Fiscal Year 2017

Budget in Brief

Strengthening Health and Opportunity for All Americans

U.S. Department of Health & Human Services

HHS.GOV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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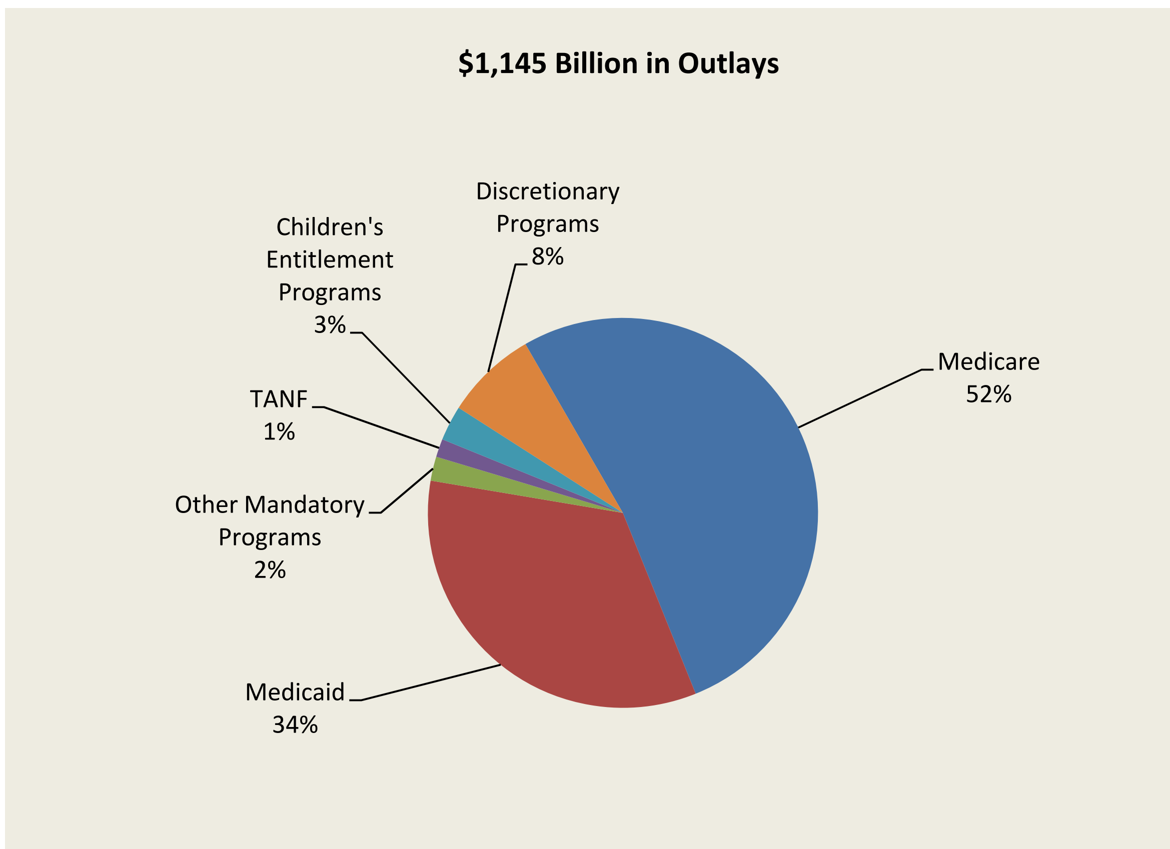
ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF THE NATION

FY 2017 President's Budget for HHS

dollars in millions	2015	2016	2017
Budget Authority	**1,045,210**	**1,116,973**	**1,150,252**
Total Outlays	**1,027,559**	**1,110,562**	**1,144,801**
Full-Time Equivalents (FTE)	75,567	77,583	79,406



General Notes

Details in this document may not add to the totals due to rounding. Budget data in this book are presented "comparably" to the FY 2017 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2017. This approach allows increases and decreases in this book to reflect true funding changes.

The FY 2016 and FY 2017 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) continues and expands on critical investments in health care, scientific research, medical innovation, disease prevention, early education, social services, human development, and emergency preparedness to protect the health and well-being of the American people.

The President's fiscal year (FY) 2017 Budget for HHS includes investments needed to support the health and well-being of the nation and legislative proposals that taken together would save on net an estimated $242 billion over 10 years. The Budget proposes $82.8 billion in discretionary budget authority and additional mandatory funding to further support specific initiatives in the discretionary budget. With this funding, HHS will continue to create opportunities for all Americans by ensuring the building blocks for success are available at every stage of life, promote science and innovation, protect the nation's public health and national security, and focus on the responsible stewardship of taxpayer dollars.

BUILDING UPON THE SUCCESS OF THE AFFORDABLE CARE ACT

The Affordable Care Act is working to expand health insurance coverage to millions of Americans, including many gaining coverage and access to health care for the first time. The Budget builds on the successes of the Affordable Care Act by extending funding for the Children's Health Insurance Program, improving and expanding coverage provided to American Indians and Alaska Natives through the Indian Health Service (IHS), expanding capacity in the nation's health centers, making strategic investments in the health care workforce to increase access for rural and underserved populations, and targeting Medicare and Medicaid payments to better support primary and preventive care. The Budget continues to make investments in federal public health and safety net programs to help individuals without coverage get the medical services they need while strengthening local economies.

Expanding Access to Health Insurance Coverage

The Affordable Care Act is making quality, affordable health coverage available to millions of Americans who would otherwise be uninsured through the expansion of Medicaid, the Marketplaces, and other private insurance reforms. As a result, nearly 18 million Americans have gained coverage since enactment of the Affordable Care Act. As of January 2016, 30 states and the District of Columbia have elected to expand Medicaid to low income adults with household income up to 133 percent of the federal poverty level (Louisiana will make the 31st state). To encourage more states to take up this important option, the Budget would give any state that chooses to expand Medicaid eligibility three years of full federal support, no matter when the state expands. This common sense proposal makes expansion as good of a deal for states that choose to expand now as states that have already done so. Finally, the Budget includes an additional two years of funding for the Children's Health Insurance Program through FY 2019 to align with the maintenance of effort requirement and ensure comprehensive and affordable coverage for beneficiaries as well as budgetary stability for states.

Health Centers

For 50 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. Throughout this time, health centers have become an essential primary care provider for the nation's most vulnerable populations. Today, more than 1,300 health centers operate over 9,000 service delivery sites and provide health care services to 1 in 14 people in the United States. The Budget invests $5.1 billion for health centers, including $3.75 billion in mandatory resources, to serve over 27 million patients in FY 2017.

Strengthening the National Health Service Corps

Since its inception, the National Health Service Corps has worked to build healthy communities by supporting qualified health care providers dedicated to working in areas across the country with limited access to primary care. The Budget invests $380 million for the National Health Service Corps for FY 2017, which includes

$70 million in additional mandatory and discretionary funding for behavioral health and opioid treatment initiatives. Specifically, this investment will place providers in rural areas and other underserved communities to expand access to mental health care and support and medication-assisted treatment and training to address opioid and heroin abuse.

Expanding Access to Health Care in Indian Country

The FY 2017 Budget continues the Administration's commitment to combat health disparities and ensure tribal communities lead healthy lives. The Budget funds IHS at $6.6 billion, an increase of $402 million over FY 2016. Since 2008, funding for IHS has increased by 53 percent. The Budget seeks to address and improve the health disparities faced by American Indian and Alaskan Natives, especially in the critical area of behavioral health. Significant new behavioral health investments will support innovative approaches to reduce rates of substance abuse, improve access to mental health services, and prevent suicide. The Budget prioritizes self-determination by fully funding contract support costs, which provides critical funding to Tribes who operate facilities under self-determination and self-governance agreements. Other increases include funding for new facilities, staffing and operations of new and replacement facilities opening between FY 2016 and FY 2017, and critical investments in Health Information Technology to improve the quality of health services and enhance care coordination.

The Budget provides $15 million in additional funding, for a program total of $29 million, to expand the Centers for Disease Control and Prevention's (CDC) Comprehensive Approach to Good Health and Wellness in Indian Country. CDC works collaboratively with Tribes, tribal organizations, and Tribal Epidemiology Centers to prevent heart disease, diabetes, stroke, and associated risk factors, such as tobacco. This funding will expand existing efforts to address these diseases and risk factors, in addition to other critical problems within this population, including suicide, prescription drug overdose, and alcohol-related motor vehicle injuries. This funding contributes to Department-wide tribal health and well-being efforts, which aim to improve health outcomes for American Indian and Alaskan Native populations.

Strengthening Health Programs in Puerto Rico and the U.S. Territories

The Budget removes the cap on funding to Medicaid programs in Puerto Rico and the U.S. Territories to better align territory Medicaid programs with those in states and expands eligibility to 100 percent of the federal poverty level in territories currently below that level. This proposal would gradually increase the share of Medicaid costs covered by the federal government as Puerto Rico and the Territories modernize their Medicaid programs. The proposal would provide critical healthcare funding to Puerto Rico and help mitigate the effects of its fiscal crisis. Additionally, the Budget proposes to change the formula for calculating Medicare Disproportionate Share Hospital payments which will provide an increased reimbursement to hospitals that treat a high proportion of low-income patients.

DELIVERY SYSTEM REFORM

HHS is focused on finding better ways to deliver care, pay providers, and distribute information. The Budget includes targeted proposals that focus on improving care for all Americans and spending federal dollars more wisely.

Incentives

HHS has introduced proposals that will reward value and care coordination, rather than volume and care duplication. The Budget includes proposals to establish competitive bidding for Medicare Advantage payments and to introduce value-based purchasing for certain Medicare providers. These proposals are designed to increasingly align payments with costs and link payments to quality and value. The Budget also encourages participation in alternative payment models through a number of proposals, including creating a bonus payment for hospitals that cooperate with certain alternative payment models. The Budget also streamlines quality reporting and measurement by establishing a hospital wide readmissions reduction measure.

Care Delivery

To drive progress in the way care is provided, HHS is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients, with an emphasis on prevention and wellness. The Budget proposes to expand the ability of Medicare Advantage plans to deliver services via telehealth and enable rural health clinics and federally qualified health centers to qualify as originating telehealth sites under Medicare.

Transparency

In an effort to promote transparency on price, cost, and billing for consumers, the Budget supports the standardization of billing documents and eliminating surprise out-of-network charges for privately insured patients receiving care at an in-network facility.

Interoperability

The Budget also provides continued investments to achieve secure, seamless data interoperability in order to better serve caregivers, providers, payers, public health officials, scientists, and ultimately enhance health for all Americans. Specifically, the Budget proposes an increase of $22 million and new authorities for the Office of the National Coordinator for Health Information Technology (ONC) to strengthen patient safety and quality of care through the nationwide advancement of interoperability, reliability, and usability of health information technology.

By combating information blocking, expanding transparency, developing a public-private partnership between health IT stakeholders, and implementing governance activities that establish standards for health IT entities, ONC will work towards a fully-integrated health IT infrastructure that protects and empowers patients.

Building Evidence to Drive Systemic Improvement

Reforming the delivery system requires an evidence base of effective practices. To further develop this evidence, the Budget proposes an increase of $24 million for health services research at the Agency for Healthcare Research and Quality (AHRQ). AHRQ evaluates alternative payment systems, preventive treatment guidelines, emerging medical technologies, and new threats to patient safety. AHRQ is a key supplier of practical and effective care re-design strategies that are implemented on a large scale by other HHS Operating Divisions, such as the Centers for Medicare & Medicaid Services (CMS), to drive nationwide improvement. The Budget invests $9 million in a new AHRQ project to better coordinate care for patients with multiple chronic conditions by developing and piloting tools based on integrated care plans, a new model that has demonstrated potential to make treatment regimens more comprehensive, responsive, and easier to adopt. AHRQ's project is designed to produce better outcomes for these patients and build evidence improvement strategies that can be applied across the country.

Reducing the Cost of Prescription Drugs in Medicaid and Medicare

The effect of high and rising drug prices on beneficiary costs and access to medications is one of the most urgent issues for patients and their families in today's health care system. Drug spending increased by 12.2 percent in 2014, making it the state and federal governments' fastest growing healthcare cost. HHS brought stakeholders together last fall to discuss opportunities to improve patient access to affordable prescription drugs, develop innovative purchasing strategies, and incorporate value-based and outcomes-based models into purchasing programs in both the public and private sectors. The FY 2017 President's Budget builds on this work with a number of proposals to improve the access and value Americans get from their medications, without discouraging important and lifesaving innovations.

Improving Healthcare for Dual-Eligible Beneficiaries

A disproportionate share of individuals enrolled in both Medicaid and Medicare have complex and often costly health care needs. With the passage of the Affordable Care Act, the Administration introduced multiple initiatives that vastly improved the coordination of care for dual-eligible beneficiaries, but there is still a lot that remains to be done. The FY 2017 President's Budget includes a series of legislative proposals to improve access to care for dual-eligible beneficiaries, while decreasing overlap and inefficiencies that currently exist between the two payors. This effort includes creating an integrated appeals process for dual-eligible beneficiaries, simplifying the process for receiving Medicare Savings Program benefits, coordinating review of dual-eligible special needs plans marketing materials, and making sure low-income individuals newly-eligible for Medicare have Part D coverage during their transition between payors and plans.

KEEPING PEOPLE HEALTHY AND SAFE

Combating Antibiotic-Resistant Bacteria

The emergence of antibiotic-resistant bacteria continues to be one of the most significant public health concerns of our time. Without aggressive intervention, even minor infections may become life threatening and put at risk our ability to perform routine surgeries or treat diseases like diabetes and cancer. The FY 2017 Budget includes $877 million, an increase of $43 million, across the National Institutes of Health (NIH), CDC, the Biomedical Advanced Research and Development Authority, the Food and Drug Administration (FDA),

AHRQ, and the Office of Global Affairs to continue expanding the nation's ability to fight antibiotic resistance, aligning with the Administration's *National Action Plan for Combating Antibiotic-Resistant Bacteria*. These critical investments will protect patients and communities by implementing interventions that reduce the emergence and spread of antibiotic-resistant pathogens. In addition, this funding will support ongoing groundbreaking research to aid the development of new drugs and diagnostic products, building the nation's treatment options for these dangerous pathogens.

Medical Product Safety and Availability

FDA ensures the safety, quality, and effectiveness of a broad scope of medical products. Within medical devices alone, FDA has oversight of at least 6,000 different product categories. FDA carries out these responsibilities while also leading the world in both numbers of new drugs approved and in the timeliness of their reviews. In 2015 alone, FDA approved 56 novel drugs and biological products. The Budget includes $2.8 billion, an increase of $116 million above FY 2016, to continue core medical product safety activities across FDA programs, including improving patient safety, developing the necessary infrastructure for a safer and more modern drug supply, and continuing expanded and improved oversight of human drug compounding.

Emergency Preparedness

Across multiple HHS programs, the Department supports life-saving preparedness and response activities aimed at addressing chemical, biological, radiological, and nuclear threats, as well as other disasters, outbreaks, and epidemics. Whether the hazard is naturally occurring, accidental, or intentional, effective public health emergency response depends on maintaining and constantly improving the preparedness capabilities of public health departments and healthcare facilities at a state and local level. The FY 2017 Budget includes $915 million in total for CDC and the Assistant Secretary for Preparedness and Response (ASPR) for these activities, which is $2 million above FY 2016. This funding will provide ongoing support to the Hospital Preparedness Program, the Public Health Emergency Preparedness program, and Global Health Protection. The Global Health Protection funding includes a $5 million increase for CDC to expand the Global Health Security Agenda to additional Phase Two countries around the world to prevent, detect, and respond to emerging outbreaks and public health threats.

Food Safety

Each year, 48 million people suffer due to a foodborne illness. The resulting direct medical costs, including hospitalizations, exceed $300 million annually. The Administration continues its commitment to modernize the nation's food safety system to one that prevents foodborne illness outbreaks and is positioned to meet the challenges of the global market. The Budget includes $1.6 billion, an increase of $212 million above FY 2016, to support FDA and CDC activities that will develop and strengthen an integrated and prevention-based food safety system. The FY 2017 Budget includes $1.5 billion for FDA to support implementation of the Food Safety Modernization Act, including increasing state capacity to implement the produce safety rules, implementing the Foreign Supplier Verification Program, and ensuring consumers are able to make healthy food choices. The Budget also includes $52 million for CDC activities which will help address the critical unmet needs in the nation's food supply safety system by focusing on monitoring, surveillance, data analysis, and dissemination of technical guidance, training, and technology to state health departments.

Mental and Other Behavioral Health Investments

The Affordable Care Act expanded behavioral health coverage for millions of Americans by putting an end to insurance company discrimination based on pre-existing conditions, requiring coverage of mental health and substance abuse disorder services, and expanding behavioral health parity, which have improved access to mental and other behavioral health services for more than 60 million Americans. Despite these gains, less than half of children and adults with diagnosable mental health issues receive the treatment they need. To address this gap, the Budget proposes a two-year initiative to expand access to mental health services financed with $500 million in new mandatory funding. This initiative supports additional states in the Certified Community Behavioral Health Clinic demonstration, increases access to early intervention programs that address serious mental illness, expands the behavioral health workforce in areas experiencing shortages of providers, prevents suicide, and enhances behavioral health services in Indian Country. In addition to this initiative, the Budget makes other investments in behavioral health and includes a total increase of $530 million in FY 2017. This funding will help ensure that the behavioral health care system works for everyone, expand service and workforce capacity, and engage individuals with serious mental illness in care.

Ensuring that Behavioral Health Care Systems Work for Everyone

The Budget includes a total of $239 million in FY 2017, an increase of $135 million, to expand access to behavioral health services for all Americans. These investments expand the number of states participating in the Certified Community Behavioral Health Clinic Demonstration established by section 223 of the Protecting Access to Medicare Act of 2014, through the Mental Health Initiative. In addition, the Budget includes funding to implement the recommendations of the National Strategy for Suicide Prevention through a new Zero Suicide Initiative, and reduce key risk factors for suicide by increasing referral and treatment for suicidal behavior. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) will expand the Project AWARE State Grants Program, to serve four million children by improving local coordination of resources and responses to youth with signs of mental illness. The Budget also proposes to add certain behavioral health providers to the Medicare and Medicaid Electronic Health Record Incentive Programs, which is a necessary first step to realizing the goal of fully integrating and coordinating behavioral health and medical care.

Capacity and Workforce

The Budget includes an additional $82 million in FY 2017, for a total of $132 million, for programs that expand, train, and improve the behavioral health workforce to ensure it is able to meet the nation's mental health treatment needs. These increases include $45 million in FY 2017 to support additional loan repayment awards for behavioral health clinicians, providing a significant increase in the number of behavioral health professionals practicing in underserved communities. This $45 million increase includes $20 million in new discretionary resources and $25 million in new mandatory funding through the Mental Health Initiative.

The Budget also provides $6 million in new funding for the Behavioral Health Workforce Education and Training program. Since this program was established in FY 2014, SAMHSA has partnered with the Health Resources and Services Administration (HRSA) to administer the program, which works to expand the behavioral health workforce by supporting clinical training for behavioral health professionals. In FY 2017, this funding will support an additional 2,650 behavioral health professionals, and 2,750 additional paraprofessionals. In addition, the Budget proposes to establish a new $10 million Peer Professionals program in SAMHSA to increase the number of peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level counselors.

Engaging Individuals with Serious Mental illness in Care

When individuals face unmet behavioral health needs, as well as chronic conditions, the challenges, costs, and likelihood of poor outcomes multiply. Individuals facing these dual health issues are at risk for decreased length and quality of life, increased functional impairment, and cost to themselves and their communities. Patients diagnosed with a serious mental illness, who are among the least likely to seek treatment, die 8 years earlier than other Americans.

The Budget includes an additional $312 million in FY 2017, for a total of $377 million, for programs to better engage these individuals in care. Within this amount, the Budget proposes $115 million in new mandatory investments in FY 2017 as part of the Mental Health Initiative to support a formula grant for states to implement evidence-based early intervention programs for individuals with serious mental illness. This program builds on research from the National Institute of Mental Health, showing that earlier intervention leads to better outcomes. The Budget also establishes a competitive grant program in SAMHSA to help communities build, fund, and sustain crisis response systems capable of preventing and de-escalating behavioral health crises and coordinating post-crisis services to mitigate recurrence and inpatient bed demand. Additionally, SAMHSA will establish a new set-aside within Children's Mental Health Services to test new interventions that include youth and young adults at risk of or before the first episode of psychosis.

This funding also supports CDC's implementation and evaluation of a comprehensive suicide prevention program in partnership state health departments. This program will focus on reducing key risk factors by increasing referral and treatment for suicidal behavior and addressing access to lethal means for individuals at greatest risk for harming self and others.

Tribal Behavioral Health

The FY 2017 Budget includes +$67 million in new investments to address high rates of mental illness, substance abuse, and suicide in tribal communities. Substance abuse and suicide rates are significantly higher among American Indian and Alaska Native people than the broader U.S. population. These serious

behavioral health issues have a deep impact on the health and well-being of individuals, families, and communities, both on and off reservations. The FY 2017 Budget proposes a series of new investments to help close the gap in behavioral health disparities experienced by American Indians and Alaska Natives. Targeted efforts within IHS, SAMHSA and CDC support new approaches to reduce rates of substance abuse, improve access to mental health services, and prevent suicide. Within these increases, the Budget includes $21 million to integrate primary and behavioral health care in the IHS system, and $15 million for Generation Indigenous to improve access to behavioral health treatment for Native Youth in partnership with SAMHSA. Further, the Budget proposes $15 million for a new crisis response fund to assist tribes experiencing behavioral health crises as part of the Mental Health Initiative. In addition, the Budget includes $4 million to implement the Zero Suicide initiative in IHS facilities. Finally, the Budget includes $2 million in new funding to support aftercare pilots for Native Youth who have been discharged from Youth Regional Treatment Centers.

Preventing Prescription Opioid and Heroin Overdose

Deaths involving opioids, a class of drugs that include prescription pain relievers and heroin, have quadrupled between 2002 and 2014, claiming the lives of 78 Americans each day. The Administration proposes a new $1 billion 2-year initiative to expand access to treatment for prescription drug abuse and heroin use. This funding will support cooperative agreements to states to expand access to treatment, increase access to medication-assisted treatment providers through the NHSC, and evaluate the outcomes of medication-assisted treatment. The Budget also includes other investments for a total increase of $559 million in FY 2017 for programs to address the opioid abuse, misuse, and overdose crisis. These efforts will help ensure that every American who wants opioid treatment will be able to access it and get the help they need.

Improving Prescribing Practices

While actions to address prescription opioid abuse must target both prescribers and high-risk patients, prescribers are the gatekeepers for preventing inappropriate access. Interventions to improve safe and appropriate prescribing must balance the use of these drugs for legitimate pain management with the need to curb dangerous practices. Within this priority area the Budget includes $18 million in additional funding above FY 2016, for a total of $85 million, for programs that support improved prescribing practices. This investment includes $13 million in additional funding, for a total of $80 million, for CDC to support improved uptake of CDC's new "Guideline for Prescribing Opioids for Chronic Pain" among providers, and also apply its scientific expertise to identify risk factors for initiating heroin use to best prioritize prevention efforts throughout the Department. The Budget also includes a $5 million increase for a new effort at ONC to improve clinical decision-making, and further the adoption of electronic prescribing of controlled substances.

Finally, the Budget proposes to require states to track high prescribers and utilizers of prescription drugs in Medicaid. By requiring states to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program, this proposal would improve program integrity, save $770 million over 10 years, and bolster other efforts to reduce abuse of prescription drugs.

Expanding the Development and Use of Naloxone

Responders to an overdose in progress have little time to effectively reverse the effects of an opioid and save a life. To best prepare communities and first responders for this contingency, the Budget includes $10 million in additional funding above FY 2016, for a total of $22 million, for programs that support the development and use of naloxone. SAMHSA will continue to provide $12 million for Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths, which equips first responders with the lifesaving overdose reversal drug naloxone and education on its use. The Budget also includes $10 million in HRSA for the Rural Opioid Overdose Reversal Grant program to target these efforts specifically to rural areas hit hardest by opioid addiction.

Expanding the Use of Medication-Assisted Treatment

Medication Assisted Treatment is a proven intervention for opioid addiction for many patients. The Budget proposes a new, two-year $1 billion mandatory investment to expand access to treatment for opioid addiction and close the treatment gap. Of this amount, $460 million per year, for a total of $920 million, will support a new State Targeted Behavioral Health Program, to support states in removing barriers preventing individuals from seeking treatment and successfully achieving recovery. This funding, combined with an additional $25 million in discretionary funding, will enable all individuals with opioid use disorder who are seeking or can be persuaded to seek treatment to get the help they need by reducing the cost of treatment, expanding access to treatment, reducing

barriers to implementation of medication-assisted treatment, engaging patients in treatment, and addressing stigmas associated with treatment. Within the new mandatory funding provided for the National Health Service Corps, $25 million in FY 2017 and FY 2018 will be used by HRSA to increase the number of behavioral health professionals able to provide evidence-based interventions through investments including enhanced loan repayment to clinicians with medication-assisted treatment training and certification. HHS will monitor the effectiveness of medication-assisted treatment programs employing different treatment modalities under real-world conditions. In partnership with the Department of Justice, HHS will implement a new, $10 million Buprenorphine-Prescribing Authority demonstration to expand the types of providers who can prescribe medication assisted treatment.

Addressing Over Prescription of Psychotropic Medications to Children in Foster Care

The Budget includes $500 million for a CMS demonstration in partnership with the Administration for Children and Families (ACF) to provide performance-based incentive payments to states through Medicaid, coupled with $250 million in mandatory child welfare funding to build provider and systems capacity through a specialized workforce with specific training, screening and assessment tools, coordination between systems, and fidelity monitoring of the evidence-based interventions. 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 to reduce the over-prescription of psychotropic medications and improve social and emotional outcomes for some of America's most vulnerable children.

Reducing Abuse of Part-D Drugs

The Budget also proposes to establish a program in Medicare Part D to prevent prescription drug abuse by requiring that high-risk beneficiaries only obtain controlled substances from specified providers and pharmacies.

BUILDING BLOCKS FOR SUCCESS AT EVERY STAGE OF LIFE

HHS seeks to serve Americans at key stages of life, when many may be at their most vulnerable. Investments that promote the safety, well-being, resilience, and healthy development of our nation's children and youth will ultimately pay dividends, as the children of today grow into the employees, parents, and leaders of tomorrow. The Budget also makes investments to help older Americans live as independently as possible while maintaining their freedom and dignity.

Head Start

Research has shown the significant positive impact that early learning programs can have on a child's development and lifelong well-being, including their potential earnings. Access to Early Head Start services has more than doubled for infants and toddlers over the course of the Administration, and significant investments have been made to strengthen the quality of services that Head Start provides. The FY 2017 Budget includes $9.6 billion for Head Start, an increase of $434 million over the FY 2016 enacted level. This level includes the resources necessary to maintain enrollment in the program, including preserving the Administration's historic expansion of Early Head Start and recent investments in the Early Head Start-Child Care Partnerships. In addition, the Budget continues to support high-quality services in Head Start with an additional $292 million above FY 2016 to increase the number of children attending Head Start for a full school day and a full school year, which is necessary to ensure that children receive services that are of the highest-quality and also helps meet the needs of working parents.

Child Care

The Budget reflects the President's continued commitment to quality, affordable child care. The Budget continues the historic proposal that provides $82 billion over 10 years in additional mandatory funds for child care. This investment will increase the number of children served to a total of 2.6 million children and guarantee that low-income working families can access high-quality child care, so that all young children are safe and ready to learn. This landmark proposal also makes significant investments in raising the quality of child care, including investments to improve the skills, competencies, and training of the child care workforce and a higher subsidy rate for higher-quality care. The Budget provides an additional $200 million in discretionary funding, which will support states, Tribes, and territories as they implement new health and safety requirements in their child care programs. The Budget also includes $40 million for pilots that will test and evaluate strategies for addressing the child care needs of working families, especially families with non-traditional working hours or in rural areas.

Home Visiting

States have made substantial progress in developing and expanding voluntary, evidence-based home visiting programs in which nurses, social workers, and other professionals meet with families and connect them to assistance to support their children's health, development, and ability to learn. A substantial body of research indicates these programs can improve parenting skills, children's development, and school readiness. The Budget continues to propose extending and expanding the Maternal, Infant, and Early Childhood Home Visiting program by $15 billion over 10 years.

Improving Outcomes for Children in the Child Welfare System

The Budget includes an investment of $505 million above baseline in FY 2017 for a suite of proposals designed to improve permanency services so children are less likely to need foster care placement in the future, strengthen tribal child welfare programs, promote family-based care for children with behavioral and mental health needs to reduce the use of congregate care, foster successful transitions from foster care to adulthood, and improve the quality of child welfare services provided to children through better trained staff and stronger information technology systems.

Enhancing Child Welfare Workforce Development

Research shows that children in the child welfare system who have caseworkers with a Bachelor's or Master's Degree of Social Work have better outcomes, including shorter time in out-of-home care, increased adoptions, and a lower likelihood of being removed from their homes. The Budget includes $1.8 billion over 10 years to ensure child welfare caseworkers and other professionals have the right skills to best meet the needs of children, youth, and families in the child welfare system. This funding will enable individuals to earn these degrees in exchange for a commitment to work for the child welfare agency for a time commensurate to the length of the education benefits. To incentivize states to exercise this option, this proposal would offer an enhanced match rate for case planning and management for children in foster care, as well as administrative activities for children who are candidates for foster care, when these activities are significantly performed by caseworkers with either degree.

Promoting Family-Based Care and Reducing the Use of Congregate Care for Children in Foster Care

The Budget includes a proposal to provide additional support and funding to the child welfare system to promote family-based care and to provide oversight of congregate care placements. The proposal includes training and resources for foster care parents to provide specialized care to children with complex mental health and behavioral health needs and to ensure that congregate care is only used when necessary.

Improve Well-Being of Children and Families Affected by Substance Abuse

According to 2014 data, parental substance abuse contributed to 30 percent of foster care placements. In response to reports from child welfare agencies across the country that increases in opioid, heroin, and methamphetamine addiction and a lack of effective treatment services are significant contributing factors to the uptick in the numbers of children entering foster care, the Budget includes an expansion of the Regional Partnership Grants from $20 million to $60 million annually to improve the well-being of children and families affected by substance abuse. Families who participated in previous Regional Partnership Grants projects experienced enhanced outcomes including increased number of children remaining at home, increased reunification rates, decreased recidivism, and dramatic differences in the rate of children who returned to out-of-home care as compared to families who did not participate in the Regional Partnership Grants projects.

Strengthening Efforts to Help Poor Families Succeed

A total of 15.5 million children lived in poverty in 2014, a staggering number that translates into lost opportunity and a lower quality of life. The FY 2017 Budget builds on the proven capacity of the nation's safety net to meet our 21st century poverty challenges. Twenty years after the creation of the Temporary Assistance for Needy Families (TANF) program, there is now substantial evidence that reforms to improve the program are needed. That is why the Budget proposes to increase the program's funding to help offset twenty years of erosion in program funding, ensure funds are spent on benefits and services that are most critical to improving the lives of poor families struggling to succeed in the labor market, finance a subsidized jobs and two generation initiatives, and establishes a workable countercyclical measure modeled after the effective TANF Emergency Fund created during the Great Recession. The Budget also calls for providing states

with more flexibility to design effective work programs in exchange for holding states accountable for helping parents find jobs. Taken together these proposals will strengthen TANF, reduce poverty, and promote self-sufficiency.

In addition, the Budget will invest resources in a new $2 billion Emergency Aid and Service Connection Grants initiative to test and scale innovative State and local approaches to aide families facing financial crisis. The funding will provide families with the emergency help they need to avert a downward spiral or to reverse one, and then connect those who need it to longer term assistance, so that parents can get back on their feet, families are stabilized, and children can thrive.

Child Support Enforcement

According to a 2012 U.S. Bureau of Census survey, child support represents 45 percent of family income for poor families with income below the poverty level who receive child support. The Budget supports efforts to direct child support payments to families, promote parental engagement in children's lives, and improve enforcement. It also makes significant investments to upgrade and replace outdated state child support systems to ensure support is paid to families in a timely manner. These efforts will reduce child poverty and promote family self-sufficiency.

Serving Refugees and Unaccompanied Children

The United States has a proud history of welcoming refugees. In light of a global displacement crisis, the Administration has committed to expanding the Refugee Admissions Program in FY 2016 and FY 2017. All refugees are subject to the highest level of security checks of any category of traveler to the United States. ACF's role is to link these newly-arrived humanitarian populations, including refugees, asylees, special immigrant visa holders, and Cuban entrants, to key resources vital to becoming self-sufficient, integrated members of American society. The Budget provides initial cash and medical assistance for 213,000 entrants in FY 2017. This includes 100,000 refugees, consistent with the Administration's commitment to admit at least this number of refugees in 2017 as well as projected increases in other categories of humanitarian entrants. HHS is legally required to provide care and custody to all unaccompanied children apprehended by immigration authorities until they are released to an appropriate sponsor, while they await immigration proceedings. Based upon the recent increase in unaccompanied children apprehended at the southwest border, ACF is adding temporary capacity so that it is adequately prepared to care for these children, a prudent step to ensure that the Border Patrol can continue its vital national security mission. ACF is continuously monitoring the numbers of unaccompanied children referred for care, as well as the information received from interagency partners on conditions that may impact migration flows. The recent history of the program demonstrates the unpredictable nature of caseloads and the necessity of prudent planning and budgeting. To ensure that HHS can provide care for all unaccompanied children in FY 2017, the Budget includes the same amount of total base resources available in FY 2016, as well as a contingency fund that would trigger additional resources only if the caseload exceeds levels that could be supported with available funding.

Supporting the Independence of Older Adults

In FY 2017, HHS continues to make investments to address the needs of older Americans, many of whom require some level of assistance to live independently and remain in their homes and communities for as long as possible.

Supporting Family Caregivers

The FY 2017 Budget provides $151 million for Family Caregiver Support Services, which supports a number of essential services that assist family and informal caregivers to care for their loved ones at home. These services include access assistance, counseling and training, and respite support. Research suggests that informal family care for the elderly is valued at over $500 billion annually, an amount that exceeded total Federal Medicaid expenditures in 2015. Additionally, studies have shown that caregiver support services can reduce caregiver depression, anxiety, and stress, enabling caregivers to provide care longer while continuing to work, thereby avoiding or delaying the need for costly institutional care for their loved ones.

The Budget also includes $5 million for Lifespan Respite Care, $2 million more than FY 2016, to ease the burdens of caregiving by improving the quality of and access to respite care for family caregivers of older adults.

Providing Nutrition Assistance for Older Americans

Nutrition Services help older Americans nationwide remain healthy and independent in their homes and communities by providing meals in senior centers or through home-delivery. The FY 2017 Budget provides $849 million in funding for the Administration for Community Living (ACL) Nutrition Services programs,

$14 million more than was provided in FY 2016. In combination with state and local funding, this increase will allow states to provide an estimated 205 million meals to over 2 million older Americans nationwide. Within the total investment in Nutrition Services, the Budget also includes a new one percent set-aside for evidence-based innovations that will help make future funding for Nutrition Services more cost-effective through improved quality and efficiency.

Addressing Alzheimer's Disease

The Budget continues the Department's commitment to support effective Alzheimer's disease research, education, and outreach, as well as patient, family, and caregiver services. Approximately 5.1 million people age 65 and older suffer from Alzheimer's disease, and the number of cases could double by 2050 as the population ages. NIH will spend an estimated $910 million in FY 2017 for basic neuroscience research, epidemiologic studies to identify risk and protective genes; and more than 35 clinical trials to test preventive and therapeutic interventions. Alzheimer's is one of the initial four diseases that are the focus of NIH's new Accelerating Medicines Partnership program of collaborations between NIH, pharmaceutical companies, and non-profit organizations. NIH is contributing $68 million over five years to this effort to evaluate biomarkers and validate biological targets that play a key role in the progression of Alzheimer's disease. Most people living with Alzheimer's disease are dependent upon family caregivers for years due to the slow loss of cognitive and functional independence. To specifically address the needs of these caregivers, the Budget invests $15 million in ACL to build on existing dementia-capable service systems and expand access to evidence-based interventions designed to assist caregivers of individuals with Alzheimer's disease.

LEADING IN SCIENCE AND INNOVATION

Advancing Scientific Knowledge

Supporting innovative research provides opportunities to generate the knowledge needed to unlock the basic building blocks of previously unanswerable questions in the biomedical field. Long-term national investments in NIH-supported research have generated scientific and technological innovations and breakthroughs that are behind many of the gains in the nation's health. The FY 2017 Budget includes $33.1 billion, an increase of $825 million to advance the Administration's commitment to support innovative research spanning from biomedical to behavioral that promotes economic growth and job creation, and advances the research field and the public's health. NIH will continue to support research grants across a wide spectrum of program areas and target resources to enhance efforts with precision medicine, antimicrobial resistance, the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative and Alzheimer's research, vaccines and cures for HIV/AIDS, and a significant investment to support the Vice President's Cancer Moonshot.

Vice President's Cancer Moonshot

Current cancer mortality rates are approximately 15 percent lower than a decade ago, due in part to investments in research that have led to significant developments in the prevention, screening, and treatment of cancer. Beginning in FY 2016, NIH and FDA will build upon innovations through a multi-year initiative that accelerates the nation's fight against cancer in an effort to even further reduce the number of Americans affected by its devastating consequences. The Budget provides $680 million to expand clinical trials for health disparity populations, pursue new vaccine technology, and fund exceptional opportunities in cancer research. These investments will drive scientific advances that aim to understand the causes of cancer, discover new prevention strategies, improve early detection and diagnosis, and cultivate effective treatments. The Budget also includes $75 million for FDA to develop the regulatory pathways for these new technologies, ensure quality systems for trials, and facilitate the sharing of important data across government, academia, and industry. NIH will support these efforts beginning in FY 2016.

Precision Medicine Initiative

Recent breakthroughs in genomics, computing, and molecular medicine have created extraordinary opportunities to advance health care into a new era where many more treatments are based on the genetic characteristics of each patient. To achieve this new paradigm, the Budget expands funding for the Precision Medicine Initiative by $100 million to a total of $300 million within NIH. At NIH these funds will support new studies on how the DNA from an individual cancer tumor can be used to predict the right choice of targeted therapies, how resistance to therapy can occur, and how to test new combinations of targeted cancer drugs. NIH will also continue scaling up a cohort study of 1 million or more Americans to gather data on the interplay of environmental exposures, physical parameters, and genetic information to lay the

foundation for a wealth of new research studies on many diseases that can lead to new prevention strategies, novel therapeutics, and medical devices. In support of these efforts, FDA will develop the regulatory pathways for these new medical technologies and ONC will facilitate the development of interoperable and secure health data exchange systems.

BRAIN Initiative

Despite the many advances in neuroscience in recent years, the underlying causes of most neurological and psychiatric conditions remain largely unknown due to the vast complexity of the human brain. To further revolutionize our understanding of the brain, the Budget provides an increase of $45 million, for a FY 2017 total of $195 million within NIH, for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. In collaboration with public and private partners, NIH is pushing the boundaries of neuroscience through the BRAIN Initiative to reveal how patterns of neural activity actually translate into emotion, thought, and memory. This research has the potential to discover underlying pathologies in a vast array of brain disorders and provide new avenues to treat, cure, and even prevent common conditions, such as Alzheimer's disease, autism, depression, schizophrenia, and addiction. In FY 2017, the increased funds will continue to support basic neuroscience research, human neuroscience, neuroimaging, and training initiatives, as well as potential projects to collaborate with industry to test novel devices in the human brain, new ways to address big data from the brain, and developing devices for mapping and tuning brain circuitry.

Laboratory Safety and Quality

CDC is committed to continuous improvements in laboratory science and safety, as well as the quality of its public health laboratory services. The FY 2017 Budget includes $33 million to continue support for CDC's implementation of laboratory safety recommendations. This funding will enable CDC to maintain its ability to respond to outbreaks, determine unexplained illnesses, support state and local diagnostics, improve pathogen identification of emerging and re-emerging diseases and maintain the world's most advanced, state-of-the-art infectious disease and environmental public health laboratories.

LEAVING THE DEPARTMENT STRONGER

The Budget better positions the Department to fulfill its core mission to protect the health of Americans and provide essential human services. Investments in programs and the infrastructures that support them will improve transparency and efficiency across HHS. These improvements will allow HHS to not only meet the challenges of today, but also those of tomorrow.

Cybersecurity

HHS is responsible for securing millions of individuals' personal health information, conducting highly sensitive biodefense work, reviewing new drug applications and clinical trial data, and issuing more grants than any other federal entity. The Budget includes $51 million within the Office of the Secretary to increase the Department's protections against cyber threats, such as unauthorized access, denial of service, malicious code, inappropriate usage, and insider threat, that pose risks to HHS critical functions, services, and data.

Investing in Facilities

The Budget requests a total of $570 million, an increase of $47 million, for IHS facilities for construction across Indian Country. Investments in construction will help IHS to build or maintain the necessary infrastructure to deliver essential health services to American Indians and Alaska Natives. Substantial increases include $27 million for health care facilities construction to reduce the number of health care construction projects list backlog. The Budget also includes $12 million for facilities and environmental health support, which sustains critical public health programs, such as the injury prevention program and environmental health services, supplements salary for support staff at 1,015 facilities, and addresses facility needs and upkeep. Finally, the Budget requests $4 million for the sanitation facilities construction program, which builds much needed facilities to deliver potable water and provide waste disposal to American Indian and Alaska Native people.

The Budget also makes investments to address infrastructure needs across HHS facilities that directly support mission critical activities. The Budget includes an increase of $24 million above FY 2016, for a total of $43 million, to improve the integrity of operations and infrastructure for CDC and FDA. This investment will address high priority facility needs, and is paramount to ensure functionality and preparedness for continued service. Within this total, an increase of $21 million, for a total of $31 million, is provided for CDC's facility repair

and improvements. These investments will directly support CDC's ability to support its mission to improve public health. In addition, the Budget also includes $12 million for FDA building and facilities, an increase of $3 million over FY 2016, to begin addressing high priority needs across facilities that support mission critical work and enable FDA to respond to food safety and medical product activities.

Strengthening Program Integrity

The FY 2017 Budget continues to make cutting health care fraud, waste, and abuse a top Administration priority. The Budget requests $199 million in new investments in program integrity programs in FY 2017, including $44 million in discretionary Health Care Fraud and Abuse Control, $130 million in recovered funds from the Recovery Audit Contractors to reduce improper payments in Medicare, and $25 million in new mandatory Medicaid Integrity Program funding in FY 2017. These investments include continuing to fund the full Health Care Fraud and Abuse Control discretionary cap adjustment and increasing mandatory Medicaid Integrity Program funding. In total, program integrity investments in the Budget will yield an estimated $23.8 billion in savings to Medicare and Medicaid over ten years. The Budget also includes proposals that will expand and strengthen the tools available to CMS to combat fraud, waste, and abuse in CMS programs.

Focusing on Stewardship

To improve the efficiency of the Medicare appeals system and reduce the backlog of appeals awaiting adjudication at the Office of Medicare Hearings and Appeals (OMHA), HHS has developed a comprehensive strategy that involves additional funding, administrative actions, and legislative proposals. The Budget includes resources at all levels of appeal to increase adjudication capacity and advances new strategies to alleviate the current backlog. The Budget includes $250 million for OMHA, of which $120 million is in budget authority and $130 million is from legislative proposals. Additionally, the Budget includes $44.2 million to support greater CMS participation in Administrative Law Judge hearings at OMHA, increase efforts to decrease the backlog through new adjudication and settlement activities, and invest in automating the first and second level appeals levels in the Medicare Appeals System. The Budget also includes a package of legislative proposals that provide new authority and additional funding to address the backlog.

HHS Budget by Operating Division

dollars in millions	2015	2016	2017
Food and Drug Administration			
Budget Authority	2,525	2,730	2,821
Outlays	2,393	2,463	2,624
Health Resources and Services Administration			
Budget Authority	10,547	10,770	10,866
Outlays	9,122	10,296	11,537
Indian Health Service			
Budget Authority	4,799	4,965	5,368
Outlays	4,550	5,074	5,260
Centers for Disease Control and Prevention			
Budget Authority	9,096	7,658	7,455
Outlays	7,019	7,242	7,877
National Institutes of Health			
Budget Authority	29,863	31,547	32,305
Outlays	29,294	30,221	32,302
Substance Abuse and Mental Health Services Administration			
Budget Authority	3,486	3,646	4,107
Outlays	3,141	3,810	3,701
Agency for Healthcare Research and Quality			
Budget Authority	364	334	280
Program Level	443	428	470
Outlays	175	195	394
Centers for Medicare & Medicaid Services /2			
Budget Authority	928,716	998,028	1,019,936
Outlays	917,644	992,531	1,017,627
Administration for Children and Families			
Budget Authority	51,725	53,141	63,005
Outlays	50,231	52,385	58,266
Administration for Community Living			
Budget Authority	1,835	1,939	1,969
Outlays	1,680	2,208	1,929
Office of the National Coordinator			
Budget Authority	60	60	-
Outlays	105	154	2

HHS Budget by Operating Division (cont.)

dollars in millions	2015	2016	2017
Medicare Hearings and Appeals			
Budget Authority	88	107	120
Outlays	88	143	120
Office for Civil Rights			
Budget Authority	39	39	43
Outlays	39	39	44
Departmental Management			
Budget Authority	471	479	504
Outlays	844	1,154	1,216
Public Health and Social Services Emergency Fund			
Budget Authority	1,951	1,533	1,431
Outlays	1,711	2,266	1,849
Office of Inspector General			
Budget Authority	73	77	86
Outlays	90	93	116
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)			
Budget Authority	740	717	751
Outlays	601	1,085	732
Offsetting Collections			
Budget Authority	-1,121	-767	-765
Outlays	-1,121	-767	-765
Other Collections			
Budget Authority	-47	-30	-30
Outlays	-47	-30	-30
Total, Health and Human Services			
Budget Authority	**1,045,210**	**1,116,973**	**1,150,252**
Outlays	**1,027,559**	**1,110,562**	**1,144,801**
Full Time Equivalents	75,567	77,583	79,406

1/ The Budget Authority levels presented here are based on the Appendix, and potentially differ from the levels displayed in the individual Operating or Staff Division Chapters

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

COMPOSITION OF THE HHS BUDGET
Discretionary Programs

dollars in millions	2015	2016	2017	2017 +/-2016
Discretionary Programs (Budget Authority)				
Food and Drug Administration	2,596	2,728	2,743	+15
Program Level	4,505	4,745	5,104	+358
Health Resources and Services Administration	6,138	6,197	5,743	-454
Program Level	10,358	10,593	10,677	+84
Indian Health Service	4,642	4,808	5,185	+377
Program Level	5,951	6,160	6,562	+402
Centers for Disease Control and Prevention /1	6,073	6,345	6,042	-303
Program Level	7,027	7,310	7,146	-164
National Institutes of Health	29,446	31,381	30,314	-1,067
Program Level	30,311	32,311	33,136	+825
Substance Abuse and Mental Health Services Administration	3,439	3,584	3,489	-95
Program Level	3,586	3,731	4,322	+590
Agency for Healthcare Research and Quality	364	334	280	-54
Program Level	443	428	470	+41
Centers for Medicare & Medicaid Services	3,975	3,975	4,110	+135
Program Level	6,061	6,228	7,356	+1,128
Administration for Children and Families /2,3,4	18,041	19,120	19,952	+832
Program Level	18,041	19,120	19,952	+832
Administration for Community Living	1,928	1,965	1,993	+28
Program Level	1,990	2,048	2,076	+28
Office of the Secretary				
General Departmental Management	448	456	479	+23
Program Level	523	531	555	+24
Office of Medicare Hearing and Appeals	87	107	120	+13
Program Level	87	107	250	+143

COMPOSITION OF THE HHS BUDGET
Discretionary Programs (cont.)

dollars in millions	2015	2016	2017	2017 +/-2016
Office of the National Coordinator	60	60	0	-60
Program Level	60	60	82	+22
Office of Inspector General	73	77	85	+9
Program Level	335	343	419	+77
Office for Civil Rights	39	39	43	+4
Public Health and Social Services Emergency Fund /1	1,233	1,533	1,431	-96
Program Level	1,233	1,533	1,431	-96
Discretionary HCFAC	672	681	725	+44
Accrual for Commissioned Corps Health Benefits	28	26	26	—
Total, Discretionary Budget Authority	**79,282**	**83,417**	**82,759**	**-658**
Title VI Ebola Funding /5	**+2,767**	**—**	**—**	**—**
Less One-Time Rescissions /6	**-6,304**	**-6,742**	**-6,525**	**+217**
Revised, Discretionary Budget Authority	**75,745**	**76,675**	**76,234**	**-441**

1/ FY 2015 funding totals include additional funding provided by the FY 2015 Continuing Resolution (P.L. 113- 164) of $58 million to PHSSEF for Ebola Medical Countermeasures and $30 million to CDC for Ebola Outbreak Response.

2/ For comparability, the FY 2015 and FY 2016 levels include the Department of Education's appropriation of $250 million for the Preschool Development Grants

3/ After FY 2015, funding for Faith-Based Centers is provided in the Office of the Secretary

4/ The FY 2017 funding reflects $10 million in mandatory funds that were transferred from the TANF Contingency Fund to the Census Bureau SIPP program as enacted by Congress for FY 2015 (P.L. 113-235) and FY 2016 (P.L. 114-113).

5/ Reflects funding provided by the FY 2015 Omnibus; Consolidated and Further Continuing Appropriations Act (P.L. 113-235).

6/ The FY 2015 rescissions are comprised of $6.3 billion from unobligated Children's Health Insurance Program (CHIP) funding and $10 million from the Independent Payment Advisory Board. The FY 2016 Consolidated Appropriations Act includes rescissions from the Independent Payment Advisory Board ($15 million), unobligated CHIP balances ($4.7 billion), and makes temporarily unavailable the balance of the CHIP Child Enrollment Contingency Fund ($2.0 billion). The FY 2017 Budget proposes to rescind $5.9 billion in unobligated CHIP balances and make $570 million from the Child Enrollment Contingency Fund temporarily unavailable for obligation.

COMPOSITION OF THE HHS BUDGET
Mandatory Programs

dollars in millions	2015	2016	2017	2017 +/-2016
Mandatory Programs (Outlays)				
Medicare /1	539,899	588,752	598,191	+9,440
Medicaid /2	349,762	367,229	385,582	+18,353
Temporary Assistance for Needy Families /3,4	16,672	16,949	17,666	+717
Foster Care and Adoption Assistance	7,314	7,478	8,058	+580
Children's Health Insurance Program /5	9,242	14,479	15,195	+716
Child Support Enforcement	4,040	4,167	4,321	+154
Child Care	2,821	2,950	5,906	+2,956
Social Services Block Grant	1,832	1,771	2,136	+365
Other Mandatory Programs	17,197	21,266	20,858	-408
Offsetting Collections	0	0	0	-
Subtotal, Mandatory Outlays	**948,779**	**1,025,041**	**1,057,913**	**+32,872**
Total, HHS Outlays	**1,027,559**	**1,110,562**	**1,144,801**	**+34,239**

1/ Totals may not add due to rounding.
2/ Total excludes $4 million in Medicaid outlays in FY 2017 due to a proposed change in a mandatory program (CHIMP) for a Department of State proposal.
3/ Includes outlays for the TANF program, TANF Contingency Fund, and the TANF Economic Response Fund.
4/ Total excludes $22 Million in discretionary outlays in FY 2017 from a CHIMP.
5/ Includes outlays from the CHIP Child Enrollment Contingency Fund.

Food and Drug Administration

dollars in millions	2015 /1	2016	2017	2017 +/– 2016
FDA Programs				
Foods	914	999	1195	+196
Human Drugs	1339	1395	1408	+13
Biologics	344	355	360	+5
Animal Drugs and Feeds	175	189	197	+8
Medical Devices	440	450	463	+13
National Center for Toxicological Research	63	63	60	-3
Tobacco Products	532	564	596	+32
Headquarters and Office of the Commissioner/2	277	290	299	+9
White Oak Consolidation	47	52	47	-5
GSA Rental Payment	228	239	240	+1
Other Rent and Rent-Related Activities	116	120	124	+4
Subtotal, Salaries and Expenses	**4,476**	**4,716**	**4,990**	**+275**
Export Certification Fund	5	5	9	+4
Color Certification Fund	8	9	10	+2
Priority Review Vouchers	8	8	8	--
Buildings and Facilities	9	9	12	+3
Cancer Initiative (Directed Mandatory Transfer from NIH)	--	--	75	+75
Total, Program Level	**4,505**	**4,745**	**5,104**	**+358**
Current Law User Fees /3				
Prescription Drug (PDUFA)	798	851	866	+14
Medical Device (MDUFA)	128	138	145	+7
Animal Drug (ADUFA)	22	23	23	+0
Animal Generic Drug (AGDUFA)	7	10	10	+1
Food Reinspection	6	6	6	--
Food Recall	1	1	1	--
Family Smoking Prevention and Tobacco Control Act	566	599	635	+36
Generic Drug (GDUFA)	312	318	324	+6
Biosimilars (BSUFA)	21	22	22	+1
Mammography Quality Standards Act (MQSA)	20	20	21	+0
Export Certification Fund	5	5	5	--
Color Certification Fund	8	9	10	+2
Third Party Auditor Fee	--	1	1	--
Voluntary Qualified Importer Program	5	5	5	--
Outsourcing Facility Fee	1	1	1	+0
Priority Review Vouchers	8	8	8	--
Subtotal, Current Law User Fees	**1,909**	**2,017**	**2,084**	**+66**

Food and Drug Administration

dollars in millions	2015	2016	2017	2017 +/– 2016
Proposed Law User Fees				
Export Certification /4	--	--	4	+4
Food Facility Registration and Inspection	--	--	61	+61
Food Import	--	--	105	+105
Food Contact Substance Notification	--	--	5	+5
Cosmetics	--	--	20	+20
International Courier	--	--	6	+6
Subtotal, Proposed Law User Fees	--	--	**202**	**+202**
Less Total, User Fee	**1,909**	**2,017**	**2,286**	**+269**
FDA Totals				
Total, Discretionary Budget Authority	**2,596**	**2,728**	**2,743**	**+15**
Full-Time Equivalents	15,620	16,341	16,771	+430

1/ In addition, the FY 2015 appropriation (P.L. 113-235) provided $25 million in emergency resources for Ebola response and preparedness activities.
2/ The FY 2015 and FY 2016 appropriations directed FDA to transfer a total of $1.5 million to the HHS Office of Inspector General for oversight activities.
3/ 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. FDA expects that collections for wholesale distributer and third-party logics provider fees in FY 2015, FY 2016, and FY 2017 will be minimal.
4/ The FY 2017 President's Budget proposes to increase the statutory user fee limit for export certification.

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 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 manufacturing, 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 2017 Budget includes $5.1 billion in total resources for the Food and Drug Administration (FDA), an increase of $358 million, or 8 percent above FY 2016. Of this increase, $15 million is in budget authority, $269 million in user fees, and $75 million in new mandatory funding. FDA's jurisdiction of products and activities is vast, ranging from over-the-counter drugs to infant formula, and the challenges to secure the safety of these products increases in complexity with a growing global market.

FDA estimates that Americans pay about two cents per day to ensure that the products FDA regulates, representing more than 20 percent of every consumer dollar spent on products in the United States are safe and effective.

The Budget will continue to invest in transforming the food safety system to address today's challenges, ensuring the safety and efficacy of medical products, supporting the Department's preparedness enterprise, reducing tobacco use, and conducting innovative research.

MODERNIZING THE FOOD SAFETY SYSTEM

FDA oversees the safety of approximately 80 percent of the food supply, including a growing proportion of imported products. The Food Safety Modernization Act (FSMA) was enacted in 2011 and provided FDA with the authorities to transform the food safety system by shifting the focus from responding to foodborne illness and other food hazards to preventing them.

Over the last five years, FDA has provided training and technical assistance to industry partners to facilitate understanding and compliance with the new standards; developed tools that will provide the information needed to focus decisions and resources on areas of greatest risk; increased capacity to support an integrated food safety system, and conducted 7,020 high-risk food establishment inspections.

In 2015, FDA issued five foundational final rules that established the framework for a secure food supply, including preventive controls for food and feed, and will continue in 2016 with finalizing two more. In FY 2017, FDA will build on these regulations and guide the modernization of our food safety system by prioritizing prevention, supporting risk-based oversight, and expanding collaboration in the food safety community. These activities ultimately will improve the public health by lowering the incidence of illness due to food hazards and will avoid interruptions to the food supply.

The Budget includes $1.5 billion for food safety across FDA programs, an increase of $212 million above FY 2016, an increase of $18 million in budget authority and $193 million in user fees. This total includes $1.3 billion in budget authority and $210 million in user fees. In FY 2017, FDA will focus on implementing produce standards for packing, harvesting, and growing fruits and vegetables; and ensuring imported foods meet the same standards of safety as those in the United States.

PROGRAM HIGHLIGHT

Empowering Americans to Make Informed Nutritional Decisions

The Nutrition Facts label, which is a label required on most packaged foods, has not changed significantly since the requirements were first introduced in 1993. FDA has proposed to update the Nutrition Facts label to reflect new public health and scientific information, including evidence on nutrition, obesity and chronic disease. This includes updating the look and content of the Nutrition Facts Label to better help consumers make informed food choices and follow healthy dietary practices. One change includes updating the label to better reflect a single serving, which has changed in the decades since the original nutrition label was created. Informed food choices is another step towards addressing the current obesity rate estimated to be over one third of the country.

In FY 2017 FDA will focus on the following objectives in support of FSMA:

- Increasing state capacity to implement FSMA produce safety rules;
- Implementing the Foreign Supplier Verification Program to ensure importers verify that imported foods have been produced in a manner consistent with FSMA's new standards for produce safety and preventive controls; and
- Expanding foreign inspections and the agency's overseas presence.

The Budget proposes new user fees including the food import fee and the food facility registration and inspection fee. The additional $193 million in new resources are vital to fully support robust implementation of a prevention based food safety system. The FDA Budget continues to propose the food contact substance notification user fee to reduce microbial food contamination through premarket notification, as well as including currently authorized fees that will support food safety across 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. These programs include: the voluntary qualified importer program, export certification, third party auditor program, and the food reinspection and recall fees.

In FY 2017, the FDA food safety portfolio will continue to support other vital food and feed safety activities that are important to the public such as improving the availability of nutritional information to assist with decisions made by individuals and their families, ensuring that food additives and coloring meet standards set by FDA, and guarding public health by ensuring information on food labels is based on the most current science. For example, the Center for Food Safety and Applied Nutrition is proposing to update the Nutrition Facts Label to better reflect new scientific information and changed consumer preferences.

ENHANCING MEDICAL PRODUCT SAFETY

FDA continues to make significant progress in reducing the number of drug shortages, from a high of 251 shortages in 2011 to just 44 new shortages in 2014. Today, FDA leads the world in both the number of new drugs approved and in the timeliness of their reviews. These are just a few examples of the critical role FDA plays on a daily basis to ensure Americans have access to safe and effective products. As the global market

grows and complex challenges arise, FDA is working to keep pace with the latest science and leverage state, local, and foreign partnerships to protect the public health. Initiatives across FDA programs continue to address new and emerging technologies in regulatory science including 3-D printing, genome sequencing, and computer simulations.

FDA ensures the safety, quality and effectiveness of a broad scope of medical products used by Americans including biologics such as vaccines, blood products, and gene therapies, prescription and over-the-counter drugs, radiation emitting products, and medical devices ranging from dental devices to surgical implants. In March 2015, FDA approved Zarxio, the first biosimilar biological product approval in the United States. Zarxio, which is biosimilar to the biological product Neupogen, is a medication that boosts the production of white blood cells and helps to ward off infection in patients receiving strong chemotherapy for some tumors. This significant accomplishment represents the next step to increasing treatment options for patients.

In 2016, FDA will support implementation of three activities of the Food and Drug Administration Safety and Innovation Act (FDASIA):

- Unique Facility Identifier;
- Unique Device Identifier; and
- Electronic Biological Product Application Submission programs.

These activities will continue in FY 2017 to improve patient safety by establishing systems that will allow standardized approaches to quickly and efficiently identify drug and device products in the market and streamline the way biologics are reviewed.

FDA is also working on long-term implementation of the track and trace system authorized in the Drug Quality and Security Act for enhanced drug distribution security. The system will further enable the identification and verification of the legitimacy of certain prescription drugs, and become an important tool in the fight against counterfeit, diverted, or stolen drugs. In addition, in 2015, FDA successfully launched a mobile application to improve public access to information, including current drug shortages, and resolve drug shortages and discontinuations of drug products. In FY 2017, FDA will continue to invest in developing a safer and more modern drug supply system by building on the infrastructure to process biological product applications and support integration of the Unique Facility Identifier into IT systems that support regulatory work.

In addition, FDA is making strides to improve the efficiency of the generic drug review process. FDA supports the program's goal to enhance access to high-quality, lower cost generic drugs. This commitment is reflected in the performance target, which increases from 75 percent of Abbreviated New Drug Application submissions reviewed in 15 months in FY 2016 to 90 percent reviewed in 10 months in FY 2017.

Medical product safety investments in the FY 2017 Budget total $2.8 billion at the program level, $116 million above FY 2016. This total includes $1.3 billion in budget authority, $1.4 billion in current law user fees, and $75 million in new mandatory funding. The Budget will advance FDA's highest priority activities to ensure that human and animal drugs, biologics, and medical devices available to the American public meet current requirements and standards for safety. In FY 2017, FDA activities include but are not limited to domestic and foreign drug establishment inspections, pre-and post-market product surveillance, research on biologics, human drugs, and devices to help inform FDA program's and the medical product community, and review of new medical products that will be available to the public.

The Budget includes a total of approximately $18 million in budget authority, an increase of $1 million above FY 2016, to continue and extend FDA's oversight of drugs produced by compounding pharmacies and outsourcing facilities. Increased efforts in these areas will help to prevent outbreaks that could result in deaths or injuries to patients who receive compounded drugs. Oversight of compounding facilities is critical to protecting patients. In FY 2015, FDA conducted 116 inspections of compounding pharmacies and outsourcing facilities across the nation. Funding requested in the Budget will build on FY 2016 activities, including inspection and enforcement, developing policies that will ensure compliance with the Drug Quality and Security Act, and facilitating state collaboration and coordination.

The Budget includes $42 million in support of the Administration's National Strategy for Combating Antibiotic Resistant Bacteria, the same as FY 2016, which will advance efforts to support the judicious use of medically-important antimicrobials in food-producing animals, to evaluate new antibacterial drugs for patient treatments, to streamline clinical trials, and to develop better vaccines for antibiotic resistant organisms. Fighting antibiotic resistance is both a public health and national security priority, and FDA has made strides to make sure effective antibiotics are available in the future. The Budget will build on

FDA's current work in this area, which includes implementing the Veterinary Feed Directive, which would make illegal the use of medically important antibiotics for animal production purposes and bring remaining uses for legitimate animal health purposes under veterinary supervision.

PROGRAM HIGHLIGHT

Developing a Collaborative Platform to Advance Precision Medicine

In January 2015, the Precision Medicine Initiative was launched to empower health care providers to tailor treatment and prevention strategies to individuals' unique characteristics and genetic makeup. Achieving this vision will require ensuring the accuracy of genetic tests in detecting and interpreting genetic variants in the human genome. More than 80 million variants have been found in the human genome.

To that end, FDA developed precisionFDA, an online, cloud-based, portal that will allow scientists from industry, academia, government and other partners to come together to foster innovation and develop the science behind a method of reading DNA known as next-generation sequencing.

precisionFDA will supply an environment where the community can test, pilot, and validate new approaches. For example, next-generation sequencing test developers, researchers, and other members of the community can share and cross-validate their tests or results against crowd-sourced reference material in precisionFDA.

FDA is also a key participant in the President's Precision Medicine Initiative. In the last year, FDA has approved several new Precision Medicine-based therapies and launched precisionFDA, a platform for academic and commercial collaboration. The Budget includes $4 million, an increase of $2 million above FY 2016, to support these activities including supporting precisionFDA and working with the scientific community to develop new reference datasets for validating genetic tests. FDA's advancement of precision medicine will help reduce the burden of disease by targeting prevention and treatment more effectively. These efforts directly support precision medicine activities across HHS.

The Budget also provides $75 million in mandatory resources over five years in order to accelerate progress in cancer as part of the Vice President's Cancer "Moonshot" initiative. FDA will closely interface with the NIH National Cancer Institute to streamline the development and expedite the approval of novel devices, drugs, biologics, and combination products. FDA will also support improved access to new treatments through cancer clinical trials and access programs, and will enhance sharing of cancer data from clinical trials to promote biological and clinical breakthroughs.

FDA INFRASTRUCTURE AND FACILITIES

FDA infrastructure and facilities, including 56 laboratories strategically located across the continental United States and Puerto Rico, directly support mission critical work and enable FDA to respond to food safety and medical product safety activities. These responsibilities have increased as a result of groundbreaking legislation Congress has passed over recent years, and as a result, FDA has experienced a significant increase in its workforce to carry out these activities. The FY 2017 Budget ensures that FDA facilities are optimally functioning to carry out its growing responsibilities for food and medical product safety. The Budget invests a total of $423 million, $4 million above FY 2016, in FDA infrastructure including costs to keep up with the science and continue planned activities in the White Oak Complex. In 2016, FDA will complete a feasibility study at the White Oak Campus to address its expanded workforce as well as the continued consolidation and construction required to accommodate them. These resources will also ensure FDA's leased offices and labs across the country are functional and support the workforce in meeting its public health mission.

In addition, the Budget provides $12 million, an increase of $3 million above FY 2016, to fund repair and maintenance of FDA-owned facilities. This investment will begin to address high priority needs across owned facilities to ensure FDA can achieve its regulatory responsibilities, strategic priorities, and program initiatives. These investments directly support FDA's ability to carry out its responsibilities in facilities that can meet modern challenges.

ADVANCING MEDICAL COUNTERMEASURES

FDA supports the establishment and sustainment of an adequate supply of medical countermeasures to protect against chemical, biological, radiological, nuclear, and emerging infectious disease threats. FDA approved the majority of medical countermeasure marketing applications under review in FY 2015 that met standards for safety, efficacy, and quality. The FY 2017 Budget includes $25 million to continue the Medical Countermeasures Initiative program which directly supports FDA's countermeasures efforts across

the agency and the Department's preparedness activities. These resources will help accelerate the development, evaluation, and approval of these countermeasures. In addition, funding will support establishing clear regulatory and policy frameworks to supports emergency preparedness and response.

REDUCING THE USE AND HARMS OF TOBACCO

Tobacco remains the leading preventable cause of disease, disability, and death in the United States. The adverse health effects from tobacco cause more than 480,000 deaths each year. In 2009, Congress enacted the Family Smoking Prevention and Tobacco Control Act, which gave FDA authorities to regulate the manufacturing, distribution, and marketing of tobacco products. This legislation has enabled FDA to make significant progress towards making tobacco-related death and disease a part of the nation's past and not its future. FDA has moved science-based tobacco regulation forward and started a rigorous tobacco research program. FDA, through the Center for Tobacco Products, executes its regulatory and public health responsibilities in program areas that support the following objectives: preventing initiation, particularly among youth; decreasing the harms of tobacco product use; and encouraging cessation.

The Center for Tobacco Products continues to build on accomplishments to prevent tobacco use in youth; educate Americans on the harms of tobacco products; ensure compliance with the Tobacco Control Act; review new tobacco products and changes to existing products to reduce harm; and, support cutting edge research. As of January 2016, FDA completed over 549,300 inspections of tobacco product retailers across the United States to ensure that industry is meeting new requirements and issued more than 38,800 warning letters to retailers for violating the law. In October 2015, FDA filed complaints initiating the first-ever No-Tobacco Sale Order actions for a group of retailers who had violated certain restrictions on the sale and distribution of tobacco products, including sales to minors. If an order goes into effect, a retailer is responsible for ensuring that the establishment does not sell regulated tobacco products during the specified period.

FDA also has contracts to conduct compliance check inspections at tobacco retail establishments with 55 states, territories, and tribal jurisdictions. FDA publishes guidance to the tobacco industry to increase awareness of their new obligations and of FDA's responsibilities.

As part of its implementation of the Tobacco Control Act, FDA will extend its tobacco authority to cover additional tobacco products that are currently unregulated in the market. This extension will enable FDA oversight and the use of regulatory tools, such as age restrictions and scientific review of new tobacco products, to help limit youth exposure that could lead to a lifetime of nicotine addiction.

PROGRAM HIGHLIGHT

Reducing Tobacco Use among At-Risk, Multi-Racial Youth

In May 2015, FDA launched the first phase of its "Fresh Empire" campaign, which is designed to prevent and reduce tobacco use among at-risk multi-racial youth aged 12 to 17 who may become regular smokers.

"Fresh Empire" targets youth who identify with the hip-hop peer crowd— a hard-to-reach group that historically has been underserved by tobacco prevention campaigns. The aim of the campaign is to associate living tobacco-free with desirable hip-hop lifestyles through a variety of interactive marketing tactics including the use of traditional paid media, engagement through multiple digital platforms, and outreach at the local level.

The launch of this campaign follows the award-winning "Real Cost" campaign from 2014, which will also receive additional advertising. As of September 2015, the campaign has reached more than 90 percent of the target audience at least 15 times a quarter, generated nearly 2.5 billion digital impressions on youth-focused websites. FDA plans to launch additional public education campaigns in 2016 including rural youth at risk of smokeless tobacco initiation and lesbian, gay, bisexual, and transgender young adults. In 2017, FDA will continue to build on these campaigns to reach out to youth.

The FY 2017 Budget includes $596 million in user fees to support the FDA tobacco program and contributes to the Department's crosscutting efforts to reduce tobacco use in the United States. FDA will focus resources on five strategic priorities: 1) product standards to protect public health; 2) an FDA-wide nicotine regulatory policy; 3) premarket and post market product controls: regulations and product reviews; 4) compliance and enforcement through inspections, investigations, monitoring, and review of covered tobacco products; and 5) public education efforts particularly among youth.

USER FEES

The Budget assumes resources from five new user fee programs, an increase to one currently authorized fee program, and scheduled increases in all currently authorized user fee programs. Resources from user fees are critical to enable FDA to carry out its mission and institute performance metrics that lead to greater efficiencies and increased speed at which products are available to the public.

In addition to the fees described above, the Budget proposes two additional user fee programs. First, the Budget continues to propose the international courier user fee, which would provide $6 million to support activities associated with increased surveillance related to the increased volume of FDA-regulated commodities, predominantly medical products, imported through express courier hubs. This request also includes the proposed cosmetic user fee totaling $20 million to 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.

Finally, the Budget proposes to increase the allowable fee amount for the export certification fee to keep up with the growing costs of these certification activities.

Health Resources and Services Administration

dollars in millions	2015	2016	2017	2017 +/- 2016
Primary Health Care				
Health Centers	4,901	4,992	4,992	--
Discretionary Budget Authority [non-add]	*1,392*	*1,392*	*1,242*	*-150*
Current Law Mandatory Funding [non-add]	*3,509*	*3,600*	*3,600*	--
New Mandatory Proposal [non-add]	--	--	*150*	*+150*
Health Centers Tort Claims	100	100	100	--
Free Clinics Medical Malpractice	0.1	0.1	1	+0.9
Subtotal, Primary Care	**5,001**	**5,092**	**5,092**	**--**
Health Workforce				
National Health Service Corps	287	310	380	+70
Discretionary Budget Authority [non-add]	--	--	*20*	*+20*
Current Law Mandatory Funding [non-add]	*287*	*310*	*310*	--
New Mandatory Proposal [non-add]	--	--	*50*	*+50*
Training for Diversity	83	83	86	+3
Training in Primary Care Medicine	39	39	39	--
Oral Health Training	34	36	36	--
Teaching Health Centers Graduate Medical Education *[Mandatory]*	--	60	60	--
Interdisciplinary Community-Based Linkages /1	108	129	105	-24
Area Health Education Centers [non-add]	*30*	*30*	--	*-30*
Behavioral Health Workforce Education and Training [non-add]	*35*	*50*	*56*	*+6*
Health Care Workforce Assessment	5	5	5	--
Public Health and Preventive Medicine Programs	21	21	17	-4
Nursing Workforce Development	232	229	229	--
Children's Hospital Graduate Medical Education	265	295	295	--
Discretionary Budget Authority [non-add]	*265*	*295*	--	*-295*
Proposed Mandatory Funding [non-add]	--	--	*295*	*+295*
National Practitioner Data Bank User Fees	19	21	21	--
Subtotal, Health Workforce	**1,093**	**1,228**	**1,273**	**+45**

Health Resources and Services Administration

dollars in millions	2015	2016	2017	2017 +/- 2016
Maternal and Child Health/2				
Maternal and Child Health Block Grant	637	638	638	--
Sickle Cell Demonstration Program	4	4	4	--
Autism and Other Developmental Disorders	47	47	47	--
Heritable Disorders	14	14	14	--
Healthy Start	102	104	104	--
Universal Newborn Hearing Screening	18	18	18	--
Emergency Medical Services for Children	20	20	20	--
Family to Family Health Information Centers [Mandatory]	5	5	5	--
Home Visiting	400	400	400	--
Subtotal, Maternal and Child Health	**1,247**	**1,250**	**1,250**	**--**
Ryan White HIV/AIDS Program				
Emergency Relief - Part A	655	656	656	--
Comprehensive Care - Part B	1,315	1,315	1,315	--
AIDS Drug Assistance Program [non-add]	*900*	*900*	*900*	--
Early Intervention - Part C	204	205	280	+75
Children, Youth, Women, and Families - Part D	73	75	--	-75
Education and Training Centers - Part F	33	34	34	--
Dental Services - Part F	13	13	13	--
Special Projects of National Significance (SPNS)	25	25	--	-25
SPNS PHS Evaluation Funds	--	--	*34*	*+34*
Hepatitis C Treatment in People Living with HIV [non-add]	--	--	*9*	*+9*
Subtotal, HIV/AIDS	**2,319**	**2,323**	**2,332**	**+9**
Healthcare Systems				
Organ Transplantation	24	24	24	--
Cord Blood Stem Cell Bank	11	11	11	--
C.W. Bill Young Cell Transplantation Program	22	22	22	--
Poison Control Centers	19	19	19	--
340B Drug Pricing Program	10	10	26	+16
User Fees [non-add]	--	--	*9*	*+9*
Hansen's Disease Programs	17	17	17	--
Subtotal, Healthcare Systems	**103**	**103**	**119**	**+16**
Rural Health				
Rural and Community Access to Emergency Devices	5	--	--	--
Rural Hospital Flexibility Grants	42	42	26	-16
Rural Opioid Overdose Reversal Grant Program	--	--	10	+10
Telehealth	15	17	17	--
Other Rural Health	86	91	91	--
Subtotal, Rural Health	**147**	**150**	**144**	**-6**

Health Resources and Services Administration

dollars in millions	2015	2016	2017	2017 +/- 2016
Family Planning	286	286	300	+14
Program Management	154	154	157	+3
Vaccine Injury Compensation Program Direct Operations	7.5	7.5	9.2	+1.7
Subtotal, Other Activities	**448**	**448**	**466**	**+18**
HRSA Budget Totals – Less Funds from Other Sources				
Total, Program Level	**10,358**	**10,593**	**10,677**	**+84**
PHS Evaluation Funds	--	--	34	34
User Fees	19	21	30	9
Current Law Mandatory Funding	4,201	4,375	4,375	--
New Mandatory Proposals	--	--	495	495
Total, Discretionary Budget Authority	**6,138**	**6,197**	**5,743**	**-454**
Full-Time Equivalents	1,863	2,109	2119	+10

1/ FY 2015 and FY 2016 final funding levels reflect funding for the Behavioral Health Workforce Education and Training program, which were appropriated to SAMHSA. This program is proposed to be transferred to HRSA beginning in FY 2017.
2/ Comparably adjusted to reflect the transfer of the Traumatic Brain Injury Program from HRSA to the Administration for Community Living beginning in FY 2016.

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 primary federal agency improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable. The FY 2017 Budget provides $10.7 billion total, including $4.9 billion in mandatory funding to promote improvements in access, quality, and equity that are essential for a healthy nation.

PROGRAM HIGHLIGHT

Ensuring All Americans Have Access to Health Care

1 in 14 people nationwide receive care at a health center. For nearly 23 million Americans, health centers are essential medical institutions where they receive affordable care and diagnoses, treatment for disease and disability, and other important health care services. About 65 percent of health centers have been designated patient-centered medical homes, which means they provide high-quality care and improve patient outcomes, while reducing disparities, despite serving a population that is often sicker and more at risk than the general population. Nearly 90 percent of health centers have electronic health records that support comprehensive care coordination and key quality improvement practices to manage patients with multiple health care needs. Health centers are a vital source of local employment and economic growth for the nation's medically underserved communities and populations.

MAKING HEALTH CARE AFFORDABLE AND ACCESSIBLE

Health Centers

For 50 years, health centers have provided high-quality preventive and primary health care to vulnerable populations across the country, regardless of ability to pay. Today, more than 1,300 health centers operate over 9,000 service delivery sites and provide valuable health care services to patients in every state, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the Pacific Basin. In 2014, 1 in every 14 people received care at a health center.

The FY 2017 Budget provides $5.1 billion for Health Centers. At this funding level, Health Centers will serve approximately 27 million patients nationwide. In addition, the funding level will support key primary care services, as well as oral health and behavioral health services, including substance abuse treatment. The FY 2017 Budget also proposes $3.6 billion in new mandatory resources in FY 2018 and FY 2019, to extend the current mandatory funding for 2 additional years.

340B Drug Pricing Program

The 340B Program requires drug manufacturers to provide outpatient prescription drugs to eligible health care organizations at significantly reduced prices. This program helps covered entities to stretch scarce resources as far as possible, reaching more eligible patients and providing more comprehensive services. Below is an example of some organizations that participate in the 340B Program:

- Safety-net clinics, hospitals, and programs (e.g., Federally Qualified Health Centers, Ryan White HIV/AIDS clinics and State AIDS Drug Assistance programs, etc.)
- Indian Health Service tribal clinic funding
- Children's hospitals
- Other community-based providers (e.g., Black Lung Clinics, Title X Family Planning Clinics, Tuberculosis Clinics, etc.)

To support these efforts, the Budget provides $17 million in budget authority for the 340B Drug Pricing Program, an increase of $7 million above FY 2016. In addition, it proposes a new user fee totaling $9 million to support the overall successful operation of the program in the long term.

The Administration is committed to program integrity in the 340B Program, and the FY 2017 Budget seeks new rulemaking authority to ensure adherence to the program's principles, compliance with the law, and the most effective use of this critical safety-net program.

STRENGTHENING THE NATION'S HEALTH WORKFORCE

HRSA health workforce programs improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. These programs address supply and distribution challenges by training and placing health care providers in underserved areas across the nation; training a diverse, qualified, and culturally competent health care workforce to meet the unique needs of patients; and transforming training for health care delivery to meet the current and future needs of people across the country.

The Budget provides a total of $1.3 billion for HRSA workforce programs, including $715 million in mandatory funding to provide access to high-quality health care professionals, particularly those living in areas across the country with shortages of health professionals. This funding includes investments in graduate medical education, the National Health Service Corps, and workforce diversity efforts. By addressing the shortage of primary care professionals that exists in certain parts of the country, HRSA health workforce programs play a critical role in making sure all Americans have access to high-quality health care.

Children's Hospital Graduate Medical Education

The Budget includes $295 million in mandatory funding in each of FYs 2017 through 2021 for the Children's Hospital Graduate Medical Education Program, which helps eligible hospitals provide graduate training for pediatricians and pediatric subspecialists, and enhances their ability to care for low-income pediatric patients. Mandatory funding will provide a predictable funding stream for this program, as is the case for other residency programs supported by HHS.

Teaching Health Center Graduate Medical Education

The Budget proposes to strengthen and extend the Teaching Health Center Graduate Medical Education Program with a request for $527 million in new mandatory funding in FY 2018 through FY 2020. This program increases access in underserved communities by supporting primary care resident training in community-based, patient care settings. Since the program's inception, nearly all residents received training in a medically underserved community, and just over 1 out of every 5 received training in a rural area.

National Health Service Corps

The National Health Service Corps is committed to serving medically underserved populations and is one of the nation's most effective programs in placing health care professionals in communities with the highest need. The Budget includes $380 million for the National Health Service Corps, including $20 million in new discretionary and $50 million in new mandatory funding. The new mandatory funding will support two key Administration Initiatives to expand access to treatment for prescription drug abuse and heroin use, and to expand access to mental health services. The funding supports additional new loan repayment awards for behavioral health clinicians, including enhanced loan repayment for providers certified in

medication-assisted treatment. The Budget also proposes to increase mandatory funding to $810 million in FYs 2018 through 2020. This funding will allow the National Health Service Corps field strength to increase to approximately 15,000.

Supporting Diversity within the Health Workforce

HRSA funding supports several workforce programs dedicated to training diverse and highly skilled health care providers across the country. The Budget provides $86 million for the Health Careers Opportunity Program, the Centers of Excellence Program, Scholarships for Disadvantaged Students Program, and the Faculty Loan Repayment Program.

Together with the National Health Service Corps, these investments are effective mechanisms for increasing diversity among health professionals and improving access to culturally competent, high-quality care in underserved areas and for vulnerable populations.

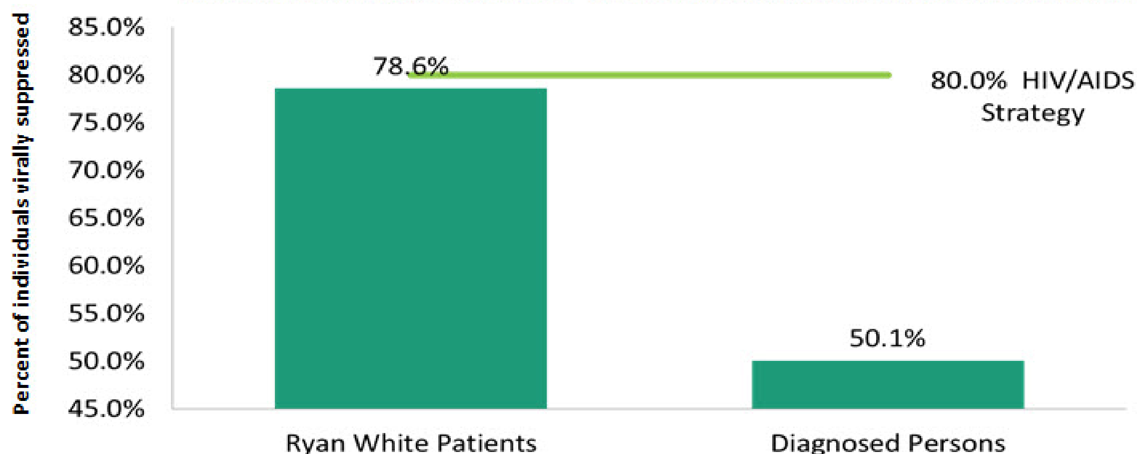
WORKING TOWARD AN AIDS-FREE GENERATION

First authorized in 1990, the Ryan White HIV/AIDS Program was established to provide services to individuals living with HIV/AIDS who do not have sufficient health care coverage or resources to access lifesaving care. The FY 2017 Budget provides $2.3 billion for the Ryan White HIV/AIDS Program to support cities, states, and community-based organizations to ensure that patients living with HIV have access to health services.

In line with the President's *National HIV/AIDS Strategy for the United States: Updated to 2020*, the Ryan White HIV/AIDS Program plays a crucial role in the goals of reducing new HIV infections, increasing access to care, and optimizing health outcomes for people living with HIV, and achieving a more coordinated national response to the HIV epidemic.

Recent studies conclude that people living with HIV on antiretroviral medication who achieve viral load suppression are less likely to transmit HIV to others, thus reducing new infections by more than 96 percent. Funding in FY 2017 will help support the *HIV Care Continuum Initiative*, which is now integrated in the *National HIV/AIDS Strategy.* This initiative focuses on testing and antiretroviral treatment to achieve viral suppression for and improve the health outcomes of individuals with HIV. In 2013, over 78 percent of patients served by the Ryan White HIV/AIDS Program achieved viral suppression, an increase from 69 percent seen in 2010. By providing primary medical care, access to medications and supportive services, the Ryan White HIV/AIDS Program helps people gain access to consistent health care services and adhere to their individualized treatment plans.

Within the requested funding level, $900 million, the same level as FY 2016, is allocated for the AIDS Drug Assistance Program, which provides grants to states to pay for HIV/AIDS medications for uninsured, underinsured, and low-income patients who cannot afford them. Since the beginning of this Administration, the number of clients served annually by state AIDS Drug Assistance Programs has increased by nearly 37 percent.



Today, it is estimated that more than 1.2 million Americans are living with HIV infection; however, amongst diagnosed persons, only 50 percent of these individuals are virally suppressed and have the virus under control.

The HIV epidemic is constantly changing, and thanks to the efforts of Ryan White HIV/AIDS Program grantees, a stand-alone, population-specific grant program is no longer needed. The Budget continues to propose to consolidate the Part D program with the Part C program to ensure resources are better targeted to points along the care continuum, improve patient outcomes, and address the emerging needs of the epidemic across all populations. The consolidated Part C program will emphasize care for women, infants, children, and youth across all funded recipients, while reducing duplication of effort and administrative burden.

NEW INITIATIVE

Hepatitis C Treatment in People Living with HIV

People living with HIV are disproportionally affected by viral hepatitis and are at increased risk for serious, life-threatening complications. About one quarter of all people living with HIV are co-infected with Hepatitis C, and the rate is even higher (80 percent) amongst people living with HIV who inject drugs. Given the changes in the health care environment and advances in Hepatitis C Treatment, the FY 2017 Budget includes $9 million to expand screening and treatment of Hepatitis C in People Living with HIV.

This year, the Budget includes $9 million for an initiative to expand Hepatitis C Treatment in People Living with HIV. This program will use existing systems to develop evidence-informed models to increase testing for Hepatitis C, build capacity to expand treatment of Hepatitis C, and disseminate the models of care to patients in need.

PROMOTING HEALTHY FAMILIES AND COMMUNITIES

Maternal and Child Health

The FY 2017 request proposes to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program by an additional $15 billion in new funds over 10 years to expand access for at-risk families to voluntary, evidence-based home visiting services where nurses, social workers, and other professionals meet with families and connect them with assistance that supports and improves their children's health, development, and ability to learn. This proposal builds on HRSA's update of the program in FY 2016 that sought to stabilize funding to states and allow programs to maximize the use of resources to deliver services to families. The Budget also provides $845 million to maintain other programs that improve the physical and mental health, safety, and well-being of the nation's mothers, children, and their families, including the Maternal and Child Health Block Grant.

Rural Health

Rural residents experience higher rates of age-adjusted mortality, chronic disease, and disability than residents of urban communities. The Budget provides $144 million for the Federal Office of Rural Health Policy, which supports rural hospitals and other rural health providers in their provision of accessible and quality health care for Americans living in rural communities. According to the Centers for Disease Control and Prevention, Americans living in rural areas are more likely to overdose from opioid drug abuse than individuals living in cities. The FY 2017 Budget includes $10 million for the Rural Opioid Overdose Reversal Program, which aims to reverse the incidence of morbidity and mortality related to opioid overdoses in rural communities through the purchase and placement of emergency devices used to rapidly reverse the effects of opioid overdoses, as well as training of licensed health care professionals and emergency responders on their use.

Family Planning

The Title X Family Planning Program is the sole federal grant program dedicated to providing individuals with quality, comprehensive family planning and preventive health services. The Budget provides $300 million, an increase of $14 million above FY 2016, to expand family planning services to individuals in need by improving access to family planning centers and preventive services. This funding will provide support to approximately 4 million women, roughly 90 percent of whom have family incomes at or below 200 percent of the federal poverty level.

At this funding level, the Family Planning Program expects to help prevent approximately 1,300 cases of infertility though chlamydia screenings, as well as help prevent over 400 cases of cervical cancer through cervical cancer screenings.

SUPPORTING HRSA PROGRAMS

Program Management

The Budget provides $157 million, an increase of $3 million about FY 2016, to support HRSA's program operations. Funding in FY 2017 will allow HRSA to enhance oversight of grant and contract recipients, improve data transparency and program integrity, develop and maintain infrastructure, train and hire quality staff, and improve overall management and program operations.

Indian Health Service

dollars in millions	2015	2016	2017	2017 +/- 2016
Services				
Clinical Services:	4,348	4,431	4,682	+252
Purchased/Referred Care (non-add)	*914*	*914*	*962*	*+48*
Medicaid (non-add)	*791*	*808*	*808*	--
Preventive Health	154	156	166	+10
Contract Support Costs	663	718	800	+82
Tribal Management/Self-Governance	8	8	8	--
Urban Health	44	45	48	+3
Indian Health Professions	48	48	59	+11
Direct Operations	68	72	70	-2
Special Diabetes Program for Indians	150	150	150	--
Subtotal, Services	**5,483**	**5,628**	**5,984**	**356**
Facilities				
Health Care Facilities Construction	85	105	132	+27
Sanitation Facilities Construction	79	99	103	+4
Facilities and Environmental Health Support	220	223	234	+11
Maintenance and Improvement	62	82	85	+3
Medical Equipment	23	23	24	+1
Subtotal, Facilities	**468**	**532**	**578**	**+47**
IHS Budget Totals – Less Funds From Other Sources				
Total, Program Level	**5,951**	**6,160**	**6,562**	**+402**
Tribal Crisis Response Fund	--	--	15	15
Health Insurance Collections	1,151	1,194	1,194	--
Rental of Staff Quarters	8	9	9	--
Special Diabetes Program for Indians	150	150	150	--
Indian Health Professions Expansion	--	--	10	10
Total, Budget Authority	**4,642**	**4,808**	**5,185**	**+377**
Full-Time Equivalents	15,103	15,119	15,135	+16

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.

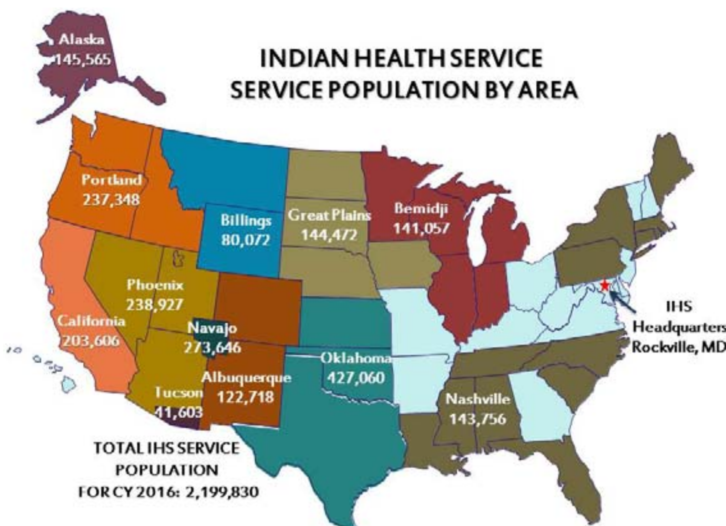
The FY 2017 Budget requests $6.6 billion for the Indian Health Service (IHS), an increase of $402 million above FY 2016 and 53 percent since FY 2008. The President is committed to a legacy of bettering the lives of Native people, especially youth, through improved access to quality health care services. Increases within the FY 2017 Budget are intended to help close the gap in health disparities experienced by American Indians and Alaska Natives and improve their overall health and well-being for generations to come. Specific investments include maximizing the benefits of the Affordable Care Act and Medicaid expansion for Indian Country, integrating medical and mental health services, expanding behavioral health services and supports for Native youth, supporting self-determination by fully funding Contract Support Costs of tribes who manage their own programs, ensuring increased health care access by fully funding staffing for new IHS health care facilities, addressing critical health care facilities infrastructure needs and renovating the IHS health information technology systems.

STRENGTHENING THE ADMINISTRATION'S COMMITMENT TO INDIAN COUNTRY THROUGH THE INDIAN HEALTH SERVICE

Long standing treaties between some Indian Tribes and the federal government ensures that comprehensive and culturally competent health services are accessible to nearly 2 million American Indians and Alaska Natives. This relationship gives the IHS the unique responsibility of providing health care to members of 566 federally recognized Tribes through hospitals, health centers, and clinics. Additional services are delivered through the Purchased/Referred Care program to ensure the full care needs of American Indians and Alaskan Natives are met. Through this program, gaps in specialized care and services are filled by purchasing care that the IHS and tribally managed programs are unable to fulfill.

Consultation with tribes is fundamental to ensuring that the care provided is focused on programs that will have a significant impact on Indian Country and ensuring that the IHS continues to respect traditional practices by providing culturally competent care. This goal is accomplished by working with tribes as partners to implement a complete health care system as authorized by the Indian Self-Determination and Education Assistance Act. Through this system, IHS and its tribal partners deliver crucial health care services throughout Indian Country.

Beyond the provision of health care, IHS provides additional public services through partnerships with other federal agencies by building sanitation systems to provide water and waste disposal for Native homes, providing scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, and supporting tribal self-governance and consultation.



PRIORITIZING HEALTH CARE SERVICES

The FY 2017 Budget includes an increase of $356 million to maintain and grow health care services and programs for American Indians and Alaska Natives. Over the course of the Administration, IHS has made significant strides and improvements including lowered rates of diabetes, increased services in preventative, primary and behavioral health through increased funding, reforms effected by the Affordable Care Act, and the permanent reauthorization of the Indian Health Care Improvement Act. Although significant progress has been made towards reducing health disparities, American Indian and Alaska Native people continue to experience lower health status when compared with other Americans. For example, suicide rates, drug induced death, and unintentional injuries, remain elevated across Indian Country. Targeted funding increases to expand successful programs and promising practices, particularly for behavioral health services are important to improving the health of tribal communities.

Increases for Behavioral Health Services

The Budget includes a total of $363 million to increase access to critical behavioral health services for youth and families. Services include the expansion of multiple successful substance abuse, mental health, and domestic violence programs. Specifically, the Budget continues to propose increasing funding of $15 million for the Generation Indigenous program, to expand the effective Substance Abuse and Suicide Prevention Program (formerly the Methamphetamine and Suicide Prevention Initiative) by increasing the number of child and adolescent behavioral health professionals who provide direct services and implement youth-based programming at IHS, tribal, and Urban Indian Health Programs, school-based health centers, and youth-based programs. The Substance Abuse and Suicide Prevention Program resulted in 12,209 individuals entering treatment for methamphetamine abuse; 16,569 encounters via tele-behavioral health; 16,250 professionals and community members trained in suicide crisis response; and 690,597 encounters with youth provided as part of evidence-based and practice-based prevention activities from 2009 to 2015. Additionally, IHS is focused on changing the paradigm of mental health and substance abuse disorder services by incorporating them into the patient-centered medical home. To support this effort, the Budget requests $21 million to facilitate the integration of behavioral health with primary care services. In addition, the Budget includes $4 million to implement Zero Suicide, a comprehensive strategy to reduce and eliminate suicide in 10 pilot projects. IHS also requests

$2 million in FY 2017 to test aftercare services at Youth Regional Treatment Centers to ease the transition to the community once residential treatment is completed.

The Budget also includes a $4 million expansion of the successful Domestic Violence Prevention Program (formally the Domestic Violence Prevention Initiative) to fund additional IHS, tribal, and urban Indian projects as well as fund its tribal forensic health care training program. Over 78,500 direct service encounters for crisis intervention, victim advocacy, case management, and counseling services were provided between August 2010 and August 2015. During the same period, more than 45,000 referrals were made for domestic violence services, culturally based services, and clinical behavioral health services. In addition, 8 Sexual Assault Examiner programs submitted 688 forensic evidence collection kits to federal, state, and tribal law enforcement.

Additionally, the Budget creates a new $15 million Tribal Crisis Response Fund, which will assist Tribes experiencing behavioral health crises, such as mass shootings, high rates of alcohol- and drug-related death rates, school violence, suicide clusters, and other emergencies. This fund will provide tribal communities with specialized crisis response staffing, technical assistance, and community engagement services.

NEW INITIATIVE

Tribal Behavioral Health Initiatives

In the FY 2017 Budget, the Administration continues to prioritize behavioral health services across Indian Country. IHS has strived to implement innovative solutions to ensure that youth and families receive increased access to mental health and substance abuse services, including interagency and external partnerships. Specifically, IHS has worked with federal agencies to help meet the Administration's goal of reducing teen suicide. Additionally, HHS is articulating a Department-wide Tribal Health and Well-Being Coordination Plan that calls on several HHS agencies—IHS, ACF, SAMHSA, HRSA, and CDC—to collaborate to improve health outcomes for American Indian and Alaska Native populations.

The Budget also provides a $10 million expansion to the Indian Health Professions Scholarship Program for a total of $59 million. This expansion will focus on increasing the number of American Indian and Alaska Native behavioral health professionals through the American Indians into Psychology program, loan repayment, and scholarships. These and other programs will support the Administration's goal of providing adequate and effective behavioral health and domestic violence prevention and services to Native youth and families across the country.

NEW INITIATIVE

Investments in Health Information Technology

Health Information Technology systems are critical to IHS's responsibility in improving patient healthcare outcomes of over 2 million patients who receive medical care from federal, tribal, and urban facilities. The Budget includes an increase of $20 million to ensure the IHS Health Information Technology system is poised to continue to make tremendous strides in a variety of areas, including Meaningful Use as established by the 2009 Health Information Technology for Economic and Clinical Health Act. Other goals of Health Information Technology include better clinical outcomes, improving population health outcomes, increasing transparency and efficiency, and empowering individuals while providing more robust research data on health systems.

Purchased/Referred Care

The Budget includes $962 million, an increase of $48 million over FY 2016, for the Purchased/Referred Care program. This program provides access to essential health care services that IHS and tribally-managed facilities are unable to provide by contracting with hospitals and other health care providers to purchase care. This program is a high priority for Tribes as it ensures that critical health services are available for eligible American Indians and Alaska Natives.

This program uses a medical priority review system to rank cases to determine eligibility for purchasing care due to limited funding. A 66 percent increase in funding since FY 2008 has allowed many facilities to pay for health care priorities beyond emergent services care. The requested FY 2017 funding increase ensures IHS can maintain the current level of services, while accounting for medical inflation and population growth.

Health Insurance Reimbursements

Third party collections from Medicare, Medicaid, the Veterans Health Administration, and private insurance allows IHS and contracting Tribes to provide additional health care services, purchase new equipment, hire necessary medical staff, and make essential building improvements. IHS estimates that in FY 2017, it will

collect approximately $1.2 billion in combined health insurance reimbursements. By law, IHS is the payer of last resort, so it is important that efforts be made to ensure the correct entity funds care provided to IHS eligible American Indians and Alaska Natives.

Improving the Quality of Health Care Delivery

Systems that support the delivery of health care across Indian Country are crucial to ensuring the provision of high-quality care. The IHS health information technology systems are used in over 400 facilities across 35 states at the point of care and support patient engagement with their health information. The request includes an increase of $20 million over FY 2016 to support the development, modernization, and enhancement of IHS' critical Health IT systems, including the electronic health record system, the personal health record portal, hospital administrative and billing systems, security systems, data exchange and interoperability services, and the IHS Integrated Data Collection System. Additionally, the request includes $2 million for the Hospital Consortium Initiative, a new program which will focus on reducing medical errors that adversely affect patients every year. The goal of this program is to reduce patient safety risks, improve patient satisfaction, and reduce costs of care. Similar efforts have been shown to reduce avoidable readmissions, hospital acquired conditions, and adverse events.

INCREASING ACCESS TO QUALITY HEALTH CARE SERVICES

Tribes receive direct care services in over 650 facilities managed by IHS, Urban Indian Health Programs, and contracting and compacting Tribes. This system of care gives each tribe the ability to provide services for its members in the best way possible.

Construction

Building new health care facilities and maintaining existing facilities are critical for providing quality health care services in for Indian people. Since 2008, the Administration has prioritized construction projects with the goal of decreasing construction backlogs. The FY 2017 Budget includes a total of $570 million for facilities and environmental health programs. Of that total, $132 million is allocated to begin new construction projects and complete ongoing construction projects within IHS. These projects include continuing construction for the Rapid City Health Center in Rapid City, South Dakota, and the Dilkon Health Center in Dilkon, Arizona; completing construction for the Salt River Northeast Health Center in Scottsdale, Arizona; as well as beginning the design for the renovation and expansion of the Whiteriver Hospital in Whiteriver, Arizona. In total, these facilities will serve a user population of approximately 63,000 patients.

Other facilities funding will allow IHS to build new health care and sanitation facilities and improve current infrastructure to ensure today's standards are met, purchase new equipment, and provide facilities and environmental health support. The $103 million requested for sanitation facilities construction, and IHS's key partnership with the Environmental Protection Agency, will help to expand on the 190,000 homes that will receive sanitation facilities for the first time under this Administration.

Staffing New and Replacement Health Facilities

The Budget requests a total of $33 million to fully staff five new state-of-the-art facilities, which are anticipated to open between FY 2015 and FY 2017. Of the newly opening facilities in FY 2017, three are Joint Venture projects, which leverage both tribal and IHS funding to ensure construction and staffing of safe and modernized facilities for American Indians and Alaska Natives. These partnerships allow IHS to provide funding for staffing, equipping, and operating the facility while the participating tribe covers the costs of design and construction. When implemented, Joint Venture projects have been successful and vital to improving access to care and reducing health disparities throughout Indian Country. The Joint Venture projects coming to completion in FY 2017 are Muskogee (Creek) Nation Eufaula Indian Health Center, Oklahoma; Flandreau Health Center, South Dakota; and Choctaw Nation Regional Medical Center, Oklahoma.

PROGRAM HIGHLIGHT

Long-Term Solution for Contract Support Costs

In FY 2016, Congress fully funded Contract Support Costs through an indefinite discretionary appropriation, marking a major achievement for tribes. In FY 2017, Contract Support Costs are continued as a discretionary indefinite appropriation and in FY 2018 and beyond, the Administration proposes to reclassify Contract Support Costs as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for Contract Support Costs. This policy supports self-determination by fully funding Contract Support Costs of tribes who manage their own programs and provides a long term solution to Contract Support Costs, which provides basic health services across Indian Country.

In addition to these Joint Venture projects, one other facility, the Northern California Youth Treatment Center, is scheduled to open in FY 2017. When these facilities are fully operational, they will serve an approximate user population of 13,000.

SUPPORTING INDIAN SELF-DETERMINATION

IHS understands that quality local health care cannot be implemented without consultation with Tribes and tribal organizations who understand the deep needs and proprieties of the local community. IHS highly values tribal partnerships and nearly 60 percent of the IHS budget is operated by tribes through the authority provided under the Indian Self Determination and Education Assistance Act, under which Tribes may assume the administration of programs and functions previously carried out by the federal government.

Contract Support Costs

The Budget fully funds estimated Contract Support Costs at $800 million, an increase of $82 million above FY 2016. In FY 2018 and beyond, the Administration proposes to reclassify Contract Support Costs as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for such costs, for both the IHS and the Bureau of Indian Affairs. This funding supports self-determination by supporting the operational costs of Tribes who administer health programs under self-determination contracts and self-governance compacts. The Budget maintains the indefinite appropriation for Contract Support Costs provided by Congress in FY 2016. This funding approach continues the policy to fully fund Contract Support Costs and guarantee program reliability.

Tribal Consultation

The Administration has made tribal consultation a priority by continuing to meet with tribal leaders, ensuring that extensive solicitation of tribal input is used to determine how programs are designed and implemented. The Administration recognizes that Tribes are in the best position to understand the unique needs of their diverse communities, and tribes play a critical role in the budget and policy making process.

In addition, HHS hosts an annual, Department-wide Tribal Budget Consultation at the beginning of each calendar year, which allows tribal leaders the opportunity to communicate with all the operating and staff divisions of HHS on budgetary issues. Tribal leaders provide HHS with their top priorities and recommendations for the upcoming year, connect with department staff, and meet colleagues who face similar challenges. Tribes also provide input through the Secretary's Tribal Advisory Committee whose goal is to seek consensus and provide recommendations to facilitate intergovernmental responsibilities or administration of HHS programs. Whenever possible, tribal recommendations are incorporated to ensure a continued legacy of health improvements throughout Indian Country.

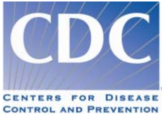
PERFORMANCE/PROGRAM HIGHLIGHT

Special Diabetes Program for Indians

In response to the growing diabetes epidemic among American Indian and Alaska Native people, Congress established the Special Diabetes Program for Indians. This effort is a $150 million per year program that provides grants for diabetes treatment and prevention services to 404 IHS, tribal, and Urban Indian Health Programs across the United States. This program has been extremely successful, including slowing the rate of increase in diabetes in American Indian and Alaska Native adults (aged 20+), with the rate climbing only from 15.2 percent to 15.9 percent from 2006 through 2012 and between 2000 and 2011, incidence rates of end stage renal disease in American Indian and Alaska Native people with diabetes decreased 43 percent—more than for any other racial group in the U.S.

Centers for Disease Control and Prevention

dollars in millions	2015 /1	2016	2017	2017 +/- 2016
Immunization and Respiratory Disease	798	798	748	-50
Prevention and Public Health Fund (non-add)	*210*	*324*	*336*	*+12*
Balances from P.L. 111-32 Pandemic Flu (non-add)	*15*	*15*	--	*-15*
Vaccines For Children	3,851	4,161	4,387	+226
HIV/AIDS, Viral Hepatitis, STIs and TB Prevention	1,118	1,122	1,128	+5
Emerging and Zoonotic Infectious Diseases	405	580	629	+50
Prevention and Public Health Fund (non-add)	*52*	*52*	*52*	--
Chronic Disease Prevention and Health Promotion	1,199	1,177	1,117	-60
Prevention and Public Health Fund (non-add)	*452*	*339*	*437*	*+98*
Birth Defects, Developmental Disabilities, Disability and Health	132	136	136	--
Prevention and Public Health Fund (non-add)	--	--	*68*	*+68*
Environmental Health	179	182	182	--
Prevention and Public Health Fund (non-add)	*13*	*17*	*14*	*-3*
Injury Prevention and Control	170	236	299	+63
Mental Health Mandatory Funding (non-add)	--	--	30	+30
Public Health Scientific Services	481	492	501	+9
Prevention and Public Health Fund (non-add)	--	--	*36*	*+36*
Occupational Safety & Health	335	339	286	-54
PHS Evaluation Funds (non-add)	--	--	*72*	*+72*
World Trade Center Health Program /2	261	300	335	+36
Energy Employee Occupational Illness Compensation Program	50	55	55	--
Global Health	446	427	442	+15
Public Health Preparedness and Response	1,353	1,405	1,402	-3
Buildings and Facilities	10	10	31	+21
CDC-Wide Activities and Program Support	274	274	114	-160
Prevention and Public Health Fund (non-add)	*160*	*160*	--	*-160*
Agency for Toxic Substances and Disease Registry (ATSDR)	75	75	75	--
ATSDR ACA Mandatory Funds /3	*19*	--	--	--
CORD MACRA Mandatory Funds /4	--	10	--	--
User Fees	2	2	2	--
Subtotal, Program Level	**11,158**	**11,781**	**11,868**	**+87**



Centers for Disease Control and Prevention

dollars in millions	2015	2016	2017	2017 +/- 2016
CDC Budget Totals – Less Funds from Other Sources				
Vaccines for Children	-3,851	-4,161	-4,387	-226
Energy Employee Occupational Injury Compensation Program	-50	-55	-55	--
Mental Health Mandatory Funding	--	--	-30	-30
World Trade Center Health Program /2	-261	-300	-335	-36
ATSDR ACA Mandatory Funds /3	19	--	--	--
PHS Evaluation Funds	--	--	-72	+72
CORD MACRA Mandatory Funds /4	--	-10	--	--
Prevention and Public Health Fund	-887	-892	-944	-52
User Fees	-2	-2	-2	--
Balances from P.L. 111-32 Pandemic Flu	-15	-15	--	+15
Total, Discretionary Budget Authority	**6,073**	**6,345**	**6,042**	**-303**
Full-Time Equivalents	11,129	11,151	11,151	--

1/ In addition, the FY 2015 appropriation (P.L. 113-235) provided $1.8 billion in emergency resources for Ebola response and preparedness activities.
2/ Federal share resources. This number does not reflect estimated carryover from FY 2016 that is available under reauthorization. Total WTCHP obligations in FY 2017 will be determined upon final review of the FY 2017 spend plan.
3/ Funds are available through FY 2020.
4/ Funds are available through FY 2017.

The Center for Disease Control and Prevention 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) is the nation's health protection agency, working to protect Americans from health and safety threats, both foreign and domestic. In addition, CDC's mission promotes quality of life and prevention of leading causes of disease, injury, disability, and death. These objectives are supported by programs that provide Americans with the essential health information and tools they need to make informed decisions, and protect and advance their health. CDC's highly trained staff provides critical national leadership that works around the world to save lives through proven prevention strategies, disease detection, and response to public health emergencies.

CDC scientists collect and analyze health data, determining how health threats affect specific populations. This has resulted in effective interventions that protect people from scores of public health threats each year. In the past two years, CDC has conducted more than 750 field investigations in 49 states, five United States territories, and in at least 35 different countries. This reach is vital to ensure CDC can determine the cause of illness and probability of additional exposure in order to facilitate proper communication and response.

The FY 2017 Budget request for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.9 billion, an increase of $87 million relative to FY 2016. This total includes $944 million from the Prevention and Public Health Fund (Prevention Fund). The Budget request advances CDC's core mission work by prioritizing efforts to combat antibiotic-resistant bacteria; address the outbreak of opioids misuse, abuse, and overdose; support the improvement of

health outcomes for American Indians and Alaskan Natives; support global health protection; and advance laboratory safety and quality. In addition, the Budget includes targeted reductions based on the increased availability of preventive services as a result of the Affordable Care Act.

IMMUNIZATION AND RESPIRATORY DISEASES

The mission of CDC's National Center for Immunization and Respiratory Diseases is to prevent disease, disability, and death through immunization and by control of respiratory and related diseases. In execution of this mission, CDC focuses on the specific needs of all populations at risk of vaccine-preventable diseases, from children to older adults.

CDC's vaccination efforts are supported by the discretionary Immunization program, and the mandatory Vaccines for Children program. These programs together help improve access to immunization services to uninsured or underinsured individuals in the United States.

The FY 2017 Budget includes $748 million for the discretionary programs supported within CDC's National Center for Immunization and Respiratory Diseases, a decrease of $50 million below FY 2016. The reduction reflects increased insurance coverage for immunization services through expansion of public and private health insurance included in the Affordable Care Act. This funding will continue to support the key activities necessary to achieve national immunization goals, sustain high vaccination coverage rates, and ultimately prevent death and disability from vaccine-preventable diseases. This funding will also continue to support influenza planning and response activities, focusing on: increased demand with healthcare providers for influenza vaccination each season through investments in health communication with providers and the general public; targeted outreach to high-risk populations; and partnerships with pharmacists as a means to extend the reach of influenza vaccinations. A study published in March 2015 indicated that seasonal influenza vaccine prevented more than 40,000 flu-associated deaths in the United States between 2005 and 2014.

HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS AND TUBERCULOSIS PREVENTION

The Budget includes $1.1 billion for domestic HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis prevention, an increase of $5 million over FY 2016. CDC will continue to align activities with *The National HIV/AIDS Strategy: Updated to 2020* through promotion of effective, scalable, and sustainable prevention strategies for individuals living with HIV, in addition to populations at the highest risk for HIV.

The Budget includes $20 million in additional funding for a new demonstration to support increased access to Pre-Exposure Prophylaxis (PrEP) for high-risk populations. PrEP has been shown to reduce the risk of HIV infection by greater than 90 percent when taken as prescribed. The demonstration proposed in the Budget will support expanded access to PrEP, building on pilot efforts to increase use of PrEP for unprotected high-risk individuals, potentially preventing a substantial number of new infections. This demonstration project will allow health departments to use up to 30 percent of these available funds to pay for PrEP medications as the payor of last resort.

The Budget includes a $5 million increase to stop transmission of the virus and prevent viral hepatitis-related illness, disability, and death. CDC's activities support effective vaccination and testing strategies, in addition to detection efforts to identify and treat outbreaks. These activities are critical given the rising infections and mortality associated with the estimated 3 million Americans living with hepatitis C. These efforts and others, align with the priorities outlined in the *HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis.*

To further improve efficiency and impact of prevention efforts, CDC initiated epidemic and economic modeling projects, which were developed in collaboration with University-based researchers. These projects inform planning and implementation of interventions targeting HIV, viral hepatitis, sexually transmitted infections, tuberculosis, and school health. These models will continue to provide critical information on the potential costs, benefits, and return on investment of specific intervention strategies that can have population-level impact.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

The Budget includes $629 million to support CDC's National Center for Emerging and Zoonotic Infectious Diseases, an increase of $50 million over FY 2016. This funding facilitates work to reduce illness and death associated with emerging and zoonotic infectious diseases and to protect against the intentional and unintentional spread of infectious diseases. CDC addresses not only rare, deadly diseases like anthrax and Ebola, but also foodborne diseases, mosquito-borne diseases such as Zika and Chikungunya, water safety issues, healthcare-associated infections, migration and quarantine issues, and the identification and control of diseases transmitted by animals and insects. CDC is staffed by some of the world's top disease detectives -- highly-trained doctors and scientists who investigate and respond to disease and other public health threats. CDC's disease experts contributed to the fight against smallpox, which resulted in eradication, in addition to the discovery of Legionnaire's disease, and work to stop the recent Ebola outbreak in West Africa.

The Budget includes $200 million, an increase of $40 million, to support CDC's Antibiotic Resistance Initiative, along with core antibiotic resistance investments of $18 million, for a total CDC investment in FY 2017 of $218 million to implement the *National Action Plan for Combating Antibiotic-Resistant Bacteria*. The Budget supports implementation of CDC's surveillance, prevention, and stewardship activities outlined in the *National Action Plan* to continue pushing forward to reach the ambitious prevention goals.

PUBLIC HEALTH SCIENTIFIC SERVICES

As a pioneer in collecting and using health data, CDC tracks the health of populations and provides timely data used to respond to urgent health issues. This vital information forms the basis of policymaking, biomedical and health services research, lab safety, and improved access to healthcare for everyone. In addition, CDC advises and supports safe, state-of-the-art laboratories across the United States, as a key line of defense against health threats.

The FY 2017 Budget includes $501 million to support these activities, a $9 million increase above FY 2016. CDC has significant impact through the development of multistate testing methods, data systems that collaborate together, and advanced management methods for domestic disease-detecting laboratories. CDC has also developed Epi INFO™, a software network that helps to rapidly identify diseases outbreaks, used by public health professionals in more than 35 countries.

PROGRAM HIGHLIGHT

Combating Antibiotic-Resistant Bacteria

Antibiotics and similar antimicrobial agents have been used for the last 70 years to treat patients who have infectious diseases. Since the 1940s, these drugs have greatly reduced illness and death. However, these drugs have been used so widely for so long that the infectious organisms the antibiotics are designed to kill have adapted to them, making the drugs less effective.

Each year in the United States, at least two million people become infected with bacteria that are resistant to antibiotics and at least 23,000 die each year as a direct result of these infections. More and more bacteria are becoming resistant to the antibiotics currently in use, which is why aggressive action is needed to prevent new resistance from developing and halt the existing resistance from spreading.

The Budget includes $200 million, an increase of $40 million, to support CDC's Antibiotic Resistance Initiative, along with core antibiotic resistance investments of $18 million, for a total CDC investment in FY 2017 of $218 million to implement the CARB Strategy. This funding will serve to implement the *National Action Plan for Combating Antibiotic-Resistant Bacteria* through activities to reduce the emergence and spread of antibiotic-resistant pathogens, protect patients and communities. CDC predicts that the implementation of measures aimed to prevent infections and improve prescribing practices could save up to 37,000 lives from drug-resistant infections over five years.

The FY 2017 Budget includes an increase of $5 million to continue support for CDC's implementation of laboratory safety recommendations, for a total of $38 million across CDC. This funding will enable CDC to maintain its ability to respond to outbreaks, determine unexplained illnesses, support state and local diagnostics, improve pathogen identification of emerging and re-emerging diseases and maintain the world's most advanced, state-of-the-art infectious disease and environmental public health laboratories.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Chronic diseases are the leading cause of poor health, disability, and death in the United States. More than half of all adults have at least one chronic disease and seven of ten deaths each year are caused by chronic diseases. The medical costs associated with chronic diseases, including mental health and substance abuse, account for 86 percent of the nation's total health care costs, estimated at $2.9 trillion annually. While chronic diseases affect all populations, incidence and prevalence is not evenly distributed. Disease rates vary based on race, ethnicity, education, and income level, with the most disadvantaged Americans most often suffering the highest burden of diseases.

The FY 2017 Budget includes $1.1 billion for chronic disease prevention and health promotion activities, $60 million below FY 2016. This funding will provide critical support to combating the most significant chronic disease issues facing Americans, including tobacco use, heart disease, stroke, diabetes, and cancer.

The FY 2017 Budget includes $30 million for the Racial and Ethnic Approaches to Community Health, which will award a new cooperative agreement incorporating best practices from prior community grant programs, resulting in a stronger, more robust program. Approaches will focus on improving poor nutrition, lack of physical activity, tobacco use, and limited access to clinical and community services by increasing access to healthier environments and quality preventive services. This program will also translate and disseminate grantees' best practices that have demonstrated cost savings and improvement across health outcomes, magnifying the program's impact.

The Budget proposes targeted reductions for direct cancer screening services, due to increased coverage through the Affordable Care Act. In FY 2017 and beyond, CDC's programs will continue to realize cost savings through the benefits provided by Affordable Care Act.

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

CDC's National Center on Birth Defects and Developmental Disabilities focuses on protecting people who are especially vulnerable to health risks – babies, children, people with blood disorders, and people with disabilities. The FY 2017 Budget includes $136 million to support this center's activities, the same as FY 2016.

Birth defects affect one in 33 babies and are a leading cause of infant mortality in the United States. More than 5,500 infants die each year because of birth defects, which is twice as many as from sudden infant death syndrome. In addition, babies who survive and live with birth defects are at increased risk for developing many lifelong physical, cognitive, and social challenges.

PROGRAM HIGHLIGHT

Good Health and Wellness in Indian Country

American Indians and Alaskan Natives bear a disproportionate burden of death, disease, disability, and injury compared to other racial and ethnic groups in the United States. For example, this population has a higher prevalence of obesity – nearly 10 percent more – than their white counterparts.

There has also been increasing concern over the persistently high rates of suicide, particularly amongst the youth in this population. In 2013, the age-adjusted suicide rate for American Indians and Alaskan Natives was 18.3 per 100,000, compared to 13.8 for the overall population. These and other health issues are driven by higher rates of poverty, unemployment, and low educational achievement, which are linked to key risk behaviors, such as alcohol and tobacco use.

The FY 2017 Budget includes $15 million in additional funding for CDC to expand its existing Comprehensive Approach to Good Health and Wellness in Indian Country grant program. Through the current program, CDC works collaboratively with Tribes, tribal organizations, and Tribal Epidemiology Centers to prevent heart disease, diabetes, stroke, and associated risk factors, such as commercial tobacco. With the additional funding, CDC will build upon its existing program to more comprehensively address these chronic conditions, in addition to expanding to address other pressing health issues facing this population, including suicide, prescription drug overdose, and alcohol-related motor vehicle injuries.

CDC works to identify causes of birth defects, find opportunities to prevent them, and improve the health of those living with birth defects. This is accomplished through CDC's implementation of three distinct activities – surveillance or disease tracking, research to identify causes, and prevention research and programs. These key activities allow CDC to rapidly translate

scientific findings into appropriate public health interventions to aid in prevention.

Developmental disabilities, including autism spectrum disorder and cerebral palsy, are impairments in physical, learning, language, or behavioral areas. CDC works to uncover the risk factors for autism and other developmental disabilities to inform prevention programs. The key to successful interventions are CDC's efforts to detect existing developmental delays and intervene early. CDC will continue to support competitive autism awards to states and universities to enhance surveillance and research for autism and other developmental disabilities, monitor prevalence and contributing risk factors, and better inform policies and programs for prevention and services. This tracking and research infrastructure is key to better understanding autism and other developmental disabilities.

The Budget will continue to support activities that improve the health outcomes for individuals with blood disorders, including hemophilia, venous thromboembolism, thalassemia, and sickle cell disease. CDC works to capitalize on opportunities to improve the quality of life for individuals with blood disorders by reducing healthcare costs, improving healthcare utilization, maximizing the impact of proven prevention strategies, and ensuring the safety of America's blood supply.

ENVIRONMENTAL HEALTH

The World Health Organization estimates that 13 percent of the overall disease burden in the United States is due to environmental factors. Specific threats posed by the environment include contamination of drinking water, dangerous retail food practices, rising sea levels, extreme heat and drought, infectious disease, and radiation emergencies.

CDC's National Center for Environmental Health works to prevent illness, disability, and death from interactions between people and the environment. Specifically, this includes supporting research to investigate the effects of the environment on health, monitoring and evaluating environmentally-related health problems through surveillance, and collaborating with international and domestic partners to prepare for and respond to natural, technologic, humanitarian, and terrorism-related environmental emergencies.

This mission will continue to be supported by the FY 2017 Budget, which includes $182 million for these activities, the same as FY 2016. This funding includes $10 million to support a new hearing loss prevention, awareness, and education program that targets young to older adults, low to moderate hearing loss, and social stigma.

PROGRAM HIGHLIGHT

Prescription Drug Overdose

More people died from drug overdoses in the United States in 2014 than during any previous year on record. From 2000 to 2014 nearly half a million people in the United States died from drug overdoses. In 2014, there were approximately one and a half times more drug overdose deaths in the United States than deaths from motor vehicle crashes.

Overdose deaths are only part of the problem – for each death involving prescription opioids, hundreds of people abuse or misuse these drugs. Emergency department visits for prescription painkiller abuse or misuse have doubled in the past few years to nearly half a million. Prescription opioid-related overdoses cost an estimated $20 billion in medical and work-loss costs each year. Stemming this epidemic is essential to CDC's goal of preventing the leading cause of disease, disability, and death.

CDC plays an important role in understanding and addressing the causes of the epidemic and has found that higher prescribing of opioid pain relievers is associated with more overdose deaths. In FY 2017, the Budget includes $80 million for CDC's efforts to address prescription opioids, which is $10 million over FY 2016.

CDC applies its scientific expertise to help curb the epidemic in three ways: improving data quality and surveillance to monitor and respond to the epidemic; supporting states in their efforts to implement effective solutions and interventions; and equipping healthcare providers with the data and tools needed to improve the safety of their patients. The increase in FY 2017 will specifically support the comprehensive translation and dissemination of CDC's Prescription Drug Overdose guidelines for chronic pain outside end-of-life care. This step is critical to ensure increased uptake in the use of the guidelines amongst providers.

INJURY PREVENTION AND CONTROL

In the United States, violence and injuries cost more than $671 billion a year in medical costs and lost productivity. Almost 193,000 individuals in the United

States die from violence and injuries each year: nearly one person every three seconds. In the first half of life, more Americans die from violence and injuries – such as motor vehicle crashes, falls, or homicides – than from any other cause.

CDC's National Center for Injury Control and Prevention is the nation's leading authority on injury and violence, researching prevention techniques and applying solutions to real-world issues, keeping Americans safe, healthy, and productive. The FY 2017 Budget includes $299 million in budget authority for injury prevention and control activities, an increase of $63 million above FY 2016.

In addition to this amount, $30 million is included in the Budget to support a new suicide prevention program through a partnership with CDC's Injury Control Research Centers, state health departments, and in collaboration with the Substance Abuse and Mental Health Services Administration. This program will focus interventions on reducing key risk factors by increasing referral and treatment for suicide behavior, including substance abuse and mental illness, and addressing access to lethal means by individuals at greatest risk of harming themselves and others.

Injury prevention touches upon a variety of issues, including motor vehicle injury, prescription opioid overdose, child abuse and neglect, older adult falls, sexual violence, youth sports concussions, rape prevention, and gun violence. CDC's work has proven that prevention can save lives. For instance, seat belts have reportedly saved an estimated 63,000 lives between 2008 and 2012. Furthermore, school-based programs for violence prevention have been shown to cut violent behavior 29 percent among high school students.

One of CDC's high priorities in the FY 2017 Budget is support to address prescription drug and illicit opioid overdose and prevention. Drug overdose deaths have skyrocketed in the past decade, largely because of prescription opioids. The FY 2017 Budget includes $86 million in funding to support these efforts, which is an increase of $10 million over FY 2016. This funding aligns with the Department-wide opioid initiative. CDC's efforts will advance the initiative's first priority: to improve opioid prescribing practices and reduce opioid use disorders and overdose.

In 2010, an estimated 2.5 million emergency department visits, hospitalizations, or deaths were associated with a traumatic brain injury in the United States. In FY 2017, CDC will continue its work addressing this problem through surveillance, the identification of effective interventions, and work towards the implementation of strategies to prevent and address these injuries, including concussions. CDC will also continue existing collaborative activities with the Administration for Community Living and other partners to address traumatic brain injuries and prevention associated with older adult falls.

OCCUPATIONAL SAFETY AND HEALTH

CDC's National Institute for Occupational Safety and Health works to protect the nation's 157 million workers through research and applied science, addressing the injuries and illnesses that cost the United States $250 billion annually. This work specifically includes: research aimed to reduce work-related illness and injury; promotion of safe and healthy workplaces through interventions, recommendations, and capacity building; and enhancement of international workplace safety and health through global collaborations. This component of CDC works closely with the United States' Department of Labor Occupational Safety and Health Administration and Mine Safety and Health Administration Research to maximize efforts to protect American workers and miners. The FY 2017 Budget includes $286 million to support these programs, a decrease of $54 million below FY 2016. Reductions reflect the elimination of funding for the Agriculture, Forestry, and Fishing program and the Education and Research Centers, given the relation to CDC's mission and the ability to achieve a national impact in a limited-resource environment.

In addition, the Budget includes $335 million in mandatory funding supported by the World Trade Center Health Program, and $55 million in mandatory funding for the Energy Employees Occupational Illness Compensation Program Act. The World Trade Center Health Program has been extended through FY 2090 under the James Zadroga 9/11 Health and Compensation Reauthorization Act. CDC will continue to provide medical monitoring and treatment for eligible responders and survivors of the terrorist attacks that affected New York City, the Pentagon, and Shanksville, Pennsylvania on September 11, 2001.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

Health security depends on the ability of our nation to prevent, protect against, mitigate, respond to, and recover from public health threats. CDC's Office of Public Health Preparedness and Response is committed to strengthening the nation's health security by saving lives and protecting against public health threats, whether at home or abroad, natural or man-made. Specifically, CDC supports state, local, tribal, and territorial partners by providing funding, building capacity, offering technical assistance, and championing their critical role in protecting the public health.

The FY 2017 Budget includes $1.4 billion for CDC's preparedness and response activities, which is $3 million below FY 2016.

PROGRAM HIGHLIGHT

Global Health Security Agenda

Launched February 13, 2014, the Global Health Security Agenda (GHSA) brings the United States and partners around the world together to protect populations from pandemic threats, economic loss, instability, and loss of life. CDC is a key implementer of the GHSA because of its technical expertise, existing country platforms, and strong government-to-government relationships.

In the FY 2017 Budget, CDC's global health and other infectious disease funding supports the goals of the GHSA and includes a targeted $5 million increase to support the Phase Two countries. This level is necessary to maintain foundational support needed to continue to prevent, detect, and respond to infectious disease threats and to address on-going epidemics. 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. If we are to save lives and protect U.S. health security, CDC must accelerate efforts to build the systems and workforce needed to better respond to a range of disease threats.

Within CDC's preparedness activities, the Public Health Emergency Preparedness program advances public health system capability development and strengthens public health emergency management and response programs within state, local, and territorial public health agencies, enabling them to respond to public health threats and build resilient communities. To provide ongoing support to these agreements, the Budget includes $660 million, a decrease of $8 million below FY 2016, which reflects elimination of the Advanced Practice Centers. CDC will continue to support research and training for public health preparedness through the public health preparedness and response agenda. The Public Health Emergency Preparedness program closely aligns with and complements ASPR's Hospital Preparedness Program.

Within this funding, CDC will provide increased support to the improvement of informatics and health information technology, focusing largely on electronic death registration, the National Syndrome Surveillance Program, and disease surveillance enhancements.

The Budget includes $575 million for the Strategic National Stockpile, the same as FY 2016. This funding will provide ongoing support to CDC's management, delivery, storage, and replenishment costs to the medical countermeasures included in the stockpile. At this level, CDC will provide for ongoing replenishments, supporting the nation's level of preparedness for a variety of threats.

Within CDC's preparedness activities, the Budget includes an increase of $5 million for the Select Agent Program. In collaboration with the United States Department of Agriculture, this program is responsible for the regulation, possession, use, and transfer of potentially dangerous biological agents and toxins in the United States. The increase for the Federal Select Agent Program will allow for improved training of inspectors, increased frequency and number of inspections, and increased assistance to registered entities to prevent accidental or intentional release of select agents. Additionally, this program supports CDC's laboratory safety and quality initiative through its work in laboratories handling dangerous pathogens and toxins.

GLOBAL HEALTH

The most effective and least expensive way to protect Americans from diseases and other health threats that begin overseas is to stop them before they spread to our shores. CDC detects and controls disease outbreaks at the source, saving lives and reducing healthcare costs. In addition, fighting diseases like HIV/AIDS, malaria, and tuberculosis help reduce poverty and strengthen stability in developing countries.

CDC engages internationally with 1,700 staff in over 60 countries to protect the health of the American people and save lives worldwide. With scientists and health experts embedded in countries around the globe, CDC works with partners to adapt scientific evidence into policies and public health actions, strengthening public health capacity and improving health outcomes in partner countries.

The FY 2017 Budget includes $449 million for CDC global health activities, which is an increase of $15 million above FY 2016. This funding will continue supporting key global health activities including global HIV/AIDs, global tuberculosis, measles and other vaccine-preventable diseases, parasitic diseases and malaria, and ongoing global health protection. This funding level also includes an increase of $5 million to expand efforts supporting polio eradication.
In addition, this funding supports efforts to expand global health protection worldwide, and implement the goals of the Global Health Security Agenda, to accelerate progress towards a world safe and secure from infectious disease threats and to promote global health security as an international security priority.

BUILDINGS AND FACILITIES

The FY 2017 Budget includes an increase of $21 million, for a total of $31 million, for CDC's facility repair and improvements. With a significant number of CDC's facilities in a mature phase of the facility life cycle, a rigorous, preventive maintenance program is paramount to ensure facility functionality and preparedness for continued service. Investments in FY 2017 will directly support CDC's ability to support its mission to improve public health.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

ATSDR serves the public by using the best science, taking responsible public health actions, and providing trusted health information to prevent harmful exposures and diseases related to toxic substances. Specific functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, health surveillance and registries, response to emergency releases of hazardous substances, applied research in support of public health assessments, information development and dissemination, and education and training concerning hazardous substances.

The FY 2017 Budget includes $75 million for ATSDR, which is the same as FY 2016. This funding level will maintain ATSDR's scientific and programmatic capabilities necessary to safeguard human health.

National Institutes of Health

dollars in millions	2015 /1	2016	2017	2017 +/- 2016
Institutes/Centers				
National Cancer Institute	4,953	5,214	5,894	+680
National Heart, Lung and Blood Institute	2,996	3,114	3,114	—
National Institute of Dental and Craniofacial Research	398	413	413	—
National Inst. of Diabetes & Digestive & Kidney Diseases	1,899	1,966	1,966	—
National Institute of Neurological Disorders and Stroke	1,605	1,695	1,695	—
National Institute of Allergy and Infectious Diseases	4,418	4,716	4,716	—
National Institute of General Medical Sciences	2,372	2,512	2,512	—
Eunice K. Shriver Natl. Inst. of Child Health & Human Development	1,287	1,338	1,338	—
National Eye Institute	677	708	708	—
National Institute of Environmental Health Sciences: Labor/HHS Appropriation	667	694	694	—
National Institute of Environmental Health Sciences: Interior Appropriation	77	77	77	—
National Institute on Aging	1,198	1,598	1,598	—
Natl. Inst. of Arthritis & Musculoskeletal & Skin Diseases	522	542	542	—
Natl. Inst. on Deafness and Communication Disorders	405	423	423	—
National Institute of Mental Health	1,434	1,519	1,519	—
National Institute on Drug Abuse	1,016	1,051	1,051	—
National Institute on Alcohol Abuse and Alcoholism	447	467	467	—
National Institute of Nursing Research	141	146	146	—
National Human Genome Research Institute	499	513	513	—
Natl. Institute of Biomedical Imaging and Bioengineering	327	344	344	—
Natl. Institute on Minority Health and Health Disparities	271	281	281	—
Natl. Center for Complementary and Integrative Health	124	130	130	—
National Center for Advancing Translational Sciences	633	685	685	—
Fogarty International Center	68	70	70	—
National Library of Medicine	337	396	396	—
Office of the Director	1,414	1,571	1,716	+145
Buildings and Facilities	129	129	129	—
Total, Program Level	**30,311**	**32,311**	**33,136**	**+825**

National Institutes of Health

dollars in millions	2015	2016	2017	2017 +/- 2016
Less Funds from Other Sources				
PHS Evaluation Funds	-715	-780	-847	-67
Type 1 Diabetes Research (NIDDK) /2	-150	-150	-150	—
Additional Mandatory Funds	—	—	-1,825	-1,825
Total, Discretionary Budget Authority	**29,446**	**31,381**	**30,314**	**-1,067**
Appropriations				
Labor/HHS Appropriation	29,370	31,304	30,237	-1,067
Interior Appropriation	77	77	77	—
Full-Time Equivalents	17,823	18,000	18,000	—

1/ In addition, the FY 2015 appropriation (P.L. 113-235) provided $239 million of emergency resources for Ebola response and preparedness research activities.
2/ These mandatory funds were appropriated in P.L. 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, and P.L. 113-93, the Protecting Access to Medicare Act of 2014.

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 National Institutes of Health (NIH) is the nation's medical research agency and leads the world in supporting innovative multidisciplinary biomedical and behavioral research. NIH investments across its 27 Institutes and Centers in basic research support translating scientific discovery into tangible improvements in our health care system. To date, 148 NIH supported researchers have been sole or shared winners of the Nobel Prize.

The FY 2017 Budget includes $33.1 billion, an increase of $825 million over FY 2016, for NIH to accelerate groundbreaking research on cancer, precision medicine, and the human brain, and to maintain the significant investments enacted in FY 2016. The Budget supports the Administration's priority to continue a strong focus in biomedical research that will increase the nation's knowledge base, cultivate a world-class scientific workforce, provide opportunity for new discovery, and promote longer and healthier lives.

In FY 2017, NIH estimates it will support a total of 36,440 research project grants, an increase of 600 above FY 2016, including a total of 9,946 new and competing grants. Of the total, approximately 81 percent of NIH resources will support the research community external to NIH which includes over 30,000 individuals at more than 2,500 organizations comprised of universities, medical schools, research facilities, and hospitals. The remaining 19 percent of resources will be invested within the agency to support clinical and basic research, as well as training to ensure that knowledge among NIH physician and scientists is leading the world.

NIH FY 2017 STRATEGIC RESEARCH PRIORITIES

In late 2015, NIH released an agency-wide research strategic plan for FY 2016 through FY 2020. This plan establishes the research framework for the next five years and describes how NIH will work with public and private sector partners to promote scientific innovation while also continuing to serve as wise stewards of resources to optimize investments for biomedical research. NIH will use this strategic plan to harmonize decisions across the agency while maintaining the visions of individual Institutes, Centers, and program offices. The NIH strategy focuses on four independent objectives:

1. Advance Opportunities in Biomedical Research;
2. Foster Innovation by Setting NIH Priorities;
3. Enhance Scientific Stewardship; and,
4. Excel as a Federal Science Agency by Managing for Results.

In FY 2017, NIH will use this strategic vision to focus on the priorities of generating basic science findings, translating these basic discoveries into improvements in personal and public health, the enhanced use of

comprehensive data sets and technology, and recruiting a diverse, creative, and talented workforce upon which the robust research enterprise depends.

The Foundation for Discoveries: Basic Research

Approximately 52 percent of the NIH research budget is devoted to basic biomedical and behavioral research. Genomics and proteomics have provided insights into how the basic components of life function. Advances in stem cells, imaging, and other technologies have transformed our understanding of how life works.

Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative: In FY 2017, NIH plans to spend $195 million, an increase of $45 million above FY 2016, to continue to address fundamental neuroscience questions and advance understanding of the human brain. In order to accomplish the ambitious goals of this Initiative, NIH will increase its investment to support groundbreaking neuroscience research, neuroimaging, and training initiatives, as well as potential projects to collaborate with industry to test and develop devices for mapping and tuning brain circuitry. Measuring activity at the scale of neural networks in living organisms has the potential to decode sensory experience, memory, emotion, and thought. Furthermore, developing these technologies may help reveal the mechanisms that underlie the pathology in various brain disorders and provide new therapeutic avenues to treat, cure, and prevent neurological and psychiatric conditions.

Translating Discovery into Health

NIH is committed to rapidly turning observations in the laboratory into effective interventions that improve the health of individuals. These new interventions include diagnostics, therapeutics, medical procedures, behavioral changes, and disease prevention strategies.

Antimicrobial Resistance: NIH estimates it will spend $413 million in FY 2017, the same as FY 2016, to respond comprehensively to the growing public health threat of antibiotic resistant bacteria. With antibiotic-resistant infections claiming the lives of 23,000 Americans each year, NIH is continuing to invest in research to support of the Administration's National Strategy to Combat Antibiotic Resistant Bacteria. These funds will accelerate the development of new therapeutics, vaccines, and first-in-class drugs to more effectively treat these "superbugs." To identify the root causes of this problem, NIH conducts basic research on how antimicrobial resistance emerges, spreads, and evolves. NIH is also intensifying studies on rapid diagnostics to help ensure that dangerous strains are quickly identified and appropriately treated; developing a national database of genome sequence data of all reported human antimicrobial-resistant infections; and creating a rapid response clinical trial network to test new antibiotics on individuals infected with resistant strains. NIH-funded researchers recently made a major breakthrough in the fight against antimicrobial resistance by using a new screening technology to discover a new, highly effective antibiotic identified from ordinary topsoil. This promising development is just one piece of NIH's ongoing efforts to fight antibiotic resistance.

Alzheimer's Disease: NIH will spend $910 million on Alzheimer's research in FY 2017, the same as FY 2016. The Budget continues to invest in aggressive efforts to understand and make progress in treating and preventing this disease. Research supported by NIH and other organizations has greatly expanded knowledge and understanding of brain function, risk factors, treatment, and prevention. NIH-supported imaging studies have provided dramatic insights into the disease's causes and progression, and the need to

NEW INITIATIVE

Vice President's Cancer Moonshot

As a part of the cancer "moonshot" announced by the President in the State of the Union Address, the Budget provides an increase of $755 million to accelerate progress in preventing, diagnosing, and treating cancer. The Budget's multi-year cancer initiative, with support beginning in FY 2016 within NIH, provides additional resources to NIH and the Food and Drug Administration in FY 2017, to improve health and outcomes for patients through investments in research and infrastructure, and brings together researchers across sectors and scientific disciplines. Within the $755 million total, the Budget allocates $680 million for NIH and $75 million for FDA.

Given new insights into the causes of cancer and its diagnosis and treatment, this initiative is poised to increase resources to make the most promising breakthroughs available to patients across America. Targeted investments will advance research on new approaches to preventing and treating cancer, such immunotherapy, enhanced early detection technologies, developing vaccines to prevent cancers caused by viruses, genomic analysis of tumor cells, and identifying common treatment opportunities for rare pediatric cancers through better collect and analysis of tumor specimens. This effort will drive progress toward a national effort to make dramatic progress in fight against cancer.

initiate clinical trials at the earliest stages of disease has become increasingly clear. While much more remains to be discovered, recent research has led to more than 90 drugs in clinical trials for Alzheimer's disease with many more in the pipeline awaiting regulatory approval to enter human testing. In addition, the Accelerating Medicines Partnership, a NIH-led public-private partnership to transform and accelerate drug development, recently launched a new Alzheimer's Big Data portal to catalyze new analyses and pharmaceutical discovery projects. These investments will contribute to meeting the goal to prevent and effectively treat Alzheimer's disease by 2025, in support of the National Plan to Address Alzheimer's Disease.

Cancer: In FY 2017, NIH plans to spend $6.3 billion on cancer research and treatment development, an increase of $680 million above FY 2016. NIH has been at the forefront of many exciting advancements such as transitioning the treatment of cancer from a one-size-fits-all approach to one in which treatments are based on the molecular characteristics of each patient's disease. Additionally, National Cancer Institute researchers have identified several types of gastrointestinal cancers that have tumor-specific mutations that can be recognized by the immune system, potentially offering a new therapeutic opportunity for patients with these tumors.

Building upon these recent developments, NIH plans to expand investments through an initiative to support the Vice President's Cancer Moonshot. In FY 2017, the Budget provides $680 million to NIH for this initiative in order to galvanize the nation's efforts to combat cancer. NIH will pursue new cancer vaccine technology, investigate novel diagnostic tests that detect tumors through simple blood tests, and expand access to clinical trial data in an effort to reduce the number of people who develop cancer and improve outcomes for those who do. These funds will also be used to invest in the Vice President's Exceptional Opportunities in Cancer Research Fund, ensuring that resources are available to pursue investigations, at academic sites or public-private partnerships, worthy of potential breakthrough status.

Strengthen and Sustain a Diverse and Talented Biomedical Research Workforce

The biomedical research workforce is the backbone is scientific discovery. Supporting a diverse, creative, innovative, and productive group of young scientists is key to sustaining the nation's biomedical research enterprise and achieving improved health for the American people. To fully support and sustain the best scientists in the biomedical workforce, NIH will expand ways to revitalize physician-scientist training, continue to encourage early stage investigators, further enhance workforce diversity, and support more person-centered grants that focus on an investigator's entire research program and their history of success rather than a specific project. In FY 2017, NIH will continue to emphasize several High-Risk, High Reward research programs to allow scientists more freedom to innovate and explore new lines of inquiry.

In order to continue to attract the brightest minds to biomedical research, NIH is committed to enhancing the diversity of its funded workforce. NIH will also continue to implement a series of steps to expand its effort to recruit and advance the careers of people traditionally underrepresented in the biomedical and behavioral research workforce. The Enhancing the Diversity of the NIH-funded Workforce initiative will make training awards focused on learning how to attract and retain students from diverse backgrounds into biomedical research, increase access to high-quality research mentorship, and develop and disseminate best practices for training and mentorship. The Budget includes an estimated total of $849 million to support 16,421 research scientist trainees through the Ruth L. Kirschstein National Research Service Awards program. To maintain stipends' purchasing power, NIH proposes a two percent stipend increase for predoctoral and postdoctoral recipients in FY 2017.

Advancing HIV/AIDS Research

In August 2015, NIH announced a strategic approach to investing resources for HIV/AIDS research by focusing on a set of new high priority areas:

- Reduce the incidence of HIV/AIDS, including by the development of safe and effective vaccines;
- Develop the next generation of HIV therapies with improved safety and ease of use;
- Improve our capability to prevent and treat HIV-associated comorbidities and co-infections; and,
- Support cross cutting areas of basic research, health disparities, and training.

These priorities, which were presented during a meeting of the Advisory Committee to the NIH Director, were identified by conducting a review of the agency-wide HIV/AIDS portfolio. The strategic focus areas will ensure that research funded is aligned with new HIV/AIDS research opportunities.

In FY 2017, NIH estimates it will maintain the level of support for research on HIV/AIDS from FY 2016 at $3.0 billion. Activities under this new framework will

invest resources in the highest priority areas and continue to support our ability to achieve the goals of the National HIV/AIDS Strategy and Federal Action Plan. With the evidence that pre-exposure preventive treatments and test-and-treat programs can reduce the incidence of new cases, coupled with the growing promise of safe, effective, and affordable vaccines, the world can realistically imagine achieving an AIDS-free generation.

PROGRAM HIGHLIGHT

Precision Medicine Initiative

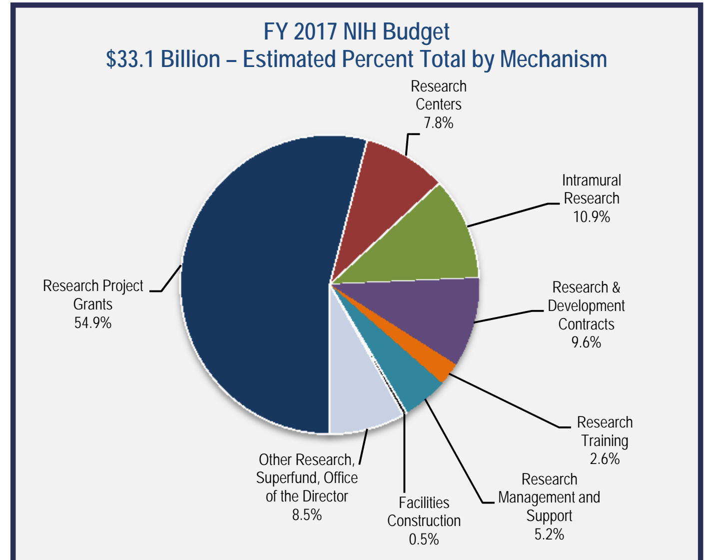
The convergence of incredible breakthroughs in genomics, computing, and molecular medicine has paved the way for a new era of medicine: one that delivers the right treatment at the right time. The Budget proposes a HHS total of $309 million to continue scaling up the Precision Medicine, which is focused on developing treatments, diagnostics, and prevention strategies tailored to the individual genetic characteristics of each patient. This includes $300 million at NIH, an increase of $100 million above FY 2016. The increase funding will support a major scale up of a research cohort of a million or more individuals to extend precision medicine to many more diseases. In addition, funding will continue for the National Cancer Institute to lead research efforts on cancer genomics.

The Budget also includes $4 million for FDA and $5 million for ONC to pursue standards and technology efforts that support precision medicine and protect user privacy.

NIH is making significant progress on this project. BY the end of 2016, NIH expects to complete a pilot of volunteer recruitment and engagement strategies for the 1 million participant cohort, enroll tens of thousands of individuals, start collecting bio-specimens for analysis, use the collected data to launch multiple research studies, secure partnerships with at least five major healthcare provider organizations, and deploy a secure, customizable digital platform for data collection and interaction with participants. A sustained investment is needed to continue scaling up these activities in FY 2017.

Research Project Grants

NIH estimates that it will allocate $18.2 billion, or 55 percent of its total budget, to finance a total of 36,440 competitive, peer reviewed, and largely investigator-initiated research project grants (RPGs) in FY 2017. Of these grants, NIH anticipates supporting 9,946 new and competing RPGs, a decrease of 807 grants from FY 2016.



INTRAMURAL BUILDINGS AND FACILITIES

In FY 2017, NIH requests a total of $179 million for intramural Buildings and Facilities, an increase of $34 million above FY 2016, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. The Building and Facilities mechanism total also includes $50 million, an increase of $34 million, requested within the National Cancer Institute budget for high need facilities repair and improvement projects at its Frederick, Maryland campus. These investments directly support mission critical activities by ensuring that our infrastructure can support the innovate work of our leading scientists.

Overview by Mechanism

dollars in millions	2015	2016	2017	2017 +/– 2016
Mechanism				
Research Project Grants (dollars)	16,442	17,821	18,207	+386
[# of Non-Competing Grants]	*[23,261]*	*[23,367]*	*[24,608]*	*[+1,241]*
[# of New/Competing Grants]	*[9,540]*	*[10,753]*	*[9,946]*	*[-807]*
[# of Small Business Grants]	*[1,578]*	*[1,720]*	*[1,886]*	*[+166]*
[Total # of Grants]	*[34,379]*	*[35,840]*	*[36,440]*	*[+600]*
Research Centers	2,663	2,645	2,589	-56
Other Research	1,803	2,011	2,084	+73
Research Training	758	830	849	+18
Research and Development Contracts	2,828	2,915	3,173	+258
Intramural Research	3,410	3,582	3,615	+33
Research Management and Support	1,620	1,685	1,719	+34
Office of the Director	573	600	645	+45
NIH Common Fund (non-add)	*[546]*	*[676]*	*[776]*	*[+100]*
Buildings and Facilities	137	145	179	+34
NIEHS Interior Appropriation (Superfund)	77	77	77	—
Total, Program Level	**30,311**	**32,311**	**33,136**	**+825**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds	-715	-780	-847	-67
Type 1 Diabetes Research (NIDDK) /1	-150	-150	-150	—
Additional Mandatory Funds	—	—	1,825	+1,825
Total, Budget Authority	**29,446**	**31,381**	**30,314**	**-1,067**
Labor/HHS Appropriation /2	29,369	31,304	30,237	-1,067
Interior Appropriation	77	77	77	—

1/ These mandatory funds were appropriated in P.L. 114 10, the Medicare Access and CHIP Reauthorization Act of 2015, and P.L. 113-93, the Protecting Access to Medicare Act of 2014.

2/ In addition, the FY 2015 appropriation (P.L. 113-235) provided $239 million in emergency resources for Ebola response and preparedness research activities.

Substance Abuse and Mental Health Services Administration

dollars in millions	2015	2016	2017	2017 +/-2016
Mental Health				
Community Mental Health Services Block Grant	483	533	533	--
Programs of Regional and National Significance	371	407	406	-0.2
Children's Mental Health Services	117	119	119	--
Set-Aside for Youth in the Prodrome Phase of Psychosis (non-add)	--	--	*12*	*+12*
Projects for Assistance in Transition from Homelessness	65	65	65	--
Protection and Advocacy for Individuals with Mental Illness	36	36	36	--
Evidence-Based Early Interventions (Mandatory)	--	--	115	+115
Subtotal, Mental Health	**1,071**	**1,159**	**1,274**	**+115**
Substance Abuse Treatment				
Substance Abuse Prevention and Treatment Block Grant	1,820	1,858	1,858	--
State Targeted Response Cooperative Agreements (Mandatory)	--	--	460	+460
Programs of Regional and National Significance	361	334	343	+9
Subtotal, Substance Abuse Treatment	**2,181**	**2,192**	**2,661**	**+469**
Substance Abuse Prevention				
Programs of Regional and National Significance	175	211	211	--
Subtotal, Substance Abuse Prevention	**175**	**211**	**211**	**--**
Health Surveillance and Program Support /1				
Program Support	72	80	78	-2
Health Surveillance	47	47	47	--
Agency-Wide Initiatives	12	13	23	+10
Public Awareness and Support	13	16	13	-2
Performance and Quality Information Systems	13	13	13	--
Data Request and Publications User Fees	2	2	2	--
Subtotal, Health Surveillance and Program Support	**159**	**169**	**175**	**+6**
SAMHSA Budget Totals, Program Level				
Total, Program Level	**3,586**	**3,731**	**4,322**	**+590**
Less Funds From Other Sources:				
Evidence-Based Early Interventions (Mandatory)	--	--	*-115*	*-115*
Cohort Monitoring and Evaluation of MAT Outcomes (Mandatory)	--	--	*-15*	*-15*
State Targeted Response Cooperative Agreements (Mandatory)	--	--	*-460*	*-460*
PHS Evaluation Funds	*-134*	*-134*	*-214*	*-80*
Prevention and Public Health Fund	*-12*	*-12*	*-28*	*-16*
User Fees for Data Request and Publications	*-2*	*-2*	*-2*	--
Total, Discretionary Budget Authority	**3,439**	**3,584**	**3,489**	**-95**
Full-Time Equivalents	614	665	665	--

1/ Comparably adjusted to reflect the transfer of the Behavioral Health Workforce Education and Training Program from SAMHSA to HRSA in FY 2017 and single appropriation for the Minority Fellowship Program.

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

The FY 2017 Budget requests $4.3 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), $590 million above FY 2016. SAMHSA programs help provide treatment and services for people with mental and substance use disorders, support the families of people with mental and substance use disorders, build strong and supportive communities, prevent costly behavioral health conditions, and promote better health for all Americans.

The Budget makes critical new investments to help to ensure that every American who wants treatment for opioid use disorder can access it, improve care to those with serious mental illness, promote mental health, prevent suicide across the entire lifespan, and help communities establish effective crisis response systems. The FY 2017 Budget continues the Administration's commitment to tackling the epidemic of overdose deaths related to opioids—a class of drugs that include prescription pain relievers and heroin—that is claiming the lives of 78 Americans every day.

Untreated behavioral health conditions have serious effects on individuals' lives and on health care costs. For example, co-occurring psychiatric conditions and chronic medical conditions are associated with significantly more expensive care due in large part to poor self-care and more acute episodes of needed healthcare. These increased costs, however, still leave people with a serious mental illness with an average life expectancy 8 years shorter than those without these conditions. Treatment of mental and substance use disorders however can lead to improved physical health and lower overall health care costs. To this end, the Budget proposes a near 16 percent increase for SAMHSA.

IMPROVING AMERICA'S BEHAVIORAL HEALTH

The Budget includes a series of new investments in SAMHSA to better address the mental and other behavioral health care needs of the American people by engaging individuals with serious mental illness in care, ensuring the behavioral health care system works for everyone, and expanding service and workforce capacity.

Engaging Individuals with Serious Mental Illness in Care

While individuals with mental illness are more likely to be victims of violence than perpetrators, recent tragedies continue to highlight a crisis in America's mental health system. Today, less than half of children and adults with diagnosable mental disorders receive the treatment they need. The Budget proposes $137 million in key new investments in SAMHSA in FY 2017 to improve access to care for those with mental disorders and proposes new flexibilities to ensure that communities have systems-wide approaches for identifying and serving individuals in or at risk of a behavioral health crisis.

The Budget proposes $115 million new mandatory investment in each of FY 2017 and 2018 for a new formula grant for states for evidence-based early intervention programs for individuals with serious mental illnesses. This effort builds on research funded by the National Institute of Mental Health, the Recovery After an Initial Schizophrenia Episode (RAISE) study, and experiences of states implementing a new set-aside within the Community Mental Health Services Block Grant. The RAISE study found that engaging individuals with or at risk for serious mental illness in to care early can reduce the disability associated with mental illness. This program enables all states to establish at least one early intervention program and enable states that already have such programs to further expand their efforts.

The Budget continues to provide $533 million, the same level as FY 2016, for the Community Mental Health Services Block Grant. Although this funding represents only one percent of all state and federal spending on mental health care in the United States, it provides significant leverage to assist public mental health systems that serve nearly 8 million individuals with serious mental illness through flexible funding for services that may not otherwise be available to them. Within this amount, the Budget maintains the 10 percent set-aside of $50 million for evidence-based programs which intervene early in the onset of serious mental illness.

The Budget also proposes a set-aside within the Children's Mental Health Services Program to dedicate up to 10 percent of the $119 million for this program to

focus on youth and young adults who are at clinical high risk for developing a first episode of psychosis. This approach builds on the abundance of data accumulated over the past two decades, including a large-scale research initiative launched in 2009 by the National Institute of Mental Health, which strongly indicate that coordinated and specialized services offered during or shortly after a first episode of psychosis are effective for improving clinical and functional outcomes among youth and young adults at risk for serious mental illness. This new demonstration will apply this research to those at high risk of first episode psychosis as well. Along with the base program, this demonstration will continue to focus on reducing the impact of serious mental illness through the development of comprehensive, community-based services that incorporate family-driven, youth-guided care.

In addition, the Budget continues a new program first funded in FY 2016, Assisted Outpatient Treatment for Individuals with Serious Mental Illness. This $15 million program will provide grants to communities to test approaches to reduce hospitalization, homelessness, and interaction with the criminal justice system while improving the health and social outcomes of the patient. Grantees will evaluate the medical and social needs of the patients who are participating in the program. Grantees also will implement a treatment plan that includes criteria for completion of court-ordered treatment and provides for monitoring of the patient's compliance with the treatment plan.

The Budget also responds to a national need for improved service and workforce capacity to respond to behavioral health crises at the state and community level through a new, targeted demonstration grant program, Crisis Systems. This $10 million program will help states and communities build, fund, and sustain crisis response systems. The funded crisis systems will be capable of preventing and de-escalating behavioral health crises. This demonstration will test models of effective, coordinated, and integrated crisis response systems. After assisting grantees to develop the necessary infrastructure for a comprehensive crisis response system, such as prevention and planning efforts, the grants will help mitigate demand for inpatient beds by those with serious mental illness and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports.

NEW INITIATIVE

Expanding Access to Treatment to Reduce Prescription Drug Abuse and Heroin Use

The Budget includes $1 billion in new mandatory funding in SAMHSA and the Health Resources and Services Administration over two years to close the gap between those who seek treatment for opioid use disorder and those who can access it. In addition to ongoing efforts to assist individuals to get into care, the Budget invests this new mandatory and discretionary funding to expand the behavioral health workforce, through new loan repayment awards, including enhanced loan repayment to clinicians with medication assisted treatment training in the National Health Service Corps, supporting innovative medication-assisted treatment delivery programs, and supplementing treatment costs for uninsured and underinsured patients. In addition, funds within this program will support additional investments in telehealth and health information technology integration.

Ensuring that the Behavioral Health Care System Works for Everyone

The Budget continues to drive services toward evidence-based practices and reach children, adolescents and young adults in the earliest stages of psychosis to prevent escalation of behavioral health conditions.

The President's *Now is the Time* initiative continues to lay out changes toward a healthier and safer country. The Budget invests a total of $198 million across the Department, an increase of $39 million above FY 2016. This funding will continue to support SAMHSA and HRSA in improving access to mental health services for young people and CDC in researching the causes of and best ways to reduce gun violence. Within SAMHSA, a total of $108 million, an increase of $15 million, will help make sure students and young adults get treatment for mental disorders. These efforts will reach one million young people every year through programs that promote mental health through identifying mental illness early and creating a clear pathway to treatment for those in need, including through additional outreach and training for those who work with youth.

The Budget includes an additional net increase of $15 million for *Now is the Time* within SAMHSA for:

- Project AWARE State Grants, a $57 million program, an increase of $7 million above FY 2016, to serve more than four million children

by improving local coordination of resources and responding to youth with signs of mental illness. This successful program helps those in contact with youth understand how to make a critical first referral to treatment, and helps communities ensure that treatment is coordinated; and

- Peer Professionals, a new $10 million program to increase the number of trained peers, recovery coaches, mental health and addiction specialists, prevention specialists, and pre-Master's level addiction counselors in light of research showing people who regularly engage in peer-delivered interventions are more likely to abstain from substance abuse.

Preventing Suicide

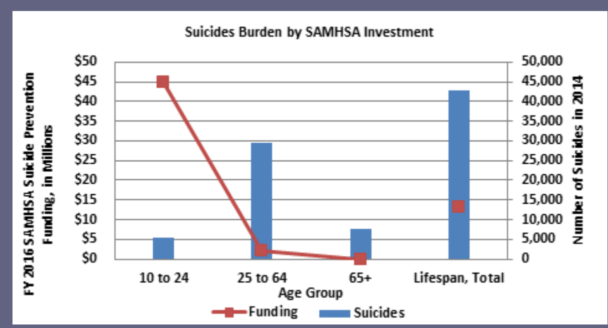
The Budget provides $88 million, an increase of $28 million above FY 2016, to prevent suicide. Suicide is the 10th leading cause of death for all ages, representing nearly 43,000 deaths in 2014. The Budget provides a critical increase in funding to expand the implementation of recommendations of the National Strategy for Suicide Prevention, the nation's blueprint for reducing suicide over the next decade. Within this increase, $26 million will support Zero Suicide, a comprehensive, multi-setting approach to suicide prevention in health systems, and $2 million to implement other recommendations of the National Strategy. Examples of the recommendations are changes in provider training requirements at the accreditation level, emergency room referral processes, and clinical care standards to maximize post-discharge continuity of care. Zero Suicide's focus on prevention within existing health systems and among a population at highest risk, such as adults between the ages of 25 and 64, will ensure the most effective use of funds toward this critical issue. This initiative will include a 20 percent set-aside for tribal communities.

In addition to these new activities, SAMHSA will continue to operate the Garrett Lee Smith and American Indian and Native Alaskan Suicide Prevention Initiative, which provides funding to states and Tribes to develop and implement youth suicide prevention and early intervention strategies. These programs operate in partnership with education and juvenile justice systems, youth support organizations, and other community organizations. The Budget also maintains the capacity of the National Suicide Prevention Lifeline, a free-to-call hotline of certified local crisis centers which answered over 1.3 million calls from those in need in 2014.

NEW INITIATIVE

National Strategy for Suicide Prevention: Aligning Resources with Needs

The Budget includes $28 million in new funding to expand implementation of the National Strategy for Suicide Prevention. This funding, including $26 million for a new Zero Suicide initiative, is designed to bring the most effective strategies targeting the most critical populations to scale. In FY 2016, 76 percent of SAMHSA suicide prevention funding was targeted to youth and young adults through age 24. However, 70 percent of suicides are completed by individuals between the ages of 25 and 64. The Budget increases suicide prevention funding for all ages to implement recommendations of the National Strategy for Suicide Prevention to focus on the entire lifespan and to enable health systems to adopt the Zero Suicide approach.



Promoting Mental Health and Preventing Suicide and Substance Abuse among Tribes

As part of the Administration's Generation Indigenous initiative, created to remove the barriers to success for Native youth, SAMHSA and the Indian Health Service (IHS) will continue to support expanded tribal behavioral health efforts. The Budget provides $30 million in SAMHSA for Tribal Behavioral Health Grants to tribal entities to promote mental health and address substance abuse among American Indian and Alaska Native young people. In collaboration with IHS and in consultation with tribal leaders, this funding will help to address the disproportionate burden of mental illness, substance abuse, and suicide faced in many American Indian and Alaska Native communities by helping Tribes implement evidence-based suicide prevention programs and integrate systems that address issues of child abuse and neglect, family violence, trauma, and substance abuse. In addition, $5 million in new funding will be available under Zero Suicide to ensure Tribes have access to the best evidence-based practices to prevent suicide within existing health systems.

EXPANDING PREVENTION AND TREATMENT OF SUBSTANCE ABUSE PREVENTION

The Budget includes $1.9 billion for the Substance Abuse Prevention and Treatment Block Grant. The block grant program maintains the nation's public substance abuse prevention and treatment infrastructure through grants to states and represents 32 percent of total state substance abuse agency funding. The block grant will support services provided through public health care systems to approximately 2 million individuals, including medical services, provider education, supported employment and housing, rehabilitation, crisis stabilization, and case management services. The program will also provide wrap around services for children and families such as education, counseling, on-site child care or transportation of children, and parenting classes. These resources provide necessary care for the uninsured and support services not paid for by insurance.

Addressing the Prescription Drug Abuse and Heroin Use Epidemic

Across the nation in 2014, nearly 29,000 individuals died from opioid overdose, primarily prescription pain relievers and heroin. Prescription opioid abuse costs alone were estimated in 2011 to be over $50 billion per year, including health care costs, workplace costs such as lost productivity, and criminal justice costs. States play a central role in the prevention, treatment, and recovery efforts for this growing epidemic.

The Budget provides $559 million in new mandatory and discretionary funding in FY 2017 across the Department to address this growing epidemic, for a total of $686 million. In FY 2016, Congress provided $93 million in new resources above FY 2015 to address this critical issue, in response to requests in the President's Budget. The Budget continues to implement and expand the Secretary's Opioid Initiative through three priority areas: improving prescribing practices, expanding the use of medication-assisted treatment, and expanding the use of the overdose-reversal agent naloxone. Within SAMHSA, the Budget provides mandatory and discretionary increases of $510 million above FY 2016, for a total of $557 million in programs that will expand the availability of naloxone and medication-assisted treatment, as well as improve state planning and coordination efforts.

The Budget includes a new mandatory investment of $1 billion across the Department over two years to help ensure every American who wants help for opioid use disorder can access it by making medication-assisted treatment affordable and available. Within SAMHSA, this investment includes $460 million per year for two years for cooperative agreements with states to support evidenced-based programs that help people access treatment and recovery support. This program will target the barriers individuals most commonly identify as preventing them from seeking and successfully completing treatment and achieving recovery.

The Budget doubles funding to $50 million within SAMHSA for Medication-Assisted Treatment for the Prescription Drug and Opioid Addiction Program in communities suffering from high rates of addiction to opioids. This funding will reach 45 states. Medication-assisted treatment is proven to be an effective intervention for individuals suffering from opioid use disorder. This program will allow grantees to offer Food and Drug Administration-approved, evidence-based opioid addiction treatment services and recovery supports. These approved services and supports will include pharmacotherapies such as methadone, buprenorphine, and naltrexone, and will also increase provider and community awareness of this important, evidence-based approach.

In addition, the Budget includes $15 million per year for two years in mandatory funds to better monitor the effectiveness of treatment programs employing different treatment modalities under real-world conditions. The program would evaluate the short-, medium-, and long-term outcomes of substance abuse treatment programs in order to increase effectiveness in reducing opioid use disorder, overdoses, and opioid-related death.

SAMHSA will continue to use $12 million, the same level as FY 2016, for grants to *Prevent Prescription Drug and Opioid Overdose Related Deaths*. The grants are for states to purchase naloxone, an overdose-reversing drug, equip first responders in high-risk communities with this drug and training on its use, prepare overdose kits, and provide education to the public. This funding complements ongoing opioid overdose prevention efforts by ensuring communities are prepared not only to resuscitate those experiencing an overdose, but also to connect them effectively to care.

The Budget also continues $10 million in the *Strategic Prevention Framework: Rx* Program for grants to states to enhance, implement, and evaluate strategies to prevent prescription drug misuse and abuse. The program also helps to improve collaboration on the risks of overprescribing and the use of monitoring systems between states' public health and education authorities and between pharmaceutical and medical communities.

In addition, the Budget provides $10 million in new funding to establish a Buprenorphine Prescribing Authority Demonstration to test the impact of expanding buprenorphine prescribing authority to non-physicians on both accesses to medication-assisted treatment and the diversion of drugs for non-legitimate purposes.

More must be done to address the shortage of providers of this medication, however. In addition to and separately from investigating the optimal types of providers, the Department is working on rulemaking to update federal regulations to take advantage of every authority available to address the need for improved access to medication-assisted treatment. Physicians are limited to prescribing buprenorphine to a maximum of 30 patients during the physician's first year of participation in the program. After 1 year, the physicians may request authorization to prescribe up to a maximum of 100 patients.

DEVELOPING INNOVATIVE SOLUTIONS FOR TOMORROW

Encouraging Innovative Approaches to Heath Care

SAMHSA's Programs of Regional and National Significance are intended to be laboratories fostering innovative solutions to substance abuse and mental health needs. The Budget includes $961 million for these programs in SAMHSA for small-scale, agile evaluations of promising approaches to the nation's most challenging behavioral health concerns.

For example, the Budget proposes a new set-aside within the Pregnant and Postpartum Women Program. Up to 25 percent of this $16 million program will be used to explore strategies to serve more women and families through direct payment of outpatient services and to establish collaborative approaches to address these needs once the grant has ended. Both the base and set-aside components of the program will continue to support the availability of comprehensive, residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women.

The Budget also continues important ongoing efforts that support the behavioral health community at large. For example, SAMHSA's National Registry of Evidence-Based Programs and Practices, a searchable online database of independently assessed mental health and substance abuse interventions, now includes more than 350 interventions, up from 340 last year. This resource helps inform the public and the medical community about the effectiveness and readiness for dissemination of interventions.

ENSURING CONTINUED IMPROVEMENTS IN PROGRAM MANAGEMENT

Health Surveillance and Program Support

The Budget provides a total of $125 million to ensure responsible and prudent management of federal resources. This amount is a reduction of $2 million below FY 2016 attributable to the elimination of one-time costs and is for the relocation of SAMHSA's headquarters in FY 2016.

The Budget continues to support national survey efforts and the analyses conducted through them, which are used by federal, state, and local authorities, as well as other health care stakeholders, to inform mental health and substance abuse policy. In addition, the Budget continues other administration and monitoring of SAMHSA programs and grantees at the same level as FY 2016. The Budget also includes a focus on program integrity to ensure that scarce resources are appropriately and responsibly monitored.

Agency for Healthcare Research and Quality

dollars in millions	2015	2016	2017	2017 +/- 2016
Health Costs, Quality and Outcomes Research (HCQO)				
Patient Safety	77	74	76	+2
Health Information Technology Research	28	22	23	+1
Health Services Research, Data, and Dissemination	112	89	113	+24
PHS Evaluation Funds (non-add)	*—*	*—*	*83*	*+83*
Budget Authority (non-add)	*112*	*89*	*30*	*-59*
U.S. Preventive Services Task Force	12	12	12	—
Subtotal, Program Level, HCQO	229	197	224	+27
Subtotal, PHS Evaluation Funds, HCQO (non-add)	*—*	*—*	*83*	*+83*
Subtotal, Budget Authority, HCQO (non-add)	*229*	*197*	*141*	*-56*
Medical Expenditure Panel Survey	65	66	69	+3
Program Support	70	71	71	—
Patient-Centered Outcomes Research Trust Fund Transfer /1	79	94	106	+12
Total, Program Level	**443**	**428**	**470**	**+41**
Less Funds from Other Sources				
PHS Evaluation Funds	—	—	-83	-83
Patient-Centered Outcomes Research Trust Fund	-79	-94	-106	-12
Total, Discretionary Budget Authority	**364**	**334**	**280**	**-54**
Full-Time Equivalents	302	325	325	—

1/ AHRQ receives mandatory funds transferred from the Patient-Centered Outcomes Research Trust Fund to implement section 937 of the Public Health Services Act.

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 within HHS and with other partners to make sure that the evidence is understood and used.

The FY 2017 Budget provides a total program level of $470 million for the Agency for Healthcare Research and Quality (AHRQ), an increase of $41 million above the FY 2016 level. The Budget funds AHRQ with three types of budgetary resources: $83 million of Public Health Service (PHS) Evaluation Funds, $280 million of budget authority, and $106 million from the Patient Centered Outcomes Research Trust Fund.

AHRQ produces and disseminates evidence to make health care higher quality, safer, and more affordable. Patients, caregivers, health care practitioners, federal agencies, researchers, and policymakers rely on AHRQ to conduct, support, and distribute the results of a broad range of health services research that informs and enhances decision-making, and improves healthcare services, organization, and financing. AHRQ has been charged with discovering how to ensure that America's annual $3.0 trillion investment in health care can be more effective, higher value, and better aligned with the needs of all Americans. In accomplishing its mission, AHRQ engages in three types of activities:

- Investing in research to make health care safer and improve quality and access;
- Creating materials to teach and train health care providers to catalyze improvements in care; and,
- Generating measures and data to track and improve performance and evaluate progress.

The goal of these activities is to build knowledge about what works and spread this information throughout the health care system. By doing so, AHRQ enables interventions to be taken to scale and achieve maximum impact. AHRQ is a key supplier of the research findings and evidence-based practices that are implemented on a large scale by other HHS Operating Divisions, such as the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services, to achieve nationwide improvement. The FY 2017 Budget reverses the significant reductions to research activities in FY 2016 and makes investments in AHRQ's core mission areas of improving patient safety, developing quality improvement tools, and sustaining key data resources on access, care delivery, and affordability.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2017 Budget includes a program level of $224 million, $27 million above FY 2016, for research to inform clinicians, providers, and policymakers on how to improve the value, effectiveness, quality, and results of health care services. AHRQ undertakes these activities through four research portfolios: patient safety; health information technology; the U.S. Preventive Services Task Force; and health services research, data, and dissemination.

Enhancing Patient Safety

Improving patient safety and reducing medical errors is a major priority of the Department. The Budget includes $76 million, an increase of $2 million above FY 2016, for the AHRQ patient safety research portfolio. This funding supports lifesaving research and projects that prevent, mitigate, and decrease the number of medical errors, patient safety risks and hazards, and quality gaps. AHRQ's patient safety projects develop the evidence base about effective practices to maximize safety, as well as disseminate and implement these practices in real world settings across the health care system. To further leverage the impact of these proven practices, AHRQ partners with private and public sector organizations such as primary care practices, the Department of Defense patient safety program, and CMS's Hospital Engagement Networks. AHRQ's approach to patient safety has yielded positive results: from 2010 to 2014, hospital-acquired infections and conditions have decreased nationally by 17 percent, which translates to an estimated 87,000 lives saved; $19.8 billion in unnecessary health care costs averted; and 2.1 million instances of harm avoided. AHRQ developed many of the resources that are used by hospitals to make care safer as well as the data strategy for measuring the impact of this effort. The FY 2017 Budget includes ongoing support for knowledge-building research grants that expand our understanding of why patient safety problems and harms occur and how to prevent them, integration of new findings into common practice, prevention and reduction of healthcare-associated infections, and adverse event reporting and data collection.

In FY 2017, AHRQ will provide $34 million, a decrease of $3.3 million from the prior year, to prevent healthcare associated infections by developing new methods of preventing these dangerous infections and promoting the adoption of these methods into settings with the highest needs, such as intensive care units. Within this amount, $12 million, an increase of $2 million, is dedicated to expanding AHRQ's efforts to address the growing public health threat of antibiotic resistant bacteria. These activities contribute to the Department's efforts in supporting the *National Action Plan for Combating Antibiotic-Resistant Bacteria*. As part of these activities, the Budget invests $4 million to continue a project of the Comprehensive Unit-based Safety Program to promote the establishment of antibiotic stewardship programs to reduce inappropriate antibiotic use in multiple health care settings.

The FY 2017 Budget also provides $7 million to continue two additional projects that will use the Comprehensive Unit-Based Safety Program in areas ripe for improvement. One project will apply new enhanced recovery protocols to improve outcomes for post-surgical patients. The other project will focus on reducing catheter associated urinary tract infections and central line associated blood stream infections in intensive care units, a setting with persistently elevated infection rates in need of targeted improvement. AHRQ is actively collaborating with CMS and CDC on decreasing the incidence of these harmful infections.

In this effort, AHRQ provides evidence from this program about how to reduce infection rates, trains hospital staff in applying effective methods of preventing infections, and uses standardized data for tracking nationwide infection rates.

PROGRAM HIGHLIGHT

A Targeted Approach to Combating Antibiotic Resistance

Antibiotic resistant infections are becoming increasingly common and harder to treat. In response, the Administration has created a cross-agency *National Action Plan for Combating Antibiotic-Resistant Bacteria*. In FY 2017, the Budget provides $4 million to slow the development of antibiotic resistance by using AHRQ's Comprehensive Unit-based Safety Program. This program, which fosters improved clinical practices, has reduced healthcare-associated infections by implementing a toolkit of evidence-based practices together with training to achieve improvements in safety culture, teamwork, and communication. In recent years, this program has achieved dramatic reductions in infections when applied to prevent central line-associated blood stream infections.

AHRQ is now targeting the Comprehensive Unit-based Safety Program at antibiotic resistance. This project will promote and guide the implementation of antibiotic stewardship programs in hospitals, ambulatory care facilities, and long-term care centers. By establishing antibiotic stewardship programs where they are currently lacking, this investment can reduce inappropriate antibiotic use, thereby reducing the emergence of antibiotic resistance and decreasing both the number and the virulence of these infections.

Health Information Technology Research

The Budget provides $23 million, an increase of $1 million above FY 2016, for the AHRQ health information technology (IT) research portfolio. Within the federal health IT ecosystem, AHRQ has a unique role: to develop the evidence-base on what works to improve the use of health IT across the healthcare system. The evidence developed by AHRQ informs the implementation, oversight, and governance decisions of other HHS agencies such as the Office of the National Coordinator for Health Information Technology, CMS, and IHS. To fulfill this role, AHRQ supports research grants to build knowledge, to develop tools to help stakeholders implement best practices, and to synthesize and disseminate evidence on the safe and meaningful use of health IT. For example, current projects include an examination of how exchanging health information can drive population-level clinical decision support and an update of a tool that evaluates the safety performance of inpatient electronic health records after deployment. The $1 million increase will support additional investigator-initiated research grants related to health IT to help ensure clinicians have the best evidence at their disposal as they incorporate health IT into daily practice.

U.S. Preventive Services Task Force

The Budget includes $12 million, the same as FY 2016 for the United States Preventive Services Task Force. The Task Force is an independent panel of national experts that reviews the medical literature and makes recommendations about the harms and benefits of clinical preventive services and health promotion to improve primary care. By statute, AHRQ provides the Task Force with scientific, administrative, and dissemination support, but the recommendations are up to the members of the panel. The Task Force provides doctors and patients the evidence they need to help determine how to maintain health and prevent disease. The Task Force's recommendations serve as a roadmap for health practitioners looking for authoritative syntheses of the latest evidence on effective prevention practices. With the requested resources, the Task Force will conduct evidence reviews of relevant topics, seek public comments on draft recommendations and disseminate the latest findings.

Advancing Health Services Research, Data and Dissemination

The Budget provides a total of $113 million, an increase of $24 million above FY 2015, for research to identify the most effective ways to organize, manage, finance, and deliver high-quality care. This research goes beyond simply the "what" of patient care to the "how"– how inputs, policies, procedures, and training can be changed to produce a better functioning health system and better outcomes for patients.

The increase of $24 million will reverse reductions enacted in FY 2016 that limited AHRQ's ability to drive quality improvement. AHRQ will invest $1 million in the Evidence-Base Practice Centers, which did not receive any discretionary funding from AHRQ in FY 2016 due to the reduced level for this portfolio, to close evidence gaps by reviewing the latest research and publishing syntheses of effective practices. Health care providers rely on this evidence to ensure that the standard of practice is based on the latest, most

accurate medical evidence. An increase of $2 million in support of AHRQ's National Healthcare Quality and Disparities Reports will allow AHRQ to analyze and produce these public data resources after operating on a reduced publication schedule in FY 2016. Additional dissemination funding will be provided to produce and disseminate the State-based information and topic-specific chapters from these reports.

PROGRAM HIGHLIGHT

Reducing Hospital Readmissions:

In October AHRQ introduced the Nationwide Readmissions Database, the first all payer nationwide data resource that supports tracking and analysis of hospital readmission rates. Hospital readmissions are a critical policy issue for health care quality and safety improvement. The new database addresses a major gap in health care data by providing the first all payer comprehensive data source on readmissions. Clinicians, researchers, public health professionals, administrators, and policymakers will be able to use the data in their analyses and decision making to target, understand and improve conditions with high rates of readmissions.

This data resource is part of the AHRQ Healthcare Cost and Utilization Project, the largest collection of all-payer, longitudinal hospital discharge and billing data in the United States. The FY 2017 Budget includes $8 million to continue this flagship project. This project supports many efforts, including the Partnership for Patients initiative to track and reduce injuries a mother may suffer during childbirth. Data from this project will provide national estimates for two quality indicators that measure this type of trauma, as well as use the readmissions database to track improvements in readmission rates as part of the Partnership for Patients.

The Budget includes new investments in high need areas of research and dissemination. AHRQ will invest $9 million in a new project to develop clinician tools to improve care for individuals with multiple chronic conditions. This initiative addresses the challenges of a high-cost, high-need, growing patient population by creating resources to help improve care coordination and quality of life, while reducing unnecessary expenses. This effort builds upon earlier descriptive research by the AHRQ-funded Multiple Chronic Conditions Research Network and supports the quality improvement goals of the HHS Strategic Framework on Multiple Chronic Conditions. In support of the Administration's Delivery System Reform initiative, the Budget also proposes over $1 million of new research on paying for value. This effort will explore new ways to link payments to quality and value, and not simply to the volume of health care services provided.

The Budget includes $3 million to continue projects to reduce prescription drug and opioid overdoses first awarded in FY 2016. These projects develop and test new methods and tools for implementing medication assisted treatment in primary care practices. This funding is a component of a Department-wide efforts being developed to ensure that this public health epidemic is addressed rapidly and comprehensively.

In FY 2017 AHRQ will provide $47 million for investigator-initiated research grants, of which approximately $11 million will be used to fund new grants. Making these new resources available allows AHRQ to support emerging and innovative proposals that may not have been available in the prior year. AHRQ will also continue several rapid cycle research networks that are designed to increase the availability of new research findings into practice. These types of activities contribute to increased quality, a stronger evidence-based culture of practice, and ultimately to better health for patients.

MEDICAL EXPENDITURE PANEL SURVEY (MEPS)

The FY 2017 Budget includes $69 million, an increase of $3 million above FY 2016, for MEPS in order to maintain the integrity of the sample size and the quality of the core data products on a state and national level. MEPS includes three interrelated surveys components: household, medical provider, and insurance. These three surveys provide the only nationally representative source of annual data on how Americans, including the uninsured, use and pay for health care. MEPS data have become the linchpin for public and private analyses of health care utilization and expenditures. In addition, MEPS provides estimates of measures related to health status, demographic disparities, employment, and health care access, coverage, and quality. In FY 2017, the requested funding increase will provide the additional resources for data collection needed to maintain the quality of state-level estimates and the timeliness of key production milestones.

PROGRAM SUPPORT

The FY 2017 Budget includes $71 million, the same as the FY 2016 level, to support agency-wide operational

and administrative costs that help ensure efficient management of research activities and stewardship of federal resources. The largest single expense category in Program Support is staff salaries, and other large expenses include employee benefits and rent. AHRQ has identified efficiencies by consolidating into less expensive office space.

PATIENT CENTERED HEALTH RESEARCH

In FY 2017 AHRQ will receive $106 million from the Patient Centered Outcomes Research Trust Fund, to advance Patient Centered Health Research (also known as Comparative Effectiveness Research). These funds are authorized for translating and disseminating comparative clinical effectiveness research and awarding grants to train researchers. Funded projects distribute up to date information about the benefit and harms of treatment options so that patients and their caregivers can make informed health care decisions. New AHRQ projects include resources for the public to more easily search for and find reliable research results, and efforts to facilitate the rapid adoption of research findings into practice.

Centers for Medicare & Medicaid Services: Overview

dollars in millions	2015	2016	2017	2017 +/– 2016
Current Law				
Medicare /1	546,228	595,317	609,541	+14,224
Medicaid /2	349,762	367,229	376,590	+9,361
CHIP	9,242	14,470	15,015	+545
State Grants and Demonstrations	589	633	543	-90
Private Health Insurance Programs	10,826	13,040	9,481	-3,559
Center for Medicare and Medicaid Innovation	971	1,408	1,595	+187
Total Net Outlays, Current Law /3	**917,618**	**992,097**	**1,012,765**	**+20,668**
Proposed Law				
Medicare	—	—	-3,729	-3,729
Medicaid	—	—	9,100	+9,100
CHIP	—	—	180	+180
State Grants and Demonstrations	—	—	25	+25
Private Health Insurance Programs	—	—	—	—
Program Management	—	—	39	+39
Total Proposed Law	—	—	**5,615**	**+5,615**
Total Net Outlays, Proposed Law /4	**917,618**	**992,097**	**1,018,380**	**+26,283**
Savings from Program Integrity Investments /5	—	—	-966	-966
Total Net Outlays, Proposed Policy	**917,632**	**992,074**	**1,017,414**	**+25,317**

1/ Current law Medicare outlays net of offsetting receipts.
2/ Total includes $4 million in Medicaid outlays in FY 2017 due to a proposed change in a mandatory program (CHIMP) for a Department of State proposal.
3/ Totals may not add due to rounding.
4/ Total net proposed law outlays equal current law outlays plus the impact of proposed legislation and offsetting receipts.
5/ 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 Medicare and 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 2017 Budget estimate for the Centers for Medicare & Medicaid Services (CMS) is $1.0 trillion in mandatory and discretionary outlays, a net increase of $26 billion above the FY 2016 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), private health insurance programs, program integrity efforts, and operating costs. The Budget continues CMS's work to implement the Affordable Care Act by improving health care for millions of Americans through comprehensive insurance reforms, policies to enhance quality, and providing access to health insurance coverage. CMS's legislative package promotes the Administration's efforts at delivery system reform, including a series of proposals across Medicare, Medicaid, and private insurance that find better ways to pay providers, deliver care, and distribute information. Other proposals in the Budget 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. In total, the Budget proposes targeted savings of $357.3 billion to CMS mandatory health programs over the next decade.

BUDGETARY REQUEST

Medicare

The Budget includes net projected Medicare savings of $419.4 billion over 10 years. Most notably, the Budget saves $77.2 billion by reforming Medicare Advantage payments to improve efficiency and achieve sustainability of the program. Other proposals increase the value of Medicare payments to providers and address the rising costs of pharmaceuticals.

Medicaid and CHIP

The Budget includes legislative proposals in Medicaid and CHIP which have an impact of $30.9 billion on net federal spending over 10 years[1] to invest in delivery system reform, provide high-quality and cost-effective care for beneficiaries, and ensure continued coverage for CHIP children. The Budget includes new proposals to improve benefits and facilitate coverage in Medicaid, including ensuring a full 3 years of 100 percent federal funding for newly eligible coverage in all Medicaid expansion states, guaranteeing comprehensive coverage for pregnant beneficiaries, and strengthening Medicaid in Puerto Rico and the U.S. Territories. The Budget also includes new proposals to make Medicaid more cost-effective, including requiring remittances from Medicaid and CHIP managed care plans for costs in excess of a minimum medical loss ratio and creating a federal-state negotiating pool for high-cost drugs. Finally, the Budget proposes to extend funding for CHIP through FY 2019.

Private Insurance

The Budget proposes a series of private insurance proposals to promote transparency in health care and implement technical fixes to improve the administration of the Affordable Care Act. The Budget strengthens consumer protections, enhances CMS' ability to verify Marketplace eligibility, and provides for a consistent definition of "Indian" to ensure all American Indian and Alaska Natives eligible for IHS services will be treated equally with respect to the Act's coverage provisions, including access to qualified health plans without cost-sharing requirements.

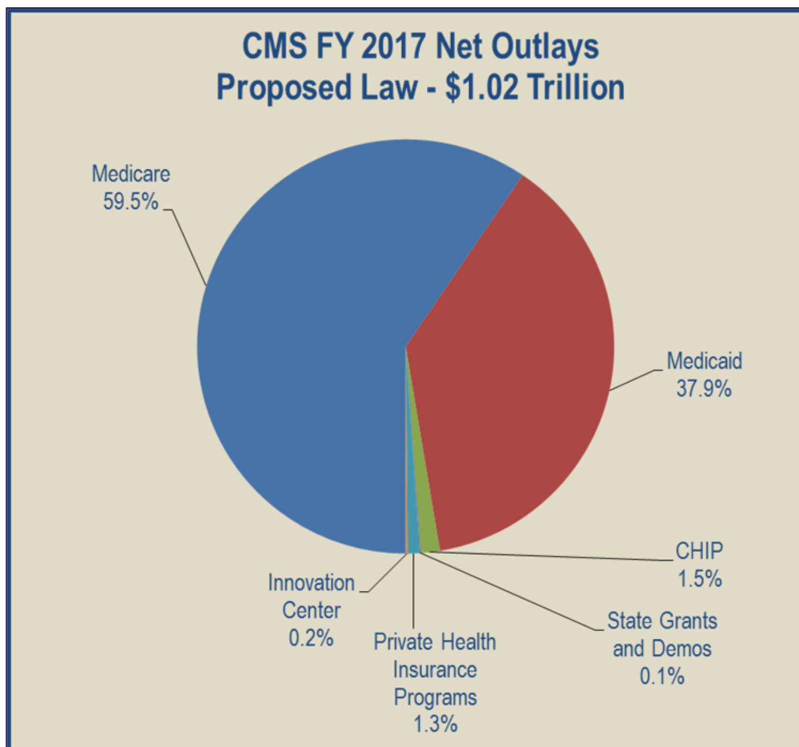
[1] This includes $30.2 billion in savings to Marketplace subsidies and related impacts, reflected in the Department of Treasury program and accounts.

Program Integrity

The Budget includes $199 million in new investments in program integrity programs in FY 2017, as part of a multi-year strategy to enable HHS and the Department of Justice to detect, prevent, and prosecute health care fraud. The Budget also proposes a series of new authorities to strengthen program integrity oversight. These investments and new authorities yield $25.7 billion in gross 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 Health Insurance Marketplaces. The request includes investments to address growing Medicare appeals workloads and improve the capacity and security of CMS' information systems.



Medicare

dollars in millions	2015	2016	2017	2017 +/- 2016
Current Law Outlays and Offsetting Receipts				
Benefits Spending (gross) /1	627,710	684,282	709,386	+25,105
Less: Premiums Paid Directly to Part D Plans /2	-8,520	-9,282	-11,132	-1,850
Subtotal, Benefits Net of Direct Part D Premium Payments	**619,190**	**675,000**	**698,255**	**+23,254**
Related-Benefit Expenses /3	12,662	13,031	13,140	+109
Administration /4	8,593	8,940	9,346	+406
Total Outlays, Current Law	**640,445**	**696,971**	**720,741**	**+23,769**
Premiums and Offsetting Receipts	-94,218	-101,655	-111,199	-9,545
Current Law Outlays, Net of Offsetting Receipts	**546,228**	**595,317**	**609,541**	**+14,225**
Proposed Law and Savings from Program Integrity Investments				
Medicare Proposals, Net of Offsetting Receipts	0	0	-3,729	-3,729
Savings from Additional Program Integrity Investments /5	0	0	-845	-845
Total Net Outlays, Adjusted Baseline, Savings from Program Integrity Investments and Proposed Law	**546,228**	**595,317**	**604,967**	**+9,651**
Mandatory Total Net Outlays, Proposed Policy /6	**539,899**	**588,752**	**598,191**	**+9,440**

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 savings from investments in Social Security disability reviews and related benefit payments, including refundable payments made to providers and plans, transfers to Medicaid, and premiums to Medicare Advantage plans paid out of the Trust Funds from beneficiary Social Security withholdings.
4/ Includes CMS Program Management, HCFAC, Quality Improvement Organizations, and other administration.
5/ Includes non-PAYGO scorecard savings from discretionary HCFAC above savings already assumed in current law, savings from Social Security Administration program integrity investment, and proposed law savings from retention of funds from Recovery Auditors for program integrity.
6/ Removes total Medicare discretionary amount: FY 2015- $6,329 million; FY 2016- $6,565 million; and FY 2017- $6,776 million.

In FY 2017, the Office of the Actuary has estimated that gross current law spending on Medicare benefits will total $709.4 billion. Medicare will provide health insurance to 58 million individuals who are age 65 or older, disabled, or have end-stage renal disease.

THE FOUR PARTS OF MEDICARE

Part A ($202.1 billion gross fee-for-service spending in 2017)

Medicare Part A pays for inpatient hospital, skilled nursing facility, home health related to a hospital stay, and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax 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 beneficiary coinsurance. In 2016, beneficiaries pay a $1,288 deductible for a hospital stay of 1–60 days, and $161 daily coinsurance for days 21–100 in a skilled nursing facility.

Part B ($192.9 billion gross fee-for-service spending in 2017)

Medicare Part B pays for physician, outpatient hospital, end-stage renal disease, laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 91 percent of all Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

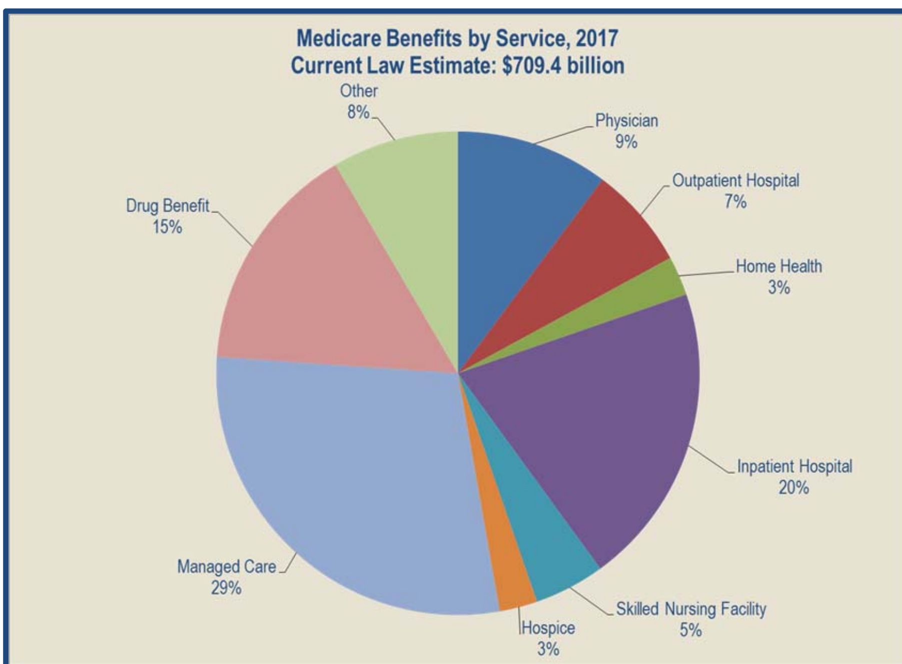
The standard monthly Part B premium is $121.80 in 2016. However, approximately 70 percent of beneficiaries are held harmless from increases to the Part B premium in 2016 compared to 2015, because the Social Security cost of living adjustment for 2016 is 0 percent. Therefore, these beneficiaries will continue to pay the 2015 premium amount of $104.90. The

Bipartisan Budget Act prevented an even higher premium from going into effect for the 30 percent of beneficiaries who are not held harmless. 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 $170.50 to $389.80 per month in 2016. The Part B deductible in 2016 is $166 for all beneficiaries.

Part C ($204.7 billion gross spending in 2017)

Medicare Part C, the Medicare Advantage 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 2017, Medicare Advantage enrollment will total approximately 19.5 million. Over the past 10 years, Medicare Advantage enrollment as a percentage of total enrollment has increased by 95 percent (see graph on Medicare Advantage Enrollment 2005-2017). CMS data confirm that Medicare beneficiary access to a Medicare Advantage plan remains strong and stable at 99 percent in 2016, premiums have remained stable, Medicare Advantage supplemental benefits have increased, and enrollment is growing faster than in traditional Medicare.



Medicare Enrollment
(person-years in millions)

	2015	2016	2017	2017 +/- 2016
Aged 65 and Over	46.0	47.7	49.3	+1.7
Disabled	9.0	9.0	9.0	+0.0
Total	**55.0**	**56.7**	**58.4**	**+1.7**

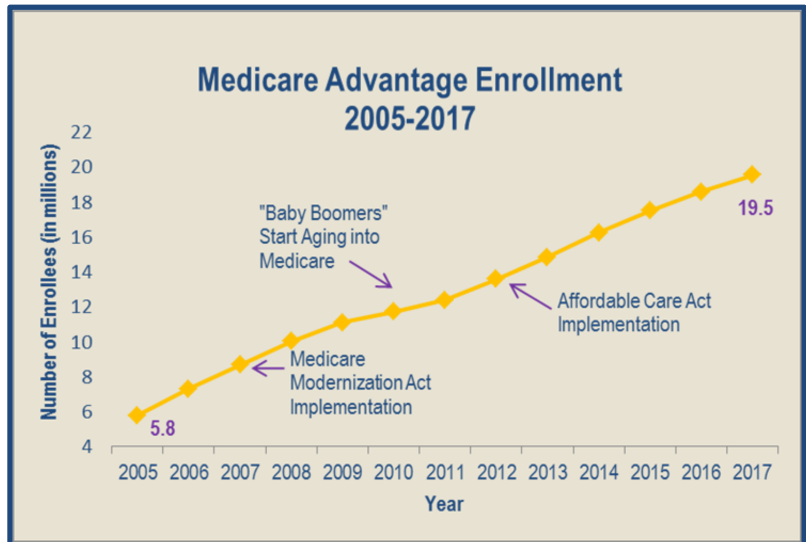
Source: CMS Office of the Actuary estimates.
Note: Numbers may not add due to rounding.

Part D ($109.7 billion gross spending in 2017)

Medicare Part D offers a standard prescription drug benefit with a 2016 deductible of $360 and an average estimated monthly premium of $41. 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 $7.40 in 2016 and low or no monthly premiums. For 2017, the number of beneficiaries enrolled in Medicare Part D is expected to increase by about 4 percent to 44.5 million, including about 12.7 million beneficiaries who receive the low-income subsidy. In 2016, approximately 58 percent of those with Part D coverage are enrolled in a stand-alone Part D Prescription Drug Plan, 38 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 88 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 ($3,310 in 2016), until they reach the threshold for qualified out-of-pocket spending ($4,850 in 2016), 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 2017, non-Low Income Subsidy beneficiaries who reach the coverage gap will pay 40 percent of the cost of covered Part D brand drugs and biologics and 51 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.



PERFORMANCE HIGHLIGHT

Hospital Harm Reduction

The Agency for Healthcare Research and Quality National Scorecard data released in December 2015 reveals great success in hospital harm reduction, such as reduced infections:

Calendar Year	# Harms per 1,000 Discharges
2010 – Baseline	145
2011	142
2012	132
2013	121

Medicare hospital value-based purchasing payment incentives, Quality Improvement Organizations, and the Partnership for Patients program have all contributed to this outcome.

In 2015, more than 5.1 million beneficiaries reached the coverage gap and saved more than $5.4 billion on their medications due to the prescription drug discount program. These savings averaged about $1,054 per person.

2017 LEGISLATIVE PROPOSALS

The FY 2017 Budget includes a package of Medicare legislative proposals that will save a net $419.4 billion over 10 years by supporting delivery system reform to promote high-quality, efficient care, improving beneficiary access to care, addressing the rising cost of pharmaceuticals, more closely aligning payments with costs of care, and making structural changes that will reduce federal subsidies to high-income beneficiaries and create incentives for beneficiaries to seek high-value services. These proposals, combined with tax proposals included in the FY 2017 President's Budget, would help extend the life of the Medicare Hospital Insurance Trust Fund by over 15 years.

Support Delivery System Reform

The following Medicare proposals represent better ways to pay providers, deliver care, and distribute information.

Payment Incentives

Reform Medicare Advantage Payments to Improve the Efficiency and Sustainability of the Program

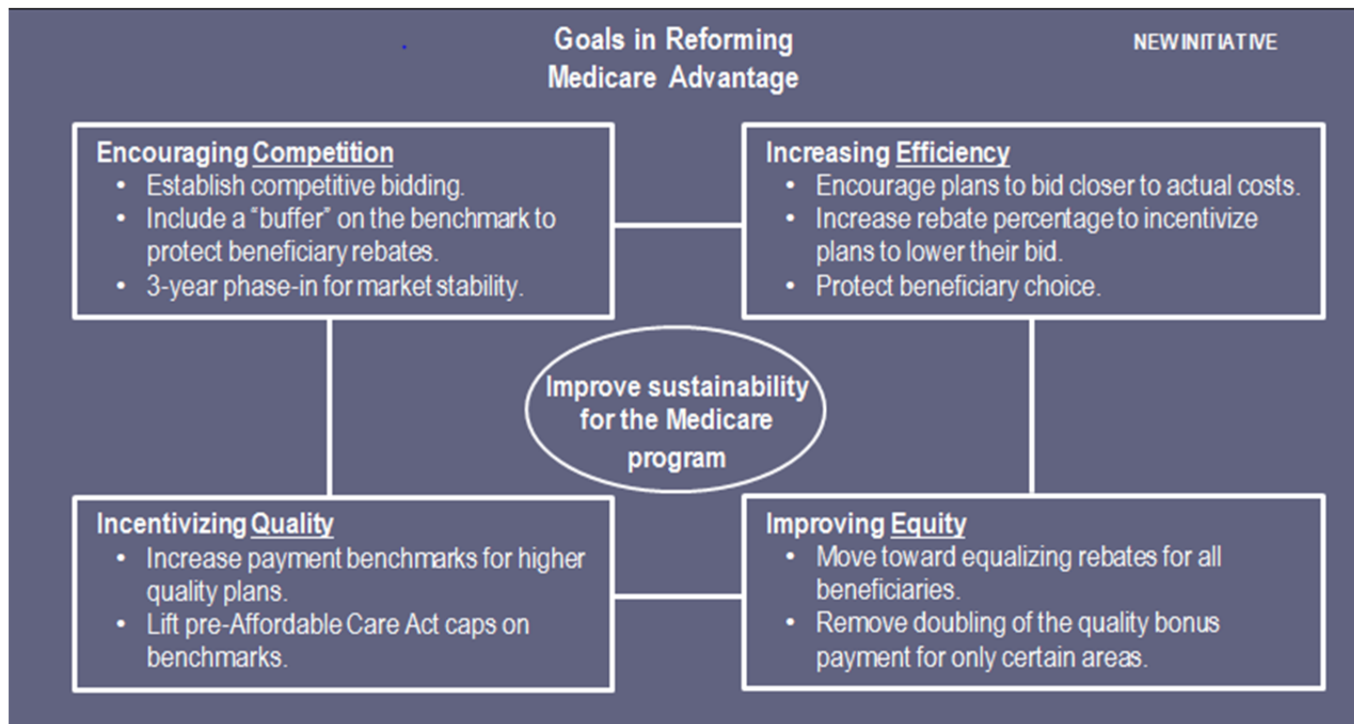
This proposal incentivizes Medicare Advantage plans to submit cost-effective bids while preserving beneficiary rebates and standardizing quality bonus payments across counties. The proposal establishes competitive bidding in Medicare Advantage by calculating an adjusted benchmark, against which plans are paid, as the lesser of the current law fee-for-service benchmark or the average Medicare Advantage plan bid plus a five percent "buffer" to protect beneficiary rebates. This competitively bid benchmark would – for the first time – allow CMS to use plan bids to set the benchmark and reward plans for lowering their bids by allowing them to retain 100 percent of the difference between their bid and the benchmark as the rebate. Additionally, the proposal would standardize quality bonus payments across counties by removing the doubling of the quality bonus payment which is only available in certain areas and lifting the cap on benchmarks for plans that are entitled to receive a quality bonus payment. This proposal prepares for the future of Medicare by

reforming Medicare Advantage payments to improve efficiency and sustainability of the program for all Medicare beneficiaries. [$77.2 billion in savings over 10 years]

Implement Bundled Payment for Post-Acute Care

Beginning in 2021, this proposal implements bundled payment for post-acute care providers, including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health providers. Payments will 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 2023. Beneficiary coinsurance will equal that under current law (e.g., to the extent the beneficiary uses skilled nursing facilities, the beneficiaries would be responsible for the current law coinsurance rate). [$9.9 billion in savings over 10 years]

assistants, and clinical nurse specialists. Statute requires that assignment of beneficiaries to an Accountable Care Organization be based on their utilization of primary care services provided by physicians. Expanding the assignment of beneficiaries to nurse practitioners, physician assistants, and clinical nurse specialists, in addition to physicians, could broaden the scope of Accountable Care Organizations to better reflect the types of professionals that deliver primary care services to fee-for-service beneficiaries. Some Medicare beneficiaries, especially those in rural or underserved areas, receive most or all of their primary care from non-physician practitioners. This proposal results in a greater number of Medicare fee-for-service beneficiaries who rely on these practitioners for their care being assigned to Accountable Care Organizations. [$150 million in savings over 10 years]



Expand Basis for Beneficiary Assignment for Accountable Care Organizations to include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists

This proposal allows the Secretary to base beneficiary assignment in the Medicare Shared Savings Program on a broader set of primary care providers. Under the proposal, beneficiaries will be assigned to an Accountable Care Organization on the basis of primary care services delivered by nurse practitioners, physician

Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program

This proposal allows the Secretary to assign more Medicare fee-for-service beneficiaries to an Accountable Care Organization under the Medicare Shared Savings Program based on primary care services furnished to them by Federally Qualified Health Centers and Rural Health Clinics. Federally Qualified Health Centers and Rural Health Clinics are important

providers of primary care services and part of the safety net for the nation's health care system. This proposal could result in assignment of a greater number of Medicare fee-for-service beneficiaries to Accountable Care Organizations and would stimulate greater interest in the program by Federally Qualified Health Centers and Rural Health Clinics and support the program's goals to improve quality of care for Medicare fee-for-service beneficiaries while reducing overall growth in costs. [$80 million in savings over 10 years]

Allow Accountable Care Organizations to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount

This proposal allows Accountable Care Organizations participating in two-sided risk models to pay beneficiaries for a primary care visit. Beneficiaries with no supplemental insurance will have all or part of their cost sharing covered by the Accountable Care Organization, and beneficiaries with supplemental insurance would receive a payment from the Accountable Care Organization. Participation from is voluntary, and no additional payments will be made to cover the costs of this investment. [$70 million in savings over 10 years]

Establish a Bonus Payment for Hospitals Cooperating with Certain Alternative Payment Models

Under this proposal, hospitals that furnish a sufficient proportion of their services through eligible alternative payment entities will receive a bonus payment starting in 2022. Bonuses would be paid through the Inpatient Prospective Payment System permanently and through the Outpatient Prospective Payment System until 2024. Each year, hospitals that qualify for this bonus will receive an upward adjustment to their base payments. Reimbursement through the inpatient and outpatient prospective payment systems to all providers will be reduced by a percentage sufficient to ensure budget neutrality. [No budget impact]

Establish a Hospital-Wide Readmissions Reduction Measure

This proposal makes revisions to the Hospital Readmissions Reduction Program to allow the Secretary to use a comprehensive Hospital-Wide Readmission Measure that encompasses broad categories of conditions rather than discrete "applicable conditions." The Secretary will be permitted to make future budget-neutral amendments to the measure to enhance accuracy as necessary. [No budget impact]

Establish Quality Bonus Payments for High-Performing Part D Plans

This proposal allows 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 Medicare Advantage 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]

Extend Accountability for Hospital-Acquired Conditions

This proposal requires hospitals to code conditions as "present on arrival" instead of "present on admission" for the purposes of the Medicare Hospital Acquired Conditions payment policy and quality reporting. [No budget impact]

Implement Value-Based Purchasing for Additional Providers

This proposal implements a budget neutral value-based purchasing program for several additional provider types, including skilled nursing facilities, home health agencies, ambulatory surgical centers, hospital outpatient departments, and community mental health centers beginning in 2018. At least two percent of payments must be tied to the quality and efficiency of care in the first two years of implementation and at least five percent beginning in 2020. [No budget impact]

Care Delivery

Expand the Ability of Medicare Advantage Organizations to Pay for Services Delivered via Telehealth

This proposal allows the Secretary discretion to expand the ability of Medicare Advantage organizations to deliver medical services via telehealth by eliminating otherwise applicable Part B requirements that certain covered services be provided exclusively through face-to-face encounters. By integrating face-to-face care with remote access care in both rural and urban areas, this proposal will improve care coordination, provide for more timely exchanges between specialists, and

facilitate beneficiary access to care in situations where traveling to provider offices would be more difficult. The decision to utilize the telehealth benefit would remain at the discretion of the beneficiary. [$160 million in savings over 10 years]

Allow the Secretary to Introduce Primary Care Payments under the Physician Fee Schedule in a Budget Neutral Manner

Beginning in calendar year 2017, this proposal allows the Secretary to introduce additional primary care payments into the Medicare Physician Fee Schedule. The new per-beneficiary payments will equal the average per-beneficiary payment under the expired incentive program. These payments will be exempt from beneficiary cost sharing and incorporated into the Physician Fee Schedule in a budget neutral manner. These payments will provide valuable long term incentives for the provision of primary care services. [No budget impact]

Information

Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Programs

This proposal expands the Medicare and Medicaid Electronic Health Record Incentive Programs to include psychiatric hospitals, community mental health centers, residential and outpatient mental health and substance use disorder treatment clinics, and psychologists. These programs currently include only a few types of providers that offer behavioral health services, such as critical access hospitals. Adoption of interoperable electronic health records by these providers has lagged behind other providers that participated in the EHR incentive program. Facilitating the adoption and meaningful use of electronic health records by the broader community of behavioral health providers will promote the sharing of clinical data needed to provide safe, timely, efficient, and effective patient-centered care. [$760 million in Medicare costs over 10 years]

Increase Value in Medicare Provider Payments

Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services

The 190-day lifetime limit on inpatient services delivered in specialized psychiatric hospitals is one of the last obstacles to behavioral health parity in the Medicare benefit. Beginning in FY 2017, this proposal would eliminate the 190-day limit and more closely align the Medicare mental health care benefit with the current inpatient physical health care benefit. Many beneficiaries who utilize psychiatric services are eligible for Medicare due to a disability, which means they are often younger beneficiaries who can easily reach the 190-day limit over their lifetimes. This proposal will expand the psychiatric benefit and bring parity to the sites of service, while also containing the additional costs of removing the 190-day limit. [$2.4 billion in Medicare costs over 10 years]

Update Medicare Disproportionate Share Formula for Hospitals in Puerto Rico

This proposal updates the Medicare Disproportionate Share Hospital formula for hospitals in Puerto Rico. It grants the Secretary the authority to use a proxy for Supplemental Security Income when calculating Medicare Disproportionate Share payments for Puerto Rico hospitals. Under current law, residents of Puerto Rico are not eligible for Supplemental Security Income. Puerto Rico hospitals are at a disadvantage in the calculation of Medicare Disproportionate Share payments because the formula relies, in part, on Medicare Supplemental Security Income inpatient days. Disproportionate Share payments to hospitals outside of Puerto Rico will not be impacted. [$70 million 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 FY 2017 and each year FY 2019 through FY 2026. For 2018, the statute requires an update of 1 percent for these post-acute care providers. 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 under an accelerated schedule, beginning with a -2.5 percent update in FY 2017; -2 percent in FY 2019; -1 percent in each year FY 2020-2023; and tapering down to a -0.97 percent update in FY 2024. Payment updates may drop below zero as a result of this proposal for skilled nursing facilities. [$86.6 billion in savings over 10 years]

Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth

The Affordable Care Act established the Independent Payment Advisory Board as a backstop to control long-term spending growth in the Medicare program. Under current law, if the projected Medicare per capita

growth rate exceeds a predetermined target growth rate, the Independent Payment Advisory Board will recommend policies to Congress to reduce the Medicare growth rate to meet a specified target. To further moderate Medicare cost growth, this proposal will lower the target rate for triggering the Board applicable for 2018 and after from gross domestic product per capita growth plus 1 percentage point to gross domestic product per capita growth plus 0.5 percentage points. [$36.4 billion in savings over 10 years]

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 2017, this proposal would reduce bad debt payments to 25 percent over 3 years for all providers who receive bad debt payments. This proposal will more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. [$32.9 billion in savings over 10 years]

Encourage Workforce Development Through Targeted and More Accurate Indirect Medical Education Payment

The Medicare Payment Advisory Commission 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 will partially correct this imbalance by reducing these payments by 10 percent, beginning in 2017. In addition, the Secretary will be granted the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage resident training in areas of emerging need, such as primary care and medication-assisted treatment of substance use disorders, and emphasize skills that promote high-quality, high-value health care. [$17.8 billion in savings over 10 years]

Reform Medicare Hospice Payments

CMS has taken steps to improve the accuracy of hospice benefit payments, but there are additional opportunities for improvement. This proposal reduces market basket updates for hospice providers by 1.7 percent in 2018, 2019, and 2020 as a first step toward aligning payment with costs of care. Payment updates for providers would not drop below zero as a result of this proposal. This proposal also permits the Secretary to implement a hospice-specific market basket by 2021. Currently, the hospice market basket is based on the hospital market basket, despite differences in the type of service provided (palliative vs. curative), the care setting (at home vs. inpatient), and the labor force utilized. Finally, this proposal permits the Secretary to make further budget neutral reforms to the hospice payment system. [$9.3 billion in savings over 10 years]

NEW INITIATIVE

Increasing Access and Encouraging Innovation in Lifesaving Drugs and Biologics

HHS is committed to working with its federal and non-federal partners and stakeholders to improve the market for affordable, innovative drugs and biologics. HHS's key priorities in this effort are:

1. Increasing Access to Information: Greater visibility into the economics of drug development and pricing provides patients and providers with relevant information to support better health care decisions.

2. Driving Innovation: The Department is working to advance research and promote innovation through expanded efforts in genomics and personalized medicine, including development of new therapeutic approaches and advancement of regulatory models.

3. Strengthening Incentives and Promoting Competition: HHS supports purchasing strategies that address costs, while improving the access and affordability of drugs for beneficiaries. The Department is working to better align financial incentives for providers, drug manufacturers, and other insurers with our goals for better care, smarter spending, and healthier people.

The Budget includes a number of proposals that work toward these goals, as well as our shared goal of encouraging payment for value rather than volume in throughout health system.

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 2018, this proposal seeks 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 is clinically integrated and required to demonstrate cost containment, as defined by the Secretary. [$5.0 billion in savings over 10 years]

Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment

Since implementation, the Competitive Bidding Program for durable medical equipment, prosthetics, and supplies has saved the Medicare program and beneficiaries billions of dollars by aligning payment amounts with market-based prices. Currently this program is restricted to certain categories of equipment, supplies and services. This proposal expands the competitive bidding program to additional categories, including: inhalation drugs, all prosthetics and orthotics, and ostomy, tracheostomy, and urological supplies. [$3.8 billion in savings over 10 years]

Encourage Appropriate Use of Inpatient Rehabilitation Facilities

This proposal adjusts the standard for classifying a facility as an Inpatient Rehabilitation Facility. Under current law, at least 60 percent of patient cases admitted to an Inpatient Rehabilitation Facility must meet 1 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 2017, this proposal reinstitutes the 75 percent standard to ensure that health facilities are classified appropriately based on the patients they serve. [$2.2 billion in savings over 10 years]

Reduce Critical Access Hospital Reimbursements from 101 Percent of Reasonable Costs to 100 Percent of Reasonable Costs

Critical Access Hospitals are generally small, rural hospitals that provide their communities with access to basic emergency and inpatient care. Critical Access Hospitals receive enhanced cost-based Medicare payments (rather than the fixed-fee payments most hospitals receive). Medicare currently pays Critical Access Hospitals 101 percent of reasonable costs. This proposal reduces this rate to 100 percent beginning in 2017. [$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 2017, this proposal prevents facilities that are within 10 miles of another hospital from maintaining designation as a critical access hospital and receiving the enhanced rate. These facilities will instead be paid under the applicable prospective payment system. [$880 million in savings over 10 years]

Allow the Secretary to Determine Hospital Acquired Condition Reduction Program Penalty Amounts and Distribution

Beginning in FY 2018, the proposal provides authority to the Secretary to specify through regulation the amount, scoring and penalty payment calculation methodology, and distribution of penalties to be assessed to eligible hospitals participating in the Hospital Acquired Condition Reduction Program. The proposal is structured in such a way that the new program produces savings at least equivalent to the current reduction program. [No budget impact]

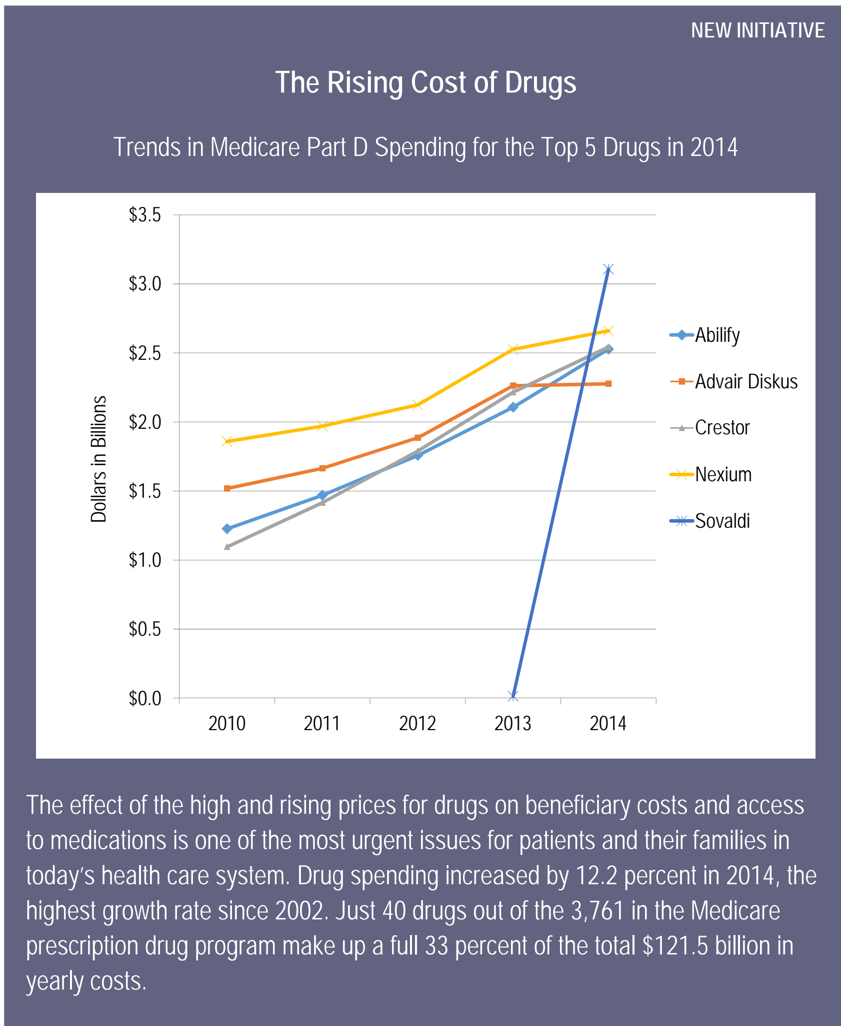
Clarify the Medicare Fraction in the Medicare Disproportionate Share Statute

This proposal clarifies 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 patient percentages. [No budget impact]

Modernize Funding for End Stage Renal Disease Networks

This proposal changes the withhold for the End Stage Renal Disease Networks from 50 cents to $1.50 per treatment, to be updated annually by the consumer price index. The withhold is deducted from each End Stage Renal Disease Prospective Payment System per-treatment payment, and has not been increased since 1986 when it first took effect. The End Stage Renal Disease Networks are currently underfunded to meet statutory and regulatory obligations. In order for the End Stage Renal Disease Networks to effectively and efficiently administer the future demands of the End Stage Renal Disease program, increased operational resources are required. [No budget impact]

Recoup Initial Clinical Laboratory Fee Schedule Payments for Advanced Diagnostic Laboratory Tests in Excess of 100 percent of the Final Payment Amount
Under current law, beginning in 2017, laboratories providing new advanced diagnostic laboratory tests receive invoice pricing for an initial period. If the price paid by Medicare during the initial period exceeds 130 percent of the final payment rate, CMS is required to recoup the difference in payment amounts enacted in the Protecting Access to Medicare Act of 2014. Beginning calendar year 2017, this proposal lowers the threshold required for CMS to recoup differences in Clinical Laboratory Fee Schedule payments for new advanced diagnostic laboratory tests from 130 percent to 100 percent. [No budget impact]



Repeal the Rental Cap for Oxygen Equipment
This proposal eliminates the 36-month rental cap for oxygen equipment and reduces the monthly payment amount for oxygen and oxygen equipment by the necessary percentage to be budget neutral. Eliminating the rental cap will improve beneficiary access to care, particularly when a patient relocates during the 36-month period, and reduce administrative burden for both CMS and suppliers. [No budget impact]

Address the Rising Cost of Pharmaceuticals

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 allows 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 2018. The proposal requires manufacturers to pay the difference between rebate levels they already provide Part D plans and the Medicaid rebate levels. Manufacturers will also be required to provide an additional rebate for brand name and generic drugs when their prices rise faster than inflation. [$121.3 billion in savings over 10 years]

Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap
Prior to the passage of the Affordable Care Act, beneficiaries were responsible for the full cost of their medications while in the Medicare Part D coverage gap. The law closes this gap by 2020 through a combination of manufacturer discounts and federal

subsidies. Currently, beneficiaries in the Medicare Part D coverage gap receive a 50 percent discount from pharmaceutical manufacturers on their brand drugs. Beginning in plan year 2018, this proposal will increase manufacturer discounts to 75 percent, effectively closing the coverage gap for brand drugs three years earlier than under current law. The phase-out for generic drugs will continue through 2020.
[$10.2 billion in savings over 10 years]

Modify Reimbursement of 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 to 103 percent of average sales price starting in 2017. If a physician's cost for purchasing the drug exceeds average sales price plus three percent, the drug manufacturer would be required to provide a rebate such that the net cost to the provider to acquire the drug equals average sales price plus three percent minus a standard overhead fee to be determined by the Secretary. This rebate will not be used in calculating average sales price. The Secretary will also be given authority to pay a portion or the entire amount above average sales price in the form of a flat fee rather than a percentage, with the modification to be made in a budget neutral manner relative to average sales price plus three percent. [$7.8 billion in savings over 10 years]

Require Mandatory Reporting of Other Prescription Drug Coverage

Although health plans offered by employers and unions are required by Medicare secondary payer-related law to report enrollment information on certain active employees, there is no requirement for other group health plans that offer a prescription drug benefit to report their plan enrollees with drug coverage to HHS or the Part D plan sponsors. This proposal extends mandatory reporting requirements to include prescription drug coverage. This extension ensures that all prescription drug coverage provided by group health plans that is primary to Medicare coverage is communicated to HHS and to Part D sponsors, thereby permitting sponsors to comply with the statutory Medicare secondary payer requirements. [$480 million in savings over 10 years]

Allow the Secretary to Negotiate Prices for Biologics and High Cost Prescription Drugs

Beginning in 2017, this proposal would give the Secretary the authority to directly negotiate prices with manufacturers for high-cost drugs and biologics covered under Part D. As a condition of participation in the Part D program, manufacturers must engage in negotiations with HHS. As part of the negotiation, manufacturers would be required to supply HHS with all cost and clinical data, as well as other information, necessary to come to an agreement on price. The final price would be indexed to the Consumer Price Index, and plan sponsors will be permitted to negotiate additional discounts off this price. HHS will monitor for increased introductions of physician administered drugs, which are reimbursed under Part B at the average sales price plus six percent instead of under Part D, and for excess price inflation for drugs currently on the market. [No budget impact]

Change the Part D Coverage Gap Discount Program Agreements from Annually to Quarterly

This proposal allows CMS to contract with pharmaceutical manufacturers on a quarterly, rather than an annual, basis for the Part D coverage gap discount program. In order for a manufacturer's agreement to be in effect in a designated quarter, the manufacturer will enter into the agreement by the first day of the preceding quarter. Increasing the frequency of the coverage gap discount program contracting process will help ensure that Medicare beneficiaries have continued access to a wide range of drugs, including newly-approved drugs, without unnecessary delays. [No budget impact]

Establish Authority for a Program to Prevent Prescription Drug Abuse in Medicare Part D

HHS requires Part D sponsors to conduct drug utilization reviews to assess the prescriptions filled by a particular enrollee. These efforts can identify overutilization that results from inappropriate or even illegal activity by an enrollee, prescriber, or pharmacy. However, HHS's statutory authority to implement preventive measures in response to this information is limited. This proposal gives the HHS Secretary the authority to establish a program in Part D that requires that high-risk Medicare beneficiaries only utilize certain prescribers and/or pharmacies to obtain controlled substance prescriptions, similar to the programs many states utilize in Medicaid. The Medicare program will be required to ensure that beneficiaries retain reasonable access to services of adequate quality. [No budget impact]

Increase Part D Plan Sponsors' Risk for Catastrophic Drugs
This proposal increases the degree to which Part D plan sponsors are at risk for drug costs in the catastrophic phase of the Part D benefit. Currently, under the defined standard benefit, Part D sponsors are at risk for 15 percent of catastrophic drug costs. This proposal increases the proportion of catastrophic costs for which Part D sponsors are at risk by 10 percentage points per year for 6 years, until the amount sponsors are at risk for in the catastrophic phase reaches 75 percent. Beneficiaries will continue to pay 5 percent coinsurance and the federal reinsurance subsidy would gradually decline to cover the remaining 20 percent. Modifying the benefit structure as proposed provides a greater incentive for sponsors to manage drug costs in the catastrophic phase. [No budget impact]

Require Evidence Development for Coverage of High Cost Drugs
This proposal creates a coverage with evidence development process for Medicare Part D. It will be modeled in part after the coverage with evidence development process in Parts A and B of Medicare and based on the collection of data to support the use of high cost pharmaceuticals in the Medicare population. For certain identified drugs, manufacturers will be required to undertake further clinical trials and data collection to support use in the Medicare population, and for any relevant subpopulations identified by CMS. Part D plans will be able to use this evidence to improve their clinical treatment guidelines and negotiations with manufacturers. The proposal helps to ensure that the coverage and use of new high-cost drugs are based on evidence of effectiveness for specific populations. [No budget impact]

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 2017, this proposal prohibits 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 genetics. This proposal saves money in both Medicare and Medicaid. [$12.3 billion in Medicare savings over 10 years]

Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics
This proposal increases competition for biological products by reducing the number of years (from 12 to 7) that a drug company has exclusivity or monopoly pricing power and prohibiting additional years of exclusivity due to minor formulation changes. The proposal also modifies how Part B pays for biosimilar and innovator biological products. For these products, reimbursement would be based on the weighted average sales price of the reference biological product and all of its biosimilars. This proposal saves money in both Medicare and Medicaid. [$6.9 billion in Medicare savings over 10 years]

Establish Transparency and Reporting Requirements in Pharmaceutical Drug Pricing
Currently, limited public information exists on how pharmaceutical manufacturers price drugs, and no law requires manufacturers to report on the costs driving their pricing decisions. To bring greater transparency to prescription drug pricing, this proposal requires pharmaceutical manufacturers to publically disclose production costs, including research and development investments, and discounts to various payers for specific high-cost drugs that the Secretary identifies through regulation based on the public's interest. Reported transparency information may provide insight into the price of a drug as compared to the value it brings to the health care system. [No budget impact]

Medicare Structural Reforms

Eliminate Beneficiary Coinsurance for Screening Colonoscopies with Polyp Removal
Medicare beneficiaries are not subject to the Part B deductible or coinsurance for most recommended preventive and screening services, including screening colonoscopies. However, if a screening colonoscopy results in removal of a polyp, ablation, or other procedure, beneficiaries are subject to 20 percent coinsurance, which presents a financial challenge for beneficiaries to receive care. This proposal eliminates beneficiary coinsurance when the screening results in removal of a polyp or other procedure, thereby removing a significant barrier that beneficiaries face in receiving necessary preventive care. [$2.4 billion in costs over 10 years]

Increase Income Related Premiums under Medicare Parts B and D

Under Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2020, this proposal restructures income-related premiums under Medicare Parts B and D by increasing the applicable percent for calculating the lowest income-related premiums by 5 percentage points, from 35 percent to 40 percent of program costs, and creating new tiers at 52.5 percent, 65 percent, 80 percent, and 90 percent. While last year's proposal had the fourth tier at 77.5 percent, this proposal keeps the tier for those making $160,000 to $196,000 at 80 percent, consistent with the new tier created by the Medicare Access and CHIP Reauthorization Act of 2015. The proposal also maintains the current income thresholds associated with these premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. This proposal will 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. [$41.2 billion in savings over 10 years]

Encourage the Use of Generic Drugs by Low-Income Beneficiaries

Beginning in plan year 2018, this proposal induces 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 the 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 will be applied to low-income beneficiaries receiving a partial subsidy upon reaching the catastrophic coverage level. Beneficiaries qualifying for institutionalized care, who currently face no copayments, will be excluded from these changes. [$9.6 billion in savings over 10 years]

Modify the Part B Deductible for New Beneficiaries

Beneficiaries who are enrolled in Medicare Part B are required to pay an annual deductible ($166 in calendar year 2016). 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 applies a $25 increase to the Part B deductible in 2020, 2022, and 2024 respectively for new beneficiaries beginning in 2020. Current beneficiaries or near retirees will not be subject to the revised deductible. [$4.2 billion in savings over 10 years]

Introduce Home Health Copayments for New Beneficiaries

This proposal creates a co-payment for new beneficiaries of $100 per home health episode, starting in 2020. Consistent with MedPAC recommendations, this co-payment will 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. [$1.3 billion in savings over 10 years]

Reforming the Medicare Appeals Process

Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use Recovery Audit Contractor Collections

This proposal expands the Secretary's authority to retain a portion of Recovery Audit Contractor recoveries for the purpose of administering the Recovery Audit Program. This proposal will allow Recovery Audit program recoveries to fully fund Recovery Audit Contractor-related appeals at the Office of Medicare Hearings and Appeals and the Departmental Appeals Board. [$1.3 billion in cost over 10 years]

Establish a Refundable Filing Fee

This proposal institutes a refundable filing fee for Medicare Parts A and B appeals for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, and requires these entities to pay a per-claim filing fee at each level of appeal. This filing fee will allow HHS to invest in the appeals system to improve responsiveness and efficiency. Fees will be returned to appellants who receive a fully favorable appeal determination. [No budget impact]

Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold

This proposal allows the Office of Medicare Hearings and Appeals to use Medicare magistrates for appealed claims below the federal district court amount in

controversy threshold ($1,500 in calendar year 2016 and updated annually), reserving Administrative Law Judges for more complex and higher amount in controversy appeals. [No budget impact]

Expedite Procedures for Claims with No Material Fact in Dispute

This proposal allows the Office of Medicare Hearings and Appeals to issue decisions without holding a hearing if there is no material fact in dispute. These cases include appeals, for example, in which Medicare does not cover the cost of a particular drug or the Administrative Law Judge cannot find in favor of an appellant due to binding limits on authority. [No budget impact]

Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review

This proposal increases the minimum amount in controversy required for adjudication by an Administrative Law Judge to the Federal Court amount in controversy requirement ($1,500 in calendar year 2016). This will allow the amount at issue to better align with the amount spent to adjudicate the claim. Appeals not reaching the minimum amount in controversy will be adjudicated by a Medicare magistrate. The minimum amount in controversy will increase consistent with the amount in controversy set for federal court. [No budget impact]

Remand Appeals to the Redetermination Level with the Introduction of New Evidence

This proposal remands an appeal to the first level of appeal when new documentary evidence is submitted into the administrative record at the second level of appeal or above. Exceptions may be made if evidence was provided to the lower level adjudicator but erroneously omitted from the record, or an adjudicator denies an appeal on a new and different basis than earlier determinations. This proposal incentivizes appellants to include all evidence early in the appeals process and ensures the same record is reviewed and considered at subsequent levels of appeal. [No budget impact]

Sample and Consolidate Similar Claims for Administrative Efficiency

This proposal allows the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques. Additionally, this proposal authorizes the Secretary to consolidate appeals into a single administrative appeal at all levels of the appeals process. Parties who are appealing claims included within an extrapolated overpayment or consolidated previously will be required to file one appeal request for any such claims in dispute. [No budget impact]

Other Proposals

Allow Beneficiaries to Pay a Sum Certain to Medicare for Future Medical Items and Services

Medicare beneficiaries are unable to satisfy Medicare Secondary Payer “Future Medical” obligations at the time of settlement, judgment, award, or other payment because the current law does not specifically permit the Secretary to deposit such payment in the Medicare Trust Funds. Future Medical is defined as Medicare covered and otherwise reimbursable items and/or services furnished after the date of settlement, judgment, award, or other payment. This proposal expands current Medicare Secondary Payer statutory authority to permit the Secretary to deposit into the Medicare Trust Funds a lump sum, upfront payment from beneficiaries when they obtain liability insurance, no-fault insurance, and workers’ compensation settlements, judgments, awards, or other payments. [$65 million in savings over 10 years]

Clarify Calculation of the Late Enrollment Penalty for Medicare Part B Premium

This proposal clarifies that the cap on increases to the Part B premium, commonly referred to as the hold harmless provision, does not apply to the calculation of the Part B late enrollment penalty, but applies only to the annual increase to the basic Part B premium. The hold harmless provision imposes a cap on increases to the basic Part B premium based on the amount of the cost-of-living adjustment increase in a beneficiary’s Social Security benefits. This clarification is consistent with current CMS practice. [No budget impact]

Reduce Fraud, Waste, Abuse, and Improper Payments in Medicare

The Budget includes a number of Medicare program integrity proposals that strengthen the Department's and states' ability to fight fraud, waste, and abuse in the Medicare program and to reduce improper payments. See the Program Integrity chapter for proposal descriptions. [$1.4 billion in PAYGO costs and $3.3 billion in non-PAYGO savings over 10 years]

Legislative Proposals for Medicare-Medicaid Enrollees

The Budget includes four proposals to improve the quality and efficiency of care for Medicare-Medicaid, dually-eligible beneficiaries. See the Medicaid chapter for proposal descriptions. [$100 million in Medicare costs over 10 years]

HIGHLIGHTS OF THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

On April 16, 2015, the President signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law. The law repealed the Sustainable Growth Rate Formula, established stable payments updates for physicians under Medicare, and promoted value-based payments and participation in alternative payment models. Furthermore, it includes a number of other provisions that affect Medicare, most notably requiring that Social Security numbers be removed from Medicare identification cards. Overall, the Congressional Budget Office estimated that the law will increase Medicare spending by a net $118 billion over 11 years (FY 2015-FY 2025).

Merit-Based Incentive Payment System and Alternative Payment Models

MACRA supports the Department's goal to reward clinicians for value over volume by creating the new Merit-Based Incentive Payment System and providing bonus payments for participation in eligible alternative payment models. The Merit-Based Incentive Payment System combines several current quality programs for physicians and healthcare professionals into one comprehensive program starting in 2019. Under the Merit-Based Incentive Payment System, positive and negative payment adjustments will be made under the Medicare physician fee schedule based on quality performance, resource use, use of electronic health records, and participation in clinical practice improvement activities. These adjustments are capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years. Between 2019 and 2024, Medicare physicians and healthcare professionals can also receive an additional positive adjustment for exceptional performance. Physicians and healthcare professionals who are new to Medicare, have a low volume of Medicare patients, or receive the incentive payment for participating in an eligible alternative payment model described below, are exempt from the Merit-Based Incentive Payment System.

For physicians and healthcare professionals who qualify to receive a separate incentive payment for participating in an eligible alternative payment model, MACRA provides a five percent lump sum payment each year from FY 2019 to FY 2024. In order to be a "qualifying alternative payment model participant," a physician or healthcare professional must receive a certain amount of their payments through an entity (such as an accountable care organization) that participates in an eligible alternative payment model. An alternative payment model is defined as a Center for Medicare and Medicaid Innovation model (but not a Health Care Innovation awardee), the Medicare Shared Savings Program, a Health Care Quality Demonstration, or any other demonstration authorized under federal law. In order to be deemed an eligible alternative payment model, the model must:

NEW INITIATIVE

Medicare Access and CHIP Reauthorization Act: Supporting Goals on Value-based Payments and Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act (MACRA) is part of a broad effort to promote quality and value in Medicare. Through MACRA, HHS aims to

- Support multi-payer initiatives and the development of alternative payment models in Medicare and Medicaid.
- Offer multiple pathways with varying levels of risk and reward for physicians and other healthcare professionals to tie more of their payments to value and expand opportunities for them to participate in alternative payment models over time.
- Increase the long-term efficiency of the Medicare program.
- Improve the quality of care that Medicare beneficiaries receive.
- Minimize additional reporting burdens for alternative payment model participants.
- Promote understanding of each physician's or practitioner's status with respect to the Merit-Based Incentive Payment System and/or alternative payment models.

1) base payment off of performance on a set of quality measures, 2) require the use of certified electronic health record technology, and 3) include greater than nominal financial risk or be a medical home expanded under Innovation Center authority. The percentage thresholds for being a qualifying alternative payment model participant increase over time. Initially there is only a Medicare threshold, but starting in 2021, there is both a Medicare payment threshold option and a combined all-payer and Medicare threshold option. Including an all-payer threshold means that physicians and healthcare professionals have the potential to be rewarded with Medicare incentive payments for alternative payment model participation that includes payers outside the Medicare program. As a result, the Medicare incentive payments envisioned in MACRA have the potential to drive greater health system-wide alternative payment model participation.

Social Security Number Removal

MACRA also included the requirement that Social Security numbers be removed from all Medicare cards in order to protect beneficiaries against identity theft. The law provides $320 million for CMS, the Social Security Administration, and the Railroad Retirement Board to implement this change by April 2019. CMS is currently working towards updates to information technology systems to support seamless implementation of this change.

HIGHLIGHTS OF THE BIPARTISAN BUDGET ACT OF 2015

The Bipartisan Budget Act of 2015 was enacted on November 2, 2015. The Act included several significant Medicare program changes—generating $9.5 billion in program savings from FY 2016 to FY 2025, in addition to $11.2 billion in savings from extending the 2 percent Medicare sequester through FY 2025.

Part B Premium Fix

The Bipartisan Budget Act of 2015 included a provision that changed the calculation of the Medicare Part B premium for 2016. Due to the 0 percent cost-of-living adjustment in Social Security benefits, about 70 percent of Medicare beneficiaries are held harmless from increases in their Part B premiums for 2016 and continue to pay the same $104.90 monthly premium as in 2015. The remaining 30 percent of beneficiaries who are not held harmless would have faced a monthly premium this year of more than $150 (a nearly 50 percent increase from 2015). Under the Act, these beneficiaries will instead pay a standard monthly premium of $121.80, which represents the actuary's premium estimate of the amount that would have applied to all beneficiaries without the hold harmless provision plus an add-on amount of $3. In order to make up the difference in lost revenue from the decrease in premiums, the Act requires a loan of general revenue from Treasury to the Part B Trust Fund. To repay this loan, the standard Part B monthly premium in a given year is increased by the $3 add-on amount until this loan is fully repaid, though the hold harmless provision still applies to this $3 premium increase. This provision will apply again in 2017 if there is a zero percent cost-of-living adjustment from Social Security.

Off-Campus Outpatient Provider Payment Policy

The Act codified the CMS definition of provider-based off-campus hospital outpatient departments (i.e., outpatient providers) as those locations that are not on the main campus of a hospital and are located more than 250 yards from the main campus. Beginning on January 1, 2017, these off-campus provider-based departments must bill under the applicable payment (likely the Physician Fee Schedule and Ambulatory Surgical Center Payment System) rather than the Outpatient Prospective Payment System, saving $9.3 billion over 10 years (FY 2016-2025). The section excludes any off-campus outpatient department provider that is already "billing" Medicare for covered outpatient provider department services under the Outpatient Prospective Payment System prior to November 2, 2015, and excludes services furnished by a dedicated emergency department. This provision is a modified version of a proposal included in the 2016 President's Budget.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

The mission of the Quality Improvement Organization Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The Organizations are experts in the field working to drive local change, which can translate into national quality improvement. The current 5 year contract cycle, or 11th Statement of Work, began on August 1, 2014, and provides approximately $580 million in FY 2017 and $4.1 billion over 5 years.

In the 11th Statement of Work, there are 14 Quality Innovation Network contracts and 5 Beneficiary and Family Centered Care contracts. Quality Innovation

Network contractors have been working to reduce patient harms such as central-line bloodstream infections, hospital readmissions, and adverse drug events. Beneficiary and Family Centered Care is the program's statutory case review work, and includes beneficiary complaints, concerns related to early discharge from health care settings, and patient and family engagement. Since August 2014, nearly 200,000 case reviews have been conducted. Effective January 2016, Beneficiary and Family Centered Care Contract Quality Improvement Organizations assumed the initial reviews of short-stay hospital claims under a probe and educate process.

PROGRAM HIGHLIGHT

Estimated Quality Improvement Organization Funding 11th Statement of Work (2014-2018)
(dollars in millions)

Clinical Quality Improvement	$827
Value-Based Purchasing Support Contracts and Quality Measures	$1,110
Infrastructure, Coordinating Centers, and Special Initiatives	$574
Beneficiary and Family Centered Care	$479
Other Support Contracts and Staff	$1,066
Subtotal Funding	$4,056

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FY 2017 Medicare Legislative Proposals

(Negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	*2017*	*2017 -2021*	*2017 -2026*
Support Delivery System Reform			
Payment Incentives			
Reform Medicare Advantage Payments to Improve the Efficiency and Sustainability of the Program	—	-19,910	-77,240
Implement Bundled Payment for Post-Acute Care	—	-470	-9,850
Expand Basis for Beneficiary Assignment for Accountable Care Organizations to include Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists	—	-40	-150
Allow CMS to Assign Beneficiaries to Federally Qualified Health Centers and Rural Health Clinics Participating in the Medicare Shared Savings Program	—	-20	-80
Allow Accountable Care Organizations to Pay Beneficiaries for Primary Care Visits up to the Applicable Medicare Cost-Sharing Amount	—	-40	-70
Establish a Bonus Payment for Hospitals Cooperating with Certain Alternative Payment Models	—	—	—
Establish a Hospital-Wide Readmissions Reduction Measure	—	—	—
Establish Quality Bonus Payments for High-Performing Part D Plans	—	—	—
Extend Accountability for Hospital-Acquired Conditions	—	—	—
Implement Value-Based Purchasing for Additional Providers	—	—	—
Care Delivery			
Expand the Ability of Medicare Advantage Organizations to Pay for Services Delivered via Telehealth	—	-60	-160
Allow the Secretary to Introduce Primary Care Payments under the Physician Fee Schedule in a Budget Neutral Manner	—	—	—
Information			
Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Programs (non-add)	—	*4,450*	*5,200*
Medicare Impact	—	650	760
Medicaid Impact (non-add)	—	*3,800*	*4,440*
Increase Value in Medicare Provider Payments			
Eliminate the 190-day Lifetime Limit on Inpatient Psychiatric Facility Services	160	1,020	2,370
Update Medicare Disproportionate Share Formula for Hospitals in Puerto Rico	—	20	70
Adjust Payment Updates for Certain Post-Acute Care Providers	-1,600	-19,160	-86,580
Strengthen the Independent Payment Advisory Board to Reduce Long-Term Drivers of Medicare Cost Growth	—	-1,067	-36,394
Reduce Medicare Coverage of Bad Debts	-410	-11,320	-32,920
Encourage Workforce Development Through Targeted and More Accurate Indirect Medical Education Payments	-1,170	-7,350	-17,800
Reform Medicare Hospice Payments	—	-2,590	-9,250
Exclude Certain Services from the In-Office Ancillary Services Exception	—	-1,750	-4,980
Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment	—	-1,070	-3,750
Encourage Appropriate Use of Inpatient Rehabilitation Facilities	-160	-960	-2,150

FY 2017 Medicare Legislative Proposals (cont.)

dollars in millions	*2017*	*2017 -2021*	*2017 -2026*
Increase Value in Medicare Provider Payments (Continued)			
Reduce Critical Access Hospital Reimbursements from 101 Percent of Reasonable Costs to 100 Percent of Reasonable Costs	-110	-690	-1,670
Prohibit Critical Access Hospital Designation for Facilities that are Less than 10 Miles from the Nearest Hospital	-60	-360	-880
Allow the Secretary to Determine Hospital Acquired Condition Program Penalty Amounts and Distribution	—	—	—
Clarify the Medicare Fraction in the Medicare Disproportionate Share Hospital Statute	—	—	—
Modernize Funding for End Stage Renal Disease Networks	—	—	—
Recoup Initial Clinical Laboratory Fee Schedule Payments for Advanced Diagnostic Laboratory Tests in Excess of 100 Percent of the Final Payment Amount	—	—	—
Repeal the Rental Cap for Oxygen Equipment	—	—	—
Address the Rising Cost of Pharmaceuticals			
Align Medicare Drug Payment Policies with Medicaid Policies for Low-Income Beneficiaries	—	-29,510	-121,250
Accelerate Manufacturer Discounts for Brand Drugs to Provide Relief to Medicare Beneficiaries in the Coverage Gap	—	-3,260	-10,210
Modify Reimbursement of Part B Drugs	—	-2,600	-7,750
Require Mandatory Reporting of Other Prescription Drug Coverage	-10	-170	-480
Allow the Secretary to Negotiate Prices for Biologics and High Cost Prescription Drugs	—	—	—
Change the Part D Coverage Gap Discount Program Agreements from Annually to Quarterly	—	—	—
Establish Authority for a Program to Prevent Prescription Drug Abuse in Medicare Part D	—	—	—
Increase Part D Plan Sponsors' Risk for Catastrophic Drugs	—	—	—
Require Evidence Development for Coverage of High Cost Drugs	—	—	—
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)	-800	-4,910	-12,250
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicare impact)	—	-1,580	-6,890
Establish Transparency and Reporting Requirements in Pharmaceutical Drug Pricing	—	—	—
Medicare Structural Reforms			
Eliminate Beneficiary Coinsurance for Screening Colonoscopies with Polyp Removal	160	950	2,430
Increase Income Related Premiums under Medicare Parts B and D	—	-5,260	-41,230
Encourage the Use of Generic Drugs by Low-Income Beneficiaries	—	-3,330	-9,630
Modify the Part B Deductible for New Beneficiaries	—	-140	-4,230
Introduce Home Health Copayments for New Beneficiaries	—	-100	-1,300
Reforming the Medicare Appeals Process			
Provide Office of Medicare Hearings and Appeals and Department Appeals Board Authority to Use Recovery Audit Contractor Collections	127	635	1,270
Establish a Refundable Filing Fee	—	—	—

FY 2017 Medicare Legislative Proposals (cont.)

dollars in millions	*2017*	*2017 -2021*	*2017 -2026*
Reforming the Medicare Appeals Process (Continued)			
Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold	—	—	—
Expedite Procedures for Claims with No Material Fact in Dispute	—	—	—
Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review	—	—	—
Remand Appeals to the Redetermination Level with the Introduction of New Evidence	—	—	—
Sample and Consolidate Similar Claims for Administrative Efficiency	—	—	—
Other Proposals			
Allow Beneficiaries to Pay a Sum Certain to Medicare for Future Medical Items and Services	—	-65	-65
Clarify Calculation of the Late Enrollment Penalty for Medicare Part B Premiums	—	—	—
Reduce Fraud, Waste, and Abuse in Medicare /1	111	612	1,443
Medicare-Medicaid Enrollee Proposals (Medicare Impact) /2	—	20	100
Interactions /3	33	15,660	71,328
Total /4	**-3,729**	**-98,215**	**-419,438**

1/ These proposals are described in the Program Integrity chapter, which reports the total cost of the proposal to both Medicare and Medicaid.
2/ These proposals are described in the Medicaid chapter, which reports the total cost of the proposal to both Medicare and Medicaid.
3/ Adjusts for reductions in baseline IPAB savings as a result of budget proposals and other Medicare interactions.
4/ This total does not include non-PAYGO savings.

Program Integrity

dollars in millions	2015	2016	2017	2017 +/-2016
HCFAC Discretionary /1	672	681	725	+44
HCFAC Mandatory /2	1,273	1,279	1,324	+45
Affordable Care Act (non-add)	*152*	*156*	*151*	*-5*
Total, Budget Authority	**1,945**	**1,960**	**2,049**	**+89**

1/ The FY 2015 and FY 2016 mandatory base includes sequester reductions.
2/ 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 2017 Budget supports fraud prevention and the reduction of improper payments, which are top priorities of the Administration. For FY 2017, the Budget proposes $199 million in new mandatory and discretionary investments to address healthcare fraud, waste, and abuse. Together, the program integrity investments in the Budget will yield $23.8 billion in 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 and cut fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

HEALTH CARE FRAUD AND ABUSE CONTROL FUNDING

The FY 2017 Budget proposes to build on recent progress by increasing support for the Health Care Fraud and Abuse Control (HCFAC) program through both mandatory and discretionary funding streams. The FY 2017 HCFAC program level is $2 billion. Of the total FY 2017 program level, $1.3 billion is mandatory funding and $725 million is discretionary funding.

HCFAC Discretionary Funds

The Budget requests $725 million in discretionary HCFAC funding, which is $44 million above the FY 2016 enacted level. Consistent with the Budget Control Act of 2011, the Budget requests base discretionary funds ($311 million) plus a discretionary cap adjustment ($414 million). The discretionary funding is allocated to CMS program integrity activities ($487 million), the Department of Justice (DOJ) ($116 million) and the HHS OIG ($122 million). Relative to the FY 2016 enacted level, the request includes more funds from the cap adjustment for HHS's law enforcement partners to expand Strike Force capacity and support rigorous data analysis and increase focus on civil fraud, such as off-label marketing and pharmaceutical fraud. The Budget request also seeks the authority to use HCFAC discretionary funds to prevent fraud, waste, and abuse in the private health insurance market, including the Marketplaces.

The HCFAC investment also supports efforts to reduce the Medicare fee-for-service improper payment rate, increase oversight in both Medicare and Medicaid

HCFAC Multi-Year Investment and Savings
(in millions)

	2016	2017	2018	2019	2020	2021	2017 -2021	2017 -2026
Mandatory Funding	1,279	1,324	1,352	1,379	1,409	1,429	6,893	14,548
Discretionary Funding	681	725	745	765	786	807	3,828	8,212
Total Program Level /1	**1,960**	**2,049**	**2,097**	**2,144**	**2,195**	**2,236**	**10,721**	**22,760**
Savings from Discretionary Investment /2	*-749*	*-795*	*-844*	*-894*	*-947*	*-991*	*-4,471*	*-10,155*

1/ Total Program Levels may not add due to rounding.
2/ Savings are the gross savings attributable only to the discretionary investment above the base discretionary funds ($311 million annually). Savings are not scorable under PAYGO.

managed care, and strengthen the Health Care Fraud Prevention Partnership among the federal government, private insurers, and other stakeholders. CMS will also make further investments in innovative prevention initiatives, such as the Fraud Prevention System and Medicare prior authorization.

HCFAC Mandatory Funds

The $1.3 billion in mandatory base funds for FY 2017 are financed from the Medicare Part A Trust Fund. The funding is allocated to: the Medicare Integrity Program; the HCFAC Account, which is divided annually among the HHS OIG; other HHS agencies; 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 reduction, provider education, data analysis, audits, investigations, and enforcement.

PROGRAM HIGHLIGHT

Expanding Program Integrity Efforts in Key Areas

CMS is applying lessons learned from successes in Medicare fee-for-service program integrity efforts to Medicaid, private insurance programs, and Medicare Parts C and D:

- In Medicaid, CMS is increasing efforts to work with states to prevent fraud and to keep fraudulent providers from enrolling in Medicaid, including plans to facilitate states' provider enrollment and provider screening efforts by making state Medicaid and CHIP provider enrollment data available to all states as part of upgrades to the Provider Enrollment, Chain, and Ownership System.
- CMS is also applying lessons learned from past data analytics and data matching projects to available Marketplace data and having regular discussions with State-based Marketplaces around best practices to detect and prevent fraud, waste, and abuse.
- The Budget also supports CMS's continued efforts to enhance Part D program integrity, including a proposal to suspend coverage and payment for drugs prescribed by providers who have been engaged in misprescribing drugs.

Return on Investment

Program integrity returns on investment are measured by program area and separately reported by activity type. There are three key ways in which returns from program integrity activities are described. First, programs supported by HCFAC mandatory funds have a proven record of returning more money to the Medicare Trust Funds than the dollars spent. The most recent estimate of the Medicare Integrity Program 3-year return on investment is $14 to $1, and the Medicare Integrity Program has recently yielded a consistent return of over $10 billion in savings annually.

Second, the 3-year rolling average return on investment for HCFAC law enforcement activities is $7.7 to $1. In FY 2014 alone, $3.3 billion was recovered, including $1.9 billion returned to the Medicare Trust Funds and $523 million in federal Medicaid recoveries returned to the Treasury.

Third, CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud; about $2 is saved or avoided. Based on these projections, the $5.1 billion in additional discretionary HCFAC funding, as part of a multi-year HCFAC investment included in the Budget, will yield additional Medicare and Medicaid savings of $10.2 billion over 10 years. The HCFAC return on investment demonstrates that in recent years the actual recoveries from HCFAC efforts have far exceeded the projected savings.

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.

PROGRAM HIGHLIGHT

Medicaid Program Integrity at a Glance

In 2015, 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 $1.0 billion in questionable reimbursements and recovered $1.0 billion in questionable costs.
- The Medicaid Integrity Institute enrolled 1,073 employees from all 50 states, the District of Columbia, and Puerto Rico in 22 program integrity training courses, 1 workgroup, and 13 webinars.
- Collaborative audits with states identified $35.1 million in overpayments.

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 such as

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 HCFAC.

SUCCESSFUL NEW TOOLS FOR COMBATING FRAUD AND ABUSE

Numerous program integrity enhancements enacted in the Affordable Care Act and subsequent legislation have allowed CMS to take the actions necessary to better ensure that the correct payment is made to the right provider for an appropriate medical service.

The Affordable Care Act

The Affordable Care Act included an additional $350 million in program integrity resources over 10 years, plus an inflation adjustment, and provided unprecedented tools to protect Medicare, Medicaid, and CHIP from fraud, waste, and abuse. These tools include enhanced provider screening, which has allowed CMS to deactivate 543,163 and revoke 34,888 providers and suppliers since 2011, ensuring that bad actors can no longer bill Medicare inappropriately. These enhanced tools have led to more than $2.4 billion in Medicare savings since 2010.

Small Business Jobs Act

In 2011, CMS began implementation of the Fraud Prevention System, which is a sophisticated predictive analytics tool, required by the Small Business Jobs Act. In the first 3 years of implementation, the Fraud Prevention System prevented or identified $820 million in inappropriate billing in the Medicare program, yielding a $10 to $1 return on investment. This system marks a significant shift from a "pay and chase" model to a prevention approach using similar technology used by the credit card industry.

The Medicare Access and CHIP Reauthorization Act

The Act provides enhanced tools to reduce fraud and improve program integrity in Medicare, including the expansion of prior authorization in Medicare fee-for-service and the removal of Social Security numbers on Medicare cards to protect against identity theft. Additionally, the Act provides the authority to use a portion of recoveries from the Recovery Audit Program determinations toward efforts that reduce improper payments. Once implemented, the provisions included in this Act will likely have a significant impact on reducing the Medicare improper payment rate and preventing fraud and abuse in the Medicare program.

The Patient Access and Medicare Protection Act

This recently enacted law includes several provisions that were included in prior Budgets that will enhance Medicare and Medicaid program integrity. The Act provides new flexibility to the Medicaid Integrity Program with respect to using contractors and dedicated staff for specific activities. Additionally, the Act includes a provision that allows more flexibility in using the funds earmarked for the Medicare-Medicaid data match program, which will allow CMS to enhance collaborative efforts between Medicare and Medicaid to fight fraud, waste, and abuse.

MEDICARE STRIKE FORCE SUCCESS

The Medicare Fraud Strike Force is a partnership between HHS and DOJ currently 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. The HCFAC law enforcement partners plan to use the additional resources appropriated to enhance efforts in existing Strike Force cities and potentially expand into new service areas based on data showing high incidences of fraud.

In June 2015, this joint effort led to a nationwide takedown resulting in charges against 243 individuals for approximately $712 million in false billing. Since its inception, Strike Force prosecutors filed more than 963 cases, charging more than 2,097 defendants who collectively billed the Medicare program more than $6.5 billion. Strike Force prosecutors secured 1,443 guilty pleas and 191 others were convicted in jury trials, and 1,197 defendants were sentenced to imprisonment for an average term of nearly 4 years. This Budget allows HHS and DOJ to continue strengthening Strike Force presence across the country.

PROGRAM INTEGRITY LEGISLATIVE PROPOSALS

The Budget includes legislative proposals to further strengthen program integrity for Medicare, Medicaid, and CHIP that will yield billions in net savings over 10 years.

Medicare

Retain a Portion of Medicare 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 Contractors to administer the program and can use some funds to implement additional corrective actions, such as new processing edits and provider education to reduce improper payments. This proposal allows additional funding for corrective actions above the amounts made available for this purpose in the Medicare Access and CHIP Reauthorization Act. [$2.5 billion in costs and $3.3 billion in non-scorable savings over 10 years]

Suspend Coverage and Payment for Questionable Part D Prescriptions and Incomplete Clinical Information

This proposal provides the Secretary authority to suspend coverage and payment for drugs when those prescriptions present an imminent risk to patients or when they are prescribed by providers who have been engaged in misprescribing or overprescribing drugs with abuse potential. In addition, the proposal provides the Secretary authority to require additional clinical information on certain Part D prescriptions, such as diagnosis and incident codes, as a condition of coverage. [$780 million in savings over 10 years]

Allow Prior Authorization for Medicare Fee-for-service Items and Services

Currently, CMS has authority to require prior authorization for specified Medicare fee-for-service items and services. This proposal extends that authority to all Medicare fee-for-service items and services, particularly those that are at the highest risk for improper payment. By allowing prior authorization on additional items and services, CMS can make sure in advance that the correct payment goes to the right provider for the appropriate service, and prevent future audits on those payments. [$75 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 allows penalties if providers and suppliers fail to update their records, providing an additional incentive to report up to date information and helping reduce program vulnerability to fraud. [$32 million in savings over 10 years]

Assess a Fee on Physicians and Practitioners Who Order Services or Supplies without Proper Documentation

This proposal allows the Secretary to assess an administrative fee on providers for claims that have not been properly documented for high risk, high cost items. The proposal only applies when there is insufficient documentation and would not apply to a determination that a fully documented ordered item or service was reasonable and necessary. The fee would be $50 per Part B item/service and $100 per Part A service. This proposal would be implemented after one year of instructional billing. [No budget impact]

Establish a Registration Process for Clearinghouses and Billing Agents

This proposal expands the provider screening authorities included in the Affordable Care Act by establishing a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers. This proposal also allows CMS to obtain organizational information from clearinghouses and billing agents. [No budget impact]

Allow Collection of Application Fees from Individual Providers and Suppliers

This proposal allows the Secretary to require a Medicare application fee for individual providers in addition to the existing fee on institutional providers. The fee will start at $50 and be adjusted by inflation annually thereafter. This fee supports provider screening, which prevents bad actors from being in the program before they can improperly bill Medicare. [No budget impact]

Pay Recovery Auditor after a Qualified Independent Contractor Decision on Appealed Claims

The proposal allows the Secretary to withhold payment to a Recovery Audit Contractor if a provider or supplier has filed an appeal with the Qualified Independent Contractor and a decision is pending. Aligning the Recovery Auditor contingency fee payments with the outcome of the appeal will make sure that CMS has assurance of the Recovery Audit Contractor's determination before making payment. [No budget impact]

Require a Surety Bond or Escrow Account to Cover Overturned Recovery Auditor Determinations

This proposal would require that payment to a Recovery Auditor must also include a surety bond to cover any potential costs associated with decisions overturned on appeal. This surety bond would apply even for decisions overturned after the conclusion of the Recover Auditor contract. The bond would protect

the federal government from having to cover the costs of an overturned Recovery Auditor determination after that entity's contract has expired. [No budget impact]

Medicaid

Expand Funding for the Medicaid Integrity Program

This proposal increases the Medicaid Integrity Program by $580 million over 10 years on top of the current funding level. The additional investment starts with an additional $25 million in FY 2017 and increases gradually to an additional $100 million in FY 2026. Thereafter, the total will be annually adjusted by the Consumer Price Index. This funding will be used to address additional program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing; technical assistance to states to address improper payments, and other efforts to assist states to fight fraud, waste, and abuse. Over time, the inflation adjusted investment will support initiatives that respond to emerging vulnerabilities. [$580 million in costs and $1.3 billion in non-scorable savings over 10 years]

Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

This proposal requires states to 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 plans to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care. This proposal is part of the Secretary's initiative for Preventing Opioid Abuse, Misuse, and Overdose, which is described in the Budget in Brief overview. [$770 million in savings over 10 years]

Strengthen CMS Compliance Tools in Medicaid Managed Care

This proposal augments CMS's financial oversight and compliance tools in Medicaid managed care by providing CMS maximum flexibility to disallow and defer individual payments or partial payments associated with contracts with managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans. This proposal allows CMS to tailor deferrals and disallowances to the severity and scope of specific violations, making these managed care compliance tools more effective and more consistent with similar authorities in fee-for-service Medicaid. [No budget impact]

Require States to Suspend Medicaid Payments when the Secretary Determines there is a Significant Risk of Fraud

This proposal requires state Medicaid agencies to suspend payments to providers when the Secretary determines that the providers pose a significant risk of fraud to the Medicaid program, unless the state agency demonstrates that the benefits of continuing payments to the provider outweigh the risk of losses to fraud. [No budget impact]

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 established in 1978, at a time

Medicaid Integrity Program Multi-Year Investment and Savings
(in millions)

	2016	2017	2018	2018	2020	2021	2017 -2021	2017 -2026
Mandatory Base Funding /1	77	84	86	88	89	91	438	928
Proposed Mandatory Funding /1	-	25	30	35	40	50	180	580
Total Program Level	**77**	**109**	**116**	**123**	**129**	**141**	**618**	**1,508**
Savings from Mandatory Investment /2:	*0*	*-85*	*-90*	*-100*	*-105*	*-115*	*-495*	*-1,255*

1/ Funding numbers reflect sequestration of base funding for FY 2016 and include an 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.

when Medicaid services were typically provided in an institutional setting, but does not reflect the shift in delivery and payment for health services to in-home and community based settings. [No budget impact, but $72 million in non-scorable savings over 10 years]

Consolidate Redundant Error Rate Measurement Programs

This proposal alleviates state program integrity reporting requirements and creates 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 principle in statute, this proposal prevents states from using federal funds to pay the state share of Medicaid or CHIP, unless specifically authorized under law. [No budget impact]

Medicare and Medicaid

Allow the Secretary to Reject Claims from New Providers and Suppliers Located Outside Moratorium Areas

This proposal permits the Secretary to reject claims for unnecessary services furnished by newly-enrolled providers and suppliers in localities outside the moratoria areas to beneficiaries located inside that area. Using the authorities provided in the Affordable Care Act, CMS has imposed temporary enrollment moratoria designed to stem the overabundance of certain types of providers and suppliers and the overutilization of certain types of services within particular geographic areas. Some providers and suppliers are circumventing the moratoria by enrolling in localities just outside the moratorium area.
[$50 million in savings over 10 years]

Protect Program Integrity Algorithms from Disclosure

The proposal would protect anti-fraud and abuse algorithms developed for Medicare, Medicaid, and CHIP from disclosure. This will allow the Secretary and states to freely share algorithms developed through new predictive analytic tools. These algorithms are vital to uncovering fraud, waste, and abuse and serve as key intelligence for combating bad actors. Should various aspects of these algorithms become known, fraudsters could utilize the information to re-direct their schemes to other areas of the Medicare, Medicaid, and CHIP programs or adjust their schemes to avoid detection. Therefore, in order to ensure states and the Department can learn from each other's experience in combating fraud, they need to do so without compromising the integrity of the algorithms.
[$90 million in savings over 10 years]

Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities

This proposal expands 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. [$70 million in savings over 10 years]

Establish Gifting Authority for the Healthcare Fraud Prevention Partnership

This proposal gives the authority to accept gifts made to the Medicare Trust Funds for particular activities funded through the HCFAC Account, such as the Healthcare Fraud Prevention Partnership. Currently, the HCFAC account can only receive gifts that are made for an unspecified purpose. This proposal allows for gifts to be made to support the Partnership directly, and allows both public and private partners to support the anti-fraud program. [No budget impact]

Publish the National Provider Identifier for Covered Recipients in the Open Payment Program

This proposal allows CMS to publish the National Provider Identifier of covered recipients on the public Open Payments website. Adding this identifier to the published data made on the Open Payments website will make it easier for data users to connect Open Payments records with covered recipient information, allowing greater access and transparency of the data. This addition will not make public any data that is not already currently available to the general public. [No budget impact]

FY 2017 Program Integrity Legislative Proposals

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

dollars in millions	2017	2017 -2021	2017 -2026
Medicare			
Retain a Portion of Medicare Recovery Audit Contract Recoveries to Implement Actions That Prevent Fraud and Abuse	130	1,010	2,520
Suspend Coverage and Payment for Questionable Part D Prescriptions and Incomplete Clinical Information	--	-280	-780
Allow Prior Authorization for Medicare Fee-for-Service Items and Services	-5	-25	-75
Allow Civil Monetary Penalties for Providers and Suppliers who Fail to Update Enrollment Records	-2	-13	-32
Assess a Fee on Physicians and Practitioners Who Order Services or Supplies Without Proper Documentation	—	—	—
Establish Registration Process for Clearinghouses and Billing Agents	—	—	—
Allow Collection of Application Fees from Individual Providers and Suppliers	—	—	—
Pay Recovery Auditors After a Qualified Independent Contractor Decision on Appealed Claims	—	—	—
Require a Surety Bond or Escrow Account to Cover Overturned Recovery Auditor Determinations	—	—	—
Medicaid			
Expand Funding for the Medicaid Integrity Program	25	180	580
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-30	-320	-770
Strengthen CMS Compliance Tools in Medicaid Managed Care	—	—	—
Require States to Suspend Medicaid Payments when the Secretary Determines there is a Significant Risk of Fraud	—	—	—
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			
Protect Program Integrity Algorithms from Disclosure	-9	-45	-90
Medicare [non-add]	*-7*	*-35*	*-70*
Medicaid [non-add]	*-2*	*-10*	*-20*
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	—	-20	-70
Medicare [non-add]	—	*-20*	*-70*
Medicaid [non-add]	—	—	—
Allow the Secretary to Reject Claims from New Providers and Suppliers Located Outside Moratorium Areas	-5	-25	-50
Medicare [non-add]	*-5*	*-25*	*-50*
Medicaid [non-add]	—	—	—
Establish Gifting Authority for the Healthcare Fraud Prevention Partnership	—	—	—
Publish National Provider Identifier for Covered Recipients in the Open Payments Program	—	—	—
Total, Program Integrity Legislative Impact	**104**	**462**	**1,233**
Subtotal, Medicare Impact	*111*	*612*	*1,443*
Subtotal, Medicaid Impact	*-7*	*-150*	*-210*

FY 2017 Program Integrity Legislative Proposals (cont.)

dollars in millions	2017	2017 -2021	2017 -2026
Non-PAYGO Savings/1			
Savings from Discretionary HCFAC Investment	-795	-4,471	-10,155
Savings from Retention of Medicare Recovery Audit Recoveries to Implement Actions	-20	-840	-3,320
Savings from Expanding Medicaid Fraud Control Unit Review to Additional Care Settings	-6	-32	-72
Savings from Expanding Funding for the Medicaid Integrity Program	-85	-495	-1,255
Savings from Social Security Program Integrity Investment	-60	-2,396	-9,027
Subtotal, Medicare and Medicaid Savings from Program Integrity Investment	**-966**	**-8,234**	**-23,829**
Total, Net Savings Program Integrity Proposed Policy	**-862**	**-7,772**	**-22,596**

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

Medicaid

dollars in millions	2015	2016	2017	2017 +/-2016
Current Law				
Benefits /1	333,019	348,362	357,618	+9,256
State Administration	16,743	18,868	18,973	+105
Total Net Outlays, Current Law /2	**349,762**	**367,229**	**376,590**	**+9,361**
Proposed Law				
Legislative Proposals /3	—	—	9,100	+9,100
Total Net Outlays, Proposed Law	**349,762**	**367,229**	**385,690**	**+18,461**
Investment Impact				
Impacts of Program Integrity Investments /4	—	—	*-121*	*-121*
Total Net Outlays, Proposed Policy	**349,762**	**367,229**	**385,569**	**+18,340**

1/ Includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention.
2/ Includes $4 million in Medicaid outlays in FY 2017 due to a proposed change in mandatory program for a Department of State proposal.
3/ Excludes program integrity investments other than those for Medicaid Fraud Control Units.
4/ Includes the net impact of non-PAYGO savings from the HHS and Social Security Administration program integrity investments on the Medicaid baseline.

Note: Numbers may not add due to rounding.

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 2015, more than 1 in 5 individuals were enrolled in Medicaid for at least 1 month during the year, and in FY 2017, more than 70 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 2017, the federal share of current law Medicaid outlays are expected to be approximately $376.6 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 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.

Medicaid Enrollment *(person-years in millions)*	2015	2016	2017	2017 +/- 2016
Aged 65 and Over	5.6	5.7	5.9	+0.2
Blind and Disabled	10.3	10.4	10.4	+0.1
Children	27.5	27.4	27.5	+0.1
Adults	24.0	25.0	26.3	+1.3
Territories	1.5	1.4	1.4	—
Total	**68.8**	**69.9**	**71.6**	+1.7

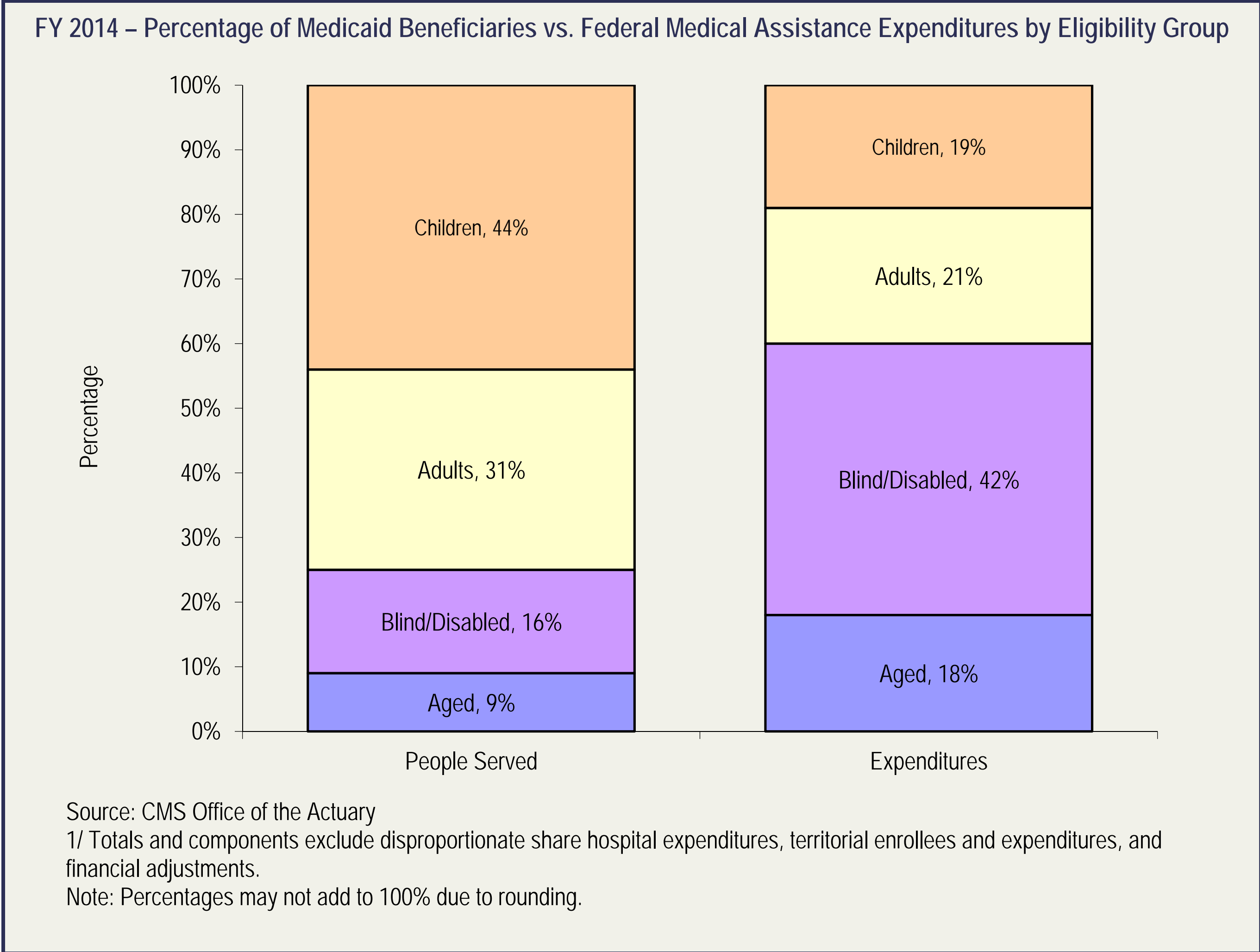
Source: CMS Office of the Actuary estimates.
Note: Numbers may not add due to rounding.

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

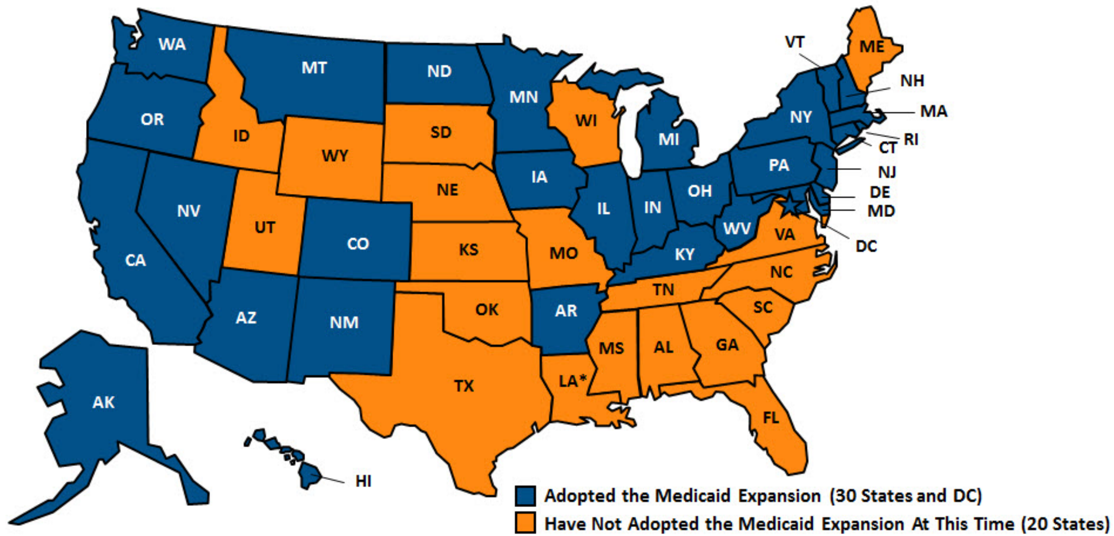
Affordable Care Act

The Affordable Care Act's Medicaid expansion, which began on January 1, 2014, allows states to expand Medicaid eligibility to individuals under age 65 with family incomes up to 133 percent of the federal poverty level (or $32,319 for a family of four in calendar year 2016). As of January 2016, 30 states and the District of Columbia have elected to expand Medicaid (Louisiana will make the 31st state).



Source: CMS Office of the Actuary
1/ Totals and components exclude disproportionate share hospital expenditures, territorial enrollees and expenditures, and financial adjustments.
Note: Percentages may not add to 100% due to rounding.

Status of Medicaid Expansion Decisions, January 15, 2016



NOTE: *Louisiana's Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

The federal government will pay 100 percent of state expenditures related to coverage for newly eligible individuals through calendar year 2016. The federal matching rate will then drop gradually to 90 percent in calendar year 2020, where it will remain. In addition, the Affordable Care Act also strengthens Medicaid program integrity efforts, improves services to Medicaid beneficiaries, and supports home and community-based settings rather than institutions.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

MACRA permanently authorized the Qualified Individual and Transitional Medical Assistance programs and extended Express Lane Eligibility authority through September 2017. The law also delayed Medicaid Disproportionate Share Hospital reductions until FY 2018 and applied an additional reduction in FY 2025.

NEW INITIATIVE

Ensure Access to Enhanced Federal Match Rate for Medicaid Expansion States

Medicaid expansion has been proven to expand insurance coverage, reduce the uncompensated care burden on state health care providers and bring additional federal resources into state economies. As of January 2016, 30 states and the District of Columbia have elected to expand Medicaid, and more states are actively discussing expansion (Louisiana will make the 31st state). Through November 2015, an additional 14.1 million individuals have gained Medicaid or CHIP coverage, many of whom would not have been eligible absent Medicaid expansion.

The Budget includes a proposal with an estimated cost of $2.6 billion over 10 years which provides all states, regardless of when they choose to expand Medicaid, the same federal share as states that expanded right away by providing 3 years of full Federal funding for newly eligible adults.

2017 LEGISLATIVE PROPOSALS

The FY 2017 Budget includes a package of Medicaid legislative proposals with a net impact to the federal government of $22.2 billion over 10 years by investing in delivery system reform efforts and improving access to high-quality and cost-effective coverage and services for Medicaid beneficiaries.[1] The Budget also strengthens Medicaid drug coverage and reimbursement and bolsters Medicaid program integrity efforts. Finally, the Budget includes proposals that impact those who are dually eligible for both Medicare and Medicaid.

Support Delivery System Reform

Reestablish the Medicaid Primary Care Payment Increase through Calendar Year 2017 and Include Additional Providers

Effective for dates of service provided on January 1, 2013, through December 31, 2014, states were required to reimburse qualified providers at the rate that would be paid for the primary care service under Medicare. The federal government covered 100 percent of the difference between the Medicaid and Medicare payment rate. This increased payment rate expired at the end of calendar year 2014. This proposal reestablishes the enhanced rate through December 31, 2017, expands eligibility to obstetricians, gynecologists, and non-physician practitioners, including physician assistants and nurse practitioners, and excludes emergency room codes to better target primary care. [$9.5 billion in costs over 10 years]

Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Programs

This proposal expands the Medicare and Medicaid Electronic Health Record Incentive Programs to include psychiatric hospitals, community mental health centers, residential and outpatient mental health and substance use disorder treatment clinics, and psychologists. This expansion will facilitate the integration of behavioral health and medical care and promote the sharing of clinical data needed to provide better patient-centered care. This proposal is described in greater detail in the Medicare chapter. [$4.4 billion in Medicaid costs over 10 years]

[1] This includes $46.0 billion in Medicaid investments offset by $23.8 billion in savings to Marketplace subsidies and related impacts, reflected in the Department of Treasury program and accounts.

Pilot Comprehensive Long-Term Care State Plan Option

This eight-year pilot program would create a comprehensive long-term care state plan option for up to five states. Participating states would be authorized to provide home and community-based care at the nursing facility level of care, creating equal access to home and community-based care and nursing facility care. The Secretary would have the discretion to make these pilots permanent at the end of the eight years. This proposal works to end the institutional bias in long-term care and simplify state administration. [$4.1 billion in costs over 10 years]

Expand Eligibility Under the Community First Choice Option

This proposal provides states with the option to make medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility. Under the current statutory language, any state interested in the Community First Choice Option must create or maintain a section 1915(c) waiver with at least one waiver service to make the Community First Choice benefit available to the special income group. The 1915(c) waivers are an option available to states to allow long-term care services in home and community-based settings under Medicaid. This process is administratively burdensome for states. This proposal provides equal access to services under the state plan option and provides states with additional tools to manage their long-term care home and community-based service delivery systems. [$3.9 billion in costs over 10 years]

Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities

This proposal provides states with additional tools to manage 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. [$1.6 billion in costs over 10 years]

Allow States to Develop Age-Specific Health Home Programs

The Affordable Care Act includes a provision that allows states to create Health Homes for Medicaid enrollees with chronic conditions. Under a Health Home program, states can develop a comprehensive system of care coordination for the purpose of integrating and coordinating all primary, acute, behavioral health, and long-term services and supports to treat the whole person. States receive an increased federal match for Health Home services for the first eight quarters of their program. This proposal allows states to target their Health Home programs by age. Currently, states are required to cover Health Home services for all categorically needy individuals with the specified chronic condition(s), regardless of age. Many states have voiced support for allowing age-specific targeting of their Health Home model to better serve the needs of youth with chronic conditions.
[$1.1 billion in costs over 10 years]

Expand Eligibility for the 1915(i) Home and Community-Based Services State Plan Option

This proposal increases states' flexibility in expanding access to home and community-based services under section 1915(i) of the Social Security Act. Currently, certain non-categorically eligible individuals who meet the needs-based criteria can only qualify for home and community-based services through the 1915(i) state plan option if they are also eligible for home and community-based services through a waiver program. This proposal removes this requirement, which will reduce the administrative burden on states and increase access to home and community-based services for the elderly and individuals with disabilities. [$374 million in costs over 10 years]

Allow Full Medicaid Benefits for Individuals in a Home and Community-Based Services State Plan Option

This proposal provides states with the option to offer full Medicaid eligibility to medically needy individuals who access home and community-based services through the state plan option under section 1915(i) of the Social Security Act. Currently, when a state elects to not apply the community income and resource rules for the medically needy, these individuals can only receive 1915(i) services and no other Medicaid services. This option will provide states with more opportunities to support the comprehensive health care needs of individuals with disabilities and the elderly. [$9 million in costs over 10 years]

Improve Access to Coverage and Services

Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults

Currently, individuals enrolled in Medicaid are required to report changes in income, assets, or other life circumstances that may affect eligibility between regularly scheduled redeterminations. This proposal creates a state plan option to allow 12 months of continuous eligibility for individuals who would otherwise be at risk of moving between insurance coverage, often referred to as churning, which disrupts existing provider relationships and increases the odds of becoming uninsured. States already have a state plan option for continuous eligibility for children in Medicaid and CHIP and that authority would be broadened to include all adults or, at state option, only adults determined eligible for Medicaid on the basis of Modified Adjusted Gross Income. [$11.1 billion in net federal costs, including $34.9 billion in Medicaid costs over 10 years]

Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid

The Budget will require coverage of preventive health services as defined in section 2713 of the Public Health Service Act without cost sharing for all adults enrolled in the Medicaid program and also expand section 4107 of the Affordable Care Act, which provides tobacco cessation services (including counseling) to pregnant women, to all Medicaid eligible populations. Such services are already required for most other populations without cost sharing, including individuals in private health plans, the Medicaid expansion population, and various other Medicaid beneficiaries. [$789 million in costs over 10 years]

Permanently Extend Express Lane Eligibility for Children

The Children's Health Insurance Program Reauthorization Act 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. MACRA extended the authorization to use Express Lane Eligibility through September 30, 2017. As of January 1, 2016, 14 states and 1 territory used this authority to partner with programs like the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families to identify, enroll, and retain children who are eligible for Medicaid or CHIP. The Budget supports a permanent extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP eligible children. [$870 million in costs over 10 years]

Require Coverage of Early and Periodic Screening, Diagnostic and Treatment Benefit for Children in Inpatient Psychiatric Treatment Facilities

While Medicaid coverage is available for children and young adults under age 21 receiving inpatient psychiatric services, these individuals are excluded from coverage of comprehensive preventive and medically necessary items and services to which Medicaid enrolled children are otherwise entitled. This proposal would lift the federal Medicaid exclusion of comprehensive children's coverage to reduce the financial burden on states and Medicaid families and encourage the provision of critical mental health services to children in Medicaid. [$505 million in costs over 10 years]

Provide Full Medicaid Coverage to Pregnant and Postpartum Beneficiaries

A statutory restriction in the Social Security Act currently allows states to limit coverage for certain eligibility groups in Medicaid to "pregnancy-related services," rather than providing full state plan benefits. CMS has issued regulations and guidance informing states that they are expected to provide comprehensive coverage to all pregnant beneficiaries, however, limitations on coverage for pregnant women persist in seven states. This proposal ensures that all pregnant and post-partum Medicaid beneficiaries have access to full Medicaid benefits. [$375 million in costs over 10 years]

Extend 100 Percent Federal Match to All Indian Health Programs

Currently, the Medicaid statute provides that a 100 percent federal match rate applies to all services provided to American Indians and Alaskan Natives for Medicaid services "received through an Indian Health Service (IHS) facility, whether operated by [IHS] or by an Indian tribe or tribal organization," which notably excludes urban Indian health programs. This proposal ensures that Medicaid services provided to American Indians and Alaskan Natives within the whole scope of the IHS/Tribal/Urban service delivery network are eligible for full federal financing. [$80 million in costs over 10 years]

NEW INITIATIVE

Strengthen Medicaid in Puerto Rico and the U.S. Territories

Federal Medicaid expenditures to the U.S. Territories are currently capped at low levels, despite much lower incomes and higher poverty rates than the mainland. While the Affordable Care Act provided $7.3 billion in additional Medicaid funding to the Territories (including $6.4 billion for Puerto Rico), Puerto Rico is projected to exhaust its enhanced funding by the end of FY 2017. Inaction would lead to drastic Medicaid cuts that will exacerbate the fiscal crisis in the Commonwealth.

As part of the Administration's roadmap to financial stability for Puerto Rico, this proposal lifts the federal cap on Medicaid funding to the Territories, expands eligibility to 100 percent of the Federal Poverty Level in territories currently below this level, raises the federal Medicaid share from 55 to 60 percent immediately, and provides financial incentives to modernize the Medicaid programs in Puerto Rico and the Territories. Under this proposal, once Puerto Rico and the Territories have ensured robust financial oversight and full mandatory benefits, including long-term care, they will become eligible for the same share of federal financial support permitted for states (83 percent).

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. 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]

Streamline Certain Medicaid Appeals Processes
Current law restricts states' ability to streamline and coordinate certain Medicaid appeals processes. This proposal increases flexibility for states in arranging their fair hearings functions and allows individuals to have a more coordinated and streamlined Medicaid fair hearings process by eliminating the requirement to provide a fair hearing at the Medicaid state agency for certain types of appeals when a state has opted to delegate Medicaid fair hearings to a Marketplace appeals entity or the Secretary. [No budget impact]

Improve Quality and Cost-Effectiveness

Extend Funding for the Medicaid Adult Health Quality Measures Program
This is a Medicaid proposal with costs to the Program Management account. See the Program Management chapter for more information.

Require Remittances for Medical Loss Ratios for Medicaid and CHIP Managed Care
This proposal gives CMS explicit authority to apply a medical loss ratio of 85 percent to Medicaid and CHIP managed care plans that includes a requirement that states collect a remittance of any amounts spent in excess of the medical loss ratio and returns the federal share to the federal government. This proposal aligns Medicaid with Medicare Advantage and private insurance requirements and builds on the policies in the proposed rule on Medicaid managed care published in June 2015. [$23.5 billion in savings over 10 years]

Rebase Future Medicaid Disproportionate Share Hospital Allotments
As the number of uninsured individuals decreases due to the coverage expansions under the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of Disproportionate Share Hospital funding needed. Current law extends and revises the aggregate Disproportionate Share Hospital funding reductions through FY 2025, but in FY 2026, allotments revert to levels that had been in effect prior to the Affordable Care Act. This proposal determines future allotments based on states' actual prior year allotments as reduced by the Affordable Care Act and subsequent legislation. [$6.6 billion in savings over 10 years]

Strengthen Medicaid Drug Coverage and Reimbursement

Create a Federal-State Medicaid Negotiating Pool for High-Cost Drugs
This proposal allows CMS and participating states to work together to curb spending on high-cost drugs. Currently, states may negotiate supplemental rebates, but CMS does not have the authority to facilitate negotiation with drug manufacturers on high-cost drugs. As a result, the federal government and states lose billions of dollars in supplemental rebates each year. This proposal will allow CMS and participating state Medicaid programs to partner with a private sector contractor to negotiate supplemental rebates from drug manufacturers. [$5.8 billion in savings over 10 years]

Lower Medicaid Drug Costs and Strengthen the Medicaid Drug Rebate Program
The Budget includes a series of targeted policies to both lower drug costs and improve drug coverage in Medicaid. First, the Budget clarifies the definition of brand drugs to prevent inappropriately low rebates. It excludes authorized generic drugs from calculations used to determine brand-name rebates. Additionally, the Budget corrects a technical error to the Affordable Care Act rebate for new drug formulations and exempts abuse deterrent formulations from the definition of "line extension" to incentivize continued development of abuse deterrent formulations. The Budget also limits to 12 quarters the timeframe for which manufacturers can dispute drug rebate amounts and clarifies the inclusion of certain prenatal vitamins and fluorides in the rebate program. The Budget also exempts emergency drug supply programs from the Medicaid rebate calculations. Finally, the Budget improves Medicaid drug pricing by calculating Medicaid Federal Upper Limits based only on generic drug prices. [$5.6 billion in savings over 10 years]

Strengthen the Integrity of the Medicaid Program

Promote Program Integrity for Medicaid Drug Coverage

The Budget enhances program integrity for the Medicaid prescription drug program in five ways. First, it eliminates incentives to improperly report information by requiring manufacturers to make drug rebates equal to the amount states pay for drugs in cases where a manufacturer either improperly reported to CMS non-drug products as covered outpatient drugs or improperly identified reported drugs as being effective when the Food and Drug Administration (FDA) has identified the drugs as less than effective through its Drug Efficacy Study. Second, it enhances existing enforcement and compliance with drug rebate requirements by allowing more regular audits and surveys of drug manufacturers where cost effective. Third, it requires drugs to be electronically listed with FDA in order for them to be eligible for Medicaid coverage, thereby aligning Medicaid drug coverage requirements with Medicare drug coverage requirements. Fourth, it increases penalties for fraudulent noncompliance on rebate agreements—particularly where drug manufacturers knowingly report false information under their drug rebate agreements. Finally, these proposals provide CMS the authority to collect wholesale acquisition costs for all Medicaid-covered drugs to ensure accurate reporting of average manufacturer prices. [No budget impact]

Cut Fraud, Waste, Abuse, and Improper Payments in Medicaid

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 and to reduce improper payments. The Program Integrity chapter describes these proposals, and their impact is accounted for either in this chapter or in the State Grants and Demonstrations chapter. [$790 million in savings over 10 years]

LEGISLATIVE PROPOSALS FOR MEDICARE-MEDICAID ENROLLEES

The Budget includes four proposals to improve the quality and efficiency of care for Medicare-Medicaid, dually-eligible beneficiaries.

Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy Income and Asset Definitions

Many of the same beneficiaries qualify for Medicare Savings Programs and Part D Low-Income Subsidies, but under current law have to go through separate and partially duplicative income and asset tests before they can receive benefits. This proposal adjusts the definitions of countable income and assets used to determine eligibility for Medicare Savings Programs to bring them into greater alignment with those used to determine eligibility for Part D Low-Income Subsidies. This will increase access to these valuable support programs for vulnerable beneficiaries and simplify eligibility determinations for a number of states. [$394 million in Medicaid costs over 10 years]

Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries

This proposal permanently authorizes a current demonstration that allows CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed. This plan serves as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. Under current law, these beneficiaries are assigned at random to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under the demonstration, the plan is paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. An on-going current demonstration, which was recently extended through 2019, has shown the proposed approach to be less disruptive to beneficiaries. [$100 million in Medicare costs over 10 years]

Allow for Federal/State Coordinated Review of Dual Eligible Special Need Plan Marketing Materials

This proposal introduces flexibility to rules around the review of marketing materials provided by Dual Special Needs Plans to beneficiaries. Under existing statute, all marketing materials provided by these plans to beneficiaries must be reviewed by CMS staff for accuracy, content, and other stated requirements. Because these plans also market to Medicaid beneficiaries, many of the same marketing materials must also go through a separate review from a state Medicaid agency for compliance with a different set of rules and regulations. Providing CMS with the ability to perform coordinated reviews of these marketing

materials for compatibility with a unified set of standards will potentially improve the quality of the products available to beneficiaries, while also reducing the burden on CMS and the states. [No budget impact]

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, while maintaining the important beneficiary protections included in both programs. [No budget impact]

MULTI-AGENCY PROPOSALS

Expand the Certified Community Behavioral Health Clinic Demonstration

This proposal would expand the Certified Community Behavioral Health Clinic Demonstration established by section 223 of the Protecting Access to Medicare Act of 2014 to an additional 6 states. The Demonstration is designed to increase reimbursement for high-quality, community-based, ambulatory mental health and substance use disorder services. This proposal is part of the broader set of new mental health investments described in the Budget in Brief overview.
[$110 million in costs over 10 years]

Establish Hold Harmless for Federal Poverty Guidelines

To protect access to programs, including Medicaid, for low income families and individuals, this proposal would treat the Consumer Price Index for All Urban Consumers 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 Index, not a decrease. [No budget impact]

FY 2017 Medicaid Legislative Proposals

dollars in millions	2017	2017 -2021	2017 -2026
Support Delivery System Reform			
Reestablish the Medicaid Primary Care Payment Increase Through CY 2017 and Include Additional Providers	7,610	9,510	9,510
Add Certain Behavioral Health Providers to the Electronic Health Record Incentive Programs (Medicaid Impact)	—	3,800	4,440
Pilot Comprehensive Long-Term Care State Plan Option	0	3,181	4,054
Expand Eligibility Under the Community First Choice Option	255	1,582	3,866
Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities	—	584	1,609
Allow States to Develop Age-Specific Health Home Programs	210	690	1,100
Expand Eligibility for the 1915(i) Homes and Community-Based Services State Plan Option	7	124	374
Allow Full Medicaid Benefits to All Individuals in a Home and Community Based Services (HCBS) State Plan Option	—	4	9
Improve Access to Coverage and Services			
Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults (non-add) /1	*467*	*4,731*	*11,135*
Medicaid Impact	800	13,000	34,900
Treasury Impact (non-add)	*-333*	*-8,269*	*-23,765*
Strengthen Medicaid in Puerto Rico and the U.S. Territories	320	9,315	29,644
Extend Enhanced Federal Match for New Medicaid Expansion States	430	2,300	2,610
Permanently Extend Express Lane Eligibility Option for Children	—	235	870
Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid	99	450	789
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Foster Care Children /2	119	624	567
Require Coverage of Early and Periodic Screening, Diagnostic, and Treatment for Children in Inpatient Psychiatric Treatment Facilities	35	215	505
Provide Full Medicaid Coverage to Pregnant and Postpartum Beneficiaries	30	165	375
Extend 100 Percent Federal Match to All Indian Health Programs	6	34	80
Expand State Flexibility to Provide Benchmark Benefit Packages	—	—	—
Streamline Certain Medicaid Appeals Processes	—	—	—
Improve Quality and Cost-Effectiveness			
Extend Funding for the Adult Health Quality Measures Program (non-add) /3	*14*	*70*	*70*
Require Remittances for Medical Loss Ratios for Medicaid and CHIP Managed Care	—	-5,100	-23,500
Rebase Future Medicaid Disproportionate Share Hospital Allotments	0	0	-6,640

FY 2017 Medicaid Legislative Proposals (cont.)

dollars in millions	2017	2017 -2021	2017 -2026
Strengthen Medicaid Drug Coverage and Reimbursement			
Create a Federal-State Medicaid Negotiating Pool for High-Cost Drugs	-200	-2,510	-5,830
Lower Medicaid Drug Costs and Strengthen the Medicaid Drug Rebate Program	-481	-2,670	-5,616
Correct the Affordable Care Act Medicaid Rebate Formula for New Drug Formulations and Exempt Abuse Deterrent Formulations (non-add)	*-410*	*-2,085*	*-4,285*
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits (non-add)	*-30*	*-370*	*-870*
Clarify the Definition of Brand Drugs to Prevent Inappropriately Low Rebates (non-add)	*-21*	*-115*	*-260*
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations (non-add)	*-20*	*-100*	*-200*
Exempt Emergency Drug Supply Programs from Medicaid Drug Rebate Calculation (non-add)	—	—	—
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters (non-add)	—	—	—
Require Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program (non-add)	—	—	—
Strengthen the Integrity of the Medicaid Program			
Promote Program Integrity for Medicaid Drug Coverage	—	—	—
Enforce Manufacturer Compliance with Drug Rebate Requirements (non-add)	—	—	—
Increase Penalties on Drug Manufacturers for Fraudulent Noncompliance with Medicaid Drug Rebate Agreements (non-add)	—	—	—
Require Drugs be Properly Listed with FDA to Receive Medicaid Coverage (non-add)	—	—	—
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States (non-add)	—	—	—
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS (non-add)	—	—	—
Cut Fraud, Waste, Abuse, and Improper Payments in Medicaid /4	-32	-330	-790
Total Outlays, Medicaid Proposals	**9,208**	**35,204**	**52,927**
Medicare-Medicaid Enrollee Proposals			
Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy Income and Asset Definitions	31	169	394
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries (Medicare Impact) (non-add)	—	*20*	*100*
Allow for Federal/State Coordinated Review of Dual Special Need Plan Marketing Materials	—	—	—
Integrate Appeals Process for Medicare-Medicaid Enrollees	—	—	—
Total Outlays, Medicare-Medicaid Enrollee Proposals	**31**	**169**	**394**

FY 2017 Medicaid Legislative Proposals (cont.)

dollars in millions	2017	2017 -2021	2017 -2026
Medicaid Interactions			
Provide States Option to Eliminate Medicaid Assignment of Cash Medical Support /5	—	36	162
Extend Special Immigrant Visa Program /6	—	32	65
Expand the Certified Community Behavioral Health Clinic Demonstration /7	20	110	110
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees /8	12	25	25
Extend CHIP Funding through 2019 /9	—	-5,560	-5,560
Prohibit Brand and Generic Drug Manufacturers from Delaying the Availability of New Generic Drugs and Biologics /10	-120	-620	-1,380
Eliminate the 190-Day Lifetime Limit on Inpatient Psychiatric Facility Services /10	-50	-310	-720
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics /10	—	-30	-130
Eliminate Medicaid Recoupment of Birthing Costs from Child Support /5	—	—	—
Establish Hold-Harmless for Federal Poverty Guidelines	—	—	—
Total Outlays, Medicaid Interactions	**-138**	**-6,307**	**-7,368**
Total Outlays, Medicaid Legislative Proposals	**9,100**	**29,065**	**45,953**
Total Outlays, Total Federal Impact /11	**8,767**	**20,796**	**22,188**

1/ The score reflects the impact on both Medicaid and U.S. Department of Treasury programs.
2/ This is a joint proposal with the Administration for Children and Families (ACF). The score reflects the impact on the Medicaid baseline. Please see the ACF and State Grants and Demonstration chapters for more information on this proposal.
3/ This proposal reflects costs to the Program Management account. See the Program Management chapter for more information.
4/ This includes proposals described in the Program Integrity chapter, excluding savings not subject to PAYGO and excluding the proposal to Expand Funding for the Medicaid Integrity Program, which is described in the Program Integrity chapter but accounted for in the tables in the State Grants and Demonstrations chapter.
5/ This proposal is included in the Administration for Children and Families' FY 2017 Budget Request.
6/ This proposal is included in the State Department's FY 2017 Budget Request. Total excludes $4 million in Medicaid outlays in FY 2017 due to a proposed change in a mandatory program for a Department of State proposal.
7/ This proposal is part of the Administration's broader investments to expand mental health described in the Budget in Brief overview.
8/ This proposal is included in the Social Security Administration's FY 2017 Budget Request.
9/ See Children's Health Insurance Program (CHIP) chapter for proposal description.
10/ See Medicare chapter for proposal description.
11/ The total federal impact reflects $23.8 billion in savings to the Marketplace subsidies and related impacts included in the Department of Treasury programs and accounts.

Note: Numbers may not add due to rounding.

Children's Health Insurance Program

dollars in millions	2015	2016	2017	2017 +/- 2016
Current Law				
Children's Health Insurance Program	9,233	14,426	15,015	+589
Child Enrollment Contingency Fund	9	53	0	-53
Total Outlays, Current Law	**9,242**	**14,479**	**15,015**	**+536**
Proposed Law				
CHIP Legislative Proposals /1	—	—	180	+180
Total Outlays, Proposed Law /2	**9,242**	**14,479**	**15,195**	**+716**

1/ The net cost of CHIP proposed law is $180 million in FY 2017, which reflects impacts to CHIP and interactions with Medicaid, the Marketplace subsidies, and related impacts. 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.

The Children's Health Insurance Program (CHIP) was originally created under the Balanced Budget Act of 1997. In 2009, CHIP was reauthorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which provided an additional $44 billion in funding through FY 2013 and created several new initiatives to improve and increase enrollment in the program. The Affordable Care Act extended funding for CHIP through FY 2015, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended funding for the program through FY 2017. The Budget proposes an additional two-year extension of CHIP, through FY 2019. Since September 1999, every state, the District of Columbia, and all five territories have approved CHIP plans.

PROGRAM HIGHLIGHT

Increasing Enrollment of Eligible Children

CMS' goal is to improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid. For FY 2014, the most recent year for which CMS has final data, 43.7 million children were covered by Medicaid or CHIP at some point during the year. In FY 2017, CMS is targeting an increase in coverage to 46.1 million children.

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 less than 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 will range from 65 to 85 percent. Beginning in FY 2016, and effective through FY 2019, each state's enhanced federal matching rate increased by up to 23 percentage points to cover between 88 and 100 percent of total costs for child health care services and program administration, drawn from a capped allotment.

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, 2016, there were 14 Medicaid expansion programs, 2 separate programs, and 40 combination programs among the states, District of Columbia, and territories.

In FY 2015, the CMS Office of the Actuary estimated that 8.9 million individuals received health insurance funded through CHIP allotments at some point during

the year. Approximately 5.8 million individuals were enrolled in CHIP on average throughout the year.

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. Payments from the Fund are currently authorized through FY 2017.

Through FY 2013, the Performance Bonus Fund authorized payments to states that performed five out of eight specific enrollment and retention activities set out in CHIPRA. In FY 2014, CMS awarded $307 million to 23 states based on actual FY 2013 performance.

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 a simplified Modified Adjusted Gross Income standard to determine eligibility for coverage under a state's CHIP program. States can offer continuous eligibility for 12 months regardless of changes in family income, fast track enrollment using Express Lane Eligibility authority, and enroll children who are eligible for family coverage under a state employee health plan into CHIP.

Enrollment and Retention Outreach

MACRA provides new funding and extends the Outreach and Enrollment Program for two years through FY 2017. Originally enacted under CHIPRA and extended by the Affordable Care Act, the Outreach and Enrollment Program provides grants and a national campaign to improve outreach and enrollment to children who are eligible for but unenrolled in Medicaid and CHIP. Of the total $40 million appropriation under MACRA, $32 million is dedicated to outreach and enrollment grants, $4 million is dedicated to outreach and enrollment grants for children who are American Indian/Alaska Native, and $4 million is dedicated to the National Enrollment Campaign. 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 2015, 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. The Protecting Access to Medicare Act of 2014 allocates $15 million of Adult Health Quality funding provided under the Affordable Care Act for the pediatric quality measures program, and MACRA provided an additional $20 million in new funding for the program.

NEW INITIATIVE

Budget Extends CHIP Funding for an Additional Two Years

The passage of MACRA ensured continued comprehensive coverage for CHIP children through FY 2017. The net federal cost to extend CHIP for an additional two years, through FY 2019, is $3.1 billion.

Dollars in Millions	FYs 2017-2026 *(10 year)*
Extend CHIP Funding for Two Additional Years	1,670
CHIP Impact (non-add) (HHS)	*13,700*
Medicaid Impact (non-add) (HHS)	*-5,560*
Marketplace Subsidies and Related Impacts (non-add) (Treasury)	*-6,470*
Extend the Child Enrollment Contingency Fund for Two Years	0
Reauthorize the Performance Bonus Fund for Four Years	1,400
Total Net Federal Cost of CHIP Proposals	**3,070**

CHIP PROPOSALS

Extend CHIP Funding through FY 2019

The Budget proposes to extend funding for CHIP for two additional years through FY 2019, to ensure continued comprehensive and affordable coverage for CHIP children. This proposal also extends the Child Enrollment Contingency Fund and reauthorizes the Performance Bonus Fund through FY 2019.

Under current law, once states exhaust their CHIP allotments, children in Medicaid-expansion CHIP programs would continue to be covered by Medicaid because of the maintenance of effort requirements, though states would experience a reduction in the federal matching rate. While many children would be eligible for financial assistance through the Marketplaces, some would transition to other forms of coverage, and others could become uninsured.

This extension beyond the two-year extension provided by MACRA aligns with the Affordable Care Act requirement for states to maintain the eligibility and enrollment policies that were in place as of March 2010 through FY 2019 for children in Medicaid and CHIP. A funding extension through FY 2019 will provide budgetary stability to states, protect children's coverage and ensure continuity of care for families who rely on the program.

Children’s Health Insurance Program

FY 2017 CHIP Legislative Proposals

(negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	2017	2017 -2021	2017 -2026
CHIP Proposals			
Extend CHIP funding through FY 2019 /1	0	13,700	13,700
CHIP Impact	*0*	*13,700*	*13,700*
Medicaid Impact (non-add)	*0*	*-5,560*	*-5,560*
Marketplace Subsidies and Related Impacts (non-add)	*0*	*-6,470*	*-6,470*
Extend the Child Enrollment Contingency Fund through FY 2019	0	0	0
Reauthorize the Performance Bonus Fund through FY 2019	180	1,400	1,400
Total Outlays, CHIP Proposals /2	**180**	**15,100**	**15,100**

1/ This score reflects the impact on CHIP. The net federal cost of this proposal is $1.7 billion over 10 years, which reflects impacts to CHIP ($13.7 billion) and interactions with Medicaid (-$5.6 billion) and Marketplace subsidies and related impacts (-$6.5 billion).

2/ There are a number of Medicaid and Program Integrity legislative proposals that have a non-budgetary impact on the CHIP program.

Note: Numbers may not add due to rounding.

State Grants and Demonstrations

dollars in millions	2015	2016	2017	2017 +/- 2016
Current Law Budget Authority				
Medicaid Integrity Program /1	77	77	84	+7
Money Follows the Person Demonstration	416	418	—	-418
Money Follows the Person Evaluations	1	1	—	-1
Demonstration Program to Improve Community Mental Health Services	—	23	—	-23
CHIP Outreach and Enrollment Grants	—	40	—	-40
Total, Current Law Budget Authority	**494**	**562**	**84**	**-478**
Proposed Law Budget Authority				
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care /2	—	—	500	+500
Expand Funding for the Medicaid Integrity Program /1	—	—	25	+25
Total, Proposed Law Budget Authority	—	—	**525**	**+525**
Total, Current and Proposed Law Budget Authority	**494**	**562**	**609**	**+47**
Current Law Outlays				
Incentives for Prevention of Chronic Diseases in Medicaid /3	18	23	16	-7
Medicaid Emergency Psychiatric Demonstration /3	35	2	—	-2
CHIP Outreach and Enrollment Grants /4	18	15	15	—
Medicaid Integrity Program /1	84	83	83	—
Psychiatric Residential Treatment Demonstration and Evaluation /3	2	20	—	-20
Money Follows the Person Demonstration	427	462	425	-37
Money Follows the Person Evaluations	1	2	2	—
Expansion of State Long-Term Care Partnership Program /3	2	—	—	—
Ticket to Work Grant Programs /3	—	1	—	-1
Emergency Services for Undocumented Aliens /3 /5	1	2	2	—
Demonstrations to Improve Community Mental Health Services	1	24	*	-24
Total, Current Law Outlays	**589**	**633**	**543**	**-90**
Proposed Law Outlays				
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care/2	—	—	—	—
Expand Funding for the Medicaid Integrity Program /1	—	—	25	+25
Total, Proposed Law Outlays	—	—	**25**	**+25**
Total, Current and Proposed Law Outlays	**589**	**633**	**568**	**-65**

1/ Budget authority for the Medicaid Integrity Program is adjusted annually by Consumer Price Index for All Urban Consumers, and outlays include some spending from prior year budget authority. 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.

5/ On 12/28/15, CMS announced the sunsetting of this program at the end of fiscal year 2016, as its goals have largely been met.

* 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, the Children's Health Insurance Program Reauthorization Act, the Deficit Reduction Act of 2005, and the Ticket to Work and Work Incentives Improvement Act of 1999. Such activities include strengthening Medicaid program integrity, supporting enrollment of children into Medicaid and the Children's Health Insurance Program (CHIP) through funding for outreach activities, and promoting prevention and wellness by providing grants to states to prevent chronic diseases.

Incentives for Prevention of Chronic Diseases in Medicaid

The Affordable Care Act provided $100 million for states to award incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in risky health behaviors and outcomes related to chronic disease, including by adopting healthy behaviors. Funds were 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, and the initial Report to Congress was submitted on December 16, 2013.

Medicaid Emergency Psychiatric Demonstration

Section 2707 of the Affordable Care Act authorizes a demonstration project where selected states may provide payment under the State Medicaid plan, under title XIX of the Social Security Act, to an institution for mental diseases that is not publicly owned or operated. Payment is for eligible Medicaid beneficiaries, ages 21 through the age of 64, who require medical assistance to stabilize a psychiatric emergency medical condition. The Affordable Care Act authorized $75 million for the demonstration, of which $68 million was for federal matching payments to the participating states, and $7 million was set aside for implementation and evaluation of the demonstration. In March 2012, CMS announced 11 participating states and the District of Columbia were selected to participate in the demonstration. The demonstration was conducted for a period of three consecutive years (July 1, 2012 through June 30, 2015), with the funding for the demonstration ending on December 31, 2015. In January 2014, an evaluation report was submitted to Congress as mandated by the demonstration's authorization. During the first 21 months of the program, the participating states and the District of Columbia reported 7,538 inpatient admissions involving 5,702 Medicaid beneficiaries to Institutions for Mental Disease. Data continues to be collected on outcomes for the enrolled participants and impacts on Medicaid costs; an updated evaluation of the demonstration will be completed 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, 2014, over 51,000 individuals across 44 states and the District of Columbia have transitioned to community services and supports through this effort. In 2013, CMS awarded funding to states and tribal partners to build sustainable community-based long-term services and supports specifically for American Indians through the tribal initiative.

STATE GRANTS AND DEMONSTRATIONS LEGISLATIVE PROPOSALS

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

The Budget continues to propose a five-year Medicaid demonstration in partnership with the Administration for Children and Families beginning in FY 2017 to encourage states to implement evidence-based psychosocial interventions targeting children and youth in the foster care system, as an alternative to the current over-prescription of psychotropic medications in this population. States will 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. The Medicaid investment of $500 million over five years will provide incentive payments to states that demonstrate measured improvement in outcomes. This investment is paired with $250 million from the Administration for Children and Families to support state efforts to build provider and systems capacity. One hundred and nine national and state child welfare organizations, including the American Psychological Association and the Child Welfare League of America, expressed their support for this proposal in a letter to the Senate Majority and Minority leaders in April 2014. [$500 million in State Grants and Demonstrations costs, $567 million in Medicaid costs, and $250 million in mandatory child welfare costs over 10 years]

Expand Funding for the Medicaid Integrity Program
This proposal is described in the Program Integrity chapter.

FY 2017 State Grants and Demonstrations Legislative Proposals

(negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	2017	2017 -2021	2017 -2026
State Grants and Demonstrations Proposals			
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care /1	—	395	+500
Expand Funding for the Medicaid Integrity Program /2	25	180	+580
Total Outlays, State Grants and Demonstrations Proposals	**25**	**570**	**1,080**

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	2015	2016	2017	2017 +/- 2016
Outlays				
Affordable Insurance Exchange Grants /1	1,372	712	319	-393
Early Retiree Reinsurance Program	-11	7	6	-1
Consumer Operated and Oriented Plan Program /2	350	739	3	-736
Pre-Existing Condition Insurance Plan Program	13	6	—	-6
Rate Review Grants to States	35	29	39	+10
Transitional Reinsurance Program /3	7,308	7,459	4,554	-2,905
Risk Adjustment Program /3	1,759	4,088	4,560	+472
Risk Corridors (non-add) /4	*2,870*	*2,870*	*2,870*	-
Total Outlays, Current Law	**10,826**	**13,040**	**9,481**	**-3,559**
Receipts (Non-add)				
Transitional Reinsurance Program, Receipts	*8,898*	*6,521*	*4,335*	*-2,186*
Risk Adjustment Program, Receipts	*2,375*	*3,858*	*4,639*	*+781*
Risk Corridors Program, Receipts (non-add) /3	-	*362*	*362*	-
Total Receipts, Current Law	***11,273***	***10,379***	***8,974***	***-1,405***

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. The final grants were awarded in December 2014. Obligations in FY 2016 and beyond are limited to administrative costs.
2/ No new loan awards have been made since 2014, outlays reflect funds obligated prior to 2015.
3/ Outlay amounts for Transitional Reinsurance and Risk Adjustment reflect sequestration of 6.8 percent in FY 2016, and that sequestered amounts become available in the following fiscal year.
4/ Risk Corridors amount reflect obligations, not outlays. Risk Corridors is part of the Program Management account. The figures for the Risk Corridors program in this table for fiscal years 2016 and 2017 are not estimates. Amounts for fiscal years 2016 and 2017 are uncertain and therefore the figures in this table simply reflect imbalances between payments out and payments in by participating plans equal to those that occurred for fiscal year 2015. In the event of a shortfall over the life of the three-year Risk Corridors program, the Administration will work with Congress to provide necessary funds for outstanding payments.

Note: Totals may not add due to rounding.

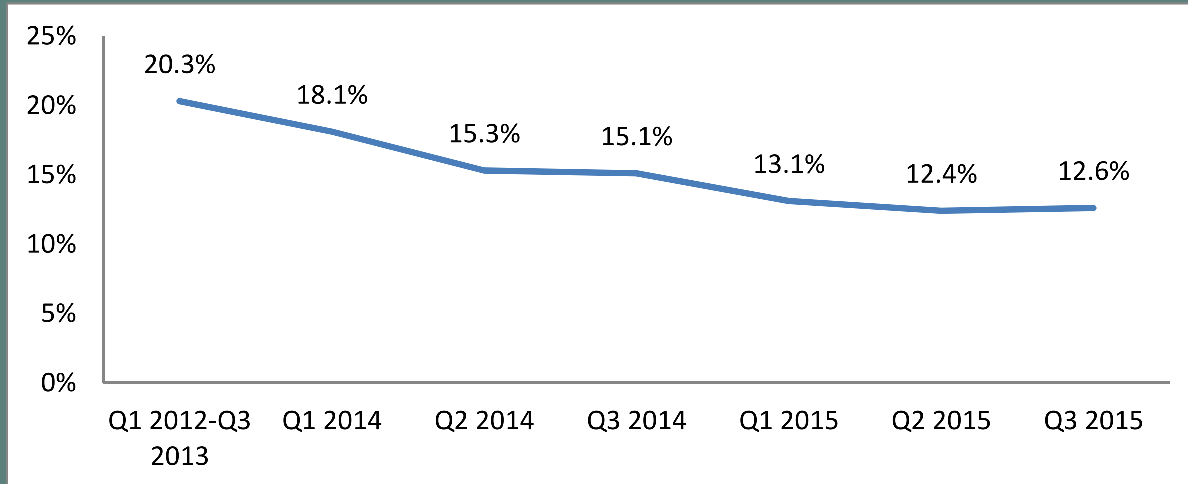
The Affordable Care Act has expanded access to affordable health insurance coverage to millions of Americans. It also continues to provide strong protections for consumers purchasing private health insurance. These protections ensure that essential care and benefits are a standard part of most private health insurance plans and that consumers can rely upon their insurance when they become ill. Consumers receive more value from their health insurance coverage due to rate review and medical loss ratio protections.

IMPROVING COVERAGE

The Affordable Care Act is making comprehensive health insurance coverage available to millions of Americans who previously lacked access to or could not afford health insurance. As the Affordable Care Act's provisions have taken effect, 17.6 million Americans have gained coverage. Since 2010, the uninsured rate in this country has fallen by nearly 45 percent, the largest reduction in decades.

Marketplaces

The introduction of qualified health plans available through the Marketplaces operating in every state play a critical role in the reduction of the national uninsured rate. 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. In the first two months of open enrollment for 2016, nearly 11.3 million individuals selected plans or were automatically re-enrolled through the Marketplaces. The Marketplaces have made purchasing health insurance simpler, more transparent, and easier to understand, providing individuals and small businesses with more options and greater control over their health insurance purchases.



Source: ASPE Issue Brief, "Health Insurance Coverage and the Affordable Care Act," September 22, 2015.

State Work to Implement Marketplaces

Currently, 16 states and the District of Columbia operate State-based Marketplaces. Four of these State-based Marketplaces utilize the federal platform for eligibility and enrollment functionality. Additionally, seven states partner with HHS to operate some functions in State Partnership Marketplaces. HHS is operating Federally-facilitated Marketplaces in the remaining 27 states. In addition to enrolling individuals, Marketplaces also determine eligibility for advance payment of the premium tax credits and cost-sharing reductions, or Medicaid and CHIP in some states; ensure health plans meet certain standards; operate a call center and website to provide consumer assistance; and assist individuals in locating and obtaining affordable health coverage.

Marketplace Establishment Grants

The Affordable Care Act provided grant funding to enable states to plan for and establish Marketplaces. The final round of grants was awarded to states in December 2014. Overall, 37 states and the District of Columbia have received approximately $5.4 billion in grants to plan, establish, and build Marketplace functionality since 2011. States may request No Cost Extensions to extend their project periods to complete approved establishment activities, but ongoing operations are self-funded through user fees or other funding.

Basic Health Program

The Affordable Care Act included a state option to provide health benefits coverage to certain low-income individuals otherwise eligible for financial assistance through the Marketplaces, improving continuity of care for people whose income fluctuates above and below Medicaid and Children's Health Insurance Program levels. Minnesota was the first state to establish a Basic Health Program with coverage beginning in January 2015, and New York soon followed in April 2015. Estimated outlays for FY 2017 are $2.6 billion, reflecting 95 percent of amounts that would have been spent on premium tax credits and cost-sharing reductions if individuals were enrolled in Marketplace coverage. These outlays are reflected in Treasury Budget documents along with the premium tax credit and cost-sharing reduction estimates.

Consumer Operated and Oriented Plans (CO-OPs)

The CO-OP loan program fosters the creation of new, private, qualified nonprofit, member-governed health insurance issuers to spur competition by offering qualified health plans in the individual and small group markets in the states in which the issuers are licensed. The Affordable Care Act required that any profits a CO-OP makes must be used to lower premiums, improve benefits, or improve the quality of health care delivered to plan members.

CO-OP loan awards to date total $2.5 billion. No new funding has been awarded since December 2014. Currently, 11 CO-OP loan recipients are licensed and have enrolled members in 13 states for 2016; the Montana CO-OP also offers coverage in Idaho and the Massachusetts and Maine CO-OPs both offer coverage in New Hampshire. At the end of 2015, 12 CO-OPs ceased operations due to lack of access to adequate capital, as well as other operational issues that most health plans face entering new markets. CMS helped consumers in these CO-OPs find new coverage in the Marketplaces for 2016. Once the wind-down process for these CO-OPs is complete, CMS will use every available tool to recoup federal funding, based on applicable law and loan agreements.

The Affordable Care Act originally appropriated $6 billion for the program. A series of congressional rescissions totaling $4.9 billion left $253 million in a contingency fund for oversight and assistance to existing loan entities, of which less than $10 million remains. The remaining balance will be exhausted by the end FY 2016.

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 took effect. Transfers from these programs first occurred in 2015 for costs related to the 2014 plan year.

Transitional Reinsurance

The transitional reinsurance program provides protection to plans in the individual market when enrollees experience high claims costs for plan years 2014 through 2016. For plan year 2014, CMS collected $8.9 billion and made payments of $7.9 billion reflecting 100 percent of issuer costs for enrollees with medical expenses between $45,000 and $250,000. Remaining collection balances will be used to increase payments for plan years 2015 and 2016. In these years, the reinsurance collections decrease based on targets set in the Affordable Care Act, reflecting a transition to a more stable individual insurance market.

Risk Corridors

The temporary risk corridors program adjusts for uncertainty in rate setting in qualified health plans in the individual and small group markets from 2014 through 2016 through shared risk in losses and gains. Payments for the risk corridor program calculated for program year 2014 exceeded collections. In the event of a shortfall over the life of the three-year risk corridors program, the Administration will work with Congress to provide necessary funds for outstanding payments.

Risk Adjustment

The permanent risk adjustment program transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against the potential effects of adverse selection inside and outside the Marketplaces. Results of the first year of the program indicate that it is working as intended. Plans that covered disproportionate shares of high need populations (e.g., persons with HIV/AIDS) and small plans with isolated cases of catastrophic illness received risk adjustment payments. Over 750 issuers nationwide participated in risk adjustment for plan year 2014, with approximately $2.4 billion in charges funding risk adjustment payments for that year.

IMPROVING BENEFITS

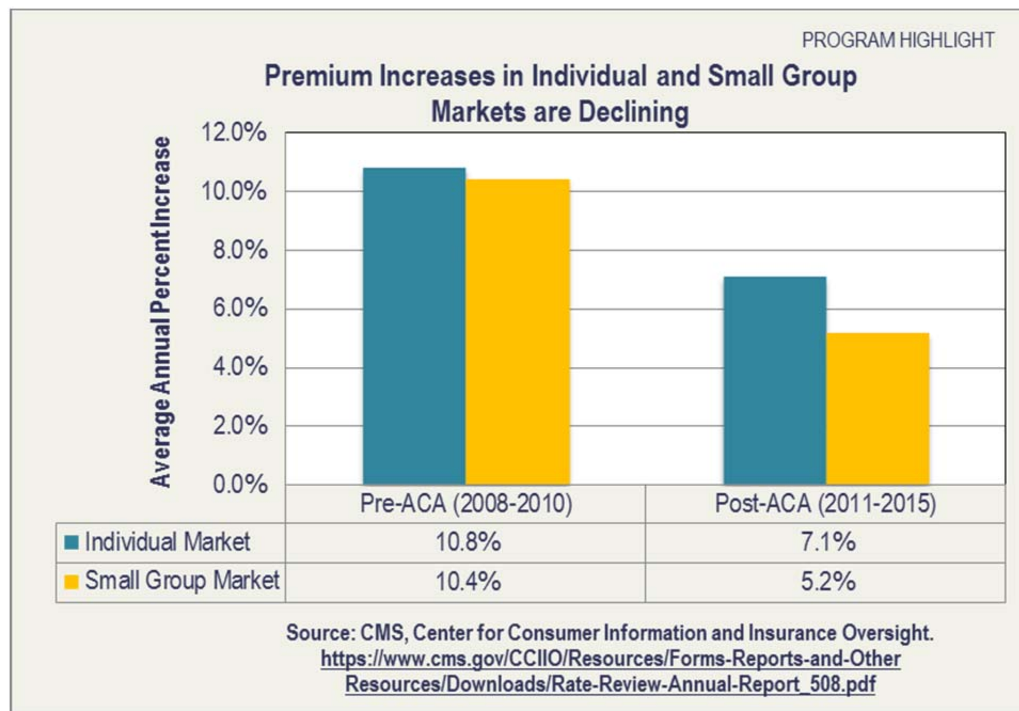
Private Insurance Market Reforms

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, approximately 5.5 million young adults gained coverage since 2010 in part by being able to stay on their parents' health plans until age 26.



	Pre-ACA (2008-2010)	Post-ACA (2011-2015)
Individual Market	10.8%	7.1%
Small Group Market	10.4%	5.2%

Source: CMS, Center for Consumer Information and Insurance Oversight. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other Resources/Downloads/Rate-Review-Annual-Report_508.pdf

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, 137 million Americans now have access to 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. Moreover, the Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal mental health parity protections to 60 million Americans.

IMPROVING VALUE

Medical Loss Ratio

The Affordable Care Act required private insurers in the individual and small group market to spend at least 80 percent of collected premium revenue on clinical expenses and quality improvement. This requirement is 85 percent for the large group market. Insurers who do not abide by this requirement must issue rebates to consumers. In 2014, consumers received $469 million in rebates, or an average rebate of $129 per family, through this provision, and consumers received additional value through lower premiums overall.

Insurance Premium Rate Review

Private insurers must submit to relevant state offices or HHS justification for any premium increase of 10 percent or more prior to implementation of the increase. This information is then made publicly available, increasing transparency for consumers. In 2015, the rate review provision alone saved 6.5 million consumers approximately $1.5 billion.

In 2010 through 2014, HHS awarded nearly $250 million to states and the District of Columbia to support their premium rate review programs. These grants supported the hiring of new staff, improved communication with consumers about rate review, the creation of data centers that analyze health costs, and the enhancement of existing infrastructure required to operate an effective rate review program. In FY 2016, HHS will use the remaining funds to support state implementation of consumer protections and insurance reforms.

2017 LEGISLATIVE PROPOSALS

Provide a Consistent Definition of "Indian" in the Affordable Care Act

Currently, the Affordable Care Act includes different definitions of "Indian" when outlining eligibility requirements for certain coverage provisions. These definitions are not consistent with eligibility requirements used for delivery of other federally-supported health services to American Indians and Alaska Natives under Medicaid, the Children's Health Insurance Program, and the Indian Health Service. The Budget proposes to standardize Affordable Care Act definitions to ensure all American Indians and Alaska Natives will be treated equally with respect to the Act's coverage provisions, including access to qualified health plans with no cost-sharing. [$520 million in costs to Treasury over 10 years; no HHS budget impact]

Allow Marketplaces to Access National Directory of New Hires

The Budget would provide CMS with access to the National Directory of New Hires, a database maintained by the Administration for Children and Families, to assist with the eligibility determination and verification process for financial assistance in the Marketplace. To determine eligibility for, and the value of, advance payments of the premium tax credit, CMS currently relies on income tax data, Social Security data, and a commercial source of income data. Access to the NDNH data would provide another source for income information. Please reference the Administration for Children and Families section for a complete description of the Administration's proposal. [No Budget Impact]

Develop Uniform and Transparent Consumer Health Care Billing Documents

The current lack of standardization and transparency for medical billing documents creates variability in the complexity, format, and comprehensiveness of information consumers receive about payments owed for medical care. This proposal allows HHS to establish uniform definitions and principles for transparency and information standardization that group and individual market issuers can adapt for their medical billing documents. Further refinements to these standards and principles could be made over time as necessary. The proposal will improve consumer readability and understanding of charges associated with health care services received. [No budget impact]

Eliminate Surprise Out-of-Network Health Care Charges for Privately Insured Patients

Some patients incur surprise out-of-network charges when they receive health care services at an in-network hospital. These surprise charges arise because, while the hospital is in-network, certain physicians who provide services to the patient during the episode of care are not part of the network. Therefore, the provider often charges patients the out-of-network cost sharing and bills the consumer for any unpaid balances for those specific services. This proposal requires hospitals and physicians to work together to ensure that patients receiving treatment at in-network facilities do not face unexpected out-of-network charges from out-of-network practitioners that cannot be avoided by the patient. Hospitals would have to take reasonable steps to match individual patients with providers that are considered in-network for their plan. Furthermore, all physicians who regularly provide services in hospitals would be required to accept an appropriate in-network rate as payment-in-full. Thus, if the hospital failed to match a patient to an in-network provider, the patient would still be protected from surprise out-of-network charges. [No budget impact]

Increase Access to Consumer Protections in Self-Insured Non-Federal Governmental Plans

This proposal restricts non-federal government health plans from opting out of four Public Health Service Act provisions: Mental Health Parity and Addiction Equity Act, Newborns' and Mother's Health Protection Act, Women's Health and Cancer Rights Act, and Michelle's Law. Many self-insured non-federal government plans have submitted opt-out requests to HHS for these provisions, which deprives state and municipal employees of protections that are afforded to employees in the private sector. [No budget impact]

FY 2017 Private Insurance Legislative Proposals

(negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	2017	2017 -2021	2017 -2026
Private Insurance Proposals			
Provide a Consistent Definition of "Indian" in the Affordable Care Act (non-add) /1	*30*	*220*	*520*
Allow Marketplaces to Access National Directory of New Hires	-	-	-
Develop Uniform and Transparent Consumer Health Care Billing Documents	-	-	-
Eliminate Surprise Charges for Privately Insured Patients	-	-	-
Increase Access to Consumer Protections in Self-Insured Non-Federal Governmental Plans	-	-	-
Total Outlays, Private Insurance Proposals	**-**	**-**	**-**
1/ The score reflects the impact on U.S. Department of Treasury.			

Center for Medicare & Medicaid Innovation

dollars in millions	2015	2016	2017	2017 +/- 2016
Obligations and Outlays				
Innovation Activities	1,096	1,484	1,143	-341
Innovation Supports	146	206	191	-15
Administrative Expenses	109	139	149	+10
Total, Innovation Center Obligations	**1,351**	**1,829**	**1,483**	**-346**
Total, Outlays	**971**	**1,408**	**1,595**	**+187**

The Center for Medicare & Medicaid Innovation ("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 Children's Health Insurance Program (CHIP) expenditures. The Affordable Care Act appropriated $10 billion to support Innovation Center activities initiated from FY 2011 to FY 2019.

The Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. Over 4.7 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 61,000 providers participating in Innovation Center payment and service delivery models. Between FY 2010 and FY 2015, the Innovation Center has obligated approximately $4.3 billion.

INNOVATION CENTER MODELS AND INITIATIVES

As of February 2016, the Innovation Center has announced or is actively testing over 25 major payment and service delivery models and other initiatives under the authority of section 3021 of the Affordable Care Act. Each of the models will be comprehensively evaluated with the potential for expansion if they are certified to be effective at improving quality without increasing spending or reducing spending while maintaining quality of care. In FY 2015, the Pioneer Accountable Care Organization model became the first model that the independent Office of the Actuary certified would reduce net Medicare spending if expanded.

Primary Care Transformation

Comprehensive Primary Care Initiative

In October 2011, the Innovation Center announced the Comprehensive Primary Care Initiative, in which 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. As of October 2015, there are 447 practices participating in the initiative. In total, 2,188 participating providers are serving approximately 2.7 million patients, of which approximately 410,177 are Medicare or Medicaid beneficiaries. The selected practices receive additional care coordination or similar payments from all participating payers. In years two through four of the initiative, practices have an opportunity to earn shared savings from Medicare as well as other participating payers.

PERFORMANCE HIGLIGHT

Delivery System Reform

In January 2015, HHS announced a new goal to increase the percentage of Medicare fee-for-service payments tied to quality and value through alternative payment models, to 30 percent by the end of 2016 and 50 percent by the end of 2018. Increasing participation in Innovation Center models and developing additional models that serve a broader range of providers and patients are key to helping to achieve this high priority goal.

In January 2015, CMS released the first annual evaluation report on this Initiative. Over the first 4 quarters, the model appears to have reduced total Medicare A and B expenditures by $14 per member per month (or 2 percent)—enough to nearly offset the care management fees paid. The model is also increasing patient access to care with 100 percent of participating practices offering expanded access to a clinician.

The Innovation Center is continuing to explore ways to encourage the delivery of more comprehensive primary care services. In February 2015, the Innovation Center released a request for information on future models that could test innovations in advanced primary care, specifically seeking comment on ways to improve the care of patients with complex needs; to facilitate robust connections to the medical neighborhood and community-based services; and to move payment from encounter-based towards value-driven, population-based care.

Accountable Care Models

As part of CMS's effort to promote accountable care, the Innovation Center has launched five accountable care initiatives. These initiatives build upon the Medicare Shared Savings Program established by the Affordable Care Act. Medicare Accountable Care Organizations (ACOs) have grown to over 477 nationwide, currently serving nearly 8.9 million beneficiaries since the Medicare Shared Savings Program and Pioneer ACO Model began in 2012. The results from the past four years have demonstrated that ACOs can provide better quality of care for beneficiaries while producing savings.

Pioneer Accountable Care Organization Model

This model has allowed 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 have assumed more risk than participants in the Shared Savings Program and have committed 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. Nine ACOs remain in the model.

Advance Payment ACO Model

This model has tested whether pre-paying a portion of future shared savings could increase participation in the Medicare Shared Savings Program. Providing up-front payments to certain physician led and rural organizations in the Shared Savings Program has allowed these ACOs to make investments in infrastructure and staff in order to improve patient care and reduce costs. Advance payments have been recouped from the actual shared savings payments that ACOs earned. Thirty-five ACOs participated in the Advance Payment Model and received their last advanced payments in June 2014.

PROGRAM HIGHLIGHT

Promising Results from the Pioneer ACO Model

In May 2015, HHS announced that the Pioneer ACO Model met the stringent criteria for expansion to a larger population of Medicare beneficiaries. The independent Office of the Actuary certified that the model would reduce net Medicare spending if expanded. Furthermore, the Secretary determined that an expansion of the model would improve patient care without limiting coverage or benefits. /1 Since the model has proven to be successful, CMS decided to incorporate elements of the model into a new track, Track 3, in the Medicare Shared Savings Program.

Further, results from the third year were announced in August 2015—and they continued to show strong performance by Pioneer ACOs. During the third performance year, Pioneer ACOs generated total model savings of $120 million, an increase of 24 percent from the second performance year. Eleven ACOs qualified for shared savings payments of $82 million. The ACOs showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures compared to the second year of the model. /1

1/ The independent Office of the Actuary certification and all other performance results can be found at https://innovation.cms.gov/initiatives/Pioneer-aco-model.

ACO Investment Model
In October 2014, the Innovation Center announced a new model that builds on the experience with the Advance Payment Model to encourage the formation of new ACOs in rural and underserved areas and assist current Medicare Shared Savings Program ACOs in transitioning to arrangements with greater financial risk. There are currently 41 ACOs participating in the model.

Next Generation ACO Model
This model operates in the original Medicare fee-for-service program and maintains key aspects of the Medicare Shared Savings Program and Pioneer ACO Model. It tests how greater ACO accountability through new design elements examining whether greater financial risk, more predictable financial targets, payment and benefit enhancements, and a focus on beneficiary engagement—can collectively accelerate and sustain improvement in health care value. 21 ACOs started the model on January 1, 2016, with more joining January 1, 2017. The 5-year testing phase will end in 2020.

Comprehensive End-Stage Renal Disease Care (ESRD) Initiative
This initiative will incentivize the provision of high-quality, efficient, and coordinated care to Medicare beneficiaries who require dialysis. In order to participate, groups of providers 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. There are 13 ESRD Seamless Care Organizations participating in the model.

Bundled Payment Models

Bundled Payments for Care Improvement Initiative
This initiative seeks to better coordinate care by providing a bundled Medicare payment for an episode of care involving one or more providers. The Innovation Center has been testing four models as part of the broader Bundled Payments Initiative—each model incorporates a somewhat different set of services and payment arrangements. Depending on the model, providers paid through the bundle may include (among others) hospitals, physicians, and skilled nursing facilities. However, within each model, providers or other risk-bearing organizations must offer a discount to Medicare as a condition of participating in the initiative. Model 1 concludes in 2016, while models 2 through 4 are ongoing. The initiative is projected to serve 130,000 Medicare beneficiaries. In these 3 models are 48 episodes that participants can choose from, such as acute myocardial infarction and urinary tract infection. Currently, the models have 1,507 participants.

Oncology Care Model
More than 1.6 million people are diagnosed with cancer each year in this country. A majority of those diagnosed are over 65 years old and Medicare beneficiaries. The Oncology Care Model is an innovative multi-payer model in which practices enter into payment arrangements that include financial and performance accountability for six-month episodes of care surrounding chemotherapy administration to cancer patients. The initiative will include 24-hour access to practitioners for beneficiaries undergoing chemotherapy, aimed at providing higher quality, more highly-coordinated, person-centered oncology care at a lower cost. This five-year model will launch in mid-2016.

Comprehensive Care for Joint Replacement Model
This model, which is launching in April 2016, supports better and more efficient care for beneficiaries undergoing hip and knee replacements. Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. Despite the high volume of these surgeries, quality and costs of care for hip and knee replacement surgeries still vary greatly among providers and geographic areas. This model tests bundled payment and quality measurement for a 90 day episode of care associated with those procedures to encourage hospitals, physicians, and post-acute care providers to collaborate to improve the quality and coordination of care from the initial hospitalization through recovery.

CMS will implement the model in 67 Metropolitan Statistical Areas encompassing approximately 800 hospitals. Hospitals paid under the Inpatient Prospective Payment System and located in the selected areas are required to participate, with limited exceptions.

Initiatives to Speed the Adoption of Best Practices

Partnership for Patients

Partnership for Patients is a collaborative effort by CMS and more than 8,000 stakeholders across the nation, including over 3,400 hospitals, to improve patient safety. The Partnership sets ambitious targets of reducing hospital acquired conditions by 40 percent and hospital readmissions by 20 percent (compared to a 2010 baseline) over 4 years. Between 2010 and 2014, approximately 87,000 fewer patients died in the hospital as a result of the reduction in hospital-acquired conditions. This Initiative among others contributed to these results. Innovation Center funding for this demonstration was extended and is scheduled to run through August 2016.

Transforming Clinical Practice Initiative

This initiative, totaling $685 million in Innovation Center funding, is testing strategies to help clinicians achieve large-scale health transformation. It will support 140,000 clinicians over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. In September 2015, the Innovation Center awarded cooperative agreement funding for 2 types of network systems under this initiative: 1) 29 Practice Transformation Network awards went to medical group practices, regional health care systems, and regional extension centers, to develop peer-based learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to practice transformation; and 2) 10 Support and Alignment Networks awards went to national and regional professional associations and public-private partnerships currently working in practice transformation efforts to provide a system for workforce development aligned with the goals of the model.

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, 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 spanned a three year time period, and approximately half of the recipients are executing no-cost extensions in FY 2016. Seven qualitative evaluation reports on the awardees were released in April 2015, with the evaluation of outcomes and results for each award underway.

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, practice transformation, and population health. A total of 39 awardees received this second round of funding. The performance period for round two began in September 2014 and extends through June 2017.

State Innovation Models

In February 2013, the Innovation Center announced a total of nearly $300 million in the first round of awards to 25 states to design or to implement health care delivery and payment system reforms in the context of a state-sponsored plan. In December 2014, the Innovation Center announced a second round of awards, providing more than $660 million to support 28 states, 3 territories, and the District of Columbia. In order to qualify for awards, states proposed reforms that incorporated multiple payers and are expected to improve quality of care and the health of the state population, while reducing costs. Some of the states are receiving funding to support the testing of such models. A total of 34 states, 3 territories, and the District of Columbia will receive funding through the model.

Innovation Accelerator Program

CMS launched the Medicaid Innovation Accelerator Program in July 2014 with the goal of supporting state Medicaid agencies' ongoing health care delivery reform efforts in key program priority areas by providing targeted, technical programmatic support. While complementing other federal-state delivery system reform efforts such as the State Innovation Model Initiative, the Innovation Accelerator Program provides additional technical assistance and tools to support states' service delivery innovations focused on reducing substance use disorders; improving care for Medicaid beneficiaries with complex needs and high-cost; promoting community integration through long-term services and supports; and integrating physical health/mental health care.

Health Care Payment Learning and Action Network

The Health Care Payment Learning and Action Network provides a forum for public-private partnerships to help the health care system meet or exceed recently

established Medicare goals for value-based payments and alternative payment models, specifically moving 30 percent of Medicare fee for service payments into alternative payment models by the end of 2016 and 50 percent into alternative payment models by the end of 2018. The Network provides payers, providers, employers, purchasers, states, consumer groups, individual consumers, and others an opportunity to discuss, track, and share best practices on how to transition towards alternative payment models that emphasize value. The Network is supported by an independent contractor that acts as a convener and facilitator. At the kickoff meeting in March 2015, nearly 200 participants attended. Nearly 5,000 individuals and 610 organizations have signed up, and many have set their own payment reform goals.

Initiatives to Accelerate New Service Delivery and Payment Model Testing

Maryland All-Payer Model

In 2014, the State of Maryland began testing the impact of all-payer hospital rate-setting on limiting overall cost growth, achieving measurable savings for Medicare, and improving on critical quality and outcome 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. In November, the New England Journal of Medicine published the first year financial and quality performance results of the model. The results showed that Maryland achieved $116 million in Medicare savings in one year alone, putting the model more than a third of the way towards its five-year savings goal of $330 million. The model also achieved a 1.5 percent growth rate in all-payer hospital cost per capita, well under the 3.58 percent cap. Maryland hospitals also achieved a modest reduction in the Medicare fee-for-service 30-day all-cause readmissions rate and a 26 percent reduction in all-payer potentially preventable conditions, which represents two-thirds of the way towards the 5-year target of 30 percent.

Medicare Care Choices Model

This model provides a new option starting in 2016 for Medicare beneficiaries with certain conditions who meet other participation criteria to receive select hospice services from participating providers while concurrently receiving curative treatment. Currently, Medicare beneficiaries are required to forgo curative care in order to receive access to palliative care services offered by hospices. This model represents a fundamental change in the delivery of care for persons with terminal illnesses. CMS will evaluate whether concurrently providing curative and palliative services to hospice beneficiaries can improve quality of life and patient and family satisfaction, increase access to supportive care services provided by hospice, and inform payment policy. Recently, 141 hospices, serving 150,000 beneficiaries, were selected to participate in this model throughout the 5-year period of performance.

Prior Authorization Models

The Innovation Center is currently testing two prior authorization models for repetitive scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy. The objective of the models is to test whether prior authorization reduces improper payments and thereby lowers Medicare costs, while maintaining or improving quality of care. The Medicare Access and CHIP Reauthorization Act of 2015 requires that the non-emergent ambulance transport prior authorization model expand from three states to nine starting in 2016 and allows this model to expand nationwide if it reduces costs while maintaining or improving quality of care.

Home Health Value-Based Purchasing

This is a five-year model which ties a portion of home health agency payment to quality. Participation in this model is required for home health agencies providing services in nine randomly selected states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. The goal of the model is to incentivize providers to offer improved care, which may result in reduced hospital admissions and skilled nursing facility stays during or immediately following home health care. Under this model, home health payments are based on a home health agency's performance relative to its peers. Payments for an individual home health agency could increase or decrease by as much as 3 percent in 2018 and by as much as 8 percent in 2022.

Initiatives Focused on Prevention

Accountable Health Communities Model

The Accountable Health Communities model will address critical gaps between clinical care and community-based services. The Innovation Center will award up to 44 5-year cooperative agreements to eligible organizations responsible for developing

referral networks of community service providers for Medicare and Medicaid beneficiaries to address their health-related social needs. Total award amounts will vary between $1 million and $4.5 million. Applications will be due by the end of March 2016 and the Innovation Center anticipates announcing awards in the fall of 2016.

Million Hearts® Cardiovascular Disease Risk Reduction Model

Heart attacks and strokes are a leading cause of death and disability for Americans. The Million Hearts® model proposes an entirely new way of lowering those risks across the population. Currently, providers are paid to meet specific blood pressure or cholesterol or other targets in their patients. The Million Hearts® model uses data-driven, widely accepted predictive modeling approaches to generate an individualized risk score for patients. Through this model, health care providers will work with Medicare beneficiaries to calculate their individual risk for a heart attack or stroke in the next 10 years based on their comprehensive profile of age, risk factors, blood tests, and behavioral factors. Patients will be shown various approaches to reduce risks—for example, stopping smoking, reducing blood pressure, or taking statins or aspirin. Providers will be paid for how much they reduce absolute risk for their high-risk patients. The model will start in 2016 and will run for five years.

PROGRAM HIGHLIGHT

Announcing the Accountable Health Communities Model

On January 5, 2016, the Department of Health and Human Services announced the first-ever CMS Innovation Center pilot project to test improving patients' health by addressing their social needs. Many of the biggest drivers of health and health care costs are beyond the scope of health care alone. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individuals' ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.

The Accountable Health Communities Model will provide up to $157 million over five years to "bridge organizations" to screen Medicare and Medicaid beneficiaries for social needs during a primary care experience and help them connect with and/or navigate the appropriate community-based services. The model will test three different approaches to addressing health-related social needs and linking clinical and community services:

1. Creating *awareness* by referring patients to community services;
2. Providing *assistance* including navigation services; and
3. *Aligning* community partners around the needs of Medicare and Medicaid beneficiaries.

Initiatives to Innovate Health Plans under Medicare

Part D Enhanced Medication Therapy Management Model

This model will test strategies to improve medication use among Medicare beneficiaries enrolled in Part D. Medication therapy management, when implemented effectively, can improve health care and outcomes for patients and has the potential to lower overall health care costs. Announced in September 2015, the model will begin in 2017 with a five-year performance period. CMS will test the model in five Part D regions across the country.

Medicare Advantage Value-Based Insurance Design Model

This model will test whether giving Medicare Advantage plans flexibility to offer targeted extra supplemental benefits or reduced cost sharing to enrollees who have specified chronic conditions can lead to higher quality, reduced utilization of avoidable high-cost care, and lower costs for plans, beneficiaries, and the Medicare program. The model focuses on Medicare Advantage enrollees with the chronic conditions of diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, and mood disorders. The model will begin January 2017 and run for five years in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee.

Initiatives Focused on the Medicaid Population

Strong Start for Mothers and Newborns

The Strong Start Initiative supports enhanced prenatal approaches to reduce the risk of significant complications and long-term health problems for both expectant mothers and newborns in Medicaid and CHIP. 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. In February 2013, CMS awarded $41.4 million to 27 recipients under this initiative in 30 states, the District of Columbia, and Puerto Rico. The model is projected to reach 80,000 women enrolled in Medicaid and CHIP over the life of the 4-year initiative.

Initiatives Supporting Medicare-Medicaid Enrollees

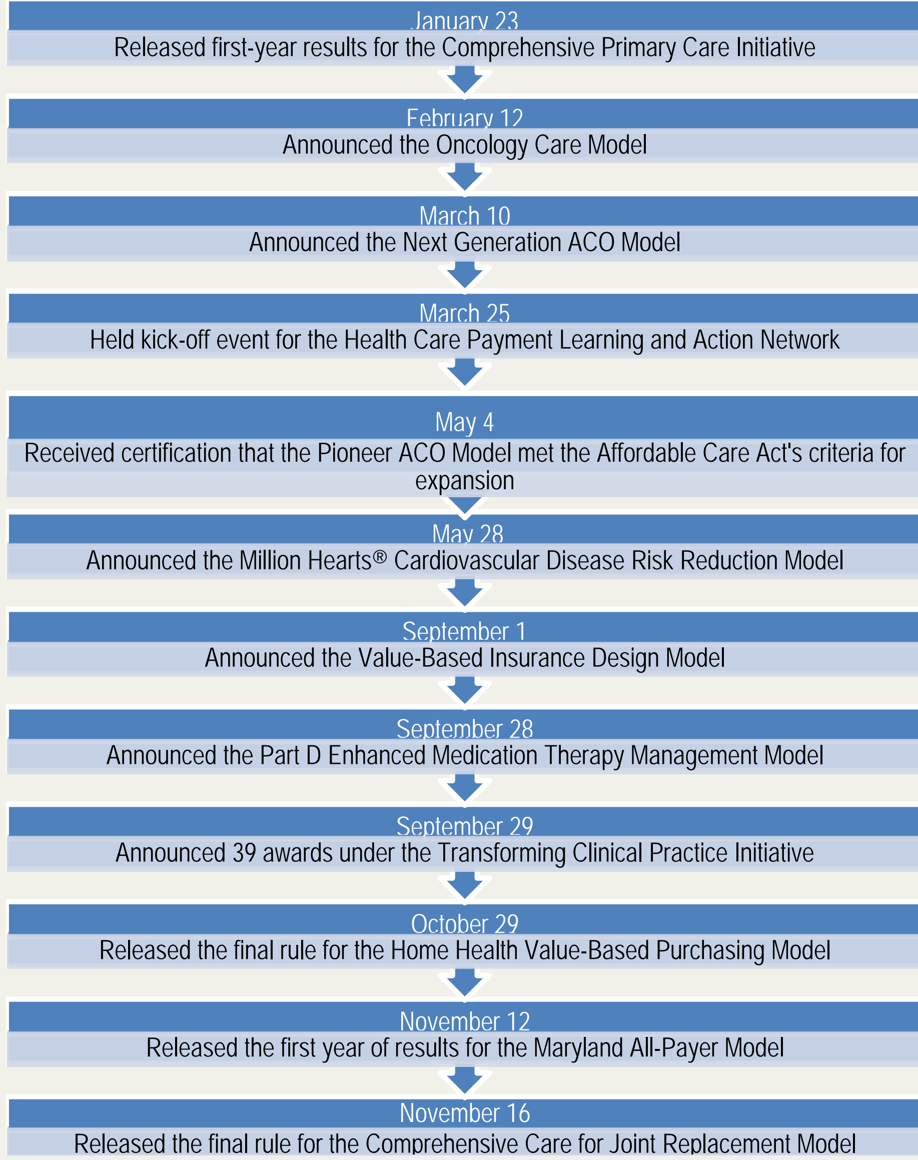
More than 10 million Americans are dually enrolled in the Medicare and Medicaid programs. Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, to promote access to care, improve the overall beneficiary 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.

Medicare-Medicaid Financial Alignment Initiative

To incentivize high-quality, coordinated care, CMS has partnered with states to design person-centered approaches to align care across primary, acute, and behavioral health and long-term supports and services. States participating in the initiative have designed models to improve quality and 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 December 2015, CMS has approved capitated models in 10 states and a managed fee-for-service model in 2 states. Additionally, Minnesota has implemented an alternative model to integrate care for Medicare-Medicaid enrollees, building on the state's current Dual Eligible Special Needs Plans infrastructure. New York has two capitated models, with one focused specifically on serving beneficiaries with intellectual and developmental disabilities.

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. The second phase of this initiative, which will launch in October 2016, will test a payment model that funds higher-intensity interventions in nursing facilities to treat beneficiaries and avoid unnecessary hospitalizations. This initiative has served an estimated 16,000 Medicare-Medicaid enrollees each month and has enhanced care for many others served by these nursing facilities.


PROGRAM HIGHLIGHT
2015: Innovation Center Year in Review
January 23
Released first-year results for the Comprehensive Primary Care Initiative
February 12
Announced the Oncology Care Model
March 10
Announced the Next Generation ACO Model
March 25
Held kick-off event for the Health Care Payment Learning and Action Network
May 4
Received certification that the Pioneer ACO Model met the Affordable Care Act's criteria for expansion
May 28
Announced the Million Hearts® Cardiovascular Disease Risk Reduction Model
September 1
Announced the Value-Based Insurance Design Model
September 28
Announced the Part D Enhanced Medication Therapy Management Model
September 29
Announced 39 awards under the Transforming Clinical Practice Initiative
October 29
Released the final rule for the Home Health Value-Based Purchasing Model
November 12
Released the first year of results for the Maryland All-Payer Model
November 16
Released the final rule for the Comprehensive Care for Joint Replacement Model

Program Management

dollars in millions	2015	2016	2017	2017 +/- 2016
Discretionary Administration				
Program Operations	2,825	2,825	2,936	+111
Federal Administration	733	733	736	+3
Survey and Certification	397	397	437	+40
Research	20	20	—	-20
Total, Discretionary Budget Authority /1, 2	**3,975**	**3,975**	**4,109**	**+135**
Mandatory Administration				
Affordable Care Act	52	0	1	+1
American Recovery and Investment Act	130	61	0	-61
Medicare Improvements for Patients and Providers Act	3	3	3	—
Protecting Access to Medicare Act (2014)	6	6	6	—
Improving Access to Medicare Post-Acute Care Transformation (2014)	107	20	21	+1
Medicare Access and CHIP Reauthorization Act	205	216	211	-5
Total, Mandatory /1	**502**	**305**	**242**	**-63**
Reimbursable Administration				
Medicare and Medicaid Reimbursable Administration /2	697	361	423	+62
Marketplace-Related Reimbursable Administration /3	888	1,225	1,604	+379
Risk Corridor Collections	0	362	362	-
Subtotal, Current Law	**1,585**	**1,948**	**2,389**	**+441**
Proposed Law (Mandatory)				
Program Management (mandatory)	—	—	400	+400
Extend Funding for the Medicaid Adult Health Quality Measures Program	—	—	14	+14
Offsetting Collections /4	—	—	201	+201
Subtotal, Proposed Law	**—**	**—**	**615**	**+615**
Program Level, Proposed Law	**6,062**	**6,228**	**7,355**	**+1,127**
Full-Time Equivalents /5	5,967	6,217	6,370	+153

1/ Totals may not add due to rounding.
2/ 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.
3/ Includes user fees charged to issuers in Federally-facilitated Marketplaces and risk adjustment.
4/ Includes proposals for six new offsetting collections. Please see Legislative Proposals section for more information.
5/ 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 2015 = 1,482; FY 2016 =1,839; and FY 2017=2,258.

The FY 2017 discretionary budget request for CMS Program Management is $4.1 billion, an increase of $135 million above FY 2016 Enacted. This request will enable CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as well as new private health insurance reforms contained in the Affordable Care Act.

BUDGET ACCOUNT SUMMARIES

Program Operations

The Program Operations request is $2.9 billion, an increase of $112 million above the FY 2016 Enacted level. The Program Operations account funds essential contractor, information technology, and outreach activities necessary to administer Medicare, Medicaid, CHIP, and private health insurance reforms and other programs instituted by the Affordable Care Act. Top priority activities for FY 2017 include:

- *Ongoing Medicare Contractor Operations:* Approximately 32 percent, or $951 million, of the FY 2017 Program Operations request supports ongoing contractor operations such as Medicare claims processing.
- *Medicare Appeals*: The Budget includes $142 million to improve the processing of provider and beneficiary claim appeals at the second level of appeals. This amount includes $44 million in new initiatives to improve the efficiency of the Medicare appeals process at the first two levels and limit appeals that escalate to the Office of Medicare Hearings and Appeals, including automating data for these levels of appeal in the Medicare Appeals System.
- *Marketplaces:* The Budget includes $535 million in requested budget authority for Marketplaces, $514 million of which supports Program Operations activities such as eligibility, plan management, and quality improvement. In addition, CMS anticipates collecting approximately $1.6 billion in user fee revenues to support Marketplace activities. See the Crosscutting Accounts section below for additional information.
- *Information Technology Systems and Support:* The Budget includes $333 million for non-Marketplace information technology systems and other support. This includes a significant investment in making essential updates to CMS' claims processing systems. This request also funds CMS' ongoing effort to enhance cybersecurity, allowing the agency to protect the valuable consumer health data of millions of Americans from outside threats. Additionally, CMS continues to transition to the use of shared systems, which allow for greater efficiency and reliability agency wide. This request also funds a large number of other essential information technology functions across the agency for Medicare Appeals, the Healthcare Integrated General Ledger Accounting System, Medicaid, and CHIP.
- *Medicaid and CHIP Operations:* The Budget requests $64 million to fund administrative activities to improve Medicaid and CHIP program operations and implement new responsibilities under the Affordable Care Act. These activities include an initiative to modernize data systems.
- *ICD-10 and HIPAA Administrative Simplification:* To help continue the successful transition to the International Classification of Diseases 10th Edition code set (ICD-10), $5.5 million in funding will continue to support industry-wide training, outreach, and education that focuses on small and rural providers. Additionally, the Budget supports implementation of the remaining HIPAA administrative simplification standards required by the Affordable Care Act, expected to save industry $8.3 billion over 10 years.

Federal Administration

For FY 2017, the Budget requests $736 million for CMS federal administrative costs, $3 million above the FY 2016 Enacted level.

Of this total, $629 million will support a direct Full-Time equivalent level of 4,112, a decrease of 266 full-time equivalents below the FY 2016 Enacted level of 4,378. One of the primary reasons for the decrease in direct FTEs is due to a shift in the funding source used to support some Marketplace FTEs from the Federal Administration account to user fees. Staff that is funded from the Federal Administration line is necessary to address the needs of a growing Medicare population, as well as to oversee expanded duties resulting from the Medicare Access and CHIP Reauthorization Act of 2015, Affordable Care Act, and other legislation passed in recent years.

Survey and Certification

The FY 2017 Survey and Certification request is $437 million, a $40 million increase over the FY 2016 Enacted level. The increased funding level is needed to maintain survey frequency levels due to growing numbers of participating facilities and improved quality and safety standards. CMS expects states to complete over 25,800 initial surveys and re-certifications and over 55,600 visits in response to complaints in FY 2017.

The Improving Medicare Post-Acute Care Transformation Act of 2014 increases hospice survey frequencies to no less than once every three years, which the FY 2017 Budget request also supports.

Over 87 percent of the request will go to state survey agencies. Surveys include mandated federal inspections of long-term care facilities (i.e., nursing homes) home health agencies, hospices, 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. In addition, CMS is currently engaged in an effectiveness and efficiency strategy aimed at quality improvement while identifying risk-based approaches to surveying.

The Budget proposes a discretionary survey and certification revisit user fee which would, if enacted, provide CMS an increased ability to revisit poor performers, while creating an incentive for facilities to correct deficiencies and ensure quality of care. The Budget assumes that no revenue will be realized in FY 2017, the year of establishment.

PERFORMANCE HIGHLIGHT

Reducing Unnecessary Antipsychotic Drug Use in Nursing Homes

The CMS survey and certification budget aims to improve dementia care in nursing homes by decreasing the percentage of long-stay nursing home residents receiving an antipsychotic medication. Antipsychotic medications have common and dangerous side effects when misused to treat the behavioral and psychological symptoms of dementia. In calendar year 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication. In calendar year 2014, CMS met its target and that rate fell to 19.1 percent. CMS set the calendar year 2017 target rate at 16.0 percent.

PROGRAM HIGHLIGHT

Survey and Certification Frequencies

Type of Facility	2016	2017
Long-Term Care Facilities *(statutory)*	Every Year (100%)	Every Year (100%)
Home Health Agencies *(statutory)*	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Hospice *(statutory)*	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Accredited Hospitals	Every 3.5 Years (28.6%)	Every 3 Years (33.3%)
Accredited Hospitals	1.0% Per Year	2.3% Per Year
Organ Transplant Facilities *(contract performed)*	Every 5 Years (20%)	Every 5 Years (20%)
ESRD Facilities	Every 3.5 Years (28.6%)	Every 3 Years (33.3%)
Ambulatory Surgical Centers	Every 4 Years (25%)	Every 3 Years (33.3%)
Community Mental Health Centers and Rural Health Clinics	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Ray	Every 7 Years (14.3%)	Every 6 Years (16.7%)

Research

Beginning in FY 2017, ongoing research activities will be funded from Program Operations.

CROSSCUTTING SUMMARIES

Health Insurance Marketplaces

The discretionary budget request is $535 million for CMS activities and administrative expenses to support Marketplace operations in FY 2017, including $21 million in Federal Administration. In addition to the Budget request, CMS will collect an estimated $1.6 billion in user fees from Marketplace issuers and reinsurance and risk adjustment eligible plans, for a total estimated program level of $2.1 billion.

Marketplaces provide affordable, quality health insurance options to individuals and small businesses, and CMS operates some or all Marketplace functions in 38 states. 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 Federally-facilitated Marketplace states 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 REFORM

Health Insurance Marketplaces

FY 2017 Program Level Request
(dollars in millions)

Activity	2017
Marketplace Operations	659
Eligibility and Enrollment (non-add)	*456*
Consumer Information and Outreach	744
Marketplace Information Technology	657
FTE and Related Expenses	85
Total, Marketplace Program Level/1	**2,145**

1/ Marketplace Program Level includes $1.6 billion in user fees and $535 million in requested budget authority.
Note: Numbers may not add due to rounding.

In FY 2017, CMS will continue to provide Marketplace consumer assistance through a call center and website, as well as in-person support through Navigator grants. CMS will focus outreach efforts on hard-to-reach populations that may not yet know about their opportunities to enroll in affordable health coverage.

In addition, CMS will concentrate IT work on system enhancements that improve capacity to perform core Marketplace functions such as eligibility, plan management, and payment functions in more efficient and consumer-friendly ways. CMS will also increase its focus on Marketplace program integrity efforts in FY 2017, including testing improper payment methodologies and investigating potential fraud, waste, and abuse.

National Medicare Education Program

Total FY 2017 budget authority for the National Medicare Education Program is $347 million. The program level includes an additional $89 million in funding from Program Management, Medicare Advantage/Prescription Drug Program user fees 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 budget authority, $306 million, or 88 percent, supports the 1-800-MEDICARE call center, which provides beneficiaries with access to customer service representatives who are trained to answer questions regarding the Medicare program. The request will support approximately 27 million calls with an average-speed-to-answer of less than 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 $76 million for beneficiary materials, the majority of which will fund the *Medicare & You* handbook. It will also provide $21 million for CMS to mail notices of minimum essential coverage to Medicare enrollees who are new, disabled, and/or under age 65.

2017 LEGISLATIVE PROPOSALS

Provide Mandatory Administrative Resources for Implementation

The President's Budget includes $400 million in no-year 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 and save as much as $357.3 billion over the next 10 years. [$400 million in costs over 10 years]

Extend Funding for the Medicaid Adult Health Quality Measures Program

The Affordable Care Act established the Medicaid Adult Health Quality Measures Program, which requires CMS to develop and annually revise a set of Adult Health Quality Measures and encourages states to voluntarily report information regarding the quality of health care for Medicaid-eligible adults. Additionally, there are standardized reporting requirements, including an annual Secretary's report for quality of care for adults

enrolled in Medicaid and a report to Congress every three years. The Affordable Care Act provided funding for this program from 2010-2014. This proposal provides an additional five years of funding for the Adult Health Quality Measure Program. [$70 million in 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]

Allow CMS to Assess a Fee on Medicare Providers for Payments Subject to the Federal Levy Program

This initiative 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 100 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]

Other User Fee Proposals

The Budget also includes several mandatory proposals that establish new user fees for: resolving Medicare appeals, registering clearinghouses and billing agents that act on behalf of Medicare providers and suppliers, and submitting provider applications for individual providers to participate in Medicare.

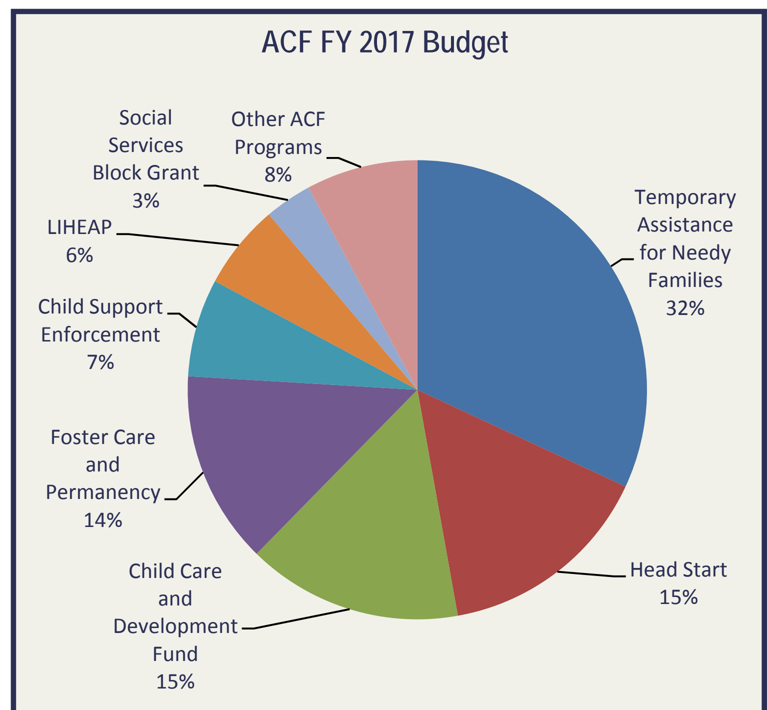
Administration for Children and Families

dollars in millions	2015	2016	2017
Mandatory			
Budget Authority	33,959	34,296	43,053
Discretionary			
Budget Authority /1	18,041	19,120	19,962
Transfer to Census for Survey of Income and Program Participation	-	-	-10
Total, ACF Budget Authority /2	**52,000**	**53,416**	**63,005**

1/ For comparability, includes the Department of Education's appropriation of $250 million in FY 2015 and FY 2016 for Preschool Development Grants.
2/ Reflects $25 million in mandatory funds that were transferred from the TANF Contingency Fund for Welfare Research ($15 million) and the Census Bureau SIPP program ($10 million) as enacted by Congress for FY 2015 and FY 2016.

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.

The FY 2017 Budget request for the Administration for Children and Families (ACF) is $63.0 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 enabling more parents to work or pursue education and training to better support their families, lifting them out of poverty, while at the same time promoting the school readiness of their children. This effort includes significant new investments for combating child poverty, helping families facing financial crises or extreme poverty, supporting working families with access to quality child care, improving outcomes for children and families involved in the child welfare system, increasing child support payments to families, continuing to strengthen Head Start, and supporting statewide integrated data systems designed to improve child and family outcomes, program effectiveness, efficiency, and integrity. Funds are also included for programs that serve the most vulnerable children and families, including runaway and homeless youth, unaccompanied children, and victims of domestic violence, dating violence, and human trafficking.



Administration for Children and Families: Discretionary

dollars in millions	2015	2016	2017	2017 +/− 2016
Early Childhood Programs				
Head Start	8,598	9,168	9,602	+434
Child Care & Development Block Grant (discretionary)	2,435	2,761	2,962	+201
Preschool Development Grants /1	250	250	350	+100
Refugee Programs				
Transitional and Medical Services	383	490	581	+91
Unaccompanied Children	948	948	1,321	+373
Contingency Fund, (non-add)	--	--	*95*	*+95*
Other Refugee Programs	229	237	283	+46
Victims of Human Trafficking (non-add)	*16*	*19*	*22*	*+3*
Subtotal, Refugee Programs	**1,560**	**1,675**	**2,185**	**+510**
Programs for Vulnerable Populations				
Chafee Education & Training for Foster Youth	43	43	43	--
Family Violence Prevention	140	158	163	+5
Adoption Incentives	38	38	38	--
Runaway and Homeless Youth Programs	114	119	126	+7
Child Abuse Prevention	94	98	109	+11
Child Welfare Programs	335	326	330	+4
Promoting Safe and Stable Families (discretionary)	60	60	80	+20
Administration for Native Americans	47	50	53	+3
Low Income Home Energy Assistance Program				
Low Income Home Energy Assistance Program	3,390	3,390	3,000	-390
Community Service Programs				
Community Services Block Grant	674	715	674	-41
Other Community Services Programs	55	55	19	-36
Subtotal, Community Service Programs	**729**	**770**	**693**	**-77**

Administration for Children and Families: Discretionary

dollars in millions	2015	2016	2017	2017 +/– 2016
Other ACF Programs				
Disaster Human Services Case Management	2	2	2	--
Social Services Research & Demonstration	6	7	11	+4
Early Childhood Evaluation (non-add)	--	--	*3*	*+3*
LIHEAP Evaluation (non-add)	--	--	*2*	*+2*
Federal Administration	201	205	206	+1
Center, Faith Based/Community Partnerships (non-add) /2	*1*	--	--	--
Children's Research and Technical Assistance (discretionary)	--	--	10	+10
Transfer to Census CHIMP /3	--	--	-10	-10
Total Discretionary Budget Authority	**$18,041**	**$19,120**	**$19,952**	**+$832**
Full Time Equivalents	1,234	1,343	1,464	+121

1/ In fiscal years 2015 and 2016, funds for Preschool Development Grants were appropriated to the Department of Education.
2/ After FY 2015, funding for Partnerships is provided in the Office of the Secretary.
3/ Reflects $10 million in mandatory funds that were transferred to the Census Bureau SIPP program as enacted by Congress for FY 2015 (P.L. 113-235) and FY 2016 (P.L. 114-113).

The Administration for Children and Families (ACF) provides critical assistance to America's most vulnerable children and families, while creating opportunities to achieve economic success. The FY 2017 Budget requests $20 billion, an increase of $832 million above FY 2016. The FY 2017 Budget builds upon important investments made in FY 2016 and provides new resources to address critical needs in Head Start, child care, domestic violence programs, child welfare, anti-trafficking programs, and services for young people experiencing homelessness. The Budget also supports other important programs that serve our nation's most at-risk children and families, including refugees and unaccompanied children.

SERVING AMERICANS AT KEY STAGES OF LIFE

Research consistently identifies the significant positive impact that early childhood care and education programs can have on the development and lifelong success of children. These impacts range from improved social and emotional development to educational outcomes and lifetime earnings potential. This evidence has been reflected in the Administration's proposals to increase investments in early learning programs and to invest in the quality of these programs to ensure that low-income children receive services that reflect the most current research and are of the highest-quality.

The FY 2017 Budget continues to build on the policies and investments made throughout the Administration to expand access to a continuum of high-quality early learning opportunities from birth to age five. This effort includes extending the school day and year for children receiving Head Start services, providing funds to help states implement the quality and safety

> **Remarks at the University of Kansas on Middle-Class Economics and Child Care**
>
> "In today's economy, when having both parents in the workforce is an economic necessity for many families, affordable, high-quality child care and early childhood education are not just nice-to-haves, they are must-haves. And studies show that children who get a high-quality early education earn more over their lifetimes than their peers who don't."
>
> President Obama,
> January 22, 2015

standards of the new bipartisan child care law, guaranteeing access to high-quality child care for all low- and middle-income families with young children, expanding access to preschool, and expanding voluntary, evidence-based home visiting programs.

Head Start

Two significant changes occurred in the Head Start program in the last year. In the summer of 2015, the Department of Health and Human Services proposed a comprehensive revision of the Head Start Performance Standards to improve the quality of Head Start services, streamline and reorganize program requirements to make it easier to operate a high-quality Head Start program, and reduce the bureaucratic burden on local programs. In addition, in December 2016, Head Start received an additional $294 million to increase the number of children attending Head Start in a full school day and year program. Research shows that full school day and year programs can produce stronger outcomes for children than programs that provide services for less time. The FY 2017 Budget builds on that investment by proposing an additional $292 million to enable more Head Start programs to offer services for more hours per day and days per year.

The FY 2017 request also includes an additional $142 million cost of living adjustment to maintain enrollment in the program, including preserving the Administration's historic expansion of Early Head Start and recent investments in the Early Head Start-Child Care Partnerships. The Administration's investments in Early Head Start and Early Head Start-Child Care Partnerships have more than doubled the number of infants and toddlers served in Early Head Start from 2008.

Combined, these two investments represent a proposed increase of $434 million above FY 2016, for a total of $9.6 billion in Head Start funding in FY 2017.

Child Care

Congress reauthorized the Child Care and Development Block Grant in November 2014 for the first time in almost two decades. The bipartisan reauthorization brought a historic re-envisioning of the program, recognizing the influence early childhood programs have on the development and lifelong potential of children, defining health and safety requirements for child care providers, ensuring continuity of services, and providing parents and the general public transparent information about the child care choices available to them. In December 2015, HHS proposed revisions to the program regulations to reflect these changes. The FY 2017 request continues to propose funds to support implementation of the changes required by reauthorization and $82 billion in additional mandatory funds over 10 years to ensure that all low-and moderate-income working families with young children have access to quality child care by 2026.

The total FY 2017 request for the Child Care and Development Fund is $9.5 billion, including $6.6 billion in mandatory funding and $3 billion in discretionary funding under the Child Care and Development Block Grant. The discretionary funds for child care provide an additional $200 million above FY 2016. These funds will help states implement the new statutory requirements of the reauthorization and include $40 million for pilots that will test innovative strategies to address the child care needs of working families, such as care during non-traditional hours and in rural areas.

Preschool Development Grants

The FY 2017 request includes $350 million for Preschool Development Grants. The program was launched in FY 2014 with awards to 18 states and provides grants to support states in building or expanding high-quality preschool systems, including investments in workforce development and quality infrastructure components or expanding high-quality preschool programs in targeted high-need communities. The program is jointly administered with the Department of Education and paves the way for the successful implementation of the President's *Preschool for All* initiative. Funding is provided within the FY 2017 HHS request pursuant to the *Every Student Succeeds Act*. The request also includes a set-aside for pilots to explore innovative approaches to improve the transitions of children from preschool into kindergarten, improve the early grades, and support exemplary child development practices.

SERVING VULNERABLE CHILDREN AND FAMILIES

The FY 2017 Budget includes new investments to prevent child abuse, enhance services for runaway and homeless youth, serve refugees and unaccompanied children, and strengthen anti-trafficking programs.

Child Abuse and Trafficking Prevention

The Budget requests $109 million for Child Abuse Prevention, including an $11 million increase for child trafficking prevention. Research shows that young people receiving child welfare services can be at-risk from traffickers luring them into the commercial sex trade. ACF plans to award grants to develop better tools to be able to identify victims, prevent child trafficking, and develop comprehensive services to foster youth who have been exploited. ACF will also fund the National Advisory Committee on the Sex Trafficking of Children and Youth. This will ensure robust implementation of the Preventing Sex Trafficking and Strengthening Families Act of 2014 and the Justice for Victims of Trafficking Act of 2015.

Runaway and Homeless Youth

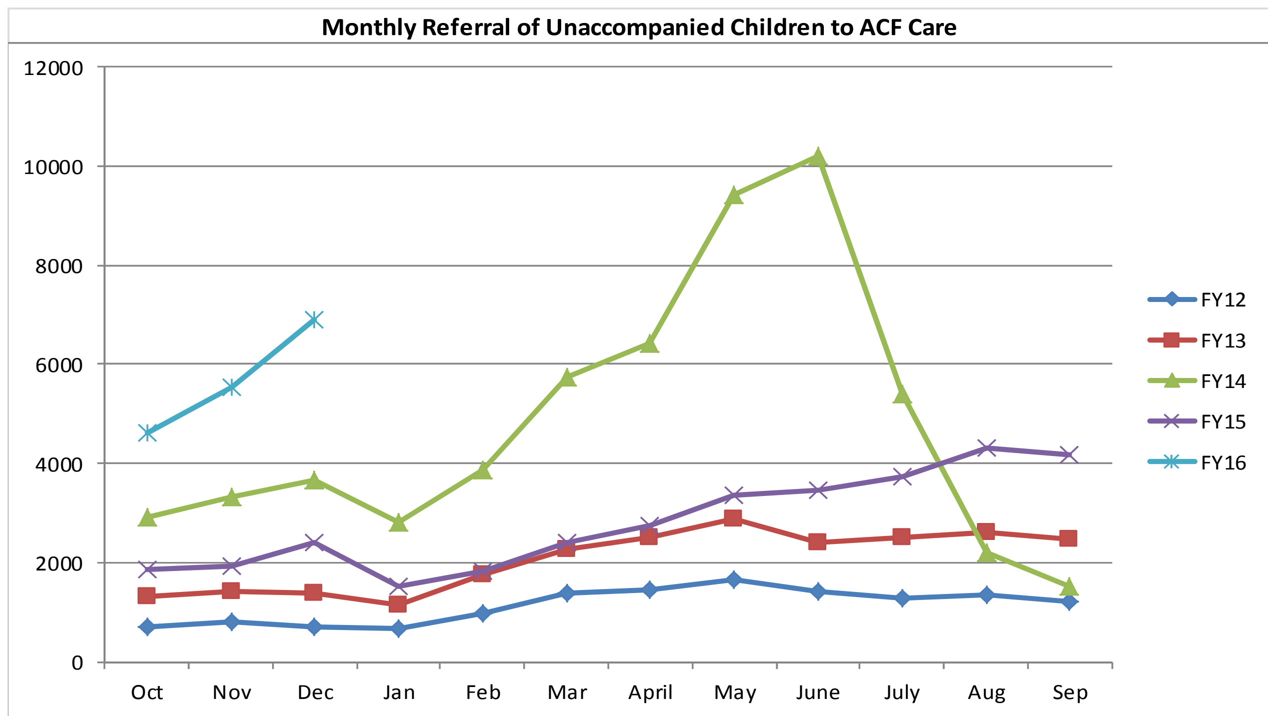
Youth experiencing homelessness face the possibility of exploitation, victimization, and other long-lasting, negative outcomes. While further study is necessary, research and program data suggest that a substantial portion of the young people who enter emergency shelter return to their families' homes within a few weeks. For that reason, the Budget requests $2 million to examine strategies to prevent those young people from experiencing homelessness at all and to more successfully ensure that, once youth reunify with their families, they do not return to homelessness. The Budget also proposes $2 million to expand transitional housing for those young people who are not able to quickly return to stable housing. In addition, the Budget requests $2 million to build on the efforts by the Department of Housing and Urban Development, in conjunction with HHS, to conduct a nationwide study of young people experiencing homelessness to better understand the entire population of young people who experience homelessness. These efforts will further the Administration's commitment to eliminate youth homelessness by 2020 and support the work of the U.S. Interagency Council on Homelessness.

PROTECTING VULNERABLE INDIVIDUALS

Refugees and Unaccompanied Children

The United States has a proud history of welcoming refugees and other vulnerable populations seeking humanitarian relief. Since the passage of the Refugee Act in 1980, over 3 million refugees from more than 70 countries have been given safe haven in the United States, freedom from persecution and displacement, and the chance at a new beginning. In light of a global displacement crisis, the Administration has committed to expanding the Refugee Admissions Program in FY 2016 and FY 2017. All refugees are subject to the highest level of security checks of any category of traveler to the United States, a multi-layered and intensive process involving various law enforcement, national security, and intelligence agencies across the federal government.

ACF's role, in collaboration with state and local governments and an extensive network of public-private partnerships, is to link these newly-arrived humanitarian populations, including refugees, asylees, special immigrant visa holders, and Cuban entrants, to key resources vital to becoming self-sufficient, integrated members of American society. To respond to the displacement crisis, The President's Budget request would support a total of 213,000 humanitarian arrivals in FY 2017, including 100,000 refugees, consistent with the Administration's commitment to admit at least this number of refugees in FY 2017. Funds would provide initial cash and medical assistance to the new arrivals and also allow HHS to continue to provide critical social services to increasing populations of humanitarian entrants. The Budget will support English language skills, job training, translation services, and remove other barriers to employment. Included in this request is a significant increase in funding for survivors of torture, as many populations expected to be admitted in FY 2017 are likely to have experienced significant trauma.



Unaccompanied Children

HHS is legally required to provide care and custody to all unaccompanied children who have been referred after being apprehended by immigration authorities, while they await immigration proceedings. Children remain in ACF's care until they can be released to an appropriate sponsor, usually a family member, while their immigration cases are processed. The overall number of unaccompanied children referred to HHS in FY 2015 was far fewer than the previous year, but still represented the second highest year in the program's history. Based upon the recent increase in unaccompanied children apprehended at the southwest border during the beginning of FY 2016, ACF is adding temporary capacity so it is adequately prepared to care for the children. This action is a prudent step to ensure that the Border Patrol can continue its vital national security mission to prevent illegal migration, trafficking, and protect the borders of the United States.

ACF is continuously monitoring the numbers of unaccompanied children referred for care, as well as the information received from interagency partners on conditions that may impact migration flows. The recent history of the program demonstrates the unpredictable nature of caseloads and the necessity of prudent planning and budgeting. To ensure that HHS can provide for all unaccompanied children referred for care in FY 2017, the Budget includes $1.3 billion, the same amount of total base resources as available in FY 2016. The Budget also includes a contingency fund that would trigger additional funds only if the caseload exceeds levels that could be supported with available base funding.

Victims of Human Trafficking

The Office on Trafficking in Persons leads ACF-wide efforts to combat human trafficking and modern forms of slavery by administering anti-trafficking programs and collaborating with federal, state, tribal, and local government and non-government organizations. Funds for this effort include the additional $11 million requested for Child Abuse and Trafficking Prevention, described above. The Budget also includes $22 million in refugee program funding to assist foreign national and domestic victims of human trafficking through victim identification, comprehensive services, research, training, and prevention. The refugee program includes an increase of $3 million to expand capacity to serve the increased number of trafficking victims requiring services.

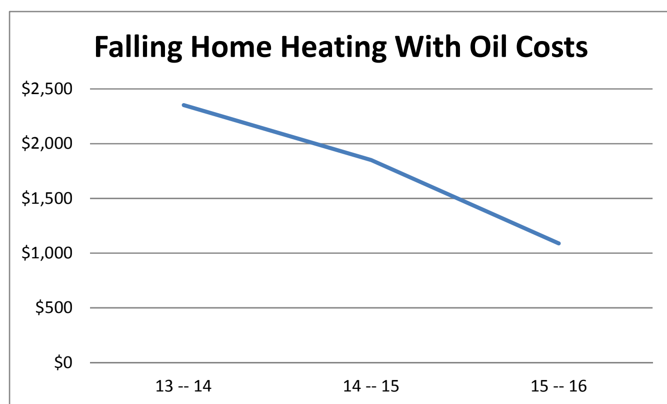
Family Violence Prevention and Services

The Family Violence Prevention and Services program is the primary federal funding stream for shelter and supportive services for victims of family violence, domestic violence, and dating violence and their dependents. The Budget includes $163 million for the program, which includes an increase of $1 million to

create an Alaska Native Tribal Resource Center on Domestic Violence and $4 million to expand the capacity of the National Domestic Violence Hotline, to ensure timely response to calls, increase bilingual services, and expand online chatting and texting services. Alaska Native villagers are disproportionately affected by domestic violence, but there is only one tribal shelter in the entire state. This shortage of services combined with the difficulty of traveling between communities requires innovative approaches for providing services and creates a unique need for capacity building and networking that the state specific resource center will provide.

Low Income Home Energy Assistance Program (LIHEAP)

The Budget includes $3 billion for LIHEAP, a decrease in funding that reflects a difficult decision in a challenging budget environment. Lower fuel prices and warmer weather have decreased home heating costs, and the Department of Energy predicts that the cost of heating a home this winter (2015 – 2016) will be less than last winter for all major fuel types. Decreases range from six percent for homes heated with electricity to forty-one percent for homes heated with oil. To help address unexpected demands on the program, the Budget again includes a new mechanism to provide additional mandatory funds triggered by significant increases in the price of fuel, the number of eligible low-income households, or extreme cold at the beginning of winter.



STRENGTHENING COMMUNITIES

Native Americans

American Indians and Alaska Natives bear a disproportionate burden of premature death, disease, disability, and injury compared to other Americans, including persistently high rates of suicide, particularly among native youth. To address these disparities, the FY 2017 Budget includes funding increases to Native youth initiatives in ACF, IHS, CDC, and SAMHSA. Within ACF, $2 million is included for Native youth resiliency and leadership development grants, as well as $1 million for a new training and technical assistance center to support capacity building and assist Tribes and native organizations in accessing federal and other funds. The Promoting Safe and Stable Families program also includes a $20 million increase to assist Tribes in developing the capacity to operate their own child welfare.

Community Services Programs

In FY 2016, Congress established a requirement that the Community Services Block Grant implementing agencies meet a set of performance standards. The Budget provides $674 million, consistent with the FY 2016 request. This budget level supports implementation of ongoing performance reforms. A new proposal provides short term flexibility for states to invest in the modernization of data systems. The budget continues to propose a set-aside for research and evaluation to help HHS and states learn more about evidence-based practices and greater authority to take timely action to protect federal funds in the event of program integrity issues. Funding is not requested for the Rural Community Facilities program or the Community Economic Development program. Similar activities are conducted in the Departments of Agriculture and Treasury, and ACF will collaborate with those agencies on continued implementation.

EVALUATION AND INNOVATION:

ACF's mission demands that it continually innovate, improve and learn. Through evaluation and the use of data and evidence, ACF and our partners learn systematically so that we can make our services as effective as possible. ACF has been recognized by the Government Accountability Office as an agency with mature evaluation capacity and an evaluation culture.

Evaluation and Innovation

While some ACF programs have dedicated research and evaluation funding, many are studied using Social Services Research and Demonstration funds. The FY 2017 Budget includes a total of $11 million for Social Services Research, including $6 million for ongoing projects, $3 million to help identify the features of early care and education that are most important in supporting early childhood development, and

$2 million for an evaluation related to LIHEAP. In addition, the FY 2017 Budget requests an additional $4 million to bring total funding for the National Survey of Child and Adolescent Well-Being to $6 million in the Child Welfare Programs.

Federal Administration

The Budget includes $206 million, an additional $1 million above FY 2016, to cover the cost of administering programs across ACF. Base funding covers the salaries and benefits of most program staff as well as other administrative expenses, such as office space and the development and maintenance of information technology. This increase will support five FTE needed to administer Preschool Development Grants jointly with the Department of Education. Funding for the Center for Faith Based and Neighborhood Partnerships is requested within the Office of the Secretary, where the Center is administered, consistent with the FY 2016 Appropriation.

Administration for Children and Families: Mandatory

dollars in millions	2015	2016	2017	2017 +/– 2016
Current Law Budget Authority				
Child Care Entitlement to States	2,917	2,917	2,917	—
Child Care and Development Fund (non-add) /1	5,352	5,678	5,678	—
Child Support Enforcement and Family Support	4,158	4,088	4,311	+223
Children's Research and Technical Assistance /2	47	49	39	-10
Foster Care and Permanency	7,386	7,755	8,067	+312
LIHEAP Contingency Fund	—	—	—	—
Promoting Safe and Stable Families (mandatory only) /3	445	472	495	+23
Social Services Block Grant	1,661	1,669	1,785	+116
Temporary Assistance for Needy Families (TANF)	16,737	16,737	16,739	+2
TANF Contingency Fund /4	608	608	608	—
Subtotal, TANF (non-add)	17,345	17,345	17,347	+2
Total, Current Law Budget Authority	**33,959**	**34,295**	**34,961**	**+666**
Proposed Law Budget Authority				
Child Care Entitlement to States	2,917	2,917	6,582	+3,665
Child Care and Development Fund (non-add) /1	5,352	5,678	9,544	+3,866
Child Support Enforcement and Family Support	4,158	4,088	4,342	+254
Children's Research and Technical Assistance (mandatory only)	47	49	88	+39
Foster Care and Permanency	7,386	7,755	8,572	+817
LIHEAP Contingency Fund	—	—	769	+769
Promoting Safe and Stable Families (mandatory only)	445	472	478	+6
Social Services Block Grant /5	1,661	1,669	2,085	+416
TANF	16,737	16,737	17,489	+752
TANF Contingency Fund/6	608	608	25	-583
Pathways to Jobs	—	—	473	+473
Two-Generation Demonstration	—	—	100	+100
TANF Program Improvement	—	—	10	+10
TANF Economic Response Fund	—	—	2,000	+2,000
Subtotal, TANF (non-add)	17,345	17,345	20,107	+2,762
Emergency Aid and Service Connection Grants	—	—	40	+40
Total, Proposed Law Budget Authority	**33,959**	**34,295**	**43,053**	**+8,758**

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/ Includes $15 million in mandatory funds transferred from the TANF Contingency Fund for Welfare Research in FY 2015 and FY 2016.

3/ 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 $60 million for PSSF in FY 2015 and FY 2016 and $80 million in FY 2017.

4/ The Consolidated and Further Continuing Appropriations Act, 2015, appropriated $608 million for the Contingency Fund in fiscal years 2015 and 2016, reserving in FY 2015 $15 million for Welfare Research funds and $10 million for a U.S. Census Bureau study. The Consolidated Appropriations Act, 2016 appropriated $608 million for the Contingency Fund in FY 2017 and reserved $15 million for Welfare Research funds and $10 million for a U.S. Census Bureau study from amounts appropriated for FY 2016.

5/ The proposed law reflects the reauthorization of the Health Profession Opportunity Grants and a new Upward Mobility proposal.

6/ The proposal to repurpose the TANF Contingency Fund would continue to reserve $15 million for Welfare Research and $10 million for a U.S. Census Bureau study in FY 2017.

The FY 2017 Budget request for the Administration for Children and Families mandatory programs is $43.1 billion. ACF serves the nation's most vulnerable populations, including those living in deep poverty at just over $12,000 for a family of 4, through mandatory programs including Temporary Assistance for Needy Families (TANF), Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

The Budget guarantees access to high-quality child care for low income working families with young children; encourages the use of evidence-based interventions to improve outcomes for children in foster care; focuses on preventing the removal of children from their families; limits the use of institutional settings and group homes for foster care placements; increases the child support that is paid directly to families; promotes fathers' involvement in the lives of their children; advances human services interoperability by investing in human services information system; and proposes to provide assistance to low-income families to help them become self-sufficient.

CHILD CARE ENTITLEMENT TO STATES

The Budget proposes a historic and necessary investment in child care to close the gap between the cost of high-quality care and what families can afford while expanding the availability of child care that is not only safe, but supports children's healthy development and their future academic achievement and success.

The Budget provides $82 billion over 10 years to expand child care assistance to all eligible families with children under age 4 by 2026. This investment will ensure that all low-income families with incomes below 200 percent of the poverty line with children ages 3 and under have access to high-quality child care so that parents can work, attend school, or participate in training.

With the Child Care and Development Fund caseload currently at the lowest point since the creation of the program in 1996, this investment will expand access to high-quality care for approximately 1.15 million additional infants and toddlers at the end of 10 years. In 2026, over 2.6 million children will be served by the Child Care and Development Fund, including nearly 1.8 million infants and toddlers.

The Budget also supports the critical role that teachers and caregivers play in providing safe, supportive, and quality learning environments for young children. The proposal would support important and tangible investments in quality improvements, including investments to improve the skills, competencies, and training of the child care workforce and a higher subsidy rate for higher quality care. This increase in the subsidy rate, paired with investments in workforce development, will improve the quality of care that children receive, in part by allowing for more adequate compensation of child care workers.

The Budget's landmark investment in the Child Care Entitlement complements investments to provide universal preschool education in the Department of Education; expand access to preschool through the

NEW INITIATIVE

Guaranteeing Access to Child Care to Support Working Families and Benefit Children

A continually growing body of evidence suggests early and continuous exposure to high-quality child care is beneficial for child development and is most impactful for children from disadvantaged backgrounds. High-quality, stable, and reliable child care can improve children's cognitive and social outcomes and reduce later costs to society. In addition to increasing the likelihood children will be in safe nurturing learning environments, access to high-quality child care also benefits children by helping parents increase their employment and earnings, thereby reducing financial hardship and possibly parental stress. The FY 2017 Budget continues to make a historic commitment to improving access to high-quality, affordable child care for low income children and addressing prohibitively high child care costs for working families by investing $82 billion in mandatory funds in the Child Care and Development Fund over 10 years. The Budget commits to providing child care assistance to more than 2.6 million children by 2026, nearly tripling the number of infants and toddlers to 1.8 million. In creating a child care guarantee for children ages 0 through 3 years old in families with incomes up to 200 percent of the federal poverty level, this historic investment will help draw into the labor force primary caregivers of young children, in particular young mothers, who have seen disproportionate declines in labor force participation since 2008.

Preschool Development Grants in HHS; extend and expand the Maternal, Infant, and Early Childhood Home Visiting program; and increase the number of children attending Head Start full school day and year programs. Together, these are the key elements of the Administration's broader education agenda, designed to ensure a cohesive and well-aligned continuum of early learning for children from birth to age five, which supports continuity of care, healthy development, learning, and stability for children in the critical years before school.

Of total funding for the Child Care and Development Fund of $9.54 billion in FY 2017, the Budget includes an additional $200 million in discretionary funds for child care above FY 2016. These funds will help states implement the new statutory requirements of the reauthorization and include $40 million for pilots that will test innovative strategies to address the child care needs of working families, such as care during on-traditional hours and in rural areas.

CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

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 request is $4.3 billion in budget authority in FY 2017 for Child Support Enforcement and Family Support Programs.

The Budget promotes strong families and responsible parenting by ensuring that children benefit when parents pay support, promoting parenting time arrangements, replacing state computer systems, and improving enforcement tools. The Budget includes $2.3 billion in net costs over 10 years for an initiative to modernize the Child Support Program and to promote responsible parenting. Of those net 10 year costs, $2.8 billion impacts the Child Support Program; Supplemental Security Income and the Supplemental Nutrition Assistance Program realize savings of $1.1 billion collectively, while there are $162 million in costs for Medicaid, and $492 million in costs for Foster Care.

The Budget also includes funding specifically to encourage states to pass through child support payments directly to families, making sure more child support collections reach children rather than being retained by the federal and state governments, and a child support research fund to encourage state Title IV-D programs to test and implement family-centered approaches.

The Budget proposes a technology enhancement and replacement fund to build child support model systems and applications to be made available for any state to use to respond to the significant need to replace aging state child support systems. This fund is estimated to save $467 million over 10 years due to efficiencies these model systems would create in the process of replacing multiple legacy state child support systems.

The Budget provides $10 million annually for grants to states to facilitate non-custodial parents' access to and visitation with their children. Research shows that non-custodial parents are more likely to pay child support when they can see 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.

PERFORMANCE HIGHLIGHT

Child Support Highlights

The Child Support program continues to make strong gains in establishing child support orders and increasing child support collections. In FY 2014:

- Child support collections increased modestly to $28.2 billion.
- 1.5 million paternities were established and acknowledged.
- Paternity was established for 96 percent of Title IV-D non-marital births, exceeding the target of 94 percent.
- Child support orders were established for 85 percent of child support cases, which surpassed the target of 80 percent.
- For every dollar invested in the program, $5.25 in child support was collected, which exceeded the performance target of $5.00.
- Six tribal programs became comprehensive, fully operational program service providers, bringing the total number of comprehensive Tribal Child Support Programs to 57.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

The Budget request includes $37 million for activities in two areas: $12 million for child support training and technical assistance and $25 million to support the operation of the Federal Parent Locator Service, which assists states in locating absent parents.

NEW INITIATIVE

Focus on Child Welfare

ACF, in partnership with states, consistently strives to improve the lives of children and families through child welfare programs. The new proposals in the Budget focus on three main areas:

1) Assist foster youth as they transition out of care and enable them to become successful adults.

- Redistribute any unobligated Chafee formula grant funds.
- Expand eligibility for the Chafee Foster Care Independence Program to youth through age 23 in states that allow youth to remain in foster care beyond age 18.
- Support funding for research and development to test innovative models to support youth aging out of foster care.

2) Strengthen the ability of title IV-E Tribes to effectively serve children, youth, and families in the child welfare system.

- Provide enhanced start-up funding for Tribes seeking to implement their own child welfare programs.
- Provide an enhanced match rate for tribal child welfare workers.

3) Enhance workforce development to ensure caseworkers and other professionals have the right training and skills to best meet the needs of children, youth, and families in the child welfare system.

- Provide title IV-E funding for Bachelor's or Master's Degree of Social Work education.
- Offer an enhanced match rate for highly trained caseworkers.

The Budget proposes to extend access to the rich data in the National Directory of New Hires, a component of the Federal Parent Locator System, to multiple agencies to improve efficiencies and strengthen program integrity while maintaining the integrity and privacy of the data in the directory.

The Budget includes $250 million over 5 years in mandatory funds complemented by a $10 million discretionary investment in FY 2017 to advance human services interoperability. The mandatory investment would establish a Statewide Human Services Data System grant program to provide grants and related technical assistance to states in support of the design, development, and implementation of statewide integrated data systems and related analytic tools. The discretionary investment would lay the groundwork for advancing interoperability efforts, including establishing a Systems Innovation Center that would design and build IT elements to be shared with states and Tribes in support of integrated health and human services eligibility and enrollment systems.

Funding for Welfare Research, which was previously funded in this account at $15 million, is requested as part of the TANF Contingency Fund. 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 $8.6 billion in FY 2017 budget authority. These programs, authorized by title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence.

The Budget includes an investment of $505 million above baseline in FY 2017 for a suite of proposals designed to improve permanency services so children are less likely to need foster care placement in the future; strengthen Tribal child welfare programs; foster successful transitions from foster care to adulthood; and improve the quality of child welfare services provided to children through better trained staff and stronger information technology systems.

The Budget requests $616 million over 10 years in matching funds for permanency and post-permanency services included as part of a child's case plan. Most of the services funded must be evidence-based or evidence-informed. Prevention and permanency interventions can reduce the likelihood that a child will have to be removed from a family and can increase the likelihood that recently established permanency arrangements can be sustained. The Budget also includes savings of $68 million over 10 years to promote family-based foster care for children with behavioral and mental health needs, as an alternative

to congregate care, and provides increased oversight of congregate care when such placements are necessary.

To strengthen the ability of title IV-E Tribes to effectively serve children, youth, and families in the child welfare system, $241 million over 10 years is included in the Budget to provide enhanced start-up funding for Tribes seeking to implement their own child welfare programs and to provide an enhanced match rate for tribal child welfare workers.

The Budget provides $1.8 billion over 10 years for an initiative to help child welfare caseworkers secure Bachelor's or Master's Degrees of Social Work and to support an enhanced match rate for highly trained caseworkers to ensure that those serving our most vulnerable children have the right training and skills to help children and families engaged in the child welfare system thrive. Children who have caseworkers with this specialized training have better outcomes, including shorter time in out-of-home care, increased adoptions, and a lower likelihood of being removed from their homes.

The Budget provides $131 million over 10 years for an enhanced match for Title IV-E administrative costs related to IT systems development in child welfare. This proposal promotes the efficient replacement of aging child welfare state systems to increase innovation, system security, and efficiency to better serve children and families in the child welfare system.

The Budget continues to request mandatory funding in ACF to support a collaborative demonstration project with the Centers for Medicare & Medicaid Services (CMS) to address the over-prescription of psychotropic medications to children in foster care. This investment includes $250 million in mandatory funding over 5 years in ACF, paired with $500 million in new performance-based incentive funds in CMS.

The Budget also includes $46 million in FY 2017 and $492 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 rather than being retained by the state.

The FY 2017 Budget includes $5.2 billion in budget authority to support the Foster Care program, including maintenance payments to children. This amount is a $493 million increase above FY 2016. The proposed level of funding will provide assistance and support to an estimated 174,500 children each month, which is approximately 8,000 more children than in FY 2016.

The proportion of all children in foster care who are title IV-E eligible continues to decline, however. This decrease is due in large part to the declining income eligibility standards used in the program, which are tied to eligibility rules in effect in 1996 for the Aid to Families with Dependent Children program. 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 2015, the federal title IV-E participation rate was approximately 42 percent of all children in foster care nationally.

The Budget includes $2.8 billion in budget authority for the Adoption Assistance program, an increase of $106 million above FY 2016. An estimated average of 467,500 children per month, an increase of 13,000 children from FY 2016, will qualify for this assistance in FY 2017.

The Budget includes $152 million for the Guardianship Assistance Program, an increase of $17 million above the FY 2016 enacted level of $123 million. The program is continuing to grow, and 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. The goal of the program is to keep children with relatives, rather than in foster care, when a relative's home is a safe and appropriate placement. An estimated average of 29,300 children per month, an increase of 3,000 children from FY 2016, will participate in FY 2017.

The Budget also includes $144 million for the Chafee Foster Care Independence Program, an increase of $4 million over FY 2016. This program funds services for youth who are likely to remain in foster care until they turn 18 and current or former foster children between the ages of 18 and 21. The Budget proposes to allow those states that provide foster care up to age 21 to use these funds for current or former foster children through age 23 to prevent an abrupt end to services when children age out of foster care in those states. The Budget also proposes $4 million for research that will identify and develop innovative, evidence-based models for independent living services. To assist foster youth as they transition out of care and enable them to successfully make the transition to adulthood, the Budget includes a proposal to redistribute any unobligated Chafee formula grant funds available at the end of the two-year expenditure

period to jurisdictions that indicate an interest in receiving those funds.

The Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2014, the latest year for which complete performance data are available. 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 for a child in care. In FY 2014, over 85 percent of children who had been in care less than 12 months had 2 or fewer placement settings, which exceeded the Department's target of 80 percent. Research shows that 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.

LIHEAP CONTINGENCY FUND

To help address unexpected demands on the program, the Budget includes $769 million in FY 2017 and $1.0 billion over 10 years to establish a contingency fund, which will provide additional mandatory funds triggered by significant increases in the number of eligible low-income households, the price of fuel, or extreme weather.

PROMOTING SAFE AND STABLE FAMILIES

The Budget includes $478 million for the mandatory portion of the Promoting Safe and Stable Families account. Of this amount, $385 million supports the Promoting Safe and Stable Families 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 Promoting Safe and Stable Families Program and the Family Connection Grants through FY 2021 and the Personal Responsibility Education Program through FY 2022.

The Child and Family Services Improvement and Innovation Act of 2011 previously reauthorized the Promoting Safe and Stable Families Program through FY 2016. Under the last reauthorization, states were required to address trauma that children in the child welfare system have experienced during their lives and to have explicit protocols for oversight and monitoring of psychotropic medications. Funding in FY 2017 and beyond 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 that address the impacts of trauma.

The $385 million for Promoting Safe and Stable Families includes an expansion of the Regional Partnership Grants from $20 million to $60 million annually to improve the well-being of children and families affected by substance abuse. Based on 2014 data, parental substance abuse contributed to 30 percent of foster care placements. Consistent with parental addiction, the rate of infants entering child welfare has also increased from a rate of 10.8 per 1,000 infants in 2013 to 11.4 per 1,000 infants in 2014. Moreover, child welfare agencies across the country have reported increases in opioid, heroin, and methamphetamine addiction and a lack of effective treatment services as significant contributing factors to the uptick in the numbers of children entering foster care. (See the SAMHSA Chapter for a discussion on opioid abuse.) Families who participated in previous Regional Partnership Grants projects experienced enhanced outcomes, including successful recovery, increased number of children remaining at home, increased reunification rates, decreased recidivism, and dramatic differences in the rate of children who returned to out-of-home care as compared to families who did not participate in the Regional Partnership Grants projects.

In FY 2014, the adoption placement rate for children from foster care moving into permanent homes was 12.1 percent (50,644 children adopted), falling just short of the target of 12.3 percent. By monitoring the adoption rate, ACF is helping to ensure there is a focus on placing children in a permanent home. While adoption is the goal for many children in foster care, the target for this measure is cognizant of the fact that many children in foster care are best served by returning to their biological parents.

The Budget also includes $22 million over 10 years to expand the Tribal Court Improvement Program to strengthen the capacity of tribal courts to exercise jurisdiction in Indian Child Welfare Act cases and to adjudicate child welfare cases in tribal court.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant is an appropriated entitlement which provides flexible grants to the 50 states and the District of Columbia, based on each state's population relative to all other states, for the provision of social services ranging from child care to residential treatment. States have broad discretion over the use of these funds. Social Services Block Grants support a variety of initiatives to support services for low-income and vulnerable individuals such as adult 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.

The Social Services Block Grant is funded at $2.1 billion for FY 2017. The Budget recommends setting aside up to one and a half percent of the funds for the Social Services Block Grant for purposes related to research, evaluation and demonstrations. Included in this set-aside is $10 million to fund a small diaper pilot project, which will enable government agencies or nonprofits to test approaches to provide low-cost diapers to low-income families with infants and toddlers. While higher-income families may benefit from having greater access to broadband connectivity and more accessible bulk purchase options for diapers, low-income families do not always have the same access to low-cost diaper options. This pilot project will test new approaches to reduce the substantial cost of this crucial item for low-income families, and mitigate health risks that can arise when low-income families do not have an adequate supply of diapers for infants and toddlers.

The Budget also includes $1.5 billion in additional funding for the Social Services Block Grant, over five years, to support the Upward Mobility Project. The Project will allow up to 10 states, localities, or consortia of states and communities more flexibility to use funds from up to 4 federal block grants—HHS' Social Services Block Grant and Community Services Block Grant and the Department of Housing and Urban Development's Community Development Block Grant and HOME Investment Partnerships Program—for efforts designed to promote self-sufficiency, improve educational and other outcomes for children, and enhance communities' ability to provide opportunities for families. Projects will rely on evidence-based programs or be designed to test new ideas and will have a significant evaluation component. The funding will be awarded competitively by ACF, in consultation with the Department of Housing and Urban Development.

The Budget supports a five-year reauthorization of the Health Profession Opportunity Grants Program and proposes to allow grantees to use these funds for subsidized employment as part of their overall efforts. Reauthorization would provide $85 million per year through FY 2022 for these grants.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

TANF provides $17.3 billion annually to states, territories, and eligible Tribes to assist low-income families and improve employment and other outcomes. TANF grant funding has not increased since the program's inception 20 years ago. For FY 2016, the Consolidated Appropriations Act, 2016 extended all TANF grants through September 30, 2016 and provided $608 million annually for the TANF Contingency Fund in FY 2016 and FY 2017. From the amounts appropriated for FY 2016 for the Contingency Fund, it transferred $15 million for Welfare Research, previously funded through Children's Research and Technical Assistance, as well as a $10 million transfer for the Census Bureau's Survey of Income and Program Participation.

TANF was designed to provide states with more flexibility while requiring them to engage recipients in work activities, but there is strong evidence that the program can do more to help families get back on their feet and work toward self-sufficiency. Currently, some states use only a small share of their TANF funds to provide assistance to very poor families or to help parents find jobs. A large share of poor families with children do not get any help from TANF, even when the parents are out of work and the family has no regular source of income. A particularly troubling indicator is the decline in the TANF-to-poverty ratio since TANF's inception: in 1996, for every 100 families in poverty, 68 received TANF assistance; by 2014, that number had dropped to just 23. Currently, just 32 percent of families that meet state eligibility requirements for TANF (such as income and asset rules) actually receive income assistance. And when families do not receive income assistance, they also typically lose access to the employment services that TANF programs provide.

One contributing factor to this drop in help for poor families is the fact that TANF funding has remained frozen since it was created in 1996, losing about one-third of its value due to inflation. And, even with

the resources available, too few TANF dollars are spent on the core purposes of supporting destitute families and helping them find jobs. In nearly half the states, less than half of federal TANF and state maintenance of effort funds are spent on basic income assistance to poor families, work programs, and child care. In addition, some federal rules limit state flexibility in a way that hinders the effectiveness of TANF employment programs.

The Budget strengthens the TANF program to make it a more effective safety net and employment opportunity program for those who need help. The Budget increases funding for the TANF Family Assistance Grants by $8 billion over 5 years, to partially address its erosion in value since 1996, and requires states to spend at least 55 percent of all funding, including state maintenance-of-effort funding, on core benefits services within TANF, defined as cash assistance, child care, and work activities. The required share of funding for core benefits and services would increase as total TANF funding increases, and would reach 60 percent by 2021.

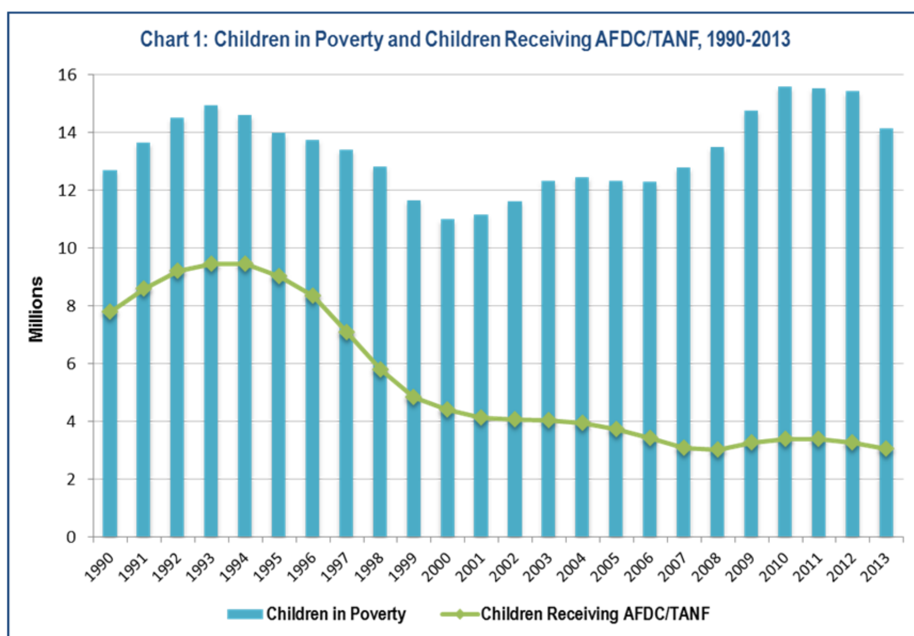
The Budget also proposes expanding the purposes of TANF to include reducing child poverty and directs HHS to publish national and state measures related to this new purpose as a means of holding states accountable for child poverty outcomes.

Some additional policy proposals include prohibiting states from claiming nongovernmental third party expenditures as state maintenance-of-effort funding requirements and requiring that all federal TANF and maintenance of effort funding be directed towards benefits and services supporting families below 200 percent of the federal poverty line.

Finally, the Budget recognizes that the current structure of work participation requirements is overly prescriptive and can hinder states' efforts to help parents find jobs. The Administration would like to work with Congress to provide states with more flexibility to design effective work programs in exchange for states being held accountable for the outcome that really matters—helping parents find jobs.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES ECONOMIC RESPONSE FUND

The current Contingency Fund does not serve as a meaningful countercyclical mechanism for TANF, nor is it structured in a way that assists states during periods of economic distress. These reasons are why during the Great Recession, Congress and the Administration had to create the temporary TANF Emergency Fund (now expired) to ensure that states had the resources required to meet the increased need. Building off the success of the Emergency Fund, the Budget establishes a TANF Economic Response Fund that uses a more straightforward and effective trigger to provide targeted funding for states to invest in efforts that address the needs of families during economic downturns. The Budget proposes $2 billion in funding over 5 years for this Fund, though an analysis of economic forecasts results in estimated outlays of $636 million over this period.



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (ASEC). TANF Data Reporting System.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES CONTINGENCY FUND

The current TANF Contingency Fund is not structured in a way that effectively assists states during periods of economic distress, as it is unnecessarily complicated and also fails to help states meet increased demands for cash assistance during economic downturns. The Budget proposes to repurpose this funding for demonstrations that will better serve low-income families.

The $473 million Pathways to Jobs initiative, would support work opportunities through subsidized employment for low-income parents, guardians, and youth. Pathways to Jobs will target individuals who are either 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 through the first 90 days of employment for eligible individuals, including eligible summer employment. Partial subsidies are also allowable after the first 90 days. 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 two-generation demonstration projects, funded by repurposing $100 million of the Contingency Fund, will help TANF agencies implement and build the evidence base for strategies that coordinate existing services, engage new partners, leverage additional resources, and supplement services to low-income families under 200 percent of the federal poverty line. The demonstration projects will focus on workforce development to help parents succeed in high demand jobs; the provision of high-quality early education and childhood development programs designed to prepare children for school success; and families' development of social capital and support networks with schools, workplace, and community organizations.

In addition, the Budget would repurpose $10 million of the Contingency Fund, to support improvements in TANF programs through technical assistance for state and tribal programs, monitoring, research, and evaluation. The Budget also includes a general provision to transfer $15 million from the Contingency Fund to support Welfare Research and $10 million for Survey of Income and Program Participation, consistent with the FY 2016 appropriations funding.

EMERGENCY AID AND SERVICE CONNECTION GRANTS

The Budget proposes a new program—the Emergency Aid and Service Connection Grants—that will test approaches to helping families facing a financial crisis.

A growing number of families with children now live on less than $2 of cash income per person per day. In 1996, 1.7 percent of all households with children were under the $2-a-day threshold. By 2011, the number of families had grown to 4 percent, representing 1.5 million families with about approximately 3 million children. [1]

The Budget provides $2 billion over a five-year period for a robust round of pilots to help families facing financial crisis. For some financially stressed families, a needed car repair or a week of missed work due to the flu can bring a family to the brink of financial collapse, including loss of a job or even homelessness. Some families have already hit bottom, living in extreme poverty without help. The pilots will test new approaches to providing emergency aid for these families. This initiative will include both short-term financial assistance, such as help paying a rental security deposit or for a car repair, and for those who need longer term assistance, connection to supports, such as TANF, employment assistance, Supplemental Nutrition Assistance Program, child care, or Medicaid, that can help persons receiving assistance find jobs, stabilize their families, and become more financial secure.

The Budget allocates $40 million in FY 2017 for a planning year for grantees, followed by $490 million annually from FY 2018 through FY 2021 to assist hundreds of thousands of families and support a strong evaluation.

1/ *$2.00 a Day* by Kathryn Edin and Luke Shaefer

50-Year Poverty Trends and Safety Net Impacts

Researchers at Columbia University have translated the federal government's supplemental poverty measure from 2012 back to 1967 to assess the full impact of the social safety net.[1] Poverty is lower now than five decades ago, declining from 25.6 percent in 1967 to 16.0 percent in 2012. Trends show the most progress in reducing poverty occurred in two distinct periods, from 1967 to 1973 and from 1993 to 2000, periods of sustained economic growth. In 1967, 25.6 percent of the population lived in poverty and the rate fell to 19.2 percent by 1973 following the economic expansions in the 1960s and early 1970s. In 1993, 20.7 percent of the population was poor and the rate fell to 14.4 percent in 2000 following the sustained economic growth of the 1990s. The supplemental poverty rate has again begun to decline with the economic recovery following the most recent recession, falling from 16.0 percent in 2012 to 15.3 percent in 2014.[2]

The federal safety net has improved the economic circumstances of low-income children and families since 1967, substantially reducing the level of poverty and hardship in the United States by providing food and housing assistance, child support for families, health care coverage, direct economic support, and benefits that enable work. The share of Americans lifted out of poverty each year by government programs has increased tenfold since the 1960s, cutting the poverty rate nearly in half in 2012 from 28.7 percent to 16.0 percent. In 2012, the poverty rate for all Americans would have been 12.7 percentage points *higher* if current safety net benefit programs didn't exist. This compares to a poverty rate that would have been 1.2 percentage points higher without safety net transfers in 1967.

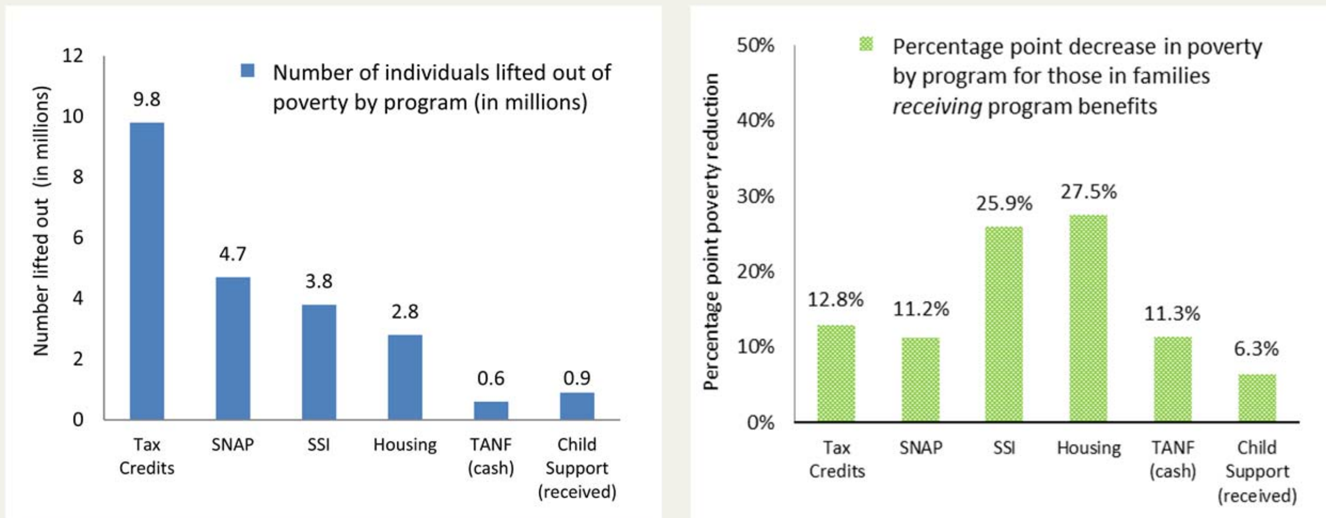
The supplemental poverty measure includes tax credits and noncash benefits when measuring a family's income and thus allows for an analysis of the poverty reduction impact of individual programs within the safety net. Program-by-program estimates show the particularly strong poverty reduction impact of refundable tax credits (including the EITC and the Additional Child Tax Credit) and SNAP. In 2014:

- Refundable tax credits lifted 9.8 million people out of poverty; and
- SNAP benefits lifted 4.7 million people out of poverty.

Some programs reach a much smaller subset of the population but have a strong poverty reduction impact among those who receive benefits. For example, among *program recipients* in 2014:

- TANF cash assistance benefits reduced the annual poverty rate among those receiving TANF cash assistance by 11.3 percentage points. However, because TANF cash assistance programs serve less than one-third of families eligible for assistance, the program's overall impact on poverty is modest.
- Child Support payments received reduced the annual poverty rate among recipients by 6.3 percentage points. Child support services are available to all who request them, but not all children receive significant child support because some noncustodial parents are unable to pay due to their own financial circumstances, are only able to pay a small amount, or do not make payments they can afford.

Impact of Select Safety Net Programs on Annual Supplemental Poverty, 2014



Note: Figures compiled by ASPE; forthcoming in *Poverty in the United States: 50-Year Trends and Safety Net Impacts*.
Source: Unpublished tabulations by the U.S. Census Bureau, Social, Economic and Housing Statistics Division; Current Population Survey, Annual Social and Economic Supplement, 2015.

[1] Analysis of the full impact of the safety net is not possible with the official poverty measure. The Columbia University poverty trends presented here are "anchored" in 2012. See Wimer, Christopher, Liana Fox, Irwin Garfinkel, Neeraj Kaushal, Jane Waldfogel. 2013. "Trends in Poverty with an Anchored Supplemental Poverty Measure," available at: http://cupop.columbia.edu/publications/2013.
[2] Because the Columbia University data are not available after 2012, the poverty rate comparison between 2012 and 2014 is based on the federal government's supplemental poverty measure.

Administration for Children and Families: Mandatory

FY 2017 ACF Mandatory Outlays

dollars in millions	2015	2016	2017	2017 +/– 2016
Current Outlays				
Child Care Entitlement to States	2,821	2,949	2,938	-11
Child Care and Development Fund (non-add) /1	5,134	5,746	5,735	-11
Child Support Enforcement and Family Support	4,040	4,167	4,290	+123
Children's Research and Technical Assistance	46	56	43	-13
Foster Care and Permanency	7,314	7,478	7,805	+327
LIHEAP Contingency Fund	—	—	—	—
Promoting Safe and Stable Families (mandatory only) /2	461	446	462	+16
Social Services Block Grant	1,653	1,675	1,772	+97
Sandy Supplemental /3	179	96	64	-32
Temporary Assistance for Needy Families (TANF)	15,942	16,393	16,439	+46
TANF Contingency Fund	730	556	615	+59
Subtotal, TANF (non-add)	16,672	16,949	17,053	+104
Total, Current Law Outlays	33,186	33,816	34,428	+612
Proposed Law Outlays				
Child Care Entitlement to States	2,821	2,949	5,907	+2,958
Child Care and Development Fund (non-add) /1	5,134	5,746	8,789	+3,043
Child Support Enforcement and Family Support	4,040	4,167	4,320	+153
Children’s Research and Technical Assistance (mandatory only)	46	56	48	-8
Foster Care and Permanency	7,314	7,478	8,058	+580
LIHEAP Contingency Fund	--	--	560	+560
Promoting Safe and Stable Families (mandatory only)	461	446	463	+17
Social Services Block Grant /4	1,653	1,675	2,072	+397
Sandy Supplemental /3	179	96	64	-32
Temporary Assistance for Needy Families (TANF)	15,942	16,393	17,024	+631
TANF Contingency Fund /5	730	556	25	-531
Pathways to Jobs	--	--	473	+473
Two-Generation Demonstration	--	--	100	+100
TANF Program Improvement			8	+8
TANF Economic Response Fund	--	--	28	+28
Subtotal, TANF (non-add)	16,672	16,949	17,668	+719
Emergency Aid and Service Connection Grants	--	--	1	+1
Total, Proposed Law Outlays	**33,186**	**33,816**	**39,151**	**+5,335**

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 $60 million for PSSF in FY 2015 and FY 2016 and $80 million in FY 2017.
3/ The Disaster Relief Appropriations Act provided $500 million in funding for Social Services Block Grant to aid in the recovery from Hurricane Sandy.
4/ The proposed law reflects the reauthorization of the Health Profession Opportunity Grants and Upward Mobility proposal.
5/ The proposal to repurpose the TANF Contingency Fund would continue to transfer $15 million for Welfare Research and $10 million for a U.S. Census Bureau study in FY 2017.

FY 2017 ACF Mandatory Legislative Proposals

dollars in millions	2017	2017 -2021	2017 -2026
Proposed Law Outlays			
Child Care Entitlement	2,969	23,728	78,327
Child Support Enforcement and Family Support Programs /1	9	337	1,639
Children's Research and Technical Assistance	5	162	250
Foster Care and Permanency	253	1,372	3,525
LIHEAP Contingency Fund	560	1,000	1,000
Promoting Safe and Stable Families	1	286	739
Social Services Block Grant	300	1,713	1,925
Temporary Assistance for Needy Families (TANF)	593	7,279	8,095
TANF Contingency Fund Repurposed /2	598	2,990	5,980
TANF Economic Response Fund	28	636	636
Emergency Aid and Service Connection Grants	1	1,369	2,000
Total Outlays, ACF Legislative Proposals	**5,317**	**40,872**	**104,116**

1/ The Child Support outlays in this table are net of estimated savings in the Supplemental Nutrition Assistance Program ($959 million over 10 years) and the Supplemental Security Income Program ($162 million over 10 years), which would result from this proposal. These outlays include the cost of $963 million over 10 years from Federal Offsetting Collections. The impact on Medicaid ($162 million over 10 years) is displayed in the Medicaid table.

2/ The outlays for this proposal are offset by repurposing the TANF Contingency Fund and do not reflect new outlays.

Administration for Community Living

dollars in millions	2015	2016	2017	2017 +/– 2016
Health and Independence for Older Adults				
Home & Community-Based Supportive Services	348	348	358	+10
Nutrition Services	815	835	849	+14
Native American Nutrition & Supportive Services	26	31	31	--
Preventive Health Services	20	20	20	--
Chronic Disease Self-Management (PPHF)	8	8	8	--
Falls Prevention (PPHF)	5	5	5	--
Aging Network Support Activities	10	10	10	--
Subtotal, Health and Independence	**1,231**	**1,256**	**1,280**	**+24**
Caregiver and Family Support Services				
Family Caregiver Support Services	146	151	151	--
Native American Caregiver Support Services	6	8	8	--
Alzheimer's Disease Demonstration Grants	4	5	5	--
Alzheimer's Disease Initiative – Specialized Supportive Services (PPHF)	11	11	11	--
Lifespan Respite Care	2	3	5	+2
Subtotal, Caregiver Services	**168**	**177**	**178**	**+2**
Protection of Vulnerable Older Adults				
Long-Term Care Ombudsman Program	16	16	16	--
Prevention of Elder Abuse & Neglect	5	5	5	--
Senior Medicare Patrol Program	9	--	--	--
Health Care Fraud and Abuse Control (HCFAC)	9	18	18	--
Elder Rights Support Activities	8	12	14	+2
Subtotal, Protection of Vulnerable Older Adults	**46**	**50**	**52**	**+2**
Disability Programs, Research and Services				
State Councils on Developmental Disabilities	72	73	73	--
Developmental Disabilities Protection and Advocacy	39	39	39	--
University Centers for Excellence in Developmental Disabilities	38	39	39	--
Projects of National Significance	9	10	10	--
Nat'l Institute on Disability, Independent Living, & Rehab. Research/1	104	104	104	--
Independent Living/1	101	101	101	--
Traumatic Brain Injury/2	9	9	9	--
Limb Loss Resource Center	3	3	3	--
Paralysis Resource Center	7	8	8	--
Subtotal, Disability Programs, Research and Services	**381**	**385**	**385**	**--**

dollars in millions	2015	2016	2017	2017 +/– 2016
Consumer Information, Access and Outreach				
Aging and Disability Resource Centers	6	6	8	+2
Voting Access for People With Disabilities	5	5	5	--
State Health Insurance and Assistance Programs	52	52	52	--
Alzheimer's Disease Initiative – Communications (PPHF)	4	4	4	--
Assistive Technology/1	33	34	32	-2
MIPPA Extensions	25	38	38	--
Subtotal, Consumer Information, Access and Outreach	**125**	**139**	**139**	**--**
Other Programs, Total, and Less Funds From Other Sources				
Program Administration	38	40	41	+1
Total, Program Level	**1,990**	**2,048**	**2,076**	**+28**
Less Funds from Other Sources	-61	-83	-83	--
Total, Budget Authority	**1,928**	**1,965**	**1,993**	**+28**
Full-Time Equivalents	200	206	234	+28

1/ These programs were transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act.FY 2015 program funding, administrative funding, and FTE for these programs are displayed comparably.
2/ Comparably adjusted to reflect the transfer of the Traumatic Brain Injury Program from HRSA to ACL in FY 2016.

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 Administration for Community Living (ACL) is committed to the fundamental principle that people with disabilities and older adults should be able to live where they choose, live with the people they choose, and fully participate in their communities. ACL programs work to remove the barriers that can make it difficult for many older adults and people with disabilities to achieve this vision. The FY 2017 Budget requests $2 billion for ACL, an increase of $28 million over FY 2016. The Budget maintains critical programs that promote self-determination, independence, productivity, and community integration for individuals with disabilities and prioritizes investments in elder justice activities, nutrition assistance, and long-term services and supports that help seniors and individuals of all ages with disabilities to remain independent.

HELPING SENIORS MAINTAIN THEIR HEALTH AND INDEPENDENCE

The Budget includes $1.3 billion in funding for essential preventive and supportive services. These resources assist older adults so they may remain in their homes and communities, leading healthy and independent lives. Within that total, the Budget requests $31 million to support the same services in Tribal communities. As the number of seniors who are at greatest risk of nursing home admission continues to rise, these services are vital to ensuring that seniors can remain in their homes and communities for as long as possible. The Budget requests $849 million for nutrition services, an increase of $14 million over FY 2016, to ensure that older adults have reliable access to nutritious meals. In FY 2017, this funding will enable ACL to support an estimated 205 million meals to over 2 million seniors nationwide. Meals are served in a variety of congregate settings and delivered to seniors' homes, reaching some of the neediest members of the community. The Budget also proposes to support evidence-based innovations that will help to modernize ACL's meal programs while improving service quality and efficiency within this funding level.

The Budget also includes $358 million, an increase of $10 million over FY 2016, to fund in-home and community-based services that enable seniors to live independently and avoid costly nursing home care. These services include transportation assistance, which

will provide more than 22 million rides for critical daily activities, such as visiting the doctor, pharmacy, or grocery store. Nearly 50 percent of seniors benefitting from transportation assistance are mobility impaired, and nearly 77 percent have severe vision problems or other chronic conditions that could impair their ability to drive safely. Transportation services will provide these seniors with the access assistance and information they need to remain independent, as over half of the participants rely on them for the majority of their transportation needs and would otherwise be homebound.

The Budget also requests $20 million for Preventive Health Services to support evidence-based programs that help seniors adopt healthy behaviors, improve their health status, and reduce their use of costly hospital services and emergency room visits. The Budget also includes $8 million for Chronic Disease Self-Management Education and $5 million for Falls Prevention. Both programs promote evidence-based practices designed to empower seniors to improve the quality of their health, with the ultimate goal of preventing more costly medical interventions. The Budget also includes $10 million for Aging Network Support Activities to help seniors to access information about their care options and benefits, including $3 million to provide supportive services for elderly Holocaust survivors who suffer from complex physical and mental health needs.

SUPPORTING FAMILY CAREGIVERS

The Budget includes $178 million to fund programs that support family and informal caregivers. Addressing the needs of unpaid caregivers is critical to helping the seniors and people with disabilities they care for to remain at home. These services allow caregivers to provide care longer than they otherwise could, which decreases the risk of institutionalization of the care recipient. With these investments, ACL supports many of the caregivers nationwide who provide an estimated $522 billion in care annually, a cost that might otherwise be billed to Medicare or Medicaid. The Budget will support approximately 900,000 caregivers who will be able to access counseling and training services to help them cope with the stresses of caregiving and respite care services to provide temporary relief from caregiving responsibilities.

PROGRAM HIGHLIGHT

Preventing Elder Abuse, Neglect, and Exploitation

Highlighted in the 2015 White House Conference on Aging, elder abuse, neglect, and exploitation are significant and under-recognized public health and human rights issues in the United States. Research has demonstrated that victims of elder abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older adults. 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 Program will enable Adult Protective Services programs to test innovations and improvements in services, data collection, and reporting and will support the implementation of ACL's National Adult Maltreatment Reporting System. With improved standards for conducting case investigations and collecting case-level data, states will be better equipped to respond in an effective and timely way to reports of elder abuse, neglect, and exploitation.

Included within this request, ACL will invest $20 million to specifically address the needs of those caring for people with Alzheimer's disease and related dementias. Most people living with Alzheimer's disease are dependent upon family caregivers for years due to the slow loss of cognitive and functional independence. The complexity of care involved can cause significant caregiver distress, and result in earlier nursing home placement. The Budget addresses these challenges by providing competitive grants that will build on existing dementia-capable service systems and expand access to evidence-based interventions designed to assist people with Alzheimer's disease and their caregivers.

The Budget also requests $5 million, an increase of $2 million over FY 2016, for the Lifespan Respite Care Program. Family caregiving is not just an aging issue; for persons with disabilities it can occur across the lifespan. The Lifespan Respite Care Program helps to ease the burdens of caregiving by providing grants to improve the quality of, and access to, respite care for family caregivers of children or adults of any age with special needs. Expanding this funding will provide more and better targeted services that will allow caregivers to continue to care for their loved ones longer, thereby allowing more care recipients to

remain at home and independent for longer periods at a lower cost than if these individuals had to be institutionalized.

PROTECTING VULNERABLE OLDER AMERICANS

Protecting older adults from abuse, neglect, and exploitation remains one of ACL's top priorities. The Budget requests $14 million for Elder Rights Support Activities, which includes an increase of $2 million to fund ACL's Elder Justice/Adult Protective Services Program. This program continues to address the negative effects of abuse, neglect, and exploitation on the health and independence of seniors and other vulnerable adults by providing competitive grants to states to develop the technology infrastructure necessary to participate in the National Adult Maltreatment Reporting System. With the ability to participate in this system, states will be better equipped to prevent, identify, report, and respond to abuse of elderly adults.

In addition, the Budget requests $16 million to support long-term care ombudsmen in their role as advocates for residents of long-term care facilities. Nearly 10,000 ombudsmen will continue to routinely monitor residential care facilities, resolve complaints on behalf of residents, and advocate for systemic improvement of long-term services and supports. The Budget also requests $5 million for the Prevention of Elder Abuse and Neglect Program and includes funding for the Senior Medicare Patrol Program, which will be financed from the Health Care Fraud and Abuse Control Account in the Centers for Medicare & Medicaid Services. These programs are critical tools that protect seniors from abuse and educate Medicare beneficiaries to prevent health care fraud.

IMPROVING THE LIVES OF INDIVIDUALS WITH DISABILITIES

ACL is committed to helping people with disabilities live independently, be contributing members of society, and live free of abuse, neglect, and exploitation. Through a variety of ongoing partnerships with states and territories, information and referral services, and research efforts, ACL works to achieve this mission.

The Budget requests $73 million to fund State Councils on Developmental Disabilities. These councils engage in systems change and capacity building efforts that promote self-determination and inclusion for people with developmental disabilities. The Budget also requests $39 million for Developmental Disabilities Protection and Advocacy programs that provide legal-based services to individuals with developmental disabilities who have been neglected, abused, or denied their rights. In addition, the Budget includes $39 million for University Centers for Excellence in Developmental Disabilities, a network of education and research centers that promotes knowledge and training in the disability field. The Budget requests $10 million for Projects of National Significance, which focus on identifying and addressing the most pressing issues that impact people with developmental disabilities and their families.

PROGRAM HIGHLIGHT

Ensuring Community Integration for People with Disabilities

The creation of the Administration on Disabilities brought together the Developmental Disabilities, Independent Living, and Traumatic Brain Injury programs along with the Paralysis Resource and Limb Loss Centers and Help America Vote Act programs in one entity. ACL has the unique ability to promote consistency and coordination in community living policy work across programs and better align critical community-based services and supports, medical supports, and clinical supports.

ACL provides a focal point for these efforts to develop policies, programs, and initiatives that support people with disabilities across the lifespan in living, working, and playing in their communities. ACL provides leadership in working with other federal agencies and non-governmental groups to assure that people with disabilities have access to home and community-based services and supports that can help individuals to fully participate in all aspects of community life.

The Budget provides $101 million for the Independent Living Program, which includes Centers for Independent Living and State Independent Living grants. The Centers for Independent Living Program supports grants to community-based nonprofit agencies that provide information and referral, independent living skills training, peer counseling, and advocacy for individuals with significant disabilities. The Independent Living Services Program supports grants to states to coordinate state independent living

services, conduct resource development, and train service providers on the independent living philosophy.

The Budget includes $9 million for the Traumatic Brain Injury Program, transferred to ACL from the Health Resources and Services Administration in FY 2016, which provides increased access to comprehensive, coordinated family and person-centered service systems for individuals who have sustained a traumatic brain injury through state-level infrastructure and service delivery systems. The Traumatic Brain Injury Program has two components: the aforementioned state program and a protection and advocacy services program for individuals with traumatic brain Injury. The Budget also requests $8 million for the Paralysis Resource Center and $3 million for the Limb Loss Resource Center to provide comprehensive information and referral services to improve the health and well-being of individuals living with paralysis or limb loss.

The Budget provides $104 million for the National Institute on Disability, Independent Living, and Rehabilitation Research for research, knowledge translation, and capacity building to enable people with disabilities to make their own choices and to maximize their integration, employment, and independent living within the community. Among other activities, grantees conduct research to improve rehabilitation methodologies and service delivery systems and support pre-service and in-service training to help rehabilitation personnel provide more effective rehabilitation services for individuals with disabilities.

MAKING COMMUNITY-BASED SERVICE DELIVERY MORE EFFICIENT

The Budget requests $8 million for Aging and Disability Resource Centers, an increase of $2 million over FY 2016, which serve as community-level entry points into long-term services and supports for people of all ages who have chronic conditions and disabilities. These systems help states streamline access to community services and supports across multiple programs and divert individuals from more costly forms of care after a hospitalization, rehabilitation, or skilled nursing facility visits. This increased investment will help state grantees continue their development and operation of these systems based on the national standards established by ACL, the Centers for Medicare & Medicaid Services, and the Veterans Health Administration.

The Budget also includes $32 million for the Assistive Technology Program, which provides states with financial assistance to increase the availability, access, provision, and training of assistive technology devices and services. Examples of such devices include computer or technology aids, modified driving controls, and durable medical equipment such as wheelchairs or walkers.

The Budget further requests $5 million to facilitate voting access for people with disabilities as well as $52 million to fund the State Health Insurance Assistance Program, which provides grants to states to support over 14,000 counselors in more than 1,300 community-based organizations across the country. These counselors provide free, one-on-one counseling and assistance to help elderly and disabled Medicare and Medicaid beneficiaries, as well as those nearing Medicare eligibility, understand and make optimal use of their healthcare benefits and navigate the complexities of health and long-term care systems.

FEDERAL ADMINISTRATION

The Budget includes $41 million for mission support and program administration including rent, staff, and support for ACL's regional offices.

Office of the Secretary, General Departmental Management

dollars in millions	2015	2016	2017	2017 +/– 2016
Budget Authority	448	456	479	+23
PHS Evaluation Funds	65	65	66	+1
Health Care Fraud and Abuse Control	10	10	10	--
Proposed Law, Recovery Audit Contractor Collections (non-add)	*--*	*--*	*2*	*+2*
Total, Program Level /1	**523**	**531**	**555**	**+24**
Full-Time Equivalents	1,460	1,491	1,583	+92
1/ This total does not include the Pregnancy Assistance Fund.				

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

The FY 2017 Budget for General Departmental Management is $555 million in program level funding, an increase of $24 million above FY 2016. The Budget supports grant programs as well as the Secretary's role in administering and overseeing the organization, programs, and activities of the Department. These efforts are carried out through 11 Staff Divisions and Offices.

TEEN PREGNANCY PREVENTION

The Budget includes $105 million to support community efforts to reduce teen pregnancy and collaborate on abstinence education projects. 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 $57 million for the Office of Minority Health, the same as FY 2016. The Office of Minority Health will lead, coordinate, and collaborate on minority health activities in the Department, with emphasis on program development. This funding will enable the Office of Minority Health to continue 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. Additionally, the Office of Minority Health will continue to fund the development of a clinical trial education action plan and a Lupus health education program.

MINORITY HIV/AIDS

The Budget includes $54 million, the same as FY 2016, 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 $32 million for the Office on Women's Health, the same as FY 2016. The Office on Women's Health will lead, coordinate, and collaborate on women's health activities and program development in the Department. This funding will

allow the Office on Women's Health to continue targeted grants and support the advancement of women's health programs through promoting and coordinating research, service delivery, and education. Funds will also allow the Office on Women's Health to continue a state partnership initiative to reduce violence against women. These programs are also carried out throughout the divisions and offices of the Department, with other government organizations, and with consumer and health professional groups.

ACQUISITION REFORM

The Budget includes $2 million, the same as FY 2016, for the Department 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 $281 million for the remainder of the activities supported by General Departmental Management in the Office of the Secretary. The Budget funds leadership, policy, legal, and administrative guidance to the Department 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 and develop and expand on three data and innovation initiatives for FY 2017.

IDEA LAB

The Budget supports the growth of the Department Idea Lab and includes $2 million to expand activities. Resources will allow the Department to pilot new programmatic activities to support innovative ideas that increase efficiency and effectiveness.

DATA ACT

The Budget includes $10 million to implement the Digital Accountability and Transparency Act of 2014, which expands the Federal Funding Accountability and Transparency Act of 2006 in an effort to improve transparency of federal spending and government-wide financial data standards. The Department plays a crucial role in the implementation of the Digital Accountability and Transparency Act of 2014. This funding will support necessary changes to IT systems and business processes across all HHS operating divisions. The funding will also support HHS's government-wide work on the grants-specific portion of the DATA Act Pilot to Reduce Recipient Reporting Burden.

AGENCY DIGITAL SERVICES TEAM

The Budget includes $5 million for the Department to establish and staff an agency Digital Services team. The request will enable the Department to focus on the implementation of milestones to build capacity and support the development of a Digital Services team and drive the efficiency and effectiveness of the Department's highest-impact digital services.

Office of the Secretary, Office of Medicare Hearings and Appeals

dollars in millions	2015	2016	2017	2017 +/− 2016
Budget Authority	87	107	120	+13
Proposed Law				
Recovery Audit Collections	0	0	125	+125
Refundable Filing Fee	0	0	5	+5
Total, Program Level	**87**	**107**	**250**	**+143**
Full-Time Equivalents	526	642	1,308	+666

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

The FY 2017 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $250 million, an increase of $143 million over FY 2016. The Budget request includes a legislative package to address the growing backlog of Medicare appeals. The Department estimates that enactment of this package will provide an additional $125 million in Recovery Audit collections and $5 million from a proposed refundable filing fee.

OMHA administers hearings and appeals nationwide for the Medicare program. OMHA began processing cases on July 1, 2005; since then, it has received approximately 1.5 million appeals 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 appeals resulting from the permanent nationwide expansion of the Recovery Audit program, administered by Centers for Medicare and Medicaid Services. These appeals, in addition to the more traditional Part A and B, have contributed to OMHA's significant workload increase. Despite efforts to mitigate the incoming workload, OMHA received 474,000 new appeals in FY 2014 alone, and 240,000 appeals in FY 2015. Both in 2014 and 2015, OMHA's annual adjudication capacity remained flat at 77,000 appeals.

The statute contemplates that these Medicare appeals will be heard within 90 days after receipt of a request for a hearing from a Medicare appellant. Due to the overwhelming growth in its workload, OMHA has not been able to meet the 90 day timeframe for case adjudication in some cases. It currently takes approximately 800 days for OMHA to adjudicate a non-beneficiary appeal.

PROGRAM HIGHLIGHT

Improving the Medicare Appeals Process

The Department has a three-pronged approach to address the significant volume of new Medicare appeals and the current backlog of claims to be adjusted:

1. **Invest resources** to increase adjudication capacity and implement new strategies to alleviate the current backlog.
2. **Take administrative actions** to reduce the backlog of appeals and the number of new cases from entering the system or escalating to higher levels of appeal.
3. **Propose legislative actions** that provide additional funding and new authorities to address the backlog.

To address these challenges, OMHA has taken a number of administrative actions to reduce the pending appeals workload. For example, OMHA is piloting settlement conference facilitations which offer alternative dispute resolution as an alternative to an Administrative Law Judge hearing, as a way to resolve pending cases. In addition, OMHA has also made statistical sampling an option available to appellants,

which has the potential to resolve large numbers of cases based on representative samples. While helpful, these initiatives alone are insufficient to keep up with the dramatic growth in claims.

The Budget request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals which reach OMHA. For more information about these proposals, please see the Medicare chapter.

With the requested funding level of $250 million, OMHA will open new field offices in addition to the five current field offices in Florida, Ohio, California, Missouri, and Virginia, and hire additional adjudicators and support staff. OMHA will continue to utilize technology, such as video telephone and teleconference hearings, to offer appellants access to multiple hearing venues and services. These additional resources are critical for OMHA to respond to the backlog of unheard appeals, while maintaining the quality and accuracy of its decisions. And more importantly, these resources are essential in order to restore the agency's ability to provide timely hearings for Medicare appellants.

Office of the Secretary, Office of the National Coordinator for Health Information Technology

dollars in millions	2015	2016	2017	2017 +/– 2016
Budget Authority	60	60	--	-60
PHS Evaluation Funds	--	--	82	+82
Total, Program Level	**60**	**60**	**82**	**+22**
Full-Time Equivalents	160	200	200	--

The Office of the National Coordinator for Health Information Technology leads the nation in transforming health and health care through the advancement of an interoperable health IT infrastructure. The Office of the National Coordinator for Health Information Technology improves the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most.

The Office of the National Coordinator for Health Information Technology (ONC) is the lead agency charged with formulating the federal government's health information technology (IT) strategy and coordinating federal health IT policies, standards, programs, and investments. ONC supports the Department's goal to strengthen health care by modernizing the care delivery infrastructure of the nation through the adoption, implementation, meaningful use, and optimization of health IT.

The FY 2017 Budget for ONC is $82 million, $22 million above FY 2016. This Budget reflects ONC's commitment to advancing progress towards a safe and secure nationwide system of interoperable health IT that focuses on safety and usability. Through the engagement and collaboration of public and private sector stakeholders, ONC will facilitate care delivery transformation and better health and health care nationwide.

In FY 2017, ONC will focus on encouraging market transparency and competition, improving electronic health record usability, and offering technical assistance to providers to help them get the most out of their health IT.

POLICY DEVELOPMENT AND COORDINATION

ONC sets federal health IT policy and provides a framework to address emerging health IT issues that compromise the use and exchange of electronic health information. In FY 2017, ONC will continue to implement the Federal Health IT Strategic Plan and promote policies that encourage interoperability.

NEW INITIATIVE

A Shared Nationwide Interoperability Roadmap

ONC released a 10-year Interoperability Roadmap detailing policy, technical, and behavioral efforts to be implemented by public and private stakeholders. The overarching goal of this Roadmap is to ensure trust among participants, as well as interoperability across networks so that health information can follow a patient regardless of where and when they access care. Efforts in FY 2017 will be targeted towards sending, receiving, finding, and using priority data domains to improve health care quality and outcomes. The Roadmap focuses on:

- Improving technical standards and implementation guidance for priority data domains.
- Rapidly shifting and aligning federal, state, and commercial payment policies from fee-for-service to value-based models.
- Adopting and using a common interoperability code of conduct that addresses policies and business practices that are impeding interoperability.

ONC will expand efforts to harmonize technical standards to support the Prescription Drug Monitoring Program and further the adoption of electronic prescribing of controlled substances to promote safer, more efficient prescribing practices and help reduce fraud and abuse. The Budget will provide targeted

technical assistance to help state monitoring programs achieve interoperability with health IT systems in an effort to increase providers' efficient and timely access to prescription drug data. ONC will also support and lead efforts, together with other HHS agencies, to further the adoption of electronic prescribing of controlled substances by identifying successful state practices and policies to inform a national, consistent approach for adoption and measurement across states.

ONC will continue to inspire consumer and provider confidence and trust in health IT by ensuring that electronic health information is private and secure wherever it is transmitted, maintained, or received. Through continued engagement with federal advisory committees, the states, and other stakeholders, ONC will assess policy gaps and weaknesses that hinder interoperability and develop appropriate policy or standards-based solutions.

Continuing in FY 2017, ONC will implement provisions of its certification rules that help automate the rights of patients to view, download, and transmit their own health information under the Health Insurance Portability and Accountability Act Privacy Rule and the CMS Electronic Health Records Incentive Program.

STANDARDS, INTEROPERABILITY, AND CERTIFICATION

ONC will continue to advance health IT standards development and certification activities to support clinical care, research, clinical quality improvement, privacy and security, and population health. These investments will ensure that the governance of the nation's health data supports equity, scalability, integrity, and sustainability of information sharing nationwide. In order to support alternative value-based payment models as described in the Medicare Access and CHIP Reauthorization Act of 2015, ONC will position itself to develop certification criteria and associated testing tools.

In FY 2017, ONC will engage industry and other stakeholders to identify the standards and policy necessary to support the Department-wide Precision Medicine initiative. By aggressively pursuing a portfolio of standards and technology activities that support precision medicine and protect user privacy, ONC will advance the basis on which precision-based medicine can be practiced.

ADOPTION, UTILIZATION, AND MEANINGFUL USE

In FY 2017, ONC will gather data and evaluate progress towards achieving interoperability as required under the Medicare Access and CHIP Reauthorization Act. ONC will work to increase providers' meaningful use of health IT, and also advance value-based payment and encourage market transparency.

In order to support the appropriate collection, use, and sharing of data, ONC will continue consumer engagement efforts by leveraging relationships with existing organizations, engaging with new stakeholders across the care continuum, and performing direct outreach.

FEDERAL HEALTH IT STRATEGIC PLAN

In collaboration with over 35 federal partners, ONC released the updated Federal Health IT Strategic Plan 2015–2020. The Plan represents the collective strategy of federal offices that use or influence the use of health IT. It aims to improve the health IT infrastructure, help transform health care delivery, and improve individual and community health. The Plan establishes a blueprint for federal partners to implement strategies that will support the nation's continued development of a responsive and secure health IT and information use infrastructure. ONC is committed to ongoing work with these federal partners as the Plan continues to be implemented.

2017 LEGISLATIVE PROPOSALS

The FY 2017 Budget includes four legislative proposals which aim to further the advancement of nationwide interoperability, reliability, and transparency of health IT. ONC is proposing additional authorities that would combat information blocking, enhance transparency, implement governance activities to guide business practices, and establish a Health IT Safety Collaborative.

Establish Health IT Governance Certification

Nationwide interoperability, reliability, and transparency cannot be accomplished through technical requirements alone. This proposal will allow ONC to establish standards, implementation specifications, and certification criteria related to the business policies, practices, and behavior of health IT entities.

Prohibit Information Blocking and Associated Business Practices

Current evidence and experience suggest that persons and entities are engaging in information blocking, interfering with the exchange and use of electronic health information. This proposal would provide a coordinated approach to explicitly prohibit information blocking and investigate and impose appropriate sanctions for offenders.

Require Health IT Transparency

This proposal would authorize the Secretary to require that certified health IT vendors submit ongoing and detailed information to the National Coordinator concerning the costs, capabilities, limitations, and other performance characteristics of certified health IT. ONC will be able to address the lack of transparency in health IT products and services, which stakeholders ranging from industry associations to Congress have identified as a serious problem impairing the efficient functioning of health IT markets.

Provide ONC Authority to Use Contracts, Grants, or Cooperative Agreements to Establish a Health IT Safety Collaborative and Provide Adequate Confidentiality Protections

Through this proposal, ONC will establish a Health IT Safety Collaborative that identifies and strengthens ways to encourage better reporting of health IT-related safety events. This public-private partnership will provide a confidential space for developers and providers to address concerns and cultivate new educational resources and training materials to build health IT safety competencies.

By coordinating and aligning patient safety activities between federal and private actors, the Health IT Safety Collaborative will ensure that approaches to health IT safety are properly implemented and evaluated. Members of the Collaborative will support and develop targeted solutions to health IT-related safety issues identified through evidence.

PROGRAM HIGHLIGHT

Privacy and Security

As traditional health care and health mobile technologies converge, they enable greater and deeper patient engagement in their health. In this environment, individuals want increased interoperability and the assurance that their information is private and secure. To support emerging health IT that meets consumer needs, ONC has used its coordinating role to work with the Federal Trade Commission on new resources for health IT developers on privacy and security best practices. ONC has applied its health IT expertise to support the Precision Medicine Initiative's objective to develop a new paradigm of patient engagement and research collaboration using health IT. Through a task force on Application Programming Interfaces, ONC is identifying privacy and security challenges presented by mobile and other emerging health information technology that need to be addressed so that individuals and providers feel confident adopting new technology. ONC continues to engage with stakeholders across the health care and public health sectors to raise awareness and identify best practices to improve the security and cybersecurity of health information.

Office of the Secretary, Office for Civil Rights

dollars in millions	2015	2016	2017	2017 +/- 2016
Program Level	**39**	**39**	**43**	**+4**
Full-Time Equivalents	170	180	198	+18

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

The FY 2017 Budget for the Office for Civil Rights (OCR) is $43 million, an increase of $4 million over FY 2016. The increase will support OCR's audit program which was mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The audit program will offer a new tool to help ensure Health Insurance Portability and Accountability Act (HIPAA) compliance by covered entities and business associates, while also informing OCR on areas in which to direct its enforcement and technical assistance. OCR will further use the increase to support enforcement of Section 1557 of the Affordable Care Act. OCR's FY 2017 Budget will also modernize HIPAA protections, support innovation in healthcare, ensure adequate protections in new programs and technologies, streamline requirements to make them less burdensome, and evaluate new areas where HIPAA does not currently apply.

CIVIL RIGHTS

General Authorities

OCR resolves over 4,500 discrimination complaints annually, conducts compliance reviews, and enforces various federal civil rights laws and regulations. These include protections against discrimination on the basis of race, color, national origin, disability, age, and sex in Department-funded programs and certain federal, state, and local government programs. In addition, under Section 1557 of the Affordable Care Act, OCR has enforcement authority with respect to race, color, national origin, disability, age, and sex discrimination in health programs that receive financial assistance or are administered by the Department or any entity established under Title I of the Affordable Care Act.

Other Compliance Activities

In addition to its direct enforcement responsibilities under federal anti-discrimination laws, OCR reviews nearly 2,500 Medicare provider applicants a year to assess compliance with federal civil rights requirements. Through its current 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 also works with its federal agency partners to ensure that language assistance services are available to limited English proficient individuals, including with regard to services under the Affordable Care Act and other activities conducted by the Department.

In addition, OCR provides technical assistance and education to states and its federal agency partners to ensure compliance with the Americans with Disabilities Act. OCR disseminates information, creates virtual learning communities, works on guidance documents, 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

General Authorities

OCR administers and enforces the HIPAA Privacy, Security, and Breach Notification Rules. OCR is responsible for policy development through the issuance of regulations and guidance. OCR also provides outreach and technical assistance to the regulated community to ensure covered entities and business associates understand their compliance obligations and to the public to increase individuals' awareness of their HIPAA rights and protections.

OCR enforces the HIPAA Rules by investigating complaints and conducting compliance reviews of alleged violations of the HIPAA Rules, providing technical assistance and obtaining corrective actions, as well as entering into resolution agreements or issuing civil monetary penalties, where appropriate. OCR resolved more than 16,000 complaints of alleged HIPAA violations in FY 2015.

Settlements and Civil Monetary Penalties

OCR has authority to enter into resolution agreements that include payment of a resolution amount and corrective action plans, as well as imposing civil monetary penalties for violations of the HIPAA Rules. OCR retains and expends these collections to support overall HIPAA enforcement activities.

HIPAA Audit Program

The HITECH Act mandates that OCR conduct periodic audits to assess entity compliance with HIPAA. OCR has conducted a pilot program to ensure that its audit functions could be performed in the most efficient and effective way. OCR plans to conduct comprehensive and desk audits of covered entities and business associates. Audits are a proactive approach to evaluating and ensuring HIPAA privacy and security compliance. The audit program will offer a new tool to help ensure HIPAA compliance by covered entities and business associates while also informing OCR on areas in which to direct its enforcement and technical assistance.

Section 1557 Enforcement

Section 1557 of the Affordable Care Act prohibits discrimination on the basis of sex. OCR is working to finalize a regulation which will educate consumers about their rights and covered entities about their responsibilities. The regulation will spell out the new prohibitions on sex discrimination in detail and also comprehensively compile in a single place the standards we apply to evaluate claims of discrimination based on race, national origin, disability and age. This initiative increases OCR's enforcement capacity due to the anticipation of a high volume of new cases that will be immensely complex in that they involve novel issues of law and complicated facts.

Modernizing HIPAA in Supporting Innovation in Healthcare

Since the issuance of the HIPAA rules, there have been significant advances and innovations in health information technology, health delivery systems, and health research. This initiative will focus efforts to modernize the health information privacy and security protections paradigm, while enabling further advances in health care, research, and technology that will improve health outcomes and improve the ability to detect and prevent cyber-attacks. This initiative also encompasses efforts to streamline HIPAA requirements to make them less burdensome—while at the same time ensuring robust enforcement—and to evaluate new areas where HIPAA does not currently apply.

Office of the Secretary, Office of Inspector General

dollars in millions	2015	2016	2017	2017 +/– 2016
Discretionary Appropriation	73	77	85	+9
HCFAC Collections	9	11	12	+1
Discretionary HCFAC	67	67	122	+55
Mandatory HCFAC	186	188	200	+13
Total Funding, All Sources	**335**	**343**	**419**	**+77**
Full-Time Equivalents	1,524	1,616	1,830	+214

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 2017 Budget request for the Office of Inspector General (OIG) is $419 million, an increase of $77 million above FY 2016. The request includes $85 million for OIG oversight of the Department's more than 100 public health and human services 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 Department Public Health and Human Services programs and Health Insurance Marketplaces.

Moreover, OIG is a key partner in the joint Department of Health and Human Services and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, and the Budget includes $334 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 2017 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 2017 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 the Department.

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

Protecting Department Grants and Contract Funds from Fraud, Waste, and Abuse

The Department is the largest grant-making organization in the federal government, awarding over 81,000 grants totaling approximately $410 billion in FY 2015. HHS is also the third largest contracting agency in the federal government, awarding more than $21 billion in contracts in FY 2015. The size and scope of departmental awards make vigilant oversight crucial to the success of programs designed to improve the health and well-being of the public. In FY 2017, 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 responsible stewardship of these program dollars.

Overseeing the Health Insurance Marketplaces

The Marketplaces add a substantial new dimension to the Department's landscape. The Centers for Medicare & Medicaid Services and the states that established Health Insurance Marketplaces must implement and operate complex program requirements. Individuals use the Marketplaces to get information about their health insurance options, be assessed for eligibility (for 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 payments, eligibility, management and administration, and information security. By focusing on these key areas, OIG will help to ensure that taxpayer dollars are spent for their intended purposes in a secure system that operates efficiently, effectively, and securely.

Recent OIG work has addressed vulnerabilities in verification procedures for Marketplaces, the security of insurance data, and the status of Consumer Operated and Oriented Plans.

INTEGRITY OF MEDICARE AND MEDICAID

Addressing Prescription Drug Vulnerabilities on a National Scale

In both the Medicare Part D and Medicaid programs, OIG has uncovered improper and potentially harmful prescribing practices, pharmacies billing for drugs not dispensed, and diversion of prescription drugs. OIG has also identified waste related to payments for prescription drugs under Department programs, increasing costs to taxpayers and beneficiaries. The need to invest additional resources in this area is clear, and additional FY 2017 funding would support the integrity of these two programs and ensure patient safety.

Overseeing Changes in Medicaid

The Congressional Budget Office projects that the number of individuals covered by Medicaid will grow approximately 37 percent by 2024. As enrollment and spending increase, there is heightened urgency to address the program integrity challenges that Medicaid already faces. These include improving the effectiveness of Medicaid data, avoiding or recovering Medicaid improper payments and payments for which a third party is liable, preventing waste and fraud in Medicaid managed care programs, and reducing waste associated with excessive payment rates to public providers.

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

Ensuring Patient Safety and Quality of Care

The FY 2017 request continues to support critical oversight for nursing home, hospice, and home- and community-based services (HCBS) programs. As the median age of Americans continues to rise, and as more Americans live with chronic medical conditions, HHS faces challenges in ensuring that beneficiaries who require services for such conditions receive high-quality care. High-quality nursing home and HCBS programs are important for the continued well-being of people who need ongoing assistance with daily living, as well as those who need additional help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries by reducing pain and addressing physical and other needs. High-quality nursing home, hospice, and HCBS personal care services can often prevent the need for disruptive and costly hospitalizations.

Delivery System Reform and Payment Accuracy

OIG will heighten its focus on delivery system reform, including accountable care organizations, bundled payment initiatives, and other innovative reforms designed to improve results and foster smarter spending. Significant reforms to payment systems in 2017, such as those included in the Medicare Access and CHIP Reauthorization Act, should create new oversight needs from a data, security, and payment perspective.

Public Health and Social Services Emergency Fund

dollars in millions	2015	2016/2	2017	2017 +/- 2016
Assistant Secretary for Preparedness and Response (ASPR)				
Preparedness and Emergency Operations	25	25	25	--
National Disaster Medical System	50	50	55	+5
Hospital Preparedness	255	255	255	--
Medical Reserve Corps /1	9	6	6	--
Biomedical Advanced Research and Development Authority	473	512	512	--
Project BioShield	255	510	350	-160
Policy and Planning	15	15	15	--
Operations	31	31	31	--
Subtotal, ASPR Budget Authority	1,113	1,403	1,248	-155
ASPR Pandemic Influenza Activities	68	68	121	+53
Subtotal, ASPR Total Program Level	**1,180**	**1,471**	**1,369**	**-102**
Other Office of the Secretary				
Office of Security and Strategic Information	7	7	7	--
Cybersecurity	41	51	51	--
Office of Global Affairs Pandemic Influenza	4	4	4	--
Subtotal, Other Office of the Secretary	**53**	**62**	**62**	**--**
Total Program Level, PHSSEF/2	**1,233**	**1,533**	**1,431**	**-102**
Total Discretionary Budget Authority, PHSSEF (non-add)	*1,233*	*1,533*	*1,431*	*-102*
HHS Pandemic Influenza Budget Authority (non-add)	*72*	*72*	*125*	*+53*
Full-Time Equivalents	709	773	789	+16

1/ Prior to FY 2015, the Medical Reserve Corps program was administered by the Office of the Assistant Secretary for Health. The shift to ASPR aligns with the statutory requirement within the 2013 Pandemic and All-Hazards Preparedness Reauthorization Act (P.L. 109-417). Total in FY 2016 reflects reallocation to ASPR.

2/ In addition, the FY 2015 appropriation (P.L. 113-235) provided $733 million in emergency resources for Ebola response and preparedness activities.

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 Public Health and Social Services Emergency Fund, in the Office of the Secretary, directly supports efforts across the government to safeguard the public and ensure that the United States is prepared for a wide range of threats to the public health. The FY 2017 Budget includes $1.4 billion, a decrease of $102 million below FY 2016. Resources support the highest priority activities, including ensuring that the Department is positioned to address the cybersecurity needs unique to its programs, supporting state and local preparedness, advancing the development of medical countermeasures, and advancing pandemic influenza preparedness. Programs and activities supported through this Fund are coordinated with complementary activities across HHS, including the Centers for Disease Control and Prevention, National Institutes of Health, Food and Drug Administration, and the Office of the Secretary.

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The Department supports bioterrorism and emergency preparedness functions across various agencies and the Office of the Secretary. Activities supported by the Public Health and Social Services Emergency Fund contribute to enhancing the nation's ability to address public health disasters and emergencies. The functions range from enhancing and maintaining state and local preparedness, response, and recovery capacity; supporting advanced development and procurement of medical countermeasures; responding to immediate emergency situations; and supporting planning and policy coordination efforts across HHS.

Assistant Secretary for Preparedness and Response

The Assistant Secretary for Preparedness and Response (ASPR) leads the nation in preventing, preparing for, and responding to public health emergencies and disasters to enhance national health security. As the principal advisor to the Secretary on public health and medical emergency preparedness and response, ASPR fulfills this mission through preparedness planning and response activities, building federal capacity for emergency medical operations, supporting research and procurement of medical countermeasures, and strengthening the capacity of hospitals and health care systems.

The FY 2017 Budget includes $1.4 billion for ASPR, a decrease of $102 million below the FY 2016 level. The Budget prioritizes resources to support hospital preparedness, advanced development and research, and disaster response training.

Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) strategically supports purchase and development of countermeasures such as human drugs, therapeutics, vaccines, and diagnostics that can help mitigate the impact of public health emergencies. BARDA achieves this objective through five goals:

- Supporting the medical countermeasure advanced development pipeline;
- Enabling core services for medical countermeasure developers;
- Supporting a sustainable manufacturing infrastructure with the agility to rapidly address emerging threats;
- Addressing threats through responsive programs and activities; and,
- Maintaining capacity to develop, manufacture, and distribute countermeasures during an emergency.

BARDA has directly supported the development of over 100 chemical, biological, radiological, and nuclear medical countermeasure product candidates. The Budget includes $512 million to maintain this important capacity within BARDA. At this level, which maintains the significant congressional investment in FY 2016, BARDA will be able to support an additional 10 to 15 medical countermeasures expected to reach sufficient maturity for procurement. In FY 2017 multiple new projects in the advanced development program will be supported including conventional and non-conventional broad spectrum antimicrobials, new treatments for radiation illnesses and burns, devices to measure an individual's exposure to biological agents, and antidotes for chemical agents.

Project BioShield supports HHS efforts to protect the public against chemical, biological, radiological, and threats through rapid support of research, late-stage development, and acquisition of high priority and novel medical countermeasures for the Strategic National Stockpile within CDC. The FY 2017 Budget includes

$350 million, which is $160 million below FY 2016, for Project BioShield to support ongoing late-stage development and procurement. At this level, BARDA will work across HHS and other partners to invest in the highest need products that are ready for acquisition to support public health security. In FY 2017, Project BioShield will support the purchase of five medical countermeasures. This plan will include biothreat pathogen antimicrobials; anthrax biodiagnostic device and reagents; a new product to address Acute Radiation Syndrome; biodosimetry diagnostics to verify exposure levels; and, new Ebola therapeutic and vaccine candidates.

Including FY 2017, Project Bioshield will have supported a between 16 and 20 novel medical countermeasure procurements which will directly support the nation's preparedness to address a wide range of threats such as anthrax, smallpox, botulism, plague, tularemia, glanders, melioidosis, viral hemorrhagic fever, and chemical, radiological, and nuclear agents. More recently, five chemical, biological, radiological and nuclear medical countermeasures were approved by FDA: Neupogen, Neulasta, Anthrasil, heptavalent Botulinum Antitoxin Therapeutic, and BioThrax. These activities play a critical role in supporting the HHS Public Health Emergency Medical Countermeasure Enterprise to coordinate enhanced federal preparedness and response.

The FY 2017 Budget includes $192 million, the same as FY 2016, to continue to support the Administration's priority to combat antibiotic-resistant bacteria. The BARDA broad spectrum research program leads efforts to leverage partnerships with public and private partners to develop products that directly support the government-wide *National Action Plan for Combating Antibiotic-Resistant Bacteria*. In the last two years, efforts by BARDA and industry partnerships have resulted in ten new broad spectrum antibiotics.

The Budget includes $255 million, the same as FY 2016, to support ASPR's Hospital Preparedness Program. This program provides support to hospitals and health care coalitions to enhance emergency preparedness capacity through planning and infrastructure. Investments in coalitions have resulted in the development of improved response systems, realistic exercises, collaborative partnerships, and information sharing that has proven valuable throughout numerous disaster responses.

PROGRAM HIGHLIGHT

Cybersecurity

The HHS Cybersecurity program maintains the security of an array of unique systems and sensitive data within the Department, including, HHS grants systems, for which the Department is the largest grant-maker, and many systems are utilized across the Federal government; personally identifiable information and health records; and, sensitive biodefense research and proprietary data. The Budget sustains the FY 2016 Enacted level, which has afforded the Cybersecurity program with a sustainable base budget. The Budget helps support a more nimble, flexible operating level to address ongoing cybersecurity concerns and to prepare for the future challenges that accompany rapidly changing technologies. The Department continues to assess evolving requirements and support for HHS specific needs as cyber threats becoming increasingly complex.

In addition, the Department will assess how to implement new authorities in the recently enacted Cybersecurity Information Sharing Act of 2015 to improve cybersecurity in the health care industry. The new authorities require a HHS-wide plan that includes a description of responsibilities to address cybersecurity threats in the health care industry, and establishment of a task force including HHS in consultation with the National Institute of Standards and Technology, and the Department of Homeland Security to convene the cybersecurity industry to assess currently implemented strategies, challenges, and to develop a plan to improve preparedness for and response to cyber threats. Finally, Congress directs the establishment of a common set of voluntary, consensus-based, and industry-led best practices and guidelines to reduce cyber risks and support voluntary adoption of activities to improve cybersecurity threats in health care.

The Hospital Preparedness Program closely aligns and complements the CDC Public Health Emergency Preparedness program. Between FY 2008 and FY 2016, the two programs have provided a combined total of over $10 billion to support flexible and adaptable community preparedness planning and encourage close coordination among a variety of stakeholders across the health spectrum. These programs were critical components of the Department's domestic response to the Ebola virus over the last year and a half.

The FY 2017 Budget includes $55 million, an increase of $5 million, to support the National Disaster Medical System, which is a federally-coordinated system that augments state and local medical response capabilities during public health emergencies. The additional resources will increase the frequency of annual trainings for 20 percent of the current workforce of more than 6,000 intermittent federal employees. Currently, 77 teams rotate to complete basic and advanced training cycles every 6 years or approximately 15 percent annually. The National Disaster Medical System supports state and local medical preparedness through real-world training exercises, including those executed through the partnership with the Department of Homeland Security's Center for Domestic Preparedness in Alabama.

The FY 2017 Budget includes $6 million for ASPR to continue management of the Medical Reserve Corps. ASPR will achieve administrative and programmatic efficiencies for the administration of the Medical Reserve Corps because of its alignment with existing program objectives. The Budget also supports the Office of Emergency Management within ASPR to support communities as they prepare for, respond to, and recover from the public health and medical impacts of emergencies and disasters.

Finally, the Budget proposes Department-wide emergency transfer authority to augment the Department's capability to respond rapidly to public health emergencies, including for states and local communities in the case of a catastrophic event.

PANDEMIC INFLUENZA

The Department supports a comprehensive pandemic influenza portfolio that has supported increased preparedness, including the retrofitting of domestic manufacturing facilities to nearly double vaccine manufacturing surge capacity. Dedicated funding for this purpose has positioned the Department to respond to emerging and evolving influenza viruses as they become a more significant global public health threat. The Budget continues to invest in this critical capacity within HHS with a total of $125 million, an increase of +$53 million above FY 2016 to support diagnostics advanced development, vaccine stockpiling, international preparedness, and the advanced development of universal influenza vaccine and influenza antivirals, and immunotheapeutics. These efforts are supported by BARDA within ASPR and through the Office of Global Health. Eight of these influenza vaccines, antivirals, and diagnostics supported by BARDA for advanced development have been approved by FDA since 2012.

PROGRAM HIGHLIGHT

Enhancing Domestic Preparedness for Highly Infectious Diseases

ASPR played a vital role in the domestic response to the Ebola outbreak in West Africa, which was the largest such outbreak on record. As American Ebola patients were transported back to the United States to receive treatment, the nation's health care system identified key opportunities for enhancing preparedness capacity to treat individuals with Ebola and other highly infectious diseases. Consistent with congressional direction, ASPR used Ebola emergency appropriations to support health care systems through a regional approach throughout the country.

Funds were used to support 1) nine regional Ebola and other special pathogen treatment centers that are poised to receive and provide specialized treatment; 2) state or jurisdiction Ebola treatment centers to support the needs of the nine Ebola Treatment Centers; 3) assessment hospitals to safely receive, isolate, and care for a patient under investigation until Ebola, or other infectious disease, is confirmed; and, 4) frontline health care facilities to rapidly identify and triage patients with exposure history and signs or symptoms compatible with Ebola and coordinate patient transfer to an Ebola assessment hospital. These investments have established a system that better positions the nation to address future emerging threats.

DEPARTMENT-WIDE INFORMATION SECURITY

Security and Strategic Information

The Budget includes $7.5 million for the Office of Security and Strategic Information, which is the same as FY 2016. The Office of Security and Strategic Information coordinates the sharing and safeguarding of classified national security information across the Department, with the Director of National Intelligence, and other federal partners including component agencies within the intelligence community. The FY 2017 Budget will allow this office to continue efforts to meet current counterintelligence requirements.

Cybersecurity

The HHS cybersecurity program ensures that all automated information systems throughout the Department are designed, operated, and maintained with appropriate information technology security and privacy data protections. The FY 2017 Budget includes $51 million for the HHS Cybersecurity Program, which maintains the FY 2016 level. Resources will be used to improve efficiencies in security tools and deploy enterprise-wide solution tools that decrease the Department's vulnerability against cybersecurity threats. This investment includes not only purchasing technology, but also building the programs and expert workforce needed to meet federal requirements and address HHS specific needs, including the protection of personally identifiable information and proprietary information for medical products and drug formularies.

ABBREVIATIONS AND ACRONYMS

A

ACA Patient Protection and Affordable Care Act
ACF Administration for Children and Families
ACL Administration for Community Living
AHRQ Agency for Healthcare Research and Quality
AIDS Acquired Immune Deficiency Syndrome
ASPR Assistant Secretary for Preparedness and Response
ATSDR Agency for Toxic Substances and Disease Registry
AWARE Advancing Wellness and Resilience Education

B

BARDA Biomedical Advanced Research and Development Authority
BRAIN Brain Research through Advancing Innovative Neurotechnologies

C

CDC Centers for Disease Control and Prevention
CHIP Children's Health Insurance Program
CHIPRA Children's Health Insurance Program Reauthorization Act
CMS Centers for Medicare & Medicaid Services
CO-OP Consumer Operated and Oriented Plan

D

DATA Digital Accountability and Transparency Act of 2014
DOJ Department of Justice

E

EHR Electronic Health Record
ESRD End Stage Renal Disease

F

FDA Food and Drug Administration
FSMA Food Safety Modernization Act
FTE Full-Time Equivalent
FY Fiscal Year

G

GDM General Departmental Management

H

HCFAC Health Care Fraud and Abuse Control
HCQO Health Costs, Quality and Outcomes Research
HHS Department of Health and Human Services
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

I

IHS Indian Health Service
IPAB Independent Payment Advisory Board
IT Information Technology

L

LIHEAP Low Income Home Energy Assistance Program

M

MedPAC Medicare Payment Advisory Commission

N

NIDDK National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS National Institute of Environmental Health Sciences
NIH National Institutes of Health

ABBREVIATIONS AND ACRONYMS

N

NLM	National Library of Medicine

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
OS	Office of the Secretary

P

PAYGO	Pay-As-You-Go Act of 2010
PHS	Public Health Service

R

RAISE	Recovery After an Initial Schizophrenia Episode

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SSI	Supplemental Security Income

T

TANF	Temporary Assistance for Needy Families