294	294	319	+25
Accrual for Commissioned Corps Health Benefits	28	27	25	-2
Total, Discretionary Budget Authority	**73,112**	**78,354**	**77,065**	**-1,289**
Discretionary Supplemental Funding /2	*+285*	—	—	—
Less One-Time Rescissions /3	*-6,578*	*-6,317*	*-5,234*	*+1,083*
Revised, Discretionary Budget Authority	**66,819**	**72,037**	**71,831**	**-206**

1/ The FY 2013 figures represent the funding levels provided by the Full-Year Continuing Appropriations Act (P.L. 113-6), and reflects the cuts required by sequestration.

2/ Reflects funding provided by the Disaster Relief Appropriations Act (P.L. 113-2).

3/ 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 rescission is $6.2 billion from CHIPRA performance bonuses. The FY 2015 Budget proposes to rescind $1.8 billion from CHIPRA performance bonuses, $2.1 billion from the CHIP Contingency Fund, and $1.4 billion from the unobligated balances of the FY 2015 CHIP national allotment.

COMPOSITION OF THE HHS BUDGET
MANDATORY PROGRAMS

dollars in millions	2013	2014	2015	2014 +/- 2013
Mandatory Programs (Outlays):				
Medicare	491,783	513,148	526,019	+12,871
Medicaid	265,392	308,615	335,962	+27,347
Temporary Assistance for Needy Families /1	17,806	17,578	17,488	-90
Foster Care and Permanency	6,847	6,803	6,955	+152
Children's Health Insurance Program /2	9,483	10,289	10,621	+332
Child Support Enforcement	4,066	3,887	4,092	+205
Child Care	2,872	2,901	3,512	+611
Social Services Block Grant /3	5,476	1,847	2,442	+595
Other Mandatory Programs	6,018	12,594	24,601	+12,007
Offsetting Collections	-2,041	-841	-787	+54
Subtotal, Mandatory Outlays	**807,702**	**876,821**	**930,905**	**+54,084**
Total, HHS Outlays	**886,472**	**958,077**	**1,010,479**	**+52,402**

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	2013	2014 /1	2015	2015 +/- 2014
Program				
Foods	813	900	1,124	+224
Human Drugs	1,187	1,289	1,336	+47
Biologics	308	338	343	+5
Animal Drugs and Feeds	155	173	190	+16
Medical Devices	384	428	441	+13
National Center for Toxicological Research	55	62	59	-3
Center for Tobacco Products	459	501	532	+30
Headquarters and Office of the Commissioner	251	275	295	+19
FDA Consolidation at White Oak	57	62	47	-15
GSA Rental Payment	199	220	236	+16
Other Rent and Rent Related Activities	100	116	121	+4
Food and Drug Safety One-Time Resource	46	--	--	--
Subtotal, Salaries and Expenses	4,014	4,366	4,723	+357
Export Certification Fund	5	5	5	+0.1
Color Certification Fund	7	7	9	+2
Buildings and Facilities	5	9	9	--
Total, Program Level	**4,031**	**4,387**	**4,745**	**+358**
Current Law User Fees /2				
Prescription Drug (PDUFA)	683	760	798	+38
Medical Device (MDUFA)	93	115	128	+13
Animal Drug (ADUFA)	23	24	22	-1
Animal Generic Drug (AGDUFA)	6	7	7	-0.4
Food Reinspection	15	15	6	-9
Food Recall	12	13	1	-11
Family Smoking Prevention and Tobacco Control Act	480	534	566	+32
Generic Drug (GDUFA)	284	306	312	+6
Biosimilars (BSUFA)	19	21	21	+0.3
Mammography Quality Standards Act (MQSA)	18	19	20	+0.4
Export Certification Fund	5	5	5	+0.1
Color Certification Fund	7	7	9	+2
Voluntary Qualified Importer Program	--	--	5	+5
Subtotal, Current Law User Fees	**1,645**	**1,826**	**1,901**	**+75**
Proposed Law User Fees				
Food Facility Registration and Inspection	--	--	60	+60
Food Import	--	--	169	+169
Food Substance Contact Notification	--	--	5	+5
Cosmetics	--	--	19	+19
International Courier	--	--	6	+6
Subtotal, Proposed Law User Fees	--	--	**260**	**+260**
Less Total, User Fee	**1,645**	**1,826**	**2,161**	**+335**
Total, Discretionary Budget Authority	**2,386**	**2,561**	**2,584**	**+23**
Full-time Equivalents	14,141	15,872	16,905	+1,033

1/ In addition to these resources, section 747 of the Consolidated Appropriations Act, 2014 makes user fees sequestered in FY 2013 available for obligation in FY 2014. The estimate as of September 30, 2013 totals $79 million and will be revised as updated information on FY 2013 collections is available.

2/ The Drug Quality and Security Act (P.L. 113-54) authorized three new FDA user fees: the outsourcing facility fees; the prescription drug wholesale distributer licensing and inspection; and, the third-party logistics provider licensing and inspection fees. It is expected that collections for FY 2015 will be minimal.

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 2015 Budget includes $4.7 billion for the Food and Drug Administration (FDA), an increase of $358 million, or 8 percent, above FY 2014. This increase consists of $23 million in budget authority and $335 million in user fees. The FDA budget advances mission critical activities as well as the highest priority public health challenges, such as modernizing the food safety system, ensuring the safety of medical products, advancing medical countermeasures, and continuing implementation of the Tobacco Control Act to reduce tobacco use and initiation as well as encourage the cessation of tobacco use.

Modernizing the Food Safety System

The Food Safety Modernization Act (FSMA) was enacted in 2011 to modernize the food safety system to meet 21st century global challenges. These new authorities enable FDA to focus on preventing outbreaks of foodborne illness and other food related hazards to improve the public's health, reduce medical costs, and avoid interruptions to the nation's food supply. Three years after the enactment of FSMA, FDA has issued required regulations, conducted stakeholder outreach, and increased capacity to support a prevention-based and integrated food safety system. FDA also created the Coordinated Outbreak Response and Evaluation (CORE) network which improves the efficiency of FDA programs, in coordination with federal and state partners, including CDC and the Department of Agriculture, to respond to and manage human and animal foodborne illness outbreaks. For example, in 2013, the network aided the response and investigation into a multi-state outbreak of *E. coli* infection which resulted in the recall of the contaminated produce that caused the outbreak. Through the CORE network, FDA was able to provide a faster and more coordinated agency-wide response to this incident.

PROGRAM HIGHLIGHT

Ensuring the Safety of Nation's Food Supply

The impact of food and feed supply contamination can be costly to consumers, the food industry, and the health care system. The Food Safety Modernization Act shifts the nation's food safety system to one that is based on prevention to protect the food supply for humans and animals. By the end of January 2014, FDA issued seven proposed rules which set requirements for farmers, food industry, and food importers to serve as the foundation for a preventive approach:

- Preventive Controls for Human Food;
- Preventive Controls for Animal Food;
- Produce Safety Standards;
- Foreign Supplier Verification Program for Importers;
- Accreditation of Third-Party Auditors;
- Prevention of International Adulteration; and,
- Sanitary Transportation of Human and Animal Food.

FDA will continue to hold public meetings on these proposed rules and conduct outreach during the relevant comment periods to gather input from a broad spectrum of stakeholders. In FY 2015, FDA will continue implementation of final regulations.

The FY 2015 Budget includes a total program level of $1.5 billion, $263 million above FY 2014, for FDA to build and expand on current food safety activities**.** With increased budget authority, in FY 2015 FDA will focus on five main activities including 1) rulemaking and guidance development to support regulatory action; 2) technical support to ensure safety standards are effective and efficient; 3) food safety regulatory training and capacity among stakeholders and partners, including federal, state, local, tribal and international entities; 4) risk analysis to support priority setting; and, 5) research to better understand the impact of antimicrobial resistance on public health.

CDC estimates that 48 million foodborne illnesses occur each year from contaminated foods. The FY 2015 total for food safety at FDA includes $229 million from the food import fee and the food facility registration and inspection fee. These proposed additional revenues are vital to funding the key FSMA activities planned for FY 2015, including enhancing food facility inspection capacity and admissibility review of food and fee imports. This increase is especially critical as FDA continues to regulate about 76 percent, more than $702 billion, of the food supply in the United States of which a growing proportion, approximately 15 percent overall and significantly more for specific products such as seafood, is imported from other countries. These resources will enable FDA to invest upfront in building the regulatory framework needed to realize the vision of FSMA.

The Budget also proposes a $5 million food contact notification user fee to better position FDA to reduce microbial food contamination through premarket notification to ensure the safety of food contact substances. In addition, currently authorized fees such as the voluntary qualified importer program, export certification, and the food reinspection and recall fees will continue to support agency-wide food safety activities. These current fees enable FDA to expedite processes such as the timely assessment of color additives used in foods, drugs, and cosmetics, and approval of certifications to facilitate international trade.

Enhancing Medical Product Safety

FDA oversees the safety, effectiveness, availability, and quality of an extensive range of regulated products available to Americans, which encompasses prescription and over-the-counter drugs; biologics including vaccines, blood products, and gene therapies; animal drugs; and, medical devices ranging from bandages to laser surgical equipment and radiation emitting products. FDA also ensures that regulated products are marketed according to federal standards and that products available to the public continue to be safe especially as new clinical information becomes available. The FY 2015 Budget includes a program level of $2.6 billion, $61 million above FY 2014, to continue core medical product safety activities across FDA. In order to address challenges with human drugs personalized for individual patient needs, known as compounding, the Budget includes $25 million for a new agency-wide initiative to expand and improve oversight of drug compounding to ensure that such products available to Americans are safe and effective. This initiative, along with clarity provided in the Drug Quality and Security Act, will position FDA to prevent events such as the multi-state outbreak of fungal meningitis in 2012 among patients who received contaminated steroid injections from a compounding center in New England. FDA will establish a more comprehensive system for drug safety. In particular, these resources will support three primary activities:

- Inspections and Enforcement: FDA will continue reactive inspections, ensure compliance with corrective actions, and conduct additional new proactive inspections of higher risk pharmacies.

- Policy Development: FDA will develop required regulations and guidances to oversee compounding pharmacies.

- State Collaboration and Coordination: FDA will strengthen coordination and communication with states to improve oversight, as well as investing in training state inspectors to improve facility compliance with FDA standards.

In 2013, FDA worked with a network of partners to help prevent 170 drug shortages to ensure the continued supply of products including lifesaving medicines. Of the total $2.6 billion for medical product programs, $1.3 billion is in budget authority to fund the highest priority drugs, biologics, and device activities in FY 2015 including applied research, domestic and foreign facility inspections, and pre and post market surveillance to ensure the products available to Americans are timely, safe, and effective. FDA will continue to implement key new responsibilities authorized in the FDA Safety and Innovation Act and the Drug Quality and Security Act.

In addition, FDA continues to work toward meeting performance goals and commitments associated with all user fees, especially the newer human generic drugs and biosimilar biological products programs. FDA is also working to implement new fees authorized in the Drug Quality and Security Act to support new provisions associated with drug safety.

NEW AUTHORIZATION

Drug Quality and Security Act

The Drug Quality and Security Act, enacted in November 2013, addresses two significant challenges for FDA in fulfilling its mission: oversight of compounding pharmacies and effective tracking of the drug supply chain.

Pharmacy Compounding: The Act helps clarify which compounded human drug products are or are not subject to FDA regulation, establishes requirements for compounding entities that register with FDA as an outsourcing facility, and specifies regulatory action that would apply to compounding pharmacies that do not register with FDA and do not fall into the categories of established exceptions.

Drug Supply Chain Safety: The Act also establishes a path to build an electronic, interoperable system that will improve the identification and traceability of certain prescription drugs available to Americans. These drug safety system enhancements are to be achieved through unique product identifiers; tracking product and transaction information as products are sold in the U.S. market; improved detection, response, and notification for any unapproved or potentially dangerous products; and, licensing of wholesale distributors and third-party logistics providers.

Reducing the Use and Harms of Tobacco

Tobacco remains the leading preventable cause of disease, disability, and death in the United States. The FY 2015 Budget includes $566 million in user fees, an increase of $32 million over FY 2014, for the FDA Center for Tobacco Products, the Office of Regulatory Affairs tobacco field programs, and related activities. These resources will be used to continue implementation of the Family Smoking Prevention and Tobacco Control 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.

FDA carries out these responsibilities by regulating the manufacturing, marketing, and distribution of tobacco products and through other public health initiatives.

In FY 2015, FDA will expand the Tobacco Retail Inspection program, which awards contracts to states and territories to conduct compliance inspections of tobacco product retail establishments; advertising and labeling activities to ensure the public does not receive deceptive information; enforcement activities including monitoring compliance with registration requirements; and research to better understand risks and potential harms of tobacco products. In addition, FDA will also continue training and educational activities for tobacco manufacturers and retailers to ensure compliance and awareness, outreach efforts to educate the public about the harms of tobacco products, inspection activities, and criminal and civil investigations. Activities will build on recent accomplishments such as the campaign launched in February 2014 to reduce tobacco use in youth.

Advancing Medical Countermeasures

The FDA Medical Countermeasure Initiative ensures the nation has countermeasures in place to protect against chemical, biological, radiological, and nuclear threats, as well as emerging infectious disease threats. The FY 2015 Budget includes $25 million for this initiative, the same as in FY 2014. These resources will help accelerate development, evaluation and approval, and establish a clear regulatory, legal, and policy framework to support emergency preparedness and response.

User Fees

The Budget proposes five new user fees across FDA and reflects scheduled increases in currently authorized user fees. Resources from these user fees are critical to enable FDA to carry out its mission. The Budget includes the proposed fees described in the narratives above as well as well as two additional user fees proposed for FY 2015. 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 as the volume of both domestic and imported cosmetic products continues to grow and manufacturing technology and ingredients become more complex. FDA will be in the process of establishing new fee programs in FY 2015 to

begin collecting revenues authorized under the Drug Quality and Security Act.

FDA Infrastructure and Facilities

The FY 2015 Budget focuses resources on the highest priority infrastructure demands to ensure that FDA facilities have the capacity to support the agency's broad and growing authorities as well as keep up with the modern economy. The amounts in the Budget reflect the current estimates of what is needed to continue efforts to consolidate FDA programs to the White Oak campus in Maryland based on the construction timeline. The Budget will support activities associated with the move of over 2,000 federal staff to the White Oak campus beginning in FY 2014 where they will have access to the state-of-the-art Life Sciences-Biodefense Complex in addition to other campus facilities.

In addition, the Budget provides $9 million, the same as FY 2014, 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.

PROGRAM HIGHLIGHT

Reducing Youth Tobacco Use

In February 2014, FDA launched the "Real Cost" campaign, a national public education effort to reduce the number of youth between the ages of 12 to 17 who become regular smokers.

The campaign will be the first of other planned educational efforts over several years to advance implementation of the Family Smoking Prevention and Tobacco Control Act. The Real Cost campaign uses multiple types of media approaches and platforms, including television, radio, print and online marketing, to engage youth on the health consequences of using tobacco products.

The investment of $115 million from tobacco user fees will support the campaign over the next year throughout the United States.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

dollars in millions	2013	2014	2015	2015 +/- 2014
Primary Care				
Health Centers	2,856	3,545	4,511	+966
ACA Mandatory (non-add)	*1,465*	*2,145*	*3,600*	*+1,455*
Health Centers Tort Claims	89	95	89	-6
ACA School Based Health Centers	47	--	--	--
Free Clinics Medical Malpractice	0.038	0.040	0.040	--
Subtotal, Primary Care	**2,992**	**3,640**	**4,600**	**+960**
Health Workforce				
Clinician Recruitment and Service:				
National Health Service Corps	285	283	810	+527
Discretionary Budget Authority (non-add)	--	--	*100*	*+100*
ACA Mandatory (non-add)	*285*	*283*	*310*	*+27*
New Mandatory Proposal (non-add)	--	--	*400*	*+400*
Other Clinician Recruitment and Services	79	81	81	--
Health Professions:				
Training for Diversity	80	81	67	-14
Health Workforce Information and Analysis	3	5	5	--
Primary Care Training and Enhancement	37	37	37	--
Oral Health Training	31	32	32	--
Interdisciplinary, Community-Based Linkages	62	72	51	-20
Prevention and Public Health Fund (non-add)	*2*	--	--	--
Public Health Workforce Development	8	18	18	--
Nursing Workforce Development	140	144	144	--
PHS Evaluation Funds (non-add)	--	--	*62*	*+62*
Children's Hospital Graduate Medical Education	251	265	--	-265
Rural Physician Training Grants	--	--	4	+4
Graduate Medical Education (New Mandatory Proposal)	--	--	530	+530
Children's Hospital Set-Aside (non-add)	--	--	*100*	*+100*
National Practitioner Data Bank User Fees	27	27	19	-9
Subtotal, Health Workforce	**1,001**	**1,045**	**1,798**	**+753**
Maternal and Child Health				
Maternal and Child Health Block Grant	605	634	634	--
Autism and Other Developmental Disorders	45	47	47	--
Traumatic Brain Injury	9	9	9	--
Sickle Cell Service Demonstrations	4	4	4	--
Universal Newborn Hearing Screening	18	18	18	--
Emergency Medical Services for Children	20	20	20	--
Healthy Start	98	101	101	--
Heritable Disorders	9	12	12	--
Family to Family Health Information Centers (Mandatory)	5	3	--	-3
Home Visiting	380	371	500	+129
ACA Mandatory Funding (non-add)	*380*	*371*	--	*-371*
New Mandatory Proposal (non-add)	--	--	*500*	*+500*
Subtotal, Maternal and Child Health	**1,193**	**1,220**	**1,346**	**+126**

HEALTH RESOURCES AND SERVICES ADMINISTRATION

dollars in millions	2013	2014	2015	2015 +/- 2014
Ryan White HIV/AIDS				
Emergency Relief - Part A	624	656	656	--
Comprehensive Care - Part B	1,288	1,315	1,315	--
AIDS Drug Assistance Program (non-add)	*886*	*900*	*900*	--
Early Intervention - Part C	194	201	280	+79
Children, Youth, Women, and Families - Part D	72	75	--	-75
Education and Training Centers - Part F	32	34	34	--
Dental Services - Part F	13	13	13	--
Special Projects of National Significance (PHS Evaluation)	25	25	25	--
Subtotal, HIV/AIDS	**2,249**	**2,319**	**2,323**	**+4**
Health Care Systems				
Organ Transplantation	23	24	24	+0.5
Cord Blood Stem Cell Bank	11	11	11	--
C.W. Bill Young Cell Transplantation Program	22	22	22	--
Poison Control Centers	18	19	19	--
340B Drug Pricing Program	4	10	17	+7
User Fee (non-add)	--	--	*7*	*+7*
Hansen's Disease Programs	17	17	17	--
Subtotal, Health Care Systems	**95**	**103**	**111**	**+7**
Rural Health				
Rural and Community Access to Emergency Devices	2	3	--	-3
Rural Hospital Flexibility Grants	38	41	26	-14
Other Rural Health	90	98	98	--
Subtotal, Rural Health	**131**	**142**	**125**	**-18**
Other Activities				
Family Planning	278	286	286	--
Program Management	151	153	157	+4
Vaccine Injury Compensation Program Direct Operations	6	6	8	+1
Subtotal, Other Activities	**436**	**446**	**451**	**+5**
Total, Program Level	**8,097**	**8,915**	**10,753**	**+1,838**
Less Funds From Other Sources				
PHS Evaluation Funds	-25	-25	-87	-62
User Fees	-27	-27	-26	+2
Prevention and Public Health Fund	-2	--	--	--
Appropriated Mandatory Funding	-2,182	-2,801	-3,910	-1,109
New Mandatory Proposals	--	--	-1,430	-1,430
Total, Discretionary Budget Authority	**5,861**	**6,061**	**5,300**	**-761**
Full-time Equivalents	1,902	1,940	1,983	+43

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 Health Resources and Services Administration (HRSA) is the principal federal agency charged with improving access to health care services for people who are medically underserved. Millions of families still face barriers to quality health care because of their income, geographic isolation, or language barriers. HRSA programs work to minimize these barriers by promoting improvements in access, quality, and equity that are essential for a healthy nation. To support this mission, the FY 2015 Budget requests $10.8 billion, including $1.4 billion for new mandatory proposals.

Providing Access to High-Quality, Affordable Primary Care

Health Centers: Health centers are a critical component of the health care system, providing comprehensive primary care services in medically underserved communities. The Budget includes $4.6 billion for the Health Center program, including $3.6 billion in mandatory funding provided through the Affordable Care Act, a total increase of $960 million above FY 2014. Funding will serve approximately 31 million patients at over 1,300 health centers that operate more than 9,500 service delivery sites and provide care in every state, the District of Columbia, Puerto Rico, the United States Virgin Islands, and the Pacific Basin.

INSURANCE EXPANSION

Outreach and Enrollment

Community health centers are on the front line of helping uninsured residents enroll in new health insurance options available in the Health Insurance Marketplaces under the Affordable Care Act, through expanded access to Medicaid in many states, and new private health insurance options and tax credits. Since FY 2013, HRSA has awarded more than $200 million in grants to over 1,100 health centers to provide expanded assistance for people in communities nationwide looking for help in understanding their insurance options and enrolling in affordable coverage.

The Budget requests resources to meet an increase in newly-insured patients seeking care at health centers across the country. After the passage of health reform in Massachusetts, health centers saw a significant increase in the number of patients, many of whom were newly insured. In addition to continuing to serve newly-insured patients in FY 2015, health centers will also remain a vital source of primary care for patients who cannot gain access to coverage, as well as insured patients seeking a quality source of care for services, including services not covered by insurance.

FY 2015 is the final year under current law for the Health Center Fund established in the Affordable Care Act. In FY 2015, $100 million is allocated to fund 150 new health center sites that will serve an additional 900,000 patients. Further, approximately $860 million is allocated for one-time quality improvement and capital development awards that will support new renovation, expansion, or construction projects, to improve health center capacity to provide quality primary and preventive health services to existing patients and expand access to new patients. The Budget includes a proposal to continue mandatory funding for health centers in FYs 2016, 2017, and 2018 at $2.7 billion per year, for a total investment of $8.1 billion.

Strengthening the Nation's Health Workforce Capacity

As health insurance coverage expansions that began in 2014 continue nationwide, it is vital to make targeted investments that promote a high-performing health workforce. In order to ensure that all Americans have access to high quality care, HRSA's health workforce programs seek to provide targeted support for health professions and for parts of the country where shortages of health professionals exist. To this end, the Budget provides a total of $1.8 billion for HRSA workforce programs, a total that includes $1.2 billion in mandatory funding, to expand the nation's health workforce capacity and to target health workforce resources to where they are needed most.

National Health Service Corps: The Budget includes $810 million for the National Health Service Corps, of which $710 million is mandatory funding. Since its inception in 1972, the Corps has worked to build healthy communities by supporting qualified health care providers dedicated to working in rural and other areas of the country where access to care is limited and where shortages of health care professionals persist. Nearly half of all current Corps providers work in rural communities. Approximately 50 percent of National Health Service Corps clinicians serve in health centers around the country. With this level of funding going forward, the Corps is projected to support a field strength of over 15,000 providers over FYs 2015-2020 and serve primary health care needs of more than 16 million patients.

Targeted Support for Graduate Medical Education: The Budget includes $530 million in mandatory funding for a new program, Targeted Support for Graduate Medical Education. This new competitive grant program will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs.

The new Targeted Support for Graduate Medical Education Program will incorporate two existing HRSA programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with a minimum of $100 million set-aside specifically for children's hospitals in FY 2015. The Budget proposes to continue mandatory funding for the new Targeted Support for Graduate Medical Education program annually in FYs 2015-2024, for a total investment of $5.2 billion.

Training and Assistance for Health Professionals: 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. Within the total provided for Health Workforce, $144 million is provided to develop the nation's nursing workforce through programs that, among other strategies, support the enhancement of advanced nursing education and practice, increased nursing education opportunities for individuals from disadvantaged backgrounds, and an expanded nursing pipeline. In addition, $32 million is provided for Oral Health Training programs, $37 million is provided for the Primary Care Training and Enhancement program, $33 million is provided for Geriatric programs, $18 million is provided for Public Health Workforce Development, and $8 million is provided for Mental and Behavioral Health Education and Training programs.

The Budget also provides for two new workforce initiatives, including $10 million to support a new Clinical Training in Interprofessional Practice program to increase the capacity of community-based primary health care teams to deliver quality care. In addition, the Budget provides $4 million to fund new Rural Physician Training grants to help rural-focused training programs recruit and graduate students most likely to practice medicine in underserved rural communities.

INITIATIVE

Building a Health Workforce for the 21st Century

The Budget proposes over $14 billion in new investments beginning in FY 2015 to bolster the nation's health workforce and to improve the delivery of health care across the country. HRSA is spearheading two components of the workforce initiative:

- Between FY 2015 and FY 2020, HRSA will devote a total of $4 billion in mandatory funding to the National Health Service Corps to address health professional shortages in high-need rural and urban communities across the country.
- Starting in FY 2015, HRSA will devote $5.2 billion to a new Targeted Support for Graduate Medical Education program, a competitive grant program aimed at supporting medical residency positions across the country that advance key workforce goals, including the training of more physicians in primary care and understaffed specialties and encouraging physicians to practice in rural and other underserved areas.
- Concurrent with these efforts at HRSA, the Medicaid primary care payment increase will be extended through CY 2015 with modifications to expand eligibility for reimbursements to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care. This extension is estimated to cost $5.4 billion.

Improving Access to and Retention in HIV Care

Ryan White HIV/AIDS Program: Working with cities, states, and local community-based organizations, the Ryan White Program provides HIV-related services to more than half a million people each year who do not have sufficient health care coverage or financial resources for coping with HIV. As a payor of last resort, the Ryan White Program fills gaps in care not covered by other sources.

Many Ryan White clients will continue to gain access to health insurance or see their current health insurance improve in FY 2015 as a result of the Affordable Care Act. To respond to these changes, as well as changes in the epidemic, the federal government will continue thoughtful and careful coordination with state and local governments, Ryan White Program grantees, and clients.

The Budget includes $2.3 billion for the Ryan White HIV/AIDS Program to improve and expand access to care for persons living with HIV/AIDS. Of this amount, $900 million, the same level provided in FY 2014, is included for the AIDS Drug Assistance Program to ensure that people living with HIV/AIDS have access to life-saving antiretroviral medications. The Budget also proposes to consolidate funds from Part D to Part C. The Part C program will emphasize care across all vulnerable populations, genders and ages thus assuring services for women, infants, children, and youth throughout the program. By consolidating the two programs, resources can be better targeted to points along the care continuum and populations most in need throughout the country among an increased number of grantees.

HIV Care Continuum

The Ryan White HIV/AIDS 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 care continuum. This continuum, also referred to as 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 HIV/AIDS 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 HIV/AIDS 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.

Enhancing the Health of Families and Communities

Maternal and Child Health: The FY 2015 Budget requests $1.3 billion to improve the health of mothers and children, an increase of $126 million. This level includes $500 million in FY 2015 and $15 billion through FY 2024 to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program, through which states are implementing evidence-based home visiting programs that enable nurses, social workers, and other professionals to meet with at-risk families and connect them to assistance to support the child's health, development, and ability to learn. These programs have been shown to improve maternal and child health and developmental outcomes, improve parenting skills and school readiness. The request also includes $634 million, the same as FY 2014, for the Maternal and Child Health Block Grant.

Investing in Critical Public Health Activities

340B Prescription Drug Discount Program: The 340B program provides discounts on outpatient prescription drugs to programs that serve a high number of low-income patients. 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 certain other community-based providers, and programs that target sexually transmitted disease and tuberculosis prevention and treatment among others. The Budget includes $17 million for the 340B program, an increase of $7 million above FY 2014, through a new cost recovery fee, which will help improve the program's operations, oversight and integrity.

Organ Transplantation: The Budget includes $24 million, a modest increase over FY 2014, to coordinate organ donation activities and provide grants to states to develop and improve donor registries. In addition, the Budget requests $33 million to support patients who need a potentially life-saving marrow or cord blood transplant and to maintain the National Cord Blood Inventory.

Rural Health: Rural Americans experience higher rates of chronic disease, disability, and mortality as well as inequities in access to health services, including preventive care. In addition to the investments in health centers and the National Health Service Corps that will improve access to health care in rural areas, the Budget provides $125 million for targeted programs to assist Americans living in rural communities.

The Budget includes $57 million for Rural Health Outreach Grants to improve access to quality care, coordination of care, and integration of services to the 50 million Americans living in rural areas. Funding will also focus on improving the health care professional workforce in rural areas. Rural Health Outreach grantees are provided with the flexibility to allocate funds in ways that best meets the needs of their community. The Budget also provides $26 million to continue funding for Rural Hospital Flexibility grants to strengthen the infrastructure of small rural hospitals and administering quality improvement activities. The Budget also provides $14 million to support HRSA's efforts to expand health technology systems and improve access to quality health care.

Supporting HRSA Programs

Program Management: The Budget requests $157 million, an increase of $4 million, to support a new consolidated facility that will improve efficiency over time. Program management funding also supports the infrastructure necessary to operate HRSA programs including rent, information technology, utilities, security, and agency oversight.

dollars in millions	2013	2014	2015	2015 +/- 2014
Services				
Clinical Services:	3,987	4,271	4,440	+169
Purchased/Referred Care (non-add)	*801*	*879*	*929*	*+50*
Medicaid (non-add)	*720*	*828*	*850*	*+22*
Preventive Health	143	148	156	+8
Contract Support Costs	448	587	617	+30
Tribal Management/Self-Governance	8	6	8	+2
Urban Health	41	41	41	+1
Indian Health Professions	38	33	38	+5
Direct Operations	68	68	68	--
Diabetes Grants	147	147	150	+3
Subtotal, Services	**4,880**	**5,302**	**5,519**	**+217**
Facilities				
Health Care Facilities Construction	77	85	85	--
Sanitation Facilities Construction	75	79	79	--
Facilities and Environmental Health Support	194	211	221	+10
Maintenance and Improvement	59	62	62	--
Medical Equipment	21	23	23	+1
Subtotal, Facilities	**427**	**460**	**470**	**+10**
Total, Program Level	**5,307**	**5,761**	**5,989**	**+228**
Less Funds From Other Sources				
Health Insurance Collections /1	-1,021	-1,172	-1,197	-25
Rental of Staff Quarters	-8	-8	-8	--
Diabetes Grants /2	-147	-147	-150	-3
Total, Budget Authority	**4,131**	**4,435**	**4,634**	**+200**
Full-time Equivalents	15,393	15,610	15,760	+150

1/ The FY 2014 President's Budget estimated reimbursements from the Department of Veterans Affairs at $52 million. Estimates are revised to $36 million for FY 2014 and $39 million for FY 2015. The FY 2013 and FY 2014 actual collections to date may be an indication that the FY 2014 and FY 2015 collections are overestimated and future year estimates will need to be adjusted accordingly.
2/ These mandatory funds were pre-appropriated in P.L. 111-309, the Medicare and Medicaid Extenders Act of 2010, P.L. 112-240, the American Taxpayer Relief Act of 2012, and are proposed for reauthorization in FY 2015.

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 2015 Budget requests $6 billion for the Indian Health Service (IHS), an increase of $228 million or 4 percent over FY 2014. The Administration seeks to reduce health disparities in Indian Country though targeted funding increases and a continued commitment to fulfilling the federal government's obligations to American Indians and Alaska Natives. The FY 2015 Budget includes an increased investment for the Purchased/Referred Care Program to cover increases in health care services costs due to medical inflation, provides funding to support the purchase of services for newly restored, reaffirmed, and federally recognized tribes, and provides funding for staffing and operating costs for new and replacement tribal and IHS health care facilities. Also, the Budget strengthens Indian self-determination and self-governance by supporting tribes and tribal organizations that administer health programs and by fully funding estimated Contract Support Costs.

Fulfilling the Mission of the Indian Health Service

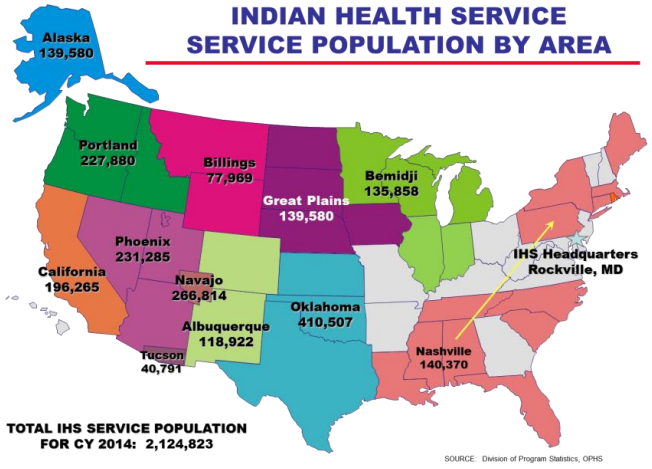
The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest possible level. IHS partners with tribes as authorized by the Indian Self-Determination and Education Assistance Act to provide health care and facilities services to a growing population of almost 2.1 million eligible American Indians and Alaska Natives. IHS and its tribal partners provide primary health care, behavioral health care, community health, and sanitation services through both IHS and tribally managed health care facilities. Tribal partnerships ensure appropriate, culturally competent care is a focus for programs that impact tribal communities directly.

IHS and tribes deliver comprehensive health services to members of 566 federally recognized tribes through direct services in over 632 hospitals, clinics, health stations on or near Indian reservations, and urban Indian health programs. IHS provides care in two ways both directly through the IHS system and by contracting with hospitals and other health care providers to purchase care when IHS is unable to provide it through its own network as part of the growing Purchased/Referred Care Program.

Additionally, IHS provides a number of services beyond the provision of health care. IHS also partners with other federal agencies to build sanitation systems to provide safe water and waste disposal for Indian homes, supports tribal self-governance and consultation to ensure American Indians and Alaska Natives can take part in determining budget needs and priorities, and provides scholarships and loan repayment awards to recruit health professionals to serve in areas with high provider vacancies.

Prioritizing Health Care Services

The Budget includes an increase of $200 million to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives.



The Affordable Care Act and the permanent reauthorization of the Indian Health Care Improvement Act strengthens the provision of health care services for American Indians and Alaska Natives and provides more options for health coverage. Despite this expansion and the fact that large funding increases have expanded IHS and tribal service levels in recent years, health disparities remain a serious problem across Indian Country. For example, suicide rates remain elevated across American Indian and Alaska Native communities as do the rates of drug-induced deaths. Preventive care screenings are also challenging for tribal communities – screening for colorectal cancer for American Indians and Alaska Natives remains below that for other races. Also, diabetes remains a serious issue, with approximately 14 percent of American Indians and Alaska Natives aged 20 years or older and receiving care by the IHS diagnosed as of 2011. Continued funding increases for health care services are essential to reducing these disparities and ensuring healthier tribal communities.

Increases for Direct Healthcare Services:

Purchased/Referred Care: The Budget includes $929 million, an increase of $50 million or 5 percent over FY 2014, for the purchase of medical care from outside the IHS system. The Purchased/Referred Care program is a top tribal priority and ensures access to health care services for eligible American Indians and Alaska Natives. Through the program, IHS purchases care when an IHS facility is unable to provide the needed services. A medical priority criteria system is used to determine preference for purchasing care when funding is limited. Services in this program have expanded to additional medical priorities beyond emergent services care in many facilities in recent years and this budget increase ensures IHS can continue that expansion despite rising system-wide costs and a growing population. With this increased investment, IHS will be able to ensure patients can receive medically necessary services in FY 2015; purchase more preventive services, such as mammograms and colonoscopies; and increase services over time, resulting in a reduction in unmet need. Absent these increases, additional patients forego vital preventive services or curative treatments.

Construction: The Budget includes $85 million for Health Care Facilities Construction to begin and complete construction on the Fort Yuma Heath Center in Winterhaven, California, to continue construction of the Gila River Southeast Health Center in Chandler, Arizona, and to complete construction of both the Kayenta Health Center in Kayenta, Arizona and the Northern California Regional Youth Treatment Center in Davis, California. Once completed, these facilities are projected to collectively serve a user population of 38,915 patients.

Staffing New and Replacement Health Facilities: The Joint Venture Program is an important cornerstone of the partnership between IHS and tribes to help deliver safe, state-of-the art facilities within the IHS system and the staff and equipment necessary to support the facilities' operations. Through this arrangement, IHS requests funds from Congress for staffing, equipping, and operating the facility while the participating tribe funds the costs of design and construction. For example, the Choctaw Alternative Rural Healthcare Center, one of the facilities receiving funding in the FY 2015 request, is a joint venture project in which IHS partners with the tribal entity. These important partnerships continue to increase access to care and decrease health disparities faced by American Indians and Alaska Natives. The Budget includes an additional $71 million to support staffing and operating costs for four new or replacement health facilities to be completed by FY 2015. When fully operational, these four facilities are projected to collectively serve a user population of over 44,885 patients.

OPPORTUNITY, GROWTH, AND SECURITY INITIATIVE

Investment Funding for Health Care Facilities Construction Projects

As part of the Opportunity, Growth, and Security Initiative in the FY 2015 Budget, the Administration has requested that Congress provide an additional $200 million for projects on the IHS Health Care Facilities Construction priority list if funding above the budgetary caps is available. The average age of IHS facilities is over 25 years, well above the industry standard for comparable private sector facilities of 9 to 10 years. Currently IHS needs to spend additional funds to ensure facilities are safe for occupancy. This investment would decrease IHS's construction and maintenance backlogs and help ensure American Indians and Alaska Natives are receiving high-quality, state-of-the-art health care services.

Health Insurance Reimbursements: In addition to funds included in this request, IHS estimates that in FY 2015, it will collect approximately $1.2 billion in health insurance reimbursements through Medicare, Medicaid, private insurers, and the Veterans Health Administration. These funds may be used to cover the costs of hiring additional medical staff, purchasing equipment, and making necessary building improvements – all essential for maintaining accreditation standards.

Potential that health insurance reimbursements to the IHS will continue to grow as a result of both IHS efforts to ensure quality services are being provided at all facilities through appropriate business planning and implementation of the Affordable Care Act. The Affordable Care Act's Medicaid expansion has ensured that additional American Indians and Alaska Natives are eligible for coverage. In participating states, Medicaid coverage will expand to cover all individuals with incomes up to 133 percent of the federal poverty level. The Affordable Care Act also offers opportunities for the IHS user population to purchase health insurance, which may increase private insurance collections at IHS and tribal facilities, by subsidizing the cost of health insurance for American Indians and Alaska Natives with incomes up to 400 percent of the federal poverty level.

IHS anticipates a $25 million increase in Medicaid collections in FY 2015. Increased collections will allow IHS to address the needs of its ever-expanding population by providing access to additional health care services, further reducing health disparities in the American Indian and Alaska Native population.

Supporting Indian Self-Determination

IHS understands that the planning and delivery of health services at the local level results in effective, quality health care and that tribes and tribal organizations are the most knowledgeable about what services are needed in their communities. About 62 percent of the IHS budget is administered by tribes primarily through the authority provided to them under the Indian Self Determination and Education Assistance Act, which allows tribes to assume the administration of programs previously carried out by the federal government.

NEW INITIATIVE

Ensuring Access to Care for American Indian and Alaska Native Veterans

In 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement. This agreement facilitates reimbursement by the VA to IHS for direct health care services provided to eligible American Indian and Alaska Native Veterans in IHS facilities. Tribally managed health programs were able to enter into reimbursement agreements with individual VA Medical Centers. As of the release of the FY 2015 Budget, implementation plans are in place and all IHS facilities are able to bill the VA. IHS estimates that collections from this agreement for both IHS and tribal programs will be $39 million in FY 2015, further narrowing the gap in the provision of care to American Indian and Alaska Native populations.

Contract Support Costs: The Budget fully funds the estimated need for Contract Support Costs (CSC) at $617 million, an increase of $30 million above FY 2014. These funds enable tribes to support the infrastructure needed to administer federal programs and cover necessary costs in the operation of their own health programs. The estimated increase includes funding for new and expanded contracts and compacts. The Administration and IHS will continue to work with tribes to develop a long-term strategy to manage CSC.

Tribal Consultation: IHS recognizes that tribal leaders are in the best position to understand the unique needs of their diverse communities. It is for this reason that IHS prioritizes consultation, a process during which these tribal representatives play an integral role in the federal decision-making process.

The most important consultation from a budgetary perspective is the HHS annual, Department-wide Tribal Budget Consultation. This event occurs at the beginning of each calendar year and provides tribal leaders an opportunity to communicate with all Departments within HHS. It is also used as an opportunity for participants to exchange updated information about grants, processes, and other forthcoming tribal consultation events. Tribal leaders share their budget priorities and, where possible, this input is reflected in the FY 2015 Budget to help ensure that the unique needs of American Indians and Alaska Natives communities are addressed.

CENTERS FOR DISEASE CONTROL AND PREVENTION

dollars in millions	2013 /1	2014	2015	2015 +/- 2014
Immunization and Respiratory Diseases	718	785	748	-36
ACA Prevention Fund (non-add)	*91*	*160*	*127*	*-33*
Balances from P.L. 111-32 Pandemic Flu (non-add)	*12*	--	--	--
Vaccines For Children	3,607	3,562	4,077	+514
HIV/AIDS, Viral Hepatitis, STDs, and TB Prevention	1,095	1,121	1,128	+7
ACA Prevention Fund (non-add)	--	--	--	--
Emerging and Zoonotic Infectious Diseases /2	341	390	445	+55
ACA Prevention Fund (non-add)	*44*	*52*	*52*	--
Chronic Disease Prevention and Health Promotion	1,003	1,188	1,078	-110
ACA Prevention Fund (non-add)	*233*	*446*	*470*	*+24*
Birth Defects, Developmental Disabilities, Disability and Health	134	132	132	--
ACA Prevention Fund (non-add)	--	--	*71*	*+71*
Environmental Health	142	180	169	-11
ACA Prevention Fund (non-add)	*21*	*13*	*37*	*+24*
Injury Prevention and Control	139	151	194	+43
Public Health Scientific Services	493	483	526	+43
ACA Prevention Fund (non-add)	*52*	--	*53*	*+53*
Occupational Safety and Health	323	333	281	-52
World Trade Center Health Program	231	268	282	+14
Energy Employee Occupational Illness Compensation Program	51	50	55	+5
Global Health /2	363	417	464	+48
Public Health Preparedness and Response	1,279	1,371	1,317	-54
CDC-Wide Activities and Program Support	251	299	124	-175
ACA Prevention Fund (non-add)	*23*	*160*	--	*-160*
Agency for Toxic Substances and Disease Registry	72	75	75	--
ACA Mandatory funds (non-add)	--	--	*20*	*+20*
User Fees	2	2	2	--
Subtotal, Program Level	**10,243**	**10,806**	**11,117**	**+311**

CENTERS FOR DISEASE CONTROL AND PREVENTION

dollars in millions	2013 /1	2014	2015	2015 +/- 2014
Less Funds Allocated from Mandatory Sources				
Vaccines for Children	-3,607	-3,562	-4,077	-514
Energy Employee Occupational Injury Compensation Prog.	-51	-50	-55	-5
World Trade Center Health Program	-231	-268	-282	-14
ATSDR ACA Mandatory Funds	--	--	-20	-20
ACA Prevention Fund	-463	-831	-810	-22
User Fees	-2	-2	-2	--
Total, Discretionary Program Level	**5,890**	**6,092**	**5,872**	**-221**
Less Funds Allocated from Other Sources				
PHS Evaluation Fund Transfers	-375	-211	-397	+187
Balances from P.L. 111-32 Pandemic Flu	12	--	--	--
Total, Discretionary Budget Authority	**5,503**	**5,882**	**5,474**	**-407**
Full-time Equivalents	11,134	11,134	11,134	--

1/ The FY 2013 amounts have been made comparable to FY 2014 and FY 2015 to reflect both the distribution of Business Support Services resources to other program budget lines and the transfer of the Paralysis Resource Center to the Administration for Community Living.
2/ FY 2013 and FY 2014 have been made comparable to FY 2015 to account for the 2013 Center for Global Health reorganization.

CDC works 24/7 to protect America from health, safety and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and protects Americans.

The Centers for Disease Control and Prevention (CDC) works to keep America safe from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, come from human error or deliberate attack, CDC fights disease, and supports communities and citizens to do the same. CDC is the nation's health protection agency — saving lives, protecting people from health threats, and saving money through prevention. The FY 2015 Budget request for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.1 billion. This total includes $810 million of the $1 billion available from the Prevention and Public Health Fund (Prevention Fund).

The Budget includes increases for a new antibiotic resistance initiative, global health security, prescription drug overdose, the *Now is the Time* initiative, food safety, and polio eradication to continue to advance CDC's core public health mission. In addition, the Budget includes targeted reductions to the 317 Immunization program, 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 expected increases in the availability of preventive and direct health care services due to the implementation of the Affordable Care Act.

Emerging and Zoonotic Infectious Disease

CDC's experts and laboratories detect and track a range of microbes, respond to outbreaks, like the 2012 fungal meningitis outbreak, and serve as an early warning system to rapidly identify new infectious disease threats. The Budget includes $445 million for Emerging and Zoonotic Infectious Disease activities, a $55 million increase over FY 2014. The FY 2015 Budget will allow CDC to further reduce healthcare-associated infections, improve food safety, modernize public

NEW INITIATIVE

Detect and Protect Against Antibiotic Resistance

The Budget includes an increase of $30 million for the Detect and Protect Against Antibiotic Resistance initiative, to enhance surveillance and laboratory capacity to detect antibiotic resistance threats and protect patients from imminent danger.

Antibiotic resistance (AR) is a rapidly growing threat that undermines the successful delivery of most clinical interventions nationally and globally. Without an effective response to this threat, not only are current treatment options for infectious diseases jeopardized, but the effectiveness of new interventions, surgeries, treatments, and effective ICU care are put at risk. For some infections, it is already a post-antibiotic world.

The Detect and Protect Against Antibiotic Resistance initiative enhances surveillance and laboratory capacity at local, state, and national levels to characterize domestic AR threats and protect patients from imminent danger. Most critically, the initiative will invest in direct action by implementing proven, evidence-based interventions that reduce the emergence and spread of AR pathogens and improve appropriate antibiotic use. Over five years, this initiative can reduce the national incidence of C. difficile by 50 percent, preventing at least 20,000 deaths, 150,000 hospitalizations, and over $1 billion in healthcare costs and possibly as much as $2 billion.

health microbiology and bioinformatics capabilities, and invest in a new antibiotic resistance detection and response initiative. This domestic initiative establishes a robust infrastructure that can "detect" antibiotic resistant threats and "protect" patients and communities, resulting in appreciable benefits in deaths prevented and money saved. The initiative will also limit the future spread of the most potentially deadly and costly antibiotic resistance pathogens. Relatedly, through data collection of healthcare associated infections (HAIs) and antibiotic use, CDC will accelerate HAI prevention across the spectrum of care. In order to target prevention efforts, CDC will use data to find problem areas in high-use Medicaid facilities.

The Budget includes $50 million for CDC's food safety activities, an increase of $10 million. This funding will support the implementation of CDC's provisions of the Food Safety Modernization Act. For instance, CDC will support and improve PulseNet in all 50 states, which is responsible for detecting about 150 potential outbreaks each year. CDC will modernize PulseNet laboratories and take advantage of tools for analyzing DNA developed by the Advanced Molecular Detection initiative.

HIV/AIDS, Viral Hepatitis, STI and TB Prevention

The Budget includes $1.1 billion for Domestic HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections and Tuberculosis, an increase of $7 million over FY 2014. The Budget will improve the timeliness, quality, and efficiency of the collection of HIV population data; as well as provide an additional $3 million for evaluation of CDC's school HIV health prevention activities. CDC will also invest $8 million to help HIV prevention grantees increase their capacity to seek reimbursement for covered services. The Budget focuses HIV resources on implementing effective, scalable and sustainable prevention strategies for persons living with HIV and populations at highest risk for HIV.

The Affordable Care Act will improve the prevention and control of HIV/AIDS, viral hepatitis, Sexually Transmitted Infections, and Tuberculosis in the United States due to expected increases in the proportion of the population with health insurance coverage, increased emphasis on preventive services, and prohibitions on denial of coverage to persons with pre-existing conditions. Decreasing illness and death due to these infections remains dependent upon CDC support of critical public health services at the state and local levels.

CDC and its public health partners provide these critical services, including surveillance, monitoring, partner services and contact investigations, laboratory services, provider training, operational research, and outreach to populations unlikely to access clinical care. Where direct services, such as screening, are provided by public health agencies, they are often provided in outreach settings in order to reach populations that would not otherwise access these services. CDC continues to work with public health agencies to build the infrastructure and capacity that state public health departments and community-based organizations will need to bill private insurers for infectious disease testing and treatment.

Immunization and Respiratory Diseases

In the United States, most vaccine-preventable diseases are at or near record lows, with a majority showing a 90 percent or greater decline in reported

cases when compared with the pre-vaccine era. CDC's $4.8 billion immunization program has two components: the mandatory Vaccines for Children (VFC) program and the discretionary Section 317 program.

In FY 2015, the Section 317 Immunization Program will continue to provide federally purchased vaccines to protect uninsured Americans from preventable diseases —and thus protect communities from the dangers of low vaccination rates. CDC estimates that although it is expected that these populations will begin to decrease with the implementation of expanded health insurance coverage provisions, there will continue to be a need for Section 317-purchased vaccines to serve uninsured adults and to provide rapid vaccination response to disease outbreaks or for non-VFC-eligible populations. In 2012, these resources were used to respond to the pertussis outbreak in the State of Washington. Pertussis, or whooping cough, can transmit from unvaccinated adolescents and adults to infants too young to be vaccinated. Washington was able to direct some of its Section 317 vaccine to targeted vaccination of pregnant women and adult caregivers of young infants—an important strategy to protect vulnerable infants from serious complications, and in some cases, death.

In FY 2015, CDC will work collaboratively with its awardees and partners to sustain record-high childhood immunization coverage rates and increase immunization coverage rates for children and adults by improving access to immunizations. Specifically, CDC will work to establish access points at complementary venues such as schools, pharmacies, and retail-based clinics; expand the network of VFC providers through recruitment efforts; purchase and deliver vaccine for at-risk populations; and ensure those with insurance have access to immunization services.

Global Health

CDC engages internationally to protect the health of the American people and save lives worldwide. CDC supports efforts around the globe to detect epidemic threats earlier, respond more effectively, and prevent more avoidable catastrophes—protecting Americans by intervening before these threats reach our borders. The Budget provides $464 million for CDC's global health activities, an increase of $48 million above FY 2014. With the increase, CDC will accelerate progress to prevent the introduction and spread of global health threats.

With scientists and health experts embedded in countries around the globe, CDC works with partners to translate and adapt scientific evidence into policies and public health actions—strengthening public health capacity and impact in partner countries. CDC builds strong national programs and sustainable public health systems that can effectively respond to the global HIV/AIDS epidemic and to other diseases that threaten the health and prosperity of the global community. In addition, the FY 2015 Budget includes an increase of $45 million for global health security activities. CDC's Global Health Security program will accelerate and expand efforts to improve detection of and response to global epidemics.

CDC's global immunization program protects the health of Americans and global citizens by preventing disease, disability, and death from vaccine-preventable diseases. Polio cases have dropped by more than 99 percent since 1988, measles deaths declined by 74 percent from 2000 through 2010, and more than 2.5 million vaccine-preventable disease deaths are prevented each year through routine immunization.

NEW INITIATIVE

Global Health Security

Epidemic threats to national security arise at unpredictable intervals and from unexpected sources. Because these threats do not recognize national borders, the health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, stability of foreign governments, and the well-being of U.S. citizens at home. In 2013 alone, the world was confronted with highly concerning and unpredictable epidemic threats from influenza A (H7N9) and the novel Middle East Respiratory Syndrome coronavirus.

CDC's Global Health Security program will accelerate sustainable capacity of countries around the world to prevent infectious diseases and detect and respond quickly and effectively. CDC will use the increase of $45 million to expand currently successful efforts, such as training field epidemiologists, deploying diagnostic tests, increasing pathogens detection, enhancing public health emergency management capacity, and supporting disease outbreak responses. CDC anticipates partnering with up to 10 countries to create a sustainable program to achieve early threat detection, effective response, and prevention of avoidable catastrophes.

The Budget includes $161 million, an increase of $10 million above FY 2014 to support the eradication of polio, which is endemic to three remaining countries and is within reach of total eradication.

Chronic Disease Prevention and Health Promotion

Chronic diseases are among the most prevalent, costly, and deadly of all health problems—and the most preventable. CDC leads the nation's efforts to prevent and control chronic diseases and associated risk factors by funding programs in states, tribes, territories, and local communities. CDC's chronic disease prevention and health promotion efforts contribute to CDC's overarching goal of preventing the leading causes of disease, disability, and death. The Budget includes $1.1 billion for chronic disease prevention and health promotion activities, $110 million below FY 2014.

CDC will continue the Partnerships to Improve Community Health program created in FY 2014, at the same funding level of $80 million. This program reaches Americans where they live, work, and play to reduce the burden of chronic diseases.

In FY 2015, CDC will also continue to fund the State Public Health Approaches to Chronic Disease Prevention program, which supports states to implement cross-cutting strategies to promote health and prevent and control chronic diseases and their risk factors. The coordinated approach is comprised of the Diabetes, Heart Disease and Stroke Prevention, School Health, and Nutrition, Physical Activity, and Obesity state programs. Collectively, these programs support a set of complementary activities and intervention strategies in four domains: epidemiology and surveillance, supportive environments, improvements in health systems, and community-clinical linkages. Coordinating these efforts into a single effort encourages states to implement a cohesive set of evidence and practice-based interventions that address four inter-related chronic diseases and risk factors and allows for increased efficiencies. These interventions are implemented in multiple settings, such as child care, schools, communities, healthcare, and work sites.

In addition, the Budget eliminates the REACH program and the Preventive Health and Health Services Block Grant; other CDC activities address the goals of these programs through the State Public Health Approaches to Chronic Disease Prevention program and the community chronic disease prevention grant program.

The Budget also proposes targeted reductions to select direct health care 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. The Budget includes $10 million for a new demonstration to transition from the existing Breast and Cervical and Colorectal screening programs to a more population based model supporting innovative strategies to increase screening for all recommended populations and link people to care.

Birth Defects and Developmental Disabilities

CDC's mission includes preventing birth defects and developmental disabilities and improving long-term health outcomes for people who have them. The Budget includes $132 million for Birth Defects and

PROGRAM HIGHLIGHT

Tips from Former Smokers Education Campaign

CDC launched the Tips from Former Smokers national tobacco education campaign in FY 2012 and introduced new ad content in FY 2013 and FY 2014. Research shows that educational efforts like this one provide an excellent return on investment, saving lives and lowering health care costs. The Tips campaigns serve as an important counter to the more than $900,000 that the tobacco industry spends each hour—more than $22 million a day—on cigarette advertising and promotion. The *Tips* campaign that ran in 2012 cost less than the tobacco industry spends in 3 days on marketing and promotion.

Smokers who want to quit have responded dramatically to the *Tips* campaigns. A study of the 2012 campaign was published in the medical journal, *The Lancet*. It reported that more than 1.6 million Americans tried to quit smoking because of the campaign and over 100,000 smokers are expected to stay quit for good.

In FY 2015, CDC will expand the national mass-media campaign to raise awareness of the health effects of tobacco use and prompt smokers to quit, as well as increase tobacco cessation quitline capacity to respond to smokers seeking help to quit. CDC estimates that the campaign will prompt an additional 750,000 quit attempts, resulting in 50,000 to 64,000 successful attempts to quit smoking permanently.

Developmental Disabilities, the same as FY 2014. CDC's core child health and development activities focus on surveillance, public health research, and prevention. In addition, CDC's Human Development and Disability program works to prevent disease and promote equity in health and development of adults with disabilities and children with hearing loss, complex disabling conditions, and mental, emotional, or behavioral disorders. These activities represent the nation's primary public health commitment to supporting populations with disabilities.

CDC protects people who have blood disorders from complications and improves long-term outcomes by gathering data on the impacts of bleeding, clotting, and red blood cell disorders and translating the information into action. CDC works with partners to identify how often and in which settings blood disorders occur to better understand who is at risk, identify effective strategies that prevent and reduce complications, and develop and promote education and awareness materials and activities.

Public Health Scientific Services

CDC provides most of the information available to the public, health care providers, and policy makers on the status of health in the United States. CDC's public health scientific support services provide expertise in health statistics, surveillance systems, epidemiologic analysis, informatics, public health workforce development, and laboratory policy and practice. Public health scientific services are the foundation of CDC's efforts to protect the public's health by supporting CDC's goal of monitoring health and ensuring laboratory excellence. The Budget includes $526 million, a $43 million increase over FY 2014, for public health scientific support services.

Without reliable, timely and constant health information and data, efforts to protect the nation's public health may be compromised. CDC strengthens these efforts through various surveillance systems, utilizing external sources of information, and sharing best practices in collecting, managing, and using information among CDC programs and the public health community. In FY 2015, analyses of data from the National Vital Statistics System will provide key information to measure the health of the United States population, including the infant mortality rate, life expectancy at birth, and the leading causes of death.

A well-trained public health workforce is critical to ensuring the highest level of efficiency and effectiveness in protecting population health—a responsibility that only public health systems ensure. The Budget includes an increase of $15 million to support fellowship programs that provide robust experiential learning while filling critical gaps in the public health workforce, as well as maintaining capacity to provide continuing education and training for the existing public health workforce. The Budget also includes $5 million to support public health systems research to identify the economic and budgetary impacts of public health interventions and healthcare delivery systems.

Environmental Health

CDC prevents illnesses, disabilities, and early death related to the environment. Knowledge about problems caused by the environment helps CDC respond to public health threats, natural disasters, and intentional or unintentional releases of chemicals and radiation. CDC's environmental health programs help all Americans, especially those who are more likely to be affected by the environment, such as children and older Americans. The Budget includes $169 million for these activities, $11 million below FY 2014.

CDC's Environmental Health Laboratory is recognized globally as the most advanced, state-of-the-art environmental public health laboratory. The lab standardizes biomarker measurements to assure their quality (accuracy and precision) and has more than 50 years of success in laboratory standardization programs. CDC's Chronic Disease Biomarkers Standardization program builds on this established role and infrastructure to develop reference methods and materials for additional cardiovascular and breast cancer disease biomarker measurements that need improvement in accuracy and precision. Ensuring the quality of these laboratory measurements helps clinicians better determine risk for and diagnose heart disease, reduces costs associated with repeated laboratory testing, and improves the diagnosis and treatment of breast cancer.

Injury Prevention and Control

CDC is the lead federal agency focusing on preventing unintentional and intentional injuries that occur outside of the workplace. The Budget includes $194 million for injury prevention and control activities, an increase of $43 million above FY 2014. Prevention activities address a wide range of topics

including intimate partner violence, sexual violence, teen dating violence, youth violence, suicidal behavior, child maltreatment, motor vehicle crashes, falls, prescription drug overdoses, traumatic brain injuries, and sports-related injuries. To prevent these injuries or mitigate their consequences, CDC collects and disseminates key public health data, identifies risk factors and injury prevention strategies, and translates scientific findings into effective community programs.

The Budget includes $5 million to fund evaluation activities with the goal of generating findings to improve sexual violence prevention nationwide. The Budget also includes $34 million for the *Now is the Time* initiative. This amount 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 $24 million to expand the National Violent Death Report System, which reports anonymous data on all types of violent deaths, to all 50 states during FY 2015.

Prescription opioid overdose deaths have increased four-fold between 1999 and 2010, and now outnumber deaths from all illicit drugs—including cocaine and heroin—combined. The Budget includes an increase of $16 million to expand the existing State Core Violence and Injury Prevention Program to additional States with a high burden of prescription drug overdose. CDC and SAMHSA will collaborate in their efforts to reduce prescription drug overdose.

Occupational Safety and Health

The mission of CDC's National Institute for Occupational Safety and Health (NIOSH) is to generate new knowledge in the field of occupational safety and health through collaborations with diverse partners, and to transfer that knowledge into workplace practice to prevent work-related injury, illness, and death. This work is a core element of CDC's goal to keep Americans safe from environmental and work-related hazards. The FY 2015 Budget provides $281 million for Occupational Safety and Health programs, $52 million below FY 2014. The Budget proposes targeted reductions to programs such as the Agriculture, Forestry, and Fishing program and Education Research Centers within the National Occupational Research Agenda. One of the emerging issues that CDC will address with FY 2015 funds is worker exposure to nanoparticles and nanomaterials. CDC's Nanotechnology Research Center will work with private sector partners to conduct eight field investigations that will provide evidence of effective interventions to control worker exposure, with specific prevention recommendations for employers that will support sustainable economic growth and job creation through increased investments in nanotechnology.

The Budget includes an increase of $14 million above FY 2014 in mandatory funding for the World Trade Center Health Program, for the addition of certain cancers to the list of related conditions, and the program inclusion of responders from the Shanksville, Pennsylvania, and Pentagon sites.

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.

Public Health Preparedness and Response

CDC operates 24-hours a day, seven days a week, to promote the security, safety, and health of Americans from intentional and naturally occurring threats. The FY 2015 Budget provides $1.3 billion for biodefense and emergency preparedness activities in CDC, a decrease of $54 million below FY 2014. Of this total, $617 million is requested for Public Health and Emergency Preparedness (PHEP) grants, $28 million below FY 2014. The PHEP program has provided approximately $7 billion in funding over the last decade to state and local entities to support preparedness efforts. Grants support local public health preparedness through enhanced laboratory capacity, health surveillance, and disaster response planning. The PHEP cooperative agreements are coordinated closely with the Hospital Preparedness program, administered by the Assistant Secretary for Preparedness and Response (ASPR). This collaboration extends to the program objectives, which are aligned around 15 core public health preparedness capabilities, of which 8 are also healthcare preparedness capabilities. These cross-cutting capabilities help to ensure that communities assess their readiness across the full spectrum of stakeholders.

In FY 2015, $158 million will support CDC's direct efforts to provide rapid responses to emerging public health threats, the same as FY 2014. This investment includes funding for the CDC Emergency Operations Center, which operates 24 hours a day to support emergency management for public health threats and

provides technical assistance to hospitals, health departments, international agencies and the general public.

Additionally, $543 million is requested to support the purchase and maintenance of medical countermeasures and other material in the Strategic National Stockpile, $8 million below FY 2014. Funds also support public health departments through preparedness training and direct technical assistance provided by subject matter experts.

Managing CDC Infrastructure and Human Capital

The Budget includes $124 million in administrative and infrastructure activities to support CDC's mission critical efforts.

Working Capital Fund: Implemented in FY 2014, CDC's new revolving fund has extended availability and serves as the funding mechanism to finance centralized business services support across CDC. Services rendered under the fund are performed at pre-established rates that are used to cover the full cost of operations and future investments. Contributions are collected for services, thereby creating market-like incentives to maximize efficiency and quality.

***Public Health Leadership and Support*:** The Budget includes $114 million to support CDC's Office of the Director, urgent and emergent public health response activities, and offices that provide agency-wide support and leadership for the US public health system. These funds are essential to CDC's ability to manage with efficiency, transparency, and accountability. In addition, these funds are used to directly support health organizations and officials across the United States.

Buildings and Facilities: The Budget includes $10 million in repairs and improvements projects to conduct all necessary repairs and improvements to existing buildings.

Agency for Toxic Substances and Disease Registry (ATSDR)

Managed as part of CDC, ATSDR supports healthy, sustainable environments in communities by identifying chemical exposures, educating the public and health care providers on how to prevent harmful exposures, and using the latest science to better characterize these exposures. The Budget provides $96 million for ATSDR, of which $20 million is mandatory funding for the early detection of medical conditions related to environmental hazards for the period of FY 2015–2019. ATSDR serves a critical role in supporting local, state, and federal efforts to protect human health from environmental threats. ATSDR's work in communities includes investigating hazards in towns with a legacy of industrial pollution to responding to environmental public health emergencies like acute chemical spills. ATSDR also uses environmental health surveillance and registries to track harmful exposures and adverse health outcomes. In FY 2015, ATSDR expects to address 2,000 technical requests, respond to 50 emergency events, and investigate exposures at 500 communities.

dollars in millions	2013	2014	2015	2015 +/- 2014
Institutes				
National Cancer Institute	4,783	4,923	4,931	+8
National Heart, Lung and Blood Institute	2,900	2,983	2,988	+5
National Institute of Dental and Craniofacial Research	387	397	397	+0
National Inst. of Diabetes & Digestive & Kidney Diseases	1,835	1,881	1,893	+12
National Institute of Neurological Disorders and Stroke	1,532	1,586	1,608	+23
National Institute of Allergy and Infectious Diseases	4,230	4,393	4,423	+31
National Institute of General Medical Sciences	2,291	2,362	2,369	+7
Eunice K. Shriver Natl. Inst. of Child Health & Human Dev	1,245	1,281	1,283	+3
National Eye Institute	656	674	675	+1
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	646	665	665	+7
Interior Appropriation	75	77	77	—
National Institute on Aging	1,039	1,169	1,171	+1
Natl. Inst. of Arthritis & Musculoskeletal & Skin Diseases	505	519	520	+1
Natl. Inst. on Deafness and Communication Disorders	392	403	404	+0
National Institute of Mental Health	1,394	1,417	1,440	+23
National Institute on Drug Abuse	992	1,016	1,023	+8
National Institute on Alcohol Abuse and Alcoholism	433	445	446	+1
National Institute of Nursing Research	136	140	140	+0
National Human Genome Research Institute	483	497	498	+1
Natl. Institute of Biomedical Imaging and Bioengineering	319	326	329	+2
Natl. Institute on Minority Health and Health Disparities	260	268	268	—
Natl. Center for Complementary and Alternative Medicine	121	124	125	+0
National Center for Advancing Translational Sciences	542	632	657	+25
Fogarty International Center	66	67	68	+0
National Library of Medicine	360	375	381	+6
Office of the Director	1,411	1,400	1,452	+52
Buildings and Facilities	118	129	129	—
Total, Program Level	**29,151**	**30,151**	**30,362**	**+211**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	—
Type 1 Diabetes Research (NIDDK) /1	-142	-139	-150	-11
Total, Discretionary Budget Authority	**29,001**	**30,003**	**30,203**	**+200**
Labor/HHS Appropriation	28,926	29,926	30,126	+200
Interior Appropriation	75	77	77	—
Full-time Equivalents	18,234	18,234	18,234	—

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, and are proposed for reauthorization in FY 2015.

NATIONAL INSTITUTES OF HEALTH

The mission of the National Institutes of Health is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.

The FY 2015 Budget requests $30.4 billion for the National Institutes of Health (NIH), an increase of $211 million, or 0.7 percent, over FY 2014, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that advances medical science while stimulating economic growth. In FY 2015, NIH estimates it will support a total of 34,197 research project grants, including 9,326 new and competing awards.

NIH serves as the nation's medical research agency and is the largest source of funding for biomedical and behavioral research in the world. NIH's budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2015, 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 personnel 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 2015

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. In FY 2015, with the $30.4 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. This robust research enterprise depends upon NIH's continued innovation as it seeks to recruit and retain diverse scientific talent and creativity.

Investing in Today's Basic Science for Tomorrow's Breakthroughs: Approximately 54 percent of the NIH research budget is devoted to basic biomedical and behavioral research that makes it possible to understand the causes of disease onset and progression. As an example, in FY 2015, NIH plans to spend $100 million to expand its investment in the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. This project will develop and apply new tools to map the circuits of the brain, measure the dynamic patterns of activity within those circuits, and understand how they create unique cognitive and behavioral capabilities. Ultimately, this fundamental knowledge will be applied to revolutionize our understanding of complex brain functions and their links to behavior and disease.

OPPORTUNITY, GROWTH, AND SECURITY INITIATIVE

NIH in the President's Opportunity, Growth, and Security Initiative

Included in the proposed Opportunity, Growth, and Security Initiative to support the President's priorities to grow the economy and create opportunities are $970 million to bring NIH to a total level of $31.3 billion in FY 2015. These funds would be used to increase the number of new grants funded and provide additional resources for signature activities such as the BRAIN Initiative, improving the sharing and analysis of complex biomedical data sets, expanding research on Alzheimer's disease and vaccine development, further accelerating partnership efforts to identify and develop new therapeutic drug targets, and other innovative projects.

Taking Advantage of Big Opportunities in Big Data: Technological advances have fueled the generation of increasingly larger and more complex biomedical data sets, such as high-resolution medical images, recorded physiological signals, and complete DNA sequences of large numbers of individuals. In FY 2015, NIH's Big Data to Knowledge program will work to facilitate sharing and protection of data among researchers across the nation, develop faster and more accurate analytical methods, and establish Centers of Excellence to help solve the most intractable Big Data problems to deepen our understanding of disease and speed translation of new treatments.

Investing in Precision Medicine: Recent insights into the molecular basis of disease have identified many promising new targets for therapeutic intervention. NIH is also focusing on research to tailor treatments to the individual characteristics of each patient, also known as "precision medicine." By better understanding human variability and susceptibility, NIH seeks to develop specific preventive and therapeutic interventions that can avoid needless treatment and expense for those who will not benefit. In FY 2015, the National Center for Advancing Translational Sciences (NCATS) will continue efforts to re-engineer the process of translating scientific discoveries into new diagnostics and therapeutics, working with partners in industry, academia, and other government agencies, such as the Food and Drug Administration and the Defense Advanced Research Projects Agency (DARPA). Within NCATS, the Budget proposes $30 million, an increase of $20 million over FY 2014, for the Cures Acceleration Network to accelerate the development of "high need cures" by reducing barriers between research discovery and clinical trials.

In FY 2015, NIH will also continue to implement the Accelerating Medicines Partnership (AMP), a bold new venture between NIH, ten biopharmaceutical companies, and several non-profit organizations to transform the current model for developing new diagnostics and therapeutics by jointly identifying and validating promising biological targets of disease. AMP's initial focus is on three- to five-year pilot projects in three disease areas: Alzheimer's disease, type 2 diabetes, and the autoimmune disorders of rheumatoid arthritis and lupus.

PERFORMANCE HIGLIGHT

Tox21 Program: Synthetic Chemicals and Health

NIH manages a program, Tox21, to investigate and catalog the health effects of many of the estimated 125,000 man-made chemicals in use commercially. NIH collaborated with the EPA and the FDA on this program to research and develop innovative test methods that characterize how chemicals interact with cellular pathways, determining chemical toxicity, as well as danger to human health. The results of these tests are important for developing prevention or mitigation strategies. NIH exceeded expectations in FY 2013 by completing 33 quantitative high-throughput screen assays on the over 10,000 compounds in the Tox21 library.

Nurturing Talent and Innovation: A diverse, well-trained, and highly creative workforce is an important part of the biomedical research endeavor and is essential for developing new scientific insights and translating these insights into improved health outcomes. In FY 2015, 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. NIH will also place additional emphasis on research innovation in FY 2015 by increasing investment in a variety of High-Risk High-Reward projects by the Institutes and Centers to $100 million, and through a $30 million investment in Common Fund projects modeled after the research flexibilities utilized by DARPA.

NIH will also continue to implement 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 providing 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 $767 million is estimated in FY 2015 to support training 15,715 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 and postdoctoral trainees in FY 2015.

HIV/AIDS: NIH estimates it will devote more than $3 billion for research on HIV/AIDS in FY 2015. 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.

Alzheimer's Disease: NIH is continuing to implement the research components of the National Plan to Address Alzheimer's Disease (AD), a roadmap to assist in meeting the goal to prevent and effectively treat AD by 2025. NIH estimates it will spend $566 million on AD research in FY 2015. NIH continues to invest in a broad spectrum of basic and translational research activities to combat Alzheimer's disease. For example, NIH has recently established the AD Genetics Warehouse to identify further genetic risk and protective factors. Scientists supported by the AD Neuroimaging Initiative have analyzed thousands of human brain scans, genetic profiles, and biomarkers in order to better detect AD in its earliest stages. More than 35 NIH-funded clinical trials are underway, and more than 40 compounds are being tested as potential preventive and therapeutic interventions for Alzheimer's and cognitive decline.

Research Project Grants: NIH estimates that it will devote $16.2 billion, or 53 percent of its total budget, to finance a total of 34,197 competitive, peer-reviewed, and largely investigator-initiated research project grants (RPGs) in FY 2015. Within this total, NIH anticipates supporting 9,326 new and competing RPGs, an increase of 329 grants over FY 2014 levels.

Science, Technology, Engineering, and Mathematics (STEM) Education: The FY 2015 Budget will propose a modified version of a major reorganization of government-wide STEM programs. Led by the Department of Education and the National Science Foundation, the STEM reorganization will create core initiatives focused on 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.

PROGRAM HIGHLIGHT

BRAIN Initiative

On April 2, 2013, President Obama launched the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative to "accelerate the development and application of new technologies that will enable researchers to produce dynamic pictures of the brain that show how individual brain cells and complex neural circuits interact at the speed of thought." A working group of advisors to the NIH Director produced a report in September 2013 that identified high priority research areas for initial NIH funding. These include:

- Generating a census of brain cell types;
- Creating structural maps of the brain;
- Developing new, large-scale neural network recording capabilities;
- Developing a suite of tools for neural circuit manipulation;
- Linking neuronal activity to behavior;
- Integrating theory, modeling, statistics, and computation with neuroscience experiments;
- Delineating mechanisms underlying human brain imaging technologies;
- Creating mechanisms to enable collection of human data for scientific research; and
- Disseminating knowledge and training.

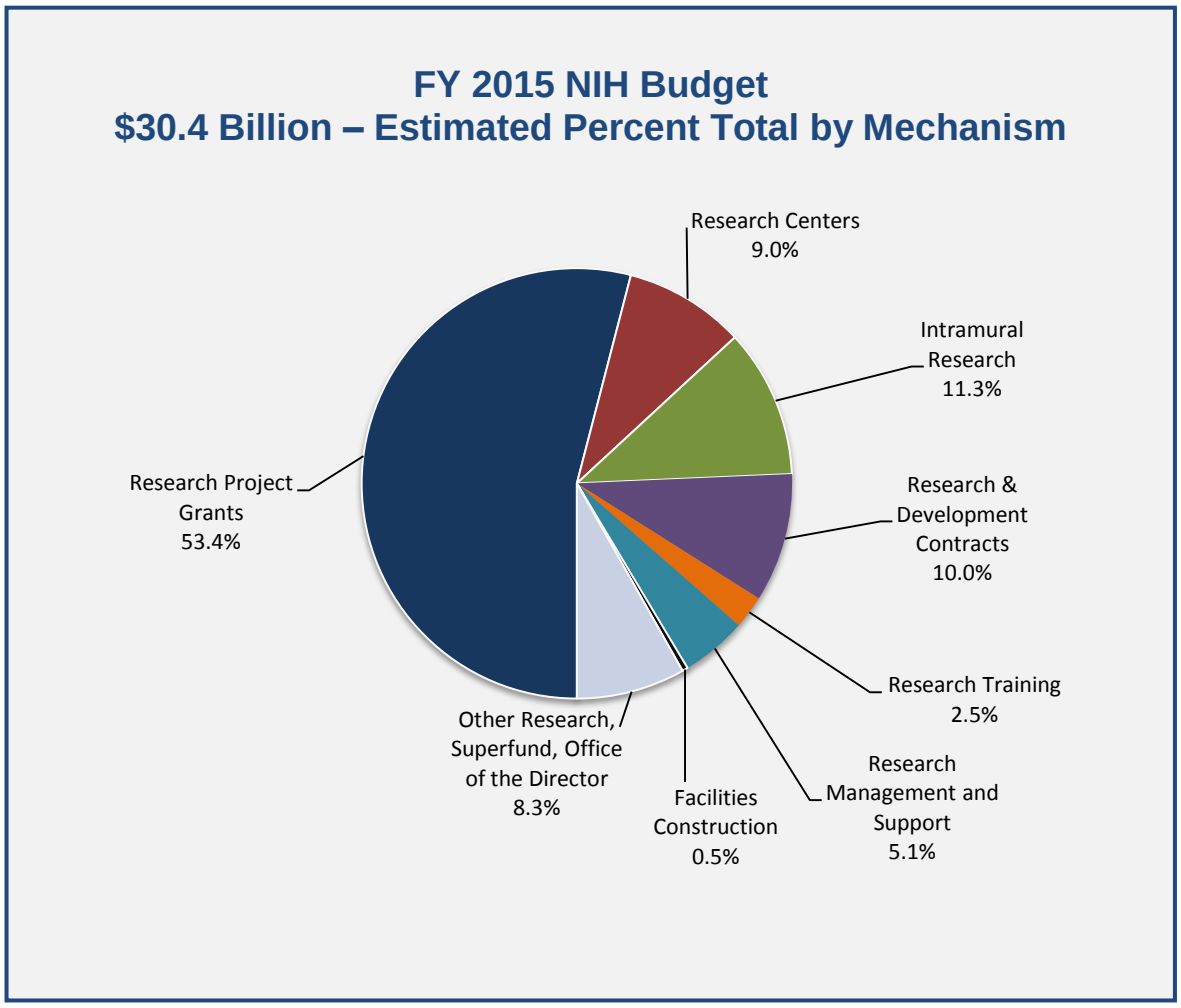
The knowledge gained from this initiative will help answer fundamental questions about the complex links between brain function and behavior. Three government agencies, NIH, the National Science Foundation, and DARPA, plan to spend a total of $200 million in FY 2015 on the BRAIN Initiative. NIH's $100 million contribution, an increase of roughly $60 million above FY 2014, is in addition to the $5.5 billion estimated in the NIH FY 2015 budget for neuroscience research.

Intramural Buildings and Facilities

A total of $137 million is requested for NIH intramural Buildings and Facilities (B&F) in FY 2015, roughly the same level as in FY 2014, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses.

In FY 2015, NIH will devote $78 million of its B&F resources as a one-time expense to expand the chilled water capacity on the Bethesda campus in order to improve the 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 $8 million requested within the National Cancer Institute budget for facilities repair and improvement projects at its Frederick, Maryland campus.



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

dollars in millions	2013	2014	2015	2015 +/- 2014
Mechanism				
Research Project Grants (dollars)	15,445	16,077	16,197	+120
[# of Non-Competing Grants]	*[25,140]*	*[23,632]*	*[23,236]*	*[-396]*
[# of New/Competing Grants]	*[8,234]*	*[8,997]*	*[9,326]*	*[+329]*
[# of Small Business Grants]	*[1,466]*	*[1,584]*	*[1,635]*	*[+51]*
[Total # of Grants]	*[34,840]*	*[34,213]*	*[34,197]*	*[-16]*
Research Centers	2,709	2,713	2,723	+10
Other Research	1,783	1,825	1,868	+43
Research Training	734	753	767	+14
Research and Development Contracts	2,895	2,990	3,031	+40
Intramural Research	3,291	3,404	3,444	+39
Research Management and Support	1,485	1,529	1,544	+15
Office of the Director	608	571	575	+4
NIH Common Fund (non-add)	*[513]*	*[533]*	*[583]*	*[+50]*
Buildings and Facilities	126	136	137	+0
NIEHS Interior Appropriation (Superfund)	75	77	77	—
Total, Program Level 1/	**29,151**	**30,151**	**30,362**	**+211**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	—
Type 1 Diabetes Research (NIDDK) /2	-142	-139	-150	-11
Total, Budget Authority 1/	**29,001**	**30,003**	**30,203**	**+200**
Labor/HHS Appropriation	28,926	29,926	30,126	+200
Interior Appropriation	75	77	77	—
Full-time Equivalents	18,234	18,234	18,234	—

1/ The amounts in the FY 2014 column take into account funding reallocations, and therefore may not add to the total budget authority reflected herein.

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, and are proposed for reauthorization in FY 2015.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

dollars in millions	2013	2014	2015	2015 +/- 2014
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	--	20	20	--
Within Health Surveillance and Program Support:				
Science of Changing Social Norms	--	--	4	+4
Workforce	--	40	51	+11
SAMHSA-HRSA Behavioral Health Expansion (non-add)	--	*35*	*35*	--
Peer Professionals (non-add)	--	--	*10*	*+10*
Minority Fellowship Program Expansion (non-add)	--	*5*	*5*	--
Workforce Data Development (non-add)	--	--	*1*	*+1*
Total, *Now is the Time* Presidential Initiatives	**--**	**115**	**130**	**+15**
Mental Health				
Community Mental Health Services Block Grant	437	484	484	--
PHS Evaluation Funds (non-add)	*21*	*21*	*21*	--
Programs of Regional and National Significance	267	378	355	-23
PHS Evaluation Funds (non-add)	--	--	*5*	*+5*
Prevention and Public Health Fund (non-add)	--	*12*	*38*	*+26*
Children's Mental Health Services	111	117	117	--
Projects for Assistance in Transition from Homelessness	61	65	65	--
Protection & Advocacy for Individuals with Mental Illness	34	36	36	--
Subtotal, Mental Health	***910***	***1,080***	***1,057***	***-23***
Substance Abuse Treatment				
Substance Abuse Prevention and Treatment Block Grant	1,710	1,820	1,820	--
PHS Evaluation Funds (non-add)	*79*	*79*	*79*	--
Programs of Regional and National Significance	404	361	297	-64
PHS Evaluation Funds (non-add)	*2*	*2*	*30*	*+28*
Prevention and Public Health Fund (non-add)	--	*50*	--	*-50*
Subtotal, Substance Abuse Treatment	**2,114**	**2,181**	**2,117**	**-64**
Substance Abuse Prevention				
Programs of Regional and National Significance	176	176	186	+10
PHS Evaluation Funds (non-add)	--	--	*16*	*+16*
Subtotal, Substance Abuse Prevention	**176**	**176**	**186**	**+10**
Health Surveillance and Program Support				--
Program Support	78	73	73	--
Health Surveillance	45	47	49	+2
PHS Evaluation Funds (non-add)	*27*	*30*	*29*	*-1*
Prevention and Public Health Fund (non-add)	*15*	--	*20*	*+20*
Data Request and Publications User Fees	--	2	2	--
Public Awareness and Support	14	14	16	+2
PHS Evaluation Funds (non-add)	--	--	*16*	*+16*

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

dollars in millions	2013	2014	2015	2015 +/- 2014
Performance and Quality Information Systems	9	13	13	--
PHS Evaluation Funds (non-add)	--	--	*13*	*+13*
Agency-Wide Initiatives	8	46	56	+10
PHS Evaluation Funds (non-add)	--	--	*1*	*+1*
Subtotal, Health Surveillance and Program Support	**154**	**194**	**208**	**+14**
Total, Program Level	**3,354**	**3,631**	**3,568**	**-63**
Less Funds From Other Sources:				
PHS Evaluation Funds	-130	-133	-211	-78
Prevention and Public Health Fund	-15	-62	-58	+4
User Fees	--	-2	-2	--
Total, Discretionary Budget Authority	**3,210**	**3,435**	**3,298**	**-137**
Full-time Equivalents	608	655	655	--

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

The FY 2015 Budget requests $3.6 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a decrease of $63 million below FY 2014. The Budget continues investments to increase access to mental health services to protect the health of children and communities, and to prevent suicide and substance abuse and promote mental health, especially among American Indian and Alaska Native communities. The Budget also invests new resources to integrate primary care and addiction services and to address prescription drug abuse. As part of SAMHSA's role in the nation's mental health and substance abuse prevention and treatment systems, SAMHSA will work to target investments more strategically by:

- Targeting resources to evidence-based prevention and treatment interventions;
- More fully integrating Minority AIDS and related programs into the HIV Continuum of Care; and
- Decreasing negative attitudes toward those with mental health and substance abuse problems and increasing their willingness to seek help.

The Budget includes funding to improve states' capacity to provide behavioral health services through the block grants and reduces funding for competitive grant activities that will now be brought to scale through other mechanisms such as the block grants or state-level funding streams.

Responding to National Mental Health Needs

Increasing Access to Mental Health Services to Protect the Health of Children and Communities: While the vast majority of Americans with a mental illness are not violent, violence continues to highlight a crisis in America's mental health system. The Budget continues key investments to expand access to care for those with mental health problems.

The Budget continues investments proposed by the President in the *Now is the Time* initiative, and lays out changes toward a healthier and safer country. The Budget includes investments of $130 million in SAMHSA 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, including through additional outreach and improvements in workforce data collection.

The objectives of this initiative 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 implement plans to keep schools safe and get students with behavioral health issues referred to the services they need and $15 million for Mental Health First Aid to encourage adolescents and families to seek treatment when mental illness is detected and equip adults who work with youth with the knowledge to aid in early detection;
- $40 million for workforce programs initiated in FY 2014, composed of $35 million to continue the partnership with the Health Resources and Services Administration to increase the number of licensed behavioral health professionals available to serve in communities across the nation, and $5 million to continue an expansion of the Minority Fellowship Program grants;
- $10 million to fund a new workforce program, Peer Professionals, to increase the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors who in some cases have the best chance of effectively reaching out to those who need treatment;
- $20 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; and,
- $5 million to change the attitudes of Americans about mental and substance use disorders and their willingness to seek help, and to improve data collection and analysis of behavioral health workforce needs.

Improving Children's Mental Health: The Budget supports coordinated and comprehensive service systems to both promote healthy child development and provide behavioral health services to vulnerable youth. The Budget includes $35 million for Project LAUNCH, the same level as FY 2014, to coordinate young child-serving systems and integrate behavioral and physical health services. The Budget also invests $117 million, the same level as FY 2014, 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.

NEW INITIATIVE

Now is the Time–Protecting Communities and Helping Young People

The FY 2014 Budget includes $115 million in SAMHSA for the President's *Now is the Time* initiative to protect the health of children and communities in response to recent tragedies. The FY 2015 Budget sustains these programs and includes an additional $10 million to strengthen the behavioral health workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16 to 25. The Budget also invests an additional $5 million for new outreach initiatives to ensure effective targeting and messaging of mental health communications, and new data initiatives to ensure the nation's behavioral health workforce needs are well defined and understood.

Preventing Suicide: The Budget provides $55 million to prevent suicide. This investment includes $5 million to continue support for competitive grants to tribal entities to promote mental health and address substance abuse among American Indian and Alaska Native young people. The Budget also invests additional funding for the National Strategy for Suicide Prevention, the nation's blueprint for reducing suicide over the next decade. Organized as a public-private partnership including experts in suicide prevention, this funding will develop and test nationwide efforts such as suicide awareness, provider credentialing changes, emergency room referral processes, clinical care practice standards, and other activities not currently being addressed in any other national initiative.

SAMHSA's suicide prevention programs fund states and tribes to develop and implement youth suicide prevention and early intervention strategies in partnership with education and juvenile justice systems, youth support organizations, and other community settings. 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. To ensure access to the latest science and best practices, the Budget also includes continued funding for the Suicide Prevention Resource

Center that will provide system-wide enhancements to the nation's mental health infrastructure related to suicide prevention.

Protecting Individuals with Mental Illness: The Budget includes $36 million to support state protection and advocacy systems to monitor residential treatment facilities which house vulnerable individuals with mental illness and serious emotional disturbances. In 2012, over 13,000 investigations into allegations of abuse, neglect, or rights violations were completed. In over 85 percent of substantiated cases, complaints of neglect handled through these systems resulted in positive changes for clients.

Assisting in the Transition from Homelessness: The Budget dedicates a total of $139 million for services for individuals facing homelessness and suffering from substance abuse or mental illness. 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.

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, the same level as in FY 2014, and $484 million for the Community Mental Health Services Block Grant, the same level as in FY 2014, 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 total substance abuse agency funding, and approximately 1 percent of all state and federal spending on mental health care in the United States, respectively.

The Budget's block grant funding is anticipated to contribute to services to over 10 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 to provide services necessary for care but not covered by insurance.

PROGRAM HIGHLIGHT

Primary Care and Addiction Services Integration

The Budget invests $20 million in new funding for Primary Care and Addiction Services Integration to enable addiction care providers to offer a full array of both physical health and substance abuse services to clients. This effort will improve the physical health status of adults with substance use disorders who have or are at risk for co-occurring primary care conditions and chronic diseases, including HIV/AIDS, which are a significant component of the overall higher cost of care for individuals with substance use disorders today.

Integrating Primary Care and Addiction Services: The Budget provides $20 million in new funding to bring primary care services to community substance abuse treatment provider sites. By co-locating primary and specialty care medical services, this program will improve the rate at which substance abuse treatment patients are successfully referred to primary care services. This effort draws on lessons from the successful and ongoing Primary and Behavioral Health Care Integration program, and will fund implementation, technical assistance, and evaluation efforts, including dissemination of successful approaches. The Budget also increases funding for existing grants to ensure states have the capacity to meaningfully use electronic health records to improve the integration of primary care and addiction services.

Responding to the Epidemic of Prescription Drug Abuse: The Budget proposes a total of $26 million in the Centers for Disease Control and Prevention and SAMHSA to address prescription drug misuse, abuse, and overdose. Within SAMHSA, this collaborative effort will invest $10 million in grants to states to enhance, implement, and evaluate strategies to prevent prescription drug misuse and abuse, and to improve collaboration on the risks of overprescribing and the use of monitoring systems between states' public health and education authorities, and pharmaceutical and medical communities. For example, epidemiological analyses using prescription drug monitoring program data can identify high-risk populations within a state to better target future state and federal efforts.

Building a Foundation on Solid Evidence: The Budget includes a set-aside of five percent of the Mental Health Block Grant for evidence-based early intervention programs to address the needs of

PERFORMANCE HIGHLIGHT

National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline, 1-800-273-TALK, provides suicide prevention and crisis intervention services to individuals seeking help at any time, day or night.

The Lifeline averaged 94,183 calls per month in 2013, including a peak of 104,754 calls in December, 24 percent above 2012. The program continues to implement new research and evaluation results, such as following up with individuals with suicidal thoughts and attempts upon discharge from health care facilities and to conduct additional research to evaluate communication beyond the telephone, such as through chat-based services.

individuals with serious mental illness. This effort will improve the dissemination of evidence-based practices and will encourage states and the federal government to track and implement these practices. In addition, SAMHSA's National Registry of Evidence-Based Programs and Practices now includes more than 320 interventions, up from 280 last year, which help to inform the public and the medical community about the effectiveness and readiness for dissemination of interventions.

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. A key part of SAMHSA's role in the health care system is to evaluate promising approaches to the nation's most challenging behavioral health concerns. The Budget includes $838 million, $78 million below FY 2014, for Programs of Regional and National Significance and other competitive and targeted grant activities. Programs in these areas are proposed at the same level as last year or are eliminated because the programs have been designed to be tested and moved into mainstream funding sources if successful.

For example, the Budget includes savings of $50 million from the elimination of the Access to Recovery program. SAMHSA will work closely in FY 2014 with states and grantees to ensure that mainstream funding sources expand the traditional provider network 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: Other than increases described above associated with the President's *Now is the Time* initiative, the Budget continues support at the same level as FY 2014 for national survey efforts, the administration and monitoring of SAMHSA programs and grantees, and public awareness activities. The Budget also includes a focus on program integrity to ensure that scarce resources are appropriately and responsibly monitored. SAMHSA's national surveys and the analyses conducted through them are used by federal, state, and local authorities, as well as by health care providers, to inform policy about substance use and mental disorders, the impact and treatment of these disorders, and the recovery process.

Data and Publication User Fees: The Budget continues SAMHSA user fees to fulfill extraordinary requests for data analyses and bulk publications. While the vast majority of data and publications will remain free, the costs of the most expensive requests will continue to be borne by the requestor.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

dollars in millions	2013	2014	2015	2015 +/- 2014
Health Costs, Quality and Outcomes Research (HCQO)				
Health Information Technology Research	26	30	23	-6
Patient Safety Research	67	72	73	+1
Patient-Centered Health Research	68	93	106	+13
PCORTF Transfer (non-add) /1	*58*	*93*	*106*	*+13*
PHS Evaluation Funds (non-add)	*10*	—	—	—
Health Services Research, Data and Dissemination	111	111	93	-18
Prevention/Care Management	26	23	11	-12
PHS Evaluation Funds (non-add)	*19*	*16*	*11*	*-5*
Prevention and Public Health Fund (non-add)	*6*	*7*	—	*-7*
Value	4	3	—	-3
Subtotal, Program Level, HCQO	300	331	306	-25
Subtotal, PHS Evaluation Funds, HCQO (non-add)	*236*	*231*	*201*	*-31*
Medical Expenditure Panel Survey	61	64	64	—
Program Support	68	69	70	+1
Total, Program Level	**430**	**464**	**440**	**-24**
Less Funds From Other Sources				
PHS Evaluation Funds	-365	-364	-334	+30
Patient-Centered Outcomes Research Trust Fund	-58	-93	-106	-13
Prevention and Public Health Fund	-6	-7	—	+7
Total, Discretionary Budget Authority	—	—	—	—
Full-time Equivalents /2	311	326	326	—

1/ In FY 2011, AHRQ began receiving mandatory 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 mission of the Agency for Healthcare Research and Quality is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with HHS and other partners to make sure that the evidence is understood and used.

The FY 2015 Budget includes a total program level of $440 million for the Agency for Healthcare Research and Quality (AHRQ), $24 million less than the FY 2014 level. Within this total, the Budget includes $334 million in Public Health Service (PHS) Evaluation Funds, a reduction of $30 million below FY 2014, and $106 million from the Patient Centered Outcomes Research Trust Fund, an increase of $13 million above FY 2014.

AHRQ's mission is to produce evidence to make American health care safer, higher quality, more accessible, equitable, and affordable, and to work with HHS divisions and other partners to make sure that the evidence is understood and used. AHRQ works toward these goals by undertaking health services research, data collection, and dissemination of evidence and evidence-based tools. AHRQ translates evidence from research into practical solutions that health care organizations can implement to prevent, mitigate, and decrease patient safety risks and hazards, and improve the quality of care. The FY 2015 Budget will provide the resources needed to continue progress on health services research to improve outcomes, affordability, and quality. The Budget also supports the collection of vital information on health care spending and use.

Health Costs, Quality, and Outcomes

The FY 2015 Budget includes a program level of $306 million, $25 million below FY 2014, for research on issues affecting the cost, quality, and effectiveness of health care services. AHRQ's research on health costs, quality, and outcomes is organized into six main research portfolios: patient safety; health information technology; patient centered health research; prevention and care management; health services research, data and dissemination; and value.

Enhancing Patient Safety: The Budget provides $73 million, an increase of $1 million above FY 2014, for the AHRQ patient safety research portfolio. This portfolio supports lifesaving research and dissemination projects that 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 funds measurement, reporting, dissemination, and implementation, while also funding research to strengthen the science base and develop more effective patient safety interventions. Research funded in FY 2015 will build on past successes and focus on the expansion of projects that have demonstrated impact in improving healthcare safety, including ongoing support for the dissemination and implementation of successful initiatives that integrate the use of evidence based resources such as the Surveys of Patient Safety Culture and Team Strategies and Tools to Enhance Performance and Patient Safety (Team STEPPS). AHRQ's research in this area provides the evidence base that CMS and other HHS agencies use to improve patient safety on a national scale.

The Budget includes $15 million for a new initiative that will expand the implementation of recent advances in patient safety: Expanding Patient Safety Improvements to All Health Care Settings. This effort will build on AHRQ's prior success in improving safety in hospitals, and expand it to other settings such as primary care practices and nursing homes, so that patients can expect safe care wherever they are. This multi-year initiative will identify, test, refine, and disseminate strategies and tools to prevent medical errors and include a rigorous evaluation component to determine what works best in providing safe care.

In FY 2015, AHRQ will provide $34 million, the same level as FY 2014, to prevent healthcare associated infections (HAIs) by supporting the creation of new knowledge and accelerating the widespread adoption of proven methods for preventing HAIs. A prime example of such an evidence-based method is the Comprehensive Unit-based Safety Program (see Program Highlight on prior page), which has been shown to be highly effective in reducing HAIs. AHRQ's prevention efforts contribute significantly to the implementation of the HHS National Action Plan to Prevent HAIs and the CMS Innovation Center's Partnership for Patients.

Health Information Technology Research: The Budget provides a total of $23 million, $6 million less than FY 2014, for the AHRQ health information technology (health IT) research portfolio. This program area develops and disseminates evidence and evidence-based tools to inform policy and practice on how health IT can improve the quality of American health care. In FY 2015, AHRQ will provide $20 million to support 40 grants for foundational health IT research to inform and support the meaningful use of health IT.

The portfolio operates in close coordination with other federal health IT programs in order to leverage resources and maximize their impact. For example, one focus of AHRQ's health IT research is whether and how health IT improves health care quality. This research 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 2015, AHRQ will end support for the development of implementation tools and increase its focus on conducting research to enhance the evidence base for the effective use of health IT.

Patient Centered Health Research: The Budget includes $106 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. The fund, established by the Affordable Care Act, transfers funding to AHRQ to build research capacity, translate and disseminate comparative clinical effectiveness research, and establish grants to train researchers. In FY 2015, investments will build on current AHRQ efforts, such as grants to improve patient outcomes by expanding the capacity of primary care practices to implement evidence-based quality improvement techniques.

PROGRAM HIGHLIGHT

Preventing Healthcare-Associated Infections

The Budget provides $9 million to support the ongoing nationwide implementation of AHRQ's Comprehensive Unit-based Safety Program. This program reduces healthcare-associated infections by improving patient safety culture and implementing evidence-based practices in various health care settings. The targeted infections include catheter-associated urinary tract infections, surgical site infections, and ventilator-associated pneumonia. This program reduced central line-associated bloodstream infections by 41 percent when implemented in over 1,000 intensive care units, thereby preventing over 2,100 infections, saving more than 500 lives, and averting over $36 million in excess costs.

Prevention and Care Management: The Budget includes $11 million, $12 million less than FY 2014, for the AHRQ Prevention and Care Management research portfolio which supports improved evidence-based clinical decision-making for preventive services through 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 2015, AHRQ will continue to focus on enhancing the quality of scientific support provided, as well as continue efforts to improve public engagement, transparency, and dissemination. AHRQ will end other research and dissemination activities previously included in this

portfolio. AHRQ can still support investigator initiated research on improving primary care in its Health Services, Research, Data and Dissemination portfolio.

Advancing Health Services Research, Data and Dissemination: The Budget includes a total of $93 million, a decrease of $18 million below FY 2014, for research focused on examining how people get access to health care, how much care costs, and what happens to patients as a result of the care they receive. This portfolio conducts crosscutting research that focuses on quality, effectiveness and efficiency of health services. For example, AHRQ funds several rapid cycle research networks that are designed to accelerate the diffusion of new research findings into practice, which contributes to increased quality, a stronger evidence-based culture of practice, and ultimately to better health for patients. One of these rapid cycle initiatives, the Evidence Based Practice Centers, reviews all relevant scientific literature on clinical, behavioral, and organizational and financing topics to produce evidence reports and technology assessments. These reports are used to develop quality measures, educational materials and tools, guidelines, and research agendas. The Budget level reduces funding for research contract support and less effective activities in this portfolio. Additionally, in FY 2015, AHRQ is eliminating the Value portfolio, a decrease of $3 million, and shifting some of these activities to the Health Services Research portfolio.

In FY 2015 AHRQ will provide $40 million for investigator-initiated research grants, of which approximately $20 million will be used to fund new grants. New investigator initiated research grants ensure that an adequate number of new and innovative ideas are pursued each year. Within the $20 million for new investigator initiated grants, $15 million will support a new initiative focusing on health economics research. AHRQ is anticipating grant proposals focused on increasing the efficiency, effectiveness, and value of the health care system. These grants could improve our understanding of the causes and consequences of lack of insurance, and of the effects of health insurance expansion on access to care, utilization of care, health care spending, health outcomes, and the labor market.

PROGRAM HIGHLIGHT

National Guideline Clearinghouse/ National Quality Measures Clearinghouse

The National Guideline Clearinghouse™ (NGC) and the National Quality Measures Clearinghouse™ (NQMC) are databases containing structured summaries of public and private sector evidence-based clinical practice guidelines and health care quality measures, respectively, and made freely available on the Web at www.guideline.gov and www.qualitymeasures.ahrq.gov. The content of both resources are used by clinicians, guideline or quality measure developers, health plans, hospitals and health systems, state and federal agencies, policymakers, researchers, and others to help inform decisions about and improve the quality of patient care. Approximately 500,000 users visit NGC and NQMC each month searching over 4,000 guidelines and measures to find those of interest.

An independent evaluation of NGC in 2011 found NGC to be the 'go to place' to find clinical practice guidelines making it a flagship tool supporting health care decision making. All of the evidence-based clinical practice guidelines in NGC meet criteria for evidence resulting from the 2011 Institute of Medicine's "Clinical Practice Guidelines We Can Trust" report.

A robust resource for finding health care quality measures, the NQMC includes measures and measure sets that meet criteria and a framework which have evolved over time as the field of health care quality measurement has evolved. NGC and NQMC show connections between guidelines and measures, when possible.

In FY 2014, with continued support in FY 2015, AHRQ will create new and updated summaries of guidelines and measures, ensuring that the content on the NGC and NQMC is up-to-date. Additionally, AHRQ will explore how to modify the NQMC inclusion criteria regarding evidence to align to the revisions made in the NGC.

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 2015 Budget includes $64 million, the same as FY 2014, for MEPS to maintain the precision and analytical capacity to continue providing valuable data on health status, medical expenditures, demographic disparities, and health care access, coverage and quality. This survey provides the only national source of annual data on how Americans, including the uninsured, use and pay for health care. MEPS includes three interrelated survey components: household, medical provider, and insurance.

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 and tax revenue.

Program Support

The FY 2015 Budget includes $70 million, an increase of $1 million from the FY 2014 level, to support agency wide operational and administrative costs. Most of the requested increase is for one-time costs associated with AHRQ's upcoming move to a different building. Program support costs largely consist of salaries, benefits, and rent.

CENTERS FOR MEDICARE & MEDICAID SERVICES
OVERVIEW

dollars in millions	2013	2014	2015	2015 +/-2014
Current Law:				
Medicare /1	497,800	512,464	521,569	+9,105
Medicaid	265,392	308,440	331,440	+23,000
CHIP	9,483	10,289	10,611	+322
State Grants and Demonstrations	517	749	673	-76
Private Health Insurance Programs	3,469	3,813	15,505	+11,692
Center for Medicare and Medicaid Innovation	656	1,054	1,444	+390
Total Net Outlays, Current Law	777,317	836,809	881,242	+44,433
Adjusted Baseline:				
Prevent Reduction in Medicare Physician Payments	—	6,180	13,657	+7,477
Total Net Outlays, Adjusted Baseline	777,317	842,989	894,899	+51,910
Proposed Law:				
Medicare	—	365	-2,365	-2,730
Medicaid	—	175	4,521	+4,346
CHIP	—	—	10	+10
State Grants and Demonstrations	—	—	25	+25
Private Health Insurance Programs	—	—	—	—
Program Management	—	—	433	+433
HCFAC Investment	—	—	378	+378
Total Proposed Law	—	540	3,002	+2,462
Total Net Outlays, Proposed Law /2	777,317	843,529	897,901	+54,372
Savings from Program Integrity Investments /3	—	—	-551	-551
Total Net Outlays, Proposed Policy	777,317	843,529	897,350	+53,821

1/ Current law Medicare outlays net of offsetting receipts.

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

3/ Includes savings not subject to PAYGO from additional investments in HCFAC above savings already assumed in current law. Includes the net impact of HHS and the Social Security Administration program integrity investments on Medicaid.

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

The FY 2015 Budget estimate for the Centers for Medicare & Medicaid Services (CMS) is $897.3 billion in mandatory and discretionary outlays, a net increase of $54.3 billion above the FY 2014 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 continues CMS's work to implement the Affordable Care Act by improving health care for tens of millions of Americans through comprehensive insurance reforms, enhanced quality, and the provision of coverage for those previously without access to it. The Budget proposes additional targeted reforms to Medicare and Medicaid that are projected to save $414.5 billion over the next decade. These reforms will improve the long-term sustainability of Medicare and Medicaid by increasing the efficiency of health care delivery without compromising the quality of care for the elderly, children, low-income families, and people with disabilities.

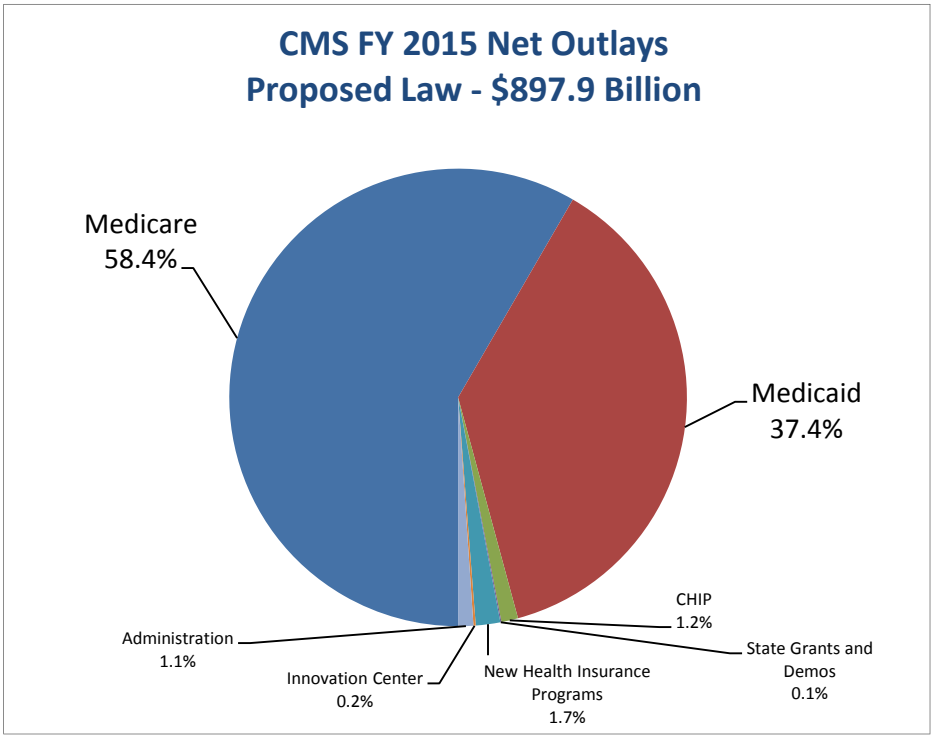
Budgetary Request

Medicare: The Budget includes projected Medicare savings of $407.2 billion over 10 years, including proposals to improve payment efficiency across providers and increase the value of the care that is provided to Americans.

Medicaid and CHIP: The Budget includes $7.3 billion in Medicaid savings and $345 million in CHIP investments over 10 years to make Medicaid and CHIP 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. In addition, the Budget, as part of the Workforce Initiative, extends both the rate increase for Medicaid primary care providers, as well as flexibilities to facilitate enrollment of Medicaid and CHIP-eligible children.

Program Integrity: The Budget includes a $403 million mandatory investment in HCFAC and the Medicaid Integrity Program in FY 2015, as part of a multi-year investment to enable HHS and the Department of Justice to detect, prevent, and prosecute health care fraud. Additionally, the Budget proposes $25 million in new discretionary HCFAC funding to support program integrity activities in private insurance, including the Health Insurance Marketplaces. These targeted investments will save an estimated $7.7 billion over 10 years. The Budget also proposes a series of new authorities to strengthen program integrity oversight. Of the total Medicare and Medicaid savings, program integrity legislative proposals yield $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 the ongoing Medicare, Medicaid, and CHIP programs in CMS, as well as the recently implemented Health Insurance Marketplace. The request also accommodates substantial increases in CMS workload because of demographic trends and program changes driving higher Medicare and Medicaid enrollment and implements responsibilities assigned in the Affordable Care Act and other legislation related to Medicare, Medicaid, and CHIP. At the same time, the Budget reflects significant operational savings which result from CMS more efficiently serving beneficiaries.



dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law:				
Outlays				
Benefits Spending (gross) /1	572,682	591,368	605,905	+14,537
Less: Premiums Paid Directly to Part D Plans /2	-6,306	-7,588	-8,778	-1,220
Subtotal, Benefits Net of Direct Part D Premium Payments	566,376	583,810	597,127	+13,317
Related-Benefit Expenses /3	20,501	14,716	14,642	-74
Administration /4	7,948	9,462	8,800	-662
Total Outlays, Current Law	594,825	607,988	620,568	+12,580
Offsetting Receipts				
Premiums and Offsetting Receipts	-97,025	-95,524	-98,999	-3,475
Current Law Outlays, Net of Offsetting Receipts	497,800	512,464	521,569	+9,105
Adjusted Baseline				
Prevent Reduction in Medicare Physician Payments	—	6,180	13,657	+7,477
Adjusted Baseline Outlays, Net of Offsetting Receipts	497,800	518,644	535,226	+16,582
Proposed Law:				
Medicare Proposals, Net of Offsetting Receipts /5	—	365	-2,772	-3,137
Program Management	—	—	30	+30
HCFAC Investment	—	—	378	+378
Total Medicare Proposals, Net of Offsetting Receipts	—	365	-2,365	-2,729
Savings from Additional Mandatory HCFAC Investments	—	—	-552	-552
Total Net Outlays, Proposed Policy	497,800	519,009	532,309	+13,301
Mandatory Proposed Law:				
Mandatory Total Net Outlays, Proposed Policy /6	491,783	513,148	526,019	+12,871

1/ Represents all spending on Medicare benefits by either the Federal government or other beneficiary premiums. Includes Medicare Health Information Technology Incentives.

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 and savings from investments in Social Security disability reviews.

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

5/ Includes SMI transfers to Medicaid of $365 million in FY 2014 and $760 million in FY 2015 to extend the Qualified Individuals (QI) Program.

6/ Removes total Medicare discretionary amount: FY 2013- $6,017 million; FY 2014- $5,861 million; and FY 2015- $6,291 million.

MEDICARE

In FY 2015, gross current law spending on Medicare benefits will total $605.9 billion. Medicare will provide health insurance to 55 million individuals who are 65 or older, disabled, or have end-stage renal disease (ESRD).

The Four Parts of Medicare

Part A ($203.1 billion gross fee-for-service spending in 2015): 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 2014, beneficiaries pay a $1,216 deductible for a hospital stay of 1–60 days, and $152 daily coinsurance for days 21–100 in a SNF.

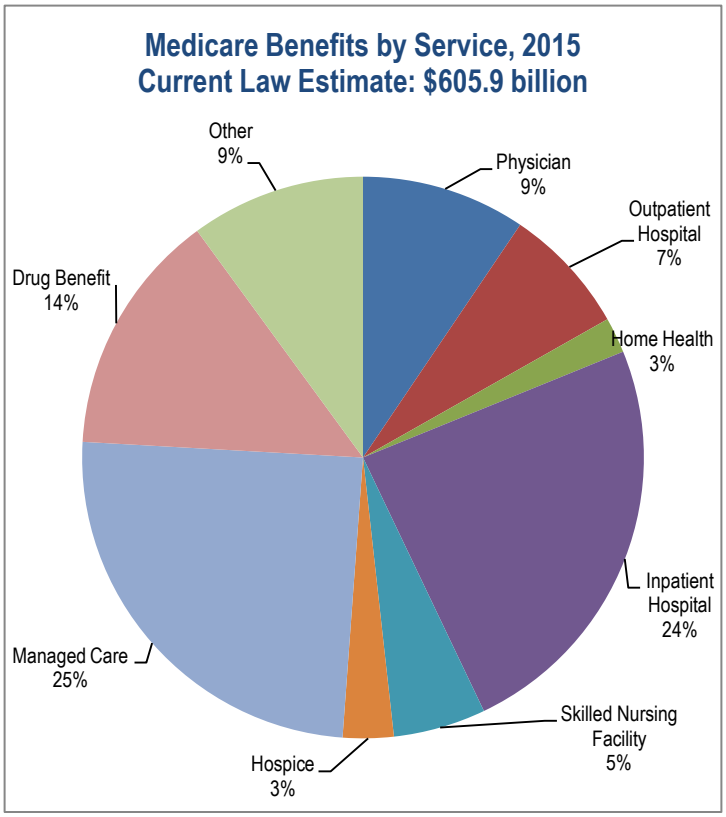
Part B ($167.8 billion gross fee-for-service spending in 2015): Medicare Part B pays for physician, outpatient hospital, ESRD, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 92 percent of all Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

The standard monthly Part B premium is $104.90 in 2014, the same as the 2013 premium. The last five years have been among the slowest periods of average Part B premium growth in the program's history. The Part B deductible will also remain unchanged at $147.

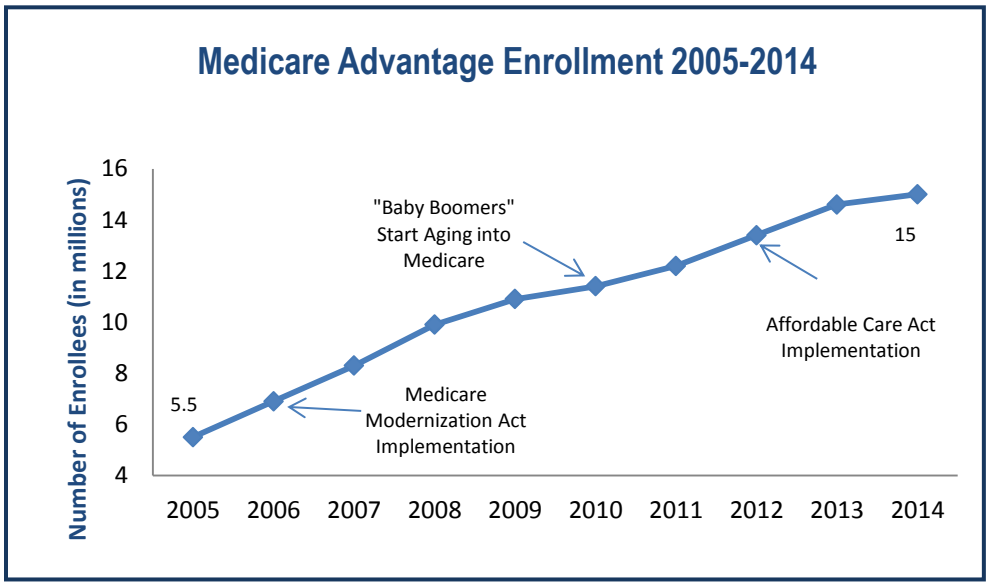
Some beneficiaries pay a higher Part B premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married) will pay from $146.90 to $335.70 per month in 2014.

Part C ($149.8 billion in 2015): Medicare Part C, the Medicare Advantage (MA) program, pays plans a capitated monthly payment to provide all Part A and B services, and 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 Parts 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. Over the past ten years, MA enrollment as a percentage of total enrollment has increased by 173 percent (see graph on Medicare Advantage Enrollment 2005-2014). CMS data confirm that Medicare beneficiary access to an MA plan remains strong and stable at 99.1 percent in 2014, premiums have remained stable, MA supplemental benefits remain largely unchanged, and enrollment is growing faster than traditional Medicare.



Part D ($85.2 billion projected gross spending in 2015):
Medicare Part D offers a standard prescription drug benefit with a 2014 deductible of $310 and an average estimated monthly premium of $32.42. 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 $6.35 in 2014 and low or no monthly premiums.



For 2015, the number of beneficiaries enrolled in Medicare Part D is expected to increase by about 3 percent to 41 million, including about 12 million beneficiaries who receive the low-income subsidy. In 2014, approximately 61 percent of those with Part D coverage are enrolled in a stand-alone Part D prescription drug plan, 34 percent are enrolled in a Medicare Advantage Prescription Drug Plan, and the remaining beneficiaries are enrolled in an employer plan or the Limited Income Newly Eligible Transition plan. 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 closes the Medicare Part D coverage gap, or "donut hole," through a combination of manufacturer discounts and gradually increasing federal subsidies. Beneficiaries fall into the coverage gap once their total drug spending exceeds an initial coverage limit ($2,850 in 2014), until they reach the threshold for qualified out-of-pocket spending ($4,550 in 2014), 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 Affordable Care Act, in 2015, non-LIS beneficiaries who reach the coverage gap will pay 45 percent of the cost of covered Part D brand drugs and biologics, and 65 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 2013, more than 4.8 million beneficiaries reached the coverage gap and saved more than $4.5 billion on their medications due to the prescription drug discount program. These savings averaged about $929 per person.

2015 Legislative Proposals

The FY 2015 Budget includes a package of Medicare legislative proposals that will save $407.2 billion over 10 years by more closely aligning payments with costs of care, strengthening provider payment incentives to promote high-quality efficient care and making

PERFORMANCE HIGHLIGHT

Healthcare Associated Infections

CMS in partnership with the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the Secretary is working to improve patient safety and reduce the national rate of hospital-acquired catheter-associated urinary tract infections. The goal is to reduce the national standardized hospital-acquired catheter-associated urinary tract infection ratio by 10 percent by September 2015 over the current March 2013 infection ratio baseline of 1.02 per 1,000 days of treatment.

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 five years.

Increase Value in Medicare Provider Payments

Reduce Medicare Coverage of Bad Debts: For most institutional provider types, Medicare currently reimburses 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 2015, 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. [$30.8 billion in savings over 10 years]

Better Align Graduate Medical Education Payments with Patient Care Costs: MedPAC has found that existing Medicare add-on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal would partially correct this imbalance by reducing these payments by 10 percent, beginning in 2015. In addition, the Secretary would be granted 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. [$14.6 billion in savings over 10 years]

Reduce Critical Access Hospital Reimbursements to 100 percent 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 pays CAHs 101 percent of reasonable costs. This proposal would reduce this rate to 100 percent beginning in 2015. [$1.7 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 2015, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced rate. These hospitals would instead be paid under the applicable prospective payment system. [$720 million in savings over 10 years]

Target Support for Graduate Medical Education: This proposal would reinvest savings in workforce development, via a targeted grant program administered by HRSA. (See the HRSA chapter for more details.) [$5.2 billion in costs over 10 years]

Adjust Payment Updates for Certain Post-Acute Care Providers: This proposal reduces market basket updates for inpatient rehabilitation facilities, long-term care hospitals, and home health agencies by 1.1 percentage points in each year 2015 through 2024. Payment updates for these providers would not drop below zero as a result of this proposal. This proposal will reduce market basket updates for skilled nursing facilities (SNF) under an accelerated schedule,

Medicare Enrollment (Enrollees in millions)

	2013	2014	2015	2015 +/-2014
Aged	43.2	44.6	46.1	+1.5
Disabled	8.7	8.9	9.1	+0.2
Total Beneficiaries	51.9	53.6	55.2	+1.7

beginning with a -2.5 percent update in FY 2015 tapering down to a -0.97 percent update in FY 2022. [$97.9 billion in savings over 10 years]

Implement Bundled Payment for Post-Acute Care Providers: Beginning in 2019, this proposal would implement bundled payment for post-acute care providers, including long term care hospitals, 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 so as to produce a permanent and total cumulative adjustment of 2.85 percent by 2021. Beneficiary coinsurance would equal that under current law (e.g., to the extent the beneficiary uses SNF services, they would be responsible for the current law coinsurance rate). [$8.7 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 Inpatient Rehabilitation Facility (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 2015, this proposal would reinstitute the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.4 billion in savings over 10 years]

Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions: A Medicare Payment Advisory Commission (MedPAC) analysis shows that roughly 19 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. To promote high quality care in SNFs, this proposal reduces SNF payments by up to three percent beginning in 2018 for facilities with high rates of care-sensitive preventable readmissions. [$1.9 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 Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs), Medicare payments are significantly higher when services are provided in an IRF. Beginning in 2015, 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. [$1.6 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 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 schedule in a budget-neutral manner. Additionally, the Budget supports policies to encourage electronic reporting of laboratory results. [$7.9 billion in savings over 10 years]

Modify Reimbursement for Part B Drugs: To reduce excessive payment of Part B drugs administered in the physician office and hospital outpatient settings, this proposal lowers payment from 106 percent of the Average Sales Price (ASP) to 103 percent of ASP starting in 2015. If a physician's cost for purchasing the drug exceeds ASP + 3 percent, the drug manufacturer would be required to provide a rebate such that the net cost to the provider to acquire the drug equals ASP + 3 percent minus a standard overhead fee to be determined by the Secretary. This rebate would not be used in calculating ASP. The Secretary would also be given authority to pay a portion or the entire amount above ASP in the form of a flat fee rather than a percentage, with the modification to be made in a budget neutral manner relative to ASP + 3 percent. [$6.8 billion in savings over 10 years]

Exclude Certain Services from the In-Office Ancillary Services Exception: The in-office ancillary services exception to the physician self-referral law was intended to allow physicians to self-refer for certain services to be furnished by their group practices for patient convenience. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely furnished on the same day as the related physician office visit. Additionally, there is evidence

that suggests that this exception may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2016, this proposal would seek to encourage more appropriate use of ancillary services by amending the in-office ancillary services exception to prohibit certain referrals for radiation therapy, therapy services, advanced imaging, and anatomic pathology services except in cases where a practice meets certain accountability standards, as defined by the Secretary. [$6 billion in savings over 10 years]

Increase the Minimum Medicare Advantage Coding Intensity Adjustment: Starting in 2016, 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 8.51 percent in 2020 and thereafter. [$31 billion in savings over 10 years]

Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids: Beginning in payment year 2016, this proposal would establish payment amounts for Employer Group Waiver Plans based on the average MA plan bid in each individual market. [$3.7 billion in savings over 10 years]

NEW INITIATIVE

Closing the Coverage Gap

Medicare Part D Coverage Gap Cost-Sharing by 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)
2010 /2	100%	100%	100%
2011	50%	50%	93%
2012	50%	50%	86%
2013	47.5%	47.5%	79%
2014	47.5%	47.5%	72%
2015	45%	45%	65%
2016	45%	25%	58%
2017	40%	25%	51%
2018	35%	25%	44%
2019	30%	25%	37%
2020	25%	25%	25%
2021	25%	25%	25%
2022	25%	25%	25%

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

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

Align Medicare Drug Payment Policies 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 2016. The proposal would require manufacturers to pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels. Manufacturers would also be required to provide an additional rebate for brand name and generic drugs whose prices grow faster than inflation. [$117.3 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 2016, this proposal would increase manufacturer discounts to 75 percent, effectively closing the coverage gap for brand drugs in 2016. The phase-out for generic drugs would continue through 2020. [$7.9 billion in savings over 10 years]

Strengthen IPAB 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 a specified target. To further moderate Medicare cost growth, this proposal would lower the target rate applicable for 2018 and after from gross domestic product (GDP) per capita growth plus 1 percentage point to GDP per capita growth plus 0.5 percentage points. [$12.9 billion in savings over 10 years]

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]

Implement Value-Based Purchasing for Additional Providers: This proposal would implement a budget neutral value-based purchasing program for several additional provider types, including skilled nursing facilities, home health agencies, ambulatory surgical centers, and hospital outpatient departments, beginning in 2016. At least 2 percent of payments must be tied to the quality and efficiency of care. [No budget impact]

Expand Medicare Data Sharing with Qualified Entities: The Affordable Care Act includes a provision which allows CMS to make Medicare Parts 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]

Modify Documentation Requirement for Face-to-Face Encounters for DMEPOS Claims: Currently, a physician must document a beneficiary's face-to-face encounter with a physician or non-physician practitioner as a condition for Medicare payment for an order. This proposal would modify that requirement by allowing certain non-physician practitioners to document the face-to-face encounter. [No budget impact]

NEW INITIATIVE

Increase Income-Related Premiums under Medicare Part B and Part D

Current Law		President's Budget 2015 Proposal	
Modified adjusted gross income threshold (MAGI)[1]	Applicable premium percentage (Percentage)	MAGI[1]	Percentage
Less than $85,000	25 percent for Part B; around 25.5 percent for Part D	Less than $85,000	25 percent for Part B; around 25.5 percent for Part D
More than $85,000 but not more than $107,000	35 percent	More than $85,000 but not more than $107,000	40 percent
More than $107,000 but not more than $160,000	50 percent	More than $107,000 but not more than $133,500	52.5 percent
		More than $133,500 but not more than $160,000	65 percent
More than $160,000 but not more than $214,000	65 percent	More than $160,000 but not more than $196,000	77.5 percent
More than $214,000	80 percent	More than $196,000	90 percent

1-The table reflects MAGI thresholds for Medicare beneficiaries who file an individual tax return with income.

Establish Quality Bonus Payments for Part D Plans Based on Quality Star Ratings: This proposal would allow Medicare to revise the Part D plan payment methodology to reimburse plans based on their quality star ratings. Plans with quality ratings of four stars or higher would have a larger portion of their bid subsidized by Medicare, while plans with lower ratings would receive a smaller subsidy. This proposal is modeled after the MA quality bonus program, but would be implemented in a budget neutral fashion. It would not impact risk corridor payments, reinsurance, low-income subsidies, or other components of Part D payments. [No budget impact]

Suspend Coverage and Payment for Questionable Part D Prescriptions: This proposal would provide the Secretary authority to suspend coverage and payment for drugs prescribed by providers who have been engaged in misprescribing or overprescribing drugs with abuse potential. The Secretary would also be able to suspend coverage and payment for Part D prescription drugs when those prescriptions present an imminent risk to patients. In addition, the proposal would provide the Secretary authority to require additional information on certain Part D prescriptions, such as diagnosis and incident codes, as a condition of coverage. [No budget impact]

Medicare Structural Reforms

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 2018, this proposal would restructure income-related premiums under Medicare Parts B and D by increasing the lowest income-related premiums five percentage points, from 35 percent to 40 percent, and creating new tiers every 12.5 percentage points 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 who need the subsidy the least. [$52.8 billion in savings over ten years]

Encourage the Use of Generic Drugs by Low Income Beneficiaries: Beginning in plan year 2016, this proposal would induce greater generic utilization by lowering copayments for generic drugs. Brand copayments would be increased to twice the level required under current law. The Secretary would have new authority to exclude brand drugs in therapeutic classes from this policy if therapeutic substitution is determined not to be clinically appropriate or a generic is not available. Brand drugs could be obtained at current law cost-sharing levels if beneficiaries successfully appeal. In addition, the change in cost-sharing would be applied to LIS beneficiaries receiving a partial subsidy upon reaching the catastrophic coverage level. Beneficiaries qualifying for institutionalized care, who currently face no copayments, would be excluded from these increases. [$8.5 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 calendar year 2014). 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 2018, 2020, and 2022 respectively for new beneficiaries beginning in 2018. Current beneficiaries or near retirees would not be subject to the revised deductible. [$3.4 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, starting in 2018. Other Medigap plans that meet minimum cost-sharing requirements would be exempt from the requirement. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium (or about 30 percent of the Part B premium). [$2.7 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 2018. Consistent with MedPAC recommendations, this co-payment would apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. 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. [$820 million in savings over 10 years]

Increase the Availability of Generic Drugs and Biologics

Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics: Beginning in 2015, this proposal would prohibit anticompetitive pay-for-delay agreements between branded and generic pharmaceutical companies. This proposal increases the availability of generic drugs and biologics by authorizing the Federal Trade Commission to stop companies from entering into anticompetitive agreements which block consumer access to safe and effective generics. This proposal would save money in Medicare and Medicaid. [$9.1 billion in Medicare savings over 10 years]

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics: This proposal would increase competition for biologic drugs by reducing the number of years (from 12 to 7) that a drug company has exclusivity or monopoly pricing power and prohibits additional years of exclusivity due to formulation changes. The proposal also modifies how Part B pays for treatment where generic biologics are available by allowing them to be classified in the same category as their biosimilar. Reimbursement would be made based on the weighted average sales price. This proposal would save money in Medicare and Medicaid. [$4 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 beneficiaries get the right care at the right time, with the goal of avoiding unnecessary duplication of services, preventing medical errors, and reducing Medicare costs. ACOs currently cover over 5.3 million Medicare beneficiaries across the country.

Medicare Shared Savings Program (MSSP): 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 also be subject to losses. Since the first cohort of ACOs entered the program in 2012, 343 MSSP ACOs have been established. In the first year of the program, Medicare ACOs generated interim shared savings totaling $128 million for the Medicare trust fund. Fifty-four ACOs had lower expenditures than projected, and 29 will share interim savings.

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 22 health care organizations and providers that already have experience coordinating care for patients across care settings and are prepared to take on greater financial risk. Initial results from the independent evaluation of the Pioneer ACO Model shows that Pioneer ACOs have generated gross savings of $147 million. In addition, all the ACOs successfully reported quality measures and performed better than their published rates on most measures.

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 25 million people with traditional Medicare reviewed their health status at a free Annual Wellness Visit or received one or more other preventive service without cost sharing during the first eleven months of 2013.

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 2015, which will be the third 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 five-star rating system beginning in 2012. In 2014, 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.

Highlights from the Pathway for SGR Reform Act of 2013

The Pathway for SGR Reform Act of 2013, passed along side with the Bipartisan Budget Act of 2013, included multiple provisions that affect Medicare.

Medicare Physician Update: The Act averted nearly a 24 percent reduction to physician payment rates and provided a half percent increase to rates for the first three months of 2014. CBO estimated the cost of this 3-month provision to be $7.3 billion over 10 years (FY 2014–2023).

Medicare Extenders: The Act included provisions that extend current Medicare payment policies for the first three months of 2014. 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 $0.8 billion over 10 years (2014 – 2023).

Mandatory Savings: The Act also included a few provisions that reduced expenditures. CBO estimated the total savings from these provisions at $8.6 billion over ten years. Major savers include:

- *Medicaid DSH allotments:* The Act made technical adjustments to the calculation of future Medicaid DSH allotments (Savings: $3.9 billion)
- *Modifications to Medicare sequestration for fiscal year 2023*: The Bipartisan Budget Act of 2013 extended the sequestration of Medicare provider payments along with the sequestration of other non-exempt mandatory programs through FY 2023. An additional provision in the Pathway for SGR Reform Act of 2013 accelerates FY 2023 savings from sequestration by applying a higher percentage Medicare reduction to the first six months. (Savings: $2.1 billion from acceleration of Medicare spending reductions in FY 2023)
- *Payment for Inpatient Services in Long-Term Care Hospitals (LTCHs):* Starting in FY 2016, the Act placed new, clinical restrictions on which inpatient hospital stays are eligible to receive the higher LTCH Medicare payment rate, as opposed to the standard inpatient hospital rate. In addition, the Act delayed implementation of certain existing restrictions on LTCH payment and reinstated a moratorium on new LTCH facilities or beds. (Savings: $3 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 upcoming five year contract cycle, or 11th Statement of Work, begins on August 1, 2014 and provides approximately $725 million in FY 2015 and $4 billion over 5 years. The 11th statement of work focuses on implementing the HHS Quality Strategy and the Institute of Medicare recommendations to continually improve health care for Medicare beneficiaries. QIOs are experts in the field working to drive local change which can translate into national quality improvement.

The 11th statement implements for the first time several changes to the QIO program enacted in the Trade Adjustment Assistance Extension Act of 2011, including the authority to determine the geographic scope of QIO contracts and contract with a broader range of entities to perform QIO functions. Additionally, the contract period is now five years, with increased flexibility to terminate a QIO for poor performance.

Major Planned Activities

Clinical Quality Improvement: The key goals for the upcoming contract cycle are improving the health status of communities; delivering patient-centered, reliable, accessible, and safe care; and better care at lower costs. Through improving cardiac health, reducing disparities in diabetic care, using immunization information systems and meaningful use of health IT to improve prevention coordination, CMS aims to improve the health status of beneficiaries. These goals will also be achieved by efforts to reduce healthcare associated infections, healthcare associated conditions in nursing homes, and hospital readmissions and adverse drug events.

Value Based Purchasing Support Contracts and Quality Measures: This work provides QIO assistance to the hospital value-based purchasing and readmission reduction programs and the physician quality reporting system. Additionally, this funding supports LTCH, IRF, Hospice, ASC and Cancer Hospital public reporting programs.

Infrastructure, Coordinating Centers, and Special Initiatives: This work includes the program's IT standard data processing system and small scale special innovative projects or special initiatives.

Beneficiary and Family Centered Care: This effort is the traditional QIO case review work, including beneficiary complaints, concerns related to early discharge from health care settings and patient and family engagement. So far in the 10th Statement of Work, QIOs have worked to resolve more than 180,000 concerns and appeals received from beneficiaries and their families.

Other Support Contracts and Staff: This work supports consumer assessment of healthcare providers and systems surveys, quality information for compare websites, the QIO quality improvement and evaluation system, other QIO needed Medicare surveys, and staff.

PROGRAM HIGHLIGHT

Estimated QIO Funding 11th Statement of Work (2014-2018)
Dollars in Millions

QIO Clinical Quality Improvement	
Healthy People Healthy Communities	$159.3
Better Healthcare: Patient-centered, Reliable, Accessible, & Safe Care	$325.4
Better Care at Lower Costs	$88.8
Technical Assistance, Phase II and III Tasks and IT	$266.4
Subtotal, Clinical Quality Improvement	**$839.9**
Value-based Purchasing Support Contracts and Quality Measures	$1,129.4
Infrastructure, Coordinating Centers, and Special Initiatives	$562.0
Beneficiary and Family-centered Care	$402.5
Other Support Contracts and Staff	$1061.8
Subtotal	**$3,995.6**

QIO Success Stories

Over the course of the current contract cycle, QIOs have worked with providers, patients, families, nursing homes, home health agencies, pharmacists and many more in the community to increase coordination of care and improve patient safety. QIOs have supported nursing homes in achieving a 34 percent reduction in pressure ulcers among nursing home residents, resulting in several thousand fewer pressure ulcers. Pressure ulcers add an estimated burden of over $1 billion of expenditures and an additional 2.2 million Medicare hospital days to the United States healthcare system and decrease the quality of life for patients. QIOs worked with communities and providers to prevent potential adverse drug events, with more than 44,000 adverse events avoided. By working with QIOs, communities across the country have collectively saved over 27,000 people from being readmitted and over 95,000 people from being admitted to the hospital, resulting in improved coordination of care and millions of dollars in savings.

FY 2015 Medicare Legislative Proposals

dollars in millions (Negative numbers reflect savings and positive numbers reflect costs)	*2015*	*2015 -2019*	*2015 -2024*
Increase Value in Medicare Provider Payments			
Reduce Medicare Coverage of Bad Debts	-340	-10,510	-30,820
Better Align Graduate Medical Education Payments with Patient Care Costs	-960	-6,050	-14,640
Reduce Critical Access Hospital Payments to 100 percent of Costs	-110	-690	-1,690
Prohibit Critical Access Hospital Designation for Facilities that are less than 10 Miles from the Nearest Hospital	-40	-300	-720
Target Support for Graduate Medical Education	530	2,430	5,230
Adjust Payment Updates for Certain Post-Acute Care Providers	-1,450	-24,060	-97,860
Implement Bundled Payment for Post-Acute Care Providers	0	-430	-8,680
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-170	-1,070	-2,420
Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions	—	-230	-1,860
Equalize Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	-110	-690	-1,620
Modernize Payments for Clinical Laboratory Services	—	-1,240	-7,890
Modify Reimbursement for Part B Drugs	-300	-2,660	-6,750
Exclude Certain Services from the In-Office Ancillary Services Exception	—	-2,120	-6,030
Increase the Minimum Medicare Advantage Coding Intensity Adjustment	—	-5,850	-30,960
Align Employer Group Waiver Plan Payments with Average Medicare Advantage Plan Bids	—	-1,180	-3,740
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	—	-31,050	-117,250
Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap	—	-1,270	-7,850
Strengthen IPAB to Reduce Long-Term Care Drivers of Medicare Cost Growth	—	—	-12,940
Clarify the Medicare DSH Statute	—	—	—
Implement Value-Based Purchasing for Additional Providers	—	—	—
Expand Medicare Data Sharing with Qualified Entities	—	—	—
Modify the Documentation Requirement for Face-to-face Encounters for DME Claims	—	—	—
Establish Quality Bonus Payments for Part D Plans Based on Quality Star Ratings	—	—	—
Suspend Coverage and Payment for Questionable Part D Prescriptions	—	—	—
Medicare Structural Reforms			
Increase Income Related Premiums Under Part B and Part D	—	-4,320	-52,790
Encourage the Use of Generic Drugs by Low Income Beneficiaries	—	-3,020	-8,490
Modify Part B Deductible for New Enrollees	—	-110	-3,410

FY 2015 Medicare Legislative Proposals

dollars in millions *(Negative numbers reflect savings and positive numbers reflect costs)*	***2015***	***2015 -2019***	***2015 -2024***
Introduce a Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap Coverage	—	-230	-2,740
Introduce Home Health Copayments for New Beneficiaries	—	-70	-820
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)	-620	-3,630	-9,090
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare impact)	—	-700	-4,020
Medicare-Medicaid Enrollee Proposals			
Ensure Retroactive Part D Coverage of Newly-Eligible Low Income Beneficiaries	—	—	—
Integrate the Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Pilot the Program of All-Inclusive Care for the Elderly to Individuals Between Ages 21 and 55 (Medicare impact)	—	—	—
Other Proposals			
Extend the Qualified Individuals Program through CY 2015 (Medicare interaction)/1	760	960	960
Reduce Fraud, Waste, and Abuse in Medicare	—	-120	-400
Interactions/2	38	1,926	22,049
Total	-2,772	-96,284	-407,241
1/ States pay 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 are reflected in Medicare outlays.			
2/ Adjusts for savings realized through IPAB and other Medicare interactions.			

PROGRAM INTEGRITY

dollars in millions	2013	2014	2015	2015 +/- 2014
Budget Authority:				
HCFAC Discretionary /1 /2	294	294	319	+25
HCFAC Mandatory /3	1,260	1,264	1,700	+436
Affordable Care Act (non-add)	*122*	*142*	*149*	*+7*
Total, Budget Authority	1,554	1,558	2,019	+461

1/ The FY 2015 President's Budget provides $319 million for HCFAC through discretionary appropriations. The Budget also proposes additional mandatory funding beginning in FY 2015.

2/ The FY 2013 discretionary base and FY 2013 and FY 2014 mandatory base include sequester reductions.

3/ Does not include Deficit Reduction Act funding for the Medicaid Integrity Program, which is discussed in this chapter but is in the State Grants and Demonstrations account.

The FY 2015 Budget supports fraud prevention and the reduction of improper payments, which are top priorities of the Administration. For FY 2015, the Budget invests a total of $428 million in new Health Care Fraud and Abuse Control Program (HCFAC) and Medicaid program integrity funds. Together the program integrity investments in the Budget will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years. The Budget also proposes legislative changes to give HHS important new tools to enhance program integrity oversight; cut fraud, waste, and abuse in Medicare, Medicaid, and Children's Health Insurance Program (CHIP); and generate an additional $1 billion in program savings over 10 years.

Health Care Fraud and Abuse Control Funding

The FY 2015 Budget proposes to build on recent progress by increasing support for the HCFAC program through both mandatory and discretionary funding streams. The FY 2015 HCFAC program level is $2 billion. Of the total FY 2015 program level, $1.7 billion is mandatory funding and $319 million is requested in discretionary funding.

The Budget includes $697 million in HCFAC program funding in FY 2015, $294 million in base discretionary funding, $25 million in new discretionary funding, and $378 million in proposed new mandatory funding. Starting in FY 2016, 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 accurate payments are made to

HCFAC Multi-Year Investment and Savings

(in millions)

	2014	2015	2016	2017	2018	2019	2015 -2019	2015 -2024
Mandatory Base Funding	1,264	1,322	1,348	1,356	1,385	1,417	6,828	14,373
Proposed Mandatory Funding /1	—	378	706	725	745	765	3,319	7,469
Discretionary Funding	294	319	—	—	—	—	319	319
Total Program Level /2	**1,557**	**2,019**	**2,054**	**2,081**	**2,130**	**2,182**	**10,446**	**22,161**
Savings from HCFAC Investment /3	—	*-552*	*-610*	*-646*	*-684*	*-725*	*-3,217*	*-7,351*

1/ Totals reflect additional HCFAC mandatory investments proposed in the President's Budget, above FY 2015 discretionary HCFAC levels.

2/ Total Program Levels may not add due to rounding.

3/ Savings are the gross savings attributable only to the incremental increase in the HCFAC investment. Savings are not scored under PAYGO.

PROGRAM HIGHLIGHT

Power Mobility Devices (PMD) Prior Authorization Demonstration

CMS implemented a Prior Authorization process for scooters and power wheelchairs in seven states with high populations of fraud- and error-prone providers (CA, IL, MI, NY, NC, FL and TX) starting in 2012. This demonstration is an approach drawn from the private sector, and is designed to ensure that Medicare only pays for PMDs that meet longstanding coverage guidelines, thereby reducing improper payments and reducing fraud, waste and abuse.

In September 2013 CMS released positive findings for the first year of implementation. Based on the initial report, in 2012 Medicare PMD expenditures per month dropped significantly in demonstration states and non-demonstration states. Additionally, CMS reported positive feedback on prior authorization from the industry because it helps reduce subjecting providers and suppliers to future post-pay audits and ensures a predictable cash flow related to billing. Finally, in the first year of implementation there were zero beneficiary complaints about the process.

The Budget proposes to expand prior authorization not only to PMD services but also to certain high risk Medicare fee-for-service categories.

legitimate providers for appropriate services for eligible beneficiaries. All proposed HCFAC program investments, including gradual growth over time, are consistent with BCA levels.

The $1.3 billion in mandatory base funds for FY 2015 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. 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 2015 Budget request of $697 million of discretionary and additional mandatory funding is allocated between CMS ($476 million), OIG ($113 million), and DOJ ($108 million). These funds are part of a multi-year program integrity investment of new mandatory funding to combat health care fraud in Medicare, Medicaid, and CHIP. To help ensure the prudent use of federal funds, the Budget includes $25 million of discretionary HCFAC funding for program integrity activities in private insurance, including the Health Insurance Marketplaces.

The HCFAC investment supports efforts to reduce the Medicare fee-for-service improper payment rate and initiatives of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team task force, including Strike Force teams in cities where intelligence and data analysis indicate high levels of fraud, and the 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 that analyzes all Medicare FFS claims using sophisticated

Medicaid Integrity Program Multi-Year Investment and Savings

(in millions)

	2014	2015	2016	2017	2018	2019	2015 2019	2015 -2024
Mandatory Base Funding /1	72	78	80	82	84	85	409	867
Proposed Mandatory Funding /1	0	25	26	26	27	27	131	276
Total Program Level	**72**	**103**	**106**	**108**	**111**	**112**	**540**	**1,143**
Savings from Mandatory Investment /2:	**0**	**0**	**-9**	**-17**	**-26**	**-35**	**-87**	**-273**

1/ Totals are post-sequestration in FY 2014 and include the annual Consumer Price Index for All Urban Consumers adjustment.
2/ Savings are attributable only to the proposed Medicaid Integrity Program investment. Savings are not scored under PAYGO.

PROGRAM HIGHLIGHT

Program Integrity Enhancements Authorized by the Affordable Care Act

- In July 2013 and January 2014, CMS issued temporary moratoria on the enrollment of home health agencies and ambulance suppliers in counties with indicators of fraud, including disproportionate number of providers to beneficiaries and extremely high utilization.
- In FY 2013, 45 states and the District of Columbia implemented Medicaid Recovery Audit Contractors returned total federal and state combined recoveries of $124.3 million.
- In February 2013, CMS issued a final rule to implement "the Sunshine Act", now called OpenPayments. This program will help increase public awareness of financial relationships between drug and device manufacturers and teaching hospitals and physicians.

algorithms to identify suspicious behavior. In FY 2015 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 more money to the Medicare Trust Funds than the dollars spent.

The 3-year rolling average return on investment for HCFAC law enforcement activities is a record 8.1 to 1. From 1997 to 2013, programs supported by HCFAC have returned over $25.9 billion to the Medicare Trust Funds. In FY 2013 alone, $4.3 billion was recovered, including $2.85 billion returned to the Medicare Trust Funds and $576 million in federal Medicaid recoveries returned to the Treasury. CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud; about $1.50 is saved or avoided. Based on these projections, the $697 million in additional HCFAC funding, as part of a multi-year HCFAC investment included in the Budget, will yield additional Medicare and Medicaid savings of $7.4 billion over 10 years. Further, the HCFAC return-on-investment 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. (See "Program Integrity Enhancements Authorized by the Affordable Care Act" for further details.) These program integrity tools fight fraud and safeguard taxpayer dollars while ensuring patient access to care is not interrupted.

Fraud Prevention System

In 2013, CMS completed its second year of full implementation of the Fraud Prevention System (FPS), marking a significant shift from a pay and chase model to a prevention approach using technology similar to the credit card industry. The FPS screens all Medicare Part A and Part B, including Durable Medical Equipment (DME), claims using 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.

Medicare Strike Force Success

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.

Since its inception, Strike Force prosecutors filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than $5.5 billion. Strike Force prosecutors secured 1,137 guilty pleas and 148 others were convicted in jury trials, and 1,087 defendants were sentenced to imprisonment for an average term of nearly 4 years.

Medicaid Integrity Program

The Medicaid Integrity Program was established by the Deficit Reduction Act of 2005, which appropriated $75 million in FY 2009 and for each year thereafter.

The Affordable Care Act later increased appropriations for FY 2011 and future years by inflation.

States have the primary responsibility for combating fraud, waste, and abuse in the Medicaid program, but the Medicaid Integrity Program plays an important role supporting state efforts, including 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 works in coordination with Medicaid program integrity activities funded through the HCFAC program. This program includes a collaborative effort across CMS to transform the Medicaid data enterprise through the Medicaid and CHIP Business Information and Solutions program.

Program Integrity Legislative Proposals

The Budget includes legislative proposals to further strengthen program integrity for Medicare, Medicaid, and CHIP, saving $1 billion over 10 years.

Medicare:

Allow Prior Authorization for Medicare Fee-for-service Items: Currently, CMS has authority to require prior authorization for Medicare DME service items. This proposal would extend that authority to all Medicare fee-for-service items, particularly those service items that are at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and prevent future Recovery Audit Contractor audits on those payments. In addition, this proposal would require the Secretary to implement prior authorization in two service areas: power mobility devices and advanced imaging. [$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 allow penalties if providers and suppliers fail to update their records, give them an additional incentive to report up-to-date information (such as adverse legal actions), and help reduce program vulnerability to fraud. [$90 million in savings over 10 years]

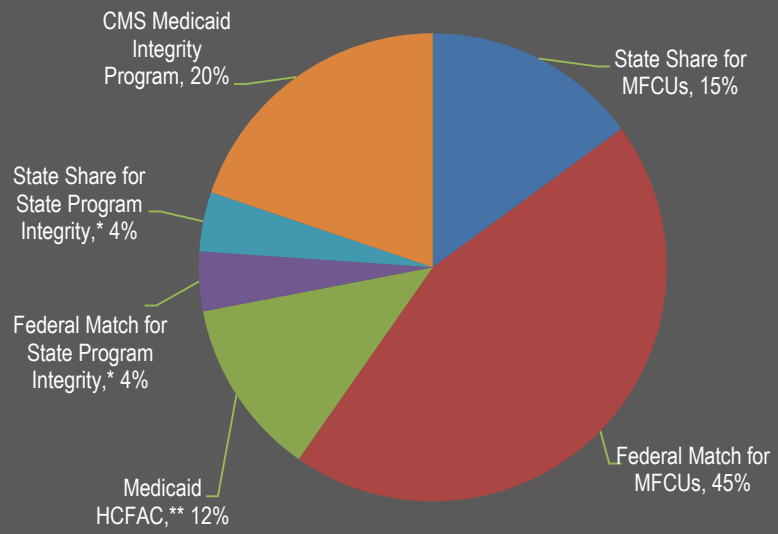
Allow the Secretary to Create a System to Validate Practitioners' Orders for Certain High-Risk Items and Services: Many current systems for ordering services lack mechanisms to determine whether the service is medically necessary or if the patient has seen a practitioner. An electronic Medicare claims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

PROGRAM HIGHLIGHT

FY 2015 Proposed CMS and State Medicaid Program Integrity Funds by Source ($522 million total)

As proposed, total resources for Medicaid program integrity will come to an estimated $522 million in FY 2015, of which $423 million is the estimated federal share. These federal funds both directly support state program integrity efforts and provide indirect support such as education and technical assistance. In 2013, state and federal program integrity officials worked together to successfully fight fraud, waste, and abuse, including the following activities:

- CMS partnered with states to avert $188 million in questionable reimbursements and recover $375 million in questionable costs.
- The Medicaid Integrity Institute enrolled 895 state employees in 18 program integrity training courses.
- Oversight of rate setting in Medicaid managed care and state financial management.
- Identifying overpayments through collaborative audits with states.



*State reported estimates do not include state spending on any program integrity-related activities reported under other administrative spending categories.
** Does not include HCFAC activities designed to benefit both Medicare and Medicaid, such as Medi-Medi.

Increase Scrutiny of Providers using Higher-Risk Banking Arrangements to Receive Medicare Payments: This proposal would 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]

Retain a Percentage of Incentive Reward Payment Recoveries: Under an incentive reward program individuals and beneficiaries reporting incidences of fraud, waste, and abuse are eligible to receive a percentage of the Medicare recoveries yielded from the tip up to $1000 reward. This proposal would work in conjunction with a proposed CMS rule expanding the program to allow CMS to retain a percentage of the recovery to administer the program. [No budget impact]

Medicaid:

Medicaid Integrity Program Investment and Expanded Authority: This proposal increases the Medicaid Integrity Program by $25 million per year (adjusted by the Consumer Price Index for All Urban Consumers). This proposal also expands the statutory authority for the Medicaid Integrity Program to increase program flexibility in protecting state and federal resources. These important reforms will support activities that protect the integrity and sustainability of Medicaid and will allow the program, in coordination with states, to strengthen initiatives that prevent fraud, waste, and abuse before it occurs. [$276 million in costs over 10 years]

Support Medicaid Fraud Control Units for the Territories: Medicaid Fraud Control Units have demonstrated success in recovering Medicaid dollars. This proposal would encourage territories to establish Medicaid Fraud Control Units to protect their Medicaid programs by exempting federal support for Medicaid Fraud Control Units from the cap on Medicaid funding for the territories and by exempting territories from the statutory ceiling on quarterly federal payments for the units. [$10 million in costs over 10 years]

Expand Medicaid Fraud Control Unit Review to Additional Care Settings: The Budget proposes to allow Medicaid Fraud Control Units to receive federal matching funds for the investigation or prosecution of abuse and neglect in non-institutional settings, such as home-based care—in which a beneficiary may be harmed in the course of receiving health care services. The current limitation on federal matching was logical when the 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 increasingly shifted to in-home and community-based settings. [No budget impact]

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid: This 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. [$540 million in savings over 10 years]

Consolidate Redundant Error Rate Measurement Programs: This proposal would alleviate state program integrity reporting requirements and create a streamlined audit program by consolidating the Medicaid Eligibility Quality Control and Medicaid Payment Error Rate Measurement programs. [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

Strengthening Program Integrity Tools

The FY 2015 Budget builds on the Affordable Care Act's unprecedented fraud-fighting authorities with 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 $1 billion over 10 years.

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]

Improvements to Program Integrity for Medicaid Drug Coverage: The President's Budget includes four related proposals to enhance program integrity for the Medicaid drug rebate program. These proposals are detailed in the Medicaid chapter.

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 recovered funds from the Recovery Audit Contractor program to administer the 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 they are 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 personal identification numbers, this proposal would strengthen penalties for knowingly distributing Medicare, Medicaid, or CHIP beneficiary identification or billing privileges. [No budget impact]

FY 2015 Program Integrity Legislative Proposals

(Non-Add: Proposed Law impacts incorporated into Medicare, Medicaid and State Grants and Demonstrations Tables)

dollars in millions	2015	2015 -2019	2015 - 2024
Medicare			
Allow Prior Authorization for Medicare Fee-for-service Items	—	-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	—	—	—
Retain a Percentage of Incentive Reward Program Recoveries	—	—	—
Medicaid			
Support Medicaid Fraud Control Units for the Territories	1	5	10
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-20	-240	-540
Consolidate Redundant Error Rate Measurement Programs	—	—	—
Expand Medicaid Fraud Control Unit Review to Additional Care Settings	—	—	—
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	—	—	—
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]	—	—	—
Subtotal, Medicare Impact	—	-120	-400
Subtotal, Medicaid Impact	-19	-275	-620
Subtotal, Program Integrity Savings	-19	-395	-1,020

FY 2015 Program Integrity Legislative Proposals

(Non-Add: Proposed Law impacts incorporated into Medicare, Medicaid and State Grants and Demonstrations Tables)

dollars in millions	2015	2015-2019	2015-2024
Program Integrity Investment/1			
HCFAC Mandatory Investment	378	3,319	7,469
Conversion of Discretionary Base to Mandatory Funding (non-add)	—	*-1,174*	*-2,642*
Net HCFAC Mandatory Investment (non-add)	*378*	*2,145*	*4,827*
Mandatory Investment from Expanding Funding and Authority for the Medicaid Integrity Program	25	131	276
Total, Program Integrity Investment	403	3,450	7,745
Non-PAYGO Savings /2			
Savings from Additional HCFAC Investment	-552	-3,217	-7,351
Savings from Supporting Medicaid Fraud Control Units for the Territories	—	-2	-2
Savings from Expanding Medicaid Fraud Control Unit Review to Additional Care Settings	-6	-32	-73
Savings from Additional Medicaid Integrity Program Investment	—	-87	-273
Savings from Social Program Integrity Investment	—	-1,061	-5,794
Subtotal, Medicare and Medicaid Savings from Program Integrity Investment	-558	-4,399	-13,493
Total, Net Savings Program Integrity Proposed Policy	-174	-1,344	-6,768
Impact Net of Conversion of Discretionary Base to Mandatory Funding (non-add)	*-174*	*-2,518*	*-9,410*

1/ Totals reflect additional HCFAC mandatory investment proposed in the President's Budget, above the 2015 discretionary levels. The Budget no longer proposes discretionary HCFAC funding after FY 2015, and instead requests mandatory HCFAC funding.

2/ Includes non-PAYGO savings from increased program integrity investments in HCFAC, Medicaid Fraud Control Units, the Medicaid Integrity Program, and Social Security disability reviews above savings assumed in current law.

MEDICAID

dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law:				
Benefits /1	250,931	289,885	312,674	+22,789
State Administration	14,461	18,556	18,766	+210
Total Net Outlays, Current Law	**265,392**	**308,440**	**331,440**	**+23,000**
Proposed Law:				
Legislative Proposals /2	—	175	+4,521	+4,346
Extend Qualified Individual (QI) Program /3	—	+365	+760	+395
Adjustment for QI Transfer from Medicare /3	—	-365	-760	-395
Total Net Outlays, Proposed Law	**265,392**	**308,615**	**335,961**	**+27,346**
Impacts of Program Integrity Investments /4	—	—	+1	+1
Total Net Outlays, Proposed Policy	**265,392**	**308,615**	**335,962**	**+27,347**

Note: Numbers may not add due to rounding

1/ Includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention.

2/ Includes a proposal to extend Transitional Medical Assistance, currently authorized through March 31, 2014; excludes program integrity investments other than those for Medicaid Fraud Control Units.

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 2015 are reflected in Medicare outlays. The QI program is currently authorized through March 31, 2014.

4/ Includes the net impact of the HHS and Social Security Administration program integrity investments on the Medicaid baseline.

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 2012, more than 1 in 5 individuals were enrolled in Medicaid for at least 1 month during the year, and in FY 2014, an estimated 65 million people on average will receive health care coverage through Medicaid.

How Medicaid Works

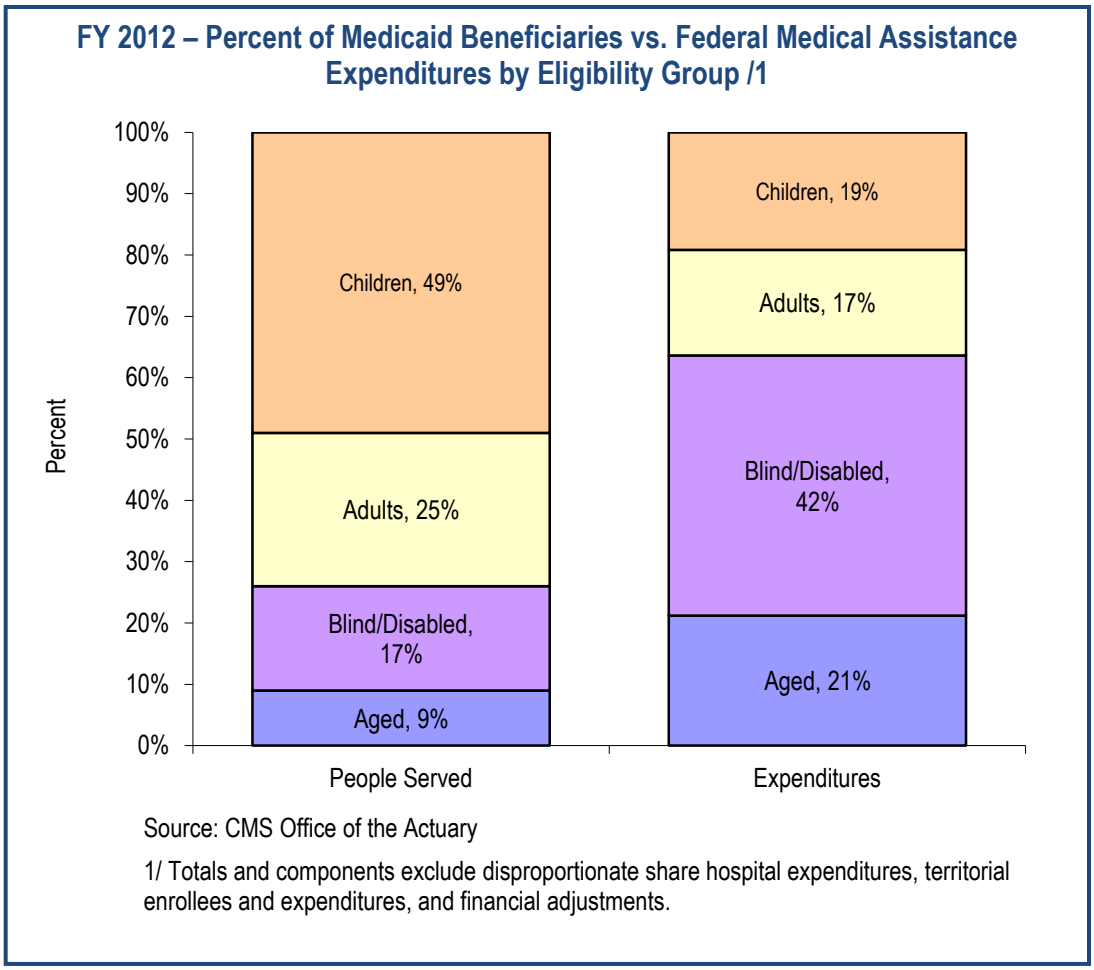
Although the federal government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. The federal government matches state expenditures on medical assistance based on the federal medical assistance percentage, which can be no lower than 50 percent. In FY 2015, the federal share of current law Medicaid outlays is expected to be approximately $331.4 billion.

States are required to cover individuals who meet certain minimum categorical and financial eligibility standards. Medicaid beneficiaries include children, pregnant women, adults in families with dependent children, the aged, blind, and/or disabled, and individuals who meet certain minimum income eligibility criteria that vary by category. States also have the flexibility to extend coverage to higher income groups, including medically needy individuals through waivers and amended state plans. Medically needy individuals are those individuals who do not

Medicaid Enrollment
(person-years in millions)

	2013	2014	2015	2015 +/- 2014
Aged 65 and Over	5.2	5.4	5.5	+0.2
Blind and Disabled	9.7	9.8	9.8	—
Children	28.3	29.5	30.8	+1.3
Adults	14.8	19.2	24.0	+4.8
Territories	1.0	1.0	1.0	—
Total	**59.1**	**64.9**	**71.2**	**+6.3**

Source: CMS Office of the Actuary estimates.



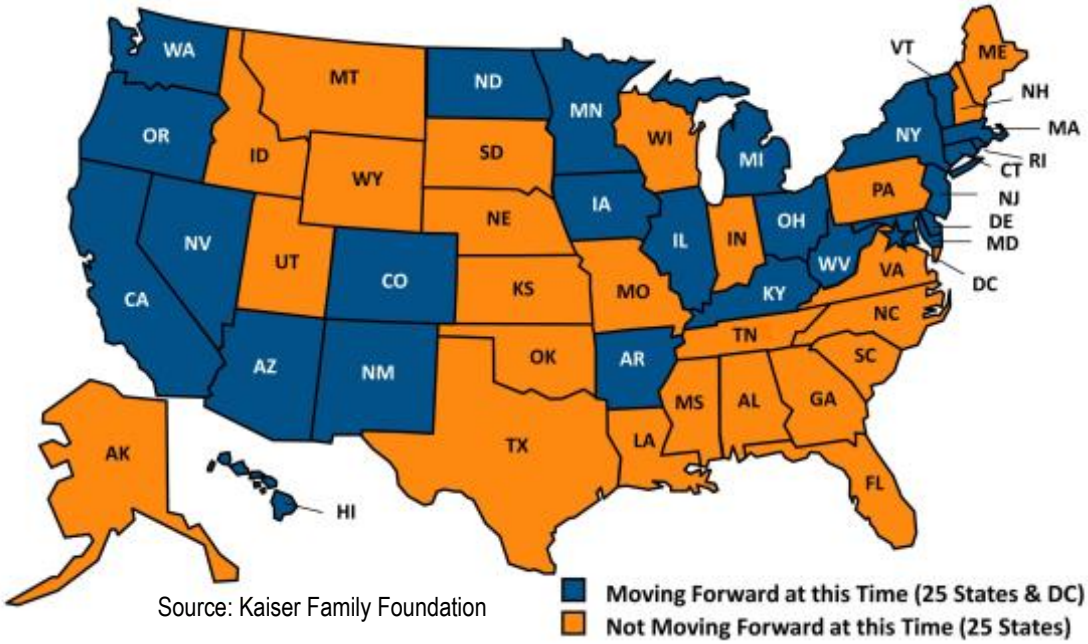
meet the income standards of the categorical eligibility groups, but incur large medical expenses such that when subtracted from their income, they fall within the financial eligibility standards.

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): The Affordable Care Act's Medicaid expansion, which began in 2014, allows states the option to expand Medicaid eligibility to individuals under age 65 with family incomes up to 133 percent of the federal poverty level (or $31,721 for a family of four in 2014). As of January 2014, 25 states and the District of Columbia have elected to expand Medicaid in 2014. The federal government will pay 100 percent of state expenditures related to newly eligible individuals through 2016. The federal matching rate will then drop gradually to 90 percent in 2020 where it will then remain. In addition, the Affordable Care Act also strengthens Medicaid program integrity efforts and improves services to Medicaid beneficiaries by increasing emphasis on providing long-term services and supports in home and community-based settings rather than institutions.

Medicaid Expansion Status by State as of January 2014



Source: Kaiser Family Foundation

Bipartisan Budget Act of 2013 (P.L. 113-67): This law extended the Qualifying Individual program and Transitional Medical Assistance program through March 31, 2014, repealed the Medicaid Disproportionate Share Hospitals (DSH) reductions scheduled for FY 2014, and delayed the DSH reductions scheduled for FY 2015 until FY 2016. It also made technical adjustments to the calculation of future Medicaid DSH allotments.

Medicaid Legislative Proposals

Extend the Medicaid Primary Care Payment Increase through CY 2015 and Include Mid-Level Providers (Workforce Initiative): Effective for dates of service provided on January 1, 2013 through December 31, 2014, states are required to reimburse qualified providers at the rate that would be paid for the primary care service under Medicare. The federal government covers 100 percent of the difference between the Medicaid and Medicare payment rate. This proposal would extend the enhanced rate through December 31, 2015, expand eligibility to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care. [$5.4 billion in costs over 10 years]

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 2023, but in FY 2024, 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. [$3.3 billion in savings over 10 years]

Permanently Extend Express Lane Eligibility for Children: The Children's Health Insurance Program Reauthorization Act (P.L. 111-3) authorized Express Lane Eligibility under which state Medicaid or CHIP agencies can use another public program's eligibility findings to streamline eligibility and enrollment into Medicaid or CHIP. As of August 1, 2013, 13 states used this authority to partner with programs like the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families (TANF) to identify, enroll, and retain uninsured children who are eligible for Medicaid or CHIP. The authority to operate expires at the end of FY 2014, and the Budget supports a permanent extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP-eligible children. [$1.1 billion including $770 million in Medicaid costs over 10 years]

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, which is expected to save Medicare more than $26.8 billion,

and Medicare beneficiaries approximately $17.9 billion, over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting federal reimbursement for a state's Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services. [$3.1 billion in savings over 10 years]

Provide Home and Community-Based Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities: This proposal would provide states with additional tools to manage their children's mental health care service delivery systems by expanding the non-institutional options available to these Medicaid beneficiaries. By adding psychiatric residential treatment facilities to the list of qualified inpatient facilities, this proposal provides access to home and community-based waiver services for children and youth in Medicaid who are currently institutionalized and/or meet the institutional level of care. Without this change to provisions in the Social Security Act, children and youth who meet this institutional level of care do not have the choice to receive home and community-based waiver services and can only receive care in an institutional setting where residents are eligible for Medicaid. This proposal builds upon findings from the five-year Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program authorized in the Deficit Reduction Act of 2005 that showed improved overall outcomes in mental health and social support for participants with average cost savings of $36,500–$40,000 per year per participant. [$1.9 billion in costs over 10 years]

Lower Medicaid Drug Costs for States and the Federal Government: The Budget includes targeted policies to lower drug costs in Medicaid. First, the Budget strengthens the Medicaid Drug Rebate Program by clarifying the definition of brand drugs, collecting an additional rebate for generic drugs whose prices grow faster than inflation, and clarifying the inclusion of certain prenatal vitamins and fluorides in the rebate program. The Budget also corrects a technical error to the Affordable Care Act alternative rebate for new drug formulations, limits to twelve quarters the timeframe for which manufacturers can dispute drug rebate amounts, and excludes authorized generic drugs from average manufacturer price calculations for determining manufacturer rebate obligations for brand drugs. Finally, the Budget improves Medicaid drug pricing by calculating Medicaid Federal Upper Limits based only on generic drug prices. [$8.6 billion in savings over 10 years]

Improvements to Program Integrity for Medicaid Drug Coverage: The Budget includes four related proposals to enhance program integrity for the Medicaid prescription drug program. The first proposal would require manufacturers to make the drug rebate equal to the entire amount that the state has paid for the drugs in cases where the state improperly reported non-drug products to CMS as covered outpatient drugs or reported drugs that the Food and Drug Administration (FDA) has found to be less than effective under the Drug Efficacy Study Implementation as if they were not found to be less than effective. By requiring full reimbursement, this proposal eliminates the incentive for manufacturers to improperly report information about drugs in these situations. [$10 million in savings over 10 years]

The second 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 third proposal would require drugs to be electronically listed with FDA in order for them to be included in 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]

Increase Access to and Transparency of Medicaid Drug Pricing Data: The Deficit Reduction Act of 2005 (P.L. 109-171) provided funding for this survey which expired in FY 2010. This proposal fully funds a nationwide retail pharmacy survey incorporating prices paid by cash-paying, third-party insured, and Medicaid insured consumers. The funding also permits collection of the actual invoice prices from retail community pharmacies to enable states to set reasonable payment rates to pharmacies. Finally, these proposals provide CMS the authority to collect wholesale acquisition costs for all Medicaid-covered drugs. [$30 million in costs 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 2015: 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, 2015. States that adopt the Medicaid expansion will be able to opt out of TMA, consistent with a related Medicaid and CHIP Payment and Access Commission recommendation. Current law extends this program through March 31, 2014. [$1.6 billion in costs over 10 years]

Extend the Qualified Individual Program through CY 2015: The Qualified Individual 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 Federal Poverty Level. This proposal extends authorization and funding of the program through December 31, 2015. Current law extends this program through March 31, 2014. [$960 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 and states' ability to fight fraud, waste, and abuse in the Medicaid program. See the Program Integrity chapter for proposal descriptions. [$620 million in savings over 10 years]

Legislative Proposals for Medicare-Medicaid Enrollees

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

Integrate the Appeals Process for Medicare-Medicaid Enrollees: Medicare and Medicaid have different appeals processes governed by different provisions of the Social Security Act, resulting in different requirements related to timeframes and limits, amounts in controversy, and levels of appeals. At times, these requirements may conflict and can result in confusion for beneficiaries and inefficiencies and administrative burdens for states and providers. This proposal provides authority for the Secretary to implement a streamlined appeals process to more efficiently integrate Medicare and Medicaid 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. These beneficiaries are assigned at random under current law 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, set to expire in December 2014, has shown the proposed approach to be more efficient and less disruptive to beneficiaries. [No budget impact]

Pilot the Program of All-Inclusive Care for the Elderly to Individuals between Ages 21 and 55: This program provides comprehensive long-term services and supports to Medicaid and Medicare beneficiaries through an interdisciplinary team of health professionals who provide coordinated care to beneficiaries in the community. For most participants,

the comprehensive service package includes medical and social services and enables them to receive care in the community rather than to receive care in a nursing home or other facility. Under current law, the program is limited to individuals who are 55 years old or older and who meet, among other requirements, the state's nursing facility level of care. This proposal would create a pilot demonstration in selected states to expand eligibility to qualifying individuals between 21 years and 55 years. This pilot demonstration would test whether the Program for All-Inclusive Care for the Elderly can effectively serve a younger population without increasing costs. [No budget impact]

Multi-Agency Proposals

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. [No budget impact]

HEALTH REFORM

The Affordable Care Act Medicaid Eligibility Expansion

The Affordable Care Act provides states 100 percent federal funding for newly Medicaid-eligible individuals up to 133 percent of the Federal Poverty Level for 3 years and no less than 90 percent Federal Medical Assistance Percentages (FMAP) thereafter. Millions of new individuals are expected to gain Medicaid coverage in the coming years due to the expanded eligibility, streamlined applications, and standardized MAGI-based eligibility determinations provided by the Act.

FY 2015 Medicaid Legislative Proposals

dollars in millions *(negative numbers reflect savings and positive numbers reflect costs)*	2015	2015 -2019	2015 -2024
Medicaid Proposals			
Extend the Medicaid Primary Care Payment Increase through CY 2015 and Include Mid-Level Providers (Workforce Initiative)	4,060	5,440	5,440
Rebase Future Disproportionate Share Hospital Allotments	—	—	-3,260
Permanently Extend Express Lane Eligibility for Children (Medicaid Impact) /1	20	245	770
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	-195	-1,300	-3,135
Provide Home and Community-Based Waiver Services to Children and Youth Eligible for Psychiatric Residential Treatment Facilities	75	770	1,908
Lower Medicaid Drug Costs for States and the Federal Government	-336	-3,390	-8,550
Clarify the Medicaid Definition of Brand Drugs (non-add)	*-16*	*-100*	*-205*
Apply Inflation-Associated Penalty to Medicaid Rebates for Generic Drugs (non-add)	—	*-150*	*-1,225*
Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program (non-add)	—	—	—
Correct the ACA Medicaid Rebate Formula for New Drug Formulations (non-add)	*-270*	*-2,610*	*-5,880*
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters (non-add)	—	—	—
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations (non-add)	*-20*	*-100*	*-200*
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits (non-add)	*-30*	*-430*	*-1,040*
Promote Integrity of Medicaid Drug Rebate Program	-1	-5	-10
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States (non-add)	*-1*	*-5*	*-10*
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)	—	—	—
Increase Access to and Transparency of Medicaid Drug Pricing Data	6	30	30
Provide Continued Funding for Survey of Retail Pharmacy Prices (non-add)	*6*	*30*	*30*
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS (non-add)	—	—	—
Expand State Flexibility to Provide Benchmark Benefit Packages	—	—	—
Extend the Transitional Medical Assistance Program through CY 2015 /2	920	1,550	1,550
Extend the Qualified Individual Program through CY 2015 /3	760	960	960
Adjustment for Qualified Individual Program Transfer from Medicare /3	-760	-960	-960
Medicaid Program Integrity Proposals /4	-19	-275	-620
Total Outlays, Medicaid Proposals	**4,530**	**3,065**	**-5,877**
Medicare-Medicaid Enrollee Proposals			
Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries	—	—	—
Pilot the Program of All-Inclusive Care for the Elderly to Individuals Between Ages 21 and 55	—	—	—
Total Outlays, Medicare-Medicaid Enrollee Beneficiary Proposals	—	—	—

FY 2015 Medicaid Legislative Proposals

dollars in millions *(negative numbers reflect savings and positive numbers reflect costs)*	2015	2015 -2019	2015 -2024
Medicaid Interactions			
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (non-add)/5	130	675	665
Establish Hold-Harmless for Federal Poverty Guidelines	—	—	—
Extend Special Immigrant Visa Program /6	0	17	36
Extend Supplemental Security Income Time Limits for Qualified Refugees /7	11	23	23
Eliminate Medicaid Recoupment of Birthing Costs from Child Support /8	—	—	—
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /9	—	-50	-190
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics /9	-150	-860	-1,960
Total Outlays, Medicaid Interactions	**-9**	**-195**	**-1,426**
Total Outlays, Medicaid Legislative Proposals	**4,521**	**2,870**	**-7,303**

1/ The score reflects the impact on Medicaid only. See CHIP Chapter for CHIP Impact.
2/ Currently authorized through March 31, 2014.
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 are reflected in Medicare outlays. The QI program is currently authorized through March 31, 2014.
4/ See Program Integrity chapter for proposal descriptions. Excludes savings not subject to PAYGO.
5/ This is a joint proposal with the Administration for Children and Families (ACF). The score reflects the non-PAYGO impact on the Medicaid baseline. Please see the ACF and State Grants and Demonstration chapters for more information on this proposal.
6/ This proposal is included in the State Department's FY 2015 Budget Request.
7/ This proposal is included in the Social Security Administration's FY 2015 Budget Request.
8/ This proposal is included in the ACF FY 2015 Budget Request.
9/ 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	2013	2014	2015	2015 +/- 2014
Current Law:				
Children's Health Insurance Program	9,469	10,189	10,511	+322
Child Enrollment Contingency Fund	14	100	100	0
Total Outlays, Current Law	**9,483**	**10,289**	**10,611**	**+322**
Proposed Law:				
Permanently Extend Express Lane Eligibility for Children /1	—	—	+10	+10
Total Outlays, Proposed Law	—	—	**10,621**	**+10**

1/ The score reflects the impact on CHIP only. See Medicaid chapter for Medicaid impact.

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 from 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, providing an additional $44 billion in funding through FY 2013 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 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, 2014, there were 13 Medicaid expansion programs, 15 separate programs, and 28 combination programs among the states, District of Columbia, and territories.

In FY 2013, the CMS Office of the Actuary estimated that 8.5 million individuals received health insurance funded through CHIP allotments at some point during the year, an increase of 2 percent over FY 2012.

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 by providing $19.1 billion for FY 2014 CHIP allotments and $21.1 billion for FY 2015 CHIP

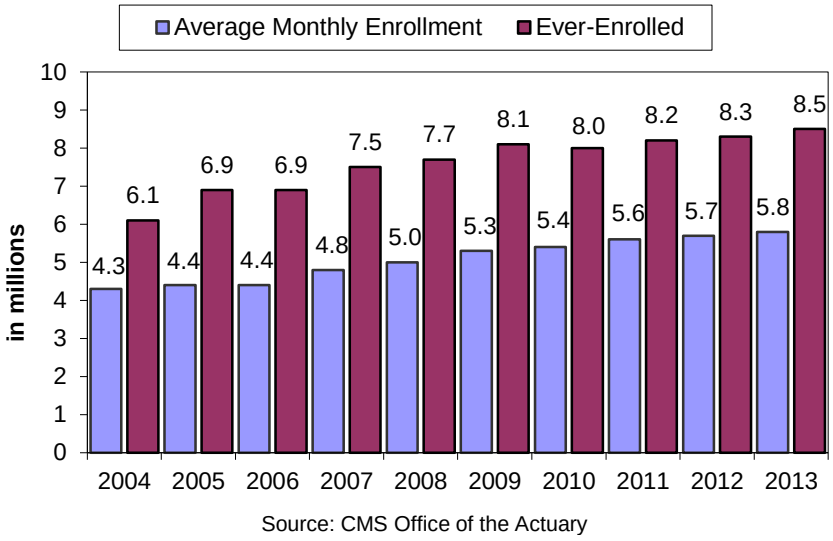
HEALTH REFORM

Increasing Enrollment of Eligible Children

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

FY 2012 actual: 44.5 million children (Target: 43.2 million)
FY 2013 target: 45.6 million children
FY 2014 target: 46.6 million children
FY 2015 target: 47.6 million children

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.



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 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.

PROGRAM HIGHLIGHT

Performance Bonus Payments

In December 2013, CMS awarded $307 million to 23 states that made significant improvement in enrolling children in the Medicaid and CHIP programs in FY 2013.

To qualify for a bonus payment, states must perform 5 of 8 specific enrollment and retention activities set out in CHIPRA. The authority to make payments for FY 2013 performance expired in FY 2014 and the Budget supports an extension of the fund through FY 2015, supporting one more year of payments for performance in FY 2014.

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

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 an additional $32 million was awarded. In FY 2014, CMS plans to award an additional $4 million in grants to continue outreach efforts to children who are American Indian/Alaska Natives, following up on $10 million in grants awarded for outreach and enrollment of American Indian/Alaska Natives in FY 2009. These grants support the Secretary's "Connecting Kids to Coverage Challenge," calling on leaders at every level of government and the private sector to find and enroll the nearly five million uninsured children who are eligible for Medicaid and CHIP. 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 2013, 18 states (across 10 grants) continued CHIPRA Quality Demonstrations to test ways to strengthen the quality

of and access to children's health care through a variety of health care delivery and measurement approaches at both the provider and patient levels. Other CHIPRA-related CMS activities included providing significant technical assistance to states on child health quality measures, partnering with the Agency for Healthcare Research and Quality to administer grants to seven Centers of Excellence in Pediatric Quality Measures, conducting a quality improvement learning series for state Medicaid staff, 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. On December 19, 2013, CMS released 2014 updates to the Child and Adult Core Health Care Quality Measurement Sets, available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

CHIP Proposals

Permanently Extend Express Lane Eligibility for Children: The authority to operate Express Lane Eligibility expires at the end of FY 2014, and the Budget supports an extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP-eligible children. See the Medicaid chapter for additional information on this proposal. [$1.1 billion including $345 million in CHIP costs over 10 years]

Extend the CHIP Performance Bonus Fund: The Administration remains committed to providing affordable, comprehensive coverage for children covered by CHIP, and the Budget proposes to extend the CHIP performance bonus fund in anticipation of working with Congress to ensure their coverage. The last bonus payment for enrollment performance during FY 2013 was made in December of 2013. The Budget supports a one-year extension of payments made for enrollment gains in FY 2014 as well as new programmatic requirements for states to qualify for payment.

FY 2015 CHIP Legislative Proposals

dollars in millions *(negative numbers reflect savings and positive numbers reflect costs)*	2015	2015 -2019	2015 -2024
CHIP Proposals			
Permanently Extend Express Lane Eligibility for Children (CHIP Impact) /1	10	135	345
Total Outlays, CHIP Proposals /2	**10**	**135**	**345**
1/ The score reflects the impact on CHIP only. See Medicaid Chapter for Medicaid Impact.			
2/ There are a number of Medicaid and Program Integrity legislative proposals that have a non-budgetary impact on the CHIP program.			

STATE GRANTS AND DEMONSTRATIONS

dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law Budget Authority:				
Medicaid Integrity Program /1	76	72	78	+6
Money Follows the Person Demonstration	426	417	449	+32
Money Follows the Person Evaluations	1	1	1	—
Total, Current Law Budget Authority	**503**	**490**	**528**	**+38**
Proposed Law Budget Authority:				
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (State Grants and Demonstrations) /2	—	—	500	+500
Medicaid Integrity program Investment and Expanded Authority /1	—	—	25	+25
Extend and Improve the Money Follows the Person Demonstration	—	—	—	—
Total, Proposed Law Budget Authority	**—**	**—**	**525**	**+525**
Total, Current and Proposed Law Budget Authority	**503**	**490**	**1,053**	**+563**
Current Law Outlays:				
Incentives for Prevention of Chronic Diseases in Medicaid /3	10	19	22	+3
Medicaid Emergency Psychiatric Demonstration /3	13	28	21	-7
CHIP Outreach and Enrollment Grants /3 /4	24	20	25	+5
CHIP Grants for Prospective Payment System Transition /3	1	*	*	—
Medicaid Integrity Program /1	57	79	47	-32
Psychiatric Residential Treatment Demo and Evaluation /3	33	50	23	-27
Money Follows the Person Demonstration	347	531	531	—
Money Follows the Person Evaluations	1	2	2	—
Expansion of State Long-Term Care Partnership Program /3	*	2	—	-2
Ticket to Work Grant Programs /3	16	3	—	-3
Medicaid Transformation Grants /3	*	—	—	—
Emergency Services for Undocumented Aliens /3	15	14	4	-10
Total, Current Law Outlays	**517**	**749**	**673**	**-76**
Proposed Law Outlays:				
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (State Grants and Demonstrations) /2	—	—	—	—
Medicaid Integrity Program Investment and Expanded Authority /1	—	—	25	+25
Extend and Improve the Money Follows the Person Demonstration	—	—	—	—
Total, Proposed Law Outlays	**—**	**—**	**25**	**+25**
Total, Current and Proposed Law Outlays	**517**	**749**	**698**	**-51**

Note: Totals may not add due to rounding.

1/ Budget authority for the Medicaid Integrity Program is adjusted annually by Consumer Price Index for All Urban Consumers. This program and the related legislative proposal are described in the Program Integrity chapter.

2/ This is a joint proposal with the Administration for Children and Families (ACF). These totals represent the proposed law budget authority and outlays for State Grants and Demonstrations. Please see the ACF Chapter for more information.

3/ Outlays are from prior year budget authority.

4/ See CHIP chapter for additional information about this program.

* Outlays are less than $500,000.

The State Grants and Demonstrations account funds a diverse set of program activities. Many activities were authorized in the Affordable Care Act, CHIPRA, the Deficit Reduction Act (DRA) 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.

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 through December 31, 2015, and states must commit to operating prevention programs for a minimum of three years. In September 2011, CMS awarded the first year of grants to 10 states. All ten state grantees are operational and currently enrolling beneficiaries. The initial Report to Congress was submitted on December 16, 2013.

Medicaid Emergency Psychiatric Demonstration: The Affordable Care Act provides $75 million for a three-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.

All of the participants began implementing their programs during 2012. The Department recently submitted a report to Congress as mandated by the demonstration's authorization. The report indicated there were 2,791 participants in the program constituting 3,458 admissions to Institutions for Mental Disease through June 30, 2013. Data continues to be collected on outcomes for the enrolled participants and impacts on Medicaid costs; the

Department will submit an updated evaluation of the demonstration in 2016.

Money Follows the Person Demonstration: This demonstration, extended by the Affordable Care Act through FY 2016, helps states support individuals to 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 billion has been awarded to 44 states and the District of Columbia since the program's inception. This demonstration is funded at $450 million for each fiscal year through FY 2016. Funding awarded to states in FY 2016 is available to states for expenditures through FY 2020. These additional funds 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 December 31, 2012, over 31,000 individuals across 44 states and the District of Columbia 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 American Indians through the tribal Initiative.

State Grants and Demonstrations Legislative Proposals

Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care: The Budget proposes to authorize a five-year Medicaid demonstration in partnership with the Administration for Children and Families beginning in FY 2015 to address the over-prescription of psychotropic medications for children and youth in foster care. States would receive performance-based Medicaid incentive payments to improve care coordination and delivery for children and youth in foster care through increased access to evidence based psychosocial interventions with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people. This investment is paired with $250 million in the Administration for Children and Families to support state efforts to build provider and systems capacity. [$500 million in Medicaid State Grants and

Demonstrations costs and $250 million in mandatory child welfare costs over 10 years]

Extend and Improve the Money Follows the Person Demonstration: This proposal would extend the demonstration period through FY 2020 to enable states to continue to rebalance their long-term care systems and transition individuals to home and community-based services within the existing appropriation. Currently, individuals must enter institutions to qualify for covered home and community-based services in the Money Follows the Person Demonstration. To support individuals remaining in the community, this proposal would modify the demonstration to allow funds to be used to prevent individuals from entering an institution in the first place, as well as transition services. This proposal would also reduce the institutional requirement from 90 to 60 days and allow skilled nursing facility days to be counted towards the institutional requirement. Lastly, this proposal would allow individuals in certain mental health facilities to transition to home and community-based services under the demonstration. [No budget impact]

HEALTH REFORM

Medicaid Incentives for the Prevention of Chronic Disease

In September 2011, CMS awarded the first year of grants to 10 states, including California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin. Grantees 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. All participating states began enrolling participants in 2012 or 2013. State programs provide a variety of direct or indirect financial incentives for program participation and health outcome attainment to beneficiaries and providers.

CMS awarded an evaluation contract in May 2012. This evaluation focuses on: 1) the effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program; 2) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; 3) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and 4) the administrative costs incurred by state agencies that are responsible for administration of the program.

The Department submitted a Report to Congress as mandated by the demonstration's authorization on December 16, 2013. As of August 31, 2013, there were 7,936 participants across the 10 states. Data continue to be collected on satisfaction and outcomes for the enrolled participants and impacts on state agency administrative costs. The Department will submit an updated evaluation of the demonstration in 2016.

FY 2015 State Grants and Demonstrations Legislative Proposals

dollars in millions *(negative numbers reflect savings and positive numbers reflect costs)*	2015	2015 -2019	2015 -2024
State Grants and Demonstrations Proposals			
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (State Grants and Demonstrations Impact) /1	—	390	500
Medicaid Integrity Program Investment and Expanded Authority /2	25	131	276
Extend and Improve the Money Follows the Person Demonstration	—	—	—
Total Outlays, State Grants and Demonstrations Proposals	**25**	**521**	**776**
1/ This is a joint proposal with CMS and the Administration for Children and Families.			
2/ The totals represent proposed budget authority for the Medicaid Integrity Program rather than outlays.			

PRIVATE HEALTH INSURANCE PROTECTIONS AND PROGRAMS

dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law:				
Affordable Insurance Exchange Grants /1	963	2,447	1,899	-548
Pre-Existing Condition Insurance Plan Program	2,141	952	—	-952
Early Retiree Reinsurance Program	59	38	1	-37
Consumer Operated and Oriented Plan	280	296	157	-139
Rate Review Grants to States	26	80	50	-30
Transitional Reinsurance Program	—	—	10,020	+10,020
Risk Adjustment Program	—	—	3,378	+3,378
Risk Corridors (non-add)/2	—	—	*5,450*	*+5,450*
Total Outlays, Current Law	**3,469**	**3,813**	**15,505**	**+11,692**
Proposed Law:				
Accelerate Issuance of State Innovation Waivers	—	—	—	—
Total Outlays, Proposed Law	**3,469**	**3,813**	**15,505**	**+11,692**
Receipts (Non-add)				
Transitional Reinsurance Program, Receipts	—	—	*10,020*	*+10,020*
Risk Adjustment Program, Receipts	—	—	*3,378*	*+3,378*
Total Receipts, Current Law	***0***	***0***	***13,398***	***+13,398***
1/ The Affordable Care Act appropriates such sums as necessary for the Secretary to award grants to states for certain activities to fund their Marketplaces.				
2/ Risk Corridors outlays are part of the Program Management account. Risk Corridors receipts are expected to total $5.45 billion in FY 2015.				

The Affordable Care Act provides vital new protections for consumers receiving or shopping for private health insurance. New reforms ensured that essential care will become a standard part of most private health insurance plans, and that consumers can continue to rely upon their insurance when they become ill. Consumers are able to purchase more efficient coverage due to rate review and medical loss ratio protections. Furthermore, millions of Americans now have access to affordable coverage as a result of the Health Insurance Marketplaces which began enrollment and operations in 2013.

Private Health Insurance Programs

Marketplaces: The Affordable Care Act provides improved insurance coverage for millions of Americans through qualified health plans offered in the Marketplaces. By providing one-stop shopping, Marketplaces have helped individuals better understand their insurance options and assisted them in shopping for, selecting, and enrolling in high quality private health insurance plans. The Marketplaces have enrolled 4 million individuals with enrollment expected to increase over the coming months and years. The Marketplaces have made purchasing health insurance easier, more transparent, and more understandable, providing individuals and small businesses with more options and greater control over their health insurance purchases.

State Highlight on Kentucky

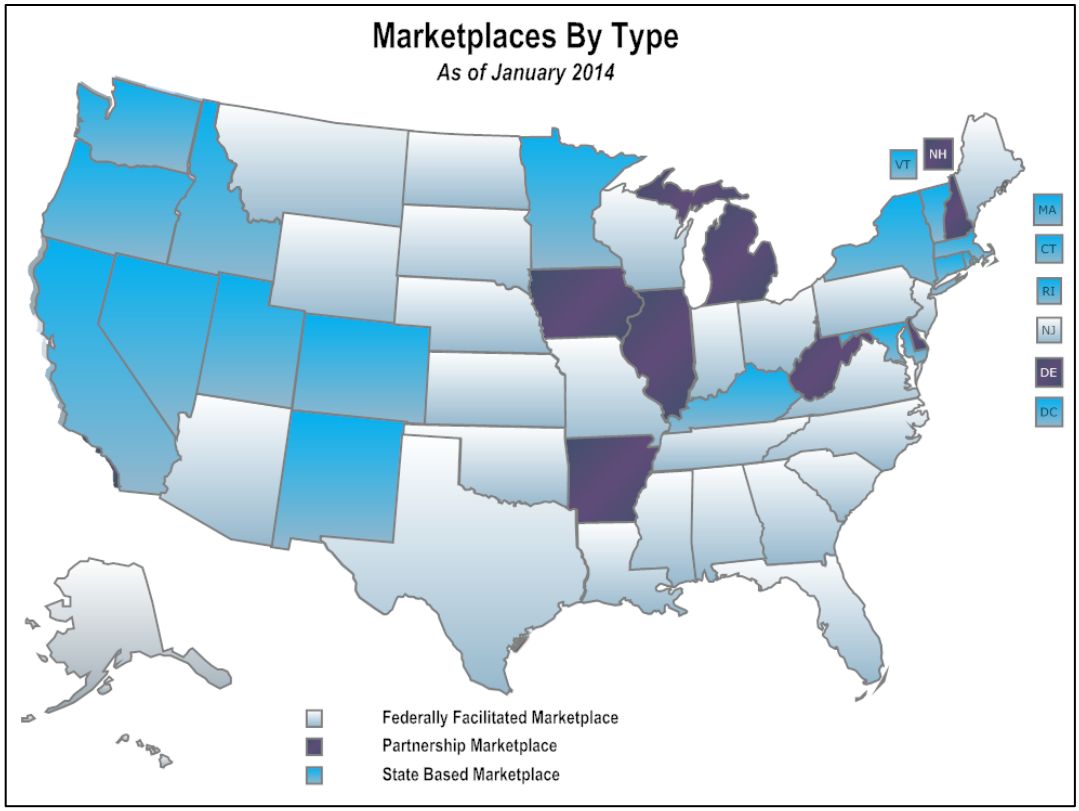
Seventeen states and the District of Columbia began full operations of their Marketplaces on January 1, 2014. Kentucky is among these states, creating its State-based Marketplace called kynect on July 17, 2012. With nearly 15 percent of the state's population, or nearly 1 in 6 residents, considered to be uninsured, Kentucky sought to improve health outcomes for its residents by offering more affordable insurance coverage options through the establishment of kynect[1]. Over 33,000 individuals of the state's estimated 640,000 uninsured individuals have enrolled in qualified health plans through kynect as of December 28, 2013.

[1] "Kynect statistics." Governor of Kentucky website. (January 2014).

State Work to Implement Marketplaces: In 2014, 17 states and the District of Columbia began operations of their Marketplaces, and seven are currently conditionally-approved to partner with HHS. HHS has begun operating the Federally-facilitated Marketplace (FFM) in the remaining states that chose not to implement their own Marketplace in 2014. In some cases, states may partner with HHS to operate some functions in a State Partnership Marketplace. In addition to enrolling individuals, Marketplaces also determine eligibility for premium tax credits and cost sharing reductions, or Medicaid and CHIP in some states; 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. States and non-profit organizations also help individuals to understand their new rights under the Affordable Care Act and learn how to navigate the healthcare system. States with Federally-facilitated or State Partnership Marketplaces may continue implementation activities in 2014, working toward establishment of State-based Marketplaces in future years.

CMS is also moving forward with making the Basic Health Plan Program available to states as another option to expand coverage.

Marketplace Establishment Grants: The Affordable Care Act provides grant funding in the initial years of establishment to enable states to plan for and establish Marketplaces. As of January 2014, 37 states and the District of Columbia had received over $4.9 billion in grants to operate Marketplaces since 2011. States may use Establishment grants to fund their start-up costs, whether for State-based or State Partnership Marketplace 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, and after their initial establishment, Marketplaces will be self-funded through user fees or other funding to support ongoing operations. So far, 14 states and the District of Columbia have received Level II Establishment funding to establish a State-based Marketplace, and grants will continue to be awarded through December 2014 to states working toward establishing State-based Marketplaces in future years.



Advance Payments of Premium Tax Credits and Cost-Sharing Reductions: Individuals who enroll in qualified health plans through the Marketplaces may qualify for insurance affordability programs to decrease their premium costs and have their out-of-pocket health care costs reduced. CMS makes advance payments of the premium tax credit to issuers each month on behalf of qualifying individuals with income between 100 and 400 percent of the federal poverty level (FPL). Individuals with income below 250 percent of FPL, and American Indians/Alaska Natives with income below 300 percent FPL, may also qualify for lower deductibles, coinsurance, co-pays and out-of-pocket limits, and CMS reimburses Marketplace issuers for these cost-sharing reductions. These payments are funded by the Department of Treasury and are therefore not part of HHS' budget.

Insurance Market Reforms

Private Insurance Market Reforms: Many important Affordable Care Act protections took effect on January 1, 2014. For example, non-grandfathered health plans in the individual and small group markets now 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. Offering essential health benefits ensures that plans cover a core set of items and services, giving consumers a consistent way to compare plans. The law also prohibits most plans from putting an annual dollar limit on the essential health benefits.

In addition, non-grandfathered plans may no longer deny coverage or charge more based on a person's health status, gender, or any factors outside of age, tobacco use, family size, and geography. That provision means women can never be required to pay higher premiums just because they are women. Further, the law limits the amount these issuers can vary premiums based on tobacco use and age. This protection means that under these plans, nobody has to worry that they will lose their insurance, or have to pay more, just because they have a pre-existing condition or if they get sick.

A number of consumer protections in the Affordable Care Act were already in effect prior to 2014. For example, more than 3 million young adults have gained coverage by being able to stay on their parents' health plans until age 26.

The law also put a ban on lifetime benefit limits, ensuring that patients can use their insurance coverage when they are sick and need it most. In addition, millions of 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.

Medical Loss Ratio: The Affordable Care Act increases healthcare efficiency by requiring insurance plans to spend at least 80 percent of collected premium revenue on health care benefits or quality improving activities annually. Insurers must inform consumers of their compliance with the medical loss ratio 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

Affordable Care Act Consumer Protections

- The Affordable Care Act requires non-grandfathered insurance plans to provide coverage for and eliminate cost sharing for many preventive services, including colonoscopy screenings, pap smears and mammograms for women, and flu shots for children and adults. To date, more than 71 million additional Americans are receiving expanded coverage of preventive services under the Affordable Care Act.
- The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal mental health parity protections to 62 million Americans.
- Thanks to the Affordable Care Act requirement that non-grandfathered insurance plans cover services in 10 essential health benefits categories, 8.7 million more women who buy coverage in the individual market will gain maternity coverage. Prior to 2014, 62 percent of individual market enrollees did not have maternity coverage.
- More than 3 million young adults under age 26 have obtained health insurance by staying on a parent's plan.

consumers nationwide received rebates totaling $1.1 billion. In 2013, consumers received an additional $500 million in rebates due to the medical loss ratio.

Insurance Premium Rate Review: Insurers must submit to relevant state offices or the Secretary a justification for any premium increase greater than ten percent prior to implementation of the increase. To date, state and national premium rate review programs have saved consumers billions through both state denials of rate increases as well as encouraging lower premiums industry-wide. In 2012 alone, this process saved consumers approximately $1.2 billion.

Through the end of 2013, HHS has awarded over $250 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.

Other Insurance Programs

Pre-Existing Condition Insurance Plan (PCIP) Program: As a bridge to 2014, when insurance companies are banned from discriminating against all Americans because of a pre-existing condition, the Affordable Care Act created a new, temporary program designed to help Americans who were locked out of the insurance market due to their health status. CMS established the PCIP Program as a temporary high-risk health insurance program to make health coverage available and more affordable to uninsured individuals who were denied health insurance because of a pre-existing condition. This temporary program was launched on July 1, 2010, just 90 days after the law's enactment, and helped over 130,000 people, many with serious medical conditions, access the health care they needed but have been unable to afford without health insurance.

Experience from the PCIP program showed that enrollees had some of the most expensive medical conditions. The average cost per enrollee in 2013 was $23,989 per year, and in one year, four percent of PCIP enrollees accounted for over 50 percent of costs. Individuals incurring high annual costs tended to present with multiple, complex diagnoses, including cancer, heart disease, and degenerative bone diseases. These individuals now have access to affordable insurance coverage through the Marketplaces.

While the program ended on December 31, 2013, remaining balances in the PCIP account have been used to provide bridge coverage to enrollees.

Early Retiree Reinsurance Program (ERRP):

Congress appropriated $5 billion for this temporary program between 2010 and 2014. ERRP has provided reimbursements to 2,850 plan sponsors spanning every state in the nation to help over 5 million early retirees maintain coverage. Both large and small plan sponsors benefited from the program, with one third of participating plans receiving $100,000 or less in total reinsurance payments from ERRP.

On January 1, 2014, while other ACA related private insurance provisions were fully implemented, ERRP sunset and no longer paid out reimbursements to plan sponsors. The remaining mandatory outlays for ERRP in FY 2014 and 2015 will be used to finalize audits and other program integrity activities.

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.

Currently, 23 CO-OP loan recipients are licensed and offering health plans in 23 states. In 22 of those states, the CO-OP loan recipients offer coverage both inside and outside of the new Marketplaces. In addition, CMS approved 3 CO-OP loan recipients to expand operations into additional states starting in 2015. Loan awards as of December 31, 2013 total $2.1 billion. The program helps foster competition in states like Maine, where the CO-OP is one of only two issuers offering plans on the Marketplace, and offers the lowest cost plans in almost all metal categories. A McKinsey and Company report examining new entrants to the Marketplaces determined that in the states with a CO-OP, 37 percent of the lowest-priced plans are offered by CO-OPs.

The Affordable Care Act appropriated $6 billion for the program. In FY 2011 Congress rescinded $2.2 billion; in FY 2012 Congress rescinded an additional $400 million; and the American Taxpayer Relief Act rescinded $2.3 billion, leaving just $253 million in a contingency fund for oversight and assistance to existing loan entities.

Each of the CO-OP awardees underwent a thorough application review loan negotiation process. Loans were made only to entities demonstrating a high probability of financial viability. 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 provides 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 through 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 inside and outside the Marketplaces. The Notice of Benefit and Payment Parameters published each year outlines specifications for these programs, and transfers resulting from these programs first occur in FY 2015 for the 2014 plan year.

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 2015, two 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 would have been provided without the waiver and must not increase the federal deficit. [No budget impact]

CENTER FOR MEDICARE AND MEDICAID INNOVATION

dollars in millions	2013	2014	2015	2015 +/- 2014
Obligations:				
Innovation Activities	856	1,424	1,306	-118
Innovation Supports	38	105	105	—
Administrative Expenses	59	108	111	+3
Total, Innovation Center Obligations	**953**	**1,637**	**1,522**	**-115**
Total, Outlays	**656**	**1,054**	**1,444**	**+390**

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 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 enrolled in 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 three plus years of operation, from FY 2010 through FY 2013, the Innovation Center obligated approximately $1.8 billion. Cumulative obligations are projected to increase to $3.5 billion by the end of FY 2014 and to nearly $5 billion by the end of FY 2015 as the portfolio of models being tested continues to expand. In FY 2014 and FY 2015, roughly 93 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. Note that while model spending is projected to slightly decrease in FY 2015 (as compared to FY 2014), this primarily reflects the estimated timing of major awards, and not a contraction in the Innovation Center's portfolio.

Innovation Center Models

As of January 2014, the Innovation Center is testing eighteen major payment and service delivery models under the authority of Section 3021 of the Affordable Care Act. The Innovation Center also administers several other Medicare demonstrations that are authorized and funded by other statutory authorities. Each of the models below will be comprehensively evaluated with the potential for expansion if they are certified 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 set ambitious targets of reducing hospital acquired conditions by 40 percent and hospital readmissions by 20 percent (compared to a 2010 baseline) over three years. While a final evaluation is not yet complete, early indicators suggest the Partnership has made significant progress towards many of these goals.

Health Care Innovation Awards: In 2012, the Innovation Center announced 107 recipients of Health Care Innovation Awards. These awardees, which include providers, payers, local governments, and other partners, are being 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.

In May 2013, the Innovation Center announced a second round of Health Care Innovation Award grants, focused on several key areas, including outpatient and post-acute care, populations with specialized needs, and population health. Awardees for this second round of funding will be announced in 2014.

Bundled Payments: The Bundled Payments for Care Improvement initiative seeks to better coordinate care by providing a bundled Medicare payment for an episode of care involving one or more providers. Providers paid through the bundle may include (among others) hospitals, physicians, and skilled nursing facilities. The Innovation Center has begun testing 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 or other risk-bearing organizations must offer a discount to Medicare as a condition of participation in the initiative. As of October 2013, providers were participating in all four of the bundled payment models. Additional participants will be added during 2014.

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. Ten organizations have since dropped out, 7 of which have already transitioned to the Medicare Shared Savings Program and one that plans to make the transition in 2015.

The Advance Payment ACO Model tests whether pre-paying a portion of future shared savings can increase participation in the Medicare Shared Savings Program.

PROGRAM HIGHLIGHT

Preliminary Results from the Pioneer ACO Model

The preliminary results from the first year of the Pioneer ACO Model are promising and demonstrate that the program can decrease costs and improve the quality of care. An independent evaluation of the Pioneer ACO Model showed that Pioneer ACOs generated gross savings of $147 million in their first year. Results showed that nine ACOs had significantly lower spending growth relative to Medicare fee for service while exceeding quality reporting requirements. Compared to local markets, Pioneer ACOs had lower growth in outpatient and physician spending and slightly higher spending growth for skilled nursing facilities and home health services.

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 36 ACOs participating in the Advance Payment Model.

FQHC Advanced Primary Care Demonstration: In 2011, the Innovation Center selected federally qualified health centers 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. Currently, 473 federally qualified health centers are participating in this three-year demonstration, serving 208,000 Medicare beneficiaries and thousands of others also receiving care at participating sites.

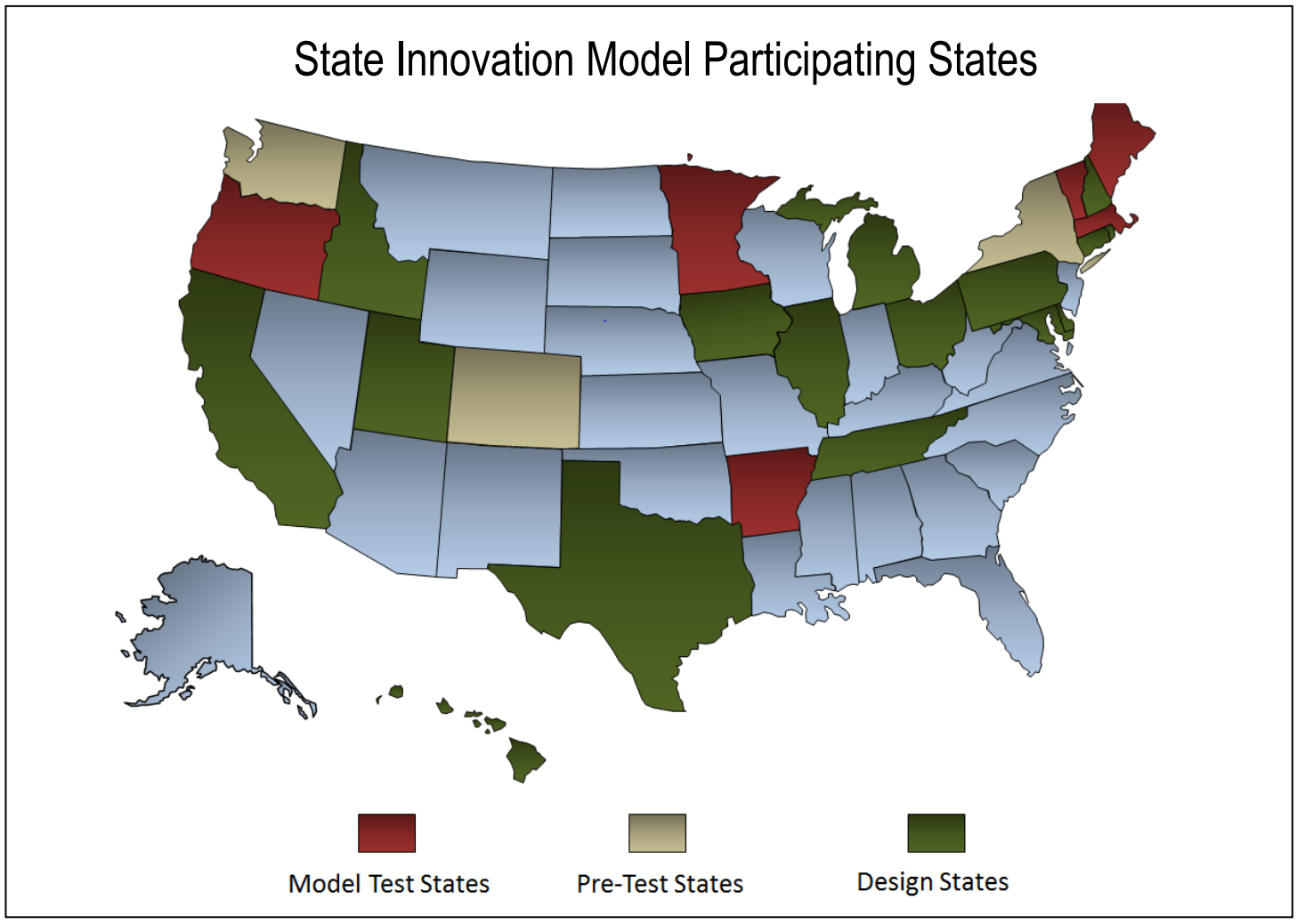
Comprehensive Primary Care Initiative: In October 2011, the Innovation Center announced the Comprehensive Primary Care Initiative. In this initiative, private payers and state Medicaid programs partner with Medicare to invest in primary care. The Initiative was rolled out in two phases. The Innovation 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. In years 2 through 4 of the initiative, practices have an opportunity to earn shared savings. The distribution of shared savings will be adjusted based on patient acuity, the number of attributed beneficiaries, and performance on quality metrics.

Strong Start for Mothers and Newborns: The Strong Start initiative, which began in February 2012, supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns. The Innovation Center has worked with 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 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 support 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. In February 2013, CMS awarded $41.4 million to 27 recipients under this initiative in 32 states and the District of Columbia and Puerto Rico, projected to reach 80,000 women enrolled in Medicaid and CHIP over the life of the demonstration.

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 proposed reforms that incorporated multiple payers and that are expected to



improve quality of care and the health of the state population, while reducing costs. Some states are receiving funding to support the design of new payment and delivery models or for similar pre-testing work. Other (more advanced) states have received funding to support the testing of such models. State awardees were announced in February 2013. See the associated map, which shows states currently receiving funding. The Innovation Center plans to make additional funds available to states on a competitive basis during 2014.

Maryland All-Payer Model: In January 2014, the Innovation Center announced that it was collaborating with the State of Maryland on a new model testing the impact of all-payer hospital rate-setting on the quality and cost of care. While Maryland has utilized all-payer rate setting for over three decades, this new model will allow the State to focus more directly on the challenges currently facing Maryland's hospitals. In particular, the new model will require limited overall cost growth, measurable savings for Medicare, and improvement on various key quality measures. If this model meets key goals over its initial five-year testing period, Maryland will have the opportunity to propose approaches to expand the model to other provider types, in addition to hospitals.

Comprehensive End-Stage Renal Disease (ESRD) Care Initiative: In February 2013, the Innovation Center announced the Comprehensive 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, which assume full clinical and financial accountability for assigned beneficiaries. These organizations will be eligible to share in any model savings with Medicare. Initial applications from providers to participate in this model have been received.

Initiatives Supporting Medicare-Medicaid Enrollees

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 Medicare-Medicaid 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. States participating in the initiative have designed models to achieve savings using either a capitated payment system or the current fee for service structure. Implementation of the first financial alignment models began in 2013. As of February 2014, CMS has approved capitated models in eight states and a fee-for-service model in one state.

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 partnered with seven organizations in 2012 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 currently impacts approximately 17,000 Medicare beneficiaries daily. This initiative supports the Partnership for Patients' goal of reducing hospital readmission rates by 20 percent.

dollars in millions	2013	2014	2015	2015 +/- 2014
Discretionary Administration				
Program Operations	2,588	2,825	2,988	+163
Federal Administration	732	733	788	+55
Survey and Certification	356	375	424	+49
Research	20	20	—	-20
State High-Risk Pools	42	20	—	-20
Total, Discretionary Budget Authority /1 /2	**3,737**	**3,973**	**4,200**	**+227**
Mandatory Administration				
Affordable Care Act	582	126	56	-70
American Recovery and Investment Act	133	130	140	+10
Medicare Improvements for Patients and Providers Act	3	3	3	—
American Taxpayers Relief Act	17	—	—	—
Pathway to SGR Reform Act	—	4	—	-4
Total, Mandatory	**735**	**263**	**199**	**-64**
Medicare and Medicaid Reimbursable Administration /3	682	908	936	+28
Marketplace-Related Reimbursable Administration/4	—	200	1,180	+980
Subtotal, Discretionary and Mandatory	**5,154**	**5,344**	**6,515**	**+1,174**
Proposed Law (Mandatory)				
Program Management (mandatory)	—	—	400	+400
Offsetting Collections /5	—	—	3	+3
Extend Funding for CMS Quality Measurement Development	—	—	30	+30
Subtotal, Proposed Law	**—**	**—**	**433**	**+433**
Program Level, Proposed Law	**5,154**	**5,344**	**6,948**	**+1,604**
Risk Corridor Charges	—	—	5,450	+5,450
Program Management Program Level with Risk Corridors	**5,154**	**5,344**	**12,398**	**+7,054**
Full-time Equivalents /6	5,889	6,044	6,380	+336

1/ Includes $114 million from the Secretary's one percent transfer authority in FY 2013. Totals may not add due to rounding.

2/ State High Risk Pools are classified as a mandatory activity in FY 2013 and FY 2014, but are included above. FY 2013 levels have been comparably adjusted for the State Health Insurance Assistance Program (SHIP) transfer to Administration for Community Living (ACL) as follows: Program Operations --$45 million, Federal Administration-- $1 million.

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

4/ Includes the following user fees: Federal Marketplaces (FY 2014 and FY 2015) and risk adjustment (FY 2015).

5/ Includes proposals for three new offsetting collections: a Survey and Certification Revisit Fee, administrative fees to offset costs incurred for the Federal Payment Levy Program, and the retention of a portion of Home Health Agency (HHA) Civil Monetary Penalties for quality improvements.

6/ 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 2013 = 1,200; FY 2014 =1,502; and FY 2015=1,622.

PROGRAM MANAGEMENT

The FY 2015 discretionary budget request for CMS Program Management is $4.2 billion, an increase of $227 million above FY 2014. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as well as new health insurance reforms contained in the Affordable Care Act. Of the total budget authority request, $629 million will support the operation of Health Insurance Marketplace, which will receive a greater amount of user fees in FY 2015.

Budget Account Summaries

Program Operations: The Program Operations request is $3 billion, an increase of $163 million above the FY 2014 enacted level. In FY 2014, CMS received an additional appropriation of $305 million for Medicare operations. The Budget does not include a separate appropriation for these activities, but includes the funding within Program Operations. 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 2015 include:

- *Ongoing Medicare Contractor Operations:* Approximately 33 percent, or $979 million, of the FY 2015 Program Operations request supports ongoing contractor operations such as Medicare claims processing.

- *Marketplace Operations:* The Budget includes $307 million to support the oversight and management-related Marketplace activities in FY 2015. See the Crosscutting Accounts section below for additional information.

- *Consumer and Beneficiary Education and Outreach:* The Budget includes $412 million in discretionary funding for beneficiary education and outreach activities, including $335 million for the National Medicare Education Program, $71 million for consumer support for the Marketplaces, and approximately $6 million for other outreach. 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 $14.7 million for CMS contracts to ensure compliance with the private insurance provisions contained in the Affordable Care Act, notably the Medical Loss Ratio and Premium Rate Review provisions.

- *IT Systems and Support:* The Budget includes $478 million for general IT systems and other support, including enterprise-wide software and hardware development and support, the Federally-facilitated Marketplace IT systems and Marketplace data services hub, and CMS's data center and telecommunications infrastructure. This amount includes a $37 million investment in CMS's IT shared services initiative, which achieves efficiencies by sharing key IT services across multiple CMS programs.

- *Medicaid and CHIP Operations:* The Budget requests $31.1 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.

Federal Administration: For FY 2015, the Budget requests $788 million for CMS federal administrative costs, approximately $55 million higher than the FY 2014 enacted level.

Of this total, $674 million will support a full-time equivalent (FTE) level of 4,738, an increase of 196 FTEs over FY 2014. 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 2015 Survey and Certification request is $424 million, a $49 million increase over FY 2014. This increase 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. The budget improves survey frequencies for dialysis facilities, non-accredited hospitals, ambulatory surgical centers, and other providers, on average, compared to 2014. CMS expects states to complete over 24,434 initial surveys and re-certifications and over 51,477 visits in response to complaints in FY 2015.

PROGRAM HIGHLIGHT

Survey and Certification Frequencies

Type of Facility	2014	2015
Long-Term Care Facilities /1	Every Year (100%)	Every Year (100%)
Home Health Agencies /1	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Accredited Hospitals	Every 4.8 Years (20.8%)	Every 3 Years (33.3%)
Accredited Hospitals	1% Per Year	2.5% Per Year
Organ Transplant Facilities	Every 5 Years (20%)	Every 5 Years (20%)
ESRD Facilities	Every 5 Years (20%)	Every 3 Years (33.3%)
Ambulatory Surgical Centers	Every 4 Years (25%)	Every 3 Years (33.3%)
Community Mental Health Centers	Not Surveyed	Every 6 Years (16.7%)
Hospice	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Outpatient Physical Therapy, Outpatient Rehabilitation, Rural Health Clinics, Portable X-Ray	Every 9 Years (11.1%)	Every 6 Years (16.7%)

Approximately 91 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 by FY 2015, 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 2015 Budget is the first to include funds to support survey and certification work in these facilities. In addition, CMS is currently engaged in an effectiveness and efficiency strategy aimed at quality improvement while identifying risk-based approaches to surveying.

Research: Beginning in FY 2015, ongoing research activities will be funded from Program Operations.

Crosscutting Summaries

Health Insurance Marketplaces (Marketplaces): The Budget includes $629 million for CMS activities and administrative expenses to support Marketplace operations in FY 2015. In addition to the Budget request, CMS will collect approximately $1.2 billion in user fees from issuers in the FFM, as well as reinsurance and risk adjustment administrative collections, for a total program level of $1.8 billion.

Marketplaces provide affordable, quality health insurance options to individuals and small businesses, and 4 million individuals have already enrolled in Marketplace plans. Enrollment is expected to increase through the initial years of implementation, and CMS operates some or all Marketplace functions in over 30 states through the Federally-facilitated Marketplace (FFM). Specifically, CMS performs eligibility and appeals work, certification and oversight of qualified health plans, payment and financial management functions, and operates the Small Business Health Options Program (SHOP). Some states in the FFM assist with plan management functions or operate their own SHOP. Additionally, CMS oversees operations of State-based Marketplaces and provides technical assistance as needed.

Health Insurance Marketplaces

FY 2015 Program Level Request (dollars in millions)

Activity	2015
Marketplace Operations	770
Eligibility and Enrollment (non-add)	*587*
Consumer Information and Outreach	774
Marketplace Information Technology	201
Federal Administration	85
Total, Marketplace Program Level/1	**1,829**

1/ Marketplace Program Level includes $1.2 billion in user fees and $629 million in requested budget authority. Numbers may not add due to rounding.

CMS provides Marketplace consumer assistance through a call center and website for the FFM, as well as in-person support through Navigator grants. Additionally, CMS will conduct an outreach campaign during the open enrollment season to inform consumers of their insurance options.

Finally, CMS operates a number of IT systems to support the Marketplaces, such as the system that operates FFM functions including eligibility, plan management, and payment functions. The data services hub provides eligibility verification services to all Marketplaces through interfaces with trusted data sources in other Federal departments. Other IT costs include hosting services and data management systems.

National Medicare Education Program (NMEP): The total FY 2015 budget authority for NMEP is $335.4 million, an increase of approximately $77.2 million above FY 2014. The NMEP program level includes $71 million in funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and Quality Improvement Organizations, allocated to the call center and beneficiary materials. 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, $250 million, or 75 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 26 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.

The request also includes $40 million for Beneficiary Materials, the majority of which will fund the *Medicare & You* handbook.

2015 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 $414.5 billion over the next ten years. [$400 million in

PERFORMANCE HIGHLIGHTS

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 December 2013, 340,046 unique eligible professionals, eligible hospitals, and critical access hospitals had received incentives from the Medicare and Medicaid EHR Incentive Programs. HHS aims to increase the number of eligible providers who receive an incentive payment to 425,000 by the end of FY 2015.

costs over 10 years]

Allow CMS to Reinvest Civil Monetary Penalties Recovered from Home Health Agencies: This proposal allows CMS to retain and invest civil monetary penalties assessed on home health agencies for activities to improve the quality of care of patients receiving home health services. The Affordable Care Act provided this authority for Skilled Nursing Facilities. [$10 million in costs over ten years]

Assess Administrative Costs for the Federal Payment Levy Program: This activity electronically matches Medicare provider payments between delinquent tax and non-tax debts and federal payments disbursed by the government. It allows the Treasury Department to levy up to 15 percent of a provider's Medicare reimbursement against an outstanding debt. This proposal will allow CMS to recoup its transaction administrative costs from the provider estimated to be $2 million each year. [No budget impact]

Enact Survey and Certification Revisit User Fees: 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 FY 2015, the year of implementation. [No budget impact]

Extend Funding for CMS Quality Measurement Development: 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 and those that were added by the Affordable Care Act and amended by the American Taxpayer Relief Act of 2012. Under current law, no additional funding will be provided after 2014. The Budget includes $30 million each year for both activities, which is available until expended. Continued funding for endorsing and maintaining performance measures and other performance measurement review functions are essential as CMS continues to implement valued-based purchasing initiatives and other models which focus on performance-based payments. [$90 million in costs over 10 years]

ADMINISTRATION FOR CHILDREN AND FAMILIES

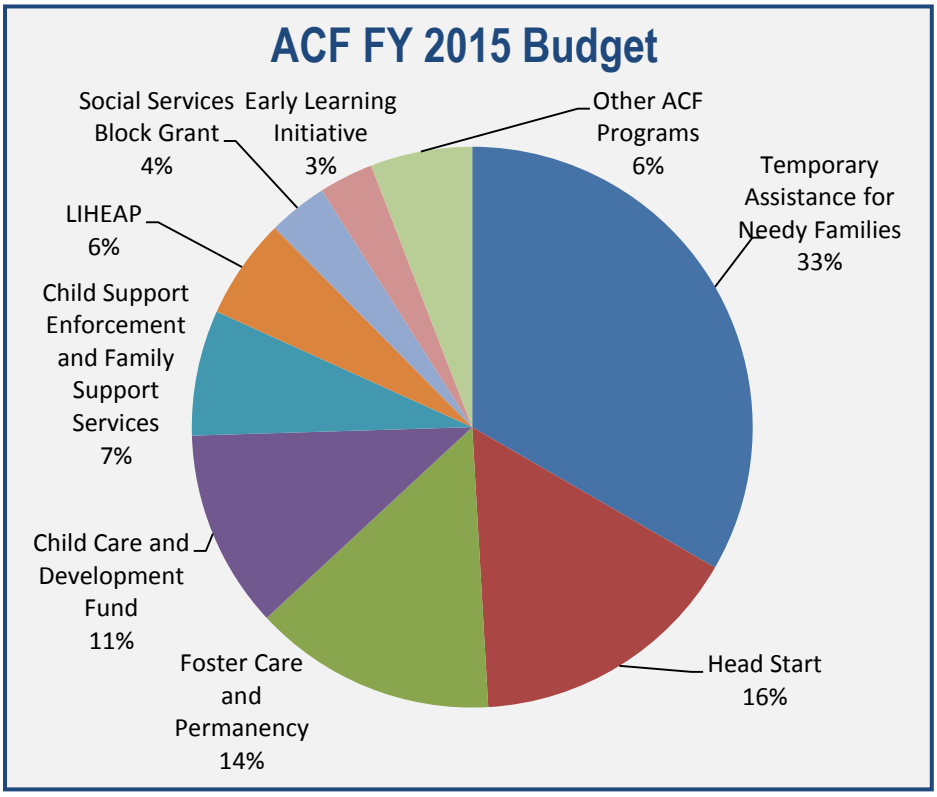
The Administration For Children and Families
Department of Health and Human Services

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	2013	2014	2015
Mandatory			
Budget Authority	33,101	33,480	34,276
Sandy Supplemental	475	—	—
Discretionary			
Budget Authority	15,759	17,677	17,040
Sandy Supplemental	95	—	—
Transfer to Administration for Community Living	162		
Total, ACF Budget Authority	**49,592**	**51,157**	**51,316**

The FY 2015 Budget request for the Administration for Children and Families (ACF) is $51.3 billion. ACF works in partnership with states and communities to provide critical assistance to vulnerable families while helping families and children achieve a path to success. ACF's budget supports expanding access to high-quality early education to prepare our youngest children for success in life. Funds are also included for programs that serve our most vulnerable children and families, including victims of domestic violence and human trafficking, and runaway and homeless youth. In addition, the Budget supports important reforms in Head Start, Child Care, and Child Support.

The Budget includes mandatory funding for a new Medicaid demonstration, in partnership with ACF, to address the over-prescription of psychotropic drugs for children in foster care by increasing access to evidence-based interventions for these children. The ACF Budget includes $250 million in mandatory funding to support state efforts to build provider capacity and other infrastructure necessary to meet the behavioral and mental health needs of children in foster care. The Budget also proposes to create subsidized job opportunities for low-income parents by redirecting $602 million in TANF funding to a Pathways to Jobs initiative.



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

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

dollars in millions	2013	2014	2015	2015 +/- 2014
Head Start	7,573	8,598	8,868	+270
Child Care & Development Block Grant (discretionary)	2,206	2,360	2,417	+57
Refugee Programs				
Transitional and Medical Services	401	391	383	-8
Unaccompanied Alien Children	376	868	868	--
Victims of Trafficking	9	14	22	+8
Other Refugee Programs	213	213	213	--
Subtotal, Refugee Programs	**999**	**1,486**	**1,486**	**--**
Child Welfare Programs	335	345	345	--
Chafee Education & Training for Foster Youth	42	43	43	--
Family Violence Prevention	124	138	140	+1
Adoption Incentives	37	38	38	--
Runaway and Homeless Youth Programs	108	114	116	+2
Child Abuse Prevention	88	94	94	--
Promoting Safe and Stable Families (discretionary)	60	60	60	--
LIHEAP				
Formula Grants	3,255	3,425	2,550	-875
Contingency Fund	--	--	200	+200
Energy Burden Reduction Grants	--	--	50	+50
Subtotal, LIHEAP Budget Authority	**3,255**	**3,425**	**2,800**	**-625**
Administration for Native Americans	45	47	47	--
Community Services Block Grant	635	674	350	-324
Other Community Services Programs	51	55	19	-36
Subtotal, Community Service Programs	**687**	**729**	**369**	**-360**
Disaster Human Services Case Management	2	2	2	--
Social Services Research & Demonstration	6	6	15	+9
National Survey, Child & Adolescent Well-Being (non-add)	--	--	*6*	*+6*
Early Childhood Evaluation (non add)	--	--	*3*	*+3*
PHS Evaluation Funds (non-add)	*6*	*6*	*6*	--
Federal Administration	198	199	206	+7
Center, Faith Based/Community Initiatives (non-add)	*1*	*1*	*1*	--
Total, Program Level	**15,765**	**17,683**	**17,046**	**-637**
Less Funds From Other Sources				
PHS Evaluation Funds	6	6	6	--
Total, Discretionary Budget Authority	**15,759**	**17,677**	**17,040**	**-637**
Full-time Equivalents (including those financed with mandatory funds)	1,303	1,344	1,402	+58

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY

The FY 2015 discretionary request for the Administration for Children and Families (ACF) is $17 billion, a decrease of $637 million below FY 2014. The Budget advances high quality care for infants and toddlers as part of the President's plan to help prepare America's children for success in life by expanding access to early education. Additional investments are also included for programs that serve our nation's most vulnerable children and families, including unaccompanied alien children, victims of domestic trafficking, and runaway and homeless youth.

Early Childhood Development

As the President stated in his State of the Union address, research shows that one of the best investments we can make in a child's life is high-quality early education. These programs can help level the playing field for children from lower-income families in vocabulary, and social and emotional development, while helping students to stay on track in the early grades. In FY 2015, the President renews his call for a series of investments that will create a continuum of high quality early learning services for children beginning at birth through age five. This initiative would help states provide high quality preschool for four year olds in low and moderate income families through a partnership with the Department of Education, expand access to high quality care for infants and toddlers through HHS' Early Head Start – Child Care Partnerships, and expand current federal investments in voluntary, evidenced-based home visiting programs.

Early Head Start – Child Care Partnerships: The Budget requests $650 million, an increase of $150 million above FY 2014, to support and expand Early Head Start – Child Care Partnerships. This funding will assist communities in increasing access to early learning programs that meet the highest standards of quality for infants and toddlers. Building off of initial funding provided in FY 2014, funds will be competitively awarded to new and existing Early Head Start programs that partner with child care providers that serve lower-income children, especially those receiving federal child care subsidies. Through these partnerships, Early Head Start programs and child care providers will work together to provide high quality full day services that offer comprehensive supports to meet the needs of working families, and prepare children for preschool, in a variety of settings.

Head Start: In addition to expanding Early Head Start-Child Care Partnerships, the FY 2015 request includes an additional $120 million to strengthen services for children by Head Start. In FY 2015, ACF will continue to require grantees who do not meet rigorous quality benchmarks to compete for ongoing federal funding. The Budget includes $25 million, the same as FY 2014, to support the transition between incumbent and new grantees through this process, minimizing the potential for service disruptions for children.

OPPORTUNITY, GROWTH, AND SECURITY INITIATIVE

Head Start in the Opportunity, Growth, and Security Initiative

As part of the FY 2015 Budget, the President has asked Congress to further expand Early Head Start – Child Care Partnerships. This $800 million investment would bring total funding for Early Head Start – Child Care Partnerships to $1.5 billion in FY 2015 and provide access to high quality infant and toddler care to more than 100,000 children. Additional resources are also provided in this initiative to support Head Start grantees that are expanding program duration and investing in teacher quality.

Child Care: The FY 2015 request for the Child Care and Development Fund is $6.1 billion, which includes $3.7 billion for the Child Care Entitlement and $2.4 billion for the Child Care and Development Block Grant. The total funding level represents an increase of $807 million over FY 2014 in combined discretionary and mandatory funds, and will support subsidies for 1.4 million children – approximately 74,000 more children than would otherwise be served.

Of the $2.4 billion available in discretionary funds for child care, $200 million is targeted to help states raise the bar on quality by developing higher health and

safety standards, improving monitoring, increasing provider quality through evidence-based professional development, and improving access to information for parents choosing a child care provider.

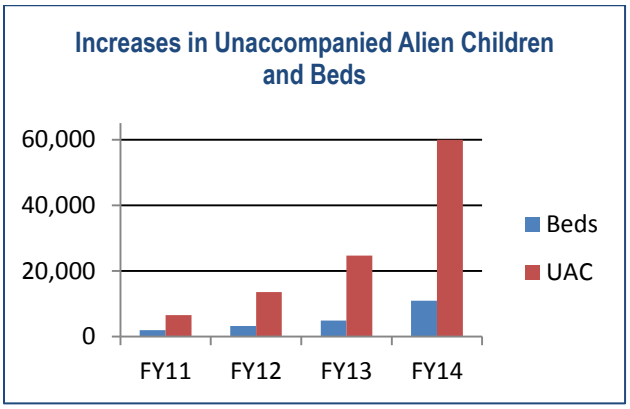
Protecting Vulnerable Individuals

Refugee-Related Programs: Refugees and unaccompanied alien children (UAC) apprehended trying to enter the United States are among the most vulnerable populations ACF serves. Refugees come to the United States fleeing violence, persecution, and even torture. Increasingly, UAC also come to the United States to escape the violence in their home countries. Both groups come seeking hope, dignity, and a chance for a better life.

ACF anticipates 70,000 refugee arrivals in FY 2015, together with 55,000 asylees and other entrants eligible for refugee benefits. These benefits consist primarily of time-limited cash and medical assistance but also include social services, primarily job training and English instruction, so adults can become self-sufficient as quickly as possible. With the implementation of the Affordable Care Act, HHS anticipates decreased refugee medical assistance costs as more refugees are covered by the Medicaid expansion in participating states. ACF has worked with the Centers for Medicare & Medicaid Services to translate the enrollment application into languages most often spoken by refugees (11 are currently available) and has developed a training curriculum so that Navigators and Certified Application Counselors can ensure that refugees and other entrants have equal access to benefits under the Affordable Care Act. The Budget includes sufficient funds to provide eight months of cash and medical assistance to these arrivals and maintain funding for social services and victims of torture.

By law, ACF takes custody of all UAC who file claims to remain in the United States under immigration law. These children reside in state-licensed shelter facilities until ACF can place them with sponsors, usually parents or other relatives. The annual number of arriving UAC has increased from 6,560 in FY 2011 to an estimated 60,000 in FY 2014. Reasons for this increase are complex but a key factor is the rising levels of violence in Central America, the place of origin for most UAC.

ACF has streamlined its placement process, reducing the average amount of time unaccompanied alien children spend in shelters. Through these and other measures, ACF is able to accommodate a 53,000 annual increase in UAC with a 9,000 seasonal increase in shelter beds. Despite these efforts, total UAC costs have increased significantly due to the rising number of UAC.



As directed by Congress, ACF is meeting with other government agencies – this has included the Departments of Homeland Security, State, and Justice – in an effort to better understand the reasons for the increase in the number of UAC arrivals and develop strategies for managing rising UAC costs. Due to the volatile nature of this program and ongoing discussions of a long term policy solution, the Administration is not able to reliably predict the number of UAC who will arrive in FY 2015 at this time. The FY 2015 Budget request for the UAC program is therefore $868 million, the same as FY 2014.

Victims of Human Trafficking: ACF is a partner in the fight against international human trafficking, identifying foreign born persons victimized in the United States and making them eligible for the same federal benefits and services provided to refugees. The budget includes an increase of $8 million to expand services for domestic victims of human trafficking. Funds will be competitively awarded to organizations working with at risk populations, including runaway and homeless youth and victims of domestic and other forms of interpersonal violence, and used to identify victims and provide them with intensive case management, including coordination of services and public befits to meet their comprehensive needs. Funds will also be used for demonstrations to provide transitional and long-term housing for young trafficking victims who cannot be reunited with their parents and to expand the hotline operated by the National Human Trafficking Resource Center.

Runaway and Homeless Youth: To support the President's Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, the Budget requests an additional $2 million to develop national data on the number of homeless youth and an improved understanding of the needs of runaway and homeless youth. The information collected through this national effort will help HHS to more effectively prevent and address youth homelessness.

Family Violence Prevention: The Budget includes $140 million, an increase of $1.5 million, for Family Violence Prevention and Services programs to help address the unmet shelter services need for victims of intimate partner violence. 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.

Low Income Home Energy Assistance Program (LIHEAP): The Budget includes $2.8 billion for LIHEAP, which represents a difficult decision in a challenging budget environment. Included in this request is $2.5 billion in formula grants, distributed to states using the same allocation Congress enacted in FY 2014, and a $200 million contingency fund to respond to emergencies such as extreme weather and spikes in fuel prices.

The Administration's LIHEAP request also includes $50 million for competitive grants to support replacement of inefficient home heating systems and other energy conservation measures that reduce home energy burdens. LIHEAP households typically spend a higher portion of their income on heating and cooling, in part because their homes tend to have older and less efficient heating systems, which are more likely to rely on more expensive fuels such as oil and propane. In some cases, the inefficiency of these heating systems 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 evidence-informed projects to reduce the energy burden of LIHEAP-eligible households by increasing the energy efficiency of their homes.

In addition, the Administration will continue companion efforts to increase energy efficiency and reduce costs. Through the Department of Energy (DOE) and the Department of Housing and Urban Development, more than 1.2 million housing units, including many low-income homes, have already received weatherization assistance during this Administration. The Administration is seeking to increase support for energy efficiency retrofits for low-income households by providing $227 million for DOE's Weatherization Assistance Program in FY 2015.

Strengthening Communities

Native Americans: As part of ACF efforts to strengthen vulnerable communities, the Administration for Native Americans funds community-designed projects for tribes and native organizations including American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders. Funds are used primarily for local economic development but also for preservation of Native language and of local natural resources. Successful grantees have used this funding to provide job training, business start-up and expansion, development of local industry, financial literacy, home ownership, and the preservation local culture. The Budget includes $47 million for the Administration for Native Americans, the same as FY 2014.

Community Services Programs: The Budget includes $350 million for the Community Services Block Grant, and supports the President's priority to build ladders of opportunity into the middle class and promote economic mobility by proposing to target funds to high-performing and innovative grantees that successfully meet community needs, and suspend funding in instances of fraud and abuse. Funding is not requested for the Rural Community Facilities program or the Community Economic Development program. However, ACF will continue to collaborate on the Healthy Food Financing Initiative with the Department of Treasury, where a commensurate increase in funding has been requested, and with the Department of Agriculture, which now has the authority to support this initiative.

Ensuring Program Effectiveness

ACF strives to utilize program evaluation to ensure that its programs are effective and to continually improve program implementation. The Budget includes $15 million, an increase of $9 million over FY 2014, for social services research and demonstration activities. This additional funding provides $6 million to continue support for 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 childhood development.

Federal Administration: The Budget includes $206 million, $7 million above FY 2014, for the administration of most ACF programs including pay and benefits for staff and operation of agency office space. Additional funds are requested for the consolidation of ACF's headquarters staff in Washington, DC, and moves of four regional offices across the United States. Move costs include reconfiguration of existing space to meet agency needs and re-installation of agency information technology systems. These moves are part of governmentwide efforts to reduce long-term rent and utility costs by reducing per person space use and, in some cases, moving from private to government-owned space.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

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

dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	2,917	—
Child Care and Development Fund (non-add) /1	*5,123*	*5,277*	*5,277*	—
Child Support Enforcement and Family Support	4,001	4,065	3,689	-376
Foster Care and Permanency	6,631	7,009	7,035	+26
Promoting Safe and Stable Families (mandatory only) /2	460	436	345	-91
Temporary Assistance for Needy Families (TANF)	16,738	16,737	16,739	+2
TANF Contingency Fund /3	612	612	612	—
Subtotal, TANF (non-add)	*17,350*	*17,349*	*17,351*	*+2*
Children's Research and Technical Assistance	49	48	52	+4
Social Services Block Grant	1,694	1,656	1,700	+44
Sandy Supplemental /4	475	—	—	—
Total, Current Law Budget Authority	**33,576**	**33,480**	**33,089**	**-391**
Proposed Law Budget Authority:				
Child Care Entitlement to States	2,917	2,917	3,667	+750
Child Care and Development Fund (non-add)	*5,123*	*5,277*	*6,084*	*+807*
Child Support Enforcement and Family Support	4,001	4,065	3,699	-366
Foster Care and Permanency	6,631	7,009	7,287	+278
Promoting Safe and Stable Families (mandatory only)	460	436	435	-1
TANF	16,738	16,737	16,749	*+12*
TANF Program Improvement (non-add)	—	—	*+10*	*+10*
Pathways to Jobs	—	—	602	*+602*
TANF Contingency Fund	612	612	—	*-612*
Subtotal, TANF (non-add)	*17,350*	*17,349*	*17,351*	*+2*
Children's Research and Technical Assistance	49	48	52	+4
Social Services Block Grant /5	1,694	1,656	1,785	+129
Sandy Supplemental	475	—	—	—
Total, Proposed Law Budget Authority	**33,576**	**33,480**	**34,276**	**+796**

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 (PSSF) includes Abstinence Education, the Personal Responsibility Education Program, and PSSF mandatory funding. In addition, there is a discretionary appropriation of $59.8 million for PSSF.

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.

5/ The proposed law reflects the reauthorization of the Health Profession Opportunity Grants.

ADMINISTRATION FOR CHILDREN AND FAMILIES: MANDATORY

The FY 2015 Budget request for ACF mandatory programs is $34.3 billion. ACF serves the nation's most vulnerable populations through mandatory programs including Temporary Assistance for Needy Families (TANF), Child Care Entitlement to States, Child Support, 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, encourages the use of evidence-based interventions to improve outcomes for children in foster care and to decrease over-prescription of psychotropic medications, increases the child support that is paid to families, promotes fathers' involvement in the lives of their children, and proposes to restructure the TANF Contingency Fund to make it more effective.

Child Care Entitlement to States

The Budget supports important investments 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 $18.8 billion over 10 years, including an increase of $750 million in FY 2015. Total child care funding for the Child Care and Development Fund is $6.1 billion in FY 2015, including $200 million in discretionary funding for formula grants focused on improving the quality of child care, including the quality of the child care workforce and health and safety measures (details in the ACF Discretionary chapter). In FY 2015, the request would enable 1.4 million children to receive child care assistance, approximately 74,000 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 $650 million in discretionary funds for new Early Head Start-Child Care Partnerships (both described in the ACF Discretionary chapter), are key elements of the Administration's broader education agenda designed to help every child reach his or her academic potential, reduce income inequality, and improve the nation's competitiveness.

PERFORMANCE HIGHLIGHTS

Child Support Enforcement

The Child Support Enforcement program continues to make strong gains in establishing child support orders and increasing child support collections. In FY 2012:

- Child support collections increased by nearly 2 percent from FY 2011 to $27.7 billion.
- 1.7 million paternities were established and acknowledged.
- Paternity was established for 97 percent of Title IV-D out-of-wedlock births, exceeding the target of 92 percent.
- Child support orders were established for 82 percent of child support cases, which surpassed the target of 77 percent.
- For every dollar invested in the program, $5.19 in child support was collected, which exceeded the performance target of $4.84.
- Four tribal programs became comprehensive, fully operational program service providers, bringing the total number of comprehensive Tribal Child Support Enforcement Programs to 45.

Child Support Enforcement and Family Support Programs

The Budget request is $3.7 billion in budget authority in FY 2015 for Child Support Enforcement and Family Support Programs. The Budget includes $1.8 billion over 10 years for an initiative to modernize the Child Support program and to promote responsible fatherhood. Of those costs, $1.5 billion impacts the Child Support program, including $655 million in savings from the Supplemental Security Income and the Supplemental Nutrition Assistance Program, and $266 million impacts Foster Care. Child Support 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 Budget promotes strong families and responsible fatherhood by ensuring that children benefit when parents pay support, promoting parenting time arrangements, and

improving enforcement tools such as the use of electronic income-withholding orders. This proposal also includes funding specifically to encourage states to pass through child support payments to families.

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

Other family support programs funded in this account include Payments to Territories and the Repatriation program. Payments to Territories fund approximately $33 million in assistance for eligible aged, blind, and disabled residents of Guam, Puerto Rico, and the Virgin Islands, per Titles I, X, XIV, and 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 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 locator service, 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 $7.3 billion in FY 2015 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 a new Medicaid demonstration, in partnership with ACF, to address the over-prescription of psychotropic medications for children in foster care. This investment includes $250 million in mandatory funding over five years in ACF, paired with $500 million in new performance-based incentive funds in the Centers for Medicare & Medicaid Services (CMS), to improve outcomes for these children. The Budget also includes $2 million in FY 2015 and $266 million over 10 years to require that child support payments made on behalf of children in foster care are used in the best interests of the child.

NEW INITIATIVE

Demonstration to Address the Over-Prescription of Psychotropic Medications for Children in Foster Care

The FY 2015 Budget includes a new five-year collaborative demonstration with ACF and CMS to encourage states to provide evidence-based psychosocial interventions to children and youth in the foster care system to reduce the over-prescription of psychotropic medications and to improve outcomes for these young people.

The need for action in this area is evident. ACF data show that 18 percent of the approximately 400,000 children in foster care were taking one or more psychotropic medications at the time they were surveyed (NSCAW II data collected Oct. 2009 - Jan. 2011). GAO has estimated an even higher range of 21 to 39 percent. Children in foster care are prescribed psychotropic medications at far higher rates than other children served by Medicaid, and often in amounts that exceed the Food and Drug Administration's guidelines.

The existing evidence-base in the area of trauma-informed psychosocial interventions warrants a large initial investment to expand access to effective interventions. The ACF investment of $250 million over five years would fund infrastructure and capacity building, while the Medicaid investment of $500 million over five years would provide incentive payments to states that demonstrate measured improvement.

The FY 2015 Budget includes $4.3 billion in budget authority to support the Foster Care program, including maintenance payments to children. This amount is a $20 million increase above FY 2014. The proposed level of funding will provide assistance and support to an estimated 150,800 children each month, which is approximately 1,900 fewer children than in FY 2014. The most important factor in the decline in the Title IV-E Foster Care caseload is that the total foster care population, not just the title IV-E eligible population, has declined in recent years. Between 2002 and 2012, the number of children entering care each year declined by approximately 15 percent from 295,000 to 252,000. The number of children in care at the end of each fiscal year decreased by almost 25 percent from 524,000 to 397,000 over the same ten-year time period. States have made important

Investing in the future of the Child Care and Development Fund

The FY 2015 Budget includes a substantial commitment to improved access to high quality child care for low income children through investments in the Child Care Development Fund and strengthening the health and safety and quality standards that support those children. With a long-term investment of $18.8 billion in mandatory funding, the Budget commits to providing child care assistance to more than 1.4 million children each year for a full ten years. In addition, in May of 2013 ACF released a Notice of Proposed Rule Making that aims to improve the health and safety standards of providers, establish family-friendly policies, improve the quality of child care, and strengthen program integrity. ACF is currently responding to public comment on the proposed rule and expects the rule to be finalized in the summer of 2014.

reforms in response to changes in Federal laws over the past 14 years that have focused on prevention and permanency. In addition, the proportion of all children in foster care who are title IV-E eligible continues to decline, in large part because eligibility for federal foster care is tied to the income eligibility standards effective in 1996 for Aid to Families with Dependent Children (AFDC), which have declined in real dollar terms since then. The federal title IV-E participation rate for maintenance payments stood at approximately 51.8 percent of all children in foster care in FY 2000, while in FY 2013, the federal title IV-E participation rate was approximately 41 percent of all children in foster care nationally.

The Budget includes $2.5 billion in budget authority for the Adoption Assistance program, an increase of $41 million above FY 2014. An estimated average of 452,000 children per month, an increase of 11,800 over FY 2014, will qualify for this assistance in FY 2015.

The Budget includes $99 million for the Guardianship Assistance program, a decrease of $25 million below the FY 2014 Enacted Level of $124,000,000 and an increase of $14,000,000 above the updated FY 2014 current law estimate. The difference from the enacted level reflects that we previously estimated a faster rate of expansion in this program than we are currently observing. However, the program is continuing to grow, and we expect there will be an increase in the number of children participating in the Guardianship Assistance program as new states and tribes begin programs, and established states expand the implementation of their 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 of 21,100 children per month, an increase of 1,900 over FY 2014, will participate in FY 2015.
The Budget also includes $140 million for the Chafee Foster Care Independence Program, the same level as in FY 2014. 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, Guardianship Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2012, 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 2012, over 85 percent of children who had been in care less than 12 months had 2 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 $435 million for Promoting Safe and Stable Families (PSSF) account. Of this amount, $345 million supports the mandatory portion of the PSSF program, $75 million supports the Personal Responsibility Education Program, 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 the PSSF program 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 trauma that children in child

welfare have experienced and to have explicit protocols for oversight and monitoring of psychotropic medications. These efforts have helped build the foundation for the collaborative demonstration to address the over-prescription of psychotropic medications for children in foster care proposed in the Budget.

In FY 2012, the adoption rate for children from foster care into permanent homes was 12 percent (52,000 children adopted), exceeding the target of 10.4 percent. By monitoring the adoption rate, 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 2014, the Consolidated Appropriations Act, 2014 (P.L. 113-76) extended all TANF grants through September 30, 2014. 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.

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 Budget includes a proposal to redirect $10 million from the $612 million TANF Contingency Fund for program improvements, including technical assistance for state programs, research, and evaluation. The Budget also proposes prohibiting the use of non-governmental third party expenditures to meet state Maintenance of Effort requirements and a provision to ensure that states use TANF funds for benefits and services for needy families.

The Budget also proposes the Pathways to Jobs initiative within TANF, which would repurpose the balance of the Contingency Fund to support work opportunities through subsidized employment for low-income parents and guardians, and youth, including summer jobs for youth. Building on the successes of the expired TANF Emergency Contingency Fund, Pathways to Jobs will target individuals who are either eligible for TANF cash assistance (including custodial and noncustodial parents with a child eligible for TANF cash assistance) or who are below 200 percent of federal poverty level and face other barriers to employment. The program would permit up to 100 percent coverage for wages, workplace benefits, training, and administrative costs associated with up to the first 90 days of employment for eligible individuals, including eligible summer employment. State subsidized employment efforts through Pathways to Jobs would be required to satisfy one or more of the four statutory purposes of the TANF program and to comply with requirements prohibiting displacement of other workers. The proposal also includes statutory changes necessary to give ACF the authority to collect data necessary to evaluate and oversee this program, and the Budget recommends setting aside 1 percent for national evaluation of the program.

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 and transitional living, and employment-related services.

SSBG, including funding for the Health Professions Opportunity Grants, is funded at $1.8 billion for FY 2015, the same as in FY 2014 before the effects of sequestration. The Budget supports a reauthorization of the Health Professions Opportunity Grants and proposes to consolidate the authority to operate this program in ACF, expand the list of partners to consult, and allow funds to be used for subsidized employment. Reauthorization would provide $85 million per year for these grants.

FY 2015 ACF Mandatory Outlays

dollars in millions	2013	2014	2015	2015 +/- 2014
Current Law Outlays:				
Child Care Entitlement to States	2,872	2,901	2,912	+11
Child Care and Development Fund (non-add) /1	*5,049*	*5,239*	*5,325*	*+86*
Child Support Enforcement and Family Support	4,066	3,887	4,082	+195
Foster Care and Permanency	6,770	6,803	6,952	+149
Promoting Safe and Stable Families (mandatory only) /2	497	491	438	-53
Temporary Assistance for Needy Families (TANF)	17 ,107	16,825	16,805	-20
TANF Contingency Fund /3	626	702	632	-70
TANF Emergency Fund /4	73	50	50	—
Subtotal, TANF (non-add)	17,806	17,577	17,487	*-90*
Children's Research and Technical Assistance	46	48	51	+3
Social Services Block Grant	1,876	1,628	1,760	+132
Sandy Supplemental /5	1	237	236	-1
Total, Current Law Outlays	**33,934**	**33,572**	**33,918**	**+346**
Proposed Law Outlays:				
Child Care Entitlement to States	2,827	2,901	3,512	+611
Child Care and Development Fund (non-add)	*5,049*	*5,239*	5,925	+686
Child Support Enforcement and Family Support	4,066	3,887	4,092	+205
Foster Care and Permanency	6,770	6,803	6,955	+152
Promoting Safe and Stable Families (mandatory only)	497	491	440	-51
Temporary Assistance for Needy Families (TANF)	17,107	16,825	16,812	-13
TANF Contingency Fund	626	702	*21*	-681
Pathways to Jobs	—	—	602	+602
TANF Emergency Fund	73	50	50	—
Subtotal, TANF (non-add)	*17,806*	*17,577*	*17,487*	*-90*
Children's Research and Technical Assistance	46	48	51	+3
Social Services Block Grant /6	1,876	1,628	1,762	+134
Sandy Supplemental	1	237	236	-1
Total, Proposed Law Outlays	**33,934**	**33,572**	**34,535**	**+963**

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 funding. In addition, there is a discretionary appropriation of $59.8 million in FY 2015 for PSSF.

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.

6/ The proposed law reflects the reauthorization of the Health Profession Opportunity Grants.

FY 2015 ACF Mandatory Legislative Proposals

Dollars in millions	2015	2015 -2019	2015 -2024
Child Care Entitlement	600	5,708	18,073
Child Support Enforcement and Family Support Programs /1	3	410	1,514
Foster Care and Permanency /2	3	324	517
Promoting Safe and Stable Families	2	228	405
Health Profession Opportunity Grant /3	2	228	425
Temporary Assistance for Needy Families (TANF)	—	—	—
Total Outlays, ACF Legislative Proposals	**610**	**6,958**	**20,934**

1/ The Child Support outlays in this table are net of estimated savings in the Supplemental Nutrition Assistance Program ($586 million) and the Supplemental Security Income program ($69 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 ACF portion of the proposal to scale-up evidence-based psychosocial interventions as an alternative to psychotropic medications for children in foster care ($250 million over ten years) and the impact of a Child Support proposal to require states to use the collections received on behalf of Title IV-E children in the best interest of the child ($266 million over ten years).

3/ The Health Profession Opportunity Grants are within the Social Services Block Grant account.

dollars in millions	2013	2014	2015	2015 +/- 2014
Health and Independence				
Home & Community-Based Supportive Services	348	348	348	--
Nutrition Services	768	815	815	--
Native American Nutrition & Supportive Services	26	26	26	--
Preventive Health Services	20	20	20	--
Chronic Disease Self-Management (PPHF)	7	8	8	--
Falls Prevention [PPHF]	--	5	5	--
Senior Community Service Employment Program	425	434	380	-54
Aging Network Support Activities	7	7	7	--
Subtotal, Health and Independence	**1,601**	**1,663**	**1,609**	**-54**
Caregiver Services				
Family Caregiver Support Services	146	146	146	--
Native American Caregiver Support Services /1	6	6	6	--
Alzheimer's Disease Demonstration Grants	4	4	4	--
Alzheimer's Disease Initiative – Services (PPHF)	--	11	11	--
Lifespan Respite Care /1	2	2	2	--
Subtotal, Caregiver Services	**158**	**168**	**168**	**--**
Protection of Vulnerable Older Adults				
Elder Justice Initiative / Adult Protective Services	2	--	25	+25
Long Term Care Ombudsman Program	16	16	16	--
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**	**33**	**58**	**+25**
Developmental Disabilities Programs				
State Councils on Developmental Disabilities	71	71	71	--
Protection and Advocacy	39	39	39	--
Projects of National Significance	9	9	9	--
Univ. Centers for Excellence in Developmental Disabilities	37	37	37	--
Youth Transitions Initiative	--	--	5	+5
Subtotal, Developmental Disabilities	**155**	**155**	**160**	**+5**
Consumer Information, Access and Outreach				
Voting Access for People With Disabilities (HAVA)	5	5	5	--
Aging and Disability Resource Centers	16	15	20	+5
National Clearinghouse for Long-Term Care Information	--	--	1	+1
State Health Insurance and Assistance Programs	46	52	52	--
Alzheimer's Disease Initiative – Outreach (PPHF)	--	4	4	--
Paralysis Resource Center /1	7	7	7	--
MIPPA Extensions	24	13	--	-13
Subtotal, Consumer Information, Access and Outreach	**97**	**96**	**89**	**-7**
White House Conference on Aging	--	--	3	+3
Holocaust Survivor Assistance Fund	--	--	5	+5
Program Administration	28	30	30	--
Total, Program Level	**2,074**	**2,146**	**2,123**	**-23**
Less Funds from Other Sources	-43	-49	-61	-12
Total, Budget Authority	**2,031**	**2,097**	**2,062**	**-34**
Full-time Equivalents	162	171	178	+7

1/ These programs are funded with PHS Evaluation Funds in FY 2015.

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 2015 Budget requests $2.1 billion for the Administration for Community Living (ACL). ACL works on behalf of both older adults and individuals with disabilities to ensure that they are able to live at home with the supports they need while also participating fully in their communities. In FY 2015, the Budget prioritizes efforts to address elder abuse, assist transitioning youth with intellectual and developmental disabilities, support caregivers, help older adults and people with disabilities access services and supports, and improve the coordination of programs across federal government that serve these populations. The Budget also includes $3 million for the decennial White House Conference on Aging to bring together stakeholders and consumers from across the country to discuss the range of aging issues they face, as well as $5 million for a new Holocaust Survivor Assistance Fund that will provide support to the approximately 130,000 elderly Holocaust survivors living in the United States, individuals who are disproportionately poorer and who suffer worse health outcomes than the elderly in general.

NEW INITIATIVE

Elder Justice: Addressing Elder Abuse, Neglect, and Exploitation

A 2004 national survey showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people. Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases, and psychological distress.

The request for ACL's Elder Justice initiative is a critical first step toward fulfilling the mandate of the Elder Justice Act and implementing the recommendations of the Elder Justice Coordinating Council. The Council first met in 2012 and is led by the HHS Secretary. Council members include the U.S. Attorney General, as well as representatives from a number of federal partner agencies, including the Social Security Administration, the Securities and Exchange Commission, and the Treasury Department. ACL's Elder Justice initiative is based off of a set of nine proposals presented to the Council in May of 2013 that call for increased federal involvement with regard to addressing elder abuse, neglect, and exploitation.

Keeping Seniors Healthy and Independent

The Budget requests a total of $1.2 billion for services that help older adults to remain independent and in the community, including $32 million to support these services in Tribal communities. Within this total, the budget requests $815 million for nutrition services to ensure that millions of older Americans remain healthy and independent by providing reliable access to nutritious food. The meals programs supported by ACL are designed to reach seniors both in their homes and in the community. ACL's meal programs reach some of the frailest, yet nevertheless independent, members of the community by delivering meals right to their homes. For seniors who are able to access community settings like senior centers, ACL supports meals in congregate settings where they get access to a nutritious meal, as well as to vital social contact. The Budget will support ACL's partnership with state and local agencies to provide 208 million congregate and home-delivered meals for over 2 million older individuals nationwide.

The Budget also includes $348 million to fund in-home and community-based services to help older Americans live independently and with dignity. These services include assistance with transportation; case management; information and referral; help with personal care, including eating, dressing, and bathing; and adult day care and physical fitness programs. The Budget, in combination with state and local funding, will support over 26 million hours of assistance to seniors unable to perform daily activities; more than 21 million rides for critical activities such as visiting the doctor, pharmacy, or grocery stores; and 8 million hours of adult day care. These services provide direct assistance to older individuals and also assist the caregiving friends and family members of these seniors by providing them with relief and flexibility to attend to other demands in their lives while also maintaining support for their friends or loved ones.

As noted, the Budget also includes $5 million for a new Holocaust Survivor Assistance Fund which will provide federal resources through a competitive grant-making process to support nonprofit service providers that work with the Holocaust survivor community. The fund will incorporate matching requirements for grantees in order to also attract private, philanthropic investment, multiplying the impact of this funding.

Protecting Older Americans and People with Disabilities

Combating the rising scourge of adult abuse, neglect, and exploitation in America remains one of ACL's top priorities. The Budget requests $25 million for a new Elder Justice initiative to address the negative effects of abuse, neglect, and exploitation on the health and independence of seniors while making key investments in Adult Protective Services, research, and evaluation activities.

With this funding, ACL will initiate the development of a national Adult Protective Services data system, including grants to states to test and develop infrastructure, and provide funding for key research, which is essential to the development of evidence-based interventions to prevent, identify and report, and respond to elder abuse. As the lead agency in addressing adult abuse, ACL will become the federal home for Adult Protective Services and will develop national standards to assist all states in improving the quality and consistency of their Adult Protective Services programs.

This investment in Adult Protective Services builds on ACL's existing consumer rights programs, which help protect seniors and people with disabilities in a number of ways. The Budget requests $16 million for the Long-Term Care Ombudsman Program, which provides support for ombudsmen who advocate on behalf of residents of long-term care facilities to ensure the protection of their rights and welfare and funds Protection and Advocacy systems, discussed below, that protect the rights of people with disabilities. The Budget also requests $18 million for other programs that address elder abuse prevention, provide legal assistance to seniors, and help educate consumers to prevent Medicare fraud.

NEW INITIATIVE

Transitioning Youth to Adulthood

Current support systems for youth with disabilities transitioning to adulthood and coordination efforts across federal agencies to assist these youth are insufficient. A 2012 GAO report strongly recommended development of an interagency approach across HHS, the Social Security Administration, and the Departments of Education and Labor to work toward improving common outcomes for transitioning youth with disabilities and their families related to health, education, employment, support services and community living.

The FY 2015 Budget includes a multi-pronged HHS effort aimed at transitioning youth, comprised of a new $5 million investment in ACL to assist youth with intellectual and developmental disabilities, funding for the Administration for Children and Families' Psychosocial Interventions for Children in the Child Welfare System effort, and the Substance Abuse and Mental Health Services Administration's Healthy Transitions program, an activity within the Now is the Time initiative. Together, these activities target populations of young Americans in the midst of difficult transitions and provide them with the tools and supports to enter adulthood.

Providing Support for Caregivers

The Budget request includes $173 million to fund programs designed to support family and informal caregivers by providing these caregivers with a number of forms of assistance, including counseling, training, information, and respite support, among other services. Assisting these hardworking and unpaid caregivers ultimately helps the seniors and people with disabilities they care for to live at home and to enjoy greater independence. When institutional care is avoided, this can translate into lower overall costs. Through these investments, ACL supports some of the many caregivers nationwide who provide $450 billion in care annually. The Budget will support an estimated 790,000 caregivers who will be able to participate in counseling, peer support groups, and training to help them manage the physical, emotional, mental, and financial stresses associated with caregiving for a family member or friend.

Included within this request, ACL will invest $19 million to specifically address the needs of those caring for persons with 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 syndrome are at greater risk of developing Alzheimer's, as well as older adults. The Budget supports a three pronged approach for addressing the challenges posed by the effects of Alzheimer's disease, including competitive grants to states that expand the availability of evidence-based interventions designed to assist persons with dementia and their caregivers; grants to strengthen the dementia capabilities of states, tribes, and localities, enabling these entities to enact permanent systems change; and outreach to inform those who care for individuals with Alzheimer's disease about resources available to help them.

Helping Individuals with Disabilities Participate in Their Communities and Achieve Their Goals

ACL is dedicated to ensuring that individuals with disabilities, as well as their families, have the opportunity to fully participate and contribute to all aspects of community life. ACL works toward accomplishing this goal through a variety of ongoing partnerships with states and territories, including State Councils on Developmental Disabilities, Developmental Disabilities Protection and Advocacy programs, and University Centers for Excellence in Developmental Disabilities.

In addition, the Budget proposes $5 million in FY 2015 for a new Youth Transitions initiative as part of a larger HHS effort young Americans in the midst of difficult transitions and provide them with the tools and supports they need to enter adulthood.

At ACL, funding for this initiative will help youth with intellectual or developmental disabilities to transition from adolescence and the supportive environment of school into an adulthood that includes post-secondary education and work opportunities, reducing their likelihood of becoming solely dependent on Social Security, Medicaid, or other similar benefits. This initiative will provide grants to replicate and evaluate the outcomes of programs that have shown promising employment results for youth with intellectual and developmental disabilities when Medicaid-funded long-term services and supports, vocational rehabilitation, Social Security, and education systems collaborate. For example, in Washington, King County changed its approach to transitioning students with intellectual and developmental disabilities from school to employment by adopting a statewide "Employment First" policy coupled with supportive services. In just 5 years, the percentage of King County youth with disabilities that were employed rose from 6 percent to 56 percent.

The Budget requests $71 million to fund State Councils on Developmental Disabilities. These councils, which operate in each state and territory, promote systems change efforts aimed at helping individuals with developmental disabilities live with self-determination, integration, and inclusion in their communities. The Budget also requests $44 million to continue funding for the Protection and Advocacy programs that assist states and territories to establish and maintain Protection and Advocacy systems. These systems protect the legal and human rights of all people with developmental disabilities by using their authority to investigate incidents of abuse and neglect against individuals with developmental disabilities, and to pursue administrative, legal, or other appropriate means when necessary. This includes $5 million to ensure that individuals with disabilities are able to fully participate in every step of the voting process. These protection and advocacy programs educate individuals on topics such as voter registration and their legal voting rights, provide them with voter registration opportunities, and help them access the polls on election day.

The Budget request also includes $37 million for University Centers for Excellence in Developmental Disabilities. These centers inform and advise federal, state, and community policymakers of the opportunities that exist 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 Budget requests $9 million for Projects of National Significance, which focus on identifying and addressing the most pressing issues that impact people with disabilities and their families. Included in the amount for Projects of National Significance is $1 million to continue efforts to identify and test coordinated transportation systems through the Transportation Research and Demonstration Program. Together, these efforts will allow ACL to enhance the independence, productivity, inclusion, and integration of people with developmental disabilities.

The Budget further requests $7 million in funding for the Paralysis Resource Center, which assists individuals living with spinal cord injury, mobility impairment, or paralysis through referral services and other resources focused on health promotion and community living after paralysis.

Promoting Efficiency in Community Based Service Delivery

The Budget requests $52 million to fund the State Health Insurance Assistance Program, which supports 12,000 counselors in more than 1,300 community-based organizations. These individuals and organizations provide Medicare beneficiaries who have a disability and/or who are elderly, as well as those nearing Medicare eligibility, with one-on-one outreach and counseling on the health insurance options available to them. This program helps beneficiaries navigate the many complexities of health and long-term care systems. Administration of this program transferred to ACL in FY 2014 from the Centers for Medicare & Medicaid Services (CMS).

The Budget also includes funding for the Senior Community Service Employment Program, proposing to move its administration to ACL from the Department of Labor at a funding level of $380 million, $54 million below the FY 2014 funding level. The program provides unemployed older adults with opportunities for community service training and employment in non-profit organizations and government agencies such as schools, libraries, and senior citizens programs. Participants are low-income older individuals with low or limited job prospects who can ultimately benefit from the social and supportive services provided by ACL's aging network. Under ACL's administration, this program will be better aligned with other ACL programs that serve program participants, such as nutrition services and home and community-based services.

Supporting Evidence-Based Initiatives and Increased Access to Services

ACL identifies, evaluates, and replicates the best models and practices nationwide across the aging and disability services networks to ensure their continued vitality and success, with a focus on funding lower-cost, non-medical services and supports. The Budget requests $20 million each year for the next 5 years in new mandatory funding for Aging and Disability Resource Centers. These centers are "no wrong door" entry points at the community level where individuals of all ages can turn for objective information and one-on one counseling on their long-term services and support options, including help, as needed, in accessing public programs. ACL, CMS, and the Department of Veteran's Affairs are now working with eight Aging and Disability Resource Center states to develop national standards for a high-performing, No Wrong Door system that serves all populations and all payers.

The Budget includes $8 million for Chronic Disease Self-Management Education programs. These programs help participants take charge in better managing their own chronic diseases by teaching them how to manage their illnesses, adopt healthy behaviors, and improve their health status, with the ultimate goal of reducing hospital stays and emergency room visits.

The Budget also includes $5 million for falls prevention, which was first funded in FY 2014. Falls are the leading cause of both fatal and nonfatal injuries for those 65 and over, and falls can result in significant loss of independence for older Americans and often trigger the onset of a series of growing medical needs. ACL's falls prevention program aims to help participants achieve improved strength, balance, and mobility and also provide education on how to avoid falls.

Federal Administration

The Budget includes $30 million in funding for program management and support activities, the same as FY 2014. This funding supports rent, staff, and other administrative costs, and is also used to support staff in ACL's regional office.

OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT

dollars in millions	2013	2014	2015	2015 +/- 2014
Budget Authority	447	458	286	-172
Prevention and Public Health Fund	N/A	*N/A*	105	+105
PHS Evaluation Funds	69	69	119	+50
Pregnancy Assistance Fund	24	23	25	+2
Total, Program Level	**540**	**550**	**535**	**-15**
Full-time Equivalents	1,577	1,574	1,590	+16

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

The FY 2015 Budget for General Departmental Management (GDM) is $535 million in program level funding, a decrease of $15 million below FY 2014. The Budget supports grant programs as well as the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These efforts are carried out through 11 Staff Divisions and Offices in GDM.

Teen Pregnancy Prevention: The FY 2015 Budget includes $105 million from the Prevention and Public Health Fund to support community efforts to reduce teen pregnancy. In addition, $7 million in Public Health Service Act evaluation funding is included for the evaluation of teen pregnancy prevention activities. Teen pregnancy funding 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 $36 million for the Office of Minority Health, a decrease of $21 million below FY 2014. The Office of Minority Health will lead, coordinate and collaborate on minority health activities in HHS, and place less emphasis on program development. This funding will enable the Office of Minority Health to continue some targeted grants and health promotion, service demonstration, and educational efforts to prevent disease, reduce and ultimately eliminate disparities in racial and ethnic minority populations across the country.

Minority HIV/AIDS: The FY 2015 Budget includes $54 million, an increase of $2 million above the FY 2014, 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 $30 million for the Office on Women's Health, a decrease of $4 million below FY 2014. The Office on Women's Health will lead, coordinate, and collaborate on women's health activities and program development in HHS. This funding will allow the Office on Women's Health to continue some targeted grants and support the advancement of women's health programs through promoting and coordinating research, service delivery, and education. These programs are carried out throughout the divisions and offices of HHS, with other government organizations, and with consumer and health professional groups.

Acquisition Reform: In addition, $2 million is included in the Budget 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 Budget includes $301 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	2013	2014	2015	2015 +/- 2014
Program Level	**69**	**82**	**100**	**+18**
Full-time Equivalents	492	514	629	+115

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 (ALJ) exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional, legal, and administrative staff.

The FY 2015 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $100 million, an increase of $18 million over FY 2014. OMHA administers hearings and appeals nationwide for the Medicare program. By statute, these 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 accessible hearings at low cost.

OMHA began processing cases on July 1, 2005; since then, it has received more than two 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 nationwide expansion of the Recovery Audit Contractor program, administered by the Centers for Medicare & Medicaid Services. These claims, in combination with the influx of Medicare enrollees due to retirement of baby boomers, have been driving OMHA's workload upward at a rapid pace. OMHA received a total of 320,000 claims in FY 2012, and over 600,000 claims in FY 2013. OMHA projects that its FY 2015 caseload will increase to approximately 850,000 total claims (a 166 percent increase over FY 2012).

Due to the overwhelming growth in the caseload, OMHA is not able to meet the required 90 day timeframe for case adjudication. It is currently taking over 300 days for OMHA to adjudicate an appeal. OMHA's backlog of claims is projected to reach 1,000,000 by the end of FY 2014.

With the requested funding level of $100 million, OMHA will increase its ALJs and support staff necessary to respond to 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 service.

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

dollars in millions	2013	2014	2015	2015 +/- 2014
Budget Authority	15	16	--	-16
PHS Evaluation Funds	45	45	75	+30
Total, Program Level	**60**	**60**	**75**	**+15**
Full-time Equivalents	171	185	191	+6

The Office of the National Coordinator for Health Information Technology fosters modernization and innovation of the American health care system through the optimization of health information technology. These investments will support better decision-making by consumers, clinicians, health care managers, and policy-makers at all levels of the health care system.

The FY 2015 Budget for the Office of the National Coordinator for Health Information Technology (ONC) is $75 million, $14 million above FY 2014. The Budget builds upon recent nationwide investments to promote the adoption of health information technology among a critical mass of providers, professionals, and consumers. ONC supports the development of standards to address technical challenges related to interoperability of systems and the exchange of health information. It also places greater emphasis on the role of health IT in ensuring patient safety, and ONC's role in assisting federal agencies in integrating health IT standards and policies that support new payment models.

Building on the Recovery Act's health IT investment to create Health IT Regional Extension Centers, the FY 2015 Budget demonstrates ONC's role as the primary convener of government-wide health IT efforts to further accelerate the nationwide implementation of health IT. The Budget includes resources to maintain core activities related to health IT standards, policy, and adoption with an emphasis on consensus-based solutions to a broad range of health IT issues. The Budget provides support for activities that directly support the meaningful use programs; a certification program that test tools for developers prior to certification and strengthened surveillance activities; the Blue Button Program, which engages providers, developers, and consumers to create solutions that empower all participants in health care; and a National Learning Consortium that disseminates best practices to providers on how to optimize health information technology and effective guidelines to achieve meaningful use of electronic health records. Additionally, new investments will support a public-private partnership aimed at enhancing patient safety and health IT usability through surveillance and analysis of safety incidents.

Patient Safety and Health IT Usability

ONC, in collaboration with the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services, released the Health IT Safety Plan in FY 2013. This plan called for greater alignment of federal and private sector programs focused on health IT safety and usability.

ONC seeks to ensure that health IT is safely designed and implemented, health care providers 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. The FY 2015 Budget supports the creation of a Health IT Safety Center with a $5 million investment to understand and correct patient harm related to the use of certified electronic health record technologies.

The Center will operate in partnership with patient safety organizations, vendors, providers, and patients to ensure that certified electronic health record technologies are safely developed, deployed, and maintained.

Standards, Interoperability, and Certification

Standards development remains a primary focus of ONC to ensure continued progress towards enhancing the nation's health information technology infrastructure and implementing nationwide solutions to health information exchange. ONC engages health care, technology, and standards stakeholders to accelerate industry consensus on the standardization of health data and health information exchange.

Through the establishment of core standards and policies that enable the electronic exchange and meaningful use of health information, ONC offers critical support to other federal initiatives. Additionally, ONC will develop and disseminate health information exchange building blocks and toolkits comprised of predefined sets of standards, protocols, legal agreements, specifications, and services that can be readily deployed by entities that manage or provide health information exchange services.

Privacy and Security

As the nationwide health IT infrastructure evolves, ONC is committed to ensuring the privacy and security of patients' health information. The Budget supports technical assistance to vendors, providers, consumers, and others on safeguarding health information to ensure that health information technology systems and workflows are protected by adequate safeguards. ONC will educate patients about their rights, and Health Information Organizations about their duties when participating in health information technology. ONC is committed to ensuring that health information is safe and secure by addressing privacy and security issues arising from new technologies and increased participation in health information technology. In an effort to increase 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.

Adoption, Utilization, and Meaningful Use of Health IT

Over eighty percent of eligible hospitals and over sixty percent of eligible professionals have adopted electronic health records; ninety-six percent of pharmacies have implemented e-prescribing. The FY 2015 Budget will allow ONC to provide essential technical assistance for health IT standards and policies in support of new payment models. Through the National Learning Consortium, ONC will assist adopters and implementers and foster a community that shares knowledge to address barriers to achieving positive health outcomes.

ONC will continue partnerships with providers, hospitals, and consumers along with the dissemination of critical implementation resources to assist the practice transformation programs of Agency for Healthcare Research and Quality and CMS. ONC will continue to convene stakeholders and develop strategies to increase consumer adoption and utilization of health IT.

ONC will continue its role as a convener by assisting partner agencies in planning, implementing and maintaining these programs in a manner that will strategically leverage health IT, and will be informed by ongoing identification and dissemination of best practices.

NEW INITIATIVE

Health IT Safety Center

ONC is committed not only to promoting the adoption of, meaningful use, and optimization of health IT, but also to ensuring that these innovative technologies are safely designed and are used in ways that improve patient safety and the quality of patient care. To achieve these aims, ONC provides leadership and coordinates activities and resources to help all stakeholders with responsibility for health IT safety implement the shared improvement strategies and actions described in the HHS Health IT Patient Safety Action and Surveillance Plan.

In FY 2015, ONC will start data collection and benchmark analysis of health IT-related adverse events to provide a baseline for the types and frequencies of events. The Center will analyze patient safety incidents associated with the use of electronic health record technology.

The results of ONC's analysis will be used to identify and analyze health IT-related patient safety risks and develop effective remediation and mitigation strategies. ONC will coordinate the work of the Center with AHRQ, Patient Safety Organizations, the Joint Commission, and FDA.

PERFORMANCE HIGHLIGHT

Health IT Adoption, Utilization, and Meaningful Use

ONC supports efforts aimed at the widespread adoption of the latest health IT by working closely with the Centers for Medicare & Medicaid Services to refine and expand the criteria governing the Medicare and Medicaid electronic health record incentive programs. Through the National Learning Consortium ONC disseminates methods by which providers and consumers can meaningfully use certified electronic health record technology to improve decision making.

In FY 2015 highlights include:

- Implement the Health IT Vanguard program, consisting of Meaningful Use Vanguards and Health IT Fellows. These providers, office staff, and administrators are advancing meaningful use of health IT systems in their organizations and are champions of health IT in their local communities.
- Support a strong national network of organizations working to assist over 145,000 providers, including over 44 percent of the nation's total primary care providers, to meaningfully use health IT. The network is also working with over 80 percent of HRSA-funded federally qualified health centers and over 50 percent of the practices enrolled in the CMMI-Comprehensive Primary Care initiative.
- Expand the capabilities of the public health IT dashboard to enable access to thousands of data points presented as user-interactive graphs and maps.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

dollars in millions	2013	2014	2015	2015 +/- 2014
Program Level	**39**	**39**	**41**	**+2**
Full-time Equivalents	212	207	218	+11

The Office for Civil Rights ensures equal, nondiscriminatory access to and receipt of all HHS services and the protection of privacy and security of health information, thereby contributing to HHS's overall mission of improving the health and well-being of all Americans affected by its many programs.

The FY 2015 Budget for the Office for Civil Rights (OCR) is $41 million, an increase of $2 million over FY 2014. The increase will support OCR's centralized case management operations and online complaint system. The Budget supports continued enforcement of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule and OCR's expanded HIPAA responsibilities. OCR evaluates and ensures HIPAA and civil rights compliance through complaint investigations, compliance reviews, audits, resolution agreements, enforcement actions and monitoring, public education, and technical assistance.

Civil Rights

OCR resolves nearly 3,000 discrimination complaints annually and enforces various federal civil rights laws and regulations that protect against discrimination on the basis of race, color, national origin, disability, age, sex and religion in HHS funded programs; disability in health care and social service programs of state and local governments; and federal health care provider conscience. 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 that receive financial assistance or are administered by HHS or any entity established under Title I of the Affordable Care Act.

Resolution Agreements and Compliance Activities: OCR reviews nearly 3,000 new Medicare applicants a year to assess compliance with federal civil rights requirements. Through formal agreements with 54 health care corporations, OCR ensures ongoing compliance in more than 4,600 facilities that serve over 11 million patients annually.

OCR conducts compliance reviews and provides technical assistance to Critical Access Hospitals, which serve rural and isolated areas, to ensure that language assistance services are available to limited English proficient individuals.

OCR provides technical assistance and education to states to ensure compliance with the Americans with Disabilities Act. OCR disseminates information, creates virtual learning communities, and provides 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 resolved more than 9,500 complaints of alleged HIPAA violations in FY 2013. OCR's HIPAA responsibilities continue to expand.

Omnibus Rule: HHS implemented 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 rule strengthened the HIPAA privacy and security protections by providing individuals new rights to their health information, and by strengthening the government's ability to enforce the law. The Privacy and Security Rule requirements apply to health care providers, health plans and entities that process health insurance claims. The HITECH Act expands many of the requirements to business associates of these covered entities, such as contractors and subcontractors. Some of the largest breaches reported to HHS have involved business associates. Penalties for noncompliance are increased 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 impose civil monetary penalties for HIPAA Privacy and Security Rule violations. OCR collected $4 million in FY 2013 and anticipates $5.5 million in FY 2014. OCR uses collections to support HIPAA enforcement activities.

OFFICE OF THE SECRETARY
OFFICE OF INSPECTOR GENERAL

dollars in millions	2013	2014	2015	2015 +/- 2014
Discretionary Appropriation	47	71	75	+4
Disaster Relief Appropriations Act of 2013	5	--	--	--
HCFAC Collections	10	11	12	+1
Discretionary HCFAC	28	28	28	--
Mandatory HCFAC	186	185	285	+100
Total Funding, All Sources	**276**	**295**	**400**	**+105**
Full-time Equivalents	1,660	1,577	1,861	+284

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 the people they serve.

The FY 2015 Budget request for the Office of Inspector General (OIG) is $400 million, an increase of $105 million above the FY 2014 enacted level. The request includes $75 million for OIG oversight of HHS's more than 300 non-Medicare/Medicaid programs, some of which are new or have grown in scope and complexity during the last decade. These funds will enable OIG to target oversight efforts of HHS public health and human services programs and the Health Insurance Marketplaces (Marketplaces).

Moreover, 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 $325 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 2015 include protecting the integrity of the expanding Medicaid program and recommending solutions to reduce improper payments in Medicare and Medicaid.

While specific oversight activities in FY 2015 will be determined through OIG's work planning process, the following are OIG's focus areas based on its assessment of the top management and performance challenges facing HHS.

Integrity of the Marketplaces

The Marketplaces add a substantial new dimension to the Department's landscape. They include state, federal, and partnership marketplaces, each of which must implement and successfully operate a complex set of program requirements. Individuals use the Marketplaces to get information about their health insurance options, be assessed for eligibility (for, among other things, qualified health plans, premium tax credits, and cost sharing reductions), and enroll in the health plan of their choice.

OIG's oversight of the Marketplaces focuses on payment accuracy, eligibility systems, contractor oversight, and data security and consumer protection. By focusing on these key areas OIG hopes to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure.

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

Grants Management and Administration of Contract Funds: HHS is the largest grant-making organization in the federal government, awarding over $345 billion in grants in FY 2013, of which approximately $88 billion were for Public Health and Human Services programs. HHS is also the third largest contracting agency in the federal government; in FY 2013, HHS awarded over $19 billion in contracts

across all program areas. The size and scope of departmental awards make operating effectiveness crucial to their success. In FY 2015, OIG will continue to examine the Department's grants management and contracting practices and its oversight of grantees and contractors. OIG will also identify misused grant and contract funds for recovery and investigate suspected grant fraud. 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: HHS is responsible for protecting public health by ensuring the safety, efficacy, and security of drugs, medical devices, biologicals, and much of our nation's food supply. Additionally, HHS must ensure that once a drug, biologic, or device has been approved for use, it is marketed appropriately. Furthermore, during a food emergency, HHS must find the contamination source and oversee the removal by manufacturers of these products from the market. In FY 2015, OIG will continue to evaluate the Department's management of food, drug, and device safety issues. Furthermore, OIG continues to work closely with Food and Drug Administration and the Justice Department to investigate illegal marketing practices by drug and device manufacturers.

Integrity of Medicare and Medicaid

Expansion of Medicaid: Beginning in 2014, states have the option to expand Medicaid eligibility to qualifying adults earning up to 133 percent of the federal poverty level. Because of this and other factors, it is anticipated that the population covered under Medicaid will grow significantly over the next few years. In addition to the challenges in implementing this expansion, increases in the Medicaid population and spending also heighten the urgency of addressing existing program integrity challenges.

OIG's work in this area will focus on ensuring that the federal government pays the appropriate share of costs; improper payments are identified and collected; eligibility is correctly determined; managed care programs, in which approximately a third of all Medicaid beneficiaries are enrolled, maintain sufficient program integrity efforts; and payment rates to health care providers are economical.

Fighting Fraud and Waste in Medicare Parts A & B: Fraud and waste in Medicare Fee-for-Service programs continue to be significant challenges. Improper payments and payment inefficiencies waste Medicare dollars and divert finite resources away from beneficiary care and services. In FY 2013, CMS reported an error rate of 10.1 percent for Medicare Fee-for-Service. OIG investigations continue to uncover durable medical equipment suppliers, home health agencies, community mental health centers, ambulance operators, and outpatient therapy providers that are defrauding the Medicare program. In national assessments, OIG has identified questionable billing patterns by home health agencies and community mental health centers and is conducting similar analysis of questionable billing by ambulance providers. Additionally, OIG work spotlights various types of waste including hospital billing error, improper payments to Skilled Nursing Facilities and misaligned payment rates. OIG will continue its work in these areas in FY 2015.

Ensuring Patient Safety and Quality of Care in Nursing Facilities and Home- and Community-Based settings: As the median age of Americans trends upward and as more Americans live with chronic medical conditions, there are challenges in ensuring that beneficiaries who require nursing facility services receive high quality care. It is also critical to ensure that appropriate home- and community-based care is available, allowing beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid institutionalization.

OIG continues to assess quality of care and patient safety across a variety of health care settings, including nursing facilities and home and community-based settings, and recommends improvements to oversight and safeguards. Additionally, OIG continues to pursue enforcement actions against nursing homes that render substandard care, while working with the Centers for Medicare and Medicaid Services and law enforcement partners at the Department of Justice to promote better care for elderly persons and to prosecute providers that subject them to abuse or neglect.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

dollars in millions	2013	2014	2015	2015 +/- 2014
Office of the Secretary, Assistant Secretary for Preparedness and Response (ASPR):				
Preparedness and Emergency Operations	28	28	25	-3
National Disaster Medical System	50	50	50	--
Hospital Preparedness	358	255	255	--
ESAR-VHP (non-add)	*1*	*1*	*1*	--
Medical Countermeasure Dispensing	--	5	--	-5
BARDA	415	415	415	--
Strategic Investor (non-add)	--	--	*20*	*+20*
Project BioShield	--	255	415	+160
Policy and Planning	15	15	15	--
Operations	31	31	31	--
Subtotal, ASPR Program Level	**897**	**1,054**	**1,206**	**+152**
Other Office of the Secretary:				
Security and Strategic Information	6	6	7	+1
Cybersecurity	38	41	45	+4
Medical Reserve Corps	11	11	9	-2
HHS Lease Replacement	16	16	--	-16
Subtotal, Other Office of the Secretary	**71**	**74**	**62**	**-12**
Pandemic Influenza	--	115	170	+55
Total Program Level, PHSSEF	**968**	**1,243**	**1,438**	**+194**
Less Funds from Other Sources:				
Use of BioShield Balances	415	--	--	--
Use of PHS Evaluation Funds	--	--	15	+15
Total Discretionary Budget Authority, PHSSEF	**553**	**1,243**	**1,423**	**+180**
Full-time Equivalents	663	741	765	+24

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.

The FY 2015 Budget includes $1.4 billion for the Public Health and Social Services Emergency Fund (PHSSEF) in the Office of the Secretary. Funds will enhance the nation's preparedness against naturally occurring and man-made health threats. The Budget continues support of the Administration's priority to lead the public and private advancement of the medical countermeasure enterprise. Across the department, the Budget provides nearly $5 billion to support the advanced development of medical countermeasures, pandemic influenza preparedness activities, and emergency preparedness.

Bioterrorism and Emergency Preparedness

The Budget supports preparedness and response activities within the Office of the Secretary, as well as the coordination of programs across HHS, to improve the nation's ability to prepare for, respond to, and recover from public health emergencies and disasters. The FY 2015 Budget request for these bioterrorism and emergency preparedness activities is $1.3 billion, an increase of $194 million over FY 2014.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) serves as the lead for federal public health and medical services response efforts under the National Response Framework. ASPR's efforts focus on promoting community preparedness and prevention; building public health partnerships with federal agencies, academic institutions, and private industry; and coordinating federal public health and medical response capability. The FY 2015 Budget provides $1.4 billion for ASPR; an increase of $207 million over FY 2014.

PERFORMANCE HIGHLIGHT

Universal Influenza Vaccine Development in the Opportunity, Growth, and Security Initiative

The advanced development of vaccine candidates for a potential universal influenza vaccine is an activity highlighted in the President's proposed Opportunity, Growth, and Security Initiative in the FY 2015 Budget. Developing a universal flu vaccine would allow individuals to receive immunity across strains, instead of requiring individual vaccination against each separate strain. These funds would also support activities to improve the basic effectiveness of existing vaccines.

PROGRAM HIGHLIGHT

BARDA and BioShield Medical Countermeasure Pipeline

Project BioShield, established to support the development and procurement of medical countermeasures, was originally authorized in 2004 and initially funded for 10 years through FY 2013. During this timeframe, BARDA procured 12 new medical countermeasures while completing research and development, which moved over 80 additional countermeasures into the pipeline for procurement. Although these accomplishments show significant progress-to-date, countermeasure development and procurement must continue to keep up with the ever-changing threats facing the country.

With this second phase of Project BioShield, BARDA anticipates procuring 12 new medical countermeasure products between FYs 2014-2018. These countermeasures include: skin therapeutics for thermal and radiation burns; devices to measure radiation exposure; chemical antidotes; broad spectrum antibiotics; and improved anthrax vaccines.

Through extensive research, development, and procurement, ASPR has significantly improved the nation's ability to respond to man-made threats such as chemical, biological, radiological, and nuclear (CBRN) agents, in addition to natural threats including pandemic influenza and other emerging infectious diseases. To build upon these improvements in emergency response, the FY 2015 Budget provides $415 million for activities to support Project BioShield (BioShield).

The Budget also includes $415 million for the Biomedical Advanced Research and Development Authority (BARDA). BARDA will fund the operating costs for the Centers of Innovation for Advanced Development and Manufacturing, which will include the development of existing promising medical countermeasure candidates, such as the anthrax

vaccine portfolio. BARDA will also invest in the development of bio-diagnostic devices, new broad spectrum antimicrobial drugs, radiological and nuclear countermeasure products, and chemical antidotes. Together, these activities will contribute to the Department's efforts to expand the medical countermeasure pipeline for procurement.

In FY 2015, $255 million is requested for the Hospital Preparedness Program, the same level as FY 2014. Funding supports state and local grants to enhance hospital and healthcare coalition planning for emergency management, and to integrate private and public response systems to improve surge capacity and enhance community preparedness for public health emergencies. Additionally, the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Program will provide $617 million to state, local, tribal, and territorial public health departments to upgrade their ability to effectively respond to a range of public health threats. The two programs are now aligned around 15 key response capabilities, and between FY 2005 and FY 2014, have provided a combined total of nearly $11 billion in cooperative agreements to support flexible and adaptable community preparedness planning and encourage close coordination among a variety of stakeholders across the health spectrum.

The Budget provides $75 million to support the department's emergency preparedness and response efforts. This request includes funding for the National Disaster Medical System, which is a nationwide system of health care providers who are able 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. In addition, $15 million will support the department's planning and response requirement-setting activities, such as the development of strategic plans and guidance for domestic and international public health emergency preparedness and response activities.

The Budget proposes an emergency transfer authority, which was first requested in FY 2014, to assist in the rapid response to public health emergencies. This authority will provide flexibility to quickly redirect resources to programs across the department in support of disaster response.

PROGRAM HIGHLIGHT

H7N9 Influenza Outbreak Response and Preparedness

In March 2013, the first human cases of the novel avian influenza strain, H7N9, were reported in China. As of January 2014, 237 cases have been identified, including 58 deaths. Although H7N9 has not reached the United States, the interim risk assessment, conducted by the Department of Agriculture and the CDC, has indicated that this strain poses pandemic potential. Fortunately, lessons learned from the 2009 H1N1 pandemic have brought about improvements in response and coordination between agencies across the Department, including BARDA, CDC, the National Institutes of Health (NIH), and the Food and Drug Administration (FDA).

Since the onset of the virus, HHS has taken steps to research and develop H7N9 vaccine candidates with the goal of producing a domestic stockpile. These candidates are currently at various stages of clinical trials testing. BARDA has also established the Fill-Finish Network, which is intended to boost the nation's ability to provide influenza vaccine domestically. Should large-scale distribution of a H7N9 vaccine be necessary, BARDA will be able to engage this network, which is anticipated to increase existing capacity by 20 percent.

The Department will continue to closely monitor the situation globally and collaborate with international partners as this influenza season proceeds.

Pandemic Influenza

The 2013 emergence of the novel avian influenza virus, H7N9, demonstrated the critical need for ongoing influenza preparedness activities. Ongoing efforts to improve pandemic flu response, preparedness, and research and development have made a tremendous impact on the ability to protect the nation's citizens. Though this progress-to-date is exceptional, it is essential that these efforts continue to further strengthen the Department's ability to combat future novel influenza strain outbreaks. The FY 2015 Budget requests $170 million to counter the continuing threat of a global influenza pandemic. This funding supports improvements in vaccine production and manufacturing efficiency, ongoing countermeasure stockpiling and storage, antiviral drug advanced development, and improvements in respiratory protection devices. This funding also supports the advanced development of potential candidates for a universal influenza vaccine, which builds upon previous research completed by NIH.

The Budget also includes support for improvements in diagnostic testing, international manufacturing and response efficiency, and diplomatic activities, including collaboration with the World Health Organization.

Cybersecurity: The Budget provides $45 million to protect the department's information technology systems and to support the safeguarding of personally identifiable information, commercial proprietary data, and scientific research of national importance. In FY 2015, funding will support the full operations of the Trusted Internet Connection, which consolidate the Department's internet traffic into three secure portals and provide for advanced threat monitoring capabilities. As cyberthreats become more frequent and more sophisticated, additional funding in the FY 2015 Budget will better enable the department to identify, and respond swiftly to mitigate, cybersecurity risks.

Security and Strategic Information: The Budget includes $7.5 million, $1 million above FY 2014, 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. Increased funding will support the Defensive Counterintelligence program, which detects vulnerabilities to HHS missions and maintains the security of classified information from insider threats.

Medical Reserve Corps: The Budget request includes $9 million for the Civilian Volunteer Medical Reserve Corps in FY 2015, which is $2 million below FY 2014, to maintain training with current units. Funding will continue to support local units that are trained and available to respond to public health emergencies.

Highlighted Bioterrorism Preparedness Activities:
Many offices and programs across the Department contribute to the nation's preparedness and response capabilities. An additional $3.5 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for CDC, FDA, NIH, and the Administration for Children and Families to support disaster services coordination, biodefense research and development, and other programs to maintain the nation's disaster readiness.

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 Advancing 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

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

ABBREVIATIONS AND ACRONYMS

GME	Graduate Medical Education

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

ABBREVIATIONS AND ACRONYMS

PDUFA	Prescription Drug User Fee Act
PHEP	Public Health and Emergency Preparedness
PHS	Public Health Service
PMD	Power Mobility Devices

Q

QI	Qualified Individual
QIO	Quality Improvement Organization

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
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