

HEALTH AND HUMAN SERVICES

Since 2001, the Administration:

- Passed and initiated implementation of comprehensive Medicare reform legislation, adding prescription drug coverage and modernizing the Medicare program;
- Enrolled nearly 24 million Medicare beneficiaries in the Medicare prescription drug benefit as of the middle of January 2006;
- Improved preparedness for a bioterror attack, providing over \$7 billion to States, localities, and hospitals;
- Fulfilled the President's pledge to double funding for medical research through the National Institutes of Health;
- Created or expanded nearly 900 Health Center sites, providing health care services to an additional 4.3 million people;
- Approved 11 Health Insurance Flexibility and Accountability demonstrations, which at full implementation, could result in approximately 825,000 individuals receiving health coverage through Medicaid and the State Children's Health Insurance Program; and
- Launched a national strategy to improve pandemic influenza preparedness.

The President's Budget:

- Proposes a new financing measure to strengthen Medicare's sustainability;
- Provides nearly \$160 million to support advanced development of biodefense countermeasures to be considered for procurement under Project BioShield;
- Provides access to health care through more than 300 new and expanded Health Center sites, including 80 new sites in counties that have a high prevalence of poverty;
- Builds on the President's health insurance reform proposals to promote Health Savings Accounts and to expand coverage to more Americans with limited incomes;
- Provides \$250 million for new healthy marriages and strengthening fatherhood initiatives to improve the well-being of children;
- Provides \$204 million for abstinence-only education programs;
- Provides \$188 million to States, Faith-Based, and Community Organizations for a new initiative to combat the spread of HIV/AIDS, particularly within minority communities; and
- Continues the President's November 1, 2005, commitment to obtain \$7.1 billion from the Congress to improve pandemic influenza preparedness.

FOCUSING ON THE NATION'S PRIORITIES

By preparing now, we can give our citizens some peace of mind knowing that our Nation is ready to act at the first sign of danger, and that we have the plans in place to prevent and, if necessary, withstand an influenza pandemic.

President George W. Bush
November 1, 2005

Protecting the Nation from an Influenza Pandemic

One of the most serious threats to public health in our time is a global influenza pandemic. Pandemics happen when a new influenza virus emerges that is efficiently transmitted between humans. Influenza pandemics in 1918, 1957, and 1968 killed approximately 40 million, 2 million, and 1 million persons worldwide, respectively. A new strain of influenza virus has emerged in Asia, one for which humans have no natural immunity. Should this new strain of influenza virus become easily transmissible from human to human, millions around the world could become infected, sparking a serious public health emergency.

The President has called attention to the seriousness of this issue and has developed a National Strategy for Pandemic Influenza to guide preparedness and response to a pandemic. On November 1, 2005, the President submitted a \$7.1 billion emergency supplemental request to the Congress to improve the Nation's readiness. The request makes possible the fulfillment of the President's strategy by investing in international health surveillance and containment efforts; medical stockpiles; the domestic capacity to produce emergency supplies of pandemic vaccine and antiviral medications; and preparedness at all levels of government. On December 30, 2005, the President signed the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006. The Act includes \$3.8 billion for pandemic influenza preparedness, the first installment of the President's request to launch these critical activities. The Budget includes a \$2.3 billion allowance for the 2007 portion of the request to fulfill the next phase of the President's strategy.

The President's Budget builds on the \$7.1 billion commitment by requesting an additional \$474 million across the Government to further improve readiness. The Budget requests \$352 million in 2007 for continued implementation of the pandemic influenza preparedness plan at the Department of Health and Human Services (HHS). Of this total, \$188 million will allow the Centers for Disease Control and Prevention (CDC) to improve public health surveillance both domestically and abroad, establish more quarantine stations, develop diagnostic tests to identify potential pandemic influenza strains rapidly, and work with foreign governments to help prevent the spread of a pandemic. The National Institutes of Health (NIH) will receive \$35 million to conduct clinical trials of pandemic influenza vaccine, and the Food and Drug Administration (FDA) will receive \$50 million to improve the Agency's ability to review new pandemic influenza vaccines and drugs rapidly while assuring their safety and effectiveness, and to maintain a library of virus strains to facilitate the rapid manufacture of vaccines as the virus evolves. The Budget also includes \$79 million in the HHS Office of the Secretary for international activities, development and deployment of rapid tests for detection, and risk communication.

All of these activities at HHS, in conjunction with pandemic influenza activities at the U.S. Department of Agriculture (USDA), Department of State, and U.S. Agency for International Development, will greatly enhance the Nation's ability to prepare for and respond to an influenza pandemic.

Health Centers: More Sites Expand Access to Quality Care



This new Health Center site in Charles City, Virginia, opened in 2004. According to Rod Manifold, Executive Director of Central Virginia Health Services, "The President's Expansion Initiative has been vital to opening health centers, like Charles City Regional Health Services, in many of our highest-need communities."

his commitment to expand services through Health Centers, 777 Health Center sites have been established or expanded, and 3.7 million more people per year are being served. An estimated 120 new and expanded sites will be created in 2006.

The 2007 Budget continues this record of progress and will complete the President's commitment to create 1,200 new or expanded Health Center sites. More than 1.2 million additional individuals will receive health care in 2007 through more than 300 new or expanded sites in rural areas and underserved urban neighborhoods. Included in the President's commitment is the goal to create a Health Center in every poor county in America that lacks a Health Center and can support one. Of the new sites created in 2007, 80 will be in high-poverty counties that lack a Health Center. Faith-based and community programs will also be encouraged to compete for these grants.

Biodefense: Protecting Against Terrorism

The threat of bioterrorism has brought new challenges to our government, to our first responders and to our medical personnel. We are grateful for their service. Not long ago, few of these men and women could have imagined duties like monitoring the air for anthrax, or delivering antibiotics on a massive scale. Yet, this is the world as we find it; this Nation refuses to let our guard down.

President George W. Bush
July 21, 2004

Biodefense Research, Development, and Procurement. The Budget continues to invest heavily in research and development that will lead to new countermeasures against the most dangerous threat agents. NIH supports basic research, which leads to breakthroughs in scientific knowledge, and advanced development that converts knowledge into products that can be manufactured in large quantities. Within the 2007 Budget's \$28.4 billion for NIH, the Administration will

continue to fund biodefense research and development activities at nearly \$1.9 billion. This includes nearly \$50 million for chemical countermeasure development and \$47 million for radiological and nuclear countermeasure development. The Budget includes nearly \$160 million for advanced development of medical countermeasures against threats of bioterrorism. Large investments in

FOCUSING ON THE NATION'S PRIORITIES—Continued

basic research for biodefense countermeasures through NIH have helped create promising products to protect Americans against the threat of a terrorist attack. These investments will accelerate development of those products to help Project BioShield acquire them more quickly for the Strategic National Stockpile.

Strategic National Stockpile. The Strategic National Stockpile contains drugs, vaccines, and other medical supplies and equipment that can be delivered anywhere in the country within 12 hours of a request for assistance. The Stockpile currently contains: enough smallpox vaccine for every American; treatments for anthrax; countermeasures for injuries following a chemical, radiological, or nuclear incident; and treatments for conventional explosive attacks. The 2007 Budget includes additional funding to improve the Nation's ability to respond to biological and chemical weapons attacks with life-saving treatments and supplies. The Budget also proposes increased funding for the storage and maintenance of next-generation countermeasures, including new products purchased through Project BioShield. The Budget continues to support State and local ability to respond quickly with the distribution of countermeasures, especially in high-threat areas.

Medical Surge Capacity. In the event of a large-scale attack in one or more cities, existing medical capacity could be quickly overwhelmed. The President designated HHS as the lead for coordinating Federal support of State and local medical and public health response to mass-casualty events. The Budget includes \$50 million to purchase and store deployable medical care units, including medical supplies and equipment that the Federal Government can deliver to an affected area. This initiative also includes \$20 million to enhance the Medical Reserve Corps and provide prior training and verification of credentials to ensure the availability of health care providers during such an emergency.

Over \$7 billion has been provided to bolster State, local, and hospital preparedness since 2001. The Budget continues support for these investments by proposing an additional \$1.3 billion. Included in the total for hospital preparedness is \$25 million for a targeted, competitive demonstration program to establish a state-of-the-art emergency care capability in one or more metropolitan areas. Equally important is ensuring the ability to know what preparedness improvements have been made across the Nation, and where vulnerabilities remain, so these continued investments can be targeted to where they are needed most. HHS is engaged with State and local partners to establish performance indicators and standards and reassess the distribution of funds, to ensure that these investments are directed to most efficiently improve State, local, and hospital preparedness. HHS is also working with the Department of Homeland Security and other Federal departments and agencies in a coordinated effort to develop a national preparedness goal and related metrics that will help assess the Nation's readiness and determine preparedness assistance needs. These steps will help maximize the effect of each dollar toward reducing our actual vulnerabilities to potential attacks.

Defending the Nation's Food Supply. The 2007 Budget continues the President's commitment to improving the safety of the food and agriculture supply. In 2007, FDA will continue to work with USDA to improve protection of the Nation's food supply from intentional or natural contamination. The Budget requests a \$20 million increase for FDA to develop testing methods to identify the presence of contamination quickly and accurately, and to improve its ability to respond once an incident has occurred. The Food Emergency Response Network will continue to expand to allow for more rapid analysis of food samples to respond to a terrorist attack and to more quickly identify outbreaks in the food supply. Each of these activities will be coordinated with USDA, which will invest an additional \$322 million in 2007, to protect the food and agriculture supply from terrorist attacks.

Promoting Health Information Technology

The Administration continues to place a high priority on making electronic health records available to most Americans, a goal set by the President in 2004. Widespread use of electronic health records will help ensure Americans receive high quality medical care by providing doctors access to patients' medical history at the time of care. The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high-quality care. To encourage doctors and patients to adopt electronic health records, the Administration's goal is to promote conditions for a thriving free market. Identifying national standards will help focus development efforts, increase demand for the technology, and ultimately create affordable technology. The creation of the American Health Information Community in the Fall of 2005 is one step toward this goal. The Community will help ensure that there are certified technology products and nationwide interoperability standards, which should help purchasers of health IT have confidence in the investments they make.

The 2007 Budget includes \$169 million to accelerate progress for this effort, including \$116 million for the Office of the National Coordinator for Health Information Technology; \$50 million for the Agency for Healthcare Research and Quality; and \$3 million for the Office of the Assistant Secretary for Planning and Evaluation. Continuing and new activities include efforts to:

- Promote nationwide interoperability of health IT systems through an industry-wide process to harmonize standard development, maintenance, and refinements;
- Define the key elements of basic electronic health records for use in clinical settings, develop working prototypes for the use of electronic health data in such priority areas as coordinated chronic disease management and improved ambulatory care, and capture laboratory test data in a standardized way;
- Pursue breakthroughs in health systems architecture, such as rapidly collecting and disseminating public health surveillance data electronically, and encouraging the use of personal health records for patients to keep their own computer-readable medical history;
- Work closely with the Centers for Medicare and Medicaid Services (CMS) to advance the use of electronic prescriptions nationally; and
- Continue to address key privacy and security issues to encourage the exchange of health information nationwide.

Expanding Affordable Health Care

The 2007 Budget includes a comprehensive, consumer-focused plan to address the problems of rising health care costs and the uninsured. The President's plan to help reduce the rising cost of health care while improving quality and safety includes an emphasis on price transparency and disclosure of quality information. The plan also contains a package of proposals to promote: the use of health savings accounts (HSAs); grants to States to encourage innovations in providing coverage to chronically ill individuals; association health plans; medical liability reform; and a national marketplace for health insurance. This package of reforms will provide new and affordable health coverage options for all Americans—targeted to those who need it most: low-income children and families; the chronically ill; employees of small businesses; and the self-employed.

Price and Quality Transparency. The President seeks the commitment of medical providers, insurance companies, and business leaders to help consumers obtain better information on health care prices and quality. The Administration will leverage Federal resources and work with the private sector to develop meaningful measures for health care quality and to emphasize the importance of all-inclusive price information.

FOCUSING ON THE NATION'S PRIORITIES—Continued

Encouraging Health Savings Accounts. HSAs are a major tool to promote the Administration's long-term vision of a more consumer-driven health care system—a system in which benefits are affordable and portable, quality and patient satisfaction are high, and medical inflation is low. HSAs combine a high-deductible health plan with a tax-advantaged personal savings account reserved for medical purchases. This innovative approach gives the consumer greater ownership and control over his or her health care, and for many consumers can be a more economical choice than traditional insurance.

Created as part of the Medicare Modernization Act (MMA) in December 2003, HSAs have already attracted an estimated one million enrollees. The Administration seeks to build on this promising beginning with a robust package of policies designed to make HSAs even more affordable and portable. For a full description of this package, see the Federal Receipts chapter in the *Analytical Perspectives* volume. The highlights include:

- Making high-deductible health plans more affordable by creating tax parity between employer-sponsored insurance and insurance purchased in the non-group market. The Budget proposes to allow all individuals who purchase a high-deductible health plan in conjunction with an HSA to deduct the amount of the health plan's premium from their income and payroll taxes. Additionally, income tax deductible contributions to an individual's HSA would also be exempt from payroll taxes, which are paid by almost all workers.
- Increasing the maximum amount individuals can contribute to their HSA. Under current law, individuals' contributions are limited to the lesser of the amount of the deductible or \$2,700 for self-only coverage (\$5,450 for family coverage) for 2006. Under this proposal, a person could contribute—without paying income or payroll taxes on the contribution—up to the plan's out-of-pocket maximum, which is higher than the deductible.
- Establishing a refundable tax credit that would be available to those purchasing an HSA-compatible high-deductible health plan.
- Enhancing portability of insurance by giving individuals the option of taking their health insurance with them. The Budget proposes to allow employers to offer and employees to select portable HSA-compatible health plans. These policies would not be subject to State mandates or regulations and would build on the 2006 proposal to create a national marketplace for health insurance.

Focusing on the Chronically Ill. Chronically ill individuals often struggle to secure health insurance coverage. The 2007 Budget proposes to create a competitive grant program whereby States compete to receive funds to implement innovative policies to promote insurance among the chronically ill. For this effort, \$500 million would be available annually.

Reforming the Health Insurance Marketplace. In addition to the new initiatives to promote affordable and effective health care, the 2007 Budget repropose three initiatives to reform health insurance markets across the country:

- Establishing association health plans that would allow small employers, civic groups, and community organizations to band together and use their purchasing power to negotiate lower-priced coverage for their employees, members, and their families.
- Creating a competitive marketplace across State lines that maintains strong consumer protections.

- Reforming medical liability law, which will increase access to quality and affordable health care for all Americans, while reducing frivolous and time-consuming legal proceedings against doctors and health care providers.

Fighting Global AIDS

The President has made fighting the global spread of HIV/AIDS a top priority of his Administration. The President's Emergency Plan for AIDS Relief is a five-year, \$15 billion commitment to support and strengthen the AIDS-fighting strategies of many nations. At the time of the Plan's inception in 2003, only 50,000 people in sub-Saharan Africa were receiving antiretroviral treatment. Today, after two years of Emergency Plan implementation, more than 395,000 sub-Saharan Africans are receiving the drugs that allow them to survive this disease. The 2007 Budget includes \$4 billion for the President's Emergency Plan for AIDS Relief, an increase of more than \$740 million over 2006, to further strengthen international efforts to combat this epidemic through support for comprehensive prevention strategies and lifesaving treatments. The President's Global AIDS Coordinator relies on HHS to help implement this expansion and meet the President's goals.

Controlling the Spread of HIV/AIDS through Testing and Treatment

One of the primary challenges in fighting the HIV/AIDS epidemic in the United States is stopping the spread of the disease through the identification and treatment of individuals who are infected with the HIV virus but do not know it. To address this problem, the Administration is proposing \$188 million for an initiative that will focus Federal resources on HIV-testing, medical care, and outreach, with the goal of ending the growth in the number of new AIDS cases and reducing the future burden of the disease.

Testing, treatment, and outreach efforts will focus on at-risk populations, including low-income and minority communities that are increasingly hardest hit with growing rates of new infections. Routine testing and awareness campaigns will also be directed at incarcerated populations and drug treatment facilities. The initiative will also provide additional funding to finance medications and treatment for those currently in need, as well as individuals newly diagnosed with HIV/AIDS due to increased testing efforts.

Improving and Modernizing Medicare

Implementing the Medicare Prescription Drug Benefit. The MMA established the most important new Medicare benefit in the program's 40-year history: new voluntary prescription drug coverage, which began on January 1, 2006. Seniors and people with disabilities who enroll in the benefit are now expected to pay an average monthly premium of around \$25 in 2006, far lower than previous projections of around \$37. In every State, beneficiaries have a choice of at least one plan with monthly premiums below \$21, and in many parts of the country beneficiaries can enroll in a drug plan for as little as \$1.87 per month. In addition, competition is enabling beneficiaries to select plans that they prefer to the standard Government-defined drug benefit.



The Medicare bus travels across the United States to educate Medicare beneficiaries about the new prescription drug benefit.

FOCUSING ON THE NATION'S PRIORITIES—Continued

In every region, prescription drug plans are available with zero deductibles or deductibles lower than Medicare's standard annual deductible, and plans are available that allow beneficiaries to fill in the "coverage gap" in the standard benefit. Through telephone and online support, and thousands of community events and activities around the country, CMS and its partners are helping beneficiaries learn about what the new drug benefit means for them. Open enrollment ends in May 2006.

The Medicare prescription drug benefit is off to a good start. As of the middle of January 2006, nearly 24 million Medicare beneficiaries are participating in this important new benefit. This 24 million figure includes more than six million Medicare-Medicaid dual eligible beneficiaries, almost seven million in employer-sponsored coverage of some kind, and about 3.6 million beneficiaries who have signed up for stand-alone prescription drug coverage. In addition, three million Medicare-eligible Federal retirees will continue to receive the drug coverage they already enjoy. Some implementation issues will arise in any undertaking of this magnitude; resolving issues as they arise is a high priority.

Low-income beneficiaries are receiving additional assistance in paying for their drugs under the new Medicare prescription drug benefit, making the drug coverage more affordable and accessible to those most in need. The additional assistance allows these beneficiaries to pay reduced premiums and deductibles for their drug coverage.

Advancing Medicare Advantage. The MMA created the Medicare Advantage (MA) program to offer greater choices and higher quality care to beneficiaries through competition among private health plans. Overall, private health plans offer more generous benefits and lower cost-sharing for beneficiaries than Medicare fee-for-service. Beneficiaries in MA now save an average of about \$100 per month in out-of-pocket costs compared to traditional Medicare, and beneficiaries in fair or poor health save significantly more. The MMA successfully reversed a downward trend in private Medicare plan enrollment, and approximately 13 percent of beneficiaries are currently enrolled in MA plans.



President Bush discusses improvements to Medicare with beneficiaries on August 29, 2005, at the Pueblo El Mirage RV Resort and Country Club in El Mirage, Arizona.

In 2006, most Medicare beneficiaries will be able to choose from a variety of options to find a MA plan that meets their needs and preferences for how to get their care. CMS expects to contract with a full range of private health plans that will include health maintenance organizations, preferred provider organizations (PPOs), fee for service plans, and "special needs" plans designed to provide specialized care and support for beneficiaries with frailty or serious chronic diseases. Approximately 98 percent of Medicare beneficiaries will have access to some kind of local private MA plan. Of the 3,066 counties in the United States, 3,004 will have a participating local plan. For the first time, PPO plans will be widely available in Medicare, with more than 80 percent of beneficiaries having access to regional PPO plans.

Encouraging Beneficiary Choice. HSAs enable individuals to take greater control of their health care choices. More than one million Americans have opted for an HSA since the President signed

them into law in December 2003. However, Medicare still does not offer any HSA options. The Administration is developing new Medicare HSA choices for beneficiaries, including allowing people to “age in” to Medicare with their existing HSAs.

Enhancing Medicaid and the State Children’s Health Insurance Program (SCHIP)

Medicaid is an open-ended means-tested entitlement program financed jointly by the Federal Government and States. The Federal Government pays on average 57 percent of Medicaid expenses. Medicaid provides health coverage and services to nearly 53 million low-income children, pregnant women, elderly persons, and disabled individuals during the year. In 2007, Federal Medicaid outlays are estimated to be \$199 billion.

SCHIP was established in 1997 to make available approximately \$40 billion over 10 years for States to provide health care coverage to low-income, uninsured children who did not qualify for Medicaid. SCHIP gives States reasonable flexibility in effective program design while protecting beneficiaries through Federal standards. Since the beginning of the Administration, total enrollment in SCHIP has grown by an estimated 1.5 million children, to a total of approximately 6.1 million in 2004. Current law rules for distributing SCHIP funds can lead to shortfalls for some States. The 2007 Budget will seek authority to target SCHIP funds more efficiently to States with the most need.

The Deficit Reduction Act (DRA) takes important steps toward achieving savings in Medicaid while promoting effective Medicaid policy. The Administration commends the Congress’ successes, as this legislation accomplishes many of the Administration’s 2006 Budget priorities. These accomplishments include provisions that reform Medicaid long-term care eligibility and help individuals prepare for possible long-term care needs, as well as provisions that build on the President’s New Freedom Initiative, promoting home- and community-based care options for people with disabilities.

Medicaid/SCHIP Modernization. In past years, States have expressed concerns regarding the complex array of Medicaid laws, regulations, and administrative guidance as overly burdensome. Medicaid rules prohibit States from providing care comparable to the private sector. States widely believe that the Medicaid program structure has out-of-date requirements, which create higher costs and prevent States from helping additional uninsured individuals get the coverage they need.

The DRA responds to State requests for additional flexibility by providing States with new options. For non-disabled, non-elderly persons who are eligible for Medicaid, the DRA allows States to follow the lead established by SCHIP and provide more flexible benefit packages that are more comparable to those in the private sector. The DRA also establishes an option for States to raise the Federal limits on allowable beneficiary cost sharing in Medicaid to offer more State flexibility and to keep pace with inflation. As in SCHIP, which is already used by many States to cover similar populations, States would be given the flexibility to apply cost sharing by income level, beneficiary category, or service type in the form of premiums and/or co-payments, totaling no more than five percent of total family income.

The changes included in the DRA represent meaningful Medicaid reform. The Administration will take further steps to support States to use these reforms effectively to improve access to needed care by developing new waiver initiatives. The Administration has achieved considerable success with



Receiving prompt care.



FOCUSING ON THE NATION'S PRIORITIES—Continued

the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, included in the President's Management Agenda, which emphasizes coordination of currently available Medicaid and SCHIP funding with private insurance. Through the HIFA initiative, States can provide health care to more beneficiaries with the same amount of funding by changing delivery systems and using mainstream coverage, including coordination with employer plans. At full implementation, approximately 825,000 individuals may receive coverage through 11 approved HIFA waivers.

Building on the HIFA initiative and the approaches adopted by innovative States such as Florida, the Administration will develop a new waiver initiative that emphasizes market-driven approaches to health care. In conjunction with the DRA, this approach allows States to emphasize expanding needed coverage to uninsured individuals and to promote greater continuity of coverage. This new model will stress consumer-driven approaches to health care with access to affordable coverage while giving States more tools to offer better health coverage to some current beneficiaries, as well as to individuals who are currently uninsured. By broadening choices and encouraging competition in the private market, Medicaid can continue to modernize through State-level reforms. The result will be more seamless access to coverage for low-income families and children in Medicaid, as well as to other uninsured persons with limited incomes.

Florida Demonstration Tests Innovative Medicaid Reform

On October 19, 2005, the Administration approved Florida's waiver request to reform its Medicaid program. Florida's innovative approach—the first of its kind—will empower participants to choose a plan that best meets their needs while creating a marketplace in which plans compete.

The reform strategy includes flexibility for provider networks to create benefit packages that meet the unique needs of patients, payments to plans based on the health status of their enrollees, and mechanisms that allow participants to select the best plan for their individual needs. Florida's reform program also provides the opportunity for participants to opt out of their Medicaid benefit and use their State-paid premium to purchase employer-sponsored insurance. Further, participants will be able to earn enhanced benefits by engaging in healthy lifestyles that will allow them to purchase health care goods and services not provided by their plan.

Governor Jeb Bush said of the State's effort, "Medicaid is a vital safety net for Florida's most vulnerable, and it's time we transformed the program to reflect the needs of patients, rather than the dictates of government."

Medicaid Commission and Modernization. This past year, the HHS Secretary established a Medicaid Commission to provide options for modernizing Medicaid in ways that would offer high-quality health care to beneficiaries. In particular, the Commission is charged with developing long-term recommendations that emphasize Medicaid's financial sustainability.

The Administration looks forward to the Medicaid Commission's recommendations as laying the groundwork for additional future reforms. The Administration is committed to pursuing Medicaid reforms that will build on the improvements included in the DRA. More progress can be made, such as in the area of integrated care for individuals dually eligible for Medicaid and Medicare.

Service Enhancements. The DRA enhances services for former welfare recipients by extending Transitional Medical Assistance (TMA) through December 31, 2006. This program provides coverage for former welfare recipients entering the workforce, and the Administration proposes extending the program through September 30, 2007. Similarly, the 2007 Budget proposes Cover the Kids, a national outreach campaign. This initiative will provide \$100 million in grants annually to enroll additional Medicaid- and SCHIP-eligible children by combining the resources of the Federal Government, States, schools, and community organizations.

Health Insurance Portability and Accountability Act (HIPAA). Since enacted in 1996, HIPAA has had the goal of increasing the continuity and accessibility of health insurance. To ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA coverage, the Administration proposes two legislative changes: 1) make eligibility for a Medicaid/SCHIP Employer-Sponsored Insurance (ESI) Program a qualifying event, allowing families to enroll in ESI immediately through special enrollment rather than waiting for an open enrollment period; and 2) require SCHIP programs to issue certificates of creditable coverage promoting portable health coverage by verifying the period of time an individual was covered by a specific health insurance policy.

Enhancing the Faith-Based and Community Initiative

Compassion Capital Fund. The 2007 Budget provides \$100 million to enhance the efforts of faith-based and community organizations serving low-income individuals and families. Specifically, grassroots organizations will receive training and technical assistance, as well as targeted capacity building to better meet the needs of the poor by improving their delivery of social services. Also, the Budget supports the First Lady's Helping America's Youth Initiative by funding the capacity-building activities of organizations with a focus on preventing violence and helping youths at risk of gang influence.

Abstinence-Only Education. The 2007 Budget proposes \$204 million for abstinence-only education programs. This includes \$137 million for the community-based abstinence education program, of which up to \$10 million will fund the national abstinence education campaign. It also includes \$50 million in mandatory funding for the State-based abstinence grants program, \$13 million for the Adolescent Family Life Program, and \$4.5 million for evaluations of abstinence programs. The Budget supports increasing funding for abstinence-only education programs to \$270 million by 2009, and to continue providing \$4.5 million for abstinence program evaluations each year.



The First Lady talks with students during a visit to the Church of the Epiphany in Washington, D.C., as part of her Helping America's Youth Initiative.

FOCUSING ON THE NATION'S PRIORITIES—Continued

Access to Recovery. Access to Recovery represents an innovative approach to facilitating recovery from addiction by providing individuals with vouchers for substance abuse treatment. These vouchers enable addicted and recovering individuals to personally choose from a range of effective treatment and recovery support options, including faith-based and community providers. The 2007 Budget includes \$98 million for grants to 20 States to provide access to effective treatments. Within this amount, \$25 million will be targeted to help individuals recover from methamphetamine abuse. Methamphetamine addiction is a growing problem in the United States that inflicts serious harm on individuals, families, and communities.

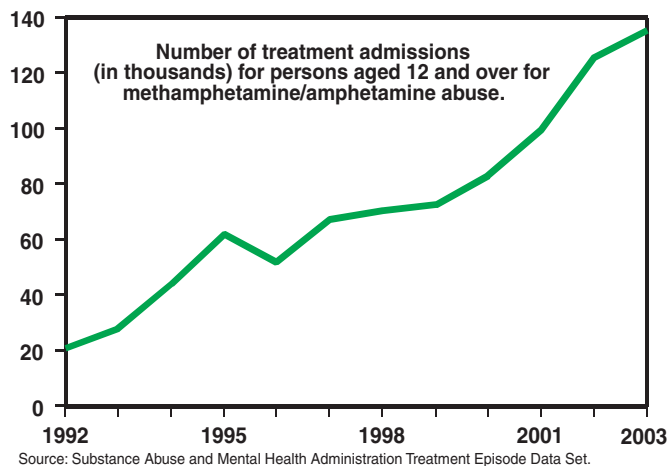
As part of the President's efforts to expand choice and individual empowerment in Federal assistance programs, the Administration will offer incentives to encourage States to provide a wider array of innovative treatment options to those in need of recovery by voluntarily using their Substance Abuse Block Grant funds for drug treatment vouchers. Building on the successful model of the Access to Recovery program, distribution of block grant funds through a voucher system will promote innovative drug and alcohol treatment and recovery programs, provide a wider array of treatment provider options, and introduce into the system greater accountability and flexibility. The Administration will also look for new opportunities to expand choice in other drug treatment activities.

Mentoring Children of Prisoners. The 2007 Budget continues to fund the President's initiative to mentor the children of prisoners. The Budget provides \$40 million to fund effective grantees.

Supporting Low-Income Families

Temporary Assistance for Needy Families (TANF). The DRA extends the successful TANF program through September 2010 to provide assistance to families with children. Since the reformed welfare program was created in 1996, the number of welfare recipients has continued to decrease, and employment and earnings among the target population have increased. This is reflected in the Program Assessment Rating Tool (PART) evaluation, where the program received a rating of Moderately Effective, because it was able to demonstrate the program's impact with performance measures and independent evaluations. Reauthorization maintains the funding level, strengthens work requirements to maximize self-sufficiency, and supports healthy marriage and family formation.

Increased Need for Methamphetamine Treatment



Supporting Healthy Marriages and Responsible Fatherhood. The Budget provides \$250 million for healthy marriage initiatives, of which \$100 million is for competitive matching grants to States for marriage promotion. It also includes \$150 million for healthy marriage and responsible fatherhood from welfare reauthorization. Of this, up to \$50 million supports the new strengthening fatherhood initiative for the 25 million children living in homes without fathers, and up to \$2 million is for the new child welfare demonstration grants for Tribes. The remaining funds support demonstrations, research, and technical assistance to promote family formation and healthy marriage. These programs are funded by redirecting a portion of the savings from the elimination of the High Performance bonus and the Reduction of the Out-of-Wedlock Birth Bonus.

Child Support Enforcement. The Child Support Enforcement program is designed to help low-income and vulnerable families with children become self-sufficient by obtaining support from the children's non-custodial parents. Welfare reauthorization includes several of the Administration's proposals to more effectively collect and distribute child support to families. The Budget repropose additional provisions to further improve the program's enforcement tools.

Enhancing Research. The Administration will explore how existing program administrative data, such as the Federal Parent Locator Service, could be used to enhance the Government's ability to do more comprehensive research on the interactive effects of participation in Child Support; TANF; Medicaid; and SCHIP, and the relationship of program participation to employment and wages. Understanding how employment patterns affect family well-being and Federal program participation will help the Administration monitor progress toward the goal of family self-sufficiency.

Strengthening Programs for Children

Early Childhood (Good Start, Grow Smart). Because it is important for children to enter school ready to learn, the Administration has worked to improve early childhood programs through the Good Start, Grow Smart initiative. The goals of this initiative are:

- Strengthening Head Start;
- Working with States to improve early childhood learning; and
- Providing parents, teachers, and caregivers with information on early learning.

To further these goals, the Budget supports reauthorization of Head Start and provides \$6.8 billion, enough to serve more than 900,000 children.

Child Welfare Program Option. The 2007 Budget seeks legislation to introduce an option for all States so they can choose an alternative system for foster care. Flexible financing will allow States to design programs with a stronger emphasis on child-abuse prevention, family support, and increased flexibility in providing services.

RESTRAINING SPENDING AND MANAGING FOR RESULTS

Prioritizing Resources

In 2006, the Congress terminated or reduced spending in a number of HHS programs that were either duplicative, inefficient, or not producing results. This produced over \$1 billion in savings. The 2007 Budget builds upon this success by identifying additional low-performing or lower priority programs that should be terminated or reduced. As the Administration strives to improve efficiency and effectiveness, the Budget redirects resources to other public health and social service activities that have greater accountability to improve the public health and welfare. Highlights are discussed below.

Proposed Terminations and Reductions (savings in millions)

Program	2006 Enacted ¹	Program	2007 Proposed ²
Terminations			
Health Facilities Construction		Community Services Block Grant.....	-630
Congressional Earmarks.....	-483	Preventive Health Block Grant.....	-99
Healthy Community Access Program	-83	Urban Indian Health Program	-33
Youth Media Campaign	-59	Community Economic Development.....	-27
Early Learning Opportunities Fund.....	-36	Emergency Medical Services for Children ...	-20
National Youth Sports	-18	Universal Newborn Screening	-10
Real Choice Systems Change Grants.....	-15	Traumatic Brain Injury	-9
State Planning Grant Program	-11	Rural Community Facilities.....	-7
Community Food and Nutrition.....	-7	Job Opportunities for Low-Income	
Direct Service Worker Delivery Grants.....	-3	Individuals	-6
Trauma-Emergency Medical Services.....	-3		
Reductions			
Health Professions	-155	Social Services Block Grant	-500
CDC Congressional Project Earmarks.....	-60	Children's Hospital's Graduate Medical	
Programs of Regional and National		Education Payments	-198
Significance.....	-40	Health Professions	-136
Preventive Health Block Grant.....	-20	Rural Health.....	-133
		Programs of Regional and National	
		Significance	-71
		CDC Administrative Expenses.....	-30
		Poison Control Centers.....	-10

¹ Difference from 2005.

² Difference from 2006.

Community Services Block Grant. The Community Services Block Grant (CSBG) provides funds through States to Community Action Agencies to fund social services to reduce poverty and increase self-sufficiency. The Budget eliminates CSBG because it lacks national performance measures and does not award grants on a competitive basis. In addition, key CSBG services targeting employment, housing, nutrition, and health care are also provided by other Federal programs. This is supported

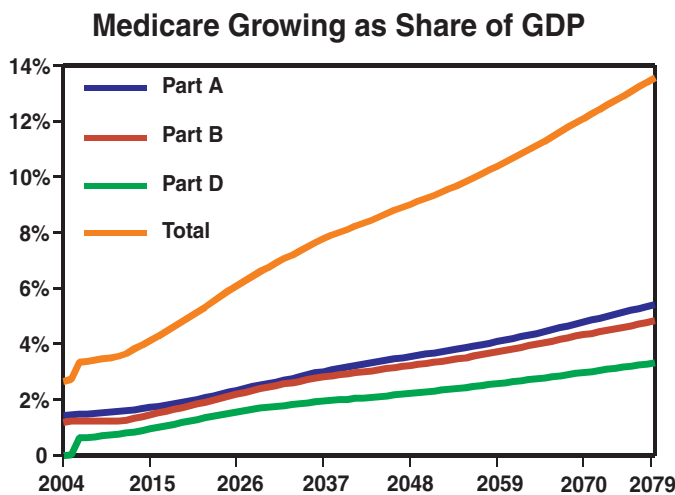
by findings from the PART evaluation, in which the program received a rating of Results Not Demonstrated.

Social Services Block Grant. The Budget reduces 2007 Social Services Block Grant (SSBG) funding by \$500 million. The 2005 PART identified several weaknesses of the block grant. While SSBG provides State flexibility, as the Congress intended, it fails to ensure that funds are directed towards activities that achieve results. Because SSBG is a funding stream, rather than a program, there are no assessments of its effectiveness. In addition, the purposes of SSBG overlap substantially with other categorical and flexible Federal social service programs.

Preventive Health Block Grant. The 2007 Budget proposes the elimination of the Preventive Health Block Grant at CDC. The Budget proposes to increase the flexibility of CDC’s existing State categorical grants by allowing a portion of these funds to support primary prevention and health services. This added flexibility maintains the accountability of CDC State categorical grants while limiting redundancy, and gives States the tools they need to address public health concerns.

Health Professions. The Budget reduces unnecessary subsidies for health professions training. The programs were created 40 years ago in response to an anticipated national shortage of physicians that does not exist today. An assessment of the program found it was ineffective. No comprehensive evaluations link Health Professions grants to changes in supply, distribution, or minority representation of physicians and other health professionals. The Budget improves access to health care by focusing investments where there is a greater need, such as Health Centers and the supply of nurses.

Rationalizing Medicare Financing



Source: 2005 Medicare Trustees Report.

Strengthening Medicare’s Long-Term Financial Security. Medicare, which represents about two and a half percent of the economy today, is projected to grow to about 12 percent of the economy by 2070. The Medicare Trustees estimate that the Medicare program will require \$29.9 trillion over 75 years from the Federal budget above and beyond dedicated revenues from the public. This rapid growth in expenditures would place a substantial burden on future budgets and the economy. Reducing program growth while continuing to promote high-quality care is critical to minimizing Medicare’s burden on the economy and ensuring the program’s sustainability and effectiveness for future

generations.

The Administration has pursued a steady course toward Medicare reform and modernization. The MMA brought Medicare into the 21st Century by adding a new drug benefit, bringing Medicare’s benefits up to date with a much greater focus on preventive care. The MMA also took a first step toward improving Medicare’s sustainability by requiring the Medicare Trustees’ Report to include a new, comprehensive fiscal analysis of the program’s financing, and issue a warning if this analysis projects Medicare’s dedicated revenues to fall below adequate levels.

The President’s Budget proposes to build on these steps toward a modern, sustainable Medicare program by requiring further action should the share of Medicare spending funded by dedicated revenues fall below adequate levels. If the Congress failed to act on recommendations to reach more

RESTRAINING SPENDING AND MANAGING FOR RESULTS—Continued

sustainable financing levels, a modest slowdown in the rate of growth would be implemented through a four-tenths of one percent reduction to all payments, similar to a reduction in the market basket update. The reduction would grow by four-tenths of one percent every year that shortfalls continue to occur. If the Congress preferred to enact more specific sustainability reforms in lieu of these modest payment trends, expedited procedures would facilitate consideration.

The Deficit Reduction Act and the MMA are important steps in the process of improving Medicare's sustainability. The Budget includes a number of proposals that build upon this foundation to take important further steps to enhance the long-term sustainability of the Medicare program. The 2007 Budget recognizes that accomplishing the goal of financial solvency for the Medicare program will require a series of incremental reforms that can be achieved most smoothly and effectively if they are implemented over many years.

Modernizing Medicare Financing. The MMA began to rationalize and strengthen financing of the Medicare program by limiting the growth in subsidies for higher-income beneficiaries who are most able to contribute to the costs of their coverage. This modernization gave these beneficiaries increased ownership of and greater responsibility for their health care needs, while preserving Medicare's capacity to provide more support for beneficiaries with more limited means. In order to strengthen the program's long-term fiscal sustainability, the Budget proposes to broaden the application of reduced subsidies for higher-income beneficiaries.

Fostering Productivity. Individuals enrolled in Medicare today benefit from innovations that enable them to have improved quality of life as they age. Many of these changes in the delivery of care and advances in technology, as well as other management improvements, also enhance the health care system by improving productivity. The Budget proposes to consider these advances in making productivity adjustments to provider updates that allow Medicare to deliver high-quality care and encourage efficiency. Prospective payments reward those providers who reduce their costs and streamline their operations. Similarly, a productivity adjustment to inflation updates encourages those facilities to improve efficiency.

Improving the Ryan White CARE Act's Effectiveness through Reform

Much has changed in the epidemiology and medical management of HIV/AIDS since the Ryan White CARE Act was enacted in 1990. Fifteen years ago, those diagnosed with the disease had little hope of survival; patients today are living longer and healthier lives. The epidemiology of the disease has also changed as minorities now make up the majority of new infections and, according to CDC, many of these individuals have insufficient access to health care and the antiretroviral medications they need.

The President has called for reauthorization of the Ryan White CARE Act to make the Act more responsive to the HIV/AIDS epidemic of today, especially for African-American and other minority communities who disproportionately suffer from the disease. The President's principles to guide reauthorization include:

- Focusing Federal resources on life-extending care, including the provision of life-saving anti-retroviral medications;
- Ensuring greater flexibility in distribution of Federal resources and targeting funding to those areas, such as minority communities, that are experiencing the greatest need; and
- Ensuring that recipients of funds can show that progress is being made and that the program is achieving results.

Enhancing the National Institutes of Health

NIH will invest \$28.4 billion to support, conduct, and foster biomedical research in 2007, embarking on several new initiatives to contribute more effectively to the Nation's strong biomedical research foundation and to prepare for the future.

Accelerating Discovery. Initiated in 2003, the NIH Roadmap for Medical Research speeds research discoveries from the bench to the bedside by directing resources to high-priority, emerging areas to encourage innovation and scientific breakthroughs. The Roadmap charts new pathways to discovery, designs interdisciplinary scientific research teams, and re-engineers the clinical research enterprise. The Budget also supports a new Genes, Environment, and Health Initiative with \$68 million to accelerate discovery of the major genetic factors for diseases that have a substantial public health impact. Additionally, the initiative will accelerate the development of technology, which will help make clear the connection between genes and the environment on human health. The request includes nearly \$160 million to support activities related to the advanced development of biodefense countermeasures and \$35 million for pandemic influenza clinical trials and studies.

Enhancing Management and Oversight. NIH will continue the establishment and staffing of the Office of Portfolio Analysis and Strategic Initiatives (OPASI). In 2007, OPASI will serve as the center of NIH portfolio management and coordination activities. OPASI will fill the crucial role of continually evaluating the benefits and impacts of NIH research investments, stimulating investments in research involving multiple Institutes and Centers, and reviewing the vast portfolio of research activities across NIH.

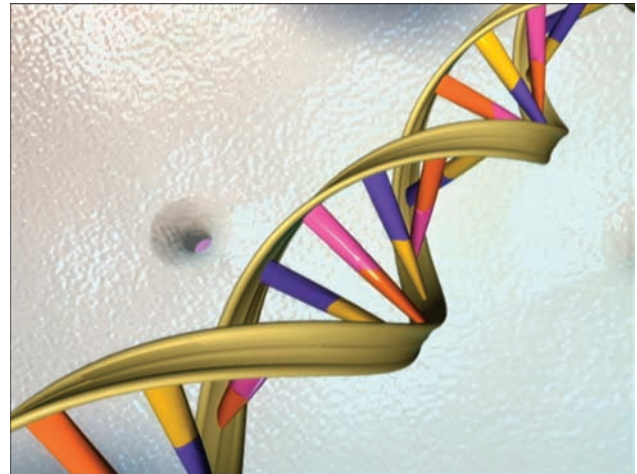
Developing Decision Support Tools. Also in 2007, NIH will continue the development of a knowledge management system to assist with the oversight of its portfolio. This knowledge management system will allow NIH to improve the reliability and consistency of reporting on NIH research investments, increase transparency, and speed the process of collecting and querying grant data.

Targeting Children's Hospital Payments

The Budget reforms Federal financing for Children's Hospitals Graduate Medical Education payments. Federal funds currently go to free-standing children's hospitals without regard to which hospitals most need the Federal assistance. The reformed payments will focus on those hospitals with the greatest financial need that treat the largest number of uninsured patients and train the greatest number of physicians.

Reforming the Community Mental Health Services Block Grant

The President's New Freedom Commission on Mental Health found that mental health services in the United States are fragmented and in disarray. The Commission put forth an agenda to transform mental health care. The Budget helps carry out that agenda by reforming the Community Mental Health Services Block Grant. The block grant allocates resources to every State for planning and services and currently offers little evidence of impact on mental health care. Under the reform proposal,



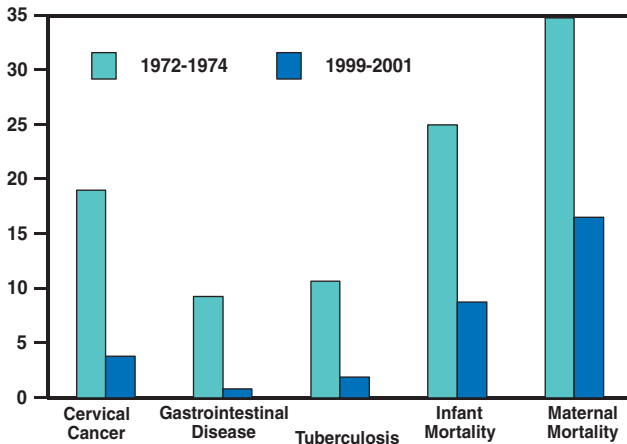
DNA Double Helix, the genetic basis of all life.

RESTRAINING SPENDING AND MANAGING FOR RESULTS—Continued

States will use these funds to transform their mental health care systems and will track and report on the results of these investments.

Improving the Health Status of American Indians and Alaska Natives

Mortality Rates for American Indians and Alaska Natives have Declined

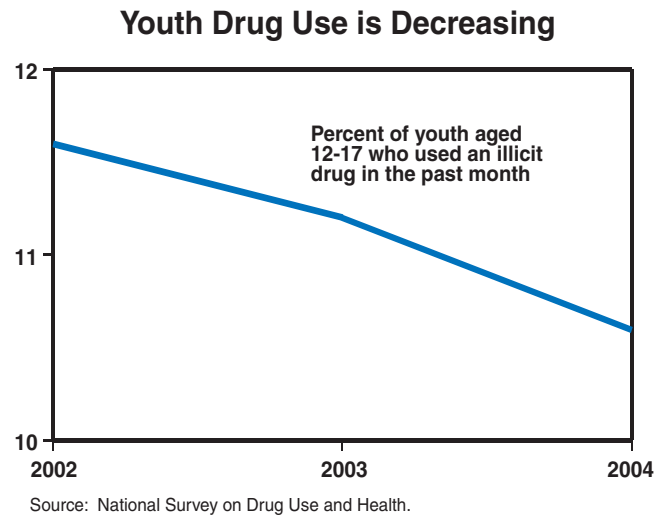


For over 50 years, the Indian Health Service (IHS) has delivered health services to American Indians and Alaska Natives. Through direct primary care, referrals for specialty care, and public health services, IHS has substantially improved the health status of this population. Since 1972, the average death rate from all causes for American Indians and Alaska Natives has declined by 26 percent overall, and as the accompanying chart shows, the reduction is even greater in many disease areas. Along with these gains come new challenges. For example, a diabetes epidemic among American Indians and Alaska Natives threatens to slow or even reverse some of this progress. During this same period, the death rate from diabetes has increased by 64 percent. American Indians and Alaska Natives are now three times more likely to be diagnosed with diabetes than other Americans.

In response to this threat, IHS has been increasing activities related to the prevention and management of diabetes and set several performance goals to measure progress. IHS has increased the percentage of American Indians and Alaska Natives with diabetes that have their blood sugar and blood pressure under control, and has improved screening rates for other complications associated with diabetes. Diabetics who control blood sugar and blood pressure and obtain recommended screenings experience fewer debilitating and costly complications from the disease. IHS is continuing to improve surveillance and data collection in order to direct and manage resources to most effectively address the growing problem of diabetes and further improve the health of American Indians and Alaska Natives.

Reducing Drug Use

Drug use by the Nation's youth puts their health and future at risk and strains families, schools, and communities. Between 2002 and 2004, drug use by the Nation's youth (between the ages of 12 and 17) fell by about 200,000, a drop of nine percent in the number of teenagers using illicit drugs. The rate of drug use among this age group fell from 11.6 percent in 2002 to 10.6 percent in 2004. The Administration is building on this progress to discourage a new generation of youth from taking these risks. Valid and reliable data are central to assessing the impact of drug control programs. The 2007 Budget strengthens data collection efforts critical to support drug policy and further reduce drug use.



Modernizing FDA User Fees Strategies

Since the authorization of the Prescription Drug User Fee Act in 1992, the collection of fees has been critical in leading to performance improvement in drug review. The Act has allowed FDA to shorten the length of new drug reviews while maintaining the safety of newly improved drugs and devices. Fees for reviews have been so successful in improving FDA performance that they have also been implemented for medical devices and animal drugs in recent years. These fees also help ensure that industries that benefit from rigorous FDA oversight share with the U.S. taxpayer the responsibility for supporting this oversight.

The Budget proposes to expand the current drug, animal drug, and medical devices export certification fee to include food and animal feed. These certificates enhance the global competitiveness of American food and feed producers by ensuring that the products meet certain requirements of law. The President's Budget eliminates the current preferential treatment of the food and feed industry.

The 2007 Budget also proposes new fees for re-inspections. FDA is statutorily required to inspect manufacturing establishments on a regular basis. To further encourage industry improvement, fees would be assessed for repeat inspections that are needed as a result of violations identified on the first inspection.

RESTRAINING SPENDING AND MANAGING FOR RESULTS—Continued

Improving Quality of Care for Medicare Beneficiaries

Encouraging Provider Quality. The Administration has undertaken initiatives to improve care, reduce errors, and improve efficiency for Medicare beneficiaries by holding providers accountable for quality and supporting care improvements that enhance quality while improving efficiency. The Medicare website now displays quality data that allow consumers to make informed choices by comparing the performances of hospitals, skilled nursing facilities, home health agencies, and dialysis facilities. Recently, Medicare has expanded these efforts to include a voluntary reporting system for physicians to provide information on the quality of beneficiary care, as well as systems for widespread reporting on hospital patient satisfaction and surgical results.



Consumers can evaluate hospital efforts to prevent surgical infections by viewing quality measures at CMS' Hospital Compare website.

The Administration supports greater availability of reliable and consistent quality information through incentives for quality reporting that do not increase Medicare costs. CMS is also working with providers to identify and test budget-neutral incentives that will stimulate Medicare providers to improve performance on quality and efficiency measures.

The Administration supports provider payment reforms that would encourage quality and efficiency, and discourage increased complications and costs. Building on provisions in the DRA, CMS will work collaboratively with private and public organizations to implement reforms that support higher-quality care and improved efficiency. Many of the opportunities to improve quality and efficiency involve post-acute care. Medicare often pays very different amounts for post-acute care for beneficiaries with similar needs, and often pays more when preventable complications leading to readmissions and other health problems occur in the post-acute system. The Budget proposes to build on the Administration's quality initiatives by ensuring that patients are served in the most medically appropriate and efficient setting for high-quality post-acute care.

An important component of these reforms is consideration of better ways to encourage more efficient and high quality physician services. The Administration supports reforms in physician payment that do not increase costs for taxpayers or for Medicare and its beneficiaries, such as differential updates initially for physicians that report on quality measures and later for physicians that achieve efficient and high-quality care.

Promoting Competition. The MMA included provisions to incorporate market competition into purchasing medical items needed to treat beneficiaries. Competition is an important approach to improving care for beneficiaries by enhancing quality and lowering costs. The Administration will implement a competitive bidding program in July 2006 to enable physicians to obtain certain drugs used in their offices at lower prices. The Administration will expand the use of additional competitive bidding programs in 2007, for example, into the purchase of medical supplies and equipment. In particular, the Budget proposes to integrate competitive bidding into payment of clinical laboratory services.

Advancing Medicare Contracting Reform

The 1965 Medicare Act mandated that Medicare use private insurance companies to process claims. Since that time, Medicare has paid the contractors based on cost with little discretion of payment for performance or efficiency. This administrative structure is not keeping pace with the evolving health care delivery system. The MMA requires that CMS transition to competitive contracts by 2011. The Administration is accelerating implementation with completion targeted in 2009. It removes the restrictions that have prevented full and open competition for the fee-for-service workload. As a result, Medicare will consolidate from the current arrangement of about 40 contractors for processing Parts A and B fee-for-service claims to 15 single or multi-State regions. The agency will award one contract for each region that covers claims processing services and re-compete these contracts every five years. CMS will tie payments to accuracy and efficiency of contractors' claims processing services. In addition, the Administration will work to improve efficiency and quality, and better target resources in the Quality Improvement Organization program.

Continuing Medicare Program Integrity

Medicare program integrity efforts have yielded savings from the recovery of erroneous overpayments and the collection of criminal fines and penalties. The 2007 Budget continues this effort with \$1.1 billion from the Health Care Fraud and Abuse Control account to fight improper Medicare payments. The Budget requests \$118 million for efforts to protect the new Medicare prescription drug benefit and the MA program against fraud, waste, and error, as well as reduce errors in Medicaid. These funds are part of a Government-wide proposal to fund program integrity activities through a discretionary cap adjustment. In addition, the Budget proposes to encourage Medicare providers to collect payments from beneficiaries who do not meet their obligations to contribute to the cost of their medical care.

Strengthening Federal Health Benefit Payments

Private health insurance payers supplement coverage for some beneficiaries enrolled in Federal health benefit programs. In certain cases, due to lack of accurate and complete information about such private coverage, the Federal Government mistakenly pays too much or too little for a beneficiary's care. To help ensure appropriate payments and assist in recouping mistaken payments, the Budget proposes to establish a data clearinghouse that would work to determine whether a private insurance company or the Government should pay for a beneficiary's health benefits. Federal health programs benefiting from this clearinghouse would include Medicare, the Department of Veterans Affairs, the Department of Defense's Tricare program, and the Federal Employees Health Benefits Program, among others.

Reforming Medicaid Financing and Services

Medicaid is an open-ended Federal-State partnership with a shared financing structure. In certain circumstances, opportunities exist for States to draw down Federal matching funds inappropriately, which threaten this joint relationship and the financial stability of the Medicaid program. The 2007 Budget proposes reforms that enhance past efforts to create service efficiencies and to assure the fiscal integrity of Medicaid and SCHIP.

Reforming Payments to Government Providers. The Administration proposes to improve further the integrity of the Medicaid matching rate system by proposing steps to curb financing arrangements used by a number of States to avoid the legally determined State matching fund requirements.

RESTRAINING SPENDING AND MANAGING FOR RESULTS—Continued

Through various mechanisms, Federal funds are returned from providers back to the State and “recycled” to draw additional Federal dollars. The Budget proposes to build on CMS’ efforts to identify and recover diverted payments that are not used for their intended purposes. The Budget also proposes to limit Federal reimbursement for Government providers to no more than cost. This proposal would curb excessive payments and still preserve a State’s ability to pay reasonable rates to Government providers.

Reforming Provider Taxes. Under certain conditions, States may use the proceeds of taxes collected from a certain class of health providers to help finance the State’s share of Medicaid expenses. Under current rules, the tax cannot exceed six percent of revenues and must be applied uniformly across all health care providers in the same class (e.g., all hospitals). Although current law requires States to tax all providers within a class—regardless of how many Medicaid patients they serve—statute allows States to tax only Medicaid managed care organizations. The DRA amends the statute to require States to tax all managed care organizations uniformly.

In addition to the reform included in the DRA that treats managed care organizations the same as other classes of health care providers with respect to provider tax requirements, HHS will publish a regulation that phases down the allowable tax rate from six percent to three percent. HHS will also take necessary administrative steps to clarify and codify existing policies used to determine whether provider taxes comply with statute including revising existing regulations.

Third Party Liability. By statute, Medicaid is the payer of last resort and should only be billed after all other liable parties have reimbursed their share of the claim. Statute and regulation require States to ensure that Medicaid recipients avail themselves of all other resources—legally responsible third parties—to pay for their medical needs before using Medicaid. The 2007 Budget includes a package of proposals designed to enhance existing third party liability policy.

Additionally, through waivers of the so-called cost avoidance methodology, HHS allows States to “pay and chase,” that is, to pay a claim when it is received initially and then to seek reimbursement from liable parties. The Administration plans, through administrative action, to require States to uphold the cost avoidance standard for pharmacy claims, thereby eliminating the pay and chase option.

Service Reforms. The service reform included in the DRA tightens the definition of targeted case management services allowable for reimbursement under Medicaid. The 2007 Budget includes a legislative proposal to align the administrative matching rate for targeted case management services to 50 percent, consistent with Federal reimbursement for case management across Federal programs.

In addition, the Budget proposes a package of initiatives designed to address service areas susceptible to abuse and to target Medicaid dollars more efficiently. To ensure proper use of Federal funds, the Administration plans to clarify through regulation the statutory Disproportionate Share Hospital program provisions and allowable services that can be claimed as rehabilitation services. In addition, the Budget plans to prohibit Federal Medicaid reimbursement for school-based administration or transportation costs established under the Individuals with Disabilities Education Act (IDEA); these are costs not traditionally paid for through Medicaid. This plan would maintain the original intent of IDEA while insuring appropriate use of Federal funds.

Cost Allocation. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 capped Federal funding for administrative costs under TANF and eliminated the open-ended matching structure for administrative costs in Aid to Families with Dependent Children (AFDC). Under the AFDC structure, States generally allocated most of the common eligibility determination costs for AFDC, Medicaid, and Food Stamps to AFDC/TANF. As a result, administrative costs associated

with Medicaid were inappropriately included in the TANF block grant. This proposal would reduce Medicaid administrative funding to reflect costs covered by the TANF block grant.

Medicaid and SCHIP Financial Management. Health Care Fraud and Abuse account entities will develop a comprehensive plan for Medicaid and SCHIP program integrity. HHS will continue activities in 2007 to measure improper payments in Medicaid and SCHIP and begin reporting error rates for certain components of Medicaid and SCHIP in the 2007 Performance and Accountability Report.

Medicaid Prescription Drugs. The DRA makes several changes to the way prescription drugs are paid for in Medicaid. First, it amends the Federal upper payment limit to apply to more drugs. Second, the DRA maximizes rebate collections for authorized generics and drugs administered in a physician's office. Third, it extends 340B drug discounts to certain children's hospitals. The 2007 Budget proposes several other changes to prescription drug coverage and payment that would:

- *Restructure Pharmacy Reimbursement.* The HHS Inspector General has documented substantial overpayment for pharmacy services in recent years. The 2007 Budget proposes building on the Federal upper payment limit calculation changes in the DRA to further reduce these overpayments.
- *Amend the Medicaid Drug Rebate Formula to Remove Best Price in a Budget Neutral Manner.* The Budget repropose a Medicaid drug rebate change from the 2006 Budget. Drug manufacturers pay rebates to States to have their drugs covered by Medicaid. Part of the rebate formula is the lowest private market price, referred to as best price. Best price effectively acts as a price floor, interfering with the competitive marketplace and preventing manufacturers from negotiating better discounts with large purchasers. Replacing the current rebate with a budget neutral flat rebate will allow private purchasers to negotiate lower drug prices, while creating neither savings nor costs for the Federal Government.
- *Allow States to Use Managed Formularies.* The 2007 Budget proposes allowing States to use managed formularies, which are a common cost control tool for private insurers. With managed formularies, States will have greater control over drug coverage and greater leverage to negotiate discounts with drug manufacturers.



The Budget proposes to reduce overpayments for prescription drugs.

Update on the President's Management Agenda

The table that follows provides an update on HHS' implementation of the President's Management Agenda as of December 31, 2005.

RESTRAINING SPENDING AND MANAGING FOR RESULTS—Continued

	Human Capital	Competitive Sourcing	Financial Performance	E-Government	Budget and Performance Integration
Status	●	●	●	●	●
Progress	●	●	●	●	●

In support of the Human Capital initiative, HHS developed a Department-wide performance appraisal system that mirrors its SES system, thus linking all employees to program goals and objectives. Initial roll-out of this system commences in the beginning of calendar year 2006. HHS estimates net savings of \$400 million over the next several years for its competitive sourcing competitions that were conducted in 2003, 2004, and 2005. HHS issued its annual Performance and Accountability Report on the November 15, 2005 due date, and for the seventh year in a row, HHS’ auditors issued an unqualified or clean audit opinion. In E-Gov, HHS leads the development of Federal health data standards, which will pave the way for consensus national standards to support implementation of electronic health records by hospitals and doctors nationwide.

Initiative	Status	Progress
Faith-Based and Community Initiative	●	●
Real Property Asset Management	●↑	●
Eliminating Improper Payments	●	●
Broadening Health Insurance Coverage through State Initiatives	●	●

Arrow indicates change in status rating since the prior evaluation as of September 30, 2005.

HHS collects accurate and timely data on the Faith-Based and Community Initiative grantees. In addition, HHS is working to implement outcome based evaluations of its main programs—Compassion Capital Fund, Access to Recovery, and Mentoring Children of Prisoners.

HHS has successfully developed a real property asset management plan; compiled an inventory of owned, leased, and otherwise managed properties; and established performance measures that are consistent with the Federal Real Property Council’s guidance.

HHS’ annual Performance and Accountability Report includes an annual estimated error rate for Medicare that accounts for nearly 50 percent of improper payments that have been reported Government-wide. Due to improvements in the stewardship of Medicare funds, the error rate dropped from 10.1 percent in 2004 to 5.2 percent in 2005, a reduction of \$9.6 billion. HHS also reduced improper payments in Head Start from 3.9 percent in 2004 to 1.6 percent in 2005, a reduction of \$145 million, and Foster Care from 10.3 percent in 2004 to 8.6 percent in 2005, a reduction of \$31 million. HHS is also working to expand the number of programs reporting estimated improper payments and improve the accuracy of estimates.

HIFA demonstrations, at full implementation, could result in approximately 825,000 individuals receiving health coverage through Medicaid and SCHIP. CMS continues to approve HIFA demonstrations and use its administrative flexibility, in conjunction with States, to increase the number of people who have health insurance.

Department of Health and Human Services
(In millions of dollars)

	2005 Actual	Estimate	
		2006	2007
Spending			
Discretionary Budget Authority:			
Food and Drug Administration	1,427	1,475	1,545
<i>Program level (non-add)</i>	1,801	1,856	1,947
Health Resources and Services Administration ¹	7,288	6,555	6,220
<i>Program level (non-add)</i>	7,332	6,600	6,264
Indian Health Service.....	2,985	3,045	3,170
<i>Program level (non-add)</i>	3,813	3,879	4,004
Centers for Disease Control and Prevention ¹	6,152	5,976	5,809
<i>Program level (non-add)</i>	6,419	6,243	6,076
National Institutes of Health ¹	28,393	28,410	28,428
<i>Program level (non-add)</i>	28,650	28,587	28,587
Substance Abuse and Mental Health Services Administration	3,268	3,205	3,134
<i>Program level (non-add)</i>	3,392	3,327	3,260
Agency for Healthcare Research and Quality.....	—	—	—
<i>Program level (non-add)</i>	319	319	319
Centers for Medicare and Medicaid Services ²	2,666	3,080	3,115
<i>Program level (non-add)</i>	4,098	3,901	3,978
MedPAC and GDM/OCR Trust Funds.....	19	19	19
Discretionary HCFAC	—	—	118
Administration for Children and Families	13,545	13,704	12,287
<i>Program level (non-add)</i>	13,905	13,764	12,847
Administration on Aging	1,393	1,363	1,335
Office of the Secretary.....	404	380	396
<i>Program level (non-add)</i>	518	492	526
Health Information Technology	—	42	88
<i>Program level (non-add)</i>	20	61	116
Office of Medicare Appeals.....	58	59	74
Public Health and Social Services Emergency Fund ¹	142	53	160
Program Support Center: Medicare eligible retiree accrual	—	34	36
Office of the Inspector General	40	39	44
Subtotal, Discretionary budget authority	67,780	67,439	65,978
Estimated future emergency funding for pandemic influenza preparedness.....	—	—	2,300
Total, Discretionary budget authority	67,780	67,439	68,278
<i>Memorandum: Budget authority from enacted supplementals</i>	408	3,410	—
Total, Discretionary outlays	66,536	67,977	70,635

Department of Health and Human Services—Continued
(In millions of dollars)

	2005 Actual	Estimate	
		2006	2007
Mandatory Outlays:			
Medicare:			
Existing law	294,334	337,922	389,502
Legislative proposal	—	—	-2,453
Medicaid/SCHIP:			
Existing law	186,849	198,109	204,689
Legislative proposal	—	—	546
All other programs:			
Existing law	32,232	35,651	34,642
Legislative proposal	—	—	389
Total, Mandatory outlays	513,415	571,682	627,315
Total, Outlays	579,951	639,659	697,950

¹ For comparability, the 2005 Actual reflects Bioterrorism funds in the individual operating divisions, instead of the Public Health and Social Services Emergency Fund.

² Amounts appropriated to the Social Security Administration (SSA) from the Hospital Insurance and Supplementary Medical Insurance accounts are included in the corresponding table in the SSA chapter.