Department of Health and Human Services

OMB Submission

Fiscal Year

1999

HHS Summary

Secretary's Letter
National Health Research Trust Fund
Children's Health
Reducing Tobacco Use
Youth Substance Abuse Prevention
Health Care Quality Improvement
Operation Restore Trust
Child Care 1999-2002
Performance Plans Summary

Secretary's Letter

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 12 1997

The Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

I am pleased to submit the fiscal year (FY) 1999 budget for the Department of Health and Human Services (HHS). Our request totals $371 billion in budget authority for FY 1999. We have worked diligently to support the investments that the President and I believe are vital to the health and economic well-being of this Nation. As we move toward the new millennium, America faces tremendous challenges related to new technology, advances in biomedical sciences, demographic changes, and transformations in the structure and the delivery of health care and social services. We must ensure that our public health and social services programs can address these changes and reflect the impact of managed care, the transformation of welfare policies, and the near doubling of our older population, especially those older than 85.

We are requesting $38.5 billion in discretionary budget authority, and, pursuant to your guidance, we finance our plan for FY 1999. We are proposing large increases in user fees and other assessments, including an expanded anti-fraud provider audit program paid for by the providers themselves. We are also proposing a novel approach to financing a dramatic expansion of the biomedical and public health research capacity in the United States.

In addition to the expansion of medical and public health research, we are requesting resources for seven additional important initiatives in the FY 1999 Budget: Children's Health, Reducing Tobacco Use, Youth Substance Abuse Prevention, Improving Health Care Quality, Operation Restore Trust, Child Care, and Welfare to Work. The objectives of these initiatives will be accomplished through improved partnerships with State and local governments, the private sector, and community organizations. Our budget proposal also continues support for high priority Presidential initiatives.

NATIONAL HEALTH RESEARCH TRUST FUND

For FY 1999, we are requesting a total of $15.2 billion to fund bold new investments in national health research. The request represents an increase of $1.9 billion (+ 15 percent) over the FY 1998 President's Budget.

1.9 b. new NIH
- how much
above existing
Congress

Health research has vastly improved human health and quality of life. Many discoveries have been translated into improved health, and as a consequence, many diseases and disabilities we once faced are now preventable or treatable. For example, we halved mortality attributable to coronary

artery disease and stroke, eradicated smallpox from the world, and eliminated indigenous polio from the Western hemisphere. Antibiotics have mitigated the severity of once fatal illnesses, such as scarlet fever and hearing loss resulting from childhood ear infections. Additionally, cancers such as childhood leukemia are treatable, childhood vaccine preventable diseases are at their lowest levels, and other preventive interventions such as seat belts and fluoridated drinking water to prevent cavities are common. We are on the brink of discoveries that may revolutionize the prevention, diagnosis, and treatment of disease, as well as the delivery of quality health care in America and the world.

The Department proposes to create a National Health Research Trust Fund that finances additional health research in the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Policy Research (AHCPR). Specifically, this investment initiative seeks to increase NIH research by 50 percent over five years and 100 percent over 10 years, and to build substantially the AHCPR research and CDC prevention research programs. Research investment increases would total $23 billion over five years and $84 billion over 10 years. In FY 1999, NIH would grow by 10 percent over the final 1998 appropriations level, CDC research would increase by $100 million, and AHCPR research would expand by $62 million. All of the FY 1999 increase, and three-fourths of the 10-year increase, would be funded through the Trust Fund. The remainder would be funded by three percent annual increases in regular appropriations starting in FY 2000.

The Trust Fund would provide a mechanism for those who benefit from health research to pay for a portion of the cost of its expansion consistent with the basic concept of user fees. Income sources include a 1.35 percent assessment on health insurance premiums and interest on balances. Funds would be allocated to the agencies through the annual appropriations process to increase research above the FY 1998 level. Discretionary spending caps would be increased by the amount appropriated from the Trust Fund which would avoid displacing other key Presidential investments.

Medical innovations and public health interventions, and their successful implementation, are the foundations upon which America's past successes in improving health were built. Innovation depends on assembling the most creative minds and giving them access to the most advanced biomedical and computational instrumentation and State-of-the-art laboratory facilities. Accordingly, continuing investment in such infrastructure elements as new buildings and refurbished facilities must be a key component of the Nation's overall strategy for sustaining its capacity for world class medical research. The NIH and the National Science Foundation estimate there is an unfunded backlog of about $4 billion in research facility construction and renovation. It is critical that the Federal government help address this as an investment in medical research. With $1 billion in resources from the Trust Fund to be available until expended, $1 billion in matching funds, and $1 billion in guaranteed loans, the proposal would generate $3 billion to eliminate three-fourths of the backlog over the next five years. CDC would administer up to $200 million of these funds over the five years for public health research facilities. This short-term, intensive effort to rebuild America's research capacity would address

medical research infrastructure needs well into the 21st century. At the completion of the five-year effort, Trust Fund monies would be devoted entirely to research.

CHILDREN'S HEALTH

The Children's Health Initiative includes resources of $4.275 billion provided by the Balanced Budget Act for the new Children's Health Insurance Program, in addition to $1.9 billion in discretionary funds, including incremental funds for FY 1999 of $258 million. This increase is + 16 percent over the FY 1998 President's Budget.

Approximately 10 million of our Nation's children lack health insurance coverage. Many lack an established source of primary care while many face preventable health conditions. HHS has developed a comprehensive strategy to improve the health of America's children. The requested funds enable HHS to decrease the number of uninsured children by an estimated 25 percent (CBO estimate) and extend outreach and enabling services—"health homes" in healthy communities—to an additional 600,000 children.

Providing children with health insurance is an important, albeit precursory, step toward improving their health. Coverage alone will not improve health outcomes. We must increase the number of children who receive health care services and who are covered by community-based prevention strategies. Experts agree that early intervention results in fewer illnesses and disabilities, along with improved development and increased productivity.

The Children's Health Initiative proposes a pragmatic, multi-year strategy which builds on existing models. It employs four strategic components:

- **Expand Health Insurance Coverage**— Provide coverage to a significant number of the 10 million uninsured children through the recently enacted State Children's Health Insurance Program.

- **Enroll Medicaid-Eligible Children**— Three million Medicaid-eligible children are not currently enrolled in the program. This initiative would increase the number enrolled, using options for continuous eligibility and presumptive eligibility for children.

- **Develop and Implement the "Health Home" Performance Measures and Increase Public Systems Capacity to Deliver Care Meeting Health Home Criteria**— Develop performance indicators and quantifiable measures for the Health Home concept—an umbrella term for high-quality, continuous, and family-centered care. These measures can be used by the public and private sectors to evaluate whether children, especially newly enrolled or insured children, are receiving high quality health care. At the same time, this initiative would build capacity to ensure the availability of health care designed to meet Health Home criteria to newly insured or enrolled children. The Department expects to reach at least an additional 600,000 children by building capacity in programs it supports

such as the Maternal and Child Health and Community and Migrant Health Center programs.

- **Strengthen Community-Based Programs**—Provide population-based public health services to children, such as immunization and injury prevention, and emphasize developmental disability prevention and substance abuse and mental health services.

HHS and States will collaborate to accomplish the goals of outreach and other changes to the Medicaid program. HHS will partner with Federal agencies, consumers, advocacy groups, communities, tribes, health and human services providers, private sector organizations, and other interested groups to achieve these results.

REDUCING TOBACCO USE

For FY 1999, the Department is requesting a total of $272 million to advance the President's goal of reducing tobacco use among young people by 50 percent within seven years. This is an increase of $144.4 million (+ 112.9 percent) over the FY 1998 President's Budget.

Every day, 3,000 of our Nation's teens become regular smokers, a decision which results in 1 million new teenage smokers per year. Intermediate objectives of this initiative seek to reduce both the supply and demand of tobacco products, primarily by changing the social acceptability of tobacco use, counteracting advertising and promotion, and delaying or preventing decisions to use tobacco.

The strategy targets five action-areas. It increases youth-center activities, empowers young people to confront peer tobacco use, deglamorizes tobacco through a coordinated partnership with the entertainment industry, implements an advertising campaign to change social mores, and most importantly, involves parents and families in addressing tobacco use among youth. Implementation and enforcement of FDA's tobacco regulation is a central component of this initiative. The FDA will solicit cooperative partnerships nationwide with State and local authorities, who will help enforce the rule by conducting investigations to ensure tobacco products are not sold to minors. Moreover, as additional components of the tobacco regulation go into effect, the Department will pursue aggressive enforcement of access restrictions and implement its advertising requirements through national outreach and enforcement programs.

In addition, the request finances the following activities:

- The Centers for Disease Control and Prevention will expand partnerships with non-governmental organizations and tobacco control programs in all 50 States and the District of Columbia, continue research with our Prevention Centers on effective strategies to address youth tobacco use, develop a nationwide counter-advertising campaign and other efforts to reduce the social acceptability of tobacco, deliver effective school health programs, and expand research, surveillance, and global health programs.

- Health Resources and Services Administration will support 12 State-based programs to prevent and reduce tobacco and marijuana use.

- The National Institutes of Health will continue research programs aimed at both youth and adults, including a multi-year proposal to conduct innovative research to reduce tobacco use among children and youth.

- The Substance Abuse and Mental Health Services Administration will continue block grant activities to reduce tobacco demand and minors' access to tobacco products.

- In addition to contracts with all 50 States for the inspection of retail facilities, and taking enforcement actions against those found to have violated the age and identification restrictions, the Food and Drug Administration will conduct outreach and education with retailers and other stakeholders about their responsibilities under the rule, and coordinate efforts with State and local public health agencies and voluntary health organizations.

Each component of this initiative employs measurable, achievable objectives and interim benchmarks. Surveillance efforts will enable tracking of tobacco use patterns among youth and subsequent refining of the Department's efforts to achieve this Presidentially mandated reduction of youth tobacco use within the next seven years.

YOUTH SUBSTANCE ABUSE PREVENTION

For FY 1999, we are requesting a total of $404.3 million to implement a key goal of the President's 1997 National Drug Control strategy: to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco. This represents an increase of $69 million (+ 20.6 percent) over the FY 1998 President's Budget.

Is this a big priority

Illicit drug use among our youth is unacceptably common. By age 15, 25 percent have tried an illicit drug. And, despite a reported leveling off of the rate of past month marijuana use among 12-17 year olds in the 1996 Household Survey, the concomitant increase in the 18-25 year population highlights the urgent need to prevent new interest in this gateway drug. The percentage of youth aged 12-17 who perceived great risk in using marijuana once a month decreased from 40 percent in 1990 to 33 percent in 1994 and remained at this low level through 1996. Furthermore, there has been an increasing trend in heroin use since 1992, with most new users under the age of 26. The estimated number of past month heroin users increased from 68,000 in 1993 to 216,000 in 1996 for all ages. Of all past year users, 9 percent were 12-17 during 1991-92 but 22 percent were 12-17 during 1995-96.

Moreover, drugs are increasingly available, and America's youth population is expected to increase from 20.8 million in 1993 to 25.2 million in 2005. We can expect an expansion of

associated economic costs and social problems if the threat is not immediately curtailed with a strong and sustained prevention effort.

The results we expect to achieve with the investment include reversing the current upward trend in marijuana use among 12-17 year olds by 25 percent. The level of funding allows us to address the associated goal of reducing other illicit drug use by 35 percent and alcohol use by 20 percent by the year 2002. These goals will be accomplished through (1) mobilizing and leveraging resources, (2) raising awareness, and (3) measuring outcomes.

HEALTH CARE QUALITY IMPROVEMENT

For FY 1999, we are requesting a total of $77.5 million for the Quality Improvement Initiative. This is an increase of $36.1 million from the FY 1998 President's Budget.

The Department significantly influences the delivery of health care in this country, acts as an advocate, an information supplier, a major purchaser and provider of health care services, a supporter and conductor of research, and it protects consumers by ensuring that health care is accessible, safe, fair, effective and accountable. In each role, the Department influences the quality of care provided to Americans.

The funds requested will enable the Department to critically examine how it influences health care quality as it fulfills each of these roles and to revise its activities to foster better quality in a rapidly changing health care system. The Department will collaborate with other Federal agencies and the private sector to achieve the following six goals:

- Support a three-year, high visibility campaign to help consumers understand the concept of health care quality and to act to improve quality ($6.1 million).
- Develop purchasing models and strategies to promote high quality in health care organizations from whom we purchase care ($1.3 million).
- Improve mechanisms, strategies, and ideas that help HHS providers deliver the highest quality care ($11.3 million).
- Expand research that improves health care quality and improves methods for translating research findings into practice ($19.2 million).
- Develop a national reporting system using leading quality indicators that can be used for monitoring progress toward improved quality ($20.6 million).
- Coordinate and improve protections for consumers ($18.3 million).

An interagency Quality Council, consisting of senior Department leadership appointed by the Secretary and meeting quarterly, will coordinate the efforts of this initiative. Each of the aforementioned goals will have a designated work group reporting to the Council. Products from this three-year initiative build on each agency's current and already proposed activities.

OPERATION RESTORE TRUST

In FY 1999, the Department is requesting $11.5 million in discretionary budget authority for Operation Restore Trust (Project ORT) to complement the $1,057.5 million in mandatory funds already provided by the Health Insurance Portability and Accountability Act of 1996. Total funding for this initiative in FY 1999 is $1,069.0 million. This represents a total increase of $473.43 million (+ 79.5 percent) over the FY 1998 funding level.

The underlying mission of Project ORT is to facilitate and ensure high-quality benefit delivery to legitimate consumers while reducing incidents and payments related to fraudulent and abusive billing practices. The funds will enable the Department to undermine subversive practices against Medicare and Medicaid. Project ORT gradually expands a two year demonstration project to eventually incorporate all care paid for by these programs nationwide. Prior to the demonstration project which ended in March 1997, program representatives, Medicare contractors, Medicaid State agencies, auditing, and law enforcement agencies rarely coordinated their investigations of fraudulent, abusive, and other inappropriate program activities. Now, Project ORT encourages participants to coordinate their efforts and focus on specific issues in defined locations.

Project ORT expects unprecedented results from these efforts. The Department will measure the effect of Project ORT by comparing its "return on investment" to the widely used and accepted governmental benchmark of $7 of benefit payments saved per $1 of administrative costs invested. The goal in the continuation of Project ORT is to have a return on investment in excess of $7 to $1. We are also exploring the feasibility of using additional benchmarks—such as utilization/provider trends, post-payment quality control reviews, and the number of providers excluded—and other departmental Government Performance and Results Act measures. Participants will aggressively pursue recoupment of the approximately $175 million owed to the Federal government, complete investigative work on about 200 ongoing cases, provide litigation support to the Department of Justice on 54 current indictments, and complete 66 enhanced survey and certification reviews in the original Project ORT States.

Furthermore, Project ORT promotes public involvement in fighting fraud and abuse. Partnerships will be formed with ombudsmen who work with the elderly and their families, and with the health care industry to publicize "best practices," promote voluntary compliance plans, and disseminate program integrity strategies. HHS is developing a data collection program to report final adverse actions, such as civil judgments, criminal convictions, license suspensions, and program exclusion decisions, against health care providers, suppliers, and practitioners.

In addition, our budget submission includes a new fiscal integrity initiative that augments the Department's fight against health care fraud, waste, and abuse and addresses the claims payment error problems cited in the Inspector General's recent Audited Financial Statement of the Medicare Program. We propose to increase Medicare Integrity Program (MIP) funding levels in FY 1999 by $468 million. This increase in mandatory funding would be offset through savings ($800 million) achieved through the additional provider audit activities that would be performed using this new funding.

CHILD CARE 1999-2002

For FY 1999, the Department is proposing to fund the Child Care Initiative with a total of $5.2 billion. This represents an increase of $2.05 billion (+ 66 percent) over the FY 1998 level. The $5.2 billion is composed of the following three categories: $1 billion in discretionary funding, the same as the President's FY 1998 request; $2.167 billion in entitlement funding—$50 million above the estimated FY 1998 level—already appropriated from Title VI of the Welfare Reform Law (P.L. 104-193); and, $2 billion in additional entitlement funding.

Adequate child care is needed by the Nation's workforce and for the development of our children. This initiative proposes a broad strategy for improving access to quality child care. It engages the Departments of Treasury, Education, and Labor to partner with HHS Operating Divisions. The initiative focuses on the following goal:

Every community should have a continuum of quality care for children from birth through early adolescence. Quality care protects children from harm; it promotes children's development, school readiness and academic achievement; and it meets parents' needs for reliable care that fits their work schedules.

The requested investment will achieve these results:

- Double the number of children receiving direct child care assistance by the year 2002, from 1 million to 2 million children.
- Improve the quality and accessibility of care in more than 500 communities across the country, ensuring the health, safety, and school-readiness of the youngest children in care.
- Double the number of after-school and summer programs serving school age children, including sports programs.
- Improve the training and compensation of the child care workforce.
- Develop the foundations for a child care system for the new millennium by means of increased consumer education and improved data collection.

This proposal requires changes in Title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Additionally, we are proposing as part of this initiative a change to the Dependent Child Care Tax Credit to make this authority more supportive of working low-income families.

WELFARE TO WORK

Total funding of $22.2 billion for this initiative will help families meet the challenges of self-sufficiency. This is an increase of $2.13 billion (+ 10.6 percent) over the FY 1998 President's Budget. Specifically, this level of funding:

- leverages the implementation of welfare reform legislation—specifically key elements of self-sufficiency such as the Temporary Assistance to Needy Families Block Grant (TANF), the Child Care and Development Fund, and Child Support Enforcement;
- showcases a range of model welfare to work activities;
- increases access to America's employer community;
- helps adults overcome barriers to work and provide support for the family; and,
- stimulates a cross-cutting research agenda to support Welfare to Work efforts.

Furthermore, the funding request allows the Department to (1) provide responsive Federal leadership and technical assistance to States as they face hard policy and implementation choices, and (2) administer TANF in a way that provides States flexibility to address families' barriers to work. Additionally, the Department will increase child support collections—estimated to increase to $15.3 billion in FY 1999—and support working families by serving more children with affordable, high quality child care. The Department's goal is that 2 million children will receive direct child care assistance by the year 2002.

The initiative offers unprecedented innovations in employment strategies. The Department will, through guidance and incentives, encourage the employment of welfare recipients in the Department's network of grantees and in the health care community, continue to collaborate with the Department of Labor to implement the Welfare to Work Grant program, and convene employer forums through regional offices.

A cross-cutting research agenda will study the effectiveness of efforts to move families from welfare to work and the impacts of welfare reform. Research to assess the impacts of reform on families and communities combined with evaluations of specific programs and policies, such as the Welfare to Work Grants, will be continued. This will promote continuous improvement in the way that human services and employment systems address issues that face families as they strive for self-sufficiency.

The Welfare to Work Initiative exemplifies HHS' commitment to supporting families' self-sufficiency by implementing programs for working families effectively and responsively, by finding innovative ways to promote employment, and by using research and evaluation to build knowledge to inform programmatic and policy choices. The combination of these strategies should permit HHS to further the President's objective of moving more than 2 million people off of welfare by 2002.

* * *

In addition to the aforementioned Secretarial Initiatives, our budget request highlights funding proposals in four high-priority areas:

Preventing Emerging Infectious Diseases

For FY 1999, we are requesting a total of $104.6 million for preventing emerging infectious diseases. This is an increase of $45.5 million (+ 77 percent) over the FY 1998 President's Budget.

Although recent medical history affirms significant progress in the mitigation and prevention of infectious diseases, we must not curtail innovations to overcome constant challenges to these scientific achievements. President Clinton and the Institute of Medicine have reaffirmed CDC's leadership role in curtailing infectious diseases. This initiative continues the phased implementation of the plan in four areas to protect America's health: Surveillance and Response, Applied Research, Prevention and Control, and Expanding laboratory capacity. The funding request enables the CDC to:

- support modern and responsive surveillance systems ranging from global to local levels, and increasing epidemiological and laboratory response capacity for outbreaks;
- develop and implement a national monitoring system for antimicrobial/antiviral use;
- expand the Nation's regional Emerging Infections Programs which conduct early warning, population-based investigations;
- implement health communication strategies and educational programs for professionals and the public, including public health fellowship programs; and,
- support WHO efforts to curtail infectious diseases globally.

Food Safety

For FY 1999, we are requesting a total of $113.1 million for the Food Safety Initiative. This is an increase of $74.6 million (+ 194 percent) over the FY 1998 President's Budget.

HHS proposes to invest an additional $74.6 million in FY 1999 through FDA ($64.6 million) and CDC ($10 million) to support major efforts that will yield enormous benefits in health and public confidence in the food supply and that could, ultimately, prevent 2 to 9 million illnesses, up to 3,000 deaths, and save society billions of dollars in preventable health care costs each year.

Ensuring the safety of America's food supply is one of government's most enduring and important functions. It is a responsibility shared by government and the private sector. In responding to new technologies that enable food producers to grow, process, and market growing varieties of food products, the private sector and Federal, State and local governments face many challenges to maintaining and improving the safety of the Nation's food supply.

Ryan White AIDS Programs

For FY 1999, the Department is requesting a total of $1.2 billion to continue to provide resources to urban areas, States, and health centers via the Ryan White AIDS programs. This is an increase of $174 million (+ 16.8 percent) over the FY 1998 President's Budget.

Between 600,000 and 900,000 people are estimated to be living with HIV in the United States. The Ryan White AIDS Care programs largely serve target populations with HIV who are uninsured or underinsured and have low incomes. The funds ensure that individuals with HIV and AIDS receive a continuum of care that emphasizes access to primary care, pharmaceuticals, and support services necessary to facilitate and improve health outcomes.

The increase includes $132 million for the AIDS Drug Assistance Programs to address the dramatic increase in demand for combination drug therapy. Our request also recognizes that to achieve our goals, increases in funding cannot be limited to drugs. We must reach hard-to-serve populations that are disproportionately represented among those infected and newly infected with HIV, meet the HIV-related needs of people with HIV who are homeless, uninsured, or active substance abusers, provide load testing to monitor patients' response to combination therapies, and address the changing patterns of the epidemic within and across urban and rural areas.

Head Start

For FY 1999, we are requesting a total of $4.634 billion for the Head Start Program. This represents an increase of $329 million (+ 7.6 percent) over the FY 1998 President's Budget. This level of funding will allow us to serve 36,000 children while maintaining the critical quality improvements that already have been achieved. The request aligns us with the President's goal to serve 1 million children by 2002.

Head Start is the Nation's premier early childhood development program. It has provided comprehensive child and family development services in the areas of health, education, social services and parent involvement to low-income preschool children and their families for over 30 years.

PERFORMANCE PLANS SUMMARY

I am personally committed to implementing the requirements of the Government Performance and Results Act. This year the Department has taken a major step in our continuing pledge to improve the lives of the American people. We have identified our strategic commitments on their behalf, which will direct our activities for the next five years. In this budget submission, we have identified the specific results that our individual programs will work to achieve in FY 1999. This is the first time that planned program results are linked to budget resources.

I am proud of this major accomplishment and think that the Department offers a commendable annual performance plan. It reflects thousands of hours of dedicated effort by ourselves, our partners, and a truly productive working relationship with OMB staff. I look forward to building on the relationship as plans evolve.

CONCLUSION

Details on our accomplishments and plans for each of the thematic areas along with summary budget tables and a Department-wide FTE table accompany this letter. Information about our implementation of the performance measurement requirements of the Government Performance and Results Act is also included.

Our FY 1999 budget is a zealous effort to prepare the Department and the Nation for the demands of the 21st century. It builds on past accomplishments and presents new strategies to help children, families and senior citizens overcome obstacles that hinder their potential as productive members of our society. It anticipates the kind of America we want to create and it protects and reinforces the values of family, work, opportunity, and responsibility. It builds on ongoing successes and, above all, it acknowledges that our greatest resource is our citizens.

Furthermore, I would like to discuss with you our FY 1999 Budget request in more detail. Together we can ensure fiscally prudent decisions which safeguard the Department's ability to provide critical social and public health services to vulnerable children, families, and older persons, maintain our national commitment to cutting-edge health and science programs, and invest wisely in health and human service programs for Americans.

On behalf of the Department of Health and Human Services, I thank you and your staff for the extraordinary assistance you provide to this Department. I anticipate successful collaboration with you to ensure the President presents the strongest possible FY 1999 budget plan possible for HHS.

Sincerely,

Donna E. Shalala

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISCRETIONARY BUDGET: FY 1999 REQUEST TO OMB
(Budget Authority in Millions)

OPDIV	FY 1997 Appropr.	FY 1998 President's Budget	FY 1998 House 1/	FY 1998 Senate 1/	FY 1999 Request	+/- FY 1998 PB	% Change
FDA:							
Salaries And Expenses (B.A.)	$ 820	$ 751	$ 853	$ 873	$ 1,018	$ 267	35.5%
Rental Payments (B.A.)	46	46	46	46	46	-	0.0%
Buildings And Facilities (B.A.)	21	23	21	23	42	19	84.3%
Subtotal FDA (B.A.)	888	820	920	942	1,106	286	34.9%
User Fees	*108*	*244*	*21*	*113*	*139*	*(105)*	*-42.9%*
FDA Program Level	*996*	*1,064*	*942*	*1,055*	*1,245*	*181*	*17.0%*
HRSA:							
Comm/Mig HCs & Homeless/HUD Health...	802	810	826	826	910	100	12.3%
Health Professions	293	130	307	220	327	197	151.5%
National Health Service Corps	112	112	120	115	122	10	8.9%
MCH Block Grant	681	681	685	681	731	50	7.3%
Healthy Start	96	96	96	96	171	75	78.1%
Emergency Medical Serv. For Children	12	12	13	13	15	3	25.0%
Organ Transplantation	2	4	2	3	4	0	5.8%
Ryan White AIDS	996	1,036	1,168	1,077	1,210	174	16.8%
Family Planning	198	203	203	208	218	15	7.4%
Rural Research	9	9	9	12	14	5	55.1%
Rural Outreach	28	25	28	30	28	3	12.0%
Health Facilities	13	-	-	10	-	-	-
Program Management	113	111	111	114	126	15	13.5%
HEAL Program Management	3	3	3	3	4	1	37.2%
Other HRSA	43	37	48	43	47	10	28.4%
Subtotal HRSA (B.A.)	3,401	3,269	3,619	3,452	3,927	658	20.1%
HRSA Discretionary Program Level	*3,407*	*3,280*	*3,627*	*3,460*	*3,942*	662	20.2%
Abstinence Education (P.L. 104-193)	-	*50*	*50*	*50*	*53*	3	6.0%
HCFAC (P.L. 104-191)	*2*	-	-	-	-	-	-
HRSA Program Level	*3,409*	*3,330*	*3,677*	*3,510*	*3,995*	*665*	*20.0%*
IHS:							
Services 2/	1,807	1,835	1,829	1,958	1,941	106	5.8%
Construction 2/	15	39	15	27	40	1	2.6%
Other Facilities	235	248	242	142	262	14	5.7%
Subtotal IHS (B.A.)	2,057	2,122	2,086	2,127	2,243	121	5.7%
Reimbursements	*294*	*303*	*303*	*303*	*303*	-	*0.0%*
IHS Program Level	*2,351*	*2,425*	*2,389*	*2,429*	*2,546*	*121*	5.0%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISCRETIONARY BUDGET: FY 1999 REQUEST TO OMB
(Budget Authority in Millions)

OPDIV	FY 1997 Appropr.	FY 1998 President's Budget	FY 1998 House 1/	FY 1998 Senate 1/	FY 1999 Request	+/- FY 1998 PB	% Change
CDC:							
Sexually Transmitted Diseases	106	111	111	111	133	21	19.3%
Tuberculosis	119	119	119	119	120	1	0.4%
HIV/AIDS	617	634	622	647	647	13	2.0%
Breast And Cervical Cancer	140	142	145	142	143	1	0.4%
Immunization	468	427	440	446	462	35	8.2%
Immunization Program Level	-	*452*	-	-	-	-	-
Heart Disease & Health Promotion	46	61	69	57	151	90	147.9%
Environmental Disease Prevention	43	42	51	51	88	46	109.2%
Preventive Health Block Grant	154	144	155	144	156	12	8.1%
Crime Act Rape Prevention / Education	35	45	45	45	45	0	0.4%
NIOSH	141	148	149	148	154	6	3.8%
Mine Safety And Health	32	32	32	40	32	0	0.4%
Health Statistics (BA)	38	19	38	18	41	22	116.5%
1% Evaluation	*48*	*70*	*48*	*70*	70	-	*0.0%*
Health Statistics Program Level	*86*	*89*	*86*	*88*	*111*	*22*	*24.8%*
Injury / Violence Control	43	49	56	48	69	20	41.2%
Crime Bill Domestic Violence Demos	6	-	-	3	-	-	-
Infectious Diseases	88	112	118	112	169	57	50.7%
ATSDR Program Level	*64*	*64*	*80*	*68*	*87*	*23*	*35.9%*
Buildings And Facilities	31	23	20	23	63	40	173.9%
Prevention Research	-	-	-	-	100	100	-
Other CDC 3/	197	207	219	213	224	17	8.2%
Subtotal CDC (B.A.)	2,302	2,316	2,389	2,368	2,797	480	20.7%
CDC Program Level	*2,416*	*2,452*	*2,519*	*2,508*	*2,956*	*503*	*20.5%*
NIH (B.A.) 3/	12,741	13,078	13,505	13,693	14,856	1,778	13.6%
Fees/Reimbursements	*19*	*24*	*9*	*9*	*9*	(15)	-62.9%
EPA Superfund (NIEHS)	*57*	*49*	*60*	*56*	*49*	-	0.0%
EPA Sci. & Tech./Air Pollution	-	-	*35*	-	-	-	-
ONDCP Forfeiture Fund	*10*	-	-	-	-	-	-
NIH Program Level	*12,825*	*13,151*	*13,609*	*13,757*	*14,913*	*1,762*	*13.4%*
SAMHSA:							
Knowledge/Development/Application	346	298	368	365	322	23	7.8%
Mental Health	*(58)*	*(58)*	*(58)*	*(58)*	*(67)*	*(9)*	*15.2%*
Substance Abuse Prevention	*(132)*	*(84)*	*(151)*	*(151)*	*(90)*	*(6)*	*7.0%*
Substance Abuse Treatment	*(156)*	*(156)*	*(159)*	*(156)*	*(165)*	*(9)*	*5.5%*
Targeted Capacity Expansion	24	67	-	10	124	57	85.6%
Mental Health	-	-	-		*(3)*	*(3)*	-
Substance Abuse Prevention	*(24)*	*(67)*	-	*(10)*	*(91)*	*(24)*	*35.8%*
Substance Abuse Treatment	-	-	-	-	*(30)*	*(30)*	-

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OPDIV	FY 1997 Appropr.	FY 1998 President's Budget	FY 1998 House 1/	FY 1998 Senate 1/	FY 1999 Request	+/- FY 1998 PB	% Change
National Data Collection/ State Infrastructure Development	-	28	15		48	20	71.4%
Mental Health	-	-	-	-	*(10)*	*(10)*	-
Substance Abuse	-	-	-	-	*(10)*	*(10)*	-
Office Of Applied Studies (OAS)	-	*(28)*	*(15)*	-	*(28)*	-	-
Mental Health Performance Partnership	275	275	275	275	305	30	10.9%
Other Mental Health	112	112	118	112	126	15	13.0%
Subtotal Mental Health (Includes KDA, Targeted Capacity Expansion, National Data Collection/State Infrastructure Development)	445	445	451	445	512	67	14.9%
Substance Abuse Performance Partner	1,310	1,320	1,320	1,310	1,405	85	6.4%
Subtotal Substance Abuse (Includes KDA, Targeted Capacity Expansion, National Data Collection/State Infrastructure Development)	1,622	1,627	1,630	1,627	1,791	164	10.0%
Other SAMHSA (Includes OAS)	54	84	71	54	92	9	10.2%
Subtotal SAMHSA (B.A.)	2,122	2,156	2,152	2,127	2,394	239	11.1%
Data Collection (1% Evaluation)	-	-	-	*10*	-	-	-
ONDCP Forfeiture Fund	*11*	-	-	-	-	-	-
SAMHSA Discretionary Prog. Level	*2,132*	*2,156*	*2,152*	*2,137*	*2,394*	*239*	*11.1%*
SA Perform. Part. (P.L. 104-121)	*50*	*50*	*50*	*50*	-	*(50)*	*-100.0%*
SAMHSA Program Level	*2,182*	*2,206*	*2,202*	*2,187*	*2,394*	*189*	*8.5%*
AHCPR:							
AHCPR (B.A.)	96	87	102	78	149	62	71.3%
1% Evaluation	*47*	*62*	*47*	*65*	*62*	-	*0.0%*
AHCPR Program Level	*143*	*149*	*149*	*143*	*211*	*62*	*41.6%*
Financing Offset For 1% Evaluation	*(96)*	*(132)*	*(96)*	*(145)*	*(132)*	-	*0.0%*

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HCFA :							
Medicare Services	1,392	1,426	1,333	1,375	1,623	198	13.9%
Quality Of Care	266	265	264	267	295	30	11.3%
Medicaid/General Fund	77	84	83	78	101	17	20.4%
Balanced Budget Act (Undistributed)	-	-	-	-	*316*	*316*	-
Current User Fees	*16*	*22*	*12*	*12*	*22*	*0*	*0.2%*
HCFA Discretionary Program Level	*1,750*	*1,797*	*1,692*	*1,731*	*2,357*	*560*	*31.2%*
Deduct Offsets	-	-	-	-	*(827)*	*(827)*	-
Deduct Current User Fees	*(16)*	*(22)*	*(12)*	*(12)*	*(22)*	*(0)*	*0.2%*
Subtotal HCFA Prog. Manage. (B.A.)	1,734	1,775	1,679	1,719	1,507	(267)	-15.1%
HCFAC (P.L. 104-191)(MIP) 4/	*440*	*500*	*500*	*500*	*955*	*455*	*91.0%*
HCFAC (P.L. 104-191) 4/	*4*	*1*	*1*	*1*	*1*	*0*	*14.7%*
HCFA Program Level	*2,194*	*2,298*	*2,193*	*2,232*	*3,313*	*1,015*	*44.2%*
FY 1998 Supplemental Costs		*(211)*					
ACF:							
Head Start	3,981	4,305	4,305	4,305	4,634	329	7.6%
Child Care Block Grant	956	1,000	937	963	1,000	-	0.0%
LIHEAP:							
LIHEAP	1,000	1,000	1,000	1,000	1,000	-	0.0%
LIHEAP Emergency Funding	(420)	(300)	(300)	(300)	(300)	-	-
LIHEAP Obligated Contingency	215	-	-	-	-	-	-
Subtotal LIHEAP	1,215	1,000	1,000	1,000	1,000	-	0.0%
Refugee And Entrant Assist...	427	396	418	396	396	-	0.0%
Community Schools	13	13	-	-	13	-	0.0%
Runaway And Homeless Youth	67	74	74	74	74	-	0.0%
Community Services Programs	536	415	537	539	431	16	3.9%
Adoption Initiative	-	21	-	-	10	(11)	-52.4%
Community-Based Resource Centers	33	33	-	33	33	-	0.0%
Child Welfare Services	292	292	292	292	292	-	0.0%
Developmental Disabilities	114	114	109	116	119	5	4.4%
Violence Against Women	74	71	84	78	74	3	3.5%
Social Services Research	44	18	21	21	18	-	0.0%
Social Services Research Mandatory	-	*21*	-	-	*21*	-	0.0%
Social Services Program Level	*44*	*39*	*21*	*21*	*39*	-	*0.0%*
Federal Administration	143	143	143	138	153	10	7.1%
Other ACF	99	99	99	103	99	-	0.0%
Subtotal ACF (B.A.)	7,994	7,994	8,020	8,058	8,346	352	4.4%
Child Support Enforcement/T&TA (@1%) And Federal Parent Locator Service (@2%) (P.L. 104-193)	*9*	*8*	*8*	*8*	*8*	-	*0.0%*
Social Services Research Mandatory	-	*21*	-	-	*21*	-	*0.0%*
ACF Program Level	*8,002*	*8,023*	*8,028*	*8,066*	*8,375*	*352*	*4.4%*

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AoA:							
Supportive Services and Centers	301	291	310	306	311	20	6.9%
Preventive Health	16	16	-	16	16	0	2.5%
Ombudsman and Elder Abuse	-	-	-	-	-	-	-
Pension Counseling, WHCoA, FCoA	-	-	-	-	-	-	-
Vulnerable Older Americans	-	9	-	-	17	7	81.7%
Research, Training and Special Projects	4	4	-	10	15	11	275.0%
In Home Svcs	9	9	-	9	9	0	2.5%
Program Administration	15	15	15	15	18	3	20.2%
Grants To Indians	16	16	16	20	21	5	31.1%
Meals	470	470	470	479	549	79	16.9%
Alzheimer's Initiative	6	8	-	-	6	(2)	-25.0%
Subtotal AoA (B.A.)	836	838	811	854	963	125	14.9%
HCFAC (P.L. 104-191) 4/	*1*	*1*	*1*	*1*	*1*	*0*	*15.0%*
AoA Program Level	*837*	*839*	*812*	*855*	*964*	*125*	*14.9%*
OS:							
GDM:							
Pop. Affairs: Adolescent Family Life	14	14	14	19	15	1	7.2%
Physical Fitness And Sports	1	1	1	1	1	0	21.8%
Minority Health	35	23	23	24	24	1	6.0%
Office On Women's Health	12	13	13	19	13	1	6.0%
Anti-terrorism/OEP	14	10	8	14	19	9	93.8%
Other GDM 3/	102	102	107	104	116	14	13.2%
Subtotal GDM B.A.	178	163	165	180	190	26	16.1%
Policy Research	18	9	14	10	14	5	55.6%
Subtotal GDM & PR	197	172	179	190	204	31	18.2%
1% Evaluation (GDM)	*21*	*21*	*21*	*21*	*21*	-	*0.0%*
HCFAC (P.L. 104-191) (OGC) 4/	*2*	*2*	*2*	*2*	*3*	*0*	*15.0%*
Subtotal GDM & PR Prog. Level	*219*	*195*	*202*	*213*	*227*	*32*	*16.2%*
OIG	35	32	32	32	33	1	4.4%
HCFAC (P.L. 104-191) 4/	*70*	*85*	*85*	*85*	*97*	*13*	*15.0%*
OIG Program Level	*105*	*117*	*117*	*117*	*131*	*14*	*12.1%*
OCR	19	21	20	20	22	2	9.3%
OCA	2	2	-	-	-	(2)	-100.0%
FY 1997 Emergency Supplemental 2/	15	-	-	-	-	-	-
Subtotal OS (B.A.)	267	226	231	242	259	33	14.5%
OS Discretionary Program Level	*288*	*247*	*252*	*262*	*280*	33	*13.3%*
OS Program Level	*359*	*334*	*338*	*349*	*380*	33	*9.8%*

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Financing Offset For 1% Evaluation	*(21)*	*(21)*	*(21)*	*(21)*	*(21)*	*-*	*0.0%*
Social Serv. Block Grant (Non-Add)	**2,500**	**2,380**	**2,245**	**2,245**	**2,380**	**-**	**0.0%**
TOTAL HHS (B.A.)	**$ 34,438**	**$ 34,682**	**$ 35,513**	**$ 35,659**	**$ 38,547**	**$ 3,865**	**11.1%**
TOTAL HHS DISC. PROG. LEVEL	*$ 35,023*	*$ 35,400*	*$ 36,044*	*$ 36,229*	*$ 40,000*	*$ 4,600*	*13.0%*
HCFAC	*$ 518*	*$ 589*	*$ 589*	*$ 589*	*$ 1,057*	*$ 468*	*79.5%*
TOTAL Mandatory Programs	*$ 59*	*$ 129*	*$ 108*	*$ 108*	*$ 82*	*$ (47)*	*-36.4%*
TOTAL HHS PROGRAM LEVEL	*$ 35,601*	*$ 36,118*	*$ 36,741*	*$ 36,926*	*$ 41,139*	*$ 5,021*	*13.9%*

1/ For FDA, the House and Senate columns reflect Floor action. For IHS, the House column reflects floor action, while the Senate column reflects the vote of the full committee. For L/HHS programs, both columns reflect the vote of the full committees.

2/ Includes FY 1997 Emergency Supplemental (P.L. 105-18) providing $3 million to IHS ($1 million to Services and $2 million to Facilities) and $15 million to OS.

3/ Includes March 17 amendment to the President's Budget, transferring $635,000 from the State Department to CDC ($522,000), NIH ($42,000) and General Departmental Management ($71,000).

4/ HCFAC program lines include the amounts requested by the participants for FY 1999. Final amounts will be negotiated with the Department of Justice and agreed upon by the Secretary and Attorney General.

HHS FTE
FY 1997-1999

		FY 1997 Budget Target	FY 1998 Request	FY 1999 Request
FDA		9,180	9,288	9,288
HRSA	a/	1,890	1,888	1,966
Stat. Exempt		*143*	*152*	*152*
IHS		14,415	14,415	14,608
Stat. Exempt		*5*	*5*	*5*
CDC		6,408	6,744	6,791
Stat. Exempt		*45*	*60*	*60*
NIH		15,153	15,153	15,960
Stat. Exempt		*14*	*14*	*33*
SAMHSA		592	592	612
Stat. Exempt	*b/*	*61*	*92*	*92*
AHCPR		252	252	282
HCFA	c/	4,085	4,085	4,381
ACF		1,669	1,584	1,620
AoA		150	150	150
OIG		1,014	1,203	1,318
OCR		242	242	260
DM		1,215	1,237	1,306
PSC		1,097	1,144	1,106
Total Ceiling		57,361	57,977	59,648
Stat. Exempt		*268*	*323*	*342*
Total Employment		*57,630*	*58,300*	*59,990*

a/ The FY 1999 request includes restoration of 100 FTEs for FOH.

b/ The 92 Statutorily Exempt FTE reflect the staffing levels for St. Elizabeth's Hospital as agreed upon with the Washington, DC government.

c/ HCFA's request for increases in FTE for FY 1999 are based on new work mandated by the Health Insurance Portability and Accountability Act and the Balanced Budget Act of 1997.

National Health
Research Trust Fund

A NATIONAL HEALTH RESEARCH INITIATIVE

INTRODUCTION

Health research has made enormous contributions to improving human health. Many of the diseases, injuries, and disabilities that our parents and grandparents faced a generation ago can now be prevented or treated. Mortality from coronary artery disease and stroke has been halved, and cancers like childhood leukemia are no longer fatal. Smallpox has been eradicated and indigenous polio has been eliminated in the Western Hemisphere. The incidence of childhood vaccine preventable diseases is at the lowest level ever. Other preventive interventions such as the use of seat belts and the cavity fighting effects of fluoridated drinking water are part of everyday life. Because of antibiotics, once fatal illnesses such as scarlet fever, and hearing loss resulting from childhood ear infections are problems of the past. Research in prevention and health services has enabled these research discoveries to be translated into improved health. Today, we are at the brink of discoveries that have the potential to revolutionize the prevention, diagnosis, and treatment of disease as well as the delivery of quality health care in America and around the world.

Franklin Delano Roosevelt (FDR) captured the essential nature of health research when he said, "The total defense which this Nation seeks involves a great deal more than building airplanes, ships, guns, and bombs. We cannot be a strong Nation unless we are a healthy Nation. And so we must recruit not only men and materials but also knowledge and science in the service of national strength." This goal, to increase knowledge and science in the service of national strength and national health, is as worthy today as it was in 1940 when FDR first spoke these words.

The Federal research enterprise has been called the "jewel in the crown" of public sector investment. Today, new strategies for the prevention and treatment of disease, never before thought possible, are within our reach. However, the discretionary caps enacted in the Balanced Budget Act of 1997 do not even provide for inflation increases between 1998 and 1999. As a result, other vital programs would suffer cuts in real terms to maintain even current funding levels for health research. How, then, can the U.S. maintain its leadership in health research, apply this capability toward meeting pressing public health problems, and still meet its mandate to reduce the deficit?

A NATIONAL HEALTH RESEARCH TRUST FUND

A new mechanism is needed to fund the substantial growth in health research warranted by today's unprecedented convergence of scientific opportunity and public health need. Accordingly, the Secretary of Health and Human Services (HHS) proposes the establishment of a National Health Research Trust Fund. The Trust Fund would provide a mechanism for those who benefit from health research to pay for a portion of the cost of its expansion, consistent with the basic concept of user fees. The Trust Fund income would be generated from a

1.35 percent assessment on health insurance premiums and interest on balances. Funds would be allocated through the annual appropriations process to increase research funds above the 1998 level. The discretionary spending caps would be increased by the amount appropriated from the Trust Fund in order to avoid profound cuts in other key Presidential investments.

There is considerable bipartisan Congressional support for a significant expansion of health research. This year, Senators Mack and Gramm proposed legislation that authorized a doubling of Federal funding for basic science and medical research over a 10-year period. Similar to the Secretary's FY99 proposal discussed herein, Senators Harkin and Specter introduced legislation to create a National Fund for Health Research to substantially increase funds for the National Institutes of Health (NIH). During Senate debate on the 1998 Budget Resolution, 98 Senators voted for a "Sense of the Senate" resolution that called for a 100 percent increase in appropriated funds for NIH research over the next five years. Forty-six Senators later voted for a proposal by Senator D'Amato to create a National Fund for Health Research to be financed by savings from the Medicare and Medicaid programs resulting from the Balanced Budget Act. Given increasing restrictions for discretionary spending, we can expect even greater support for dedicated financing of a health research initiative.

The proposed Trust Fund Initiative would finance expanded health research at the NIH, the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Policy and Research (AHCPR). Specifically, this initiative seeks to increase NIH funding by 50 percent over five years, to double it within 10 years, and to build substantial AHCPR research and CDC prevention research programs. Research investment increases would total $23 billion over five years and $84 billion over 10 years. As proposed, the Trust Fund would finance the entire 1999 increase and three-fourths of the total 10-year increase. The remainder would be funded by 3 percent increases in annual Congressional appropriations, starting in 2000. The Trust Funds would be made available through the annual appropriations process.[1] Specifically, in 1999:

- NIH's budget would grow by 10 percent over the final 1998 appropriations level. This funding level would allow NIH to increase support for laboratory, clinical, epidemiological, and health services research, which would lead to a better understanding of the biological and behavioral basis for disease, and would provide the basis for improving the prevention and treatment of human disorders. This increase would also allow NIH to fund approximately 1 of every 3 applications, thereby reaching the optimum success rate of 33 percent.

- CDC would be increased by $100 million to create within academic health centers, schools of public health, and other public and private research institutions, the capacity to conduct population-based, prevention research needed to protect and enhance the health of the American people--a capacity most of these organizations now lack. With continued funding over the next five years, it would build laboratory infrastructure, provide training programs for prevention researchers, and develop access to integrated information systems at the Federal, State, and local levels.

- The $62 million increase for AHCPR will lead to an expansion of the Nation's capacity to improve and safeguard the quality of patient care in daily practice. This investment will develop practical strategies for overcoming barriers to the best use of effective therapies that all too often are now used inconsistently. It will provide patients with the information they need to make informed choices and provide clinicians with science-based evidence on: what works best and is most cost-effective for different patient groups; the potential trade-offs and side effects of alternative treatments; and new approaches to assess and improve the quality of patient care.

THE ROLE OF RESEARCH IN THE CHANGING WORLDS OF MEDICINE AND HEALTH CARE

Why do we call for such a significant expansion of health research now? There are three converging factors that signal the need for an aggressive effort in health research today. First, over the next several decades, social and demographic changes will stress both health care and entitlement programs. The aging of the baby boom generation will increase the incidence and prevalence of chronic diseases, and preventing or delaying their onset can have significant social and economic benefits. The growing diversity of the U.S. population makes it imperative to address the specific health needs of minority and socioeconomically disadvantaged populations. Infectious diseases, as evidenced by the HIV/AIDS pandemic, the emergence of drug-resistant forms of tuberculosis and other antibiotic-resistant diseases, and the widespread prevalence of malaria, represent pressing global health problems.

Second, the traditional health care system has been dramatically transformed by the rise of managed care organizations that are pursuing the long-sought goal of cost control in the face of competing demands for accountability and high-quality care.

Third, the very nature of health research is changing and, along with it, the practice of medicine and the focus on prevention. Advances in molecular and cellular biology, neuroscience, and imaging technologies, among others, are dramatically altering how we study health and how we approach the prevention and treatment of disease.

Health research is a continuum which encompasses laboratory, clinical, epidemiologic, behavioral, social, health services, and outcomes research. Laboratory research leads to fundamental discoveries about life processes and is the foundation for virtually all progress in the diagnosis, treatment, and prevention of disease. Clinical research translates laboratory findings into innovative treatments, while epidemiology explores the origins and prevalence of disease within populations. Behavioral and social research provide answers to fundamental questions about personal choices and environmental conditions that lead to disease, injury, and disability, and explores ways to help individuals and communities understand and change risky behaviors. Research on disease prevention and control reduces the human toll and economic burdens of disease tomorrow. Finally, health services research holds the promise of increasing

the effectiveness, quality, and efficiency of patient care, all vital to a sound health care delivery system. Improvements in health are dependent on this chain of research. One weak link can reduce the likelihood that major findings in another arena will benefit the public.

This continuum of research is supported and/or conducted by three agencies within HHS. The NIH supports and conducts medical research into the causes, diagnosis, prevention, and treatment of diseases and disabilities and promotes the acquisition and dissemination of medical knowledge to health professionals and the public. The CDC supports and conducts research related to the prevention and control of disease, injury, and disability in individuals and families, but especially in communities. The AHCPR supports research on how the health care system works, how it can be improved, and how the implementation of medical knowledge affects the effectiveness, efficiency, cost, and quality of health care.

Health research also plays a vital role in the Nation's economic health both directly and indirectly. The $50 billion biotechnology industry is the progeny of research in molecular biology. The pivotal discovery of two classes of enzymes, one class that cuts DNA and another class that joins DNA fragments, have allowed researchers to splice together DNA from different sources using this "chemical tool kit" to produce drugs. Today, the biotechnology industry produces large quantities of valuable proteins, such as human insulin and hepatitis B vaccine, which are used to effectively treat or prevent a variety of diseases and conditions; 33 approved biotechnology drugs are on the market, and 494 others have reached clinical testing stages. Finally, the nation's economic health is dependent on a workforce whose health is maintained effectively, and by a health care system that uses its limited resources efficiently.

Overall, these changes impose profound new challenges to future advancements in health research and the practice of public health and delivery of care that must both be understood and met, if we are to ensure the health of our Nation. The American people have expressed strong and sustained support for health research and the benefits it brings to them, their loved ones, and future generations. As we approach the year 2000, the confluence of the changing nature of both the world and modern laboratory biology and clinical, prevention, epidemiologic, and health services research have created a unique opportunity. Our personal health and the Nation's health require that we not be timid about this effort. For these reasons, we call for a bold, new investment in health research. This proposal puts forth the rationale for a major expansion of these vital efforts.

EXPANDING THE RESEARCH EFFORT

Much of health care today still involves treating the symptoms of disease without understanding the underlying causes of the disease and how they might be prevented. Biological and environmental determinants of health, including the biological, physical, and social factors that play a role in the onset and progress of diseases and disability are not fully understood. To the same extent, much of modern health care delivery is not based on research about the most effective and efficient means of delivering care or preventing disease.

While we herald advances in diagnosis, treatment, and prevention daily, there remain enormous challenges on all fronts. Although the outcome of much of health research cannot be predicted, we know that expanded efforts yield expanded results. There are several broad areas of research which show great promise for addressing public health needs and yielding medical advances that will lead to dramatic improvements in human health.

New emphasis on the biology of brain disorders reflects the extraordinary rate at which the neurosciences, with strong support from the fields of molecular genetics, imaging, and cell biology, is growing. Advances in neural development and neurodegeneration, especially in Alzheimer's disease, Parkinson's disease, mental illness, and traumatic injury to the brain and spinal cord are but a few examples of the promise of this field.

Innovative approaches to pathogenesis, resulting from more precise understanding of genes, proteins, and cells, are transforming traditional descriptions of disease processes. For example, research in this arena will uncover new mechanisms of carcinogenesis and cardiovascular disease and will lead to better understanding of osteoarthritis, birth defects, and growth disorders. These new insights into pathogenesis are, in turn, stimulating new preventive strategies such as the development of new vaccines against a variety of pathogens or the consumption of folic acid by women of childbearing age to prevent spina bifida and anencephaly in their babies.

New avenues for the development of therapeutics—the result of efforts in chemistry, structural biology, genetics, and cellular and molecular biology—are providing new means to design therapies for a variety of diseases. Drugs and biologics to combat cancer and drug and alcohol addiction, and methods of bioengineering to repair or regulate tissues are ripe for discovery.

In the realm of genetic medicine, the rapid progress of the Human Genome Project, a growing understanding of the genomes of other species, and new methods for the manipulation of genes are swiftly changing concepts of disease and strategies for its control. The real possibilities of being able to identify the inherited mutations that contribute to cancer risk, developmental abnormalities, immunodeficiencies, and mental and neurological diseases (such as epilepsy, stroke, autism, and sensory disorders) and to identify effective preventive interventions deserve significant new effort.

Recent advances in basic biology, genetics, diagnosis, and health care are closely linked to the development of new research instruments and computer hardware and software. Improvements in the detection of early cancers and technologies to better visualize the living body in health and disease states will provide a wealth of knowledge that can lead to new and improved diagnostics, treatments, and prevention strategies.

Expanded efforts are also needed to strengthen epidemiological research that links diseases to environmental and occupational exposures, to expand exposure assessment capability in the U.S. population, to develop biomarkers of exposure and effect, and to incorporate our

evolving knowledge of how individual differences affect responses to environmental and occupational exposures. Escalated research efforts on injury prevention could lead to reduced disabilities. Many risk factors for chronic diseases and conditions, such as smoking, alcohol consumption, diet and activity patterns, injuries, and sexual behavior, can be prevented or mitigated by additional investments in behavioral and social research. The expansion of research in behavioral and social sciences will lead to scientifically-informed public policy and, ultimately, improved national health and productivity.

Health research includes the science of clinical practice and of health services as well, especially to translate both clinical advances and new forms of organizing and financing care into higher quality health care and, ultimately, better health. Health services research can identify new ways of measuring health outcomes and applying them in the critical assessment of which services work best and when. These measures of improved outcomes can be used not only to use limited health care resources more effectively, but also to assess and improve the quality of care. New information and technologies will give health plans, physicians, and patients the tools and the information they need to understand and compare this information on outcomes and quality and on the costs and cost-effectiveness of care. By identifying which services are effective and when in ordinary settings and by helping the health marketplace understand the consequences and implications of the myriad choices it faces, health care innovations can be integrated into an efficient and high-quality health care system. Increased research on the health care delivery system and how it finances, organizes, and provides services will yield critical insights into the gaps between knowledge and practice.

SECURING A SOUND INFRASTRUCTURE FOR RESEARCH

Medical innovation and public health interventions are the foundation upon which America's past successes in improving health care were built and future hopes lie. Public health research is dependent upon an adequate infrastructure, i.e., a trained cadre of multidisciplinary public health researchers with "state-of-the-art" computerized information systems and laboratory facilities. Medical innovation is dependent on assembling the most creative minds and giving them access to the most advanced biomedical and computational instrumentation and state-of-the-art laboratory facilities.

The changing frontiers of science require a continuing supply of personnel prepared to understand the implications of current discoveries and apply them to future research opportunities. To address the human resource needs, the Nation must be committed to strengthening research training and career development and ensuring the recruitment and retention of under-represented groups into science.

While research has enlightened, it has also revealed the complexity of disease and its etiology. To solve the complex health problems that have their origins in social, behavioral, environmental, and/or biological factors, health research must also become more multidisciplinary. For this reason, today's research team must include a cadre of investigators

armed with a breadth of knowledge and a variety of skills. Many advances in diagnostics, treatment, and prevention make use of real time imaging and high speed data analysis and are the result of the work of engineers, physicists, and computer experts. Research efforts must also include, for example, sociologists, anthropologists, economists, and environmental and industrial engineers. In addition, growing needs to translate laboratory advances into applications that benefit the public require innovative training programs for new and mid-career clinical, public health, and health services investigators. Fellowships for prevention researchers, who will be conducting population-based studies in communities, are also needed. Implementation and application of laboratory advances are a result of clinical and public health scientists and those whose evaluation research has tested the best way to deploy these scientific advances. In order to sustain the pace of this progress, more of these individuals need to be trained and recruited into the field of health research, at sufficient salaries to attract and retain them.

Advances in health research also will require timely access to high-quality data on a wide range of indicators of health status, risk factors, and services. Because researchers will be studying problems in communities across the country, information must be made available to them about the populations in which they are working. An integrated health information system is needed to provide researchers with access to data and information.

Assuring further medical progress requires a sound and modernized physical infrastructure. Accordingly, continuing investment and support in such infrastructure elements as new buildings and refurbished facilities, and state-of-the-art instrumentation and information technology must be a key component of the Nation's overall strategy for sustaining its capacity for world class health research. This infrastructure needs to encompass traditional academic partners and State and local health department laboratories. A 1994/95 National Science Foundation (NSF) report found that the majority of the nation's health research facilities do not meet regulatory and environmental standards, that many have deteriorated so badly that they must be replaced, and that construction costs to meet the changing technological and regulatory requirements for research facilities have increased exponentially. Many institutions cannot generate sufficient funding from other sources to adapt existing space or add new space for health research. Based on the 1996 NSF survey at academic institutions, medical research space needs totaling $3.6 billion have been deferred due to lack of funds.

With $1 billion in resources from the Trust Fund, to be available until expended, $1 billion in matching funds, and $1 billion in guaranteed loans, this proposal would generate $3 billion to eliminate three-fourths of this backlog over the next five years. CDC would administer up to $200 million of these funds over the five years for public health research facilities. This would be a short-term, intensive effort by NIH and CDC to rebuild our Nation's research capacity. At the completion of this five-year effort, Trust Fund monies would be devoted entirely to research.

It is not a coincidence that the pace of health research has matched the stride of the technological revolution. Technology, including remarkable advances in computational science, have paved the way for research efforts, like the Human Genome project, that just a decade ago would not have been possible. Expanded investments in medical instrumentation are needed to take advantage of technology developed in other fields for other purposes and for the development of specific instrumentation that can be applied to modern biological inquiry. Integrated health information systems are also crucial for monitoring trends in disease, injury, and disability, identifying new and emerging health problems, and monitoring access to and quality of health services.

Many of the stunning innovations in sophisticated, but often costly, research technologies go far beyond the capacity of all but a handful of institutions to purchase, construct, or maintain. As these sophisticated instruments become more and more a part of the essential tools of research, it is vital that investigators have access to shared resources—core facilities, tissue and cell banks, animal research centers, computation centers, information systems—necessary to conduct modern research. Centers for shared resources provide the most cost-effective way to support complex research, while speeding the translation of ideas into patient care and cures. Today, 60 centers encompassing more than 7,000 investigators use shared resources centers. This program needs significant expansion to ensure broad access to these and other research resources and to create efficiencies that makes the research dollar go further, while providing critical resources to all scientists.

Laboratory capacity and expertise are maintained at CDC to support a national network for surveillance and emergency public health response. That research capacity and expertise, which are not needed or effectively provided in every state or region, is maintained at CDC to provide necessary response, investigations, and training. This intramural capacity must be continually maintained and enriched. For example , CDC's Biosafety Level 4 maximum security laboratory, the only "civilian spacesuit" laboratory in the country, is currently 10 years old and will soon need to be replaced. Without this laboratory investment, CDC will be unable to meet the domestic and global microbial public health challenges of the next century. In addition to this high-containment lab, other CDC labs have not been appropriately modernized since the 1960s.

SUMMARY

The words "the past is prologue to the future" have been used in many venues. Nowhere are they more appropriate then when they are applied to health research. The rate of improvement in the "practice" of medicine and public health is limited by the rate of new discovery. And because we cannot know when major discoveries will occur or what opportunities they will create, our health research investment portfolio must be diverse—encompassing many scientific disciplines and a wide range of diseases and conditions. Only in this way can advances in health research be converted into benefits for our citizens.

Present and future successes in health research depend on well-trained, multidisciplinary scientists, an energized network of academic and government laboratories, innovative pharmaceutical and biotechnology industries, and most importantly, sustained support of research by the Federal government. We have an obligation to ensure a strong scientific infrastructure, with a high quality workforce and superior research facilities.

Today, health research is moving forward at an unprecedented pace. We are revolutionizing our understanding of the nature of health and of disease as well as the behaviors and environmental factors that influence them. This is a result of decades of investment in innovative basic science, epidemiology, behavioral sciences, and health services research and extraordinary developments in genetics, immunology, molecular biology, and many other fields. Transforming these findings into effective interventions will require a concomitant investment in clinical and public health research. More research is needed on quality of health care services; on the prevention and treatment of diseases, injuries, and disabilities; and to identify gaps between knowledge and practice and test the most effective ways to address those gaps. Given the remarkable rate of discovery and the ever diminishing time between a finding in basic research and changes in clinical and public health practice, America cannot afford to slow this vital work.

[1] FINANCING THE NATIONAL HEALTH RESEARCH INITIATIVE

Investments to be financed: The National Health Research Initiative seeks to double NIH over 10 years, and build up CDC and AHCPR research programs to an appropriate level. Research investment increases would total $23 billion over five years and $84 billion over 10 years. In 1999, NIH would grow by 10 percent over the final 1998 appropriations level, CDC would increase by $100 million, and AHCPR would expand by $62 million. All of the 1999 increase, and three-fourths of the 10-year increase would be funded through the National Health Research Trust Fund. The remainder would be funded by 3 percent annual increases in basic appropriations in 2000 and subsequent years that generally cover the effect of inflation on research costs.

Income sources: The Trust Fund would provide a means for those who benefit from health research to contribute to its expansion, consistent with the basic concept of user fees. The Trust Fund income sources would be a 1.35 percent assessment on insurance premiums and premium equivalents (such as self-insurance costs) and interest on balances that would build up in the first few years. This would cover all major types of insurance with the exception of Medicare Part B premiums. This assessment would provide $4.8 billion in Trust Fund income in 1999, $27 billion over five years, and $63 billion over 10 years. Interest on balances would provide an additional $2 billion over five years, and $6 billion over ten years.

Appropriations control & discretionary cap adjustments: The allocation of Trust Funds among the research agencies would be set through the annual appropriations process. Trust funds would be available to the Appropriations Committees only if they maintain regular funding at or above the 1998 level. This would prevent the Trust Fund from being used to supplant current appropriations and ensure that the assessments on insurance premiums fund increases in research investments. In addition, the proposal seeks to avoid displacing other key investments such as Head Start. The discretionary spending caps would be raised by the amount appropriated from the Trust Fund to ensure that the Appropriations Committees can provide the added research funding without reducing such other key investments.

Bob Nash

Children's Health

CHILDREN'S HEALTH INITIATIVE

The Nation is currently faced with large numbers of children without health insurance coverage or an established source of primary care. In addition, many of the children are at risk for health conditions or injuries which are preventable through public health measures. Recognizing the complexity of the problem, the Secretary has charged the components of HHS to develop a comprehensive initiative that brings together the resources of the Department to improve the health of America's children. The overarching goal of this initiative is to improve the health of America's children by increasing the number who are insured and have a "health home" in a healthy community.

In implementing this initiative, HHS will work in partnership with States to accomplish the goals of outreach and the new insurance program. We will also work in close partnership with other Federal agencies, consumers, advocacy groups, communities, tribes, health and human services providers, private sector organizations, the faith communities, and other interested groups.

The following concerns, which contribute to the poor health of children, are interrelated and call for a comprehensive approach:

- In 1995, 14 percent of all children--an estimated 10 million children--were not covered by health insurance and were either ineligible or not enrolled in publicly financed medical assistance programs. These children resided in every community in every state. While most of these children were members of working families, nearly three million were estimated to be eligible for Medicaid.

- Studies show that compared to their insured counterparts, uninsured children are less likely to access primary care services and are at increased risk for receiving lower quality care.

- As a result of their inadequate health care, children without health insurance are more susceptible to disease and experience more severe consequences from injury than their insured peers.

Due to the complexity of the problem, no single solution exists. Providing children with health insurance is an important first step toward improving the health of this population. Providing health insurance coverage by itself, however, is not sufficient to achieve improvements in our children's health. We must also increase the number of children who receive appropriate health care services and bring to bear the health benefits associated with community-based prevention strategies. Experts agree on the importance of early intervention, since the result is less illness and disability, and more learning, better development and increased productivity.

In an effort to improve the health of children, and to ensure the inclusion of those prevention strategies that are most important to this population, the Children's Health Initiative proposes a multi-year strategy with broad participation. The proposed strategy is a pragmatic one of building on existing and proven models while experimenting with a few promising new approaches. The Initiative will employ a comprehensive strategy to improve childrens' health by:

- **Expansion of Health Insurance Coverage** - through the recently enacted State Children's Health Insurance Program.

- **Outreach to Medicaid Eligible Children** - working with States and other partners to enroll Medicaid-eligible children not currently enrolled.

- **Identification of a Health Home and Systems Capacity Building** - to assure access to services for newly insured or enrolled children through a "Health Home."

- **Strengthening Community-Based Programs for Children**: to provide for population-based public health initiatives, such as immunization and injury prevention.

Budget Assumptions

Our proposal includes $4.275 billion under the Balanced Budget Act for the new Children's Health Insurance Program, plus approximately $1.9 billion in discretionary funds, which includes incremental funds for FY99 of $258 million.

The State Children's Health Insurance Program provides for approximately $24 billion for FY98 - FY02, and about $50 billion over 10 years. The new legislation lays out the total allotments for this program. For the next five year period, these are as follows:

FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
$ 4.275 B	$4.275 B	$4.275 B	$4.275 B	$3.15 B

It is estimated that over time as much as $4 billion may be used to cover the cost of changes made in the Medicaid program which are intended to increase coverage of children. The costs of the following changes are to be attributed to the total funding limits:

- States are required to maintain Medicaid eligibility for children who are no longer eligible for the Supplemental Security Income (SSI) program as a result of the new definition of childhood disabilities.

- States are permitted to provide a full continuous 12 months of Medicaid eligibility for children.

- States are permitted to offer "presumptive eligibility" to children.

- States are permitted to claim an enhanced match for covering the older "phase-in" children.

- Medicaid enrollment of children will increase as a result of outreach activities.

- Special projects for children:

  - $30 million a year for FY98-FY02 for research on Type I diabetes
  - $30 million a year for FY98-FY02 in support of prevention and treatment services for diabetes in Indians.

In addition to the amount in the budget agreement, we are proposing increases in discretionary spending of approximately $258 million in FY99 for selected programs which contribute to the overall initiative.

Proposal for Intensive State Partnerships

Every State is expected to participate in the Children's Health Insurance Program. In addition, we anticipate working with a select group of states on a more intensive basis. This more intensive partnership would focus on those components of the initiative which focus on Medicaid Outreach to Medicaid-eligible children and the effort to link each newly enrolled or insured child with a Health Home. We propose to start this on a limited basis, and depending on the level of success, expand the rate of participation.

Given the nature of the theme on Strengthening Community-Based Programs, many of these efforts (e.g., immunization) are ongoing in nearly every state. These efforts may be further intensified or integrated in participating states.

The following page lays out total projected funding for FY99 for the Children's Health Initiative. It reflects the FY99 Department request as well as the increment over the President's Budget for FY98.

Children's Health Initiative
($ in 000's)

Agency/ Program	FY 1997 Appropriation	FY 1998 Pres. Budget	FY 1999 Department Request	Incremental Request +/- PB
HCFA:		$4.275 billion in Reconciliation Act.	$4.275 billion in Reconciliation Act.	
(1) State Children's Health Insurance Program				
(2) Administrative Funding:				
(a) Insurance Expansion (New Law)		FY98	6,519	6,519
(b) Medicaid Outreach (Current Law)		supplemental for	1,998	1,998
© Pediatric AIDS Init. (Current Law)	-	admin. costs	2,000	2,000
Subtotal		pending	10,517	10,517
HRSA: Health Home and Systems Capacity				
(1) Primary Health Care	346,000	349,000	411,500	62,500
(2) Maternal and Child Health Block	681,000	681,000	731,000*	44,000
(3) Healthy Start	95,982	95,982	170,982	75,000
Subtotal	1,122,982	1,125,982	1,313,482	181,500
CDC: Community-Based Health				
(1) New Born Hearing Screening	-	-	3,000	3,000
(2) Fetal Alcohol Syndrome	3,000	3,000	3,000	-
(3) Immunization	20,000	20,000	20,000	-
(4) Folic Acid	0	0	7,000	7,000
Subtotal	23,000	23,000	33,000	10,000
AHCPR: Health Home Definition and Data Collection	-	-	6,500	6,500
SAMHSA: Health Home and Community-Based Health				
(1) Starting Early/Starting Smart	6,630	6,630	6,630	-
(2) Children's Mental Health Services	69,896	69,927	79,927	10,000
(3) Vulnerable Populations	-	-	7,000	7,000
(4) HIV/AIDS Prevention	-	-	3,000	3,000
(5) Public Awareness Campaign	-	-	4,000	4,000
(6) MH Early Intervention Models	-	-	2,400	2,400
(7) Fetal Alcohol Syndrome	-	-	5,000	5,000
(8) Substance Exposed Children Treat.	23,400	8,632	5,491	(3,141)
Subtotal	99,926	85,189	113,448	28,259
Indian Health Service: Health Home	373,842	387,000	407,000	20,000
NIH: Community-Based Health	1,200	1,280	1,535	255
OCR: Adoption and Foster Care Non-Discrimination Provisions Enforcement	-	500	1,400	900
Initiative Total: Discretionary Components	1,620,950	1,622,951	1,886,882	257,931

*Includes $6 million tied to Quality Initiative

With regard to funding by theme, the following table provides an overview summary:

($ in 000's)

Component	Agency	FY 1998 Pres. Budget	FY 1999 Department Request	Increment over Pres. Budget
I. and II. Insurance Expansion and Medicaid Outreach Plus administrative funding for insurance expansion (new law); Medicaid Outreach (current law); and Pediatric AIDS initiative (Current law)	HCFA	$4.275 billion in Reconciliation Act FY98 supplemental for administrative costs pending.	$4.275 B in Reconciliation Act 10,517	10,517
III. Health Home and Systems Capacity	HRSA, IHS, AHCPR, OCR, SAMHSA	1,590,039	1,814,939	218,900
IV. Strengthening Community-Based Systems	CDC, HRSA, SAMHSA, NIH	32,912	61,426	28,514
Total: Discretionary Funding		1,622,951	1,886,882	257,931

* Includes $6 million tied to Quality Initiative.

Descriptions of Budget Themes

I. INSURANCE EXPANSION

The new legislation establishes the State Children's Health Insurance Program under a new Title XXI of the Social Security Act. States are given a choice in how they choose to participate in the program. Each state may choose to spend its allotment through:

- a State designed plan; or
- through an expansion of its Medicaid program above current state eligibility requirements for coverage of children; or
- a combination of both.

Among major provisions:

- Each participating State will submit a plan to describe its approach to expanding health insurance coverage to children. The plan will describe eligibility standards, use of cost-sharing and performance goals.

- Each state is guaranteed a fixed allotment based on a blend, over time, of its percentage of children in the nation who are uninsured and its percentage of children who live in families with income less than 200 percent of the poverty level.

- For States selecting the grant program, States may choose one of three benefits minimums:

  - Plan equivalent to benchmark plan.
  - Plan with the same actuarial value as benchmark plan.
  - Secretary-approved plan.

- Benchmark plans include:

  - FEHBP Blue Cross/Blue Shield PPO Option.
  - State employee health plan that is generally available.
  - Most popular HMO in the state.
  - For New York, Florida and Pennsylvania, their current state-only programs' benefit plans.

- Medicaid Approach: With the Medicaid approach, states may receive additional Federal funds to expand Medicaid coverage of children above the level of Medicaid eligibility in their states as of April 15, 1997. The enhanced match will apply to the costs of covering children in the expanded eligibility category until the allotment for the year is exhausted. Once the allotment is exhausted, the regular Medicaid matching rates will apply.

HCFA and HRSA, in cooperation with other participating agencies, are in the process of carrying out a detailed legislative implementation plan.

II. OUTREACH

The legislation provides that limited state funds (up to 10 percent) may be used for outreach and administrative costs. From the Federal perspective, we are interested in both outreach to Medicaid eligible children and to other groups of uninsured children. A major component of this initiative will focus on Medicaid Outreach, which is directed at identifying those children who qualify for Medicaid but are not currently enrolled and assisting them to obtain Medicaid coverage. Current reports on uninsured children suggest that a large number of the 10 million children who lack health insurance could receive the coverage they need simply by enrolling in Medicaid.

State Roles: States are the primary implementers of an initiative to enroll more children into Medicaid. States have developed many innovative methods to address barriers to health care coverage including Medicaid. Barriers to Medicaid eligibility such as complicated eligibility application forms, lack of knowledge on the part of parents about the possibility of Medicaid

eligibility for their children, and the sometimes insufficient amount of resources allocated to conducting an aggressive outreach effort are being addressed by the States. While local governments and communities are important contributors to any successful outreach effort, State governments are uniquely positioned to provide implementation leadership, including the promotion of collaborative efforts among relevant State agencies serving low-income populations.

Federal Roles: The Department of Health and Human Services can work in partnership with the States to accomplish the goals of Medicaid outreach. We can serve as a clearinghouse for information on outreach efforts. At present, we are surveying Medicaid agencies across the country to learn about States' experiences in conducting outreach to bring people into the Medicaid program. We are also surveying other Federal Agencies, such as the Departments of Education and Labor, to learn about their experiences in outreach related to other programs serving low-income populations. DHHS also intends to provide guidance on other issues, such as ways for school-based clinics to qualify for Medicaid payments, how States can claim Federal share of the Medicaid cost of outreach, and how child care centers can be used as vehicles for conducting Medicaid outreach.

We are prepared to serve as a facilitator for bringing other partners into the outreach effort, including a variety of private and public entities committed to improving children's health. We will systematically assess programs within DHHS' purview to identify Medicaid outreach opportunities. We will work intra-departmentally to strengthen linkages among federal programs, such as Medicaid, MCH, WIC, Head Start, etc., to help promote enrollment and reduce unnecessary barriers. In accord with States' desires for outreach partners, we can initiate invitations to national representatives of child advocacy organizations to collaborate in outreach planning efforts in individual States. The specific details on how to conduct outreach within a given State are clearly within the States' discretion; we stand ready to provide additional assistance to the extent that the State welcomes it.

Outcome: The desired outcome of this strategy is directly linked to the purpose of Medicaid outreach--to find those children eligible for Medicaid and enroll them in the program. As partners in this initiative, States, undoubtedly will, want to know to what extent their outreach efforts have yielded increased Medicaid enrollment for eligible children. We want to work with States to assure that there is a data tracking system which can measure the trends in enrollment of various targeted groups of children.

III. HEALTH HOME AND SYSTEMS CAPACITY

As private and public health insurance coverage is extended to more children, purchasers of care want to assure that the care they are buying is of high quality and is appropriate. The proposed approach to doing this is to assure that each such child is enrolled in and receives care from a quality health home. By "health home," we mean a source of coordinated, continuous and family-centered care, which is able to manage or facilitate most aspects of a

child's health care. It builds off the work of the American Academy of Pediatrics, which has worked at defining and promoting the concept of a medical home. The view that children (and others) benefit from having a health home is not new. The American Academy of Pediatrics developed a definition of a medical home which states that:

> *...the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them.*

A major concern is that as health insurance coverage or enrollment in Medicaid is increased, problems of access to quality care for children still exist and need to be addressed. Due to lack of capacity in certain rural and inner city areas, or provider reluctance to accept additional Medicaid-eligible children, it is essential that families and their children are linked to a high-quality health provider. For some, this will be accomplished through enrollment in a managed care plan that links children and their families to a specific provider and set of appropriate services. For others, primary care physicians or well-organized primary care health centers will provide a health home. Strong linkages and partnerships between the public and private sectors need to be developed, so that an early connection is made between the effort to enroll children and the availability of services.

A variety of program components are contributing to the effort to develop a Health Home for children newly covered by health insurance or enrolled in Medicaid, and to build appropriate systems capacity. Major program efforts are discussed briefly below:

Primary Health Care

The primary health care programs within HRSA, which include the Primary Care Health Centers, school-based centers, and the National Health Service Corps, are working to provide such a Health Home and to expand systems capacity. For FY99, their participation in this initiative is designed to address the health needs of additional children by:

- developing the capacity of communities to provide health homes for children through Health Centers and the National Health Service Corps; and

- improving and expanding outreach strategies to link children with these health homes.

HRSA's efforts to build additional capacity for serving children are important to the success of the Administration's initiative, since insurance coverage alone will not assure the availability of primary health care services or access to providers for children in many communities. In

many communities, private providers will be reluctant to accept additional Medicaid eligible children. Other communities have neither the facilities nor the providers to deliver care to additional children.

The $62.5 million increment will be targeted to the development of additional Health Center sites, including sites for homeless children and school-based health care services, and for expanding capacity by increasing staff and space to provide a health home for both newly insured children and those who will remain uninsured. With the requested funds, HRSA will support the provision of comprehensive primary health care services, as well as those services not generally covered by insurance, such as outreach and enabling services (e.g., transportation, translation, case management) to an additional 600,000 children.

Maternal and Child Health Block Grant

Under the Maternal and Child Health Block Grant, particular emphasis will be focused on increasing outreach to enroll children in Medicaid or private insurance coverage and ensuring that newly enrolled children have access to a quality health care home. Among program efforts that will be undertaken:

- Outreach activities to help find the three million children who are eligible for, but not enrolled in, Medicaid, and to help enroll them in a comprehensive Medicaid health home. This outreach role is one that MCH departments must play by law.

- Oversight and assessment activities to identify areas where inadequate or no health homes exist for newly insured children.

- Leadership activities to develop data and call together purchasers, providers and patients to reach agreements that as children become enrolled in Medicaid or receive private health insurance, they will be encouraged and able to enroll in quality health homes.

- Capacity/infrastructure building activities that strengthen the development of health homes and systems integration to provide health homes for newly enrolled children.

- Preventive care program development and implementation to promote population-based public health initiatives to assure a healthy community, particularly in the areas of the "Back to Sleep" campaign, injury prevention, and disability prevention such as newborn hearing screening.

Of the total proposed increase of $50 million for the Maternal and Child Health Block grant, $44 million will be focused on support of the Children's Health Initiative through the types of efforts described above.

Healthy Start

There are approximately 300 communities, urban and rural, with infant mortality rates (IMR) at least 1.5 times the national average for the years 1992-1994. The Healthy Start program is designed to implement strategies at the community level which address the broad range of health, social, economic and educational unmet needs that contribute to high infant mortality rates.

The program is currently in the replication phase. In 1997 some 30 communities have received grants to carry out one or more of the nine effective IMR reduction strategies that emerged from the demonstration phase. The lessons learned from Healthy Start were designed to be shared with the wider maternal and child health community.

The FY99 budget request of $171 million would allow Healthy Start to broaden its focus on decreasing infant/child morbidity rates, promoting risk reduction strategies to reduce adolescent use of tobacco products and alcohol/drugs, moving Healthy Start families from welfare to work, and improving linkage to child care systems.

Agency for Health Care Policy and Research

Beginning this year, AHCPR will develop a working concept paper on the Health Home. This will include definitions and potential performance indicators/measures. They will also begin discussing the paper with State Medicaid agencies and private sector organizations such as the National Committee on Quality Assurance (NCQA), and the Foundation for Accountability (FACCT) as they take steps toward developing a framework for measuring quality of care for children, as well as other professional associations and purchasers.

As part of the FY99 budget, AHCPR is requesting funds for the following components of the Children's Health Initiative for a total of $6.5 million:

- *Refinement and testing of indicators for the Health Home for use by federal agencies, regions, States, local markets, and individual purchasers: $500,000*

- *Measuring effects of insurance expansion, outreach, and implementation of the health home concept, including:*

  - *Continued oversight from a Technical Advisory Group (to be established prior to FY99) including quarterly meetings: $200,000*
  - *Case studies in selected markets and for special populations: $1.3 million*
  - *Adaptation and expansion of SLAITS (CDC's State and Local Area Integrated Telephone Survey) to specific markets, built up to a representative sample of children at greatest risk of being uninsured: $4.5 million. SLAITS is consistent with the DHHS plan for survey integration. It uses a standardized core questionnaire, survey methodology, and mode of administration, but allows for*

flexible addition of questions and samples approved by OMB and of interest to particular regions, States, localities, markets, and child and family populations. For example, the sampling frame could be expanded to answer questions specific to markets with high concentrations of young families and/or ethnic groups particularly likely to be uninsured.

Substance Abuse and Mental Health Services

Two programs are included in Theme III - Health Home and Systems Capacity:

- *Starting Early/Starting Smart: Integrating mental health and substance abuse prevention and treatment in primary care service settings. SAMHSA: No increment*

- *Comprehensive Community Mental Health Services for Children. SAMHSA: Increment $10 million*

Indian Health Service

Each year over 6 million ambulatory care visits and 90,000 hospital admissions are provided to approximately 1.5 million users in the Indian Health Service (both IHS and tribal facilities). This system of health care provides comprehensive preventive, curative, and rehabilitative health services to Indian people in 34 states, with children and adolescents representing about 42 percent of the population. A precise estimate of the number of Indian children eligible for Medicaid is not currently available; however, a significant number of Indian children and youth are either now registered or are eligible for registration. This assumption is based on the fact that 31.6 percent of Indian households are below the poverty level and 24 percent of the overall IHS registered population is currently also registered for Medicaid.

In FY98, the IHS will spend an estimated $387 million on health services for Indian children and youth. These services include comprehensive ambulatory care, inpatient care, dental care, mental health and social services, treatment for substance abuse and health education. The estimate was developed based upon the average number of health services provided annually to Indian children and youth and the IHS reimbursement rate for Medicaid visits. In FY99, the IHS budget request includes an increase of $20 million which will maintain or improve the internal capacity of IHS and tribal health care programs to deliver comprehensive and continuous health services to Indian children and youth.

Office of Civil Rights

Enforcement of adoption and foster care non-discrimination provisions will support the Children's Health Initiative by speeding up the placement of minority children into permanent and stable family situations, thereby increasing attention to and the likelihood of being served by a continuous source of care.

An increment of $900,000 is directed in support of this initiative.

IV. STRENGTHENING COMMUNITY-BASED PROGRAMS

Public health population-based strategies involve the development, implementation and continued support of preventive care initiatives to improve the health status of all children. While the Children's Health Care Initiative will expand the number of children with access to health care, population-based strategies are also needed to ensure that certain basic health interventions reach all children. Efforts to implement preventive health interventions targeted to children on a population basis are not restricted to a specific group or sub-population. However, these efforts must be coordinated with the other building blocks of this initiative.

Each of the population-based strategies to be included in this initiative includes action steps aimed at integrating the message of prevention in a variety of health providers beyond the traditional public health agencies and includes managed care organizations, primary health care centers, and others involved in the efforts to identify a health home for children. Providers of the prevention message can also be utilized in the outreach effort to identify Medicaid eligible children. The efforts to improve the health of American children by increasing the number who have a health home in a healthy community must be a seamless effort and the Focus on the Community activities are an integral part of that overall goal.

In addition to having a personal health home, it is important that children grow up in national, state and local "communities" that employ population-based interventions to improve health. These are as important as clinical services to children's health and well being. Although multiple components of the Department have major, ongoing efforts to institutionalize population-based interventions, there is still a general lack of appreciation about the importance of such interventions to improving health status. Proposed areas for special involvement include:

- Immunization.
- Developmental disability prevention.
- Substance abuse and mental health services for children.
- *Back to Sleep* Public Education Information Campaign.

Incremental funding for CDC includes $3 million in the area of Newborn Hearing Screening and $7 million for activities related to improving knowledge on folic acid.

Incremental funding for SAMHSA is focused on Vulnerable Populations ($7 million); HIV/AIDS Prevention ($3 million); Public Awareness Campaign ($4 million); Mental Health Early Intervention Models ($2.4 million); and Fetal Alcohol Syndrome ($5 million) for a total of $21.4 million.

Incremental funding for NIH is estimated at $255,000 related to the Back to Sleep Campaign.

Childhood asthma is a major public health problem. More than 7 percent of children under 18 suffer from asthma--some to a life-threatening degree. Moreover, asthma is a growing public health problem; the prevalence in children under 18 has increased by more than 80 percent since 1982. Several DHHS agencies, led by the NIH, have substantial ongoing programs related to elucidating the causes of asthma, developing improved means to manage it, translating research results into practical preventive and therapeutic interventions, and educating physicians, patients, and their families about the latest health-care advances.

Further, asthma is but one of several disorders that disproportionately affect children and are known to be caused or exacerbated by environmental factors. In April of 1997, President Clinton issued an Executive Order on this subject. Among other things, the Order establishes a Task Force that is co-chaired by Secretary Shalala and USEPA Administrator Browner and includes essentially all the Cabinet Officers and other senior officials whose agencies have a substantial role related to the environment and how environmental factors contribute to the diseases, disorders, and disabilities of children. A much-needed step is to determine how much of the burden of illness from respiratory diseases such as asthma and chronic bronchitis are attributable to outdoor air pollutants. DHHS agencies conduct and sponsor the bulk of the research related to the public-health consequences of air pollution; CDC is uniquely positioned to initiate planning for a national monitoring network for asthma and other respiratory diseases in concert with USEPA's efforts to monitor air quality. Public health efforts to improve respiratory health would be enhanced considerably by data on the incidence and prevalence of respiratory diseases--especially if such data were gathered in a coordinated way with data on air quality.

CONCLUSION

The Children's Health Initiative provides an excellent opportunity to work with States and to enhance the efforts they already have underway to enroll children in both private insurance and in public programs such as Medicaid. As the public and private sectors work together to extend health insurance coverage to more children, it is also essential that we build our efforts on the foundation of a health home, which links children and their families to a specific provider or provider team and an appropriate set of services. It is also necessary to strengthen the range of population-based prevention programs for children. The high quality care, improved health outcomes and cost savings we gain by insuring children and helping place them with a quality provider promises the highest return on our investment.

REDUCING TOBACCO USE AMONG TEENS AND PRE-TEENS

Since the release of the first Surgeon General's report in 1964, calling for "appropriate remedial action," 10 million Americans have died as a result of cigarette smoking. Children are the future of this country; yet, more than 5 million children living today will die prematurely because of a decision to smoke cigarettes that they made as teenagers, resulting in almost $200 billion in future health care costs.

A comprehensive, collaborative effort to reduce tobacco use among youth is the most effective way to alter teen's perceptions of smoking and tobacco use. The tobacco industry spends billions of dollars each year on advertising and promotional campaigns. Among youth, these advertisements and promotions create an atmosphere of friendly familiarity with tobacco products. Everyday, youth are bombarded with enticing images of tobacco use, portraying it as glamorous, cool, fashionable, socially acceptable, and harmless.

Both the President and Secretary Shalala have stated that reducing tobacco use among young people is a priority. During this past year, Secretary Shalala has launched a new initiative targeting tobacco use among young people. The primary aim of this Initiative is to contribute to the achievement of the President's goal of reducing tobacco use among young people by 50 percent in 7 years. The activities in this Initiative contribute to the overall Department effort to reach the President's goal. Although reducing the supply of tobacco products is an important component of efforts to reduce use, this Initiative focuses on reducing the demand for tobacco products among youth by changing the social acceptability of tobacco use, counteracting tobacco advertising and promotion, and delaying or preventing decisions to use tobacco.

In order to elicit these responses from young people, this Initiative focuses on five action areas: (1) promoting positive alternatives to tobacco use through sports and other youth-centered activities; (2) empowering young people to address tobacco use among peers; (3) deglamorizing tobacco use through a coordinated Entertainment Industry strategy; (4) implementing a paid counter-advertising campaign to change social norms about tobacco use; and (5) involving parents and families in addressing tobacco use among young people. Underpinning these action areas is the need for strong state and community programs.

STATE AND COMMUNITY INFRASTRUCTURE

This Initiative recognizes the widespread impact of tobacco use on the programmatic efforts and resources of diverse HHS agencies, and is designed to enhance collaboration between these agencies. The interagency work group for this Initiative has identified the need for a strong state and community-based infrastructure to implement the goals of the action plan. By expanding resources to fully fund state health departments, state departments of education and national organizations, this Initiative seeks to create a national infrastructure for tobacco

control efforts, encourages collaboration, and consolidates resources. These partners serve as a critical link to communities across the country, thereby increasing the impact of this multi-pronged strategy.

State-based Tobacco Control Programs: *These programs are vital to the success of this Initiative. It is critical that HHS maintain the nationwide infrastructure developed through the ASSIST and IMPACT programs, as well as expand funding to support state-based tobacco control efforts. These programs serve as "delivery systems" for the activities in this Initiative and function as the primary link to the communities that need to be reached if this Initiative's efforts are to be successful. In FY99, HHS proposes to increase funding by $43 million to expand existing State-based tobacco control programs, develop a national infrastructure, including partnerships with state departments of education and national organizations, and provide technical assistance and training to these partners.*

PROMOTING POSITIVE ALTERNATIVES TO TOBACCO USE

Everyday 3,000 teenagers become regular smokers, resulting in 1 million new teenage smokers a year. In order to reduce the number of young people who use tobacco products, the functional utility of not using tobacco products needs to be demonstrated for young people. Positive alternatives to tobacco use must be developed and offered to youth. By engaging young people in alternative activities, such as sports, youth groups and clubs, and increasing their awareness of the harmful effects of tobacco use throughout their developmental years, this Initiative seeks to delay the onset of tobacco use among youth. Studies have shown that if individuals do not begin smoking during adolescence, then they are unlikely to take up smoking as an adult.

Community-Based Smoke-Free Youth Activities: *HHS proposes to introduce tobacco control messages and materials into existing community-based youth outreach programs and activities: ACF's National Youth Sports Program Fund, which provides youth with sports instruction, competition, and educational programs on college campuses; ACF's Community Schools Program, which provides constructive recreation and academic activities for youth in at-risk neighborhoods during non-school hours; ACF's Runaway and Homeless Youth Basic Center Program, Transitional Living Program for Homeless Youth, and Street Outreach Program, which provide services for youth at high risk for substance abuse; and HRSA's Community and Migrant Health Centers. By engaging these community-based centers and programs, HHS is continuing to expand the national tobacco control infrastructure and increase its capacity to tackle the problem of tobacco use among young people.*

Tobacco-Free Lifestyle "Brand": *This activity will establish a national "branding" campaign for a tobacco-free lifestyle, including some type of "badge identity" such as discount cards for movies and teen consumer items (clothing, fast food, sporting equipment). HHS plans to utilize its national tobacco-control infrastructure, including*

ASSIST, IMPACT, smokeless states, national and community organizations, marketing and advertising experts, to develop and disseminate the branding strategy. Funding for this activity is contained within the proposed national counter-advertising campaign.

EMPOWERING YOUNG PEOPLE

Harnessing and channeling the energy, ideas, and enthusiasm of young people may provide the best hope for reducing the demand for tobacco products. Young people are capable of influencing each other's perceptions, attitudes, and behaviors. By engaging in this Initiative's activities, young people will develop the skills and knowledge necessary for them to actively participate in the reduction of tobacco use among teens and pre-teens.

School Programs to Prevent Tobacco Use: *School-based programs offer an opportunity to prevent the initiation of tobacco use and, therefore, help young people avoid the difficulties of trying to stop after they are addicted to nicotine. It is imperative that these programs be culturally, ethnically and racially appropriate. In FY99, this Initiative proposes an increase of $2 million for tobacco-related school health to empower youth. HHS will continue to promote two effective tobacco use prevention curricula and will work with state departments of education to integrate these curricula into school systems across the country and into the Safe and Drug Free Schools and Communities Program. This Initiative also proposes to expand dissemination of school health guidelines to prevent tobacco use and addiction.*

National Diffusion of Media Sharp: *Through technology-based channels, a national press conference, and this Initiative's partners, HHS will distribute the Media Sharp Media Literacy Program across this nation in FY99. In cooperation with the National Education Association, HHS will participate in regional/national Media Sharp teacher training sessions, promote this program and its messages, and develop methods to link this program to community organizations and activities.*

DEGLAMORIZING TOBACCO USE

Over their lifetimes, today's teenagers have been exposed to billions of dollars worth of image advertising for tobacco, which present tobacco use as sexy, cool, and fashionable. In addition to this type of exposure, young people watch movies and television programs that glamorize tobacco use. Even the most subtle pro-tobacco image can entice children and teenagers to use tobacco products. This action area's objective is to engage the entertainment industry, including the pop culture industry, in a cooperative process to reduce favorable or neutral depictions of tobacco use and increase anti-tobacco depictions in the movies and on television programming.

Coordinated Entertainment Industry Strategy: *In FY99, HHS will expand its entertainment industry strategy, building on existing relationships and developing new collaborative efforts with celebrities, the Hollywood creative community, and the music industry. This activity will focus on deglamorizing the use of tobacco products, working with celebrities, the Hollywood creative community, and the music industry to change the favorable manner in which tobacco use is portrayed in television, movies, and music videos.*

IMPLEMENTING A PAID COUNTER-ADVERTISING CAMPAIGN

Existing data show that media approaches successfully reduce tobacco use. If these campaigns are combined with school-based and community-based activities, youth smoking can be reduced by 20 to 40 percent. The objective of this effort is to continue to increase teens' perceptions of the hazards of tobacco use and reduce teens' perceptions of the acceptability of use. Counter-advertising can achieve such outcomes if messages are communicated with sufficient reach, frequency, and duration. This is possible only through a national campaign that includes paid media placements. Such a campaign should utilize marketing and advertising experts to create a variety of media messages that are as powerful as the multitude of pro-tobacco use images to which teenagers have already been exposed. These experts can advise HHS agencies on the best messages, the best ways to target and time those messages, and the best ways to tie in with local programs. In FY99, this Initiative plans to spend $40 million to support the development and implementation of this paid national media campaign, including the following activities.

National Paid Media Campaign: *This Initiative will provide support for a nationwide paid counter-advertising campaign to deglamorize tobacco use, especially among young people, and for multiple strategies that address the psychosocial factors related to tobacco use. Activities will capitalize on existing resources by expanding dissemination and paid placement of high-quality media materials, including Massachusetts, Arizona and California items, catalogued in CDC's Media Resource Center. These efforts will be closely coordinated to reinforce and supplement the interagency efforts inherent to the Secretary's Initiative action plan and FDA's education program activities.*

In-Theater Counter-Advertising: *In FY99, HHS is proposing to partner with national theater chain(s) and State departments of health to develop and implement tobacco use counter-advertising messages that will be shown prior to youth-targeted feature films. By utilizing this delivery system, this activity will increase the outreach capabilities of this Initiative, reaching not only youths, but also their parents and families.*

Home Video Counter-Advertising: *Another activity proposed for FY99 is the creation of home video counter-advertising messages. By placing tested tobacco use counter-advertising messages before youth-oriented videos, this activity will increase the frequency, outreach, and impact of counter-advertising messages.*

INVOLVING PARENTS AND FAMILIES

Utilization of parents and families to convey the risks associated with tobacco use and to influence youth's perceptions of tobacco use is a resource pool that has been largely untapped. A supportive family environment has a strong preventive effect on young people's decisions to use tobacco, whereas an environment that neglects, condones, or gives mixed messages about tobacco use has a strong pro-use effect. Furthermore, parental use of tobacco products and parenting style have a significant impact on use of tobacco among their children.

National Communications Campaign for Parents and Families: *In FY99, HHS will launch this national, culturally diverse parent and family oriented campaign to help young people avoid the use of tobacco and other substances. In order to maximize this campaign's impact, this Initiative will utilize a variety of media formats and vehicles for communicating this information, including, an adaptable campaign kit to facilitate use by national, state, local, and community organizations; a "National Parenting Quiz" for TV broadcast; an interactive Internet site; and a community-based parent-to-parent outreach program.*

Guidelines for Adolescent Preventive Services: *In FY99, HHS proposes $1 million in additional funding for HRSA to target young people for the prevention of tobacco and marijuana use. This would fund 12 State-based "Guidelines for Adolescent Preventive Services" (GAPS) programs directed at about 100 Health Centers that would support tobacco/marijuana cessation efforts for about 10,000 preteens/teens. The program includes screening of adolescents from age 11 through age 21 for tobacco and marijuana use; a confidential, interactive health guidance process between the primary health care provider, the adolescent, and often, the parent; and establishment of a written contract that establishes a plan for behavioral change.*

SUPPLY REDUCTION

Limiting youth access to tobacco products is a major component of supply reduction. HHS has contributed to efforts to reduce youth access throughout the 1990's, starting with an Inspector General report in 1990 and continuing with current efforts focused on implementation of the Synar Amendment and FDA regulations. Enforcement of these regulations is critical to the success of this Initiative. Progress toward reducing supply will be monitored as part of this Initiative and information releases on supply issues also will be incorporated.

Supply Reduction: *In FY99, HHS plans to spend $13.35 million to support SAMHSA's supply reduction strategies, $1.35 million on national coordination and $12 million on state block grant programs. In addition to supporting SAMHSA's efforts, HHS will spend $80 million on FDA supply reduction programs; $20 million will be used on outreach efforts and $60 million will be spent on enforcement and evaluation of the FDA rule.*

RESEARCH

Tobacco use among youth is a complex, multi-faceted problem, requiring an intense research agenda. This agenda must include research on health effects related to tobacco use and the additives in tobacco products, attitudes and developmental markers of at risk youth, the tobacco industry's use of advertising and promotional activities, social perceptions of tobacco use, including the impact of role modeling on perception, and tobacco control efforts. In addition to this research agenda, surveillance and evaluation must be conducted to monitor tobacco use and to assess the impact of tobacco control efforts.

Surveillance and Epidemiologic Studies: *In FY99, HHS plans to spend $3 million to enhance CDC's national surveillance system, to monitor state-specific tobacco use, especially among youth and special populations. These expanded resources will enable HHS to more immediately assess the impact of Federal and state initiatives, and of cigar and new cigarette product use by measuring national as well as state-specific attitudes, behaviors, and practices, allowing HHS to respond quickly to changes within target populations.*

Research: *Under this Initiative, HHS proposes to increase funding to CDC by $2 million. This increase will allow a modest expansion of research activities. Areas for investigation include the health risks of nicotine, additives, and other potentially toxic compounds in tobacco through investigation of additives, refinement of tar and nicotine measurement methods, measurement of carcinogens in cigarettes, and studies of environmental tobacco smoke exposure. In addition, HHS is requesting an increase of $32.6 million to support NIH research on tobacco.*

EVALUATION

Measurable objectives for each activity will be developed. Surveillance elements will enable adequate tracking of tobacco use patterns among young people. Interim benchmarks to monitor progress in reducing tobacco use will be used to modify policy and/or program activities. Evaluation also will address methods to assess effective program policies and interventions that incorporate the learning experiences of states such as California, Massachusetts, Arizona and Oregon. This Initiative addresses the GPRA and the Healthy People objectives.

CONCLUSION

By increasing collaboration and developing linkages among local, state and Federal agencies, community organizations, businesses, and the entertainment industry, this strategy increases the national infrastructure for tobacco control activities and increases the outreach capabilities of these efforts. These partners serve as a critical link to communities across the country,

thereby increasing the impact of this multi-pronged strategy. Our goal is to reduce tobacco use among young people by utilizing this collaborative, multi-disciplinary network to disseminate existing information, programs and curricula and to develop comprehensive education and outreach efforts, combining media, school-based and community-based activities.

SECRETARIAL INITIATIVE
REDUCING TOBACCO USE AMONG TEENS AND PRETEENS
(Dollars in Millions)

	FY 1997 Appropriation	FY 1998 Pres. Bud.	FY 1999 Request	Request +/- PB
Centers for Disease Control and Prevention				
Preventing Tobacco Use by Youth.....	21.41	36.41	126.51	+90.00
Food and Drug Administration				
Supply Reduction: Outreach	2.34	10.00	20.00	+10.00
Supply Reduction: Enforcement and Evaluation.....	2.54	24.00	60.00	+36.00
Health Resources and Services Administration*				
Guidelines for Adolescent Preventive Services.....	---	---	1.00	+1.00
National Institutes of Health				
Tobacco and Youth.....	32.60	33.90	40.90	+7.50
Substance Abuse and Mental Health Services Administration				
Supply Reduction: National Coordination.....	1.50	1.50	1.35	-0.15
Supply Reduction: State Block Grant Programs.....	12.00	12.00	12.00	+0.00
Demand Reduction: State Block Grant Programs.....	10.00	10.00	10.00	+0.00
Initiative Total	**82.39**	**127.81**	**271.76**	**144.35**

* HRSA has expressed support for implementing interventions developed by this Initiative through its program delivery systems including MCH block grantees, Healthy Start programs, community/migrant health centers, and school health programs. For example, in FY 1997, $225 million of MCH block grant funding is being used for adolescent health programs; these programs can deliver tobacco use prevention and cessation programs to young people.

YOUTH SUBSTANCE ABUSE PREVENTION

INTRODUCTION

Marijuana use among our Nation's youth is at unacceptable levels. This is true for African American, Hispanic and White youth alike. Despite a reported leveling off in the rate of youth marijuana use in the 1996 Household Survey on Drug Abuse, we must continue to guard against new or renewed interest in this gateway drug; we must not become complacent. Although the 1996 National Household Survey on Drug Abuse showed a decrease in the rate of past month illicit drug use among youths age 12-17, it revealed an increase for those age 18-25 years. Furthermore, an estimated 2.4 million people started using marijuana in 1995, the same number as in 1994. New heroin use has increased since 1992. Most new users were under the age of 26, and a large proportion of these recent new users were smoking, snorting, or sniffing heroin. The estimated number of past month heroin users increased from 68,000 in 1993 to 216,000 in 1996.

The decreasing perception of risk associated with drug use among youth is especially troubling. The percent of youths age 12-17 that perceived great risk in using marijuana once a month decreased from 1990 (40 percent) to 1994 (33 percent), but remained constant from 1994 to 1996. Youth perceptions precede changes in behavior. By age 15, 25 percent have tried an illicit drug other than alcohol. There was an upward trend in the initiation of drug use for youths age 12-17 including marijuana, heroin, cocaine/crack cocaine, hallucinogens, inhalants and alcohol. With increasing drug availability, a projected increase in the youth population from 20.8 million in 1993 to 25.2 million by 2005, continuing waves of youngsters aging into their teens, and declines in perception of harm related to drug use, the threat of expanding drug abuse problems looms large on the Nation's agenda. In addition to devastating health problems, drug-associated violence, crime, family discord, school failure, teen pregnancy, and HIV/AIDS threaten our youth and our communities. The economic costs of health care, welfare, and criminal justice add significantly to the toll. A strong and sustained prevention effort must be implemented.

Goal number one of the President's 1997 National Drug Control strategy is to "Educate and enable America's youth to reject illegal drugs as well as the underage use of alcohol and tobacco." The goal for this initiative is to reverse the current upward trend in marijuana use among 12-17 year olds by 25 percent by the year 2002. This reduction would reduce marijuana use among youth from its current baseline of 8.2 percent to 6.2 percent. Associated goals of the initiative are to reduce other illicit drug use by 35 percent and alcohol use by 20 percent by the year 2002. These goals will be accomplished through: (1) Mobilizing and leveraging resources; (2) Raising awareness; and (3) Measuring outcomes.

MOBILIZING AND LEVERAGING RESOURCES

The major cornerstone of this Initiative will be to mobilize and leverage resources through collaborative activities on the Federal level and in collaborative partnerships with the States. There are a number of collaborative efforts in the planning stages. The following is a summary of programs that support the Initiative:

SAMHSA Programs - Total direct support for the Secretary's initiative is $109.1 million and indirect support is $113 million. The largest program (direct support) will be the State Incentive Grants ($75 million). Beginning in FY97 and continuing into FY98, SAMHSA will have awarded 20 State Incentive Grants. The 1999 request proposes that five additional grants be awarded. These grants call upon State Governors to develop comprehensive strategies for youth substance abuse prevention in their States. These strategies will include identification of program and funding gaps, coordination and/or combining of resources and funding streams, and the development of co-operative efforts with other state and local agencies. Included in this leveraging of resources will be the 20 percent Substance Abuse Performance Partnership Block Grant Set-Aside ($15 million), and other Federal programs. The Regional Centers for the Application of Prevention Technology ($9.2 million) will support the States that receive the incentive grants by ensuring that they implement promising research-based prevention programs, practices and policies at the state and community level. The Children's Mental Health Services Program ($80 million-indirect) will focus on increasing the mental health of children and ensuring that children and their parents have access to mental health services. Research shows that mental disorders often occur first during adolescence, 5 to 10 years before an addictive disorder. In addition, adolescents with psychosocial problems are more likely to use cigarettes or engage in "binge" drinking and much more likely to use marijuana than those with little or no indication of mental health problems. This provides a "window of opportunity" for targeted substance abuse prevention interventions.

Health Education in Communities and Schools - Funding of $53.07 million will be devoted to health education in communities and schools. Through collaboration with CDC, ACF, HRSA and IHS, current health education programs in the schools and communities will be examined; and substance abuse prevention components will be either added or enhanced. This figure includes an estimated $25 million for indirect costs for HRSA for programs that focus on the health of the Nation's youth with aspects that pertain to substance abuse.

Child and Adolescent Research Initiative - NIAAA and NIDA are devoting $84.3 million to research on alcohol and substance abuse prevention among children and adolescents. The focus will be on the etiology of alcohol and substance abuse to better understand risk and protective factors in initiating and continuing use and the development and testing of prevention models to be used by practitioners in the field.

RAISING AWARENESS

SAMHSA will continue to focus on the raising awareness component of this initiative. It is imperative that the anti-drug message be kept on the national agenda. CDC, NIDA and CSAP ($6.9 million) will be involved in a number of media programs targeted towards youths and responsible adults. These programs include media campaigns, development and dissemination of educational materials, a media literacy project, and building collaboration with the entertainment industry. In collaboration with ONDCP, SAMHSA will build on the past media campaigns of "Girl Power!" and "Reality Check," and will introduce a new targeted campaign to reinforce previous messages. The "Get Involved" Campaign is designed to promote efforts that engage adults more effectively in the lives of youth. Another campaign which will be developed with the Department of Education will focus on increasing awareness of health and social risks of drug use. Cutting edge media technologies will be utilized.

MEASURING OUTCOMES

SAMHSA will modify its National Household Survey on Drug Abuse to provide State level estimates on marijuana, alcohol and tobacco use by the population age 12 and older. Therefore, $28 million (direct) per year is requested to obtain State level estimates for FY98-FY02. These estimates will allow SAMHSA to know where its efforts are succeeding and where improvements can be made. It will also enable SAMHSA to obtain better national data on youth substance use, especially cocaine and heroin. Further, SAMHSA will award additional needs assessment contracts to strengthen States' abilities to plan and conduct effective prevention efforts. SAMHSA will contribute $10 million (indirect) for State Data Infrastructure Development for both prevention and treatment. In addition to SAMHSA's efforts, NIDA's Monitoring the Future Survey, CDC's Youth Risk Behavior Surveillance Survey and private sector surveys will also be conducted. All activities will follow the GPRA model using both process and outcome data. In addition, SAMHSA is developing and updating its Geographical Information System (GIS). Federal Partners, both in and outside of DHHS, are being asked to provide the latest information on their programs. This information will be used to identify and encourage collaboration, review possible duplicative efforts, determine where the gaps are and target resources in areas with the greatest need.

CONCLUSION

The Secretary's Initiative on Youth Substance Abuse Prevention seeks to reduce use of marijuana, other illicit drugs and alcohol among 12-17 year olds by the year 2002. Success in reaching these goals is contingent on development of collaboration and strategic alliances with other Federal agencies and State and community partnerships through mechanisms such as State Incentive Grants, Centers for the Application of Prevention Technology and establishment of a Federal Partners Team. The Federal Partners Team is focusing on an

ecological approach targeting substance abuse prevention and Federal barriers involving policy or regulations that may hinder collaboration at the State or community level. Mobilizing and leveraging resources, raising public awareness and measuring outcomes are key strategies for achievement of the goals of the initiative.

YOUTH SUBSTANCE ABUSE PREVENTION

Youth Substance Abuse (dollars in thousands)	FY 1997 Appropriation	FY 1998 Pres. Budget	FY 1999 Department Request	Incremental Request +/- PB
SAMHSA				
Direct Support				
State Incentive Grants	$15,000	$57,700	$74,904	$17,204
Media/Public Education	4,000	4,000	4,000	0
Regional Centers	5,000	5,000	9,200	4,200
National Organizations	0	0	2,500	2,500
Youth Marijuana Initiative	1,400	2,000	2,000	0
Integrated Juvenile Offenders	0	7,000	7,000	0
Dually Diagnosed Adolescents	0	4,000	4,000	0
Targeted Treatment Adolescents	0	8,000	8,000	0
Youth Heroin Initiative	0	0	1,500	1,500
State Data Collection	0	28,000	28,000	0
California/Arizona Survey	3,300	0	0	0
State Data Infrastructure	0	0	10,000	10,000
Subtotal Direct	28,700	115,700	151,104	35,404
Indirect Support				
Children's Mental Health	70,000	70,000	80,000	10,000
HIV/AIDS Prevention	0	0	3,000	3,000
Vulnerable Populations	0	0	7,000	7,000
Youth Treatment Capacity	0	0	6,000	6,000
SA Early Warning System	0	0	2,000	2,000
SA Prevention Set-aside	13,101	13,201	15,000	1,799
Subtotal Indirect	83,101	83,201	113,000	29,799
Total SAMHSA	111,801	198,901	264,104	65,203
CDC				
National Center for				
Chronic Disease Prevn:				
Media Literacy/Media Sharp	375	100	150	50
Sports and Performance	0	50	150	100
Parent Project	0	250	250	0
Entertainment Industry	0	200	100	(100)
Total CDC	375	600	650	50

YOUTH SUBSTANCE ABUSE PREVENTION

Youth Substance Abuse (dollars in thousands)	FY 1997 Appropriation	FY 1998 Pres. Budget	FY 1999 Department Request	Incremental Request + / - PB
ACF				
Family and Youth Service Program:				
Community Schools Grant	12,800	12,800	12,800	0
Homeless Youth	11,720	11,720	11,720	0
Total ACF	24,520	24,520	24,520	0
NIH				
NIDA:				
Child and Adolescent Initiative	52,600	57,900	60,200	2,300
Information Dissemination/				0
Research Science Education	2,118	2,190	2,300	110
Subtotal	54,718	60,090	62,500	2,410
NIAAA:				
Youth Focused Prevention				
Research Initiative	22,000	22,800	24,100	1,300
Subtotal	22,000	22,800	24,100	1,300
Total NIH	76,718	82,890	86,600	3,710
IHS				
Prevention Programs:				
Youth Community Prevention				
Efforts	3,500	3,500	3,500	0
Total IHS	3,500	3,500	3,500	0
HRSA				
Youth Related Activities	25,000	25,000	25,000	0
Total HRSA	25,000	25,000	25,000	0
Initiative Total	$241,914	$335,411	$404,374	$68,963

Health Care
Quality Improvement

HEALTH CARE QUALITY IMPROVEMENT

Market forces have generated unprecedented changes in our health care system. Health care today is characterized by intense competition, with growing demand from purchasers for accountability and value, and emerging concerns among consumers/patients about the quality of their care.

The Department of Health and Human Services (Department/DHHS) plays many roles that significantly influence the delivery of care in this country. The Department is an advocate on behalf of consumers, particularly consumers who through race, ethnic origin, cultural differences, disabilities or other factors, may have special needs or particular difficulty in obtaining appropriate health care. The Department disseminates health care information. The Department is a major purchaser and provider of health care services. The Department supports and conducts research that identifies what health care can do and the gaps between what is achievable and what we are achieving now. Finally, the Department has a responsibility to protect consumers by ensuring that health care is accessible, safe, fair, effective and accountable.

Recognizing that the changing health care system may threaten health care quality, but simultaneously offers opportunities to improve quality of care, the Secretary has created this Quality Improvement initiative. The potential impact of this initiative is great. An integrated effort of this magnitude will allow the Department to better fulfill its many roles, but requires that all facets of the Department commit to a common vision of health care quality and actions to improve it. The purpose of this initiative is to stimulate new ideas and creative solutions.

Six goals have been identified that, when achieved, will improve the current quality of health care and establish a framework in which the Department will continuously improve its performance in advocating, purchasing, providing, and researching health care quality while protecting consumers from poor quality. The six goals are:

- Facilitate Consumers' Use of Information on Quality
- Strengthen DHHS Value-based Purchasing
- Improve the Services Delivered by DHHS Health Care Programs
- Promote Research that Improves Quality
- Measure National Health Care Quality
- Enhance Consumer Protections

The Department's efforts on many of these goals would be enhanced by collaboration with other Federal agencies (e.g., the Departments of Defense, Labor, and Veterans Affairs, and the Office of Personnel Management) and the private sector, and their cooperation in this initiative will be sought.

The work of this initiative will be coordinated through a Quality Council which will consist of senior Department leadership appointed by the Secretary. They will oversee the work of six work groups, each of which will be tasked with identifying how the Department should respond to the challenge of improving its performance on one of the six goals.

It is clear that to achieve the goals of this initiative, the current ways in which the Department fulfills its obligations will have to be modified, and as with any change process, this will require the redirection of resources; alterations in existing legislation, regulation, or procedures; and perhaps some retraining of personnel. Identification of the necessary factors to be changed will be part of the work of each work group, but implementation of the changes will fundamentally be part of the responsibility of the affected agencies under the direction of the Secretary. Products from this initiative will build on each agency's current and already proposed activities, but are expected to be new and innovative.

This initiative extends for three years, from September 1997 through September 2000.

GOALS

The six goals of this Initiative are related, and generally support the activities and products of each other. All the goals will influence the messages developed for Goal 1: Facilitate Consumers' Use of Information on Quality.

Goal 1: Facilitate Consumers' Use of Information on Quality: Our goal is to help consumers understand the concept of health care quality, and to act to improve quality. The Department has a wealth of resources that can be used to assist consumers, particularly regarding choices of treatments for specific conditions. The Secretary will launch in 1997 a three-year, high-visibility national campaign to inform consumers of the key health care decision points for which using information and asking the right questions can help to improve the quality of care they receive. The campaign will also foster dialogue on issues of consumer/provider communication and shared decision making.

Primary audience: All U.S. consumers of health care.
Lead agency: AHCPR

A total of $6,095,000 to advance the work of this goal in FY99. These funds will be spent to develop pamphlets, workbooks and other tools that will assist consumers in considering how to make choices about their health care insurance, providers, and treatment alternatives that will enable them to get better quality.

Goal 2: Strengthen DHHS Value-based Purchasing: The goal is to use the Department's purchasing power more effectively to obtain high quality care. We will use key elements in purchasing, such as reimbursement criteria, contracts, performance

measures to assess health care quality, and access to culturally competent providers and adequate provider networks. We will develop purchasing models, strategies and implementation plans for strengthening our purchasing power.

Primary audience: DHHS programs purchasing health care on behalf of their consumers.
Lead agency: HCFA

A total of $1,250,000 has been requested to aid in the accomplishment of this goal. Largely, this money will be spent on small studies and expert meetings that will assist the DHHS programs that purchase health care identify the lessons to be learned from successful and less than successful purchasing strategies that have been utilized by private sector and other purchasers in their efforts to maximize the value of the health care provided within the constraints of their budgets. A portion of the budget will also be used to defray administrative costs of supporting the goal.

Goal 3: Improve the Services Delivered by DHHS Health Care Programs: The goal is to assist DHHS providers to deliver the highest quality care. DHHS provides direct care through many programs, and each program has quality improvement activities. We will find and share quality improvement mechanisms, strategies, and ideas that work. For example, some Peer Review Organizations have extensive experience in specific quality improvement areas; they may serve as models that can be adapted to DHHS health care programs. We will target a small number of clinical topics where there is divergence between the achievable outcomes and what the Department's direct care providers are achieving and work collaboratively to improve outcomes. We will ensure that each DHHS agency's quality improvement activity incorporates the latest research results into its improvement efforts.

Primary audience: DHHS direct health care providers and related quality improvement programs.
Lead agency: HRSA

For this goal, $11,250,000 has been requested. A portion of this money will be used to conduct research or to analyze research results to ensure that the most effective diagnostic and treatment strategies for health issues of particular importance to the populations directly served by DHHS are known. The larger portion of the money will be used to communicate with the DHHS direct health care providers to ensure they know of the recommended approaches and are aware of strategies for improving their performance to ensure they are in compliance with the relevant accreditation standards.

Goal 4: Promote Research that Improves Quality: The goal is to identify and expand research that improves health care quality and improves methods for translating research findings into practice. Under this goal, we will identify research needs related to quality and strategies for funding research; expand capacity to conduct research; and develop strategies and methods for integrating quality measurement and improvement into professional curricula and practice.

Primary audience: Research community, providers, policy makers.
Lead agencies: NIH and AHCPR

A total of $19,200,000 is requested for this goal. Of this amount $7,000,000 is requested to conduct research on effective means of translating advances in knowledge about what works and what doesn't into the actual practice of medicine. Finally, $12,200,000 has been requested to add to our knowledge about the provision of effective mental health services through a managed care plan.

Goal 5: Measure National Health Care Quality: The goal is to develop a national quality reporting system. The system will provide information from leading health care quality indicators on a broad range of quality issues, including clinical and access measures, that can be used for monitoring progress toward improved health care quality. These data can be used to identify potential quality problems and opportunities for quality improvement. Activities under this goal will identify new data sources, as well as draw on current data collection efforts.

Primary audience: Health policy makers and all U.S. consumers of health care.
Lead agencies: CDC and AHCPR

A total of $20,600,000 has been budgeted to augment or refine existing national surveys being conducted by AHCPR, CDC, and SAMHSA to collect the data needed to create an accurate picture of the status of health care quality in America. It is anticipated that other sources of data will be used as well, but it was not possible to estimate what the budgetary implications were for acquisition of the information until more is known about what else would be required for the report.

Goal 6: Enhance Consumer Protections: Our goal is to identify activities that DHHS can undertake to coordinate and to improve protections for consumers in both fee-for-service and managed care settings. This activity will require coordination with states, accrediting organizations, and other entities that help to form the network of consumer protections.

Primary audience: All U.S. consumers of health care.
Lead agencies: ASPE and HCFA

A total of $18,300,000 has been requested in this goal to enable DHHS programs that act on behalf of consumers who may be particularly vulnerable. In particular, $13,000,000 have been requested to expand the ombudsman programs that have been used to assist the elderly in nursing homes. An additional $2,700,000 has been requested to investigate the particular problems that minorities, people with differing ethnic or cultural backgrounds and persons with disabilities have in accessing appropriate care in the rapidly changing health care market. Also, $1,600,000 has been requested to investigate similar issues for persons with mental health or substance abuse problems. Finally, $1,000,000 has been requested to augment the Medical Expenditure Panel Survey, which collects data from a representative sample of households in America with questions about the information on patient rights and responsibilities that is made available to consumers as they select among health plans.

INTERAGENCY QUALITY COUNCIL

An interagency quality council (the Quality Council) will be responsible for the success of the initiative and for coordinating the Department's quality efforts. The Administrator of the Agency for Health Care Policy and Research (AHCPR) will chair the Quality Council, comprised of senior Department leadership appointed by the Secretary. Specifically, the Quality Council will:

- report to and advise the Secretary on quality issues;
- support work groups which will carry out the initiative;
- approve the goal implementation plans, action steps, timelines and work plans;
- ensure that cross-cutting health care quality issues are addressed;
- resolve obstacles;
- serve as a forum for revising implementation strategies;
- address key policy issues to guide Department and Administration decisions; and
- approve work groups' requests for technical assistance and additional staff for breakout work groups.

The Quality Council will meet at least quarterly. AHCPR will provide a coordinator for the initiative, and will also serve as liaison between the Council and the work groups.

WORK GROUPS

Six goal work groups will be assigned to carry out the initiative and will report to the Quality Council. Each work group will be comprised of representatives from the lead agencies and designated participating agencies.

Work groups will have responsibility for developing detailed implementation and work plans, timelines, and products related to the goal statements. Plans must include methods for measuring progress toward achieving each goal. Work groups report to the Quality Council through the lead agency, and it will be the responsibility of the work groups to keep the Quality Council informed of their progress.

The work groups will have the flexibility to work in subgroups, to bring in additional staff to handle special topics to meet specific work plan objectives, and to seek advice and technical assistance from experts from within and outside the Department. Work groups are expected to identify current activities and resources that will help them achieve their goals. For example, the Goal 2 work group should coordinate with the DHHS Performance Measurement Work group; the Goal 3 work group may consult with the Quality Improvement Organizations; and the Goal 5 work group may confer with the DHHS Data Council. Moreover, work groups should evaluate how current and planned DHHS activities may contribute to meeting the goals. For example, CDC's Behavioral Risk Factor Surveillance Survey, HCFA's new Medicare Quality of Care Surveillance System; and AHCPR's Medical Expenditure Panel Survey are potential data sources for Goal 5; the Cooperative Cardiovascular Project sponsored by NIH, HCFA, and AHCPR for Goal 3; and SAMHSA's Managed Care and Prevention Resource Guide and HRSA's programs to develop provider capacity may inform all the work groups.

ROLE OF THE LEAD AGENCIES

The lead agencies for each goal will:

- chair their respective work groups;
- schedule meetings;
- arrange for a facilitator for work group meetings;
- assure that the group develops detailed implementation and work plans with timelines and specific products to achieve the stated goal;
- provide periodic reports to the Council on each goal's progress; and
- make a commitment of staff FTEs to support the work group (e.g., administrative support).

IMPLEMENTATION PLAN

Each goal implementation plan must describe the work group's scope of work, products, critical actions and timelines. However, some issues must be addressed in each plan including the following:

- priority populations, as well as the general population;
- provider capacity (e.g., an adequate number and geographic distribution of primary care physicians, nurses, home health providers, facilities);
- non-DHHS Federal agencies, State, and Tribal Nations;
- how the plan affects traditional and managed care delivery systems;

- private sector activities;
- *Healthy People 2000* and *2010; and*
- *The Children's Health Initiative.*

CONCLUSION

In fulfilling its commitment to the American people, the Department engages in a wide variety of activities that significantly influence the care delivered to the populations it serves directly, those for whom it purchases care, and the entire American population. Through this Initiative, the Secretary has challenged the Department to examine how it fulfills its responsibilities to those it serves and to alter or refine how it fulfills its mission so that it is promoting high quality health care through its actions. A total of $77,495,000, including $800,000 to support the Quality Council and the staff responsible for coordinating the activities of the initiative, has been requested in FY99 to enable the Department to progress toward meeting the Secretary's challenge. Specific changes will be recommended and implemented of over the next three years that will improve the quality of care delivered, but the real potential for this Initiative will be realized if through the efforts of those involved, mechanisms are developed and a culture is created in which it is expected that the Department's staff will continuously examine how the work is accomplished and search for opportunities to positively affect the care delivered in this country.

Health Care Quality Improvement
(Dollars in Thousands)

OPDIVS:	FY 1997 Appropriation	FY 1998 President's Budget	FY 1999 * Request- Initiative Only	Request +/- Pres. Budget
AHCPR:	13,946	15,000	25,800	10,800
HRSA:	0	0	10,000	10,000
CDC:	0	0	6,000	6,000
HCFA:	0	500	500 **	0
SAMHSA:	14,715	14,995	19,495	4,500
Office of the Secretary/Office for Civil Rights (OCR)	NA	1,700	2,700	1,000
Administration on Aging	9,181	9,181	13,000	3,819
Total, Quality Initiative	$37,842	$41,376	$77,495 ***	$36,119

* The FY 1999 Request for the Secretarial Initiative for Health Care Quality only includes funds directly related to the Quality Initiative. OPDIVS are engaged in a myriad of activities relating to health care quality that have not been included in the Secretarial Initiative funding level.

** Less than two weeks ago, the HCFA Administrator agreed to be co-lead of Goal #6 and has not had adequate opportunity to understand the implications for their FY 1999 budget.

*** Includes $800,000 to support the work of the Quality Council and the staff responsible for coordinating the activities of this initiative.

NOTE:
This table only includes OPDIVS requesting funds in their FY 1999 Request for the Quality Initiative.
Other participants in the Quality Initiative include:

-- NIH: Since NIH considers all of its activities as ultimately leading to improvements in the quality of care, it is not feasible to segregate out that portion of the FY 1999 Budget dedicated to the Quality Initiative.

-- OIG, OPHS, FDA, IHS, ACF, and ASPE.

OPERATION RESTORE TRUST

INITIATIVE OBJECTIVE

For 30 years, health care expenditures in the United States have risen faster than inflation and population. One factor is the unnecessary cost of fraud and abuse. Operation Restore Trust (Project ORT) is a long-term initiative to fight fraud and abuse in Medicare and Medicaid. It has two distinct phases: (1) a 2-year demonstration confined to five States and specific program areas; and (2) a multi-year continuation which will institutionalize the "best practices" refined in the demonstration. The second phase focuses on additional geographical areas, and it includes all Medicare and Medicaid program areas with a few initially selected for special attention. This project will help assure that the cost of health care is reasonable and provided only when medically necessary. The large increases in health expenditures (both appropriate and inappropriate) have caused significant financial stress on the Federal budget, State budgets, and on the beneficiaries who pay "out-of-pocket" coinsurance. Project ORT is designed to help protect beneficiaries from health care providers who unfairly, and often illegally, seek to enrich themselves.

THE FIRST 2 YEARS

Project ORT started as a 2-year demonstration project that developed innovative ways to fight fraud, waste and abuse in the five States with the largest Medicare and Medicaid expenditures. An interdisciplinary team of Federal, State and local government representatives targeted Medicare and Medicaid abuses in California, Florida, New York, Texas and Illinois. About 12.4 million Medicare and almost 13.6 million Medicaid beneficiaries live in these States. The project focused on the areas of home health care, nursing homes (including hospices), and medical equipment and supplies. These are three of the fastest growing sectors of Medicare and Medicaid and have accounted for about $63 billion in expenditures in 1996.

The 2-year demonstration project changed the way Government fought health care fraud. Prior to the demonstration project, program representatives, Medicare contractors, Medicaid State agencies, auditing, and law enforcement agencies rarely coordinated their attack on problem areas. Traditional techniques were sequential, lengthening the time between identifying problems and solving them. Front-line employees rarely participated in selecting targets and developing strategies to combat fraud. Project ORT broke with tradition by encouraging participants to coordinate their efforts earlier and focus on specific issues in defined locations. Front-line employees were now actively involved early, and national and State-specific plans were developed and implemented.

The Project ORT demonstration cultivated teamwork among various governmental groups, including three agencies within the United States Department of Health and Human Services (HHS)--the Office of Inspector General (OIG), the Health Care Financing Administration (HCFA), and the Administration on Aging (AoA). Other participants included the Department

of Justice (DOJ), representatives of State agencies, long-term care ombudsmen, and fraud specialists. Where before Federal, State and local governments rarely worked closely together, Project ORT used teams made up of these different groups to maximize their talents in an effective combination of auditors, evaluators, quality assurance specialists, program officials, ombudsmen, payment safeguard staff, attorneys, and prosecutors. The teams' use of joint planning, sharing of databases to target problems, and blending diverse skills has helped restore financial integrity to Medicare and Medicaid and set an example for others to follow.

FUTURE YEARS

The continuation of Project ORT was publicly announced by The Secretary on May 20, 1997 and is designed to aid in the implementation of the Government's broader responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA required the Secretary, acting through the Inspector General, and the Attorney General to establish a "fraud and abuse control program" that would, among other things, coordinate Federal, State, and local law enforcement programs and expand their activities on a nationwide, "all-payer" basis. The OIG and DOJ have issued extensive guidelines for operation of the fraud and abuse control program, have established a process for issuing "advisory opinions' as required under the law, and are expanding efforts to establish law enforcement task forces in each of the 96 judicial districts in the country along with the other health-related Inspector Generals (Department of Labor, Department of Veterans Affairs, Office of Personnel Management and the Department of Defense).

While the fraud and abuse control program includes all public and private health plans, Project ORT continues as a focused effort to eliminate fraud and abuse specifically in the Medicare and Medicaid programs, and is intended to develop and refine new tools that may be used as a model for other efforts. As such, the continuation of Project ORT is designed to help implement HIPAA mandates.

Work needs to continue in the areas of home health, nursing facilities, and medical equipment started during the demonstration phase. We will aggressively pursue recoupment of the approximately $175 million identified as being owed to the Government. We will complete investigative work on about 200 ongoing cases. We will furnish the DOJ with appropriate litigation support on 54 current indictments.

Phase two of Operation Restore Trust seeks to capitalize and expand on the initial demonstration. This continuation project is designed to institutionalize the lessons learned, expand the geographical and program areas covered, and improve on the results of the demonstration project. Project ORT will continue to use a coordinated team approach to conduct anti-fraud and abuse activities.

BASELINE/OUTCOMES

The lack of baseline data on the incidence of payment errors has confounded program managers since the 1966 inception of the Medicare program. The 10 percent error rate quoted by the General Accounting Office is not supported by comprehensive empirical data. Project ORT, however, is designed to reduce payment errors that result from fraud and abuse. We believe that one way to measure the effect of Project ORT is to compare its "return on investment" to the widely used and accepted government benchmark of $7 of benefits per $1 of costs. Our goal in the continuation of Project ORT is to have a return on investment in excess of $7 to $1. For example, the OIG will devote approximately $70 million in support of all Medicare and Medicaid work in FY97. These expenditures are expected to yield returns in excess of $490 million. HCFA will devote approximately $440 million in FY97--the amount included in the Medicare Integrity Program--in support of its Medicare program safeguard activities. These expenditures are expected to yield returns in excess of $3 billion. Similar returns are expected in FY99. We are also exploring the feasibility of using additional benchmarks (such as utilization/provider trends, post payment quality control reviews, and the number of providers excluded) and other departmental Government Performance and Results Act measures.

INTERAGENCY COOPERATION AND COORDINATION

The Project ORT team includes eight agencies within HHS. Other governmental groups that are important to ORT include the DOJ, Medicare claims processing contractors, State agencies (including Medicaid fraud control units, State auditor offices, and certification offices), State long-term care ombudsmen, State units on aging and others.

Lead Agencies

Within HHS, the OIG and HCFA jointly lead Project ORT activities. The mission of the OIG is to improve HHS programs and operations and protect them against fraud, waste and abuse. They do this through a planned series of audits, investigations, and evaluations resulting in objective fact-finding, prosecutions, and policy recommendations. The HCFA provides leadership in operating the Medicare program and overseeing States in operating the Medicaid program. The HCFA contracts with fiscal intermediaries and carriers to process Medicare claims. The contractors' activities include analysis of claims for potential fraud and abusive situations. In addition, HCFA developed an innovative way of using State survey and certification staff in integrity activities during the Project ORT demonstration phase.

Participating Agencies

Within HHS, six other agencies participate in Project ORT:

- The Administration on Aging (AoA) concentrates on two overall tasks:
  (1) training and assisting both paid and volunteer long-term care ombudsmen, insurance

benefits counseling personnel, case managers and other direct personnel, especially those associated with the Older American Act (OAA) programs and services, in effectively recognizing actual and potential practices and patterns of fraud and abuse and to advise clients, as appropriate; and (2) engaging in outreach and education activities to educate and empower older Americans, their families, and their communities to recognize fraudulent and abusive situations and to prevent or minimize victimization by such behavior;

- the Assistant Secretary for Management and Budget (ASMB) is primarily involved in coordinating the activities of the various partners;

- the Office of the General Counsel (OGC) provides legal advice on Project ORT, with particular emphasis on Medicare and Medicaid statutes, regulations and policies. OGC will have an active role in advising HCFA on projects such as the use of Federal and State survey and certification personnel to identify and report medically unnecessary or noncovered services; imposition of payment suspensions; and provider enrollment/termination matters. The OGC also defends the Department in lawsuits such as those resulting from payment denials or suspensions, bankruptcies, refusal to grant a provider number and provider number revocation or termination. In addition, OGC is available to offer assistance to both DOJ and OIG in criminal and civil prosecutions that result from Project ORT and will pursue recovery of Medicare overpayments;

- the Health Resources and Services Administration plays a key role in developing and operating a fraud and abuse data collection program -- legislatively mandated by HIPAA -- with and on behalf of the OIG; and

- the Substance Abuse and Mental Health Services Administration and the Food and Drug Administration (FDA) provide technical expertise on selected Medicare and Medicaid projects and will do some outreach and education on mental health issues.

ACTION FRAMEWORK

Much of Project ORT is concerned with expanding the use of new methods of "doing business," i.e., we will emphasize the use of these strategies "fine tuned" during the 2-year demonstration.

Strategy #1 - Targeting, Execution and Resolution

Project ORT will continue to develop new ways of working with program managers, using payment data, and profiling possible abusers to help target audits, investigations, and other program reviews on the most abusive providers in certain program areas. Together, reviewers, investigators, auditors and appropriate program managers will employ more sophisticated methods of analyzing claims data to make these assessments. Where appropriate,

they will be joined by medical personnel to identify and quantify payments for unnecessary care. These teams will also make referrals to criminal investigators when warranted. In addition, we will coordinate with DOJ and other entities to assure that monies owed to the Government are collected and accounted for properly.

Strategy #2 - Coordination of Law Enforcement Actions

Project ORT will continue to emphasize increased coordination between program representatives, auditors, evaluators and criminal investigators. We will improve our coordination with other law enforcement agencies, such as the Federal Bureau of Investigations (FBI), to further reduce duplication, and work with DOJ so that our final products contain the information essential for criminal and/or civil litigation. As a result, we anticipate a large number of criminal convictions and civil recoveries. We will also assure that former "problem" providers remaining in the program have stringent corporate integrity plans in place to ensure better compliance with existing health laws and regulations.

Strategy #3 - National Policies and Procedures

Project ORT will continue to identify needed improvements in national policies and procedures to eliminate fraud and abuse. Program evaluations and audits will expand on provider-specific audits and investigations. Both multi-state and multiple provider reviews will focus on individual aberrant providers and the systemic weaknesses allowing for such behavior. This work will measure the extent of problems nationwide and analyze the underlying incentives and weaknesses in the Medicare and Medicaid program. Project ORT will recommend national policy or system changes to improve these programs. We will continue to monitor the status of policy changes identified in the demonstration.

Strategy #4 - Quality and Program Integrity

Project ORT will facilitate the integration of quality processes with program integrity. State and Federal survey and certification officials visit nursing homes, hospice providers and home health agencies on a regular basis, which places them in an excellent position to spot possible instances of fraud and abuse. Traditionally, their orientation has been on program compliance and certification issues. As part of Operation Restore Trust, however, they are trained to identify and report (to Medicare contractors) instances of medically unnecessary or noncovered services. They are provided billing information from the Medicare contractors before they go onsite. The information that is collected is provided to Medicare contractors for decisions about payment and possible integrity violations. Project ORT will also explore whether this approach can be used in other types of services where quality is reviewed onsite. Prior to ORT, State long-term care ombudsmen have viewed their roles as resolving problems between patients and nursing home/home health agency providers. During the demonstration phase of ORT, they were provided training to expand their role to identify cases of fraud and abuse.

Strategy #5 - Public Education and Involvement

Project ORT outreach activities will include educating and training aging network personnel, such as local and State ombudsmen and senior volunteers, to better identify fraud and abuse. We also will be operating and enhancing a "user-friendly" fraud hot line and developing additional strategies to involve the public. We will also provide training to providers.

Strategy #6 - Industry Partnerships

Project ORT will proactively involve health care providers. We will provide industry guidance through safe harbors, fraud alerts and other means. We will consult with provider representatives in developing our study plans to better focus our efforts on the most vulnerable program areas. We will work with industry groups to develop voluntary compliance models through which health care providers can operate their own program integrity initiatives. In addition, we will continue to explore the use of a program to enable providers to voluntarily disclose overpayments. Finally, we will establish a fraud and abuse data collection program.

CONCLUSION

Operation Restore Trust (Project ORT) is a Secretarial initiative to reduce the incidence of fraud and abuse in the Medicare and Medicaid programs. Moving from a two year demonstration project, ORT will expand to incorporate all care paid for by these programs throughout the country. Project ORT is co-chaired by the OIG and HCFA and utilizes partnerships with other Department components, other Federal units (such as the Department of Justice) and state and local agencies (such as the Medicaid Fraud Control Units). Emphasizing an interdisciplinary and intergovernmental approach, ORT will improve the Department's ability to identify fraudulent and abusive health care providers, and correct systemic problems. It will integrate the talents of local aging organizations, state survey officials and ombudsmen in identifying and reporting fraud and abuse. Project ORT will also promote public education and involvement in fighting fraud and abuse. In addition, Project ORT will foster partnerships with the health care industry to publicize "best practices", promote voluntary compliance plans, and establish an adverse action data bank.

OPERATION RESTORE TRUST

Funding of the Initiative: (Dollars in thousands)

	FY 1997 Appropriation	FY 1998 Pres. Budget	FY 1999 Department Request	Incremental Request +/- PB
HIPAA: 1/				
Medicare Integrity Program				
HCFA Only	$440,000	$500,000	$955,000	+$455,000
HCFAC Program Funds: 2/				
OIG	70,000	84,650	97,350	+12,700
HCFA	3,750	950	1,090	+140
AoA	1,100	1,300	1,495	+195
OGC	1,600	2,200	2,530	+330
HRSA	2,000	---	---	---
Subtotal, HCFAC	78,450	89,100	102,465	+13,365
Subtotal, HIPAA	$518,450	$589,100	$1,057,465	+$468,365
Other Appropriated Funds:				
AoA	$4,449	$6,449	$11,500	+$5,051
SAMHSA	---	---	10	+10
Subtotal, Other Funds	4,449	6,449	$11,510	+$5,061
Total, ORT Funding 3/	$522,899	$595,549	$1,068,975	+$473,426

1/ Health Insurance Portability and Accountability Act of 1996 (mandatory appropriation).

2/ The FY 1997 Enacted and FY 1998 Estimate reflect current negotiated amounts within the Health Care Fraud and Abuse Control (HCFAC) Program. The FY 1999 Estimate will change pending negotiation and agreement between the Secretary of HHS and the Attorney General.

3/ Funding for ORT under the HCFAC Program represents those funds in HHS components only. This does not include HCFAC Program funds for the Department of Justice or other non-HHS/DOJ agencies.

Child Care 1999-2002

THE WORKING FAMILY
CHILD CARE INITIATIVE 1999-2002

During the last quarter century, the entrance of mothers into the paid labor force has changed the face of the American work force. Currently, a majority of American families is comprised of either two working parents or is headed by a single working parent. Child Care has become the "new neighborhood." Millions of America's families depend on access to affordable quality child care in order to be productive workers. Their children depend on child care that provides safe, healthy and productive learning environments.

Child Care is an issue that cuts across income lines. However, the struggle to find affordable quality care is particularly acute for low-income working families. The new work requirements contained in the welfare reform law will result in a great number of parents going to work and placing their children in child care. With welfare reform's emphasis on labor force participation of mothers, child care has become an integral aspect to determining the success of welfare to work efforts. As a result, access to affordable and high-quality child care is of primary concern.

As we move into the 21st century, it is time to take bold new action to develop a child care system that works for all of America's working families. This initiative is designed to assure that the FY99 budget lays the foundation upon which we can begin to build a more effective child care system to support working families and promote child development. It is designed to move us towards a vision in which:

Every community will have a continuum of affordable, quality care for children from birth through early adolescence.

THE NEED FOR AFFORDABLE QUALITY CHILD CARE

AFFORDABILITY

Access to affordable and high-quality child care remains out of reach for many American families. While the average family pays about 7 percent of its income for child care, child care consumes about a quarter of the income of low-income families who pay for care. Furthermore, as the demand for affordable child care services increases, waiting lists for child care assistance for these families continue to grow.

Federal child care assistance in FY97 provides $2.9 billion in direct subsidies, serving a little more than one million children. Although estimating the extent of the need for child care assistance is difficult, if we consider working families with children earning at or below 150 percent of poverty (or about $20,000 for a family of three), we are currently providing child care subsidies for less than one quarter of them.

In addition to child care assistance, the Dependent Care Tax Credit provides more than $2 billion in tax relief for child care expenses. However, because it is not refundable, the vast majority of low-income working families are unable to access this assistance. For these families, the amount of the credit has not been adjusted since 1982, despite significant increases in the cost of care over the last 15 years.

SUPPLY OF CARE

Even when funds are available, the lack of adequate supply leaves many families without access to care. A recent GAO report documents the need for more child care, particularly for infants and toddlers, school age children and children with disabilities. For example, while there are currently 50,000 school age programs, serving 1.7 million children across the country, there are more than 16 million school age children who have working families. Moreover, this situation is further exacerbated by the lack of "odd-hour care" for families working night shifts.

QUALITY

Research has documented the importance of quality child care programs to school readiness. The first years of life are critically important to determining academic success, and studies have shown that quality school age child care can have a positive impact on academic achievement, especially for children who are most at risk for school failure.

Despite this correlation between quality of care and education, many stories have raised serious concern about child care quality during the past decade. From the "National Child Care Staffing Study," released in 1989, to the more recent "Cost and Quality Study," we know that the quality of child care for most children remains far from adequate. Furthermore, in recent months, even the basic health and safety of child care has become a national concern.

Although 4 percent of federal dollars are set aside to address quality, there are limited additional resources to help build infrastructure, provide training and consumer services, and make other improvements. Child care providers are the key to a quality program. However, the majority of states require no pre-service training for teachers or family child care providers. Child Care teaching staff typically earn about $6.50 an hour or a little more than $12,000 per year and often receive no benefits. This lack of support for the child care workforce results in high turnover, affecting the overall quality of care.

GUIDING PRINCIPLES FOR CHILD CARE POLICY

Meeting this critical need calls for major new public and private investment and a bold comprehensive approach based on the following principles:

- Child care is critical to workforce development and child development.

- A broad range of working parents need some assistance in accessing affordable quality care.

- The quality of care affects school readiness and academic achievement.

- The quality of care is directly related to the investments made in programs and providers.

- All segments of society: parents, schools, employers, health providers, other community agencies, states and the federal government must be involved to ensure access to adequate care.

GOALS AND OUTCOMES

This initiative sets forth an approach to address three key issues: affordability, school-age care and quality.

We propose the following outcomes for this investment.

To improve the economic and social well-being of working families with children by:

- Increasing the number of low income families with access to affordable child care by doubling the number of children receiving direct child care assistance by the year 2002 (reaching 2 million low-income children).

- Increasing the number of families with school-age children who have access to child care by doubling the number of programs serving school age children in after-school and summer programs, including youth sport programs.

To improve the quality of child care to promote childhood development by:

- Improving the quality and accessibility of care in more than 500 communities across the country, with a particular focus on assuring the health and safety and school readiness of children 0-5.

- Increasing the number of trained child care providers by expanding access to training and other supports for 50,000-75,000 child care providers per year.

- Increasing the number of informed consumers and improving child care data and the use of technology by increasing access to consumer education, innovation and data collection in every state.

FY 1999 Budget Request

This proposal will require changes in Title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1986. The proposed funding level for **The 1998 Amendments to The Child Care and Development Block Grant** (CCDBG) is $2 billion in mandatory funding for FY99.

We are also proposing that this effort be accompanied by changes in the Dependent Care Tax Credit to make this authority more supportive of working low-income families.

The following five initiatives are designed to address the three key issues of **affordability, quality and school age care**. These initiatives build on existing developments in the field, attempting to bring promising programs and practices to scale.

Affordability

1. Child Care Assistance for Working Families

- Increase funding for the Child Care and Development Fund (CCDF) by $700 million in order to provide at least 1.25 million child care slots in FY99, increasing to 2 million slots by FY02.

- States would be allowed to integrate these funds into their Child Care and Development Fund and match with state, local or private sector dollars.

- Like existing resources in the CCDF, these dollars would enable parents to choose child care in their preferred setting, subject to State health and safety standards.

- States would be required to set benchmarks to expand eligibility to serve more working families, to make copayments more affordable, and to improve reimbursement rates.

Quality

2. Child Care Caring Communities

- Increase CCDF funding by $800 million.

- Distribute through the CCDBG State formula.

- Grants of $500,000-$2 million would be made to establish family child care networks, promote accreditation, provide consumer education, provide training, meet standards, promote health and parent education in child care and improve access and affordability. Communities would select priorities based on local need, with a focus on care for infants and toddlers.

- Funds would be Federal with a 20 percent local match. Funds would go from the State level to communities across the states.

- States would have to assure that they would take steps to incorporate key protections for children's health and safety outlined in "Stepping Stones" developed by the American Academy of Pediatrics and the American Public Health Association.

- Communities would have to form partnerships with the private sector to access funds.

3. T.E.A.C.H. USA (Teacher Education and Compensation Helps).

- Increase CCDF funding by $150 million.

- This builds off the success of the T.E.A.C.H. program launched in North Carolina and now emerging in 4 other states. (T.E.A.C.H. is a State program that offers a variety of educational scholarship opportunities to child care providers that enhances their skills and marketability.)

- Funds would be all federal to state, using the CCDBG formula.

- States would have to agree to set standards for child care provider preparation. The licensure of providers would be encouraged.

- Funds would primarily be for scholarships; however, states could set aside a portion for program development.

4. The 21st Century Child Care Fund

- Increase CCDF funding by $50 million.

- Funds would be administered directly from the Federal level. HHS would:

  - Establish a consumer hotline for parents which would connect with local resource and referral agencies.

  - Launch a public awareness campaign for parents on choosing and monitoring quality care and parent involvement.

- Establish a National Center for Child Care Statistics.

- Support innovations in the use of technology to encourage distance learning and interactive computer programs as part of child care teacher preparation.

- Support research and demonstrations on child care issues that could benefit other communities.

School-Age Care

5. **Making the Most of Out of School Time** (The MOST USA Initiative is a community-wide process for expanding the supply of school age child care.)

   - Increase CCDF funding by $300 million.

   - This builds upon projects successfully launched across the country to build the quality, supply and affordability of school age care in communities.

   - Funds would be distributed to the states based on the CCDBG formula.

   - Funds would be federal with a 20 percent local match. Funds would go from the State to schools or community based agencies.

   - Funds would be provided to improve and expand school age services from preschool to early adolescence.

   - The National Youth Sports Program would be integrated into this part of the initiative in order to give children opportunities to participate in organized sports programs during the time they are not in school.

OTHER PARTICIPATING AGENCIES

The involvement of other Federal agencies, both within and outside of HHS, will be determined in the upcoming weeks.

Dependent Care Tax Credit

HHS staff is currently working with Treasury to develop proposals to expand the Dependent Care Tax Credit and make it more supportive of low income working families. Issues under consideration include increasing the income level at which families receive the full credit, increasing the amount that can be claimed towards the credit, and exploring issues around refundability.

Child Care Initiative

	FY 1997 Appropriation	*FY 1998 President's Budget*	*FY 1999 Request*	*Request +/- PB*
Administration for Children and Families				
Child Care and Development Block Grant	$ 19,120,000	$1,000,000,000	$1,000,000,000	-0-
Child Care Entitlement	$ 1,967,000,000	$2,117,000,000	$4,167,000,000	+$2,050,000,000
Total, ACF	$ 1,986,120,000	$3,117,000,000	$ 5,167,000,000	+ $2,050,000,000
Initiative Total				+ $2,050,000,000

Performance Plans Summary

PERFORMANCE PLANS SUMMARY

For over three years, the Department of Health and Human Services (HHS) has worked actively to plan for and develop its first Annual Performance Plan under the Government Performance and Results Act (GPRA). As we anticipated, it has been a challenge to prepare a plan that identifies detailed performance information covering some 300 separate program activities and a dozen agencies, while attempting to link that information to a new Department-wide GPRA strategic plan. Yet, the first HHS Annual Performance Plan for FY99 achieves our objective to comply with the provisions of the GPRA and Office of Management and Budget (OMB) Circular A-11, Part 2, and to initiate extensive but fundamental performance planning and measurement for the programs administered by the Department. It is the primary purpose of this document to summarize the Departmental and program performance elements of the Annual Performance Plan, to identify and address the challenges still before the Department in implementing GPRA, and to provide appropriate references to detailed performance measurement information contained in the annual performance plans of HHS components.

The HHS Annual Performance Plan focuses on two important and very different aspects of performance assessment. The first aspect is performance assessment at the Department level. The Annual Performance Plan is an essential tool for the assessment of the HHS Strategic Plan because it builds on and supports the Plan, and provides specific performance measures for the Strategic Plan. This aspect of the Annual Performance Plan is addressed under ***Strategic and Annual Performance Planning*** below. The second aspect of performance assessment is at the agency and program level. This level of assessment responds to the GPRA requirement for the assessment of program activities through annual plans. Because the two processes (budget and performance plan) were developed together, HHS is able to provide the necessary link of performance goals to budgetary resources. This aspect of performance assessment is addressed under ***The Performance Plan and the Budget*** below.

The most fundamental, substantive content of the HHS Annual Performance Plan is the identification of performance goals and indicators for FY99 for HHS's program activities. These goals and indicators, which are summarized here and presented in detail in the individual budget and performance plan submissions of HHS components, provide a portrait of what HHS and its program performance partners will achieve through HHS programs in FY99. Under ***Performance Goals and Indicators***, we address performance goals and indicators in the context of GPRA requirements, and provide summaries of the annual performance plan content and approaches of the HHS components.

(NOTE: Because of the volume of the attachments addressed in this document, HHS has not included them here, but has sent them under separate cover to the Office of Management and Budget.)

Throughout the GPRA development phase, OMB, the General Accounting Office (GAO) and others noted the challenges that Federal agencies and their partners will face with the implementation of GPRA. It led GAO, OMB and others to acknowledge that implementation will be uneven in the first plans submitted by Federal agencies in FY97, and will require "iterative" implementation for virtually all Federal agencies. Given the number, size, diversity, funding, and administrative complexity of HHS programs, there are numerous challenges that HHS will face with the implementation of GPRA. Significant challenges and issues surrounding this first annual performance plan are addressed below under ***Annual Performance Measurement Challenges for HHS.***

The attachments to this document identify all performance goals and indicators included in the HHS Annual Performance Plan. The attachments display goals and indicators as they relate to the HHS Strategic Plan and to individual programs, and will facilitate the review of the HHS Annual Performance Plan. They will also serve as a resource to OMB to assist in the identification of goals and indicators to incorporate into a government-wide annual performance plan. To facilitate this effort, HHS has displayed its performance goals and indicators according to Federal Budget functions.

STRATEGIC AND ANNUAL PERFORMANCE PLANNING

As indicated in the draft HHS Strategic Plan submitted to OMB in compliance with the GPRA on August 15, 1997, the Strategic Plan is the first and guiding element in HHS performance management under GPRA. It is the Mission of HHS ***to enhance the well-being and health of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.*** To carry out that mission, the HHS Strategic Plan identifies the following six goals that define the performance management framework of the Department:

- Reduce the Major Threats to the Health and Productivity of All Americans;
- Improve the Economic and Social Well-being of Communities, Families, and Individuals in the United States;
- Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs;
- Improve the Quality of Health Care and Human Services;
- Improve Public Health Systems; and
- Strengthen the Nation's Health Sciences Research Enterprise and Enhance Its Productivity.

The Strategic Plan goes on to identify and describe strategic objectives that will lead to the attainment of the Department wide goals, explains the processes that will contribute to the assessment of performance under the Strategic Plan, and defines success measures that will constitute the principal basis for the assessment of the achievement of HHS goals and objectives.

The second element of HHS performance management, and one which is essential to the assessment of the Strategic Plan, is the HHS Annual Performance Plan. HHS will rely extensively on its Annual Performance Plan to define the progress being made during a fiscal year toward achieving the general goals and objectives that appear in the Strategic Plan. As a result, the majority of the success measures identified in the HHS strategic plan have direct counterpart measures in the Annual Performance Plan. Attachment 1 identifies the specific success measures of the Strategic Plan alongside the counterpart measures included in the Annual Performance Plan.

The success measures do not constitute the entire universe of performance measures that HHS will use to assess its programs. There are many performance goals and indicators in the HHS Annual Performance Plan that do not at present appear as success measures in the Strategic Plan. At some point, a number of these may also be used to assess agency-wide strategic goals, and will be used for internal management purposes. To facilitate an understanding of the potential linkage of the remaining indicators to the HHS Strategic Plan, Attachment 2 arrays all annual performance goals and indicators in the HHS Annual Performance Plan under a specific HHS strategic goal.

Other HHS activities and initiatives are also critical to the success of the HHS Strategic Plan and will factor into its assessment. The Secretary's initiatives in particular, described in detail in other parts of the HHS Budget Summary, represent the Secretary's priorities for the Department and, as such, are an important element of HHS efforts to achieve its mission, goals and objectives. They will contribute significantly to the assessment of HHS' success in achieving its strategic goals. The initiatives, which reflect important strategies related closely to the HHS goals themselves are:

- National Health Research;
- Children's Health Initiative;
- Reducing Tobacco Use;
- Youth Substance Abuse Prevention;
- Health Care Quality Improvement;
- Operation Restore Trust; and
- Child Care 1999-2002.

Similarly, through its participation in the Vice President's National Performance Review, HHS will track the progress of three HHS Reinvention Impact Centers: ACF, FDA, and HCFA, in achieving bold goals to deliver great service, foster partnership and community solutions, and reinvent to get the job done with less. The reinvention performance goals of these three agencies are identified in Attachment 3.

THE PERFORMANCE PLAN AND THE BUDGET

Just as OMB Circular A-11, Part 2, has stipulated that "the program activity structure is the foundation for defining and presenting performance goals and indicators," HHS has determined that the Budget of HHS, which describes HHS program activities and necessary resources, provides a solid framework and the necessary structure for the development and presentation of an annual performance plan for an agency that administers some 300 program activities. In line with the determination of GPRA and OMB Circular A-11, Part 2, that annual performance plans must become an integral part of agency budget requests, HHS has elected from the outset to incorporate its Annual Performance Plan directly into the HHS Budget. The decision to present performance information in the format of the budget reflects HHS's intent to begin immediately to enhance its budget justification and decision making with performance measurement information.

There are other significant advantages to incorporating the Annual Performance Plan into the HHS Budget. The Budget routinely describes program activities and specifies associated resource needs, which is information that is also required by GPRA for inclusion in annual performance plans. Combining the performance plan and the budget not only minimizes burden on program managers but ensures the consistency of information used for budget and performance planning purposes. Finally, because the HHS Budget routinely covers all HHS program activities, including the performance plan in the Budget provides the framework to ensure that performance information fully covers these activities as well.

As a result, just as the HHS budget request is presented in multiple volumes that address the resource needs and justifications of the individual operating and staff components of HHS, so also is the HHS annual performance plan presented in the same manner. The detailed and substantive information that fully explains program-level performance and that constitutes the plans for the individual HHS components is included in the budget presentations and annual performance plans of those agencies. A thorough understanding of HHS program-level performance information requires the study of the annual performance plans of the HHS components.

PERFORMANCE GOALS AND INDICATORS

The most fundamental, substantive content of the HHS Annual Performance Plan is the performance goals and indicators for FY99 for HHS's program activities. All HHS programs are represented in the Annual Performance Plan by quantitative performance goals and indicators, and many of these goals and indicators are related to program outcomes and results. HHS's annual performance goals and indicators, which are presented and explained in detail in the individual budget and performance plan submissions of HHS components, provide a definitive portrait of what HHS and its program performance partners will achieve through HHS programs in FY99. In addition, the goals and measures go a long way toward explaining how resources administered by and through HHS are used, and what results are to be accomplished with these resources.

To accommodate a summary review of the performance goals and measures presented in the FY99 Budget and Annual Performance Plan, we have presented all of the goals and measures in a summary matrix in Attachment 4 of this document. The attachment identifies all goals and measures by HHS component agency and by program activity or aggregated program activity. Although all goals and indicators are included, the appendix is necessarily a summary document that should not be relied on to understand and explain the substance, rationale, context and significance of the individual measures. A review of the individual submissions of the HHS program and staff agencies is essential for that level of understanding.

Although reviewers must refer to the budget submissions of HHS components for detailed performance information, we provide in this document a general description of how the performance goals and objectives of individual HHS components support the Department's Strategic Plan, and how these varied components have approached the implementation of GPRA requirements for annual performance plans. The following sections summarize pertinent information about performance assessment approaches and identify significant areas of performance objectives and measures that the HHS components have identified for FY99.

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

ACF provides critical, and in some cases primary, program support for the achievement of HHS goals to: improve the economic and social well-being of communities, families and individuals in the United States; improve access to health services and assure the integrity of the nation's health entitlement and safety net programs; and improve the quality of health care and human services. ACF programs and agency objectives that support HHS goals include welfare to work, parental responsibility, early childhood intervention, child care and child protection, teen pregnancy prevention, community development and support for people with disabilities. ACF has lead responsibility for the Department for coordinating and assisting in the national effort to

move families from welfare to work under the Temporary Assistance for Needy Families (TANF) program. The agency has had extensive consultation with States and other customers/partners for the purpose of developing work participation standards, the High Performance Bonus program, and the TANF data collection system.

ACF's Annual Performance Plan reflects that ACF administers a variety of programs in a complex funding and partnership environment where control over how programs are carried out varies greatly. ACF's plan establishes eight cross-cutting strategic objectives under which 35 budget activities have been consolidated into thirteen key program areas. Performance goals and measures are stated under the program sections. The selection of performance objectives, measures and targets has generally involved the participation of partners, including States and Territories, Tribes and Native American organizations, nonprofit grantees, local communities, and universities. ACF's approach enables its partners to use the various program resources within ACF to provide early childhood enrichment and to increase the economic and social well-being and productivity of families

ACF's ability to measure results is affected by the availability and reliability of data. Pertinent data systems are largely operated by ACF's partners. Investments in the collection of information have resulted in good data in many cases, but in other areas, partners have had to balance paying the costs of data collection against the critical need to deliver program services.

The ability of ACF and its partners to achieve program results may also be substantially affected by external factors. For example, programs seeking to improve economic independence and self-sufficiency, such as TANF, Child Support Enforcement, Refugee, will be affected by such factors as the job market, economic cycles, changing demographics, the mores of family formation and child bearing.

ADMINISTRATION ON AGING (AoA)

AoA is a key contributor to the HHS goals of improving the well-being of individuals, families, and communities, and of improving the quality of health care and human services. AoA advocates on behalf of the aging population to increase their opportunities for an active and healthy aging experience. AoA is working toward expanding the access to consumer directed, home and community-based long-term care and health services. AoA's success in accomplishing both of these HHS objectives will be gauged by the improvements that AoA and its partners, the aging network, make in providing services to the elderly.

AoA's aggregated presentation of performance information reflects the coordinated network approach for nutrition, health, rights, abuse prevention, counseling and other support services which are funded in part by AoA, and which are provided by the States, Indian tribes, area agencies on aging, and providers. To help secure and maintain maximum independence and dignity for older individuals, AoA has identified capacity and output targets for access to an

array of community-based services. The number of older individuals receiving case management is to increase in FY99 by 93,800, and an additional 70,000 functionally impaired individuals will receive services.

The study,"Infrastructure of Home and Community-Based Services for the Functionally Impaired Elderly", which catalogued measurements of the need for and provision of long-term care services in home and community-based settings, has affected some AoA performance decisions. In FY99, AoA plans to increase the proportion of older people who are nutritionally healthy or to prevent their decline, by providing high risk individuals with home-delivered meals. The success of this goal will be determined by the increases in the numbers of people who receive home-delivered meals and the number of meals. Due to the great demand for these services, AoA is proposing to increase the number of people served by 495,000 (50 percent) and meals by 72 million (60 percent) in FY99.

AoA also will seek to maintain the level at 123.4 million meals for 2.4 million people who receive congregate (group) meals. In addition, AoA has also focused on Long-Term Care Ombudsman, Native American, Alzheimer's, and Community Service Employment needs of senior Americans, and a research program under AoA's Title IV authorization, which will expand the success of the long-term care ombudsman to 15 health care ombudsman demonstration and evaluation projects.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR)

Health services research sponsored and conducted by AHCPR provides essential knowledge on what works, and at what cost, in health care and the health care delivery system of the United States. Areas of study include the outcomes, effectiveness, cost-effectiveness, quality and quality measurement, cost, financing, and organization and delivery of health care. Products and tools based on research findings facilitate the dissemination and use of this knowledge in Departmental programs and by patients and their care givers, clinicians, policy makers, planners, purchasers, health care institutions and systems, and researchers.

AHCPR-sponsored research will be essential to improving the quality of health care as discussed under HHS strategic goal 4, both through its own portfolio and through its support of the Secretary's Improving Health Care Quality initiative. In addition, AHCPR's work will make significant contributions to advancing knowledge about health sciences under strategic goal 6.

For fiscal year (FY) 1999, AHCPR's research will focus on: (1) New Investigator-Initiated Research; (2) Key Areas of Emphasis; and (3) Cross-Cutting Themes. This is reflected as the main emphasis of its performance plan. The Agency's research funding is described in the budget line entitled, Research on Health Costs, Quality, and Outcomes (HCQO). In addition

to AHCPR's research initiatives, the funding for AHCPR's support of three Secretarial Initiatives: (1) Improving Health Care Quality, (2) Children's Health, and (3) Moving from Welfare to Work is listed under HCQO.

Funding for the development and maintenance of the Medical Expenditure Panel Surveys is detailed under the MEPS budget line; funding for program support activities is under the Program Support budget line. These budget lines have corresponding goals and objectives in the annual performance plan.

The AHCPR FY99 Annual Performance Plan describes the goals, objectives, and strategies that the Agency will use to accomplish its mission, and the indicators it will use to assess its achievements. For example, as noted in Goal 1, objective 1e, AHCPR will measure the impact of its research, products, and tools on the health care system through evaluative studies during the coming year. AHCPR has made laudable efforts in quantifying its proposed results, where possible. For instance, to support new knowledge, investigator-initiated research will be increased to 50 percent of the AHCPR research portfolio and 223 new, priority research grants will be awarded. These indicators will be supplemented by reviews and metric assessments.

AHCPR also will use a variety of mechanisms to validate the information and data presented to describe what has been achieved for the indicators. A great deal of the information needed relates to the funding and results of research. The AHCPR financial and grants management computer systems automatically collect much of this information. Many Agency activities (e.g., tool development) have evaluation components built directly into the projects. Where there are no tracking systems in existence, e.g., the training of future researchers, AHCPR will also undertake an evaluation study to determine the impact of AHCPR-sponsored and conducted research on the health care system. Finally, as the results of the assessment activities are produced, the Agency will evaluate whether the right indicators are being used to measure its success.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Through programs and initiatives associated with key HHS priorities, CDC has principal and central responsibility for HHS success in reducing major threats to the health of Americans. CDC has developed outcome performance goals for program activities, such as Vaccine-Preventable Diseases, Immunization, HIV/AIDS, Diabetes, Breast and Cervical Cancer, Environmental Disease, Occupational, and Toxic Substances. These will improve the overall health of Americans by reducing disease and injury rates. Since prevention and control of diseases is the key mission of CDC, it has also targeted capacity, process, and output improvements in the infrastructure necessary to identify, prevent, and control these rates.

CDC has identified significant measures to assess program performance that are critical to HHS performance objectives.

- To assess the success in reducing health threats due to unsafe sexual behaviors, CDC will use the rate of the perinatally-acquired HIV/AIDs. In FY99, CDC has committed to reduce the number of babies with perinatally acquired HIV/AIDs by up to 50 percent.

- CDC and its partners will reduce the morbidity and mortality rates of other diseases by ensuring that 92 percent of 2 year olds are immunized to meet the targeted reduced rates of measles, polio, pertussis, tetanus, etc.

- At least 85 percent of contacts of infectious TB cases will complete a regimen of preventive therapy.

- States will have improved tobacco prevention activities to reduce related diseases.

- States will have enhanced capabilities to quickly identify and respond to food-borne illnesses such as E. coli.

- No more than 40 in 100,000 women over 50 who participate in the national early detection program for cervical cancer, will develop invasive cancer.

- To ensure safe and healthy working conditions for 127 million American workers, CDC will join with other federal agencies in FY99 in initiating a surveillance system for workplace hazards; the results of this information will then be disseminated to prevent injuries and death.

FOOD AND DRUG ADMINISTRATION (FDA)

The programs of the Food and Drug Administration (FDA) protect and promote the health and safety of the American people by the regulation of foods, cosmetics, human and animal drugs, animal feed, tobacco, and the biological products and devices used for medical purposes. The role of FDA is prominent in the HHS goal to improve public health systems, and particularly with the strategic objective of HHS to assure food and drug safety by increasing the effectiveness of science-based regulation. FDA's annual performance plan provides the assessment capacity for HHS to identify incremental progress in achieving this objective. Similarly, FDA shares significantly in the Department's goal to reduce threats to the health of Americans through its regulatory efforts related to tobacco and food labeling.

FDA laid out its performance measurement approach in a strategic framework which focuses on its pre-market review and post-market assurance regulatory activities. There are numerous goals that address FDA's review time for food additives, new drugs, biological products (blood, tissue, vaccines) and medical devices; and its efforts to ensure that manufacturing establishments for these products conform to FDA standards. There are some outcome measures such as the availability and usage of food labels in making nutritious food selections and the response time for outbreaks associated with food hazards. In addition, FDA also included measures for the underlying processes and research that support these efforts. FDA

has also included process measures for many of the actions and data collection systems that are necessary to report additional outcome measures.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Through its administration and management of the Medicare and Medicaid programs HCFA and its partners are primary performers in HHS goals to improve access to health services, the integrity of entitlement programs, and the quality of health care, as well as the strengthening of the nation's health sciences and research enterprise. The performance goals and indicators of HCFA are particularly important to the Department's commitment and efforts to eliminate fraud, abuse and mismanagement in Medicare and Medicaid. HCFA addresses this major HHS management challenge and high-risk area with definitive goals and measures to reduce fraud, particularly in the vulnerable home-health sector, to reduce improper payments, and to increase electronic transactions that are less prone to problems.

To achieve HHS's overarching goals and HCFA's own well defined strategic goals and objectives, HCFA has identified 21 performance measures, subdivided into three levels of activity associated with beneficiary service and support. The HCFA measures that are most closely aligned with beneficiaries, and thus are more outcome oriented, are at the core of the Agency's approach to performance measurement and constitute the first level of measurement focus. This core consists of measures of beneficiary access to care, beneficiary satisfaction, and measures of the content of care that beneficiaries receive. A second level of measures supplements the core beneficiary-centered measures, are also closely related to beneficiaries, and in some cases are considered proxies for the core beneficiary-centered measures. For example, measurement of beneficiaries' receipt of influenza vaccines and mammograms are both direct measures of HCFA quality efforts, but also are considered supplemental proxy measures of beneficiary access to care. The third level of measures rounds out HCFA's approach by incorporating measures that are of the "output" variety and are more closely aligned with administrative functions. An example of a measure in this third level relates to improvements in payment safeguard strategies.

This tri-level approach to performance measurement provides comprehensive coverage of Medicare and Medicaid, using a balancing among types of measures connecting to the Agency business functions. HCFA has focused on identifying a set of significant meaningful performance measures that speak to both the fundamental program purposes, but also incorporates key output-oriented measures that tie to administrative budget activities. Within the performance goal identification process, HCFA has focused on selecting measures that will be meaningful to its program managers.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

The performance goals and program efforts in HRSA's Annual Performance plan are consistent with and supportive of the Department's strategic goals. The Maternal and Child Health program will contribute significantly to reducing the major threats to Americans' health. The activities of a majority of the programs in the Bureau of Health Professions (BHPr), and the HIV/AIDS and rural health programs focus on improving access to health services and assuring the integrity of the Nation's health entitlement and safety net programs. In particular, the BHPr programs are designed to foster a primary care and public health workforce that is qualified, diverse, and appropriately distributed to meet the needs of underserved, vulnerable, and special needs populations. Improving the quality of health care is addressed by the National Practitioner Data Bank and the Vaccine Injury Compensation Programs and by efforts to develop a highly skilled health care workforce. The organ procurement and transplantation program also addresses quality with particular emphasis on reducing the disparities in the receipt of quality health care services and reducing the injury in health care delivery.

The HRSA performance plan includes performance information for each of the agency's program activities. HRSA has made a strong effort to build a performance management approach into the way it conducts its business. The agency structured the development of its Strategic Plan to be consistent with the requirements of GPRA. The goals in the plan have guided the development of the Annual Performance Plan for FY99. HRSA's performance measurement effort has included an assessment of all programs and their readiness for measuring performance. The agency, using each major program budget line:

- Identified both strengths and weaknesses in terms of ability to measure performance.
- Assessed the current availability of indicators and data that can be used to ensure effective management of resources.
- Identified key areas where developmental activities are needed and have channeled agency resources to these areas.

One highlight of HRSA's plan is the Bureau of Health Professions' (BHPr) request to consolidate many categorical programs. The Bureau has developed four cross-cutting goals to begin to integrate the activities of the categorical programs. The consolidation itself would: (1) achieve a common set of specific outcomes in the area of health workforce diversity and distribution; (2) streamline the administration of Federal program initiatives; (3) explore new directions for national policies in the health professions; and (4) continue the content and effectiveness of ongoing training activities central to HRSA's mission. The flexibility of broader, consolidated authorities would allow institutions and their partners to be more responsive to community/regional workforce needs.

INDIAN HEALTH SERVICE (IHS)

IHS is a significant internal HHS partner in reducing health threats and improving health quality and access to health care for American Indians (AI) and Alaska Natives (AN). Improving the health status of American Indians and Alaska Natives is a specific strategic objective of the Department, which relies on annual goals established and indicators defined by IHS. In addition, IHS efforts to prevent and treat alcohol dependence continues to be a special area of emphasis for the agency and an important component of HHS's Department-wide objective to reduce alcohol abuse.

The IHS performance plan includes 25 performance indicators that are consistent with the IHS history of focusing on health improvements for the population it serves. The indicators were developed in partnership with the critical stakeholders including tribal representatives. The performance indicators represent sentinel indicators for the IHS in that they are specifically focused on the 12 most significant health problems affecting AI/ANs, and/or the essential services that address them. These problems include: diabetes, obesity, cancer, heart disease, alcohol and substance abuse, family abuse and violence, injuries, dental diseases, poor living environment, mental health, tobacco use, and maternal and child health. They all represent important links in the GPRA/Public Health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it occurs (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., reducing diabetic complications). Given that there will always be ten leading causes of death, the focus of IHS is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than target end point problems such as heart attacks and stroke. This is the approach that has resulted in the improvements in health status of AI/AN people.

IHS has also included indicators for assessing how its consumers perceive the quality of and access to services, and how its stakeholders perceive its performance in assuring adequate consultation and advocating for the needs of AI/AN people. Finally, IHS has developed indicators addressing its effectiveness in building collaborative relationships with other organizations and meeting its obligations as an Agency in the Department.

NATIONAL INSTITUTES OF HEALTH (NIH)

NIH programs and activities are central to the mission of HHS to foster sustained advances in the sciences underlying medicine and public health. Through its related mission to sponsor and conduct research that leads to better health for all Americans, NIH supports its own well-defined strategic plan and HHS's strategic goals to reduce threats to the health of Americans, improve public health systems, and strengthen the nation's health research enterprise. In line with the substance and structure of its strategic plan and the need to focus performance on the

achievement of advances in science, NIH has determined that a *combination* of qualitative and quantitative performance goals and indicators will provide the most meaningful and appropriate basis for GPRA assessments of NIH's programs.

Consistent with its strategic plan, has aggregated its program activities for measurement purposes into three categories of activity: the **Research Program**, the **Research Training and Career Development Program**, and the **Facilities Program**. For the **Research Program**, qualitative measures will of necessity play a primary role in gauging NIH performance in achieving advances in science to meet that aspect of the HHS mission. For example, narrative descriptions of research accomplishments will be put into the context of what was previously known and unknown. Where possible, the economic impact of advances in science will also be addressed. This kind of information will provide a perspective for where an advance fits within the continuum of medical research, and its contribution to understanding and improving human health. Nonetheless, quantitative indicators will also be employed where possible.

Evaluations of the **Research Training & Career Development** and the **Facilities** programs better lend themselves to quantitative measures. And such indicators will be prominent with these programs. But even here, quantitative measures alone do not provide an informed basis for judging program success, and a mix of quantitative and qualitative indicators will be utilized.

In its explanation for its approach, which is consistent with the findings of other research agencies actively implementing the provisions of GPRA, NIH observes that missions directed primarily at advancing fundamental science face unique challenges in implementing the quantitative evaluations preferred under GPRA. It is neither feasible nor sufficient to capture the breadth and impact of such research activities through strictly numeric goals and measures. Conventional scientific research metrics measure only some dimensions of output. These measures provide relevant data, but are insufficient for generating the necessary, larger picture of the quality, relevance, and impact of an overall research program. As the General Accounting Office, the President's Office of Science and Technology Policy (OSTP) and numerous others who have studied the processes of science & technology and innovation have noted, the linkages between inputs and outputs in basic science (the predominant share of NIH's activities) are complex, can take many years to reach fruition, and, very often, are difficult to accurately anticipate in advance. Research agencies should rely on a combination of quantitative and qualitative measures to assess performance under the GPRA.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA has an important role in supporting the goals, and many of the specific objectives, of the HHS strategic plan. For example, SAMHSA's goals of reversing the upward trend and use of marijuana among 12-17 year olds and reducing tobacco use among teens and preteens are integral to the Department's strategic goal to reduce major threats to the health and

productivity of all Americans. SAMHSA components are contributing to improving the health of American children through a number of specific objectives: increasing the number who have a "healthy home" in a healthy community; improving Health Care Quality through an enhanced research base, improved clinician's access to information, improved consumer understanding of quality service choices, and improved processes and standards that protect consumers. SAMHSA will also assist in moving families from welfare to work by increasing work opportunities and economic independence for welfare recipients and low-income working families, while ensuring their well-being.

SAMHSA's performance plan establishes performance goals and measures for the agency's program activities which mirror its existing primary budget lines and one proposed additional line item.

Part I of the plan includes performance measures for three cross-cutting budget lines (Knowledge Development and Application; Performance Partnerships/Block Grants; and Data Infrastructure). The measures in Part I require further development and the plan briefly describes activities for evolving improved outcome measures over the next several years. Part II includes performance measures for budget line items that are within the purview of individual Centers. Part III currently includes measures for SAMHSA's managed care activity, one of the cross-cutting priority activities highlighted in SAMHSA's Strategic Plan for which there is no associated budget line item.

SAMHSA's FY99 performance plan contains a primarily output measures. These measures are useful in showing how well its programs are being managed and how many units of an intended product resulted from the program's activities. Output measures can also show what is actually being purchased for the dollars expended. SAMHSA programs also include various types of outcome measures which usually describe the impact of the program on the problem it seeks to address. SAMHSA's focus at this point is on developing outcome measures that show the direct results of SAMHSA dollars expended. A recent National Academy of Science report recognized that sufficient outcome measures and supporting data do not yet exist for substance abuse and mental health.

PROGRAM SUPPORT CENTER (PSC)

The Program Support Center provides a wide range of support and administrative services to components of the Department and other Federal agencies. The PSC annual performance plan on improving the cost competitiveness and quality of its administrative services in the areas of human resources, financial management, administrative operations and information technology. The PSC performance objectives are inked indirectly to the HHS strategic plan in that by achieving its goals, the PSC will provide the support necessary to help the HHS OPDIVs meet their missions and programmatic goals and objectives.

OFFICE OF THE SECRETARY (OS)

Two components within the Office of the Secretary with programmatic responsibilities, the Office for Civil Rights and the Office of the Inspector General, have prepared Annual Performance Plans. Four Staff Divisions, encompassing almost 70 percent of the total Departmental Management funding, have prepared performance information (i.e., performance goals and measures). The four divisions are the Office of Public Health and Science, Assistant Secretary for Management and Budget, Assistant Secretary for Planning and Evaluation and the Departmental Appeals Board. OCR's performance objectives are primarily supportive of the Department's strategic goal to improve access by identifying and eliminating discriminatory practices in HHS programs and by HHS grantees. The OIG's primary link to the HHS Strategic plan is to assure the integrity of the Nation's health entitlement and safety net programs. While the OIG will be deterring fraud, waste and abuse, the Office will also be recommending systemic improvements to HHS programs which will indirectly assist in these programs in meeting their own programmatic performance goals and objectives. The submissions from the OS Staff Divisions represent first good effort by components not usually included in performance measurement initiatives. Many of the ASMB performance objectives address high priority management areas (e.g., improving grants and contracts administration and financial management, achieving progress in implementing GMRA and ITMRA).

ANNUAL PERFORMANCE MEASUREMENT CHALLENGES FOR HHS

As the General Accounting Office observed in its March 1997 Report, *"The Government Performance and Results Act: 1997 Government wide Implementation Will Be Uneven,"* performance measurement under the GPRA rubric will be a developmental and iterative process. Although HHS has identified significant and substantive performance information across the Department, there will be performance information gaps for many program activities, particularly in this first year of full implementation. Because the majority of issues that will be confronted apply to specific program activities, the performance plans of the individual components address the detailed issues that we will confront. Nevertheless, many of these apply more generally on a broader scale and warrant discussion here.

Data Challenges

The HHS Strategic Plan explains one of the most critical challenges in the implementation of GPRA for the Department. The absence in many cases of timely, reliable, and appropriate data is a critical limiting factors in developing performance objectives, goals and indicators for HHS programs. This issue applies throughout the Department for many program activities, the details of which are explained in component plans. It is related significantly, however, to

the decentralized and distributed nature of program implementation throughout the Department, and to the extensive involvement and authority of non-Federal partners in program implementation and management. The issue and its implications are addressed in detail in the HHS Strategic Plan.

Data validation, which is a fundamental GPRA requirement, will also be a challenge for many HHS components. Because the circumstances and sources of performance information are so varied across the Department, the summarization of data validation is not feasible. It is addressed by the individual HHS components in their performance plans. Nevertheless, a common attribute of validation across the Department is that it will be resource intensive and require extensive coordination with performance partners.

Performance Baselines and Targets

For a number of program activities, there are outcome goals and objectives for which baseline and target data are not currently available. This is related to the issue addressed immediately above, but warrants a separate mention because the establishment of baselines are fundamental requirements of GPRA. This issue alone is adequate to explain the necessity of the iterative implementation of GPRA requirements. There are gaps in the establishment of baselines and targets for some performance goals and measures of HHS components. However, HHS and its components will identify baseline and target data for missing or developing objectives and measures as program managers and their performance partners are able to do so.

Types of Measures: Outcome vs. Output

HHS has included a balance of outcome and output measures throughout the annual performance plan. Many HHS programs directly affect the health and well-being of individuals, and should, where feasible, be measured by improved outcomes. However, as OMB Circular A-11, Part 2 anticipates, measures of output can be the predominant goals and indicators in an annual performance plan. Although the HHS plan focuses on annual results, in those instances where outcomes will require years to achieve, output measurement is essential on an annual basis. Where the contribution of a Federal agency to the production of outcome is not realistically measurable, efficiency and customer satisfaction may be assessed on an ongoing basis. Finally, the most critical results for some program activities are not always outcomes. Frequently it is the processes associated with Federal programs, regulations and activities that have the greatest impact on people and industries; and improving the timing and quality of outputs and processes may be the most appropriate and effective objectives for such programs. These instances are apparent in individual agency performance plans.

Nevertheless, some HHS components have initially made greater use of process and output measures than they will in the future because of the lack of adequate data to measure performance outcomes. As a result, future iterations of the HHS Annual Performance Plan will include substantially more outcome measures than the initial plan. A review of component performance information will identify where these circumstances occur.

Performance Partners and Stakeholders

Related also to the first two issues identified above, is the involvement of partners and stakeholders in the development of performance objectives and measures. The vast majority of funds administered through HHS are expended by groups outside the Federal Government, particularly State and local agencies, universities, insurance companies and health-care practitioners. In addition, numerous others in the community supplement and coordinate services funded by HHS and comparable service agencies. HHS's experience with performance measurement pilots and performance partnerships has demonstrated that HHS must include these performance partners and stakeholders extensively in the development of performance goals and measures, and can rely only on them for much of the information that will serve to assess the results produced by HHS programs. Achieving this in a manner that avoids prescriptive and burdensome requirements is a prominent challenge for any Federal agency, but particularly HHS because of the extent of its reliance on outsiders for program performance.

Coverage and Aggregation of Program Activities

The HHS annual performance plan provides performance information for a mixture of direct and aggregated program activities, but coverage of major HHS program activities is complete. HCFA, NIH and ACF have aggregated program activities as permitted by the GPRA, and have explained the rationale for aggregation in their parts of the HHS plan. Others, such as HRSA, CDC and FDA have elected to provide performance information for all program activities in the P and F schedule. For reporting and presentation purposes there do not appear to be significant benefits or detriments to either approach. Both allow for substantive performance information that is meaningful to HHS and the Government as a whole.

Crosscutting goals and indicators

With the development of the first annual performance plan, HHS has observed that GPRA implementation has achieved one of its early objectives. The identification of performance goals and objectives across HHS programs has provided definitive information about where greater program coordination is necessary and feasible. At this point, it appears to us that the programs and strategies of related HHS operating divisions complement each other in providing needed services, and that the various programs are not characterized by duplicative or

contradictory strategies and methods. Nevertheless, with the development of the first annual performance plan, HHS and other agencies will be better able to routinely coordinate program activities and ends toward improving outcomes for people.

Capital Planning

HHS is working to strengthen capital asset project planning and management in its implementation of OMB Circular A-11, Part 3 ("Planning, Budgeting and Acquisition of Capital Assets.") Based on the relative dollar magnitude , risk and strategic importance of HHS's capital asset portfolio, HHS is providing FY99 capital asset budget exhibits for FDA, IHS, CDC, NIH and HCFA. However, as a matter of good business practice, HHS is working will all appropriate HHS components to track the progress of their capital asset projects against cost, schedule and performance goals.