























DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVENUE S.W., WASHINGTON, D.C. 20201

THIS DOCUMENT IS ALSO AVAILABLE AT HTTP://WWW.HHS.GOV/BUDGET

TABLE OF CONTENTS

Overview 1

Food and Drug Administration 14

Health Resources and Services Administration 19

Indian Health Service 25

Centers for Disease Control and Prevention 28

National Institutes of Health 36

Substance Abuse and Mental Health Services Administration 44

Centers for Medicare & Medicaid Services 49
- Medicare 51
- Program Integrity 57
- Medicaid 59
- Children's Health Insurance Program 64
- State Grants and Demonstrations 68
- Program Management 70

Administration for Children and Families 74
- Discretionary Programs 75
- Mandatory Programs 79

Administration for Community Living 85

Office of the Secretary 89
- General Departmental Management 89
- Office of Medicare Hearings and Appeals 91
- Office of the National Coordinator for Health Information Technology 93
- Office for Civil Rights 95

Office of Inspector General 97

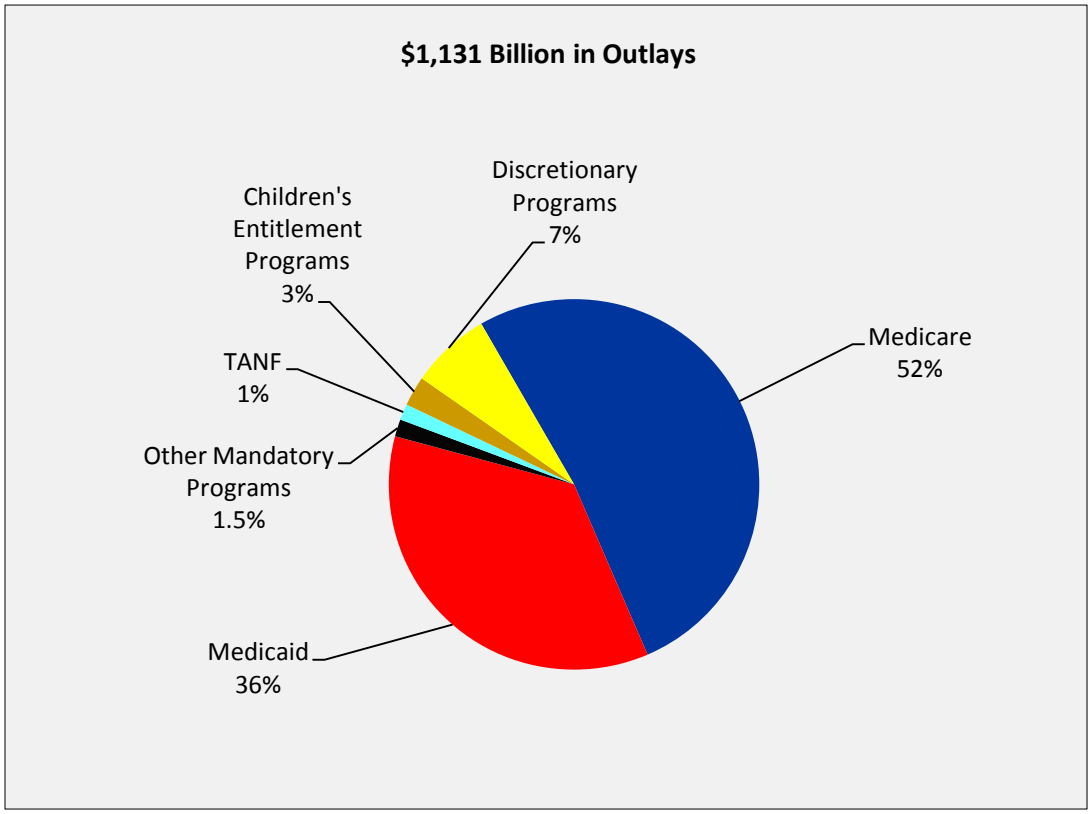
Public Health and Social Services Emergency Fund 99

Abbreviations and Acronyms 104

PUTTING AMERICA'S HEALTH FIRST

FY 2018 President's Budget for HHS

dollars in millions	2016	2017 /1	2018
Budget Authority	**1,119,166**	**1,126,789**	**1,112,883**
Total Outlays	**1,103,145**	**1,130,835**	**1,131,256**
Full-time Equivalents (FTE)	77,499	79,505	80,027
1/ A full-year 2017 appropriation was not enacted at the time the budget was prepared; therefore, the budget assumes operations under the Further Continuing Appropriations Act, 2017 (P.L. 114–254). The amounts included for 2017 reflect the annualized level provided by the Continuing Resolution.			



General Notes

Detail in this document may not add to the totals due to rounding. Budget data in this book are presented "comparably" to the FY 2018 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2018. This approach allows increases and decreases in this book to reflect true funding changes. The FY 2017 and FY 2018 mandatory figures reflect current law and mandatory proposals reflected in the Budget.

PUTTING AMERICA'S HEALTH FIRST

The Department of Health and Human Services (HHS) is enhancing the health and well-being of the American people by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

The President's Fiscal Year (FY) 2018 Budget supports the Department's mission by making strategic investments to protect the health and well-being of Americans; delivering hope and healing to the American people; promoting patient-centered care; strengthen services to tribes; investing in the health of America's future; and ensuring responsible stewardship of taxpayer dollars for long-term sustainability. Achieving these goals will require HHS to make strategic investments and carry out our mission in the most effective manner possible.

The President's Budget request for HHS proposes $69 billion in discretionary budget authority and $1,046 billion in mandatory funding to help HHS deliver on the promises the Administration has made to the American people. The Budget focuses resources on direct services and proven investments while streamlining or eliminating programs that are duplicative or have limited impact. The Department's approach to budgeting this fiscal year puts the American people first by supporting fiscal discipline within the Federal Government and saving taxpayers a net estimated $665 billion over 10 years.

A COMMITMENT TO FISCAL RESPONSIBILITY—RESTORING TRUST TO GENERATIONS OF AMERICANS

The FY 2018 President's Budget brings Federal spending under control and returns the Federal budget to balance within ten years. Of its total net estimated ten-year savings over this period, the HHS Budget contributes $665 billion in mandatory savings primarily from giving States new flexibilities to operate their Medicaid programs under per capita caps or block grants beginning in Fiscal Year 2020. The President has embraced these bold reforms that save, strengthen, and secure the promises of the Federal Government's major benefits programs. The Budget ensures that Medicaid and other programs focus on the most vulnerable Americans that they were intended to serve—the elderly, people with disabilities, children, and pregnant women.

Failing to tackle unsustainable deficit spending means passing growing debt on to our children and grandchildren and creating serious economic damage. The Federal Government's deficit spending has created a growing debt that cannot be sustained, because it is consuming an increasing portion of national income and limiting resources for private investment and public programs. Over the next ten years, interest payments on our national debt are projected to consume trillions of dollars and surpass annual spending on national defense, Medicaid, or science.

Without action, future generations of Americans will be burdened with unsustainable debt. To restore the people's trust, we must take a fiscally sustainable approach. The Budget begins the process of expanding choices for individuals and families; enabling market forces and competition to encourage innovation and restrain costs; encouraging self-sufficiency; and promoting federalism, allowing States and localities the flexibility they need to serve their populations.

With responsibility for the major drivers of mandatory spending in the Budget, HHS is in a unique position to help lead the Administration's efforts to rebuild fiscal solvency and to secure the trust of current and future generations of Americans.

REFORMING THE AMERICAN HEALTH CARE SYSTEM

Providing Relief from Obamacare

The Budget includes $250 billion in net deficit savings over 10 years associated with health care reform as part of the Administration's commitment to expand choices, increase access, and lower premiums. The Administration continues to support a repeal and replace approach that improves Medicaid's sustainability and targets resources to those most in need, eliminates Obamacare's onerous taxes and mandates, provides funding for States to stabilize markets and ensure a smooth transition away from Obamacare, and helps Americans purchase the coverage they want through the use of tax credits and expanded Health Savings Accounts. The Administration urges the Congress to continue its work to repeal and

replace Obamacare. The $250 billion in combined savings accrue to both Treasury and HHS.

The Administration will continue to work with Congress to provide for a stable transition from the burdensome requirements of Obamacare to a health care system that provides Americans with access to care that meets their needs and increases options for patients and providers. The Administration also supports State flexibility to create a free and open health care market and will empower States to make decisions that work best for their markets. In light of these goals, the Budget promotes efficient operations and funds critical activities to continue to operate the law's health insurance Exchanges.

Reforming Medicaid

The Budget fulfills the President's pledge to give States the resources and flexibility they need to care for the most vulnerable in their communities through Medicaid. To this end, the Budget reforms Medicaid funding to States starting in FY 2020 through either a per capita cap or a block grant. The Budget also provides other flexibilities to States and encourages them to innovate and test new ideas that will improve access to care and health outcomes. These proposals will save $610 billion through FY 2027 and will allow States to prioritize Federal resources for the most vulnerable populations.

The Budget extends the Children's Health Insurance Program for two years (through FY 2019) and makes modest reforms that taken together save a net $5.8 billion over the Budget window. The reforms to the Children's Health Insurance Program ensure the program's focus on serving the most vulnerable low-income families.

Modernizing the Medical Liability System

The current medical liability system disproportionately benefits a relatively small group of plaintiffs and trial lawyers at the expense of adding significantly to the cost of health care for every American and imposing a significant burden on health care providers. The current medical liability system does not work for patients or providers, nor does it promote high-quality, evidence-based care. The Budget proposes medical liability reforms that will save HHS programs $31.8 billion over 10 years and $55 billion to the Federal Government overall. A significant portion of these savings are attributable to the estimated reduction in unnecessary services and curbing the practice of defensive medicine. These medical liability reforms will benefit all Americans by cutting unnecessary health care spending.

In addition to reducing health care costs, these reforms will help physicians focus on patients and on evidence-based medicine rather than on frivolous lawsuits. By providing a safe harbor based on clinical guidelines, physicians can focus on delivering effective care, and - if an inherently risky medical procedure does not work out as intended - physicians will be able to express sympathy to a grieving family without fear of giving rise to a lawsuit.

Specifically, the Budget proposes the following medical liability reforms:

- Capping awards for noneconomic damages at $250,000 indexed to inflation;
- Providing safe harbors for providers based on clinical standards;
- Authorizing the Secretary to provide guidance to States to create expert panels and administrative health care tribunals;
- Allowing evidence of a claimants' income from other sources such as workers compensation and auto insurance to be introduced at trial;
- Providing for a three-year statute of limitations;
- Allowing courts to modify attorney's fee arrangements;
- Establishing a fair-share rule to replace the current rule of joint and several liability;
- Excluding provider expressions of regret or apology from evidence; and
- Requiring courts to honor a request by either party to pay damages in periodic payments for any award equaling or exceeding $50,000.

Enhancing Direct-to-Patient Relationships

HHS is committed to reducing regulatory burdens facing medical professionals, especially those serving in rural areas. To achieve this goal, HHS continues to look for ways to improve or eliminate regulations that impede the ability of medical professionals to provide the best possible care to their patients. HHS also believes that health care providers are a valuable resource whose input and ideas are essential to a positive health care reform effort. HHS also is committed to an open and transparent process for developing new voluntary payment models that providers can participate in. Finally, HHS has established various avenues of technical assistance to

help clinicians be successful in providing efficient, high-quality care to their patients.

Achieving the President's goals to reform Medicaid will require providing States with more flexibility to improve healthcare delivery to meet the needs of their unique populations. Direct Primary Care practices, in which physicians offer primary care services to patients at a set price, generally without payer or insurer involvement, are a mechanism to improve physician-patient relationships. Some State Medicaid programs are already testing this innovative care delivery model. HHS will explore opportunities for States and providers to further expand Direct Primary Care, which will support improved health outcomes for Medicaid populations.

PROTECTING THE HEALTH AND WELL-BEING OF AMERICANS

Supporting Life-Saving Preparedness and Response Activities

The Department fills a unique Federal role in emergency preparedness and response. HHS is the Federal Government's lead agency in responding to public health emergencies. The Department coordinates the prevention of, preparation for, and response to public health emergencies and disasters. It supports numerous critical activities to enhance the Federal, State, and local capacity to respond to public health disasters—from outbreaks of infectious disease to chemical, biological, radiological, nuclear, and cyber threats.

The Budget provides $2.9 billion to ensure that the Department is equipped to support life-saving preparedness and response activities aimed at addressing public health disasters and threats. This includes maintaining key investments in biodefense capabilities.

Emergency preparedness initiatives to address pandemic influenza, as well as the research and development of medical countermeasures, are described in greater detail below.

Pandemic Influenza

The Budget supports activities within the Public Health and Social Services Emergency fund to respond to and protect the American people from pandemic influenza threats, such as the H7N9 virus circulating in China. These activities include maintenance of the current stockpiles of vaccines as well as sustaining domestic vaccine manufacturing infrastructure.

Human infections with a new avian influenza (H7N9) virus were first reported internationally in China in March 2013. The World Health Organization has reported 566 human infections with the H7N9 virus during the fifth epidemic, making it the largest to date. This count brings the cumulative number of H7N9 cases reported by the World Health Organization to 1,364.

The FY 2018 Budget includes a $207 million investment to respond to the needs of the American people in the event of an influenza pandemic.

Research and Development of Medical Countermeasures

The Budget invests $1.02 billion into the research and development of medical countermeasures needed during disasters. Using these funds, the Department partners with industry leaders to develop an effective response capability to protect Americans from radiological, nuclear, chemical, and biological threats. The Department supports a broad portfolio of countermeasures to bridge the gap from early discovery to advanced development and procurement. These investments meet a unique Federal role to partner with industry in developing drugs and other countermeasures for which a sufficient market is lacking.

Preparedness Grants

The Budget restructures HHS preparedness grants to direct resources to States with the greatest need and innovative approaches. The Budget will introduce competition, risk, and link awards to performance across ASPR's Hospital Preparedness Program and CDC's Public Health and Emergency Preparedness Program. The grants will support entities that are most innovative in their approach to health care delivery system readiness and public health preparedness.

DELIVERING HOPE AND HEALING TO AMERICA

The opioid epidemic is the deadliest drug epidemic in American history. Deaths from opioid overdose have risen steadily over the past two decades and have become the leading cause of death from injury in the United States, claiming 91 lives every day. We are losing more Americans to overdoses every year than we did during the entire Vietnam War.

The Administration has made combating opioid abuse and fighting addiction an Administration-wide effort and priority, and the Budget reflects this commitment. It continues to invest in activities to fight opioid abuse, maintains funding for substance abuse treatment, and seeks to improve prescribing practices and the use of medication-assisted treatment.

The Budget also invests in high-priority mental health initiatives by targeting resources for serious mental illness, suicide prevention, homelessness prevention, and children's mental health.

Improving Prescribing Practices and Expanding Use of Medication-Assisted Treatment

To fight against opioid abuse, medication must be correctly prescribed and utilized. HHS is focused on providing support for cutting-edge research on pain addiction and strengthening our understanding of the epidemic through health surveillance. In addition, the Budget makes investments to improve access to treatment and recovery services, target the availability and distribution of overdose-reversing drugs, and advance better practices for pain management.

Improving Access to Treatment and Recovery Services

Medication-assisted treatment is a proven effective intervention for individuals suffering from addiction. The Budget includes $500 million for the Substance Abuse and Mental Health Administration's State Targeted Response to the Opioid Crisis Grants authorized in the 21st Century Cures Act to expand access to life-saving, transformative treatments, including Medication-Assisted Treatment. The Budget also continues the $1.9 billion Substance Abuse Block Grant, which States can use to provide life-saving treatments, and $25 million in SAMHSA for other targeted efforts focused specifically on expanding access to critical interventions.

Targeting Availability and Distribution of Overdose-Reversing Drugs

First responders to an overdose in progress have precious little time to save a life by reversing the effects of an overdose. The FY 2018 Budget for SAMHSA includes $24 million to equip first responders with overdose reversing drugs and to train them on their use, supporting the implementation of key provisions of the Comprehensive Addiction and Recovery Act.

Advancing Better Practices for Pain Management

While actions to address prescription opioid abuse must focus on both prescribers and high-risk patients, prescribers are the first line of defense for preventing inappropriate access. The FY 2018 CDC Budget includes $75.4 million to improve the way opioids are prescribed through clinical practice guidelines and support State programs, which help health care providers offer safer, more effective treatments while reducing opioid-related abuse and overdose. CDC aims to save lives and prevent prescription opioid overdoses by equipping providers with the knowledge, tools, and guidance they need.

In addition, the Centers for Medicare and Medicaid Services' Budget continues to support the agency's work to implement more effective, patient-centered strategies to reduce the risk of opioid use disorders, overdoses, inappropriate prescribing, and drug diversion.

Improving Access to Mental Health Treatment

In 2015, an estimated 10 million American adults battled serious mental illness, such as a psychotic or serious mood or anxiety disorder. The Budget includes high-priority mental health funding that addresses suicide prevention, homelessness prevention, and children's mental health. It also includes funding to address the needs of adults with serious mental illness and children experiencing a mental health crisis. The Budget provides $119 million for the Children's Mental Health Services program, which helps States, Tribes, and communities deliver evidence-based services and support for children and youth with serious mental health concerns. These funds facilitate effective collaboration between child and youth-serving systems such as juvenile justice, child welfare, and education. The Budget also proposes that up to 10 percent of the funds will be available for a new demonstration project focused on earlier interventions. This new set-aside reflects recent research by the National Institute on Mental Health indicating that earlier psychosocial interventions with those who are high-risk may prevent the further development of serious emotional disturbances and ultimately serious mental illness.

The Budget maintains $60 million in critical funding for grants to States, colleges, and the suicide prevention resource center to raise suicide awareness and disseminate best practices for prevention. The Budget also continues to provide funding for the National Suicide Prevention Lifeline, which coordinates a

national network of crisis centers by providing suicide prevention and crisis intervention services. Those seeking help can reach the Lifeline at 1-800-273-TALK at any time, day or night.

Providing Patient-Centered Care

HHS is committed to addressing the challenges many Americans continue to confront under a health care system that is failing to meet their needs. The Department is supporting a patient-centered health care reform effort that is aimed at empowering patients, families, and doctors when it comes to making health care decisions. HHS is making progress toward this priority by taking administrative and regulatory actions that will provide the American people relief from the current law, build a partnership with states to improve health care choices for patients, reform the medical liability system, and enhance the doctor-patient relationship. In FY 2018, the Department will invest nearly $400 million in services, training for medical professionals, and approaches that respond to the diverse health care needs across America.

Strengthening Services to Tribes

HHS is committed to providing quality health care to over 2.2 million American Indian and Alaska Native people by effectively leveraging resources and implementing new and innovative ways to improve access to and the delivery of quality health care. As part of the unique government-to-government relationship between the Federal Government and Tribal Governments, the Indian Health Service provides health care to members of more than 567 Federally-recognized tribes. The FY 2018 IHS Budget prioritizes funding for direct health care services, including behavioral health services.

Prioritizing Direct Health Services in Indian Country

The Budget reflects HHS's high-priority commitment to Indian Country and protects direct health care investments. In FY 2018, the Budget maintains funding for clinical services at $3.3 billion, which includes inpatient and outpatient care in hospitals and clinics, behavioral health services, and dental health services. In FY 2018, IHS estimates that they will serve 2.2 million American Indians and Alaska Natives.

INVESTING IN THE HEALTH OF AMERICA'S FUTURE

The percentage of children with obesity in the United States has more than tripled since the 1970s. Today, nearly 20 percent of school-aged children are obese. Children with obesity are at higher risk for having other chronic health conditions and diseases that impact physical health, such as asthma, sleep apnea, bone and joint problems, type 2 diabetes, and risk factors for heart disease.

The Budget represents a commitment to uplifting the health of the next generation by investing in services that promote healthy eating and physical activity. To accomplish this priority, the Budget invests in a new CDC block grant to address childhood obesity and other state priorities, and enhances Children's Health Insurance Program flexibility.

CDC Childhood Obesity and America's Health Block Grant

The FY 2018 Budget will support investments in the most effective childhood obesity prevention and intervention strategies within CDC and promote better nutrition, increased physical activity, and prevention of future chronic illness. CDC will continue to provide funding to States to implement programs intended to reduce the risk factors associated with childhood obesity, manage chronic conditions in schools, and promote the well-being and healthy development of all children and youth.

The Budget includes a new CDC $500 million *America's Health* Block Grant to increase State flexibility and focus on leading public health challenges. The newly-established block grant will provide flexibility in FY 2018 for each State to implement specific interventions that address its population's unique public health issues, including interventions to spur improvements in physical activity and the nutrition of children and adolescents.

RESPONSIBLE STEWARDSHIP OF TAXPAYER DOLLARS AND REDEFINING THE FEDERAL ROLE

The Budget allows HHS to continue to support priority activities at an overall lower level while restoring fiscal discipline and promoting long-term fiscal stability across the Federal Government. In order to make targeted, strategic investments and carry out the Department's mission in the most efficient manner possible, the Budget proposes reorganizations and specific HHS efficiencies, proposals to revisit key partnerships within the private sector, and proposals to strengthen the integrity of the Medicare and Medicaid programs.

Reorganizations and HHS-Specific Efficiencies

While large-scale reorganization, workforce restructuring, and efficiency proposals are under development within the Department, the Budget offers select HHS restructuring and efficiency proposals.

Medicare Appeals

HHS remains committed to working with Congress on comprehensive and common sense reforms to the Medicare appeals process. The Budget includes investing $1.3 billion over ten years to address the pending backlog and HHS is pursuing reforms to revamp the process to address appeals as early as possible and prevent escalation to subsequent levels. These changes will make the appeals system easier to navigate, increase adjudicatory capacity to address incoming annual receipts, and reduce backlogged appeals pending at the Office of Medicare Hearings and Appeals and the Departmental Appeals Board. The Department is committed to work with Congress to address the Medicare appeals backlog.

National Institutes of Health (NIH) Structural Changes

NIH will continue to support core mission-critical activities in the Budget, while implementing policies to reduce burden on its grantees. On average, from FY 1994 to FY 2014, NIH spent approximately 30 percent of its research resources on indirect costs, leaving only 70 percent for direct research and other supporting research activities. Other entities, including private foundations and payers, spend a much higher portion of their grants on direct science. The current indirect rate setting process requires each grantee to provide hundreds of pages of documentation to negotiate their indirect rate with the Government.

NIH will implement reforms to release grantees from the costly and time-consuming indirect rate setting process and reporting requirements. Applying a uniform indirect cost rate to all grants mitigates the risk for fraud and abuse because it can be simply and uniformly applied to grantees.

The Budget includes this critical reform to reduce indirect costs and preserve more funding for direct science.

The Budget also proposes the elimination of the Fogarty International Center, but retains all Federal staff and maintains key activities in other NIH Institutes and Centers. This change will enable NIH to focus on higher priority activities.

The Budget consolidates the Agency for Healthcare Research and Quality into NIH and maintains $272 million in discretionary funding for these activities. As part of this consolidation, NIH will conduct a review of health services research across NIH and develop a strategy to ensure that the highest priority health services research is conducted and made available across the Federal Government. The consolidation proposal preserves key activities, such as patient safety research, that improve the quality and safety of American health care. The Budget reduces or eliminates lower-priority programs that overlap with activities administered by other components of HHS.

Revisiting Key Partnerships with the Private Sector

The Budget envisions a recalibration of how to pay for the Food and Drug Administration's (FDA) premarket review activities. Industry fees are increased to fund 100 percent of costs for premarket review and approval activities in the animal drug, animal generic, prescription and generic drug, biosimilar, and medical device programs. In a constrained budget environment, industries that directly benefit from FDA's administrative actions can and should pay to support FDA's capacity. The fee-funded approach is consistent with the overarching goals of the Administration's Budget, which are to reprioritize Federal spending to advance the safety and security of the American people. The Budget also includes reforms that balance the demand for scientific rigor and access to reliable, life-saving cures. In addition, the Budget will include regulatory relief to the industry and speed the development of safe and effective medical products.

The Budget allows FDA to remain an acknowledged leader among the world's regulatory agencies in both the number of new drugs approved each year and in the timeliness of review. These proposals will allow FDA to continue carrying out its statutory responsibilities of protecting public health by promoting innovative, safe treatments that are responsive to the needs of the American people.

Strengthening the Integrity of Medicare and Medicaid

The Budget strengthens the integrity and sustainability of Medicare and Medicaid by investing an additional $70 million in new Health Care Fraud and Abuse Control Program funding in FY 2018, targeting activities

that prevent fraud, waste, and abuse and promote quality, patient-centered health care.
The increase in funding reflects the Administration's commitment to fighting fraud and the belief that this investment will pay off in significant returns to the Medicare Trust Fund and the Treasury. For example, recent reports to Congress show Medicare program integrity efforts yielding approximately a $12 to $1 return and law enforcement and litigation efforts yielding a $5 to $1 return.

HHS BUDGET BY OPERATING DIVISION /1

dollars in millions	2016	2017	2018
Food and Drug Administration			
Budget Authority	2,725	2,741	1,891
Outlays	2,566	2,698	2,080
Health Resources and Services Administration			
Budget Authority	10,777	10,654	10,205
Outlays	10,263	10,372	10,828
Indian Health Service			
Budget Authority	4,916	4,953	4,898
Outlays	4,682	5,191	4,939
Centers for Disease Control and Prevention			
Budget Authority	8,698	7,696	6,374
Outlays	7,504	7,920	7,275
National Institutes of Health			
Budget Authority	31,718	31,829	26,049
Outlays	29,280	32,117	30,195
Substance Abuse and Mental Health Services Administration			
Budget Authority	3,642	4,156	3,771
Outlays	3,443	3,672	3,688
Agency for Healthcare Research and Quality			
Budget Authority	334	333	0
Program Level	428	426	0
Outlays	269	300	288
Centers for Medicare & Medicaid Services /2			
Budget Authority	999,037	1,006,775	1,009,626
Outlays	990,120	1,006,929	1,019,633
Administration for Children and Families /3			
Budget Authority	53,068	54,116	46,535
Outlays	50,905	54,479	48,289
Administration for Community Living			
Budget Authority	1,936	1,937	1,851
Outlays	1,972	1,956	1,935
Office of the National Coordinator			
Budget Authority	60	60	38
Outlays	85	128	43

HHS BUDGET BY OPERATING DIVISION

dollars in millions	2016	2017	2018
Medicare Hearings and Appeals			
Budget Authority	107	107	242
Outlays	107	107	242
Office for Civil Rights			
Budget Authority	38	38	33
Outlays	16	41	33
Departmental Management /4			
Budget Authority	478	578	270
Outlays	889	1,956	576
Public Health and Social Services Emergency Fund			
Budget Authority	1,948	1,530	1,663
Outlays	1,516	2,792	1,736
Office of Inspector General			
Budget Authority	77	77	68
Outlays	82	107	84
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds)			
Budget Authority	707	707	737
Outlays	546	1,568	760
Offsetting Collections			
Budget Authority	-975	-1,373	-1,243
Outlays	-975	-1,373	-1,243
Other Collections			
Budget Authority	-125	-125	-125
Outlays	-125	-125	-125
Total, Health and Human Services			
Budget Authority	**1,119,166**	**1,126,789**	**1,112,883**
Outlays	**1,103,145**	**1,130,835**	**1,113,256**
Full-time Equivalents	77,499	79,505	80,027

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

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

3/ The amounts listed for FY 2018 Budget Authority and Outlays do not take into account updated scoring of legislative proposals in Temporary Assistance for Needy Families that are displayed in ACF budget documents.

4/ Includes the Pregnancy Assistance Fund, Transfer from the Patient-Centered Outcomes Research Trust Fund, Health Insurance Reform Implementation Fund, Payment to the State Response to the Opioid Abuse Crisis Account and the Nonrecurring Expenses Fund.

COMPOSITION OF THE HHS BUDGET DISCRETIONARY PROGRAMS

dollars in millions	2016	2017	2018	2018 +/-2017
Discretionary Programs (Budget Authority):				
Food and Drug Administration	2,728	2,743	1,888	-855
Program Level	*4,745*	*4,660*	*5,116*	*+456*
Health Resources and Services Administration	6,147	6,150	5,548	-602
Program Level	*10,543*	*10,401*	*9,941*	*-460*
Indian Health Service /1	4,808	4,798	4,739	-59
Program Level	*6,160*	*6,148*	*6,091*	*-57*
Centers for Disease Control and Prevention	6,345	6,368	5,054	-1,314
Program Level	*12,028*	*12,096*	*11,059*	*-1,037*
National Institutes of Health	31,381	31,674	25,883	-5,791
Program Level	*32,311*	*32,593*	*26,920*	*-5,673*
Substance Abuse and Mental Health Services Administration	3,634	4,144	3,771	-373
Program Level	*3,781*	*4,291*	*3,892*	*-399*
Agency for Healthcare Research and Quality /2	334	333	0	-333
Program Level	*428*	*426*	*0*	*-426*
Centers for Medicare & Medicaid Service	3,975	3,967	3,588	-379
Program Level	*6,476*	*6,031*	*5,609*	*-422*
Administration for Children and Families /3	18,870	19,284	14,482	-4,802
Program Level	*18,870*	*19,284*	*14,482*	*-4,802*
Administration for Community Living	1,965	1,961	1,851	-110
Program Level	*2,048*	*2,042*	*1,907*	*-135*
Office of the Secretary:				
General Departmental Management	456	455	305	-150
Program Level	*552*	*550*	*399*	*-151*
Office of Medicare Hearing and Appeals	107	107	117	+10
Program Level	107	107	242	+135

COMPOSITION OF THE HHS BUDGET DISCRETIONARY PROGRAMS

dollars in millions	2016	2017	2018	2018 +/-2017
Office of the National Coordinator	60	60	38	-22
Program Level	*60*	*60*	*38*	*-22*
Office of Inspector General	77	76	68	-8
Program Level	*343*	*341*	*359*	*-18*
Office for Civil Rights	39	39	33	-6
Public Health and Social Services Emergency Fund	1,533	1,530	1,663	+133
Program Level	*1,533*	*1,530*	*1,663*	*+133*
Discretionary HCFAC	681	681	751	+70
Accrual for Commissioned Corps Health Benefits	26	28	31	+3
Total, Discretionary Budget Authority	**83,167**	**84,401**	**69,810**	**-14,591**
NEF Cancellation /3	—	-400	-560	-160
Less One-Time Rescissions	*-6,742*	*-6,806*	*-4,472*	*+2,334*
Revised, Discretionary Budget Authority	**76,425**	**77,195**	**64,778**	**-12,417**
Discretionary Outlays	**80,216**	**90,832**	**79,552**	**-11,280**
1/ The FY 2016 level includes a revised estimate of $718 million for Contract Support Costs and the FY 2017 level reflects an estimated actual cost of Contract Support Costs.				
2/ The 2018 Budget includes $272 million within NIH to consolidate AHRQ's activities within NIH.				
3/ The 2017 amount reflect the $300 million transfer to ACF and $100 million rescission included in the 2017 CR.				

COMPOSITION OF THE HHS BUDGET
MANDATORY PROGRAMS

	2016	2017	2018	2018 +/-2017
Mandatory Programs (Outlays):1/				
Medicare	588,309	592,593	586,579	-6,014
Medicaid	368,280	378,455	403,713	+25,258
Temporary Assistance for Needy Families /2 /3	16,196	17,120	15,436	-1,684
Foster Care and Adoption Assistance	7,700	8,025	8,457	+432
Children's Health Insurance Program /4	14,358	16,879	13,417	-3,462
Child Support Enforcement	4,079	4,266	4,302	+36
Child Care Entitlement	2,788	2,968	2,946	-22
Social Services Block Grant	1,780	1,699	362	-1,337
Other Mandatory Programs	20,414	19,371	17,735	-1,636
Offsetting Collections	-975	-1,373	-1,243	+130
Subtotal, Mandatory Outlays	1,022,929	1,040,003	1,051,704	+11,701
Total, HHS Outlays	**1,103,145**	**1,130,835**	**1,131,256**	**+421**

1/ Totals may not add due to rounding.

2/ Includes outlays for the TANF program and TANF Contingency Fund.

3/ The amounts listed for FY 2018 Outlays do not take into account updated scoring of legislative proposals in Temporary Assistance for Needy Families that are displayed in ACF budget documents.

4/ Includes outlays for the Child Enrollment Contingency Fund.

Food and Drug Administration

dollars in millions	2016	2017 /1	2018 /5	2018 +/- 2017
FDA Programs /2				
Foods	1,010	993	922	-71
Human Drugs	1,391	1,324	1,612	+287
Biologics	355	339	366	+27
Animal Drugs and Feeds	189	191	183	-7
Medical Devices	450	441	490	+49
National Center for Toxicological Research	63	63	60	-3
Tobacco Products	564	563	626	+63
Headquarters and Office of the Commissioner	300	291	322	+31
White Oak Consolidation	52	52	57	+5
GSA Rental Payment	224	236	250	+14
Other Rent and Rent Related Activities	120	116	133	+17
Subtotal, Salaries and Expenses	**4,716**	**4,609**	**5,021**	**+411**
Export Certification Fund	5	5	9	+4
Color Certification Fund	9	10	10	+0
Rare Pediatric Priority Review Vouchers	8	8	8	--
Buildings and Facilities	9	9	9	--
21st Century Cures Act	--	20	60	+40
Total, Program Level	**4,745**	**4,660**	**5,116**	**+456**
Current Law User Fees /3				
Prescription Drug /4	851	755	1,262	+508
Medical Device /4	138	126	439	+313
Animal Drug /4	23	24	70	+47
Animal Generic Drug /4	10	11	18	+7
Food Reinspection	6	6	6	--
Food Recall	1	1	1	--
Family Smoking Prevention and Tobacco Control Act	599	598	672	+74
Generic Drug /4	318	323	616	+293
Biosimilars /4	22	22	87	+65
Mammography Quality Standards Act	20	21	21	--
Export Certification Fund	5	5	5	--
Color Certification Fund	9	10	10	+0
Rare Pediatric Priority Review Vouchers	8	8	8	--
Voluntary Qualified Importer Program	5	5	5	--
Third Party Auditor Program	1	1	1	--
Outsourcing Facility	1	1	1	+0
Subtotal, Current Law User Fees	**2,017**	**1,917**	**3,223**	**+1,306**
Proposed Law User Fees				
Export Certification /6	--	--	4	+4
Subtotal, Proposed Law User Fees	--	--	**4**	**+4**
Less Total, User Fee	**2,017**	**1,917**	**3,228**	**1,311**
FDA Totals				
Total, Discretionary Budget Authority	**2,728**	**2,743**	**1,888**	**-854**

dollars in millions	2016	2017	2018 /4	2018 +/- 2017
Full-time Equivalents	16,527	17,134	17,614	+480

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

2/ Reflects a transfer of $1.5 million to the HHS Office of Inspector General for FDA oversight activities as specified in the FY 2016 appropriation and continued by the FY 2017 Continuing Resolution less a rescission.

3/ Does not reflect priority review voucher user fee for Medical Countermeasures as FDA continues to develop an estimated fee level.

4/ The prescription and generic drug, biosimilar, and medical device user fee programs expire on October 1, 2017. The Budget includes legislative proposals to reauthorize these four user fee programs. The Budget also includes legislative proposals to increase fees for the animal drug and animal generic drug user fee programs in their fifth and final year of authorization.

5/ All figures are displayed comparable to the FY 2018 President's Budget. The FY 2016, FY 2017, and FY 2018 columns have been updated to reflect reallocated funding across the programs addressing previous reorganizations that consolidated economists in Headquarters and established the Oncology Center of Excellence, as well as to better aligning the funding structure to services related to intergovernmental affairs.

6/ The FY 2018 President's Budget proposes to increase the statutory user fee limit for export certification.

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

FDA PROGRAMS

The Food and Drug Administration (FDA) protects and advances public health through an array of programs and activities, ranging from minimizing occurrences of drug shortages to carrying out inspections of imported food products. FDA estimates that Americans currently pay approximately two cents per day to ensure that the products it regulates—which account for more than 20 percent of every consumer dollar spent on products in the United States—are safe and effective. The Fiscal Year (FY) 2018 Budget includes $5.1 billion in total resources for FDA—an increase of $456 million or 10 percent above the FY 2017 Continuing Resolution. At this total level, the Budget provides an increase of $1.3 billion in user fees, while reducing budget authority by $854 million. With the proposals in this budget, the burden on American taxpayers will be even lower—a little over one cent per American per day.

The Budget prioritizes resources across core public health activities including advancing the development and approval of safe and effective medical products, supporting the continued transformation of the food safety system, supporting the Department's preparedness enterprise, and conducting innovative research.

ADVANCING ACCESS TO SAFE AND EFFECTIVE MEDICAL PRODUCTS

FDA's Center for Drug Evaluation and Research approved 22 novel drugs in calendar year 2016. Approvals included the first treatment for patients with spinal muscular atrophy, a new drug to treat patients with a rare chronic liver disease known as primary biliary cirrhosis, and two new treatments for patients with hepatitis C. Additionally, 2016 marked the highest number of generic drug approvals and tentative approvals—more than 800—in the history of FDA's generic drug program. Many of these approvals were for first-time generic drugs, with the introduction of a generic counterpart for a brand-name product for which there was previously no generic.

These examples reflect only a few of the many medical product responsibilities FDA carries out. FDA oversees the safety, effectiveness, availability, and quality of an extensive range of regulated products available to Americans, which encompass prescription and over-the-counter drugs; biologics including vaccines, blood products, and gene therapies; animal drugs; and, medical devices ranging from bandages to laser surgical equipment and radiation-emitting products. FDA also ensures that regulated products are marketed according to Federal standards and that products available to the public continue to be safe especially as new clinical information becomes available. Across the vast jurisdiction of FDA-regulated products and activities, FDA continues to incorporate cutting-edge regulatory science into its evaluations to support patient access to safe and effective medical products.

As a result of the 21st Century Cures Act (P.L. 114-255), FDA will continue to build on ongoing efforts to advance medical product innovation and ensure that patients get access to treatments as quickly as possible, with continued assurance from high quality evidence that they are safe and effective. Examples of the new activities carried out include:

- Further incorporating the patient perspective in the drug review process;
- Supporting the Oncology Center of Excellence;
- Advancing the review of breakthrough devices;
- Incorporating the latest in regulatory science evidence; and
- Continuing work on regenerative advanced therapies.

The FY 2018 Budget supports FDA's critical role to ensure safe and effective medical products are advanced to market by recalibrating how to finance these activities. In a constrained budget environment, the Budget acknowledges medical product industries have sufficiently matured to assume a greater share of costs associated with FDA's administrative actions. User fees have been instrumental in allowing FDA to build capacity and improve the timeliness of the medical product review process without compromising the agency's high standards. As part of this recalibration, accompanying the Budget will be four legislative proposals to reauthorize the prescription and generic drugs, biosimilar, and medical device user fee programs as well as additional proposals to revise the animal drugs and animal generics programs. The

PROGRAM HIGHLIGHT

Drug Shortages

FDA not only makes available safe and effective medical products, but also takes great efforts—within its legal authority—to address and prevent drug shortages. Drug shortages can occur for many reasons, including manufacturing and quality problems, delays, and discontinuations. FDA works closely with manufacturers of drugs in short supply to communicate the issue and to help restore availability. FDA also works with other firms who manufacturer the same drug, asking them to increase production, if possible, in order to prevent or reduce the impact of a shortage. In 2016, FDA prevented 115 drug shortages.

Budget increases user fee resources by over $1 billion to support all medical product review and approval activities across these programs. To support speeding patient access to safe and effective medical products, the Budget also includes a portfolio of administrative actions to achieve regulatory efficiencies through programs and process improvements. These actions include:

- Encouraging the use of 21st Century Cures Act tools for drug evaluation, review, and approval;
- Simplifying administrative requirements to reduce drug and device manufacturers' reporting burden;
- Clarifying treatment of value-based purchasing arrangements; and
- Improving predictability for payers and enhanced dissemination of evidence by fostering the exchange of scientifically sound information between manufacturers and payers pre-approval to reduce uncertainty and improve payer ability to more accurately set premiums.

The Budget will advance FDA's highest priority activities to ensure medical products available to the American public meet current requirements and standards for safety and efficacy. Medical product safety investments in the FY 2018 Budget total $3.2 billion at the program level, which is $505 million above the spending appropriated under the annualized level of the FY 2017 Continuing Resolution. This total includes $648 million in budget authority, and

$2.5 billion in user fees. In FY 2018, FDA activities include—but are not limited to—review of new medical products, research to inform sound regulatory decisions about benefits and risks of products that increasingly involve new technologies, and monitoring of the quality of marketed medical products through surveillance, inspections, and compliance programs.

PROGRAM HIGHLIGHT

Regulatory Reform

The President is committed to fostering an environment that enables industry to advance innovative, safe, and effective treatments and cures to the patients who need them as quickly as possible. To achieve this goal in FY 2018, FDA will implement programs and process improvements to achieve greater regulatory efficiency and speed the availability of innovative, safe, and effective medical products in the market.

Outcomes of these efforts will include increasing engagement with manufacturers, including providing standardized and predictable pathways for early interactions to help reduce uncertainty in medical product development; reducing review times by streamlining processes and gaining efficiencies to the greatest extent possible; and reducing regulatory burden and leveraging FDA's statutory mandates, including recent enhancements through the 21st Century Cures Act.

CONTINUING THE TRANSFORMATION OF THE FOOD SAFETY SYSTEM

FDA has issued all seven foundational final rules that established the framework for a strengthened and modernized food safety system, including preventive controls for manufactured food and feed where compliance dates for larger business began in fall 2016. In FY 2017, FDA will build on these regulations and guide the modernization of our food safety system by prioritizing prevention, supporting risk-based oversight, and expanding collaboration in the food safety community. These activities ultimately will improve public health by lowering the incidence of illness due to food hazards and will avoid interruptions to the food supply.

In FY 2018, the FDA food safety portfolio will continue to support other vital food and feed safety activities that are important to the public such as improving the availability of nutritional information to assist with decisions made by individuals and their families, ensuring that food additives and color additives standards set by FDA and guarding public health by ensuring information on food labels is based on the most current science.

The Budget includes $1.3 billion for food safety across FDA programs, a decrease of $83 million below the funding appropriated by the FY 2017 Continuing Resolution. This total includes $1.2 billion in budget authority—a reduction of $109 million—and $42 million in user fees, an increase of $26 million.

In FY 2018, FDA will continue its most critical public health and safety activities, including outbreak response, implementation of Food Safety Modernization Act regulations, and ensuring that foods are safe and properly labeled. FDA will make targeted reductions to the Food Safety program, including reducing staff levels through attrition. FDA will continue support for food safety research, cosmetics safety, partnerships with academic institutes, and international capacity building at reduced levels.

Currently authorized fees support programs such as the voluntary qualified importer program, export certification, and the third party auditor program.

FDA INFRASTRUCTURE AND FACILITIES

FDA infrastructure and facilities, including 56 laboratories strategically located across the continental United States and Puerto Rico, directly support mission critical work and enable FDA to respond to food safety and medical product emergencies. These responsibilities have increased as a result of groundbreaking legislation passed over recent years, which also has resulted in additional staff. The FY 2018 Budget ensures that FDA laboratories and offices can continue to support staff in carrying out the Agency's growing responsibilities for food and medical product safety. The Budget invests a total of $440 million - $36 million above the FY 2017 Continuing Resolution - in FDA infrastructure, including costs to keep up with the science and continue planned activities at both headquarters (including the White Oak Campus) and in the field.

The Budget also provides $9 million, the same as the FY 2017 Continuing Resolution, to fund repairs and improvements of FDA-owned facilities.

ADVANCING MEDICAL COUNTERMEASURES

FDA actively supports the establishment and sustainment of an adequate supply of medical countermeasures to protect against chemical, biological, radiological, nuclear, and emerging infectious disease threats such as pandemic influenza, Ebola virus, and Zika virus. Since FY 2016, FDA mobilized more than 500 staff members to support the agency's critical contributions to the U.S. Government's response to the Zika virus outbreak in the Americas, and sustained response effort to the 2014 Ebola epidemic in West Africa, and the Middle East Respiratory Syndrome coronavirus outbreak, which was first noted in 2012. FDA has enabled the use of 30 diagnostic tests under its Emergency Use Authorizations authority and facilitated the development of therapeutics and vaccines to respond to those threats. FDA also issued an Emergency Use Authorizations to permit the emergency use of an atropine auto-injector to help strengthen the Nation's public health protections against chemical threats. FDA approved the majority of medical countermeasure marketing applications under review in FY 2016 that met standards for safety, efficacy, and quality. The FY 2018 Budget includes $25 million to continue the Medical Countermeasures program which directly supports medical countermeasures efforts across FDA in support of the Department's preparedness and response activities. These resources will help accelerate the development, evaluation, and approval of critical medical countermeasures. In addition, this funding will support the development and coordination of policies to advance emergency preparedness and response.

REDUCING THE USE AND HARMS OF TOBACCO

FDA, through the Center for Tobacco Products, executes its regulatory and public health responsibilities in program areas that support the following objectives: preventing initiation; decreasing the harms of tobacco product use; and encouraging cessation. Tobacco use is the leading cause of preventable disease, disability, and death in the United States. The United States spends nearly $170 billion on medical care to treat smoking-related disease in adults each year.

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

The FY 2018 Budget includes $672 million in user fees to support the FDA tobacco program.

USER FEES

The Budget assumes resources from reauthorizing the human and generic drug, medical device, and biosimilar user fee programs set to expire at the end of FY 2017, increasing total fees collected under the animal drugs program, increasing the allowable fee amount for the export certification fee, and additional increases in all currently authorized user fee programs. Resources from user fees are critical to enable FDA to carry out its mission and institute performance metrics that lead to greater efficiencies and increased speed at which products are available to the public.

dollars in millions	2016 /1	2017 /2	2018	2018 +/- 2017
Primary Health Care				
Health Centers	4,992	4,900	4,989	+89
Discretionary Budget Authority [non-add]	*1,392*	*1,389*	*1,389*	--
Mandatory Funding [non-add]	*3,600*	*3,511*	*3,600*	*+89*
Health Centers Tort Claims	100	100	100	--
Free Clinics Medical Malpractice	0.1	0.1	0.1	--
Subtotal, Primary Care	**5,092**	**5,000**	**5,089**	**+89**
Health Workforce				
National Health Service Corps [Mandatory]	310	289	310	+21
Training for Diversity	83	83	--	-83
Training in Primary Care Medicine	39	39	--	-39
Oral Health Training	36	36	--	-36
Teaching Health Centers Graduate Medical Education [Mandatory]	60	56	60	+4
Area Health Education Centers	30	30	--	-30
Health Care Workforce Assessment	5	5	5	--
Public Health and Preventive Medicine Programs	21	21	--	-21
Nursing Workforce Development	229	229	83	-146
Children's Hospital Graduate Medical Education	295	294	295	+1
National Practitioner Data Bank User Fees	21	18	18	--
Other Workforce Programs	49	48	--	-48
Subtotal, Health Workforce	**1,178**	**1,148**	**771**	**-377**

dollars in millions	2016 /1	2017 /2	2018	2018 +/- 2017
Maternal and Child Health				
Maternal and Child Health Block Grant	638	637	667	+30
Sickle Cell Demonstration Program	4	4	--	-4
Autism and Other Developmental Disorders	47	47	--	-47
Heritable Disorders	14	14	--	-14
Healthy Start	104	118	128	+10
Universal Newborn Hearing Screening	18	18	--	-18
Emergency Medical Services for Children	20	20	--	-20
Family-to-Family Health Information Centers [Mandatory]	5	5	5	--
Home Visiting [Mandatory]	400	372	400	+28
Subtotal, Maternal and Child Health	**1,250**	**1,236**	**1,200**	**-35**
Ryan White HIV/AIDS Program				
Emergency Relief - Part A	656	655	655	--
Comprehensive Care - Part B	1,315	1,313	1,313	--
AIDS Drug Assistance Program [non-add]	*900*	*899*	*899*	--
Early Intervention - Part C	205	205	205	--
Children, Youth, Women, and Families - Part D	75	75	75	--
AIDS Education and Training Centers - Part F	34	34	--	-34
Dental Services - Part F	13	13	13	--
Special Projects of National Significance (SPNS)	25	25	--	-25
Subtotal, Ryan White HIV/AIDS	**2,323**	**2,318**	**2,260**	**-59**
Healthcare Systems				
Organ Transplantation	24	24	24	--
Cord Blood Stem Cell Bank	11	11	11	--
C.W. Bill Young Cell Transplantation Program	22	22	22	--
Poison Control Centers	19	19	19	--
340B Drug Pricing Program	10	10	10	--
Hansen's Disease Programs	17	17	13	-4
Subtotal, Healthcare Systems	**103**	**103**	**99**	**-4**
Rural Health				
Rural Outreach Grants	64	63	51	-13
Rural Hospital Flexibility Grants	42	42	--	-42
Telehealth	17	17	10	-7
Rural Health Policy Development	9	9	5	-4
State Offices of Rural Health	10	9	--	-9
Radiation Exposure Screening and Education	2	2	2	--
Black Lung Clinics	7	7	7	--
Subtotal, Rural Health	**150**	**149**	**74**	**-75**

Health Resources and Services Administration

dollars in millions	2016 /1	2017 /2	2018	2018 +/- 2017
Family Planning	286	286	286	--
Program Management	154	154	152	-2
Vaccine Injury Compensation Program Direct Operations	8	7	9	+2
Subtotal, Other Activities	**448**	**448**	**448**	**--**
HRSA Budget Totals—Less Funds from Other Sources				
Total, Program Level	**10,543**	**10,401**	**9,940**	**-460**
User Fees	21	18	18	--
Current Law Mandatory Funding	-4,375	-4,232	--	+4,232
New Mandatory Proposals	--	--	-4,375	-4,375
Total, Discretionary Budget Authority	**6,147**	**6,150**	**5,548**	**-602**
Full-time Equivalents	1,996	2,211	2,117	-94

1/ In addition, the FY 2016 Zika Response and Preparedness Act (P.L. 114-223) provided $387 million in supplemental resources to the Public Health and Social Services Emergency Fund for Zika response and preparedness activities, of which $66 million was allocated for HRSA.
2/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

The Health Resources and Services Administration is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. The FY 2018 Budget provides a total of $9.9 billion in funding for HRSA, which is $460 million below the funding level provided by the FY 2017 Continuing Resolution, and prioritizes the provision of direct health care services.

ENSURING ACCESS TO DIRECT HEALTH CARE SERVICES

The Fiscal Year (FY) 2018 President's Budget prioritizes direct health care services within the Health Resources and Services Administration (HRSA), including Health Centers and Ryan White HIV/AIDS programs. These safety-net providers deliver critical health care services to low-income and vulnerable populations.

Health Centers

For over 50 years, health centers have provided high-quality preventive and primary health care to Americans across the country. More than 24 million people—1 in 13 nationwide—receive direct health care services at health centers. Health centers advance a model of coordinated, comprehensive, and patient-centered medical, dental, behavioral, and patient services. Today, nearly 1,400 health centers operate over 10,400 service delivery sites and provide affordable health care services to patients in every State, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the Pacific Basin. The FY 2018 Budget provides $5.1 billion for Health Centers, which includes an additional $3.6 billion in new mandatory resources in Fiscal Years 2018 and 2019. At this funding level, health centers will serve nearly 26 million patients across the United States and its Territories in FY 2018. Within this funding, the FY 2018 Budget continues $50 million for grants from the prior year related to the treatment, prevention, and awareness of opioid abuse.

Ryan White HIV/AIDS Programs

For nearly three decades, the Ryan White HIV/AIDS Program has provided medical and support services to low-income individuals living with HIV/AIDS who do not have sufficient health care coverage or resources to access lifesaving care. As the largest Federal program focused exclusively on domestic HIV/AIDS care, the Ryan White HIV/AIDS Program reduces the use of more costly inpatient care, increases access to health services for underserved populations, improves survival, and reduces HIV transmission.

The FY 2018 Budget provides $2.3 billion—$59 million below the FY 2017 Continuing Resolution—for the Ryan White HIV/AIDS Program. The Ryan White HIV/AIDS Program provides a comprehensive system of primary medical care, treatment, and supportive services to

more than half of the people in the United States who have been diagnosed with HIV. The Budget proposes prioritizing funding for direct health care services to people living with HIV by discontinuing the Ryan White HIV/AIDS Part F AIDS Education and Training Programs and Special Projects of National Significance.

DIRECT SERVICES PROGRAMS

Ryan White HIV/AIDS Program

Individuals receiving HIV care through Ryan White achieve higher viral suppression, in comparison to the national average of 54.7 percent. In 2015, 83.4 percent of clients served by the Ryan White HIV/AIDS Program achieved viral suppression.

Within the requested funding level, the Budget provides $899 million, the same level as the FY 2017 Continuing Resolution for the AIDS Drug Assistance Program. This essential program provides grants to States to pay for HIV/AIDS medications and related services for uninsured, underinsured, and low-income patients who cannot afford them.

The Administration looks forward to working with Congress to reauthorize the Ryan White program to ensure that Federal funds are allocated to address the changing landscape of HIV across the United States. Reauthorization of the Ryan White program should include changes to the funding methodologies for Parts A and B to ensure that funds may be allocated to target populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. African Americans, for example, account for a higher proportion of new HIV diagnoses, those living with HIV, and those ever diagnosed with AIDS as compared to other races/ethnicities. The new Ryan White authorization should allow for resources to be focused on populations with disproportionately high rates of new infections/diagnoses.

OPTIMIZING THE NATION'S HEALTH WORKFORCE

The FY 2018 Budget provides $771 million in mandatory and discretionary resources for HRSA health workforce programs, which is $377 million below the FY 2017 Continuing Resolution. At this level, funding is maintained for activities that directly increase the number of health care professionals working in communities facing a shortage of such specialists by providing scholarships and loan repayments and by requiring service commitment.

National Health Service Corps

Since its inception in 1972, the National Health Service Corps has been committed to providing services to underserved populations. The National Health Service Corps provides scholarships and loan repayment to health care professionals in return for service commitments in communities experiencing a shortage of health professionals. The Budget includes $310 million in new mandatory resources for the National Health Service Corps in both FY 2018 and FY 2019, which will support an approximate field strength of 8,600 providers in FY 2018. The program continues to be one of the Nation's most effective programs in placing health care professionals in communities with the greatest need.

Children's Hospitals Graduate Medical Education

The Budget provides $295 million in discretionary funding for the Children's Hospital Graduate Medical Education Program, which advances children's health by providing funding to eligible freestanding hospitals to support the training of pediatricians and other residents. This program enables residents to provide health care services dedicated to children's unique health care needs. Adequate residency training in pediatric care is important for residents who pursue a variety of specialties. In FY 2015, Children's Hospitals Graduate Medical Education grantees reported training a total of 6,877 resident full-time equivalents on- and off-site. The Budget request will maintain this resident FTE level in FY 2018.

Teaching Health Center Graduate Medical Education

The Budget maintains funding for the Teaching Health Center Graduate Medical Education Program and requests $60 million in new mandatory funding in both FY 2018 and FY 2019. This program increases health care access in underserved communities by supporting primary care resident training in community-based, patient care settings. Since the Teaching Health Center Graduate Medical Education program's inception in 2010, the number of supported programs has grown from 11 residency programs in the first year of funding to 59 programs in Academic Year 2016-2017 located in 24 different States across the Nation.

NURSE Corps Scholarship and Loan Repayment Program

The NURSE Corps Scholarship and Loan Repayment Program provides scholarships and loan repayment for individuals who are enrolled in an accredited school of nursing or nurses with eligible nursing educational loans in exchange for health care services in areas with critical nursing shortages. The Budget provides $83 million—the same level as the FY 2017 Continuing Resolution—to support over 1,200 nurses and nursing students.

Health Care Workforce Assessment

The Health Care Workforce Assessment Program supports the collection and analysis of data and information necessary to evaluate the effectiveness of the health workforce nation-wide. The Budget provides $5 million for this program—the same level as the FY 2017 Continuing Resolution—to continue supporting high-quality information collection and up-to-date research on the impacts of health workforce activities.

Workforce Program Eliminations

Priority is given to health workforce programs that support more targeted efforts to provide direct health care services to patients in primary care settings and in medically underserved communities. The Budget reduces funding for health workforce activities by $403 million by discontinuing diversity training programs, mental and behavioral health programs, oral health programs, and select nursing and physician training programs.

KEEPING FAMILIES AND COMMUNITIES HEALTHY

Maternal and Child Health

The FY 2018 Budget prioritizes direct health care services and provides States and communities the flexibility to meet local needs. The request increases the funding that States receive through the Maternal and Child Health Block Grant to $667 million, which is an increase of $30 million above the FY 2017 Continuing Resolution. This funding supports services to more than half of the pregnant women and nearly one-third of all infants and children in the country. The additional funding will support greater State investment to improve the health of all mothers, children, and adolescents, particularly those in low-income families. The FY 2018 Budget also provides $128 million for the Healthy Start Program, which is a $10 million increase above the FY 2017 Continuing Resolution. The Healthy Start Program connects individuals with services that can reduce infant mortality and improve perinatal outcomes while allowing grantees to tailor services according to community need. In prioritizing the Maternal and Child Health Block Grant and Healthy Start, the Budget achieves a savings of $103 million by discontinuing smaller maternal and child health programs. States may continue to support these activities with their Maternal and Child Health Block Grant awards.

SECRETARY'S PRIORITIES

Response to Zika

In FY 2017, HRSA received $66 million in emergency supplemental funds to provide access to comprehensive health care and support services for children and families affected by the Zika virus in the United States and its Territories. Additionally, this funding played a critical role in increased clinical expertise of pediatric clinicians to provide care, and provided training and technical assistance on family-to-family support and referral services for children exposed to or affected by Zika in United States and its Territories.

The Budget also provides $400 million in new mandatory resources in Fiscal Years 2018 and 2019 for grants to States to provide home visiting services to at-risk pregnant women, mothers, and their families. These services build upon decades of scientific research that shows that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life have the potential to improve the lives of children and families. Additionally, research shows that home visits provide a positive return on investment by reducing reliance upon emergency room visits and public benefits receipt, decreasing interaction with child protective services, and increasing parental earnings.

Rural Health

The Federal Office of Rural Health Policy provides technical assistance, conducts research, and makes grants to enhance health care delivery in rural communities. The President's Budget provides $74 million—$75 million below the FY 2017 Continuing Resolution—to target funding for critical rural health activities such as Rural Health Outreach Network and Quality Improvement Grants, Rural Health Policy Development, Black Lung Clinics, and Telehealth. These investments will improve access to quality health care services in rural and underserved areas. Rural

Hospital Flexibility Grants and State Offices of Rural Health are discontinued to prioritize programs that provide direct services.

Family Planning

The Budget provides $286 million—the same level as the FY 2017 Continuing Resolution—to support low-income individuals with comprehensive family planning and related preventive health services through the Title X Family Planning program. Historically, 90 percent of family planning clients have family incomes at or below 200 percent of the Federal poverty level. In FY 2017, approximately 90 percent of family planning funding will be used for clinical services, including the treatment and prevention of sexually transmitted diseases and cervical cancer. These services, along with community-based education and outreach, assist individuals and families with pregnancy leading to healthy birth outcomes and preventing unintended pregnancies.

ADDITIONAL HRSA PROGRAMS

340B Drug Pricing Program

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient prescription drugs to eligible health care organizations at reduced prices. This program helps safety-net health care providers to optimize scarce resources and expand access to care. The Budget provides $10 million for the 340B Drug Pricing Program, the same level as the FY 2017 Continuing Resolution. Additionally, the Budget proposes to update regulatory authority in the 340B Drug Pricing Program to increase transparency and improve program integrity.

Program Management

The Budget requests $152 million—which is $2 million below the FY 2017 Continuing Resolution—to support the infrastructure necessary to operate HRSA programs. Funding in FY 2018 will allow HRSA to maintain oversight of grant and contract recipients, support program integrity efforts and reduce improper payments, develop and maintain its information technology infrastructure, train and support skilled staff, improve processes and business operations, and eliminate duplication.

Indian Health Service

dollars in millions	2016	2017 /1	2018	2018 +/- 2017
Services				
Clinical Services:	3,237	3,231	3,253	+22
Purchased/Referred Care (non-add)	*914*	*912*	*914*	*+2*
Preventive Health	156	155	157	+2
Contract Support Costs	718	717	718	+1
Tribal Management/Self-Governance	8	8	5	-3
Urban Health	45	45	45	--
Indian Health Professions	48	48	43	-5
Direct Operations	72	72	72	--
Subtotal, Services	**4,284**	**4,276**	**4,292**	**+16**
Facilities				
Health Care Facilities Construction	105	105	100	-5
Sanitation Facilities Construction	99	99	75	-24
Facilities and Environmental Health Support	223	222	192	-30
Maintenance and Improvement	74	73	60	-13
Medical Equipment	23	23	20	-3
Subtotal, Facilities	**523**	**522**	**447**	**-75**
Total, Budget Authority	**4,808**	**4,798**	**4,739**	**-59**
Funds From Other Sources				
Health Insurance Collections	1,194	1,194	1,194	--
Rental of Staff Quarters	9	9	9	--
Diabetes Grants	150	147	150	+3
Total, Program Level	**6,160**	**6,148**	**6,091**	**-56**
Full-time Equivalents	15,059	15,096	15,096	--

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

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

As part of the unique Government-to-Government relationship between the Federal Government and Tribal Governments, the Indian Health Service (IHS) provides health care to members of more than 567 Federally-recognized Tribes.

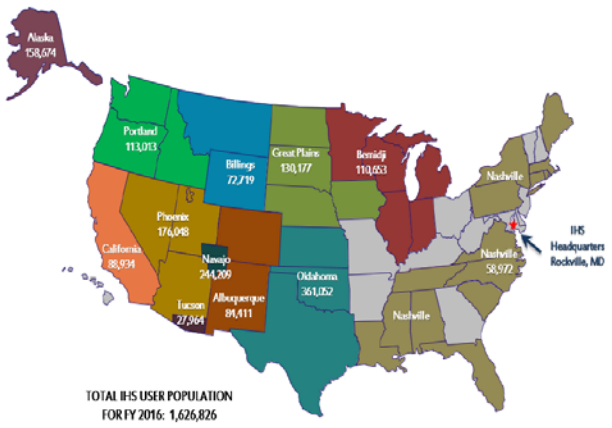
The Fiscal Year (FY) 2018 Budget requests $6.1 billion for IHS, which is $56 million below the FY 2017 Continuing Resolution. The FY 2018 Budget prioritizes funding the delivery of health care services to American Indians and Alaska Natives across Indian Country.

PRIORITIZING HEALTH CARE SERVICES

IHS provides comprehensive healthcare services through a network of over 679 hospitals, clinics, and health stations on or near Indian reservations. The Budget reflects the high priority commitment to Indian Country, protecting direct health care investments in the context of an 18 percent reduction to the overall HHS discretionary budget. The FY 2018 Budget provides $3.3 billion for clinical services, which is an increase of $22 million above the FY 2017 Continuing Resolution—restoring funding for direct health care services to FY 2016 levels. Direct health care services

include outpatient and inpatient care in hospitals and clinics, behavioral health services, and dental health services. In FY 2018, IHS estimates that they will serve approximately 2.2 million American Indians and Alaska Natives.

IHS USER POPULATION BY AREA



Purchased/Referred Care

The Purchased/Referred Care program is a high priority for American Indians and Alaska Natives because it provides, through contracts with hospitals and other health care providers, the critical health care services that IHS and tribally-managed facilities are otherwise unable to provide. The Budget provides $914 million for Purchased/Referred Costs—an increase of $2 million above the FY 2017 Continuing Resolution—to support medical care for catastrophic injuries, specialized care, and other critical care services.

Behavioral Health

While Tribes battle several chronic health problems, high rates of alcohol and substance abuse, mental health disorders, suicide, and chronic diseases are particular scourges that have had a tragic impact on American Indian and Alaska Native communities. The FY 2018 Budget requests a total of $288 million for Mental Health and Alcohol and Substance Abuse to support ongoing efforts to meet these persistent behavioral health challenges in Indian Country. This represents an increase of $1 million above the FY 2017 Continuing Resolution.

Preventive Health Services

In FY 2018, the Budget provides $157 million for preventive health services, which is an increase of $2 million above the FY 2017 Continuing Resolution. IHS, in partnership with Tribes, uses evidence-based practices at the local level to reduce the incidence of preventable disease, and increase the health of individuals, families, and communities across Indian Country. Programs such as public health nursing, health education, and community health representatives deliver culturally appropriate services to American Indian and Alaska Natives and serve as a link to accessing care for many who live in rural and isolated communities.

Staffing for Newly Opened Facilities

The Budget request includes funding to support the staffing of two newly opened facilities. In FY 2018, IHS will support staffing in two Joint Venture projects, the Choctaw Nation Regional Medical Center in Oklahoma and the Flandreau Health Center in South Dakota. Under Joint Venture agreements, IHS partners with Tribal entities to provide funds for staffing, equipping, and operating a facility while participating Tribes cover the design and construction costs associated with the new facility. These funds will allow the new facilities to expand the provision of health care in areas where the existing capacity is overextended, while balancing the need to maintain existing services across the country.

Special Diabetes Program for Indians

The Budget requests $150 million in mandatory funding for the Special Diabetes Program for Indians, an increase of $3 million above the FY 2017 Continuing Resolution. Diabetes health outcomes have improved significantly in American Indian and Alaska Native communities since the inception of the Special Diabetes Program for Indians, which provides grants for evidence-based diabetes treatment and prevention services across Indian Country. One of the most important achievements has been an eight percent reduction in the average blood sugar level of American Indian and Alaska Natives with diagnosed diabetes between 1997 and 2015. Improved blood sugar control reduces complications from diabetes.

Health Insurance Reimbursements

The FY 2018 Budget request for IHS estimates $1.2 billion in health insurance reimbursements from third party collections. The collection of health insurance reimbursements for the provision of care to people covered by Medicare, Medicaid, the Veterans Health Administration, as well as by private insurance, allows IHS and contracting or compacting Tribes to expand the provision of health care services, purchase

new medical equipment, maintain and improve buildings, and meet accreditation standards.

Other Programs

To prioritize health services and staffing for new facilities, the Budget reduces funding for Self-Governance and Indian Health Professions and discontinues the Tribal Management Grant Program.

The FY 2018 Budget requests $5 million for Self-Governance, which is $1 million below the FY 2017 Continuing Resolution.

The Indian Health Professions program funds efforts to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indian and Alaska Native communities. The Budget provides a total of $43 million for Indian Health Professions, which is $5 million below the FY 2017 Continuing Resolution. This funding level will maintain funding for current scholarship and loan payments.

FACILITIES AND CONSTRUCTION

The FY 2018 Budget request includes a reduction of $75 million below the FY 2017 Continuing Resolution in facilities improvements and construction costs, for a total of $447 million in FY 2018, to prioritize funding for direct health care services to American Indians and Alaska Natives as well as staffing costs for newly opened health care facilities.

Health Care Facilities Construction

In FY 2018, the Budget provides $100 million for Health Care Facilities Construction, which is $5 million below the FY 2017 Continuing Resolution. The Budget requests $100 million for the on-going construction of the following three facilities: the Alamo Health Center in New Mexico; the Rapid City Health Center in South Dakota; and the Dilkon Alternative Rural Health Center in Arizona.

Sanitation Facilities Construction

The Sanitation Facilities Construction Program supports construction projects that ensure access to safe drinking water and waste disposal across Indian Country. The Sanitation Facilities Construction program has had much success in disease prevention by ensuring that Tribal communities have access to safe drinking water and waste disposal. The Budget requests $75 million for these activities—$24 million below the FY 2017 Continuing Resolution—to maintain IHS's agreement to fund staffing in joint venture agreements and to ensure direct patient care services are funded.

Other Facilities Improvement and Construction Programs

The FY 2018 Budget reduces funding for Maintenance and Improvement, Facilities, and Environmental Health Support and Equipment. The Budget requests $60 million for Maintenance and Improvement, which is $13 million below the FY 2017 Continuing Resolution. These funds are the primary source of funding to maintain, repair, and improve existing IHS and Tribal health care facilities. The Budget requests $192 million for the Facilities and Environmental Health Support program, which is $30 million below the FY 2017 Continuing Resolution. This program supports an extensive array of real property, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The Budget also includes $20 million for Equipment, which is $3 million below the FY 2017 Continuing Resolution. The Budget will allow IHS to maintain its responsibility and commitment to patient care services as well as joint venture agreements with Tribes.

FURTHERING INDIAN SELF-DETERMINATION

Under the Indian Self-Determination and Education Assistance Act of 1975, Tribes and Tribal organizations can take over the operation of Indian Health Service programs. IHS recognizes the importance of their partnerships with Tribes and also understands that Tribes and Tribal organizations are the most knowledgeable about the needs in their communities. More than 60 percent of the IHS budget is administered directly by Tribes.

Contract Support Costs

Contract support costs funding supports certain operational costs of Tribes and Tribal organizations administering health care service programs under self-determination contracts and self-governance compacts. The Budget fully funds contract support costs at an estimated $718 million, and continues the use of an indefinite appropriation. The indefinite appropriation allows IHS to guarantee full funding of contract support costs while protecting funding for direct service Tribes.

Centers for Disease Control and Prevention

dollars in millions	2016 /1	2017 /2	2018	2018 +/- 2017
Immunization and Respiratory Disease	797	783	701	-82
Prevention and Public Health Fund (non-add)	*324*	*324*	*204*	*-121*
Balances from PHSSEF Pandemic Flu (non-add)	*15*	-	-	--
Vaccines For Children	4,400	4,437	4,598	+161
HIV/AIDS, Viral Hepatitis, STIs and TB Prevention	1,121	1,120	934	-186
Emerging and Zoonotic Infectious Diseases	582	579	514	-65
Prevention and Public Health Fund (non-add)	*52*	*52*	*137*	*+85*
Chronic Disease Prevention and Health Promotion	1,177	1,175	952	-222
Prevention and Public Health Fund (non-add)	*339*	*338*	*500*	*+162*
Birth Defects, Developmental Disabilities, Disability and Health	136	135	100	-35
Environmental Health	182	217	157	-60
Prevention and Public Health Fund (non-add)	*17*	*17*	-	*-17*
Injury Prevention and Control	236	236	216	-19
Public Health Scientific Services	491	491	460	-31
PHS Evaluation Funds (non-add)	-	-	*143*	*143*
Occupational Safety & Health	339	338	200	-138
World Trade Center Health Program /3	313	347	366	+18
Energy Employee Occupational Illness Compensation Program	50	50	55	+5
Global Health	427	426	350	-76
Public Health Preparedness and Response	1,413	1,402	1,266	-136
Buildings and Facilities	10	10	20	+10
CDC-Wide Activities and Program Support	411	273	105	-168
Prevention and Public Health Fund (non-add)	*160*	*160*	-	*-160*
Agency for Toxic Substances and Disease Registry (ATSDR)	75	75	62	-13
CORD MACRA Mandatory Funds	10	-	-	--
User Fees	2	2	2	--
Subtotal, Program Level	**12,172**	**12,096**	**11,059**	**-1,038**
CDC Budget Totals—Less Funds from Other Sources				
Vaccines for Children	4,400	4,437	4,598	+161
Energy Employee Occupational Injury Compensation Program	50	50	55	+5
World Trade Center Health Program /3	313	347	366	+18
PHS Evaluation Funds	-	-	143	+143
CORD MACRA Mandatory Funds	10	-	-	--
Prevention and Public Health Fund	892	891	841	-51
User Fees	2	2	2	--
Balances from PHSSEF Pandemic Flu	15	-	-	--
Total, Discretionary Budget Authority	**6,489**	**6,368**	**5,054**	**-1,315**
Full-Time Equivalents	11,806	11,948	11,948	--

1/ In addition, the FY 2016 Zika Response and Preparedness Act (P.L. 114-223) provided $397 million to CDC for Zika preparedness and response.
2/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

3/ Reflects Federal share obligations only; NYC share is not included. Obligations for FY 2016 reflect actual; FY 2017/FY 2018 reflect estimates.

The Centers for Disease Control and Prevention (CDC) works 24/7 to protect America from health, safety, and security threats, both foreign and in the United States. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise.

The Centers for Disease Control and Prevention (CDC) is the Nation's health protection agency, working 24/7 to conduct critical scientific research, provide information that protects our nation against dangerous health threats, and respond when such threats arise. CDC increases the health security of our nation. As the nation's health protection agency, CDC is committed to maximizing the impact of every dollar entrusted to it and continuing critical work to increase public health capacity at local, State, national, and global levels.

CDC keeps America secure by controlling disease outbreaks; making sure food and water are safe; helping people avoid leading causes of death such as heart disease, cancer, stroke, and diabetes; and working globally to reduce threats to the Nation's health. Good public health decision-making depends on the right information. CDC monitors health-related issues, informs decision-makers, and provides the public with information so they can take responsibility for their own health. By connecting State and local health departments across the United States, CDC can discover patterns of disease and respond when needed. Local and State labs must be able to safely detect and respond to health threats in order to prevent premature death, injury, and disease. CDC trains and guides State and local public health lab partners.

CDC is the key source of information for health professionals around the world. Ranging from recommendations from the Advisory Committee on Immunization Practices to clinical guidance on emerging health threats like Zika virus and Ebola, health professionals count on CDC for accurate and timely guidance and situational updates.

The Fiscal Year (FY) 2018 Budget for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $11.1 billion, a decrease of $1.0 billion relative to FY 2017. This total includes $5.1 billion in budget authority, $841 million from the Prevention and Public Health Fund, and $143 million in Public Health Service (PHS) Evaluation Funds.

At this funding level, CDC will continue to protect the nation and the world by: detecting, responding to, and stopping new and emerging health threats; preventing injuries, illness, and premature deaths; and discovering new ways to protect and improve the public's health through science and advanced technology. The Budget prioritizes funding for key areas where CDC can have the greatest impact, including: continuing the fight against opioid abuse, misuse, and overdose; supporting efforts to combat childhood obesity; protecting the Nation's national security through medical countermeasure stockpiling; and investing in CDC's infrastructure to ensure the safety, security and productivity of CDC staff.

The Budget provides CDC with increased flexibility to allocate resources and implement policies that best support mission-critical activities based on current science and public health expertise. This programmatic flexibility will enable the CDC to focus on programs that have been proven effective, while reducing costs and improving the efficient use of resources. The Budget establishes the new *America's Health* Block Grant, reforming the model of existing state-based chronic disease programs to increase flexibility, allowing States to focus on leading public health challenges specific to their State.

IMMUNIZATION AND RESPIRATORY DISEASES

CDC protects Americans from infectious diseases by issuing recommendations and guidance for the prevention and control of vaccine-preventable diseases and respiratory diseases. Through programs such as the Vaccines for Children Program, CDC improves access to immunization services for uninsured and underinsured United States populations and supports the scientific base for vaccine policy and practices. CDC delivers critical epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable and respiratory infectious disease threats and conducts preparedness planning for pandemic influenza.

The FY 2018 Budget includes $701 million for the discretionary programs supported within CDC's National Center for Immunization and Respiratory

Diseases, $82 million below the funding level reflected in the FY 2017 Continuing Resolution. Within this funding level, the influenza prevention and control program is prioritized to ensure domestic and global capacity is supported to respond to annual seasonal influenza epidemics, detect and mitigate the next influenza pandemic, and respond to other influenza emergencies. Core influenza activities are a critical foundation in supporting any effective pandemic response, which is especially pertinent given the recent H7N9 influenza outbreak in China.

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

CDC's National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis Prevention prioritizes cost-effective, scalable programs, policies, and research to achieve the greatest impact on reducing the incidence of HIV, viral hepatitis, sexually transmitted infections, and tuberculosis and preventing related illness and death. These infections result in high personal, societal, and economic costs, both in the United States and around the world.

The Budget includes $934 million for domestic HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis prevention, a decrease of $186 million below the spending level allowed by the FY 2017 Continuing Resolution.

CDC leads the fight to prevent new HIV infections, to eliminate tuberculosis, and to control sexually transmitted infections. The Budget prioritizes the most effective, evidence-based activities and maintains funding levels for hepatitis. Today, an estimated 4.4 million Americans from all walks of life are living with chronic viral hepatitis infection and are at increased risk for liver disease, liver cancer, and death. In 2012, hepatitis C-related deaths surpassed deaths from all other reportable infectious diseases combined and continued to rise in 2013 and 2014, killing more Americans each year. At this funding level, CDC will continue to support: vaccination-based prevention strategies; new infections detection, investigation, and response efforts; and expansion of testing and linkage to medical care.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

CDC's National Center for Emerging and Zoonotic Infectious Diseases is committed to protecting people from infectious diseases no matter where they occur. CDC targets infectious diseases ranging from the familiar, such as foodborne illnesses and healthcare-associated infections, to the less common but deadly, such as anthrax and Ebola. CDC manages a broad portfolio of science-based programs that combine laboratory, epidemiologic, analytic, and prevention technologies with public health tools. CDC collaborates with state and local health departments, other Federal government agencies, industry, and foreign ministries of health. The Budget includes $514 million to support CDC's National Center for Emerging and Zoonotic Infectious Diseases, a decrease of $65 million below the spending level allowed by FY 2017 Continuing Resolution.

Diseases spread by mosquitos and ticks will continue to evolve and move into new areas, including the United States. Outbreaks like Zika will not be a one-time event. Capacity building at all levels, as well as innovation in diagnostics, is needed to prevent and control these outbreaks and understand more about the vectors. To continue supporting CDC's efforts around Zika preparedness and other vector-borne diseases, the Budget includes an increase of $23 million above the spending level allowed by the FY 2017 Continuing Resolution for a total of $49 million.

Foodborne illness is a common, costly—yet preventable—public health problem. CDC estimates that one in six Americans get sick from contaminated foods or beverages and 3,000 die each year. The United States Department of Agriculture estimates that foodborne illnesses cost $15.6 billion dollars each year.

PROGRAM HIGHLIGHT

America's Health Block Grant Program

The Budget reforms the CDC through a new $500 million *America's Health* Block Grant to increase State, tribal and territorial flexibility and focus on the leading chronic disease challenges specific to each State. The newly-established *America's Health* Block Grant will provide flexibility in FY 2018 for each state to implement specific interventions that address leading causes of death and disability, including interventions to spur improvements in physical activity and the nutrition of children and adolescents, and other leading causes of death such as heart disease.

CDC provides the vital link between illness in people and the food safety systems of government agencies and food producers. The Budget maintains support for CDC's Food Safety activities at a total of $51 million. This funding will support: investigations of current outbreaks and evaluations of past outbreaks; State and local health agencies to enhance national surveillance, improving foodborne outbreak detection, response, and prevention; and data analysis to drive prevention efforts.

PUBLIC HEALTH SCIENTIFIC SERVICES

CDC's Office of Public Health Scientific Services leads CDC's efforts to improve the collection, analysis, and availability of public health data and information to improve America's health, safety, and security. CDC provides guidance and advice across HHS and advances data system modernization and interoperability, information innovation, and enhanced data analysis, synthesis, and translation.

High-quality health statistics are necessary to make evidence-based decisions to improve health and healthcare in the United States. The National Center for Health Statistics serves as one of the nation's principal statistical agencies, collecting, analyzing, and disseminating accurate, objective data to monitor long-term trends as well as detect short-term changes of public health importance. Leaders, health professionals, and an increasingly connected public look to CDC for relevant, credible, and objective health information.

The FY 2018 Budget includes $460 million to support public health scientific services activities, a decrease of $31 million below the spending level allowed by the FY 2017 Continuing Resolution. CDC will continue to support the most effective public health workforce training and workforce development programs, and core health care statistics at the reduced level.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Chronic diseases are the main cause of sickness, disability, death, and health care costs. They are often preventable. Most chronic diseases are caused by a few risk behaviors: tobacco use, poor nutrition, lack of physical activity, and excessive alcohol consumption.

CDC's National Center for Chronic Disease Prevention and Health Promotion works to prevent these behaviors and support healthy living from birth through old age. CDC research indicates chronic diseases are responsible for seven of 10 deaths each year, and treating people with chronic diseases accounts for 86 percent of our nation's health care costs.

PROGRAM HIGHLIGHT

Childhood Obesity

Childhood obesity is a serious problem in the United States. Today, three times as many children are obese as compared to rates from the 1970s. Obesity during childhood can have a harmful effect on the body in a variety of ways. Not only is childhood obesity associated with negative health consequences in childhood, these risks continue into adulthood increasing the likelihood of type 2 diabetes, cardiovascular disease, and certain cancers. Despite recent declines among preschool-aged children, obesity amongst all children is still too high, affecting one in six children and adolescents. Research has shown that well-designed, well-implemented school programs can effectively promote physical activity and healthy eating. Healthy eating and regular physical activity play a powerful role in preventing chronic diseases, including heart disease, cancer, and stroke—the three leading causes of death among adults aged 18 years or older.

In the FY 2018 Budget, CDC will continue to support its School Health programs, which provide funding to States to implement efforts to reduce the risk factors associated with childhood obesity, manage chronic conditions in schools, and promote the well-being and healthy development of all children and youth.

In addition, the newly-established *America's Health* Block Grant will provide flexibility for each state to implement specific interventions to address its population's unique public health issues, which could include interventions to spur improvements in physical activity and nutrition of children and adolescents.

The FY 2018 Budget includes $952 million for chronic disease prevention and health promotion activities, a decrease of $222 million below the spending level allowed by the FY 2017 Continuing Resolution. At this funding level, CDC will maximize its efficiency and public health impact by focusing on programs that implement evidence-based strategies and improve results across a variety of health outcomes. In alignment with this strategy, the Budget establishes a

new *America's Health* Block Grant to provide flexibility for each state to implement specific interventions to address its population's unique public health issues. States could use this funding to support interventions such as: tobacco prevention and control; diabetes; heart disease and stroke; nutrition, physical activity, and obesity; and arthritis.

The Budget includes $337 million for cancer prevention and control, a decrease of $18 million below the spending level allowed by the FY 2017 Continuing Resolution. This new approach will allow CDC to address the highest priorities and foster a more efficient cancer program overall, allowing cross-cutting activities to provide support to multiple types of cancer.

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

CDC's National Center on Birth Defects and Developmental Disabilities prevents birth defects and developmental disorders where possible and enhances the health and quality of life for people who live with them. The early years of life (birth to five years of age) are critical to a child's cognitive, social, and emotional development. CDC works with partners to develop public health tools and interventions that give all children the opportunity to reach their full potential.

Every four and a half minutes, a baby is born with a birth defect in the United States, resulting in nearly 120,000 babies affected by birth defects each year. CDC's state-based birth defects tracking and public health research provide a wealth of information used to identify causes of birth defects, find opportunities to prevent them, and improve the health of those living with birth defects.

Developmental disabilities, such as attention deficit/hyperactivity disorder, autism, cerebral palsy, hearing loss, and vision impairment, are some of the most significant child health issues facing families and our nation today. About one in six children in the United States have developmental disabilities or other developmental delays. CDC works to understand how common developmental disabilities are, identifying factors that can put children at risk, exploring possible causes, and improving identification of developmental delays so children and families can get the services and support they need as early as possible.

The FY 2018 Budget includes $100 million to support birth defects and developmental disabilities, a decrease of $35 million below the spending level allowed by the FY 2017 Continuing Resolution. At this funding level, CDC will focus its birth defects and developmental disabilities portfolio on core public health activities that align with CDC's mission and have proven interventions to make an impact on America's health.

ENVIRONMENTAL HEALTH

CDC protects America's health from environmental hazards that can be present in the air we breathe, the water we drink, and the world that sustains us. The National Center for Environmental Health investigates

PROGRAM HIGHLIGHT

Childhood Lead Poisoning Prevention

Nearly 24 million homes in the U.S. have deteriorated lead-based paint and lead-contaminated house dust. In children, lead exposure can result in serious effects on cognitive and physiological development. Lead can reduce kidney function and increase risk of hypertension and essential tremor among adults. The lead contamination crisis in Flint, Michigan, affecting approximately 99,000 residents, has renewed the nation's focus on this major problem.

In response to this crisis, CDC received $35 million in additional funding in FY 2017, available through FY 2018, to: implement a lead exposure registry; establish an advisory committee; and provide increased support to CDC's Childhood Lead Poisoning Prevention Program. CDC has assisted Flint with monitoring blood lead levels in more than 50 percent of the community's children under six years of age and connected more than 90 percent of children with elevated blood lead levels to case management.

Lead poisoning is 100 percent preventable, and the effects of elevated blood lead levels can be mitigated through timely provision of educational, medical, and behavioral interventions and social services. The FY 2018 Budget continues to support CDC's Childhood Lead Poisoning Prevention program, which provides national expertise and works with States to monitor childhood blood lead levels to prevent lead poisoning and help those who have elevated blood lead levels by assuring appropriate follow up and access to services. This program also supports State and local efforts to collect vital lead data that enables them to target and implement primary prevention and response activities.

the relationship between environmental factors and health, develops guidance, and builds partnerships to support healthy decision-making. These investments contribute to CDC's overall goal of keeping Americans safe from environmental hazards.

The FY 2018 Budget includes $157 million to support environmental health—$60 million below the spending level allowed by the FY 2017 Continuing Resolution—which includes $35 million for lead prevention and safe water activities, available through FY 2018. CDC programs will monitor environmentally related diseases, respond to urgent public health threats, provide training and guidance for the nation's environmental health workforce, and assist in emergency preparedness and response efforts.

The Budget includes $17 million in funding for the Childhood Lead Prevention Program, which is flat with the program's base spending allowed by the FY 2017 Continuing Resolution. In FY 2018, this program will continue to build upon CDC's past success in reducing children's blood lead levels in the United States.

INJURY PREVENTION AND CONTROL

Injuries and violence affect everyone, regardless of age, race, or economic status. In the first half of life, more Americans die from violence and injuries—such as motor vehicle crashes, falls, or homicides—than from any other cause, including cancer, HIV/AIDS, or the flu.

As the nation's leading authority on violence and injury prevention, CDC's National Center for Injury Prevention and Control is committed to saving lives, protecting people, and lowering the social and economic costs of violence and injuries. CDC collects data to identify problems and monitor progress, uses research to understand what works, and promotes evidence-based strategies to inform real-world solutions. CDC's goal is to offer individuals, communities, and states timely, accurate information and useful resources to keep people safe where they live, work, play, and learn.

The FY 2018 Budget includes $216 million in budget authority for injury prevention and control activities, a decrease of $19 million below the spending level allowed by the FY 2017 Continuing Resolution.

One of CDC's top priorities in the FY 2018 Budget is to sustain support to activities preventing opioid abuse and overdose. CDC applies its scientific expertise to help curb the epidemic in three ways: improving data quality and surveillance to monitor and respond to the epidemic; supporting States in their efforts to implement effective solutions and interventions; and equipping healthcare providers with the data and tools needed to improve the safety of their patients. The FY 2018 Budget includes $75 million in funding to support these efforts, maintaining the spending level allowed by the FY 2017 Continuing Resolution funding level.

PROGRAM HIGHLIGHT

Preventing Opioids Abuse and Overdose

Opioids, such as prescription opioids and heroin, killed more than 33,000 people in 2015, more than any year on record. Since 1999, the number of overdose deaths involving opioids quadrupled. From 2000 to 2015 more than half a million people died from drug overdoses. Ninety-one Americans die every day from an opioid overdose.

CDC's latest national analyses indicate that the increase in opioid overdose death rates is driven in large part by illicit opioids, like heroin and illicitly-manufactured fentanyl, a synthetic opioid. Historical data have also indicated that increased prescribing and sales of opioids—quadrupling since 1999— helped create and fuel this epidemic.

CDC is committed to an approach that protects the public's health and prevents opioid overdose deaths. The FY 2018 Budget includes $75 million to continue supporting this mission, specifically by:

- Improving data quality and timeliness to better track trends, identify communities at risk, and evaluate prevention strategies;
- Improving patient safety by equipping health care providers with the data and tools needed to improve opioid prescribing; and
- Strengthening State efforts by scaling up effective interventions.

The Budget prioritizes domestic violence prevention programs, such as the Rape Prevention Program, which provides funding to grantees to implement statewide sexual violence prevention plans, implement and evaluate prevention programs, and address local sexual violence prevention needs.

OCCUPATIONAL SAFETY AND HEALTH

CDC's National Institute for Occupational Safety and Health is the only Federal entity responsible for conducting research and making recommendations for the prevention of work-related injury and illness.

NIOSH works closely with the Occupational Safety and Health Administration and the Mine Safety and Health Administration in the United States Department of Labor to protect American workers and miners. NIOSH also administers the World Trade Center Health Program, which provides medical monitoring and treatment for eligible 9/11 responders and survivors and funds research into health conditions associated with the September 11, 2001, terrorist attacks.

The FY 2018 Budget includes $200 million to support occupational health and safety, a decrease of $138 million below the spending level allowed by the FY 2017 Continuing Resolution. NIOSH will conduct research to reduce worker illness and injury, and to advance worker well-being, but will not continue to fund State and academic partners for conducting, translating, or evaluating research.

In addition, the Budget includes $366 million in mandatory funding supported by the World Trade Center Health Program, and $55 million in mandatory funding for the Energy Employees Occupational Illness Compensation Program Act.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

CDC's Office of Public Health Preparedness and Response works to strengthen and support the Nation's health security to save lives and protect against public health threats. CDC protects the safety, security, and health of the United States by providing lifesaving response to chemical, biological, radiological, and nuclear threats, as well as other disasters, outbreaks, and epidemics. The Budget provides $1.3 billion for public health emergency preparedness activities within CDC, which is $136 million below the spending level allowed by the FY 2017 Continuing Resolution.

A critical component of CDC's preparedness and response activities are the Public Health and Emergency Preparedness cooperative agreements, which directly support State and local health departments. The Budget provides $551 million to the cooperative agreements to enable public health agencies to build resilient communities that have strong public health emergency management and response systems, all resulting in improving the overall safety of American communities. State and local health departments use this funding to advance, sustain, and develop the necessary tools to ensure local communities can effectively management public health emergencies. The program will implement reforms to improve the efficiency of the program; these reforms are complementary to the programmatic changes in the Hospital Preparedness Program within the Assistant Secretary for Preparedness and Response. The Budget restructures HHS preparedness grants to reduce overlap and administrative costs and directs resources to States with the greatest need. The Budget will introduce competition, risk, and link awards to performance. These grants will support entities that are most innovative in their approach to health care delivery system readiness and public health preparedness. These reforms will provide resources to localities with the greatest need, and encourage innovation by introducing competition to the grant program. Additionally, the program will focus funding decisions on performance by providing awards to recipients who are demonstrating critical emergency preparedness outcomes.

The Budget includes $575 million for the Strategic National Stockpile—$1 million above the spending level allowed by the FY 2017 Continuing Resolution—to maintain a repository of medical countermeasures that can be rapidly deployed to support State, territorial, and local response to public health threats. CDC's Strategic National Stockpile is the largest Federally-owned supply of lifesaving pharmaceuticals and medical equipment available for emergency use. At this funding level, CDC will be able to maintain inventory levels for the majority of stockpiled products and continue training responders nationwide to receive and use medical countermeasures when deployed.

The Budget provides reduced funding for operations for CDC's Emergency Operation Center, which conducts real-time research monitoring of public health events, outbreaks, and hazardous agents and the Select Agents Program, which keeps communities safe by overseeing laboratories that work with deadly pathogens and toxins.

GLOBAL HEALTH

By ensuring that countries have the capacity to prevent, detect, and respond to threats within their borders, CDC's Center for Global Health helps prevent regional and global health crises that affect health, security, and economic stability abroad and at home. These activities provide a global safety net by monitoring for disease outbreaks 24/7 around the world. CDC uses scientific data to track diseases and other health threats and target services to those who

need them most across a variety of programs, including global immunization, HIV/AIDS, tuberculosis, parasitic diseases and malaria, and disease detection and response, as well as health systems and laboratories.

The FY 2018 Budget includes $350 million for global health activities, a decrease of $76 million below the spending level allowed by the FY 2017 Continuing Resolution. This funding will support key global health activities including polio eradication, global tuberculosis, measles and other vaccine-preventable diseases, parasitic diseases and malaria, and ongoing global health protection.

This funding level also includes support of ongoing efforts in polio eradication. CDC's leadership and guidance in accountability, environmental surveillance, and scientific and programmatic implementation has contributed substantially to the more than 99.9 percent decline in global and United States polio cases. In FY 2018, CDC will focus its polio eradication efforts on core public health activities that align with CDC's mission and use proven interventions to move towards global eradication to ensure Americans are not at risk from this deadly disease anymore.

BUILDINGS AND FACILITIES

The FY 2018 Budget includes $20 million for CDC's facility repair and improvements, an increase of $10 million above the spending level allowed by the FY 2017 Continuing Resolution. This additional funding will support infrastructure repairs and improvements to ensure CDC's critical public health work can continue in buildings and facilities that support a safe, world-class research environment. Investments in CDC's infrastructure are essential to ensure that CDC can respond to the public health needs in the next decade.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

The Agency for Toxic Substances and Disease Registry (ATSDR) is a nonregulatory environmental health agency that provides public health expertise to keep Americans safe from hazards in the environment. Environmental factors contribute to more than 25 percent of diseases worldwide, including cancer, asthma, and heart disease.

ATSDR experts provide a 24/7 response to toxic chemical exposure, hazardous leaks and spills, environmentally related poisonings, natural disasters, and terrorist acts. ATSDR works in communities to assess human exposures to potentially harmful contaminants; advises Federal and State regulatory agencies and community members on actions needed to protect health; answers questions about environmental exposures; and provides guidance to health care providers.

The FY 2018 Budget includes $62 million for ATSDR, a decrease of $13 million below the spending level allowed by the FY 2017 Continuing Resolution. At this funding level, ATSDR will support the highest priority community requests for public health assessments and consultations.

National Institutes of Health



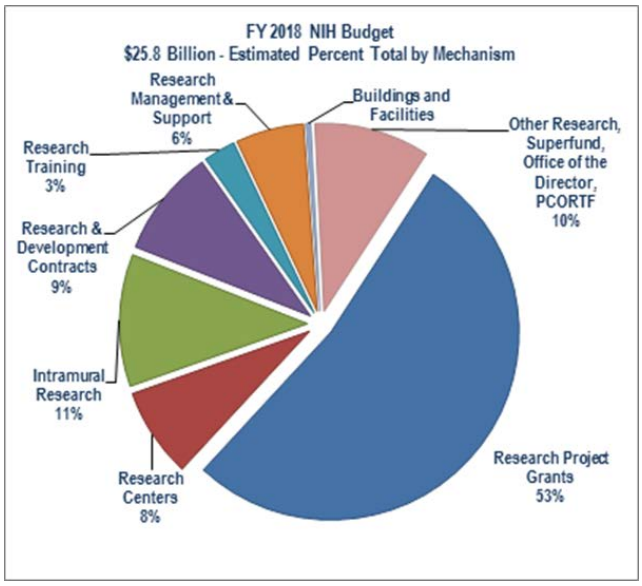
dollars in millions	2016 /1 /2	2017 /3	2018 /5	2018 +/- 2017
Institutes/Centers				
National Cancer Institute	5,206	5,505	4,474	-1,031
National Heart, Lung and Blood Institute	3,109	3,110	2,535	-575
National Institute of Dental and Craniofacial Research	413	415	321	-94
National Inst. of Diabetes & Digestive & Kidney Diseases	1,964	1,955	1,600	-355
National Institute of Neurological Disorders and Stroke	1,693	1,693	1,356	-337
National Institute of Allergy and Infectious Diseases	4,797	4,621	3,783	-838
National Institute of General Medical Sciences	2,509	2,509	2,186	-323
Eunice K. Shriver Natl. Inst. of Child Health & Human Development	1,338	1,337	1,032	-305
National Eye Institute	707	715	550	-165
National Institute of Environmental Health Sciences: Labor/HHS Appropriation	693	692	534	-159
National Institute of Environmental Health Sciences: Interior Appropriation	77	77	60	-18
National Institute on Aging	1,596	1,597	1,304	-294
Natl. Inst. of Arthritis & Musculoskeletal & Skin Diseases	541	541	418	-123
Natl. Inst. on Deafness and Communication Disorders	422	422	326	-96
National Institute of Mental Health	1,517	1,545	1,245	-301
National Institute on Drug Abuse	1,049	1,075	865	-210
National Institute on Alcohol Abuse and Alcoholism	467	467	361	-105
National Institute of Nursing Research	146	146	114	-33
National Human Genome Research Institute	513	518	400	-118
Natl. Institute of Biomedical Imaging and Bioengineering	343	346	283	-64
Natl. Institute on Minority Health and Health Disparities	280	279	215	-64
Natl. Center for Complementary and Integrative Health	130	131	102	-29
National Center for Advancing Translational Sciences	684	684	557	-127
Fogarty International Center	70	70	--	-70
National Library of Medicine	395	394	373	-21
Office of the Director	1,571	1,620	1,452	-168
Buildings and Facilities	129	129	99	-30
National Institute for Research on Safety and Quality /5			379	+379
Total, Program Level	**32,358**	**32,593**	**26,920**	**-5,674**

dollars in millions	2016 /1 /2	2017 /3	2018 /5	2018 +/- 2017
Less Funds from Other Sources				
PHS Evaluation Funds (NLM)	-780	-780	-780	—
Type 1 Diabetes Research (NIDDK) /4	-150	-140	-150	-10
Patient-Centered Outcomes Research Trust Fund /5			-107	-107
Total, Discretionary Budget Authority	**31,428**	**31,674**	**25,883**	**-5,791**
Appropriations				
Labor/HHS Appropriation	31,351	31,597	25,823	-5,917
Interior Appropriation	77	77	60	-18
Full-Time Equivalents /6	17,723	18,105	18,352	+247

1/ In addition, the FY 2016 Zika Response and Preparedness Act (P.L. 114-223) provided $152 million in supplemental resources to NIH for Zika response and preparedness activities.
2/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
3/ These mandatory funds were appropriated in P.L. 114-10, the Medicare Access and CHIP Reauthorization Act of 2015.
4/ The FY 2018 Budget consolidates Agency for Healthcare Research and Quality (AHRQ) within NIH as the National Institute for Research on Safety and Quality. AHRQ previously received mandatory funds transferred from the Patient-Centered Outcomes Research Trust Fund to implement section 937 of the Public Health Service Act. This institute is proposed to receive the mandatory resources from the Patient-Centered Outcomes Research Trust Fund in FY 2018 ($107 million).
5/ Full time equivalent levels exclude AHRQ in FY 2016 and FY 2017, and include FTE consolidated from AHRQ in FY 2018.

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

The National Institutes of Health is the largest public funder of biomedical research in the world. NIH expands the biomedical knowledge base by funding cutting-edge research, improves health by seeking new treatment and prevention options, supports the training of the current and future biomedical workforce, and drives economic growth and productivity.



NIH builds its research portfolio by evaluating current scientific opportunities and public health needs while maintaining strong support for investigator-initiated research. NIH strategic planning and priority setting processes provide an established framework within which priorities are identified, reviewed, and justified.

The Fiscal Year (FY) 2018 Budget provides $26.9 billion for NIH, which is $5.7 billion below the FY 2017 Continuing Resolution level. The FY 2018 Budget eliminates the Fogarty International Center while retaining a total of $25 million in mission-critical international research and research related activities within NIH Office of Director.

The FY 2018 Budget also includes $272 million in budget authority within NIH to preserve key research activities previously carried out by the Agency for Healthcare Research and Quality (AHRQ), including critical survey activities, support for the U.S. Preventive Services Task Force, evidence-based practice centers, patient safety, investigator-initiated grants, and researcher training grants. Remaining funds will be directed towards evidence-based practice centers, addressing the opioid epidemic, and the Healthcare Cost and Utilization Project. This reorganization within

NIH would structure AHRQ as an institute and preserve links between many of the closely-related continuing activities, simplify administrative responsibilities for consolidating and continuing the programs, and maintain an entity that can serve as a center of excellence for improving the quality and safety of health care services.

More than 80 percent of NIH's budget supports the extramural research community through nearly 50,000 competitive grants. These grants support work by more than 300,000 researchers at more than 2,500 universities, medical schools, and other research institutions in every State and around the world. About 10 percent of the NIH budget supports projects conducted by nearly 6,000 scientists in its own laboratories, most of which are on the NIH campus in Bethesda, Maryland. Within the FY 2018 Budget, NIH will also support planning, policy-making, administration, management, and communication of NIH research.

RESEARCH PRIORITIES IN FY 2018

Fundamental Science Enhanced by Technological Advances

NIH invests in the essential building blocks of research, including basic science (knowledge of the mechanisms of biology and behavior), data science, and the development of new technologies. This research can be applied across NIH's disease portfolio and forms the foundation for translational and clinical studies. For example, researchers are developing cryo-electron microscopy techniques to determine the atomic structures of proteins more rapidly than current methods allow. These advances will identify more accurate protein structures and aid the development of more targeted and effective drugs. Another example of potentially pivotal basic research is NIH's investment in single cell analysis. Though individual cells within a cluster may seem to be of the same type, such as a neuron or a nephron, in fact they can differ dramatically, with important consequences for the function of the entire organism. By analyzing the dynamic states of single cells it may be possible to predict which cells in a group are more likely to become infected with a virus, or are more prone to cancer, or even to becoming drug resistant. NIH-funded investigators have revealed a huge diversity of neuronal subtypes in the human brain. Single cell analysis has the potential to uncover fundamental biological principles and ultimately improve the detection and treatment of diseases and conditions. Basic research represents more than half of NIH's research budget and will continue to be a very high priority.

Treatments and Cures

Designing effective treatments and cures depends upon innovative researchers translating fundamental knowledge about cells, systems, and organisms, into potential targets for therapeutic development. Cell or tissue samples, animal models, and computer simulations often are used to design and test candidate approaches for diagnostics, devices, treatments, and cures. The most promising are then moved into human clinical trials, where they are tested first for safety and then efficacy. NIH supports research all along this pipeline to facilitate discovery of novel treatments for myriad diseases and conditions.

One groundbreaking treatment supported by NIH resources is cancer immunotherapy. This powerful technique harnesses a patient's own immune system to attack cancer cells. Patients with a variety of cancers have benefitted from immunotherapy, and ongoing and future NIH-supported research aims to understand what enables immunotherapy to work in some patients, but not in others, as well as to expand the use of immunotherapy to other types of cancer. Studies also will test the efficacy of cancer immunotherapies earlier in disease progression as well as in combination with other standard cancer treatments such as chemotherapy and/or radiation.

Health Promotion and Disease Prevention

NIH supports research to promote health, prevent disease, and develop strategies to address the progression of disease before symptoms appear. Advances in these research areas require a deep understanding of the many factors that affect health, and include identification and assessment of genetic and environmental risk factors, screening of at-risk individuals for diseases, development of risk-reduction strategies, as well as translation, dissemination, and implementation of strategies to prevent diseases and conditions. One important preventive strategy is vaccination, which is the safest, most cost-effective, and efficient way to reduce the burden of infectious diseases. NIH is engaged in research to develop vaccines for many diseases, including a universal influenza vaccine to protect against seasonal infection that can sometimes lead to very serious health complications. Such a vaccine would induce a strong,

long-lasting immune response to the part of the virus that does not change much from year to year, and several NIH-funded researchers have made progress towards this goal.

Enhancing Stewardship

As stewards of Federal investments in biomedical research, NIH strives to earn and maintain the public's trust. The role of the United States as a leader in biomedical research depends not only on innovation in the laboratory and the clinic, but also innovation in how science is funded, performed, and managed. NIH is engaged in many efforts to encourage good stewardship practices across all levels of the biomedical research enterprise. These include ways to streamline administrative processes for investigators, efforts to support new and early stage investigators, and a focus on cultivating a world-class biomedical research workforce.

A key way in which NIH is strengthening stewardship is through new policies designed to enhance reproducibility of scientific research through increased rigor and transparency in reporting. NIH has released principles and guidelines for reporting preclinical research and created training materials for graduate students and fellows in best practices in experimental design. Planned future activities include extending NIH's previously established Rigor and Reproducibility Policy to additional types of grants, collaborating with scientific journal editors and other stakeholders to improve rigor and reproducibility in publications, and working to improve data sharing and accessibility.

21st Century Cures Act

Funding for NIH Innovative Research Initiatives under the Cures Act.*

Fiscal Year	BRAIN	PMI	Cancer Moonshot	Regenerative Medicine
		millions of $		
2017	10	40	300	2
2018	86	100	300	10
2019	115	186	400	10
2020	140	149	195	8
2021	100	109	195	
2022	152	150	194	
2023	450	419	216	
2024	172	235		
2025	91	36		
2026	195	31		
10-Yr total	1,511	1,455	1,800	30

PROGRAM HIGHLIGHT

Childhood Obesity

Obesity is a critical public health crisis in the United States, and the percentage of obese children has tripled since the 1970s. The most recent National Health and Nutrition Examination Surveys (2011-2014) indicate that about 17 percent of children ages 2-19 years are obese. An additional 16 percent are considered overweight. Childhood obesity can increase risk for other chronic health conditions, including asthma, sleep apnea, bone and joint problems, type 2 diabetes, and heart disease. NIH conducts and supports research on a broad range of areas related to excess weight gain in children, including the causes, effects, prevention and treatment of obesity and related conditions. Because environment and genetics play important roles in childhood obesity, NIH works to increase understanding of the metabolic and behavioral factors involved in determining body weight regulation and body composition during childhood. Prevention is an important focus of NIH efforts. Developed by NIH, We Can! (Ways to Enhance Children's Activity & Nutrition) is a national movement designed to provide parents, caregivers, and communities with resources to encourage improved nutritional choices, increased physical activity, and reduced screen time in youth ages 8–13. Research shows that parents and caregivers are the primary influence on this age group, and We Can! focuses on programs and activities for parents and families to promote healthy, active lifestyles. We Can! also outlines ways that school systems, parks and recreation departments, health care systems, and community based organizations can help youth in their community lead healthier lives.

In FY 2017, Congress enacted the 21st Century Cures Act, authorizing $4.8 billion over ten years in support of high priority NIH initiatives and research areas: the Precision Medicine Initiative; the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative; the Beau Biden Cancer Moonshot; and Regenerative Medicine. The NIH FY 2018 Budget includes $496 million authorized for these initiatives.

Precision Medicine Initiative: This initiative was launched in 2015 to accelerate our understanding of individual variability and its effect on disease onset, progression, prevention, and treatment. Toward this goal, NIH is establishing a group of one million or more volunteer participants that reflect the diversity of the United States to contribute health information over many years, known collectively as the All of Us Research Program. This national resource of clinical, environmental, lifestyle and genetic data will help uncover new information that can be used to find new

strategies for preventing and treating diseases that account for individual variability.

BRAIN: Informed by a report (BRAIN 2025: A Scientific Vision) of a working group of the Advisory Committee to the NIH Director, the BRAIN Initiative seeks to accelerate the development and application of innovative technologies to produce a new, dynamic picture of the brain that shows how individual cells and the neural circuits they form interact in time and space. This information will fill current knowledge gaps and provide opportunities to explore how the brain records, stores, processes, and uses information. This understanding will provide important new insights on the connection between brain function and behavior and could transform our ability to diagnose and treat neurological and mental disorders.

Beau Biden Cancer Moonshot: By capitalizing on emerging scientific discoveries, the Beau Biden Cancer Moonshot aims to accelerate progress in cancer research, improve prevention and early diagnosis, and ensure access to cancer treatment and clinical trials for all patients. A Blue Ribbon Panel of experts established ten scientific priorities for the initiative, including enhanced data sharing, developing new cancer technologies, expanded use of prevention and early detection strategies, cancer immunotherapy, and pediatric cancer. NIH released funding opportunity announcements related to these priorities in FY 2017, and more are planned for the future.

Regenerative Medicine: Regenerative medicine seeks to develop functional tissues and organs to repair or replace biological function that has been lost due to congenital abnormalities, injury, disease, or aging. The state-of-the-art in regenerative medicine integrates tissue engineering (based on advanced biomaterials development) and cell-based therapy, springing from advances in stem cell research and developmental biology. Funding from the 21st Century Cures Act will be awarded in coordination with the Food and Drug Administration to support clinical research using adult stem cells, which could open doors for possible new treatments.

MAXIMIZING EFFICIENCY AND EFFECTIVENESS

The institutes, centers, and offices that make up NIH work together to coordinate and collaborate on research priorities, leveraging resources and expertise toward the common goal of improving health. Through trans-NIH efforts at planning and assessment and in consultation with HHS leadership, NIH continually seeks innovative ways to streamline its processes and structure to ensure efficient and effective scientific management.

Restructuring Global Health Research at NIH



The Budget for NIH eliminates the Fogarty International Center. Approximately $25 million within the Office of the Director will be dedicated to coordinating global health research across the NIH, including issues regarding workforce development and engagement with NIH's international biomedical research partners.

PROGRAM HIGHLIGHT

Opioids

In 2015, a record number of Americans—more than 33,000—died from an overdose of opioids. Addressing the opioid epidemic continues to be a high priority for NIH and all of HHS, and as outlined in the HHS National Pain Strategy, released in March 2016. NIH supports research efforts focused on: preventing opioid misuse and addiction; developing new and improved treatments for opioid addiction; improving the deployment of evidence based strategies for combatting overdose and preventing and treating addiction; and developing more effective treatments for pain with reduced potential for addiction and misuse. By building on findings such as the recent development of Probuphine, an implantable formulation of buprenorphine (an opioid used to treat opioid addiction) that delivers a constant dose for six months, NIH continues to seek better treatment for those addicted to opiates. And to prevent addiction, NIH is aggressively addressing better pain management approaches. For example, NIH is currently exploring potential partnerships with other federal and private stakeholders to capitalize on the emergence of numerous potential targets for non-addictive pain medications and preliminary research findings that could lead to the development and validation of biomarkers for pain which would result in better targeting of pain treatment. Efforts also are underway to identify new opioid pain medicines with reduced misuse, tolerance, and dependence risk, as well as alternative delivery systems and formulations for existing drugs that minimize diversion and misuse (e.g., by preventing tampering) and reduce the risk of overdose deaths.

Consolidation of Healthcare Research and Quality

To help focus resources on the highest priority research and reorganize federal activities in a more effective manner, the Budget consolidates the Agency for Healthcare Research and Quality (AHRQ) into NIH. The Budget consolidates select research activities within a new National Institute for Research on Safety and Quality (NIRSQ) to improve efficiency, minimize potential overlap, and increase coordination of health services research. The creation of NIRSQ will simplify administrative responsibilities for consolidating and continuing former AHRQ programs, and maintain an entity that can serve as a center of excellence for improving the quality and safety of health care services.

The Budget includes $272 million in budget authority for the NIRSQ. As part of the consolidation, the institute will invest $5 million in a comprehensive review of health services and translational research across NIH to identify gaps and develop a strategy for investing in the highest priority research and ensuring that the research is adopted by other Federal agencies and stakeholders. The Budget also preserves key activities that were previously funded in AHRQ to improve the quality and safety of American health care, while reducing or eliminating lower priority programs that may potentially overlap with activities administered by other components of HHS.

The Budget continues funding for select former AHRQ activities that have a demonstrated record of effectiveness and make unique contributions to quality improvement and patient safety through supporting the data generation, analysis, and evaluation necessary to improve quality of care and enhance patient safety. The Budget includes support for research to enhance patient safety at AHRQ's FY 2017 Continuing Resolution level to continue driving progress on reducing healthcare-associated infections, and developing and disseminating evidence on the frequency and prevention of safety incidents.

Many public and private healthcare organizations across the country rely on this evidence base to provide the strategies and tools needed to minimize risks and harms to patients. Funding for the Medical Expenditure Panel Survey will continue at $70 million—$4 million above the FY 2017 Continuing Resolution level—to maintain the integrity of the national and State sample sizes and the quality of the core data products. As the only national source for comprehensive annual data on the use of medical care in the U.S., the survey provides an important data source for research efforts aimed at improving health services.

PROGRAM HIGHLIGHT

Tissue Chip Technology

The tissue-on-a-chip research initiative funded by the National Institutes of Health and several partners, both private and public, is aimed at developing 3-D human tissue chips that accurately model the structure and function of human organs, allowing for better, more human-oriented safety and efficacy testing for medications. Research teams have begun to develop 3-D cellular microsystems that recreate approximately 10 different human organ systems, including the heart, lung, and nervous system. Researchers also are beginning to integrate their individual microsystems onto miniaturized platforms that combine 2-4 systems together. Recently, a team of scientists built EVATAR™, a miniaturized 3-D representation of five organs of the female reproductive system, along with the liver, on an integrated tissue chip platform. The system successfully mimicked the processes in a woman's body, including the 28-day reproductive cycle. The team plans to use EVATAR™ to better understand the basic hormonal and cellular functioning of the reproductive tract. At present, the effects of hormonal changes in women in drug metabolism are largely understudied and have led to gender-specific adverse drug reactions. When coupled with other tissue chips, EVATAR™ will be an invaluable tool in optimizing drugs and therapies for women.

NIRSQ will continue to provide administrative support for the United States Preventive Services Task Force at $7 million, a reduction of $4 million below AHRQ's FY 2017 Continuing Resolution level. Within Health Services Research, Data, and Dissemination, the Budget includes funding of $46 million for investigator-initiated research grants and research training, $10 million for the Healthcare Cost and Utilization Project, $1 million for Evidence-Based Practice Centers, and $3 million for opioid treatment research grants. These investments will provide researchers the support needed to conduct studies that focus on quality, effectiveness, and efficiency of health care services, and provide a means for the dissemination of research results with the greatest potential to improve care.

The Budget reduces or eliminates potentially overlapping or lower priority programs. For instance, no funding is included for the research and

dissemination activities of the Health Information Technology portfolio, which could potentially be funded by other continuing programs. Many contract-funded activities in Health Services Research, Data, and Dissemination, such as development of quality measures are discontinued due to potential overlap with other HHS programs.

In addition, NIRSQ is projected to receive $107 million in mandatory resources from the Patient-Centered Outcomes Research Trust Fund to continue translating and targeted dissemination of comparative-clinical effectiveness-research study results and workforce development efforts. These funds will also support training researchers to conduct high quality studies in this area and research designed to help patients and providers make better informed health care decisions.

Indirect Costs

Increasing efficiencies within the NIH remains a priority of the Administration. The FY 2018 Budget changes reimbursement of indirect costs for NIH grants, which will be capped as a percentage of total research, in order to better target available funding toward high priority research. In addition, Federal research requirements for grantees will be streamlined to reduce grantee burden through targeted approaches as proposed by NIH.

Overview by Mechanism

dollars in millions	2016 /2	2017 /3	2018	2018 +/- 2017
Mechanism				
Research Project Grants (dollars)	17,837	17,927	14,189	-3,739
[# of Non-Competing Grants]	*[23,528]*	*[24,595]*	*[24,499]*	[-96]
[# of New/Competing Grants]	*[10,364]*	*[8,974]*	*[7,326]*	*[-1,648]*
[# of Small Business Grants]	*[1,689]*	*[1,780]*	*[1,578]*	*[-202]*
[Total # of Grants]	*[35,580]*	*[35,349]*	*[33,403]*	*[1,946]*
Research Centers	2,575	2,496	2,080	-417
Other Research	2,020	2,151	1,732	-420
Research Training	804	843	738	-106
Research and Development Contracts	2,915	2,912	2,489	-423
Intramural Research	3,685	3,673	3,064	-609
Research Management and Support	1,653	1,718	1,577	-142
Office of the Director /4	599	650	777	127
NIH Common Fund (non-add)	*[676]*	*[674]*	*[454]*	*[-220]*
Buildings and Facilities /5	144.863	144.618	109	-36
NIEHS Interior Appropriation (Superfund)	77	77	60	-18
Patient Centered Outcomes Research	--	--	107	+107
Total, Program Level	**32,311**	**32,593**	**26,920**	**-5,674**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM) /6	-780	-780	-780	--
Type 1 Diabetes Research (NIDDK) and PCORTF /7	-150	-140	-257	-117
Total, Budget Authority	**31,381**	**31,673**	**25,883**	**-5,790**
Labor/HHS Appropriation	31,304	31,596	25,824	-1,067
Interior Appropriation	77	77	60	-17

1/ Subtotals and Totals may not add due to rounding.
2/ In addition, the FY 2016 Zika Response and Preparedness Act (P.L. 114-223) provided $152 million in supplemental resources to NIH for Zika response and preparedness activities.
3/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
4/ Number of grants and dollars for the Common Fund and ORIP components of OD are distributed by mechanism and are noted here as a non-add. The Office of the Director - Appropriations also is noted as a non-add because the remaining funds are accounted for under OD - Other.
5/ Includes B&F appropriation and funds for facilities repairs and improvements at the NCI Federally Funded Research and Development Center in Frederick, Maryland.
6/ Number of grants and dollars for Program Evaluation Financing are distributed by mechanism above; therefore, the amount is deducted to provide subtotals only for the Labor/HHS Budget Authority.
7/ Number of grants and dollars for mandatory Type I Diabetes are distributed by mechanism above; therefore, Type I Diabetes amount is deducted to provide subtotals only for the Labor/ HHS Budget Authority.

Substance Abuse and Mental Health Services Administration

dollars in millions	2016	2017 /1	2018	2018 +/-2017
Mental Health				
Community Mental Health Services Block Grant	533	532	416	-116
Programs of Regional and National Significance	415	414	277	-136
Suicide Prevention Programs (non-add)	*60*	*60*	*60*	--
Children's Mental Health Services	119	119	119	--
Projects for Assistance in Transition from Homelessness	65	65	65	--
Protection and Advocacy for Individuals with Mental Illness	36	36	36	--
Subtotal, Mental Health	**1,167**	**1,165**	**912**	**-252**
Substance Abuse Prevention				
Programs of Regional and National Significance	211	223	150	-73
Subtotal, Substance Abuse Prevention	**211**	**223**	**150**	**-73**
Substance Abuse Treatment				
Substance Abuse Prevention and Treatment Block Grant	1,858	1,855	1,855	--
State Targeted Response to the Opioid Crisis Grants	--	500	500	--
Programs of Regional and National Significance	337	342	342	--
Subtotal, Substance Abuse Treatment	**2,195**	**2,696**	**2,696**	**--**
Health Surveillance and Program Support				
Program Support	80	79	73	-6
Health Surveillance	47	47	34	-13
Performance and Quality Information Systems	13	13	13	--
Public Awareness and Support	16	16	12	-4
Data Request and Publications User Fees	2	2	2	--
Agency-Wide Initiatives	51	51	1	-50
Behavioral Health Workforce Education & Training (non-add)	*50*	*50*	--	*-50*
Subtotal, Health Surveillance and Program Support	**208**	**207**	**134**	**-74**
SAMHSA Budget Totals, Program Level				
Total, Program Level	**3,781**	**4,291**	**3,892**	**-399**
Less Funds from Other Sources:				
Prevention and Public Health Fund	*-12*	*-12*	--	*+12*
PHS Evaluation Funds	*-134*	*-133*	*-120*	*+13*
User Fees for Data Request and Publications	*-2*	*-2*	*-2*	--
TOTAL, Discretionary Budget Authority	**3,634**	**4,144**	**3,771**	**-374**
Full-Time Equivalents	620	615	610	-5

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

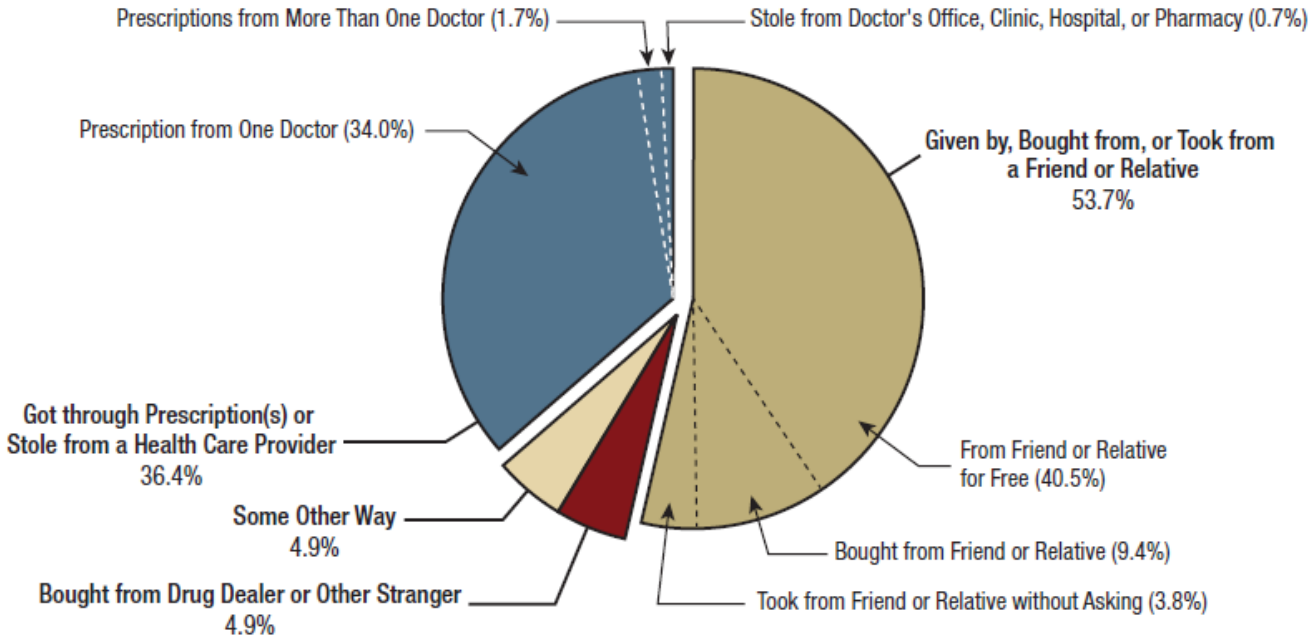
The Substance Abuse and Mental Health Services Administration reduces the impact of substance abuse and mental illness on America's communities.

The Fiscal Year (FY) 2018 President's Budget provides $3.9 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a reduction of $399 million below the FY 2017 Continuing Resolution. The Budget focuses on addressing the Nation's opioid crisis, expanding suicide prevention efforts, and addressing serious mental illness. More broadly, SAMHSA will support its core mission and carefully consider the organization's unique Federal role.

SUBSTANCE ABUSE

An estimated 21 million Americans needed treatment for a serious substance abuse problem in 2015. Substance abuse is associated with significant health impacts and increased costs for health care, but also vast financial and social consequences extending beyond the health care system. Deaths from drug overdose have risen steadily over the past two decades, and have become the leading cause of death from injury in the United States. From 2000 to 2015, more than half a million people died from drug overdoses, and 91 Americans die every day from an opioid overdose. The Budget provides $2.7 billion—the same amount as in the FY 2017 Continuing Resolution—for substance abuse treatment activities.

HHS is committed to fighting the opioid epidemic. In 2015, the National Survey on Drug Use and Health estimated that 3.8 million people misused prescription pain relievers such as opioids in a given month. A greater number of people, 12.5 million, reported misusing prescription pain relievers such as opioids at some point in the past year. Individuals who misuse pain relievers obtain them from a variety of sources, as described in the following chart.



12.5 Million People Aged 12 or Older Who Misused Pain Relievers in the Past Year

Source: SAMHSA. Prescription drug use and misuse in the United States: Results from the 2015 National Survey on Drug Use and Health. Hughes, A., Williams, M. R., Lipari, R. N., Bose, J., Copello, E. A. P., & Kroutil, L. A. NSDUH Data Review, September, 2016.

Fighting the Opioid Epidemic

The opioid epidemic is the deadliest drug epidemic in American history. The Budget includes $589 million in SAMHSA targeted to fighting the opioid epidemic. This includes $500 million authorized in the 21st Century Cures Act in each of FY 2017 and FY 2018 for States to increase access to treatment and to reduce unmet need and overdose related deaths. First year grants were awarded to States in April 2017 to provide opioid abuse prevention, treatment, and recovery support services.

The Budget also includes $17 million—the same amount as in the FY 2017 Continuing Resolution—for programs newly authorized under the Comprehensive Addiction and Recovery Act of 2016. The programs will expand efforts to train first responders on the use of the opioid overdose reversing drugs and to equip them with the needed drugs, provide additional recovery support services to help those in recovery succeed, and provide additional support for pregnant women and families struggling with addiction. The Budget also maintains $56 million for other efforts in SAMHSA to ensure the most effective evidence-based treatment for opioid abuse—known as medication-assisted treatment—is widely available and to ensure Opioid Treatment Programs are operating safely and effectively.

Substance Abuse Prevention and Treatment Block Grant

The Budget provides $1.9 billion for the Substance Abuse Prevention and Treatment Block Grant, which is the same amount as in the FY 2017 Continuing Resolution. This grant is provided by formula to States to assist in the treatment of approximately 2 million individuals. This funding is a cornerstone of States' substance abuse financing, and it accounts for over a third of public funds expended for prevention and treatment of substance abuse.

Promoting Effective Prevention of Substance Abuse

The Budget includes $150 million for substance abuse prevention efforts, which is $73 million below the FY 2017 Continuing Resolution. This total includes $62 million—the same level as in the FY 2017 Continuing Resolution—for programs that support Federal drug-free workplace efforts, fight underage drinking, and support grants to expand the provision of opioid overdose reversing drugs. Also within this group of programs are those that expand tribal behavioral health, training for the minority behavioral health workforce, and provide technical assistance and training to States, Tribes, and communities. The Budget reduces funding for the Strategic Prevention Framework to $58 million—$61 million below the FY 2017 Continuing Resolution—to prioritize other high-need programs. The Budget also reduces funding for the Minority AIDS programs, as States can use the Substance Abuse Prevention and Treatment Block Grant for activities to prevent the onset of substance abuse and the transmission of HIV/AIDS.

MENTAL HEALTH

In 2015, an estimated 43 million American adults—18 percent—met the medical standard for having a mental, behavioral, or emotional disorder that substantially interfered with or limited major life activities. Of these, 10 million people—or four percent of all American adults—had a serious mental illness.

A 2011 study estimated that societal costs of mental disorders exceeded the costs of diabetes, respiratory disorders, and cancer combined. Including estimated expenditures for mental health treatment with projections of lost earnings and public disability insurance payments associated with mental illness, the financial cost of mental disorders was at least $467 billion in the United States in 2012. The Budget provides $912 million—$252 million below the FY 2017 Continuing Resolution—for mental health activities.

Community Mental Health Services Block Grant

The Budget includes $416 million for the Community Mental Health Services Block Grant, which is a reduction of $116 million below the FY 2017 Continuing Resolution. The block grant is a flexible source of funding that allows States to target resources to local needs. The funding will continue its focus exclusively on addressing the needs of adults living with serious mental illness and children experiencing serious emotional disturbances, and will continue to direct States to spend at least 10 percent of the funds on early interventions to assist those experiencing a first episode of psychosis. This funding represents just one percent of total public spending on mental health. Historically, the provision of mental health services has largely rested with States.

Children's Mental Health Services

The Budget continues the Children's Mental Health Services program at $119 million, which is the same amount as the FY 2017 Continuing Resolution. This

program helps States, Tribes, and communities deliver evidence-based services and supports for children and youth with serious emotional disturbances. These funds ensure effective collaboration between child- and youth-serving systems such as juvenile justice, child welfare, and education. The Budget also proposes that up to 10 percent of the funds will be available for a new demonstration to translate recent research by the National Institute of Mental Health indicating that earlier psychosocial intervention with those at high risk may prevent the further development of serious emotional disturbances and ultimately serious mental illness.

Suicide Prevention

The Budget continues support for Suicide Prevention programs, providing $60 million—the same amount as in the FY 2017 Continuing Resolution—to reduce the overall suicide rate and number of suicides in the United States. This program supports State efforts to raise suicide awareness and improve emergency room referral processes and clinical care practice standards. States will also be supported to develop and implement youth suicide prevention and early intervention strategies involving public-private collaboration among youth-serving institutions. The funding also supports American Indian/Alaska Native Suicide Prevention through specialized technical assistance and support.

Increasing the Focus on Serious Mental Illness

To ensure that the Budget targets those who need help most, the Budget includes $5 million in new funding for Assertive Community Treatment in SAMHSA. This is a new program authorized by the 21st Century Cures Act. The program will help communities establish, maintain, or expand evidence-based efforts to avoid the dangerous and unsettling cycling of patients with mental illness through emergency and inpatient settings. This practice is proven to reduce hospitalization of those with serious mental illness at the same cost with higher patient satisfaction.

Youth Violence Prevention

The Budget continues support for the Youth Violence Prevention Program at $23 million—the same amount as in the FY 2017 Continuing Resolution—to implement an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug use. The Budget seeks to eliminate duplication of the school-based programs and to that end discontinues funding for both Project Advancing Wellness and Resiliency in Education (AWARE) and the Healthy Transitions program.

Primary and Behavioral Healthcare Integration

The Budget does not include funding for the Primary and Behavioral Healthcare Integration program, which is a reduction of $52 million below the FY 2017 Continuing Resolution. Under the Budget, States can choose to dedicate Federal resources received through the block grant or other sources of funding to integrate primary and behavioral health care. For example, eight States will participate in a Medicaid demonstration in FY 2018 to operate Certified Community Behavioral Health Centers.

PERFORMANCE HIGHLIGHT

National Suicide Prevention Lifeline

The Budget supports the National Suicide Prevention Lifeline (Lifeline), 1-800-273-TALK, which coordinates a network of 164 crisis centers across the United States by providing suicide prevention and crisis intervention services for individuals seeking help at any time, day or night. The Lifeline averaged nearly 124,000 calls per month in FY 2016, with over 90 percent of callers reporting that calling the crisis hotline helped stop them from killing themselves. More than 40,000 callers per month identified themselves as veterans and were seamlessly connected to a specialized veterans' suicide prevention hotline developed in collaboration with the Department of Veterans Affairs.

HEALTH SURVEILLANCE AND PROGRAM SUPPORT

The Budget includes $107 million for staff and related program management expenses necessary to effectively monitor a wide array of Federal programs, as well as for Health Surveillance, which in total is a reduction of $20 million below the FY 2017 Continuing Resolution. This funding level prioritizes activities for which there is a unique Federal role, such as certain public health surveillance associated with the National Survey on Drug Use and Health and the National Registry of Evidence-Based Programs and Practices.

Behavioral Health Workforce Education and Training

No funding is provided for the Behavioral Health Workforce Education and Training program—a reduction of $50 million below the FY 2017 Continuing Resolution—to prioritize targeted efforts to provide

direct health care services. For example, the National Health Service Corps administered by the Health Resources and Services Administration directly hires behavioral health professionals serving in communities with shortages, directly responding to public health needs.

Public Awareness and Support

The Budget includes $12 million for Public Awareness and Support—a reduction of $4 million below the FY 2017 Continuing Resolution—to raise the public's awareness of mental and substance use disorders and inform public health efforts to advance the behavioral health of the nation through programmatic data collection and monitoring. Savings are achieved through reductions in the scope of other communications and public affairs activities and through the natural conclusion of the Science of Changing Social Norms program, which has successfully met its objectives.

Centers for Medicare & Medicaid Services: Overview

dollars in millions	2016	2017	2018	2018 +/– 2017
Current Law /1				
Medicare /2	594,483	599,678	593,154	-6,524
Medicaid	368,280	378,455	407,570	+29,115
CHIP	14,358	16,879	12,017	-4,862
State Grants and Demonstrations	553	537	534	-3
Other Health Insurance Programs	11,561	9,637	7,225	-2,412
Center for Medicare and Medicaid Innovation	1,156	1,294	1,408	+114
Total Net Outlays, Current Law /3	**990,391**	**1,006,480**	**1,021,908**	**+15,428**
Proposed Law				
Medicare—Benefits /2	-	-	39	+39
Medicare - Administration			2	+2
Medicaid	-	-	-3,857	-3,857
CHIP	-	-	1,400	+1,400
Medical Liability Reform Impacts *(non-add)*	-	-	*-149*	*-149*
Discretionary Program Management	-	-	26	+26
Total Proposed Law	**-**	**-**	**-2,390**	**-2,390**
Total Net Outlays, Proposed Law /4	**990,391**	**1,006,480**	**1,019,559**	**+13,059**
Savings from Program Integrity Investments /5	-	-	-102	-102
Total Net Outlays, Proposed Policy	**990,391**	**1,006,480**	**1,019,416**	**+12,936**

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ Current law Medicare outlays net of offsetting receipts.
3/ Totals may not add due to rounding.
4/ Total net proposed law outlays equal current law outlays plus the impact of proposed legislation and offsetting receipts.
5/ Includes non-PAYGO scorecard savings from discretionary Health Care Fraud and Abuse Control Program (HCFAC) above savings already assumed in current law.

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

The Fiscal Year (FY) 2018 Budget estimate for the Centers for Medicare & Medicaid Services (CMS) is $1 trillion in mandatory and discretionary outlays, a net increase of $13 billion from the FY 2017 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), other health insurance programs, program integrity efforts, and operating costs. CMS's legislative package promotes fiscal responsibility, State flexibility, and curbs the practice of defensive medicine. In total, the Budget proposes targeted savings of $636 billion to CMS Federal health benefit programs over the next decade.

BUDGETARY REQUEST

CMS is dedicated to moving toward a health care system that will drive down costs, give Americans more choices, and put patients and doctors in control of their health care. To achieve this, CMS will empower patients and doctors to make decisions about their health care while reducing burdensome regulations and building a patient-centered system of care that increases competition, quality, and access. CMS will usher in a new era of state flexibility and local leadership. Because the States are in the best position to assess the unique needs of their populations and drive reforms, this shift will result in better health care outcomes.

Medicare

The Budget does not include any direct Medicare cuts. The Budget proposes to repeal the Independent Payment Advisory Board and also provides resources and signals a commitment to reform the Medicare appeals process.

Medicaid and CHIP

The Budget includes legislative proposals in Medicaid and CHIP, which have a net savings of $616 billion on Federal spending over 10 years.[1] The Budget makes fundamental reforms to Medicaid's fiscal structure and gives States greater flexibility to implement solutions reflective of the needs of their unique populations. The Budget includes an initiative that helps to rebuild the patient-physician relationship. Finally, the Budget extends CHIP for two years through FY 2019, along with reforms to return the focus of the program to the most vulnerable low-income families and children that the program was intended to serve.

Repeal and Replace

The Budget includes $250 billion in net deficit savings over 10 years related to repealing and replacing Obamacare, and implementing reforms that provide the American people with access to the kind of high-quality, affordable care that works best for them. The Budget promotes efficient operations and funds necessary activities to continue to operate the Exchanges in 2018. This will provide for a stable transition from the burdensome requirements of Obamacare to a patient-centered health care system focused on increasing choices for patients and providers and promoting state flexibility and control.

Medical Liability Reform

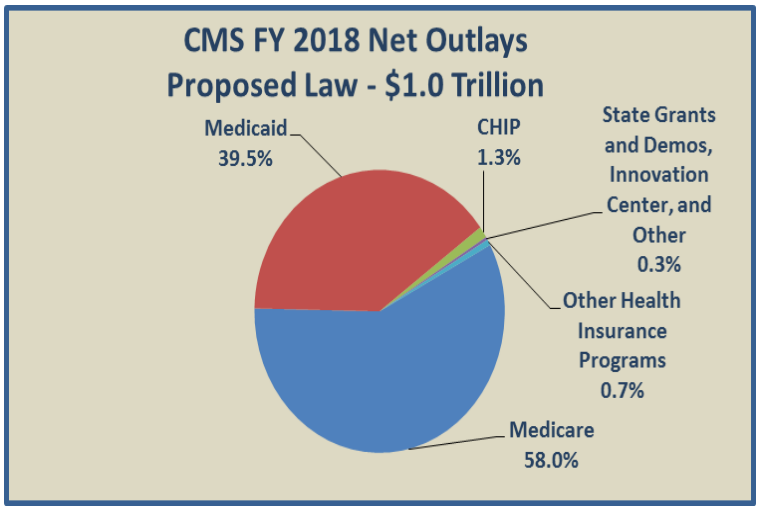
The Budget proposes nationwide medical liability reforms that will reduce medical malpractice costs and the practice of defensive medicine, saving HHS programs a combined $31.8 billion over ten years; decreasing provider burdens; and reducing costs for patients, States, and insurers.

Program Integrity

The Budget includes a new $70 million investment in the Health Care Fraud and Abuse Control Program within HHS and the Department of Justice to enhance efforts to identify and prevent fraud and abuse before it happens and restore taxpayer dollars to the Medicare Trust Funds.

Discretionary Program Management

The Budget for Program Management enables CMS to continue to effectively administer Medicare, Medicaid, and CHIP. The Budget also includes one new discretionary user fee.



[1] This includes $3 billion in savings to Exchange subsidies and related impacts, reflected in the Department of Treasury programs and accounts.

dollars in millions	2016	2017	2018	2018 +/- 2017
Current Law Outlays and Offsetting Receipts				
Benefits Spending (gross) /1	682,994	696,219	704,588	+8,369
Less: Premiums Paid Directly to Part D Plans /2	-9,115	-10,050	-10,868	-818
Subtotal, Benefits Net of Direct Part D Premium Payments	**673,879**	**686,169**	**693,720**	**+7,551**
Related-Benefit Expenses /3	16,239	14,079	14,883	+804
Administration /4	8,492	10,260	9,474	-786
Total Outlays, Current Law	**698,610**	**710,508**	**718,077**	**+7,569**
Premiums and Offsetting Receipts	-104,127	-110,830	-124,923	-14,093
Current Law Outlays, Net of Offsetting Receipts	**594,483**	**599,678**	**593,154**	**-6,524**
Proposed Law and Savings from Program Integrity Investments				
Medicare Proposals, Net of Offsetting Receipts	0	0	39	+39
Medicare Trust Fund Administration /5	0	0	2	+2
Savings from Program Integrity Investments /6	0	0	-102	-102
Total Net Outlays, Adjusted Baseline, Savings from Program Integrity Investments and Proposed Law	**594,483**	**599,678**	**593,093**	**-6,585**
Mandatory Total Net Outlays, Proposed Policy /7	**588,309**	**592,593**	**586,579**	**-6,014**

1/ Represents all spending on Medicare benefits by either the Federal Government or other beneficiary premiums. Includes Medicare Health Information Technology Incentives.
2/ In Part D only, some beneficiary premiums are paid directly to plans and are netted out here because those payments are not paid out of the Trust Funds.
3/ Includes savings from investments in Social Security disability reviews and related benefit payments, including refundable payments made to providers and plans, transfers to Medicaid, and premiums to Medicare Advantage plans paid out of the Trust Funds from beneficiary Social Security withholdings.
4/ Includes CMS Program Management, Health Care Fraud and Abuse Control Program (HCFAC), Quality Improvement Organizations, and other administration.
5/ Includes the following proposed administration in FY 2018: $18 million in outlays for supporting the continuation of four Administration for Community Living programs, and -$16 million in reduced outlays from eliminating the Independent Payment Advisory Board.
6/ Includes non-PAYGO scorecard savings from discretionary HCFAC above savings already assumed in current law.
7/ Removes total Medicare discretionary amount: FY 2016 -$6,174 million; FY 2017 -$7,085 million; and FY 2018 -$6,514 million.

In Fiscal Year (FY) 2018, the Office of the Actuary has estimated that gross current law spending on Medicare benefits will total $704.6 billion. Medicare will provide health insurance to 60 million individuals who are age 65 or older, disabled, or have end-stage renal disease.

THE FOUR PARTS OF MEDICARE

Part A ($202.8 billion gross fee-for-service spending in 2018)

Medicare Part A pays for inpatient hospital, skilled nursing facility, home health related to a hospital stay, and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax paid by both employees and employers.

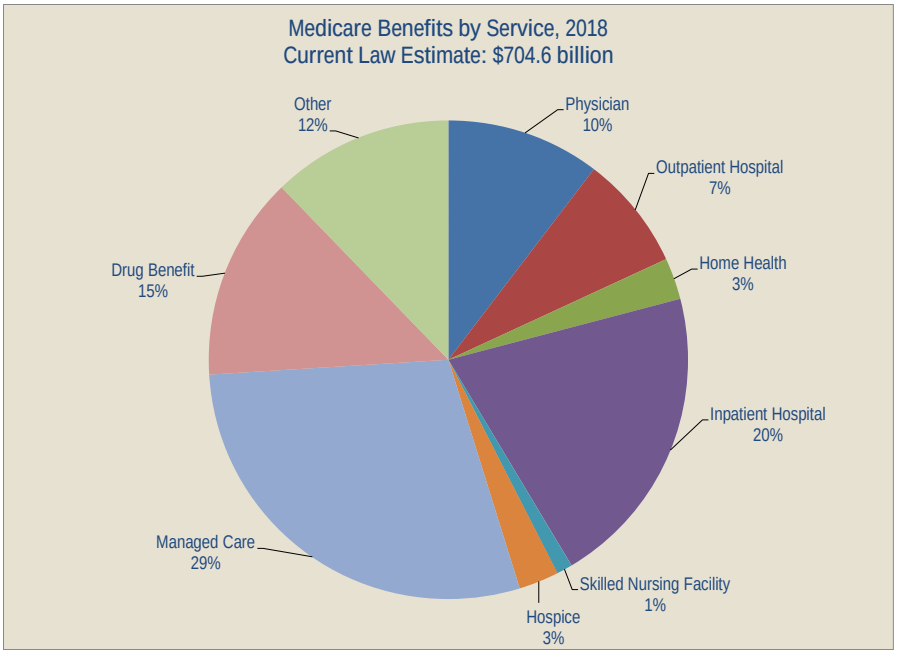
Generally, individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most services require beneficiary coinsurance. In 2017, beneficiaries pay a $1,316 deductible for a hospital stay of 1–60 days, and $164.50 daily coinsurance for days 21–100 in a skilled nursing facility.

Part B ($201.9 billion gross fee-for-service spending in 2018)

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

The standard monthly Part B premium is $134 in 2017, an increase of $12.20 over the 2016 standard premium amount. However, approximately 70 percent of Part B

enrollees are held harmless from the full increase in the Part B premium and will pay a premium of $109 per month, on average. Some beneficiaries pay a higher Part B premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married) will pay from $187.50 to $428.60 per month in 2017. The Part B deductible in 2017 is $183 for all beneficiaries.



Part C ($203.0 billion gross spending in 2018)

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

In 2018, Medicare Advantage enrollment will total approximately 20.8 million, or approximately 38 percent of all Medicare beneficiaries. Centers for Medicare and Medicaid Services (CMS) data confirm that 99 percent of Medicare beneficiaries will have access to at least one Medicare Advantage plan in 2018. Additionally, while premiums have remained stable, Medicare Advantage supplemental benefits have increased, and enrollment is growing faster than in traditional Medicare.

Part D ($96.8 billion gross spending in 2018)

Medicare Part D offers a standard prescription drug benefit with a 2017 deductible of $400 and an average estimated monthly premium of $35. Enhanced and alternative benefits are also available with varying deductibles and premiums. Beneficiaries who choose to participate are responsible for covering a portion of the cost of their prescription drugs. This portion may vary depending on whether the medication is generic or a brand name and how much the beneficiary has already spent on medications that year. Low-income beneficiaries are responsible for varying degrees of cost-sharing, with co-payments ranging from $0 to $8.25 in 2017 and low or no monthly premiums. For 2018, the number of beneficiaries enrolled in Medicare Part D is expected to increase by about 3.5 percent to 45.7 million, including about 12.9 million beneficiaries who receive the low-income subsidy. In 2017, approximately 57 percent of those with Part D coverage are enrolled in a stand-alone Part D Prescription Drug Plan, 39 percent are enrolled in a Medicare Advantage Prescription Drug Plan, and the remaining beneficiaries are enrolled in an employer plan or the Limited Income Newly Eligible Transition plan. Overall, approximately 76 percent of all Medicare beneficiaries receive prescription drug coverage through Medicare Part D or employer-sponsored retiree health plans, and approximately another 10 percent though other creditable coverage.

Medicare Enrollment
(person-years in millions)

	2016	2017	2018	2018 +/- 2017
Aged 65 and Over	47.5	49.2	51.0	+1.8
Disabled	9.0	9.0	9.0	+0.0
Total	56.5	58.2	60.0	+1.8

Source: CMS Office of the Actuary estimates.

The Medicare Part D coverage gap, or "donut hole," is being closed through a combination of manufacturer discounts and gradually increasing Federal subsidies. Beneficiaries fall into the coverage gap once their total drug spending exceeds an initial coverage limit ($3,700 in 2017), until they reach the threshold for qualified out-of-pocket spending ($4,950 in 2017), at which point they are generally responsible for five percent of their drug costs. Previously beneficiaries were responsible for 100 percent of their drug costs in the coverage gap. In 2018, non-low income subsidy beneficiaries who reach the coverage gap will pay 35 percent of the cost of covered Part D brand drugs and biologics and 44 percent of the costs for all generic drugs in the coverage gap. Cost-sharing in the coverage gap will continue to decrease each year until beneficiaries are required to pay only 25 percent of the costs of covered Part D drugs in 2020 and beyond.

In 2016, more than 4.9 million beneficiaries reached the coverage gap and saved more than $5.6 billion on their medications due to the prescription drug discount program. These savings averaged about $1,149 per person.

PERFORMANCE HIGHLIGHT

Hospital Harm Reduction

The Agency for Healthcare Research and Quality National Scorecard data released in December 2015 reveals great success in hospital harm reduction, such as reduced infections. The data demonstrate a reduction in harm to patients of 21 percent over 5 years.

Calendar Year	# Harms per 1,000 Discharges
2010—Baseline	145
2011	142
2012	132
2013	121
2014	121
2015	115

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

PROGRAM UPDATE

Medicare Access and CHIP Reauthorization Act: Progress Implementing the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act (MACRA) repealed the Sustainable Growth Rate for physician fee schedule payments and created clinician payment provisions that collectively comprise the Quality Payment Program. The Quality Payment Program includes two tracks: the Merit-based Incentive Payment System and incentive payments for participation in Advanced Alternative Payment Models. The goal of the program is to provide the resources and tools clinicians need to provide the best possible care to their patients.

While the program officially began on January 1, 2017, clinicians have the flexibility to start their participation anytime between January 1 and October 2, 2017. HHS envisions the first year as being a trial run for clinicians in order for them to get experience participating in the program and being assessed on their performance. Clinicians ready to fully participate are encouraged to do so and may be eligible for additional bonus payments. HHS will carefully monitor how the first year progresses and, as HHS develops policies for future years, will work to reduce provider burden while providing incentives for providing high-quality care.

MEDICARE HIGHLIGHTS - 21ST CENTURY CURES

On December 7, 2016, Congress passed the 21st Century Cures Act, which includes a number of key changes to the Medicare program.

These include clarifying that certain hospital outpatient departments should be exempt from site-neutral payment policies and by allowing rural and critical access hospitals to operate under requirements that reflect the realities of their environments and support patients' access to care. The 21st Century Cures Act extends the Rural Community Hospital Demonstration by five years. The Act also provides relief for long-term care hospitals, including through an exception to the current moratorium on new beds, a one-year pause in enforcement of the 25-percent threshold policy, and an exemption for certain clinical services from site-neutral payments.

The 21st Century Cures Act will also increase choice for Medicare beneficiaries by allowing people with End-Stage Renal Disease to enroll in Medicare Advantage starting in 2021 and by allowing beneficiaries to switch between Medicare Advantage and traditional Medicare one time, during the first three months of the year, starting in 2019.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

The mission of the Quality Improvement Organization Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The Organizations are experts in the field working to drive local change, which can translate into national quality improvement. The current five-year contract cycle, or 11th Statement of Work, began on August 1, 2014, and provides approximately $802 million in FY 2018 and $4.4 billion over five years. The 12th Scope of Work will begin in FY 2019.

In the 11th Statement of Work, there are 14 Quality Innovation Network contracts and five Beneficiary and Family Centered Care contracts. Quality Innovation Network contractors have been working to reduce patient harms such as central-line bloodstream infections, hospital readmissions, and adverse drug events. Beneficiary and Family Centered Care is the program's statutory case review work, and includes beneficiary complaints, concerns related to early discharge from health care settings, and patient and family engagement. Since 2016, Quality Innovation Network contractors have provided clinicians with technical assistance related to MACRA's Quality Payment Program, with a focus on those with the greatest need.

PROGRAM HIGHLIGHT

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

Clinical Quality Improvement	$805
Beneficiary and Family Centered Care	$433
Infrastructure, Support, and Special Initiatives	$2,060
Other Support Contracts and Staff	$1,070
Subtotal Funding	$4,368

2018 LEGISLATIVE PROPOSALS

The FY 2018 Budget reflects the President's commitment to preserve Medicare and does not include direct Medicare cuts. The Budget repeals the Independent Payment Advisory Board, commits to improving the Medicare appeals process, and supports efforts to limit defensive medicine as a part of a larger medical liability reform effort.

Reforming the Medicare Appeals Process

The Budget includes the following proposals to reform the Medicare appeals process.

Provide Additional Resources for Medicare Appeals: This proposal would provide the Department mandatory funding to implement system reforms and invest in addressing the backlog of pending appeals. The Secretary would be authorized to transfer funding across all levels of the appeals system. [$1.3 billion in costs over 10 years]

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

Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review: This proposal increases the minimum amount in controversy required for adjudication by an Administrative Law Judge to the Federal District Court amount in controversy requirement ($1,560 in calendar year 2017 and updated annually). This will allow the amount at issue to better align with the amount spent to adjudicate the claim. Appeals not reaching the minimum amount in controversy will be adjudicated by a Medicare magistrate. The minimum

amount in controversy will increase consistency with the amount in controversy set for Federal court. [No budget impact]

Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold: This proposal allows the Office of Medicare Hearings and Appeals to use Medicare magistrates for appealed claims below the Federal District Court amount in controversy threshold ($1,560 in calendar year 2017 and updated annually), reserving Administrative Law Judges for more complex and higher amount in controversy appeals. [No budget impact]

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

HHS is committed to working with Congress on a comprehensive and common sense reform package to improve the Medicare appeals process and address the pending backlog.

Other Proposals

Repeal the Independent Payment Advisory Board: The Budget proposes to repeal the Independent Payment Advisory Board, created by Section 3403 of the Affordable Care Act, and all amendments thereto. All remaining unobligated administrative funds would be rescinded. [$7.6 billion in costs over 10 years]

Medical Liability Reform: The Budget includes a set of proposals for medical liability reform. This initiative will reduce Federal spending on healthcare, including by curbing the provision of unnecessary services in Medicare. See the Budget in Brief Overview for proposal descriptions. [$31.4 billion in Medicare savings over 10 years]

FY 2018 Medicare Legislative Proposals

(Negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	*2018*	*2018 -2022*	*2018 -2027*
Medicare Appeals Proposals			
Provide Additional Resources for Medicare Appeals	127	635	1,270
Remand Appeals to the Redetermination Level with the Introduction of New Evidence	—	—	—
Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review	—	—	—
Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold	—	—	—
Expedite Procedures for Claims with No Material Fact in Dispute	—	—	—
Other Medicare Benefits Proposals			
Repeal the Independent Payment Advisory Board	—	—	7,621
Medicare Interactions			
Medical Liability Reform (Medicare Impact)	-88	-6,422	-31,449
Total /1	***39***	**-5,787**	**-22,557**

1/ Total may not add due to rounding.

Program Integrity

dollars in millions	2016	2017	2018	2018 +/-2017
Health Care Fraud and Abuse Control Discretionary /1	681	681	751	+70
Health Care Fraud and Abuse Control Mandatory /2 /3	1,279	1,270	1,352	+82
Total, Budget Authority	**1,960**	**1,951**	**2,103**	**+152**

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ The FY 2016 and FY 2017 mandatory base includes sequester reductions.
3/ Does not include Deficit Reduction Act funding for the Medicaid Integrity Program, which is discussed in this chapter but is in the State Grants and Demonstrations account.

The Fiscal Year (FY) 2018 Budget strengthens the integrity and sustainability of Medicare and Medicaid by investing in activities that prevent fraud, waste, and abuse and promote quality and efficient health care. For FY 2018, the Budget assumes $2.1 billion in total mandatory and discretionary investments in the Health Care Fraud and Abuse Control program.

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

The FY 2018 Budget proposes to build on recent progress by increasing support for the Health Care Fraud and Abuse Control program through both mandatory and discretionary funding streams. The FY 2018 Health Care Fraud and Abuse Control program level is $2.1 billion. Of the total FY 2018 program level, $1.4 billion is mandatory funding and $751 million is discretionary funding.

Discretionary Health Care Fraud and Abuse Control Account

The Budget requests $751 million in discretionary Health Care Fraud and Abuse Control funding, $70 million above the FY 2016 enacted level. The Budget requests base discretionary funds ($317 million) plus a discretionary cap adjustment ($434 million), which is consistent with the Budget Control Act of 2011. The discretionary funding is allocated to CMS program integrity activities ($610.4 million), the Department of Justice ($66.4 million), and the HHS Office of Inspector General ($74.2 million).

Recent investments in Health Care Fraud and Abuse Control have allowed for the expansion of fraud and abuse prevention efforts and led to a shift away from the "pay-and-chase" model toward preventing fraud, waste, and abuse on the front end. The Health Care Fraud and Abuse Control investment also supports efforts to reduce the Medicare and Medicaid improper

Health Care Fraud and Abuse Control Multi-Year Investment and Savings
(in millions)

	2018	2019	2020	2021	2022	2018 -2022	2018 -2027
Mandatory Funding	1,352	1,382	1,414	1,436	1,469	7,054	14,924
Discretionary Funding	751	778	805	833	857	4,024	8,718
Total Program Level /1	2,103	2,161	2,219	2,269	2,326	11,078	23,642
Savings from Discretionary Investment /2	*-923*	*-980*	*-1,040*	*-1,102*	*-1,158*	*-5,203*	*-11,677*

1/ Total Program Levels may not add due to rounding.
2/ Reflects savings already assumed in current law, as well as savings attributable to the new discretionary investment request above current law. Savings are not scoreable under PAYGO.

payment rates, while implementing new processes to reduce provider burden.

Mandatory Health Care Fraud and Abuse Control Account

The $1.4 billion in mandatory base funds for FY 2018 are financed from the Medicare Part A Trust Fund. The funding is allocated to: the Medicare Integrity Program; the Health Care Fraud and Abuse Control Account, which is divided annually among the HHS Office of Inspector General; other HHS agencies; Department of Justice; and the Federal Bureau of Investigation. These dollars fund comprehensive efforts to combat health care fraud, waste, and abuse, including prevention-focused activities, improper payment reduction, provider education, data analysis, audits, investigations, and enforcement.

PROGRAM HIGHLIGHT

Key Program Integrity Initiatives

- Medicaid Data Systems: Both the Office of Inspector General and the Government Accountability Office have highlighted inadequacies in Medicaid data and data systems as a significant program integrity concern for Medicaid. The Budget will invest in Medicaid data systems to address these concerns and help States to better fulfill their responsibilities to address fraud, waste, and abuse in Medicaid.
- Medicaid Financial Management and Oversight Program: CMS funding specialists partnered with States to avert $666 million in questionable reimbursements and recovered $230 million in questionable costs in 2016. The Budget would invest additional funding to better support this effort.
- Medicare Program Integrity: The Budget reduces provider burden while protecting the Medicare Trust Funds by: modernizing Medicare documentation standards for medical review; enhancing provider education efforts; and improving provider interactions with CMS by consolidating provider portal entry points into CMS systems, and enhancing visibility into their current and historic billing and audits.

Return on Investment

Program integrity returns on investment are measured by program area and separately reported by activity type. There are three key ways in which returns from program integrity activities are described. First, programs supported by Health Care Fraud and Abuse Control Program mandatory funds have a proven record of returning more money to the Medicare Trust Funds than the dollars spent. The most recent estimate of the Medicare Integrity Program return on investment is $12 to $1, and the Medicare Integrity Program has recently yielded a consistent return of over $10 billion in savings annually.

Second, the three-year rolling average return on investment for Health Care Fraud and Abuse Control law enforcement activities is $5 to $1. In FY 2016 alone, $3.3 billion was recovered, including $1.7 billion returned to the Medicare Trust Funds and $235.2 million in Federal Medicaid recoveries returned to the Treasury.

Third, CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud about $2 is saved or avoided.

MEDICAID INTEGRITY PROGRAM

The Medicaid Integrity Program was established by the Deficit Reduction Act of 2005, which appropriated $75 million in FY 2009 and for each year thereafter. The Patient Protection and Affordable Care Act later increased appropriations for FY 2011 and future years by inflation.

States have the primary responsibility for combating fraud, waste, and abuse in the Medicaid program, but the Medicaid Integrity Program plays an important role supporting state efforts, including through contracting with eligible entities to carry out activities such as reviews, audits, identification of overpayments, education activities, and technical support to states. The Medicaid Integrity Program works in coordination with Medicaid program integrity activities funded through Health Care Fraud and Abuse Control.

Medicaid

dollars in millions	2016	2017	2018	2018 +/-2017
Current Law				
Benefits /1	351,106	357,628	386,762	+29,134
State Administration	17,175	20,828	20,808	-20
Total Net Outlays, Current Law /2	**368,281**	**378,455**	**407,570**	**+29,115**
Proposed Law				
Legislative Proposals	—	—	-3,857	-3,857
Total Net Outlays, Proposed Law /2	**368,281**	**378,455**	**403,713**	**+25,258**

1/ Includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention.
2/ Totals may not add due to rounding

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In Fiscal Year (FY) 2016, more than one in five individuals were enrolled in Medicaid for at least one month during the year, and in FY 2018, over 76 million people on average will receive health care coverage through Medicaid under current law.

HOW MEDICAID WORKS

Although the Federal Government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal Government matches State expenditures on medical assistance based on the Federal Medical Assistance Percentage, which can be no lower than 50 percent. In FY 2018, the Federal share of current law Medicaid outlays is expected to be approximately $407.6 billion. Without reforms, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimates total Federal and State Medicaid spending will be nearly $1.1 trillion by FY 2027, comprising 3.5 percent of the Nation's gross domestic product.

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

Medicaid Enrollment
(person-years in millions)

	2016	2017	2018	2018 +/- 2017
Aged 65 and Over	5.7	5.8	6.0	+0.2
Blind and Disabled	10.6	10.6	10.7	+0.1
Children	28.1	28.2	30	+1.8
Adults	26.5	27.8	28.4	+0.6
Territories	1.4	1.4	1.4	—
Total /1	72.3	73.8	76.5	+2.7

Source: CMS Office of the Actuary estimates.
1/ Totals may not add due to rounding.

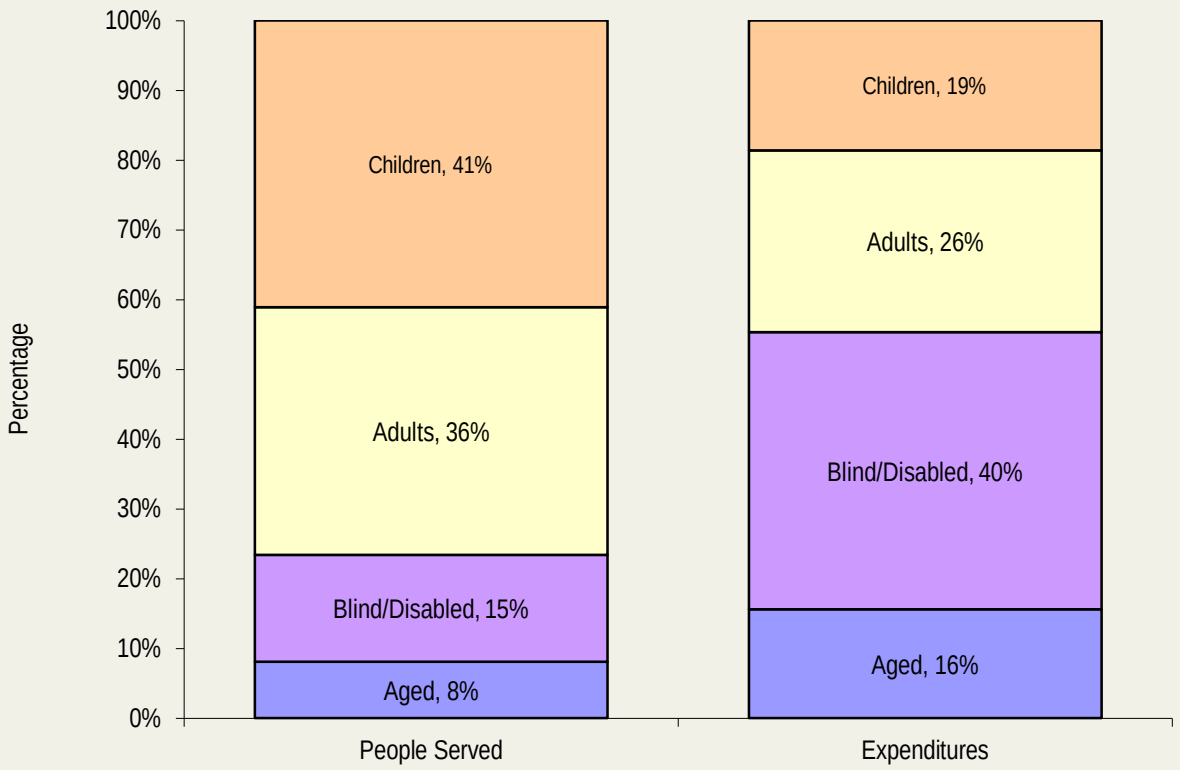
Under Medicaid, States must cover certain medical services and are provided the flexibility to offer additional benefits to beneficiaries. Medicaid also covers most of the costs of providing long-term care services. Medicare and private health insurance often furnish only limited coverage of these benefits.

RECENT PROGRAM DEVELOPMENTS

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

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

FY 2015—Percentage of Medicaid Beneficiaries vs. Federal Medical Assistance Expenditures by Eligibility Group /1 /2



Source: CMS Office of the Actuary
1/ Totals and components exclude Disproportionate Share Hospital expenditures, territorial enrollees and expenditures, and financial adjustments.
2/ Percentages may not add to 100% due to rounding.

21st Century Cures Act of 2016

This law expands access to comprehensive medical care for children receiving inpatient psychiatric hospital services, requires States to implement an electronic visit verification system for personal care and home health services, and accelerates the implementation of a limit on Federal reimbursement for durable medical equipment from January 1, 2019, to January 1, 2018.

2018 LEGISLATIVE PROPOSALS

The FY 2018 Budget puts Medicaid on a path to fiscal stability by restructuring Medicaid financing and reforming medical liability laws. In total, the Budget includes a net savings to Medicaid of $627 billion over 10 years, not including additional savings to Medicaid as a result of the Administration's plan to repeal and replace Obamacare with solutions that focus Medicaid on the most vulnerable Americans—the elderly, people with disabilities, children, and pregnant women—those Medicaid was intended to serve.

Reform Medicaid Funding to States and Provide Additional Flexibility

The Budget provides additional flexibility to States and reforms the fiscal structure of Medicaid, allowing a choice between a per capita cap or a block grant beginning in FY 2020. Rigid and outdated Federal rules and requirements prevent States from prioritizing Federal resources to their most vulnerable populations and from innovating and testing new ideas that will improve access to care and health outcomes. This proposal will free States to advance solutions that best serve their unique populations—for example, encouraging work, promoting personal responsibility, and meeting the spectrum of diverse needs of their Medicaid populations. States, as administrators of the program, are in the best position to assess the unique needs of their populations. The Administration is determined to work with Congress to put in place a plan to give States the flexibility they need to achieve better health outcomes for patients while putting Medicaid on a more sustainable fiscal trajectory. [$610 billion in Medicaid savings over 10 years]

PROGRAM UPDATE

Letter to Governors from Secretary Price and CMS Administrator Verma

On March 14, 2017, Secretary Price and CMS Administrator Verma sent a letter to all 50 State governors committing to "...usher in a new era for the federal and state Medicaid partnership" and to "...empower all States to advance the next wave of innovative solutions to Medicaid's challenges." The Administration also supports legislation to build on the tools provided within existing authorities to further expand State flexibility in how they spend their Medicaid dollars. The letter notes several key areas of focus for the Administration:

1. Improving Federal and State program management;
2. Supporting innovative approaches to increase employment and community engagement;
3. Aligning Medicaid and private insurance policies for non-disabled adults;
4. Providing reasonable timelines and processes for home and community-based services transformation; and
5. Providing States with more tools to address the opioid epidemic.

The full letter to governors is available at the following URL: https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf

Medical Liability Reform

The Budget includes a set of proposals to reform medical liability, which will reduce medical malpractice costs and the practice of defensive medicine, while supporting State efforts to reduce Medicaid costs. See the Budget in Brief Overview for proposal descriptions. [$399 million in Medicaid savings over 10 years]

NEW INITIATIVE

Medicaid Direct Primary Care Initiative

Starting in FY 2018, the Department looks forward to collaborating with States to expand Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician-patient relationships through enrolling Medicaid patients in DPC practices. These practices enhance physicians' focus on patient care by simplifying health care payments for patients and physicians. DPC arrangements also often include benefits such as extended visits and electronic communication, which allows for improved patient access to primary care services. DPC arrangements have the potential to improve Medicaid in the following manner:

- Increasing access. While approximately 70 percent of physicians are accepting new Medicaid patients nationally, there is wide variation across States and one-third of physicians still do not accept Medicaid patients. Specialists are also more likely to take Medicaid patients than primary care physicians. Moreover, many physicians refuse to treat Medicaid patients for various reasons including low reimbursement rates.

- Supporting positive health outcomes for Medicaid patients. While limited, data available for patient outcomes for patients in DPC practices has been relatively positive. The American Journal of Managed Care evaluated a DPC group with practices in many States, and data illustrated positive patient outcomes with decreases in preventable hospital use that resulted in considerable savings.

- Putting patients and doctors in more control of health care. DPC practices will support the vital role primary care plays in patient health, including providing preventive services, monitoring health conditions, and improving the crucial physician-patient relationship. By creating DPC practices that would encourage affordable care for patients, these patient-centered reforms would help build a more innovative and responsive health care system—one that empowers patients and ensures they and their doctor have the freedom to make health care decisions without bureaucratic interference or influence.

Working with States and primary care physicians, HHS will support the development of DPC practices, identify barriers to their entry into Medicaid, and outline flexibilities under existing authorities to facilitate these innovative approaches to strengthening the relationships between patients and physicians.

FY 2018 Medicaid Legislative Proposals

dollars in millions	2018	2018 -2022	2018 -2027
Medicaid Fiscal Sustainability and Flexibility			
Reform Medicaid Funding to States and Provide Additional Flexibility	—	-70,000	-610,000
Medicaid Interactions			
Medical Liability Reform (Medicaid Impact) /1	-62	-399	-399
Extend CHIP Funding through 2019 (Medicaid Impact) /2	-3,800	-16,700	-16,700
Extend Special Immigrant Visa Program (Medicaid Impact) /3	5	49	94
Total Outlays, Legislative Proposals /4	**-3,857**	**-87,050**	**-627,005**

1/ See the Budget in Brief Overview for proposal descriptions.
2/ See Children's Health Insurance Program chapter for proposal description.
3/ This proposal is included in the State Department's FY 2018 Budget Request.
4/ Totals may not add due to rounding.

Children's Health Insurance Program

dollars in millions	2016	2017	2018	2018 +/- 2017
Current Law				
Children's Health Insurance Program (CHIP)	14,305	16,655	12,017	-4,638
Child Enrollment Contingency Fund	53	224	0	-224
Total Outlays, Current Law	**14,358**	**16,879**	**12,017**	**-4,862**
Proposed Law				
CHIP Legislative Proposals /1	—	—	*1,400*	*+1,400*
Total Outlays, Proposed Law	**14,358**	**16,879**	**13,417**	**-3,462**

1/ This score reflects the impact on CHIP. The net Federal cost of the proposal is -$5.8 billion over 10 years, which reflects impacts to CHIP ($13.9 billion) and interactions with Medicaid (-$16.7 billion) and other Federal programs and accounts (-$3.0 billion). See Medicaid chapter for Medicaid impact.

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

HOW CHIP WORKS

CHIP is a partnership between the Federal Government and States and Territories to help provide low-income children under age 19 with health insurance coverage so they can access health care. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid but too low to afford private health insurance.

States with an approved CHIP plan are eligible to receive an enhanced Federal matching rate, which will range from 65 to 85 percent. Beginning in FY 2016, and effective through FY 2019, each State's enhanced Federal matching rate increased by up to 23 percentage points to cover between 88 and 100 percent of total costs for child health care services and program administration, drawn from a capped allotment.

States have a high degree of flexibility in designing their programs. They can implement CHIP by expanding Medicaid, creating a separate program, or a combination of both approaches. As of January 1, 2017, there were 14 Medicaid expansion programs, two separate programs, and 40 combination programs among the States, District of Columbia, and Territories.

In FY 2016, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimated that 9.2 million individuals received health insurance funded through CHIP allotments at some point during the year. Approximately 6.3 million individuals were enrolled in CHIP on average throughout the year.

A Child Enrollment Contingency Fund was established for States that predict a funding shortfall based on higher than expected enrollment. The Contingency Fund received an initial appropriation of $2.1 billion in FY 2009 and is invested in interest bearing securities of the United States. Payments from the fund are currently authorized through FY 2017.

RECENT PROGRAM DEVELOPMENTS

Financing

Current law provides an increase in each State's enhanced Federal match rate by 23 percentage points, not to exceed a total match rate of 100 percent, between FY 2016 and FY 2019.

Eligibility and Coverage

States use a Modified Adjusted Gross Income standard to determine eligibility for coverage under a State's

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

Enrollment and Retention Outreach

MACRA provided new funding and extends the Outreach and Enrollment Program for two years through FY 2017. Originally enacted under CHIPRA and extended by the Patient Protection and Affordable Care Act, the Outreach and Enrollment Program provides grants and a national campaign to improve outreach and enrollment to children who are eligible for but unenrolled in Medicaid and CHIP. Of the total $40 million appropriation under MACRA, $32 million is dedicated to outreach and enrollment grants, $4 million is dedicated to outreach and enrollment grants for children who are American Indian/Alaska Native, and $4 million is dedicated to the National Enrollment Campaign. Outlay totals for Outreach and Enrollment Grants are reflected in the State Grants and Demonstrations chapter.

Improving Quality

CHIPRA provided $225 million over five years for activities that improve child health quality in Medicaid and CHIP, and 18 States (across 10 grants) participated in CHIPRA Quality Demonstrations to test ways to strengthen the quality of and access to children's health care through a variety of health care delivery and measurement approaches at both the provider and patient levels. The Protecting Access to Medicare Act of 2014 allocates $15 million of Adult Health Quality funding for the pediatric quality measures program, and MACRA provided an additional $20 million in new funding for the program.

NEW INITIATIVE

Budget Extends CHIP Funding for an Additional Two Years

The passage of MACRA ensured continued comprehensive coverage for CHIP children through FY 2017. Extending CHIP for an additional two years through FY 2019 will save a net $5.8 billion.

Dollars in Millions	FYs 2018-2027 *(10 year)*
Extend CHIP Funding for Two Additional Years	-5,815
CHIP Impact (non-add) (HHS)	*13,900*
Medicaid Impact (non-add) (HHS)	*-16,700*
Other Federal Impacts (non-add) (Treasury)	*-3,015*
Extend the Child Enrollment Contingency Fund for Two Years	0
Total Net Federal Cost of CHIP Proposals	-5,815

CHIP PROPOSALS

Extend CHIP Funding through FY 2019

The Budget proposes to extend funding for CHIP for two additional years through FY 2019. Extending CHIP funding for two years provides stability to States and families while the future of the program is addressed alongside other health reforms. The Budget also proposes a series of improvements that rebalance the State-Federal partnership and increase State flexibility. This proposal also extends the Child Enrollment Contingency Fund through FY 2019.

This proposal ends the 23 percentage point increase in the enhanced Federal match rate and the current law maintenance of effort requirement after FY 2017.

This funding extension would also cap the level at which States could receive the CHIP enhanced Federal matching rate at 250 percent of the Federal Poverty Level. These provisions would return the focus of CHIP to the most vulnerable and low-income children.

Under current law, States were required to transition children ages 6 to 18 in families with incomes between 100 and 133 percent of the Federal Poverty Level off of CHIP to Medicaid. The Budget proposes allowing States to move these children back into CHIP.

Without Congressional action, CMS estimates States will begin to experience funding shortfalls in December 2017 and all States will run out of funding before the end of FY 2018.

FY 2018 CHIP Legislative Proposals

(negative numbers reflect savings and positive numbers reflect costs)

dollars in millions	2018	2018 -2022	2018 -2027
CHIP Proposals			
Extend CHIP funding through FY 2019 /1	1,400	13,900	13,900
CHIP Impact (non-add)	*1,400*	*13,900*	*13,900*
Medicaid Impact (non-add)	*-3,800*	*-16,700*	*-16,700*
Other Federal Impacts (non-add)	*41*	*-3,015*	*-3,015*
Extend the Child Enrollment Contingency Fund through FY 2019	0	0	0
Total Outlays, CHIP Proposals /1 /2	**1,400**	**13,900**	**13,900**

1/ This score reflects the impact on CHIP. The net Federal cost of the proposal is -$5.8 billion over 10 years, which reflects impacts to CHIP ($13.9 billion) and interactions with Medicaid (-$16.7 billion) and other Federal programs and accounts (-$3.0 billion).
2/ Totals may not add due to rounding.

State Grants and Demonstrations

dollars in millions	2016	2017	2018	2018 +/- 2017
Current Law Budget Authority /1				
Medicaid Integrity Program /2	77	78	86	+8
Money Follows the Person Demonstration	418	—	—	—
Money Follows the Person Evaluations	1	—	—	—
Demonstration Program to Improve Community Mental Health Services	23	—	—	—
Children's Health Insurance Program (CHIP) Outreach and Enrollment Grants	40	—	—	—
Total, Current Law Budget Authority	**559**	**78**	**86**	**+8**
Current Law Outlays /3				
Medicaid Integrity Program /2	73	80	86	+6
Money Follows the Person Demonstration	450	425	425	—
Money Follows the Person Evaluations	1	1	—	-1
Demonstration Program to Improve Community Mental Health Services	8	7	4	-3
CHIP Outreach and Enrollment Grants /5	6	14	13	-1
Incentives for Prevention of Chronic Diseases in Medicaid /4	12	9	6	-3
Medicaid Emergency Psychiatric Demonstration /4	1	—	—	—
Emergency Services for Undocumented Aliens /4 /6	2	1	—	-1
Total, Current Law Outlays	**553**	**537**	**534**	**-3**

1/ The Budget Authority table does not include Funding for the Territories due to a rescission in this program.
2/ Budget authority for the Medicaid Integrity Program is adjusted annually by Consumer Price Index for All Urban Consumers and outlays include some spending from prior year budget authority. This program is also described in the Program Integrity chapter.
3/ The following programs/laws were excluded from the Current Law Outlays table (either because outlays were less than $1 million or were rescinded): Ticket to Work and Work Incentives Improvement Act, the National Clearinghouse for Long-Term Care Information, and the Psychiatric Residential Treatment Facilities Demonstration.
4/ Outlays are from prior year budget authority.
5/ See CHIP chapter for additional information about this program.
6/ On December 28, 2015, the Centers for Medicare & Medicaid Services announced the sunsetting of this program at the end of Fiscal Year 2016.

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

Enrollment and Retention Outreach

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided new funding and extended the Outreach and Enrollment Program for two years through Fiscal Year (FY) 2017. Originally enacted under CHIPRA, the Outreach and Enrollment Program provides grants and a national campaign to improve outreach and enrollment to children who are eligible for but unenrolled in Medicaid and CHIP. Of the total $40 million appropriation under MACRA, $32 million is dedicated to outreach and enrollment grants, $4 million is dedicated to outreach and enrollment grants for children who are American Indian/Alaska Native, and $4 million is dedicated to the National Enrollment Campaign.

Medicaid Integrity Program

The Medicaid Integrity Program was established by the Deficit Reduction Act of 2005, which appropriated $75 million in FY 2009 and for each year thereafter. Congress later increased appropriations for FY 2011 and future years by inflation.

States have the primary responsibility for combating fraud, waste, and abuse in the Medicaid program, but the Medicaid Integrity Program plays an important role supporting State efforts, including through contracting with eligible entities to carry out activities such as

Centers for Medicare & Medicaid Services reviews, audits, identification of overpayments, education activities, and technical support to States. The Medicaid Integrity Program works in coordination with Medicaid program integrity activities funded through the Health Care Fraud and Abuse Control program.

Money Follows the Person Demonstration

This demonstration, extended by the Patient Protection and Affordable Care Act through FY 2016, helps States support individuals to achieve independence. While all the money has been obligated, States have continued to operate this demonstration since 2007. States that are awarded competitive grants receive an enhanced Medicaid matching rate to help eligible individuals transition from a qualified institutional setting to a qualified home or community based setting.

Demonstration Program to Improve Community Mental Health Services

Section 223 of the Protecting Access to Medicare Act created this demonstration program for States to implement from FYs 2017-2019. The program provides an enhanced Federal Medicaid match rate for certified community behavioral health clinics with the aim of improving access to behavioral health services for Medicaid beneficiaries.

Program Management

dollars in millions	2016	2017	2018	2018 +/- 2017
Discretionary Administration				
Program Operations	2,821	2,817	2,441	-376
Federal Administration	733	733	723	-10
Survey and Certification	397	397	406	+9
Research	20	20	18	-2
Total, Discretionary Budget Authority /1 /2	**3,971**	**3,967**	**3,588**	**-379**
Mandatory Administration /3				
Obamacare	0	1	1	-
American Recovery and Reinvestment Act	61	0	0	-
Medicare Improvements for Patients and Providers Act	3	3	3	-
Protecting Access to Medicare Act (2014)	6	6	6	-
Improving Medicare Post-Acute Care Transformation (2014)	20	20	19	-1
Medicare Access and CHIP Reauthorization Act	216	196	163	-33
Total, Mandatory /1	**305**	**225**	**191**	**-34**
Reimbursable Administration				
Medicare and Medicaid Reimbursable Administration /3	680	427	514	+87
Exchange-Related Reimbursable Administration /5	1,154	1,309	1,188	-122
Risk Corridor Collections	362	103	103	-
Subtotal, Reimbursable Administration	**2,196**	**1,839**	**1,805**	**-34**
Proposed Law (Discretionary)				
Offsetting Collections /6	0	0	26	+26
Subtotal, Proposed Law	**0**	**0**	**26**	**+26**
Program Level, Proposed Law	**6,472**	**6,031**	**5,610**	**-448**
Full-Time Equivalents /7	6,238	6,495	6,340	-155

1/ Totals may not add due to rounding.
2/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
3/ Includes the following user fees: Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program education campaign, recovery audit contractors, and provider enrollment fees.
4/ The FY 2016 Zika Response and Preparedness Act (P.L. 114-223) provided $387 million in supplemental resources to the Public Health and Social Services Emergency Fund for Zika response and preparedness activities, of which $75 million was allocated for CMS for FYs 2016 and 2017.
5/ Includes user fees charged to issuers in Federally-facilitated Exchanges, State-based Exchanges using the Federal platform, and risk adjustment.
6/ Include a proposal for one new discretionary offsetting collection. Please see Survey and Certification section for more information.
7/ Full-Time equivalent (FTE) totals include FTE from other funding sources: Health Care Fraud and Abuse Control Program (HCFAC), state grants, reimbursables, and mandatory appropriations. CMS will fund the following FTE from other sources: FY 2016 = 1,720; FY 2017 = 1,970; and FY 2018 = 1,970.

The FY 2018 discretionary budget request for CMS Program Management is $3.6 billion, a decrease of $379 million below the FY 2017 Annualized Continuing Resolution level. This request will enable CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The FY 2018 Budget reflects CMS's key priorities to: reduce costs through contract efficiencies; prioritize customer service; invest in program integrity; stabilize and streamline Exchanges; and strengthen the Federal workforce.

BUDGET ACCOUNT SUMMARIES

Program Operations

The Program Operations request is $2.4 billion, a decrease of $375 million below the FY 2017 Annualized Continuing Resolution level. The Program Operations account funds essential contractor, information technology, and outreach activities necessary to administer Medicare, Medicaid, CHIP, and private insurance programs. Top priority activities for FY 2018 include:

- *Ongoing Medicare Contractor Operations:* Approximately 36 percent, or $885 million, of the FY 2018 Program Operations request supports ongoing Medicare contractor operations. This workload includes processing 1.3 billion Medicare Part A and B claims, enrolling providers in the Medicare program, handling provider reimbursement services, processing 4.8 million first-level appeals, responding to provider inquiries, educating providers about the program, and administering the participating physicians/supplier program.
- *Medicare Appeals:* The Budget includes $87 million to timely process about 970,000 provider and beneficiary claim appeals at the second level of appeals.
- *Information Technology Systems and Support:* The Budget includes $329 million for non-Exchange information technology systems and other support, including cybersecurity, allowing the agency to protect the valuable consumer health data of millions of Americans from outside threats. Additionally, CMS continues to transition to the use of shared systems, which allow for greater efficiency and reliability agency wide.
- *Medicaid and CHIP Operations:* The Budget requests $45 million to fund administrative activities to improve Medicaid and CHIP program operations, including the modernization of data systems.
- *Exchanges:* The Budget includes $471 million in requested budget authority for the Exchanges, $453 million of which supports Program Operations activities such as eligibility, call center operations, and information technology. In addition, CMS anticipates collecting approximately $1.2 billion in user fee revenues to support Exchange activities. The total estimated program level, including sources in other accounts, is $1.7 billion.

Federal Administration

For FY 2018, the Budget requests $723 million for CMS Federal administrative costs, $10 million below the FY 2017 Annualized Continuing Resolution level.

Of this total, $651 million will support a direct full-time equivalent level of 4,370, a decrease of 155 full-time equivalents below the current level. With this level of

PROGRAM HIGHLIGHT

Survey and Certification Frequencies

Type of Facility	2017	2018
Long-Term Care Facilities *(statutory)*	Every Year (100%)	Every Year (100%)
Home Health Agencies *(statutory)*	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Hospice *(statutory)*	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Accredited Hospitals	Every 3.9 Years (25.6%)	Every 4 Years (25%)
Accredited Hospitals	1.5% Per Year	1.0% Per Year
ESRD Facilities	Every 3.8 Years (26.3%)	Every 4 Years (25.0%)
Ambulatory Surgical Centers	Every 4.7 Years (21.3%)	Every 4 Years (25.0%)
Community Mental Health Centers and Rural Health Clinics	Every 12 Years (8.3%)	Every 11 Years (9.1%)
Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Ray	Every 12 Years (8.3%)	Every 10 Years (10.0%)

staff, CMS will be able to support operations. The reduction in workforce will occur through natural attrition across CMS.

Survey and Certification

The FY 2018 Survey and Certification request is $406 million, a $9 million increase over the FY 2017 Annualized Continuing Resolution level. The increased funding level is needed to maintain survey frequency levels due to growing numbers of participating facilities and improved quality and safety standards. CMS expects States to complete over 23,800 initial surveys and re-certifications and over 56,200 visits in response to complaints in FY 2018.

PERFORMANCE HIGHLIGHT

Reducing Unnecessary Antipsychotic Drug Use in Nursing Homes

The CMS survey and certification budget aims to improve dementia care in nursing homes by decreasing the percentage of long-stay nursing home residents receiving an antipsychotic medication. Antipsychotic medications have common and dangerous side effects when misused to treat the behavioral and psychological symptoms of dementia. In calendar year 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication. In calendar year 2015, CMS exceeded its target of 19.9 percent to finish the year at 17.1 percent. CMS set the calendar year 2018 target rate at 15.7 percent.

Over 87 percent of the request will go to State survey agencies or Federal direct survey costs. Surveys include mandated Federal inspections of long-term care facilities (i.e., nursing homes), home health agencies, hospices, as well as Federal inspections of other key facilities. All facilities participating in the Medicare and Medicaid programs must undergo inspection when entering the program and on a regular basis thereafter.

The Budget also proposes to levy a fee for survey and certification revisits that occur as a result of deficiencies found during initial certification, recertification, or substantiated complaints surveys. The fee would provide CMS with an increased ability to revisit poor performers, while creating an incentive for facilities to correct deficiencies and ensure quality of care. The Budget assumes a five month lag for collecting fees in the initial FY 2018 year of operation. [$26 million in user fee revenue in FY 2018]

Research

For FY 2018, the Budget requests $18 million for Research—$2 million below the FY 2017 Annualized CR level—to maintain the Medicare Current Beneficiary Survey and other research databases which support Medicare rate-setting.

CROSSCUTTING SUMMARIES

National Medicare Education Program

Total FY 2018 program level for the National Medicare Education Program is $366 million, including $255 million in budget authority. In order to ensure that beneficiaries have accurate and up-to-date information on their coverage options and covered benefits, beneficiary education remains a top priority for CMS.

Of the total program level, $279.8 million, or 77 percent, supports the 1-800-MEDICARE call center, which provides beneficiaries with access to customer service representatives who are trained to answer questions regarding the Medicare program. The request will support approximately 27 million calls with an average-speed-to-answer of less than five minutes. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations.

The request also includes $50.5 million for beneficiary materials, the majority of which will fund the *Medicare & You* handbook.

PROGRAM HIGHLIGHT

National *Medicare & You* Education Program (NMEP) FY 2018 Program Level
(dollars in millions)

Activity	2017	2018
Beneficiary Materials (e.g., Handbook)	54.9	50.5
1-800-MEDICARE and Beneficiary Claims Contact Center	294.7	279.8
Internet	20.1	20.1
Community-Based Outreach	1.9	2.1
Program Support Services/National Ad Campaign	9.0	13.2
Total, NMEP Program Level /1	380.6	365.7

1/ Includes funding from Program Management, user fees, and Quality Improvement Organizations.

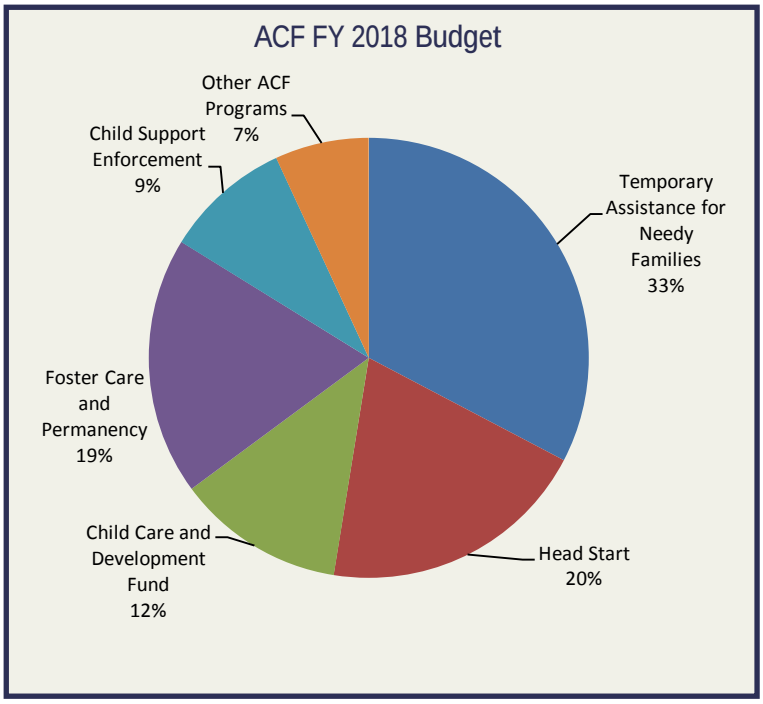
Administration for Children and Families

dollars in millions	2016	2017 /1	2018
Mandatory			
Budget Authority	34,217	34,841	31,700
Discretionary			
Budget Authority	18,870	19,284	14,482
Total, ACF Budget Authority	**53,087**	**54,125**	**46,182**

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

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

The FY 2018 Budget request for the Administration for Children and Families (ACF) is $46.2 billion. ACF works in partnership with States and communities that provide critical assistance to vulnerable families while helping families and children achieve a path to success. ACF's Budget supports enabling more parents to find work and achieve self-sufficiency, lifting their families out of poverty and promoting the school readiness of their children. This effort includes combating child poverty, helping families facing financial crises or extreme poverty, supporting working families with access to quality child care, improving outcomes for children and families involved in the child welfare system, increasing child support payments to families, and continuing to support Head Start. Funds are also included for programs that serve runaway and homeless youth and victims of domestic violence, dating violence, and human trafficking.



Administration for Children and Families: Discretionary

dollars in millions	2016	2017 /1	2018	2018 +/– 2017
Early Childhood Programs				
Head Start	9,168	9,151	9,168	+17
Child Care and Development Block Grant (discretionary)	2,761	2,756	2,761	+5
Subtotal, Early Childhood Programs	**11,929**	**11,906**	**11,929**	**+23**
Programs for Vulnerable Populations				
Runaway and Homeless Youth Programs	119	119	119	--
Child Abuse Prevention	98	98	98	--
Child Welfare Programs	326	325	316	-9
Chafee Education & Training for Foster Youth	43	43	43	--
Adoption and Guardianship Incentives	38	38	38	--
Native Americans Programs	50	50	50	--
Family Violence Prevention and Services Programs	158	158	159	+1
Promoting Safe and Stable Families (discretionary)	60	60	60	--
Subtotal, Programs for Vulnerable Populations	**892**	**891**	**883**	**-8**
Refugee Programs				
Transitional and Medical Services	490	489	320	-169
Unaccompanied Alien Children	948	1,396	948	-448
Refugee Support Services /2	203	202	159	-43
Other Refugee Programs	34	34	29	-5
Subtotal, Refugee Programs	**1,675**	**2,122**	**1,457**	**-665**
Discontinued Programs				
Low Income Home Energy Assistance Program	3,390	3,384	--	-3,384
Community Services Block Grant	715	714	--	-714
Other Community Services Programs	55	55	--	-55
Subtotal, Discontinued Programs	**4,161**	**4,153**	**--**	**-4,153**
Other ACF Programs				
Social Services Research & Demonstration	7	7	7	--
Disaster Human Services Case Management	2	2	2	--
Federal Administration	205	205	205	--
Subtotal, Other ACF Programs	**213**	**213**	**213**	**--**
Total Discretionary Budget Authority	**$18,870**	**$19,284**	**$14,482**	**-$4,802**
Full-Time Equivalents	1,334	1,352	1,320	-32

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ Includes funding for Social Services and Targeted Assistance for FY 2016 and FY 2017. The Budget proposes to combine these programs into a new Refugee Supportive Services program in FY 2018.

ACF provides work supports that families need as they endeavor to become self-sufficient. The Fiscal Year (FY) 2018 Budget requests almost $14.5 billion, a decrease of $4.8 billion relative to the FY 2017 Continuing Resolution. The FY 2018 Budget prioritizes funding for early care and education programs for children, which are valuable resources for families, making it possible for them to seek and maintain employment and participate in job-related training.

PROVIDING WORK SUPPORTS FOR FAMILIES

Head Start and Child Care, frequently referred to as early care and education programs, allow parents and caregivers to build or maintain their self-sufficiency while ensuring their children receive high-quality care and education. The FY 2018 request preserves funding for Head Start and Child Care relative to FY 2016 levels, for a total investment of $14.8 billion (including $2.9 billion in mandatory child care funds). Nearly 1.4 million children will be served by the child care investments, and nearly 890,000 children will be served by Head Start.

SERVING VULNERABLE CHILDREN AND FAMILIES

The FY 2018 Budget preserves funding for services to the most vulnerable children and families, including runaway and homeless youth and victims of child abuse and family violence.

Runaway and Homeless Youth

Youth experiencing homelessness face the possibility of exploitation, victimization, and other long-lasting, negative outcomes. The FY 2018 Budget continues to support emergency shelter, transitional housing, and street outreach programs for young people who experience homelessness through a $119 million investment, the same as the FY 2017 Continuing Resolution. At this level, more than 34,000 youth will receive emergency shelter or transitional housing and an array of supportive services.

Child Abuse Prevention

ACF supports programs, research, and monitoring systems that prevent child abuse and neglect while ensuring that children who are victims receive treatment and care. Funds are provided to States and Tribes for child abuse investigations, prevention activities, and research into the causes, prevention, and treatment of child abuse. The Budget requests $98 million for these activities, the same as the FY 2017 Continuing Resolution.

Child Welfare Programs

ACF provides funds to State and Tribal child welfare programs to promote positive outcomes for children and families involved in child welfare. Activities include supporting at-risk families, promoting the well-being of children in foster care, and training to ensure a well-qualified child welfare workforce. ACF research supports the demonstration of promising new practices and training for caseworkers.

The Budget requests a total of $316 million for these activities, a decrease of $9 million below the FY 2017 Continuing Resolution. This funding level prioritizes direct service programs and makes a targeted reduction to technical assistance efforts in the Adoption Opportunities Program.

Native Americans

The Administration for Native Americans in ACF serves Native Americans, including Federally recognized tribes and Native Hawaiian organizations. ACF promotes self-sufficiency for Native Americans by competitively funding community-based projects that foster the development of stable, diversified local economies to provide jobs, promote community and economic well-being, encourage community partnerships, and reduce dependency. Funds also support the preservation of native languages and the environmental protection of Tribally-controlled lands. The FY 2018 Budget includes $50 million to support these activities, the same as the FY 2017 Continuing Resolution.

Family Violence Prevention and Services

The Family Violence Prevention and Services Program is the primary Federal funding stream for shelter and supportive services for victims of family violence and their dependents. The Budget includes $159 million for the program, preserving essential Federal support for these activities, including $1 million for an Alaska Native Tribal Resource Center. Within this amount, the Budget maintains funding for the National Domestic Violence Hotline at $8 million. The Hotline receives an average of 25,000 calls and 163,000 website visits each month.

REFUGEES, ENTRANTS, AND UNACCOMPANIED ALIEN CHILDREN

Refugees and Other New Arrivals

ACF works with State and local governments and a large network of nongovernmental organizations to provide services to refugees and other eligible new entrants like asylees to help them become self-sufficient, integrated members of American society. The Budget includes $320 million to continue to provide up to eight months of cash and medical assistance for 98,000 new arrivals, including 50,000 refugees.

The Budget also includes $159 million to provide English language skills, job training, and translation services to refugees and other new arrivals in FY 2018. ACF proposes to combine the two programs that currently deliver these services, achieving greater efficiencies and reducing the administrative burden on States. The Budget includes $29 million to identify and serve victims of trafficking and provide medical and psychological services to survivors of torture. Studies suggest that 44 percent of refugees/asylees have experienced torture. Funding for both programs is maintained at their FY 2017 Continuing Resolution levels. No funds are included for Preventive Health grants (-$5 million less than the FY 2017 Continuing Resolution) as these services can also be provided through other ACF refugee programs.

Unaccompanied Alien Children

HHS is legally required to take custody of all unaccompanied alien children who are referred to ACF's Office of Refugee Resettlement after being apprehended by immigration authorities. Children remain in the Office of Refugee Resettlement's custody until they can be released to an appropriate sponsor while they await their immigration proceedings. The monthly number of unaccompanied children referred to ACF has decreased rapidly since December of 2016 and is now at a five-year low. In response to this trend, ACF has closed the temporary shelters that operated earlier in FY 2017 and is reducing standard permanent bed capacity to match the lower number of children in care. The Budget requests $948 million for this program, $448 million less than the FY 2017 Continuing Resolution. While the history of this program shows that referral levels can fluctuate considerably, the Administration does not anticipate a significant increase in referrals in FY 2018.

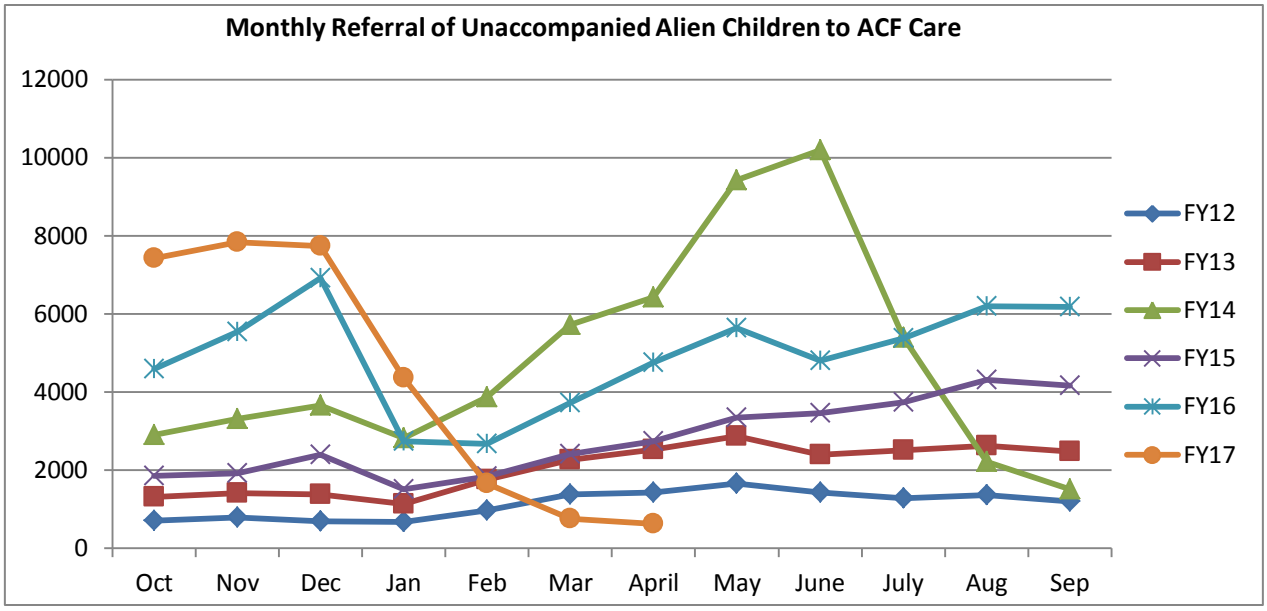
PROGRAM ELIMINATIONS

Low Income Home Energy Assistance Program (LIHEAP)

The FY 2018 Budget eliminates funding for LIHEAP, for a savings of $3.4 billion. LIHEAP is unable to demonstrate strong performance outcomes. Utility companies, as well as State and local governments, provide significant heating and cooling assistance and the majority of States prohibit utilities from discontinuing heating during the winter months.

Community Services Programs

The FY 2018 Budget discontinues funding for the Community Services Block Grant and the Community Economic Development, Rural Community Facilities, and Assets for Independence Programs, for a savings of $769 million.



The Community Services Block Grant accounts for only five percent of total funding received by the local agencies that benefit from these funds. In addition, grantees can continue receiving funds even if they have not demonstrated strong performance, because the formula for distribution is not directly tied to local agency performance.

To reduce duplication of programming across the Federal Government, the Budget does not request funding for Community Economic Development or Rural Community Facilities.

The Budget also proposes to discontinue the Assets for Independence Program. Historically, the Assets for Independence Program has failed to use all of the funds appropriated for the program.

EVALUATION AND INNOVATION

Research and Demonstration

Research, evaluation, and the demonstration of new approaches to providing services allow ACF to improve the efficiency and efficacy of its programs. Current projects include continued use of behavioral science to examine program interventions and address research gaps in the understanding of family self-sufficiency and stability. The FY 2018 Budget includes $7 million, which is the same as the FY 2017 Continuing Resolution.

Federal Administration

The Budget includes $205 million, the same as the FY 2017 Continuing Resolution, to cover the cost of administering programs across ACF, including staffing and other fixed administrative expenses, such as office space and the development and maintenance of information technology.

Administration for Children and Families: Mandatory

dollars in millions	2016	2017 /1	2018	2018 +/– 2017
Current Law Budget Authority				
Child Care Entitlement to States	2,917	2,917	2,917	—
Child Care and Development Fund (non-add) /2	5,678	5,673	5,678	+5
Child Support Enforcement and Family Support	4,125	4,167	4,395	+228
Children's Research and Technical Assistance /3	49	35	39	+4
Foster Care and Permanency	7,665	8,254	8,728	+474
Promoting Safe and Stable Families (mandatory only) /4	472	461	345	-116
Social Services Block Grant	1,669	1,662	1,700	+38
Temporary Assistance for Needy Families (TANF)	16,737	16,737	16,739	+2
TANF Contingency Fund /5	583	608	608	—
Subtotal, TANF (non-add)	17,320	17,345	17,347	+2
Total, Current Law Budget Authority	**34,217**	**34,841**	**35,471**	**+630**
Proposed Law Budget Authority				
Child Care Entitlement to States	2,917	2,917	2,917	—
Child Care and Development Fund (non-add) /2	5,678	5,673	5,678	+5
Child Support Enforcement and Family Support	4,125	4,167	4,286	+119
Children's Research and Technical Assistance /5	49	35	54	+19
Foster Care and Permanency	7,665	8,254	8,746	+492
Promoting Safe and Stable Families (mandatory only)	472	461	495	+34
Social Services Block Grant /6	1,669	1,662	85	-1,577
TANF	16,737	16,737	15,117	-1,620
TANF Contingency Fund	583	608	--	-608
Subtotal, TANF (non-add)	17,320	17,345	15,117	-2,228
Total, Proposed Law Budget Authority	**34,217**	**34,841**	**31,700**	**-3,141**

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ The Child Care and Development Fund includes mandatory funding from the Child Care Entitlement to States and discretionary funding from the Child Care and Development Block Grant.
3/ Includes $15 million in mandatory funds transferred from the TANF Contingency Fund for Welfare Research in FY 2016.
4/ The total for Promoting Safe and Stable Families includes Abstinence Education and the Personal Responsibility Education Program, with a proposed reauthorization in FY 2018. In addition, there is a discretionary appropriation of $60 million for PSSF in FY 2016, FY 2017, and FY 2018.
5/ Includes $15 million in mandatory funds transferred from TANF for Welfare Research in FY 2018.
6/ The proposed law reflects the reauthorization of the Health Profession Opportunity Grants.

The Fiscal Year (FY) 2018 Budget requests $31.7 billion for the Administration for Children and Families (ACF) mandatory programs. ACF serves the nation's most vulnerable populations through mandatory programs including Temporary Assistance for Needy Families, Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Guardianship Assistance, Independent Living, and Promoting Safe and Stable Families.

CHILD CARE ENTITLEMENT TO STATES

The Child Care Entitlement to States was created by the welfare reform law enacted in 1996, which directly appropriates annual mandatory child care funding for States and tribes. The program requires States to spend at least 70 percent of mandatory child care funding on families receiving Temporary Assistance for Needy Families, transitioning from Temporary Assistance for Needy Families, or at risk of becoming eligible for Temporary Assistance for Needy Families.

States must also spend a minimum percentage of all child care funds to improve the quality and availability of healthy and safe child care for all families. Together with the Child Care and Development Block Grant, the program provides funding to States to help families access and afford child care.

The FY 2018 Budget provides $2.9 billion for the Child Care Entitlement to States. Total child care funding for the Child Care and Development Fund, which includes mandatory and discretionary child care funding, is $5.7 billion in FY 2018. In FY 2018, the request would enable nearly 1.4 million children to receive child care assistance through this State-administered program.

CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

Child Support is a joint Federal, State, tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The Budget requests $4.3 billion in budget authority in FY 2018 for Child Support Enforcement and Family Support Programs.

Child Support collected $32.4 billion in FY 2015, the last year from which data is available, a return of $5.26 per dollar invested in the program. In FY 2015, paternity was established for 1.5 million parents (100 percent of Title IV-D non-marital births), and child support orders were established for 86 percent of cases. Additionally, Child Support operates several demonstration projects to increase employment and child support payment rates among non-custodial parents. In FY 2015, the Tribal Child Support Program oversaw 59 comprehensive tribal IV-D programs, including two new comprehensive programs and an additional three start-up tribal programs.

The Budget promotes strong families and responsible parenting by engaging more parents in payment of child support, improving enforcement tools, and transitioning more responsibility to the States. These proposals are estimated to save $698 million over 10 years. Supplemental Security Income and the Supplemental Nutrition Assistance Program realize savings of $527 million collectively.

In addition, the Budget includes $833 million in net savings over 10 years for a technology enhancement and replacement fund to build model child support systems and applications. This would enable States and tribal child support programs to replace out-of-date child support systems with a customizable uniform model system, improving efficiency and reducing long-term costs for States, tribal child support programs, and the Federal Government. An enhanced federal match rate of 90 percent would incentivize States to modernize more quickly and avoid system failure. The savings result from efficiencies these model systems would create in the process of replacing multiple legacy state child support systems. This proposal reflects the benefits of private sector approaches of operating government programs.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

Children's Research and Technical Assistance supports state child support programs by disseminating information and providing training and technical assistance, including assistance with State automated systems and training of staff. Children's Research and Technical Assistance also operates the Federal Parent Locator Service, which assists States in locating absent parents to establish, enforce, or modify orders for child support, custody, and visitation.

The FY 2018 President's Budget includes $37 million in this account, devoted to training and technical assistance ($12.3 million) and operating the Federal Parent Locator Service ($24.6 million).

FOSTER CARE AND PERMANENCY

The Budget requests $8.7 billion for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs. These programs, authorized by title IV-E of the Social Security Act, support safety and permanence for children separated from their families and prepare older foster youth for independence.

Funding primarily goes to States for board and care payments for children in foster care who are eligible for title IV-E funding, as well as to the Chafee Foster Care Independence Program, which offers assistance to current and former foster youth aged 16-21 in obtaining education, employment, and life skills for self-sufficiency. The Foster Care program also works with tribal agencies to help strengthen their child welfare systems.

PROMOTING SAFE AND STABLE FAMILIES

The Budget includes $495 million in total for the mandatory portion of the Promoting Safe and Stable Families program. These funds provide formula grants to States to provide services to families, to address child safety at home, and to provide supportive services for reunifying and adoptive families. Funding also supports Regional Partnership Grants, a competitive grant program that reduces the risk of foster care due to parental substance abuse. The Budget proposes to reauthorize Promoting Safe and Stable Families (title IV-B) through FY 2022 at $345 million per year.

This account includes two other programs, the Personal Responsibility Education Program and Abstinence Education. The Personal Responsibility Education Program provides formula grants to States to educate adolescents on pregnancy prevention, sexually transmitted diseases, and adulthood preparation subjects such as relationship skills and financial literacy. Abstinence Education provides formula grants to States to support programs that present ways teens can develop healthy and positive relationships and promote reasons to delay sexual activity. Projects focus on youth who are homeless, in foster care, live in rural areas or areas with high teen birth rates, or come from racial or ethnic minority groups with disparities in teen birth rates. The Budget proposes to reauthorize both programs through FY 2019 at the current levels of $75 million per year for each program, which will cost $300 million.

SOCIAL SERVICES BLOCK GRANT

The FY 2018 Budget eliminates funding for the Social Services Block Grant for a savings of $1.4 billion in FY 2018 and $16.7 billion over ten years. The Social Services Block Grant provides funding that is duplicative of resources available through other federal programs and has not demonstrated its effectiveness in reducing dependency on welfare and supporting self-sufficiency. As a 2011 U.S. Government Accountability Office report pointed out, the Social Services Block Grant is fragmented, provides duplicative or overlapping services, and has limited accountability. The Social Services Block Grant essentially offers a no-strings-attached approach to taxpayer funds. Eliminating the Social Services Block Grant aligns with the Administration's goal of supporting welfare programs that effectively help low-income families gain self-sufficiency through paid employment. Furthermore, the proposal represents the Administration's commitment to focus limited taxpayer dollars on the outcomes, not inputs, of programs to ensure they are effectively helping low-income families.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Temporary Assistance for Needy Families provides States, Territories, and eligible Tribes the opportunity to design creative programs to help families transition from welfare to self-sufficiency. States have tremendous flexibility in determining how to use their Temporary Assistance for Needy Families dollars to meet their citizen's needs and get them back on their feet. States now spend much less on cash assistance payments than during the early years of Temporary Assistance for Needy Families implementation and more on education and training, child care, and other work supports.

The Budget proposes $15.1 billion for the Temporary Assistance for Needy Families State and Territory Family Assistance Grants, to build on the successes of welfare reform and to strengthen and re-focus Temporary Assistance for Needy Families as an effective anti-poverty program that fosters child and family well-being through job-readiness programs and employment opportunities programs. This request aligns with the proposal to zero-fund the Social Services Block Grant. States will continue to have broad flexibility in determining how to spend their remaining Temporary Assistance for Needy Families block grant funds, including a focus on welfare-to-work activities. The budget includes a legislative proposal to fund Welfare Research and the Census Bureau Survey of Income Program Participation, at $15 million and $10 million respectively, through a $25 million set-aside from the Temporary Assistance for Needy Families block grant.

The Budget also proposes to eliminate the Temporary Assistance for Needy Families Contingency Fund, saving $6 billion dollars over 10 years. While the intent of the Contingency Fund is to assist States experiencing increased demand for cash assistance during economic declines, recent experience has demonstrated that the Contingency Fund is an ineffective mechanism for responding to economic downturns. This proposal advances the Administration's goal of reducing duplication and increasing the effectiveness and

efficiency of federal benefit spending programs. The Administration looks forward to working with Congress to ensure Temporary Assistance for Needy Families resources are targeted to families that are temporarily in need of additional support while maintaining welfare reform's emphasis on gainful employment.

Administration for Children and Families: Mandatory

FY 2018 ACF Mandatory Outlays

dollars in millions	2016	2017/1	2018	2018 +/– 2017
Current Outlays				
Child Care Entitlement to States	2,788	2,968	2,946	-22
Child Care and Development Fund (non-add) /2	5,306	5,693	5,718	+25
Child Support Enforcement and Family Support	4,079	4,266	4,412	+146
Children's Research and Technical Assistance	67	52	42	-10
Foster Care and Permanency	7,700	8,025	8,439	+414
Promoting Safe and Stable Families (mandatory only) /3	421	465	451	-14
Social Services Block Grant	1,780	1,699	1,770	+71
Sandy Supplemental /4	96	64	—	-64
Temporary Assistance for Needy Families (TANF)	15,624	16,504	16,628	+124
TANF Contingency Fund	572	616	618	+2
Subtotal, TANF (non-add)	16,196	17,120	17,246	+126
Total, Current Law Outlays	**33,031**	**34,595**	**35,306**	**+711**
Proposed Law Outlays				
Child Care Entitlement to States	2,788	2,968	2,946	-22
Child Care and Development Fund (non-add) /2	5,306	5,693	5,718	+25
Child Support Enforcement and Family Support	4,079	4,266	4,302	+36
Children's Research and Technical Assistance (mandatory only)	67	52	57	+5
Foster Care and Permanency	7,700	8,025	8,457	+432
Promoting Safe and Stable Families (mandatory only) /3	421	465	454	-11
Social Services Block Grant /5	1,780	1,699	362	-1337
Sandy Supplemental /4	96	64	—	-64
Temporary Assistance for Needy Families (TANF)	15,624	16,504	15,395	-1,119
TANF Contingency Fund	572	616	51	-565
Subtotal, TANF (non-add)	16,196	17,120	15,446	-1,674
Total, Proposed Law Outlays	**33,031**	**34,595**	**32,024**	**-2,645**

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

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

3/ The total for Promoting Safe and Stable Families includes Abstinence Education, the Personal Responsibility Education Program. In addition, there is a discretionary appropriation of $60 million for this account in 2016, FY 2017 and FY 2018.

4/ The Disaster Relief Appropriations Act of 2013 provided $500 million in funding for Social Services Block Grant to aid in the recovery from Hurricane Sandy.

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

FY 2018 ACF Mandatory Legislative Proposals

dollars in millions	2018	2018 -2022	2018 -2027
Proposed Law Outlays			
Strengthening Child Support Enforcement and Establishment /1	-21	-259	-698
Technology Enhancement and Replacement Fund	-110	-609	-833
Subtotal, Child Support (non-add)	-131	-868	-1,532
Abstinence Education	1	136	136
Personal Responsibility Education Program	2	136	141
Subtotal, PSSF (non-add)/2	3	272	277
Health Profession Opportunity Grant	3	170	170
Foster Care and Permanency /3	18	109	224
Social Services Block Grant	-1,411	-8,194	-16,694
Subtotal, Social Services Block Grant (non-add)	-1,390	-7,915	-16,300
Welfare Research and Census SIPP Set-Aside	25	125	250
Temporary Assistance for Needy Families (TANF)	-1,243	-7,581	-15,866
TANF Contingency Fund	-567	-2,999	-6,039
Subtotal, TANF (non-add)	-1,785	-10,455	-21,655
Total Outlays, ACF Legislative Proposals	-3,303	-18,968	-39,211

1/ The Child Support outlays in this table are net of estimated savings in the Supplemental Nutrition Assistance Program ($418 million over 10 years) and the Supplemental Security Income program ($109 million over 10 years), which would result from this proposal. These outlays include the cost of $175 million over 10 years from Federal Offsetting Collections.

2/ Costs of extending PREP and Abstinence Education through FY 2019. There is not cost for reauthorizing PSSF through FY 2022.

3/ Reflects interaction effects from proposal to eliminate SSBG.

dollars in millions	2016	2017 /1	2018	2018 +/- 2017
Health and Independence Services				
Home & Community-Based Supportive Services	348	348	348	--
Nutrition Services	835	833	833	--
Native American Nutrition & Supportive Services	31	31	31	--
Preventive Health Services	20	20	20	--
Chronic Disease Self-Management	8	8	5	-3
Falls Prevention	5	5	5	--
Aging Network Support Activities	10	10	10	--
Subtotal, Health and Independence	**1,257**	**1,255**	**1,252**	**-3**
Caregiver Services				
Family Caregiver Support Services	150	150	150	--
Native American Caregiver Support Services	8	8	8	--
Alzheimer's Disease Program	19	19	19	--
Lifespan Respite Care	3	3	3	--
Subtotal, Caregiver Services	**180**	**180**	**180**	**--**
Protection of Vulnerable Older Adults				
Long Term Care Ombudsman Program	16	16	16	--
Prevention of Elder Abuse & Neglect	5	5	5	--
Senior Medicare Patrol Program (HCFAC)	18	18	18	--
Elder Rights Support Activities	12	12	12	--
Subtotal, Protection of Vulnerable Older Adults	**51**	**51**	**51**	**--**
Disability Programs, Research and Services				
Partnerships for Innovation, Inclusion, and Independence	0	0	45	+45
State Councils on Developmental Disabilities	73	73	0	-73
Developmental Disabilities Protection and Advocacy	39	39	39	--
Projects of National Significance	10	10	8	-2
University Centers for Excellence in Developmental Disabilities	39	39	39	--
Nat'l Institute on Disability, Independent Living, & Rehab. Research	104	104	95	-9
Independent Living	101	101	78	-23
Traumatic Brain Injury	9	9	3	-6
Limb Loss Resource Center	3	3	0	-3
Paralysis Resource Center	8	8	0	-8
Subtotal, Disability Programs, Research and Services	**386**	**386**	**307**	**-79**

dollars in millions	2016	2017	2018	2018 +/-2017
Consumer Information, Access and Outreach				
Voting Access for People With Disabilities (HAVA)	5	5	5	--
Aging and Disability Resource Centers	6	6	6	--
State Health Insurance Assistance Program	52	52	0	-52
Assistive Technology	34	34	32	-2
MIPPA Programs (Mandatory)	38	35	38	+2
Subtotal, Consumer Information, Access and Outreach	**135**	**132**	**81**	**-52**
Other Programs, Total, and Less Funds From Other Sources				
Program Administration	40	40	38	-2
Total, Program Level	**2,048**	**2,042**	**1,907**	**-135**
Less Funds from Other Sources	-83	-81	-56	-25
Total, Budget Authority	**1,965**	**1,961**	**1,851**	**-110**
Full-time Equivalents	196	199	187	-12
1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.				

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

Since its creation in 2012, the Administration for Community Living (ACL) has helped increase access to community supports, while focusing attention and resources on the unique needs and strengths of the populations served.

The Fiscal Year (FY) 2018 Budget requests $1.9 billion for ACL, which is $135 million below the FY 2017 Continuing Resolution. The Budget prioritizes funding for critical programs that help support older Americans, individuals living with disabilities, and their caregivers and connect them with direct services across the United States. Consistent with the President's priorities, the Budget also maximizes Federal investments by promoting efficiencies and supporting evidence-based approaches.

MAINTAINING HEALTH AND INDEPENDENCE FOR OLDER ADULTS

The United States population over age 60 is projected to increase by 20 percent between 2014 and 2020, from 64.8 million to 77.6 million people. The Budget preserves funding for essential community-based services and supports that assist efforts to help older Americans stay healthy, independent, and living in their communities.

Nutrition Services Programs

The Budget requests $833 million for Nutrition Services—the same level as the FY 2017 Continuing Resolution—which includes funding for Congregate Meals, Home-Delivered Meals, and the Nutrition Services Incentive Program. ACL's nutrition programs help ensure that millions of older Americans have access to meals, nutrition screening and education, and the opportunity to engage socially with others in their communities. This funding represents the vast majority of Federal funding for nutrition services for seniors, and in combination with State and local contributions, the Budget will support 216 million congregate and home-delivered meals for approximately 2.3 million older adults nation-wide, as well as 5.8 million meals to over 100,000 Native American seniors.

Home and Community-Based Supports

The Budget also includes a total of $368 million for Home and Community-Based Supportive Services and Preventive Health Services, which maintains funding at the FY 2017 Continuing Resolution level. The Home and Community-Based Supportive Services Program

provides formula grants to States and Territories to fund a broad array of services that enable seniors to remain in their homes. These services include—but are not limited to—transportation assistance, case management, adult day care, and in-home services. In the most recent fiscal year for which data is available, the program provided over 9.9 million hours of care for dependent adults in a group setting and 23.6 million rides to doctors' offices, senior centers, meal sites, and other locations.

The Preventive Health Services Program also provides formula grants to States and Territories to fund evidence-based programs that educate older adults about the importance of healthy lifestyles to help prevent or delay chronic disease and disability.

Other Programs

The Budget maintains funding at a total of $51 million for other health and independence services, which provide a range of services designed to ensure the safety and well-being of seniors who are in danger of being mistreated, neglected, or exploited in both at-home and institutional settings.

The Budget also maintains mandatory funding for the State Health Insurance Assistance Program, Aging and Disability Resource Centers, Area Agencies on Aging, and the National Center for Benefits Outreach and Enrollment. These programs provide funding for targeted one-on-one counseling and outreach to low-income and rural populations to assist with Medicare enrollment. The National Center for Benefits Outreach and Enrollment supports an online enrollment benefit tool as well as a nation-wide network of 59 Benefits Enrollment Centers that help connect low-income populations to public benefits.

SUPPORTING CAREGIVERS

The Budget includes $161 million to fund three programs designed to support and provide services to family and other informal caregivers, the same as the FY 2017 Continuing Resolution. Research has shown that these caregivers make an important economic contribution to the care of people needing long-term services and supports. Without them, the cost and burden to the Nation's long-term care system would be substantial.

The National Family Caregiver Support Program and the Native American Caregiver Support Services Program provide caregivers with a range of support services such as counseling, respite care, and training. In FY 2018, the Family Caregiver Support program will support approximately 850,000 family caregivers with respite care services, access assistance services, counseling and training. The Lifespan Respite Care program focuses on easing the burdens of caregiving by helping States develop more efficient, evidence-based, and cost-effective methods to improve quality and access to respite care. These caregiver programs enable individuals across the lifespan to stay at home longer and enjoy greater independence, which can translate into lower costs when institutional care is avoided.

Alzheimer's Disease

In FY 2018, the Budget maintains funding for Alzheimer's Disease activities at $19 million, consolidating all related Alzheimer's Disease activities across ACL into a single grant program. An estimated 5.2 million individuals in the United States are living with Alzheimer's Disease and related dementias; that number is expected to increase by about 40 percent by 2025. Consolidating similar Alzheimer's Disease activities into a single grant program will provide greater flexibility to States, Territories, Tribes, and localities to meet the needs of their communities.

IMPROVING THE LIVES OF INDIVIDUALS WITH DISABILITIES

ACL is dedicated to ensuring that individuals with disabilities and their families are able to fully participate in and contribute to all aspects of community life. Through partnerships with States, Territories, communities, and non-profit organizations, ACL works to improve opportunities for people with disabilities to access quality services and supports, achieve economic self-sufficiency, and experience equality and inclusion in all facets of community life.

Protection and Advocacy

The Budget requests $39 million to maintain funding for the Developmental Disabilities Protection and Advocacy Program. Protection and Advocacy Systems work at the State level to protect individuals with developmental disabilities by investigating incidents of abuse and neglect, and pursuing legal, administrative, or other appropriate remedies.

University Centers for Excellence

The Budget also requests $39 million—the same funding level as the FY 2017 Continuing Resolution—to continue funding for University Centers for Excellence in Developmental Disabilities, a nationwide network that provides an array of interdisciplinary programs to improve the quality of services and supports for individuals with developmental disabilities and training for professionals. The Centers also advise Federal, State, and community policymakers about opportunities that can advance research related to the needs of individuals with developmental disabilities and their families as well as emerging issues in the field.

Partnerships for Innovation, Inclusion, and Independence

Finally, the Budget restructures activities carried out by the State Councils on Developmental Disabilities, Independent Living and Traumatic Brain Injury programs into a single state grant program. The Budget requests $45 million for the Partnerships for Innovation, Inclusion, and Independence program, which will combine these activities into a single statewide, cross-disability entity, promoting evidence-based approaches, efficiencies, and a more cohesive approach to disability partnerships. This restructuring of State council activities into a single grant program achieves $57 million in savings in FY 2018, while ensuring that States have the tools they need to coordinate care for individuals with disabilities.

Other Disability Programs

The FY 2018 Budget reduces funding for Projects of National Significance and the National Institute on Disability, Independent Living, and Rehabilitation Research to prioritize funding for direct service programs. The Budget requests $8 million for Projects of National Significance, which is $2 million below the funding level provided by the FY 2017 Continuing Resolution. The Budget includes $95 million—$9 million below the FY 2017 Continuing Resolution—for the National Institute on Disability, Independent Living, and Rehabilitation Research.

PROGRAM HIGHLIGHT

Nutrition Services

Most participants reported that the ACL Nutrition Services programs had helped them to eat healthier foods, and up to 86 percent indicated the program had improved their health. Additionally, 63 percent of congregate and 93 percent of home-delivered meal participants reported that the program had helped them to live independently and remain in their own home.

STREAMLINING PROGRAMS AND DELIVERY OF SERVICES

The Budget proposes to discontinue funding for programs whose activities could be carried out with existing funding streams to deliver services more efficiently.

The FY 2018 Budget request achieves $63 million in savings by discontinuing discretionary funding for the Limb Loss Resource Center, the Paralysis Resource Center, and the State Health Insurance Assistance Program. The activities carried out by these programs are duplicative of other Federal efforts. Activities carried out by the Limb Loss and Paralysis Resource Centers will be merged into the National Institute on Disability, Independent Living and Rehabilitation Research and Aging and Disability Resource Centers. The Budget discontinues discretionary funding for the State Health Insurance Assistance Program leveraging alternative sources for Medicare beneficiaries to obtain access to reliable information to better understand and manage benefits.

Program Administration

The Budget includes $38 million for program management and support activities. This funding supports rent, staff, and other administrative costs.

Office of the Secretary, General Departmental Management

dollars in millions	2016	2017 /1	2018	2018 +/– 2017
Budget Authority	456	455	305	-150
Public Health Service (PHS) Evaluation Funds	65	65	57	-8
Health Care Fraud and Abuse Control	7.5	7	10	+3
Proposed Mandatory Funding—Departmental Appeals Board	--	--	2	+2
Total, Program Level /2	**528**	**527**	**374**	**-153**
Full-Time Equivalents	1,482	1,557	1,581	+24

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ This table does not include funding or FTE for the Pregnancy Assistance Fund.

The General Departmental Management budget line supports the Secretary's role as chief policy officer and general manager of the Department.

The Fiscal Year (FY) 2018 President's Budget requests a program level of $374 million for General Departmental Management, a decrease of $153 million below the funding level provided in the FY 2017 Continuing Resolution. The Budget supports the Secretary's role in administering and overseeing the organization, programs, and activities of the Department. These efforts are carried out through 11 Staff Divisions within the Office of the Secretary.

OFFICE OF MINORITY HEALTH

The Budget includes $57 million for the Office of Minority Health, the same as the funding level provided in FY 2017 Continuing Resolution. The Office of Minority Health will continue to lead, coordinate, and collaborate on minority health activities across the Department, including leadership in coordinating policies, programs, and resources to support implementation of the HHS Disparities Action Plan and the National Partnership for Action to End Health Disparities.

OFFICE ON WOMEN'S HEALTH

The Budget includes $32 million for the Office on Women's Health, the same as the funding level provided in the FY 2017 Continuing Resolution. The Office on Women's Health will continue to lead, coordinate, and collaborate on women's health activities across the Department. This funding will allow the Office on Women's Health to continue targeted grants and support the advancement of women's health programs through the promotion and coordination of research, service delivery, and education. Funds will also allow the Office on Women's Health to continue a state partnership initiative to reduce violence against women. These programs are also carried out throughout the divisions and offices of the Department, with other government organizations, and with consumer and health professional groups.

SEXUAL RISK AVOIDANCE

The Budget includes $10 million for Sexual Risk Avoidance education grants, the same as the funding level provided in the FY 2017 Continuing Resolution. This program supports an evidence-based approach defined as voluntarily refraining from non-marital sexual activity.

DEPARTMENTAL APPEALS BOARD

The Budget includes $17 million for the Departmental Appeals Board, comprised of $15 million in discretionary budget authority and $2 million in proposed mandatory funding. This is an increase of $6 million above the funding level provided in the FY 2017 Continuing Resolution. The Departmental

Appeals Board provides high-quality adjudication and other conflict resolution services in administrative disputes involving HHS, including Medicare appeals. The Budget increase for FY 2018 will provide additional support to the Medicare Appeals Council to keep pace with the growing number of Medicare appeals. Within HHS, the Council provides the final administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage, and payment filed by beneficiaries or health care providers and suppliers.

OTHER GENERAL DEPARTMENTAL MANAGEMENT

The Budget includes $258 million for the remainder of the activities supported by General Departmental Management in the Office of the Secretary. The Budget funds leadership, policy, legal, and administrative guidance to Department components and includes funding to continue ongoing programmatic activities, including strengthening program integrity by reducing fraud, waste, and abuse.

Office of the Secretary, Office of Medicare Hearings and Appeals

dollars in millions	2016	2017 /1	2018	2018 +/– 2017
Budget Authority	107	107	117	+10
Proposed Mandatory Funding	--	--	125	+125
Total Program Level	**107**	**107**	**242**	**+135**
Full-Time Equivalents	557	671	980	+309

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

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

The Fiscal Year (FY) 2018 Budget requests $242 million in program level funding for the Office of Medicare Hearings and Appeals (OMHA), an increase of $135 million over the funding provided in the FY 2017 Continuing Resolution. The increase outlined in the FY 2018 Budget request is composed of a $10 million increase in discretionary budget authority and a $125 million proposed mandatory funding increase. The Budget request also includes a legislative package to address the Medicare appeals backlog.

OMHA administers hearings and appeals nation-wide for the Medicare program. OMHA began processing cases on July 1, 2005; since then, it has received approximately 1.7 million appeals for Medicare Parts A, B, C, and D, as well as for Medicare entitlement and eligibility. In FY 2011, OMHA began receiving additional appeals resulting from the permanent nation-wide expansion of the Recovery Audit program administered by the Centers for Medicare & Medicaid Services. These appeals, in addition to the more traditional Part A and B appeals, have contributed to OMHA's significant workload increase. Despite efforts to mitigate the incoming workload, unsustainable appeal receipt volumes continued: FY 2014—474,000; FY 2015—240,000; and FY 2016—184,000. The slight decline in FY 2016 receipts was due to a contract protest which slowed the rate of receipts. Annual adjudication capacity in FYs 2014 and 2015 was 77,000 appeals. In FY 2016, OMHA adjudicated 87,000 appeals.

Current law requires that Medicare appeals at the OMHA level be heard within 90 days after receipt of a request for a hearing from an appellant. Due to the overwhelming growth in its workload, OMHA has not been able to meet the 90-day time frame for case adjudication in some cases. It currently takes approximately 1,000 days for OMHA to adjudicate a non-beneficiary appeal.

PROGRAM HIGHLIGHT

Improving the Medicare Appeals Process

The Department has a three-pronged approach to address the significant volume of new Medicare appeals and the current backlog of claims to be adjusted:

1. Invest resources to increase adjudication capacity and implement new strategies to alleviate the current backlog;
2. Take administrative actions to reduce the backlog of appeals and the number of new cases from entering the system or escalating to higher levels of appeal; and
3. Propose legislative actions that provide additional funding and new authorities to address the backlog.

To address these challenges, OMHA has taken a number of administrative actions to reduce the pending appeals workload. For example, OMHA is pursuing alternative dispute resolution as an alternative to an Administrative Law Judge hearing. In addition, OMHA has made statistical sampling an option available to appellants, which has the potential

to resolve large numbers of cases based on representative samples. While helpful, these initiatives alone are insufficient to keep up with the dramatic growth in Medicare appeals.

The Budget will increase OMHA adjudicatory capacity by adding up to 106 new Administrative Law Judge teams, which will result in 106,000 additional dispositions per year. OMHA will continue to utilize technology, such as video telephone and teleconference hearings, to offer appellants access to multiple hearing venues and services. The requested resources are critical for OMHA to respond to the backlog of unheard appeals while maintaining the quality and accuracy of its decisions. These resources are also essential to provide timely hearings for Medicare appellants.

For more information about the Medicare appeals legislative proposals, please see the Medicare chapter.

Office of the Secretary, Office of the National Coordinator for Health Information Technology

dollars in millions	2016	2017 /1	2018	2018 +/- 2017
Budget Authority	60	60	38	-22
Program Level	**60**	**60**	**38**	**-22**
Full-time Equivalents	176	190	164	-26

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

The Office of the National Coordinator for Health Information Technology leads the Nation in transforming health and health care through the advancement of an interoperable health information technology infrastructure. The Office of the National Coordinator for Health Information Technology improves the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most.

The Office of the National Coordinator for Health Information Technology (ONC) leads the Government's efforts to promote and coordinate the nation-wide use of health information technology and flow of electronic health data to transform health care. ONC serves as a resource to the entire health care community, aligning the needs of patients and providers with the innovation of health information technology (IT).

The Fiscal Year (FY) 2018 Budget for ONC is $38 million, $22 million below the spending level appropriated through the FY 2017 Continuing Resolution. The Budget reflects ONC's successful progress in increasing provider adoption rates, improving usability, and advancing interoperability in order to ensure the seamless and secure flow of health information.

ONC's budget focuses on two key priorities: interoperability of health information, and the usability of electronic health records. The interoperability of health information is central to the core mission of the Department of Health and Human Services to enhance and protect the health and well-being of all Americans. ONC's FY 2018 Budget emphasizes ONC's continued policy coordination work, utilizing ONC's new Health IT Advisory Committee, as required by the 21st Century Cures Act. ONC will also focus on thwarting information blocking and prioritize its work on standards coordination, implementation, testing, and pilots to accelerate industry progress towards interoperability.

POLICY COORDINATION

ONC will continue to develop and coordinate Federal health IT policies through collaboration with a broad range of stakeholders in order to build the necessary foundation for an interoperable, learning health system that can support a wide variety of national priorities.

NEW INITIATIVE

21st Century Cures Act Implementation

Improving interoperability and usability are priorities not just in ONC's budget but also in the 21st Century Cures Act. The Cures Act directs ONC to implement activities that advance interoperability through continued work combating information blocking and building health IT exchanges. In FY 2018, ONC will continue to address and discourage information blocking by aggressively implementing ONC Certification Program rules, creating and promoting channels for reporting information blocking, and enforcing information blocking provisions required by the Cures Act. The certification program will continue its oversight responsibilities and will look to improve the surveillance of certified products for ongoing adherence to technical, security, and regulatory requirements for interoperability as well as the surveillance of any potential for information blocking.

In FY 2018, ONC will combine its two Federal advisory committees into a single Health Information Technology Advisory Committee as directed by the

21st Century Cures Act. The Health Information Technology Advisory Committee will retain the task of providing policy and standards recommendations while focusing on three priority areas: achieving interoperability; promoting and protecting the privacy and security of health information, and facilitating secure access.

Through new authorities provided in the 21st Century Cures Act, ONC will work with the Office of Inspector General to investigate and issue penalties for developers, networks, and exchanges engaged in information blocking. By curbing this harmful practice, ONC will ensure that patients and providers have access to critical electronic health information.

ONC will continue to encourage the interoperable exchange of health information by convening public and private sector stakeholders to develop and support a trusted health IT exchange network, and enhance usability.

STANDARDS, INTEROPERABILITY, AND CERTIFICATION

ONC develops standards and works closely with Federal agencies and other stakeholders to implement solutions that advance the seamless and secure flow of critical health information where and when it is needed most. ONC supports a variety of programs and efforts that underpin nationwide progress toward an interoperable learning health IT infrastructure that promotes the delivery of safe, efficient, cost-effective and high-quality care.

The FY 2018 Budget continues to promote interoperability through advancements to the ONC Health IT Certification Program, such as requiring as a condition of certification for health IT developers to attest that they do not engage in information blocking. Additionally, ONC will consult with stakeholders to develop reporting criteria that measure usability and security as part of a new electronic health record reporting program created by the 21st Century Cures Act.

ONC will continue to publish the Interoperability Standards Advisory which coordinates the identification, assessment, and public awareness of interoperability standards and implementation specifications. This web-based resource is used by the health care industry to address specific interoperability needs, including—but not limited to—clinical, public health, and research purposes.

ADOPTION AND MEANINGFUL USE

ONC's efforts have led to high health IT adoption rates across the country. As of 2015, more than 96 percent of hospitals and 78 percent of physician offices were using certified electronic health record technology.

As a result of ONC's shifting agency priorities and renewed focus on core health IT functions, ONC will reduce adoption support activities such as the National Learning Consortium and the Consumer e-Health program and focus efforts on statutorily required planning, evaluation, and monitoring of interoperability. ONC also will continue to provide the latest information for patients, providers, and developers on its website, HealthIT.gov.

PROGRAM HIGHLIGHT

ONC Health IT Certification Program

The ONC Health IT Certification Program provides comprehensive, independent mechanisms to evaluate health IT for conformance to standards and functional requirements. ONC also maintains the Certified Health IT Product List, a publicly available list on ONC's website of all health IT products certified through the ONC Health IT Certification Program. The list generates a Centers for Medicare and Medicaid Services (CMS) electronic health record identification number that is representative of the Certified Electronic Health Record Technology used to participate in several CMS payment programs. To date, there are over 800 health IT developers with over 4,000 unique products that have been certified against 2014 Edition Certification Criteria. ONC recently produced a new website to align with the 2015 Edition final rule's additional data needs and to support greater transparency and open data accessibility. The new website includes additional functionality, such as advance search, product compare, and application programming interface methods to enable stakeholders to openly access and combine these data with their datasets.

Office of the Secretary, Office for Civil Rights

dollars in millions	2016	2017 /1	2018	2018 +/- 2017
Program Level	**39**	**39**	**33**	**-6**
Full-Time Equivalents	170	179	162	-17

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.

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

The Fiscal Year (FY) 2018 Budget request for the Office for Civil Rights (OCR) is $33 million, $6 million below the FY 2017 Continuing Resolution level. The Budget supports OCR's essential programmatic focus as the primary defender of the public's right to nondiscriminatory access to and receipt of HHS funded health and human services, conscience protections, consumer access to health information, and privacy and security protections for individually identifiable health information. In FY 2018, OCR will reduce overhead and non-personnel costs. OCR will also use civil monetary settlement funds to support Health Insurance Portability and Accountability Act (HIPAA) enforcement activities.

CIVIL RIGHTS

General Authorities

OCR works to safeguard individuals' access to health care, health coverage, and human services without discrimination, as well as protecting conscience rights. In addition, OCR enforces civil rights protections with respect to race, color, national origin, disability, age, and sex discrimination in health programs that receive financial assistance or are administered by the Department. OCR also enforces protection of conscience rights of individuals, providers, and entities that object to abortion and sterilization procedures.

Other Compliance Activities

OCR reviews nearly 2,500 Medicare provider applicants a year to assess compliance with Federal civil rights requirements. Through its current formal agreements with 54 health care corporations, OCR ensures ongoing compliance in more than 4,600 facilities that serve over 11 million patients annually.

OCR works with its Federal agency partners to ensure language accessibility and will continue to work with colleagues across the Department to ensure that all individuals, including those with limited English proficiency, have access to HHS-conducted programs and activities, and can obtain the health care, health coverage, and human services they need to lead fulfilling lives.

OCR provides technical assistance and education to States and its Federal agency partners to ensure compliance with the Americans with Disabilities Act. OCR disseminates information, creates virtual learning communities, works on guidance documents, and provides webinars on topics such as housing and Medicaid services that provide individuals with disabilities opportunities to live in their communities.

HEALTH INFORMATION PRIVACY AND SECURITY

General Authorities

OCR administers and enforces the HIPAA Privacy, Security, and Breach Notification Rules. OCR is responsible for policy development through the issuance of regulations and guidance. OCR also provides outreach and technical assistance to the regulated community to ensure covered entities and business associates understand their compliance obligations and to the public to increase individuals' awareness of their HIPAA rights and protections.

OCR enforces the HIPAA Rules by investigating complaints and conducting compliance reviews of alleged violations of the HIPAA Rules, providing technical assistance and obtaining corrective actions, as well as entering into resolution agreements or

issuing civil monetary penalties, where appropriate. OCR resolved more than 23,000 complaints of alleged HIPAA violations in FY 2016.

Settlements and Civil Monetary Penalties

OCR has authority to enter into resolution agreements that include payment of a resolution amount and corrective action plans, as well as imposing civil monetary penalties for violations of the HIPAA Rules. OCR retains these collections and expends some of such funds to support overall HIPAA enforcement activities.

Office of the Secretary, Office of Inspector General

dollars in millions	2016	2017 /1	2018	2018 +/- 2017
Discretionary Appropriation /2	77	76	68	-8
Health Care Fraud and Abuse Control Program (HCFAC)	11	11	12	+1
Discretionary HCFAC	67	67	74	+7
Mandatory HCFAC	188	186	204	+18
Total Funding, All Sources	**343**	**341**	**359**	**+18**
Full-time Equivalents	1,575	1,590	1,677	+87

1/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
2/ Includes the $1.5 million permissive transfer from the Food and Drug Administration appropriation in FY 2016 and FY 2017.

The mission of the Office of Inspector General is to protect the integrity of Department of Health and Human Services programs as well as the health and welfare of the people they serve.

The President's fiscal year (FY) 2018 Budget requests $359 million for the Office of Inspector General (OIG), an increase of $18 million above the FY 2017 Continuing Resolution. These funds will enable OIG to target oversight efforts and ensure efficient and effective use of resources within the programs.

OIG's areas of oversight fall into two broad categories: Public Health and Human Services Oversight and Medicare and Medicaid Oversight.

PUBLIC HEALTH AND HUMAN SERVICES OVERSIGHT

OIG uses funding from its discretionary budget authority to conduct program integrity and enforcement activities for HHS programs and operations. OIG will continue to review activities for any evidence of fraud, waste, and abuse and oversee new and emerging issues related to HHS's international and domestic response to public health concerns and new cyber security threats facing the Department.

The FY 2018 Budget request for Public Health and Human Services Oversight is $68 million, which will support the following investments to strengthen the integrity of HHS programs including:

- **Protecting HHS Grants from Fraud, Waste and Abuse:** OIG will continue focus on grant oversight efforts on high risk grant programs, including grants for services to children and substance abuse grant funding provided under the 21st Century Cures Act for opioid abuse prevention and treatment programs.
- **Oversight of Indian Health Services:** OIG will continue oversight of quality of care and program administration.
- **Public Health Emergencies**: OIG will continue oversight of HHS grants for emergency preparedness and provide training and education to promote preparedness and prevent fraud, waste, and abuse.
- **Ensuring Privacy and Security Information:** OIG will work to increase oversight and investigative response to threats from computer hacking groups intent on compromising systems and releasing sensitive data. OIG conducts general security control audits of information and technology supporting HHS programs and conducts network and web application penetration testing to assess HHS's network security to determine vulnerability.

MEDICARE AND MEDICAID OVERSIGHT

Through its multi-disciplinary oversight work, OIG saves taxpayer dollars and works to ensure that patients receive medically appropriate care in the Nation's largest health care programs—Medicare and Medicaid. OIG relies on principles of prevention, detection, and enforcement to address fraud, waste, and abuse in

these programs. Two key focus areas are sound fiscal management of the programs and ensuring that beneficiaries have access to quality care in the right setting as determined by the beneficiary and his or her medical providers.

OIG protects these programs and their beneficiaries using a multidisciplinary approach and through important partnerships, including with the Department of Justice and State Medicaid Fraud Control Units. Fraudulent providers often cheat both Medicare and Medicaid (and their beneficiaries), and thus OIG fraud-fighting and patient protection activities often have cross-cutting impacts. The Health Insurance Portability and Accountability Act (HIPAA) established the HCFAC Program to combat fraud, waste, and abuse in health care. The funds OIG receives under HIPAA are dedicated to activities relating to Medicare and Medicaid. Overall, HCFAC funding constitutes the major portion of OIG's annual operating budget.

The FY 2018 Budget request for OIG includes $290.7 million for Medicare and Medicaid oversight, an increase of $26.4 million over the FY 2017 Continuing Resolution.

The FY 2018 Budget supports the Administration's priorities of addressing fraud, waste, and abuse in Federal health care programs and strengthening the fight against opioid abuse in this country. OIG's work reflects issues of access and affordability, increased Medicare and Medicaid enrollment and spending, innovations in health care and data analytics, quality of care, and the increase in complexity and technical sophistication of fraud schemes. OIG will continue its work from FY 2017 to address fraud, waste, and abuse in prescription drugs, including abuse and diversion of opioids.

Prescription Drug Abuse and Fraud Prevention Authorities

Opioid abuse and abuse of prescriptions for non-controlled potentiator drugs that enhance the euphoric effects of opioids endanger patients, communities, and taxpayer dollars.

OIG uses its legal authorities including law enforcement authorities, data analytics, investigation, audit, and evaluation capabilities, to strengthen the Administration's fight against opioid abuse. OIG addresses prescription drug fraud along the entire supply chain, from manufacturers who make and promote products to physicians and pharmacies.

Additional HCFAC funding will provide OIG with resources to increase investigations into fraudulent prescribing and dispensing of opioids, including forensic accounting and medical record reviews to increase the number of investigated cases and their expedient investigation and prosecution. OIG will further enhance its data analytics capabilities for identifying aberrant opioid prescribing or dispensing patterns and target interventions to combat prescription drug abuse.

Public Health and Social Services Emergency Fund

dollars in millions	2016 /1	2017 /2	2018	2018 +/- 2017
Assistant Secretary for Preparedness and Response (ASPR)				
Preparedness and Emergency Operations	25	25	25	--
National Disaster Medical System	50	50	50	--
Hospital Preparedness	255	254	227	-27
Medical Reserve Corps	6	6	6	--
Biomedical Advanced Research and Development Authority	540	511	512	1
Project BioShield	510	509	510	1
Policy and Planning	15	15	15	--
Operations	31	31	31	--
Subtotal, ASPR Program Level	**1,431**	**1,400**	**1,375**	**-25**
Other Office of the Secretary				
Security and Strategic Information (OSSI) /3	8	8	8	--
Cybersecurity /3	50	50	72	22
Subtotal, Other Office of the Secretary	**58**	**58**	**81**	**+22**
Pandemic Influenza				
No-Year Funding	40	40	175	+135
Annual Funding	32	32	32	--
Subtotal, Other Office of the Secretary	**72**	**72**	**207**	**+135**
Total Program Level, PHSSEF	**1,561**	**1,530**	**1,663**	**+133**
Total Budget Authority, PHSSEF	**1,561**	**1,533**	**1,663**	**+133**
Full-time Equivalents	714	750	780	+30

1/ In addition, the FY 2016 Zika Response and Preparedness Act provided $387 million in supplemental resources for Zika response and preparedness activities, including $245 million for BARDA, $75 million for CMS, and $66 million for HRSA.
2/ Reflects the annualized level of the Continuing Resolution that ended April 28, 2017, including the across the board reduction, the 21st Century Cures Act, and directed transfers.
3/ Totals reflect a realignment of $1.04 million from Cybersecurity to OSSI to support the cyber threat activities carried out by OSSI.

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

Within the Office of the Secretary, the Public Health and Social Services Emergency Fund directly supports efforts across the Government to safeguard the public and improve the Nation's preparedness for acts of terrorism, natural disasters, and other threats to public health. The Fiscal Year (FY) 2018 Budget includes $1.7 billion, an increase of $133 million above FY 2017, to maintain and build on the Department's capacity to address biodefense and cybersecurity needs, support state and local preparedness, and respond to emerging influenza viruses with pandemic potential.

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The Department supports bioterrorism and emergency preparedness activities within the Office of the Secretary and across programs and agencies to enhance the Nation's ability to prepare for, respond to, and recover from, a wide range of natural and man-made threats to public health. The Public Health and Social Services Emergency Fund supports the Department's cross-cutting efforts to strengthen public health and medical preparedness, provide direct response to emergency situations, develop and procure medical countermeasures, and coordinate emergency preparedness policy and planning efforts across the Department of Health and Human Services (HHS).

EMERGENCY RESPONSE FUND

The FY 2018 Budget proposes the establishment of an Emergency Response Fund to enable a swift response to emerging public health threats that have significant potential to affect the health and security of United States citizens. In addition to current transfer authority, HHS would have Department-wide transfer authority to support the Fund in the case of a natural or man-made disaster or threat. This Fund would be available to receive a transfer of up to one percent of any HHS account, without any limitation on the total, for use in emergency preparedness and response. Through this mechanism, HHS would have the ability to respond quickly when public health threats arise, as learned through previous public health threats such as Ebola and Zika. Such a fund will help bridge the Department's response in situations that exceed the planned scope of preparedness and response programs and activities or where the emergency occurs late in the fiscal year.

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

The Assistant Secretary for Preparedness and Response (ASPR) is tasked with fulfilling HHS's responsibilities as the lead Federal agency for public health emergency preparedness and response. ASPR fulfills these responsibilities by strengthening existing public health systems across the Nation, increasing the capacity of State and local governments to respond to public health threats, expanding advanced research, development and procurement of medical countermeasures, and providing operational leadership and policy development for a wide range of public health incidents.

The FY 2018 Budget includes $1.6 billion for ASPR, an increase of $110 million above the FY 2017 Continuing Resolution. The Budget prioritizes resources to support critical biodefense programs and maintain essential support for pandemic influenza preparedness and response. These investments fulfill a unique Federal role where no other entity is active in protecting the health and safety of the United States population.

The Budget includes $512 million—an increase of $1 million above the FY 2017 Continuing Resolution—for ASPR's Biomedical Advanced Research and Development Authority (BARDA) to support the development of medical countermeasures that can mitigate potential health effects of chemical, biological, radiological, and nuclear agents and emerging infectious diseases. BARDA transitions medical product candidates, such as vaccines, antivirals, diagnostics, and medical devices, from early development into advanced development and regulatory approval. To maintain a robust product development pipeline and meet national demands during a public health emergency, BARDA routinely collaborates with Federal agencies and leverages unique public-private partnerships. These partnerships rely on core services that BARDA provides to aid medical countermeasure developers, including assistance with clinical study protocols and final product manufacturing.

Since its inception, BARDA has directly supported the development of over 80 chemical, biological, radiological, and nuclear medical countermeasure product candidates. The FY 2018 Budget will maintain a robust pipeline of candidate products that will transition to Project BioShield, and expand the portfolio of candidate products to address chemical, radiological, nuclear, and biological threats, including viral hemorrhagic fever viruses. BARDA also supports countermeasures to address influenza viruses. These efforts will attempt to address remaining gaps for these threats. Multiple candidates in the advanced development program will progress into Phase II and Phase III clinical studies, including broad spectrum antimicrobials, new treatments for radiation illnesses and thermal burns, and next-generation vaccines.

The Budget includes $510 million—an increase of $1 million above the FY 2017 Continuing Resolution—for Project BioShield to support late-stage

development and procurement of high priority and novel medical countermeasures for the Strategic National Stockpile within the Centers for Disease Control and Prevention (CDC). At this funding level, BARDA will build on investments in the medical countermeasure development pipeline by purchasing promising products that are sufficiently mature and ready for use during a public health emergency. In FY 2018, Project BioShield will support the late-stage development and procurement of three new medical countermeasures, including products to address biological pathogens and antimicrobial resistance; lung injury resulting from exposure to chemical agents; and an intravenous formulation of a smallpox antiviral. In addition, the FY 2018 Budget will sustain the development and procurement of Ebola vaccines and therapeutics and the next generation anthrax vaccine, as well as maintain preparedness levels for chemical, smallpox, and nuclear medical countermeasures.

Since its inception, Project BioShield has supported the development and procurement of 21 novel medical countermeasures to address a wide range of threats such as anthrax, smallpox, botulism, viral hemorrhagic fever, and chemical, radiological, and nuclear agents. Six products have achieved Food and Drug Administration (FDA) approval, and BARDA anticipates an additional three products will be approved by FDA in FY 2018, in addition to five new products supported under Project BioShield. The sustainment of Project BioShield is fundamental in supporting the Nation's ability to prepare for and respond to acts of terrorism, biological outbreaks such as Ebola, and other public health threats. Sustainment of the capabilities and capacity to manufacture these life-saving products is key to the continued success of Project BioShield.

The Budget includes $192 million—the same as the FY 2017 Continuing Resolution—to continue BARDA's efforts to combat antibiotic-resistant bacteria. BARDA's broad spectrum antimicrobial program will continue to leverage partnerships with public and private partners to develop products that directly support the government-wide *National Action Plan for Combating Antibiotic-Resistant Bacteria*. Most recently, BARDA has collaborated with the National Institutes of Health and the private sector to launch the Combating Antibiotic Resistant Bacteria Biopharmaceutical Accelerator (CARB-X), a trans-Atlantic public-private partnership focused on preclinical discovery and development of new antimicrobial products. To maximize the use of

PROGRAM HIGHLIGHT

Hospital Preparedness Program

The Hospital Preparedness Program (HPP) enables health care systems to save lives during emergencies that exceed the day-to-day capacity of health and emergency response systems. The program has identified key reforms that, once implemented in FY 2018, will allow the program to be more efficient and effective in delivering results and protecting the health and lives of Americans.

One primary reform that will be implemented by the Hospital Preparedness Program is to transition to a competitive cooperative agreement program, by directing funds to States, jurisdictions, and Territories with the greatest need with respect to disaster preparedness. The introduction of a competitive cooperative agreement process will foster innovation and offer new opportunities for improved emergency preparedness and response, ensuring that the United States health care delivery system is better able to respond to emergencies that impact the public's health. Additionally, the Hospital Preparedness Program will use risk-scores which identify the potential hazards and vulnerabilities, to direct resources to the States, jurisdictions, and Territories with the greatest need. The Hospital Preparedness Program's risk score incorporates FEMA's State and Homeland Security Program risk score, accounting for a range of factors including population and threat of terrorism. HPP will also incorporate a thorough assessment to account for natural disaster risk. Additionally, the program has identified methods that would directly link the cooperative agreement awards to performance. This new approach holds awardees accountable for improving performance by withholding funds from awardees that fail to deliver results.

The Hospital Preparedness Program enhances health care delivery system capabilities to ensure they have the training and resources available to respond to public health and medical emergencies swiftly and effectively. The reforms to this program work in concert to ensure that the Hospital Preparedness Program is delivering critical results for the American people in the most efficient and effective manner possible.

resources, the Budget proposes authority to transfer resources between ASPR's advanced research and development and Project BioShield programs. This authority will better enable ASPR to manage resources across the advanced development and procurement stages to most effectively bring medical countermeasures through the pipeline.

The Hospital Preparedness Program increases the ability of local, State and regional health care and emergency response systems to save lives during emergencies. Funding incentivizes diverse and often competitive health care organizations with differing priorities and objectives to work together through health care coalitions. Health care coalitions enable communities to develop comprehensive and collaborative health care response plans, ensure communities have the adequate health care resources and trained personnel to respond to a disaster, and conduct joint planning, exercises, and trainings to ensure operational readiness should disaster strike. The Budget includes $227 million, a decrease of $27 million below the FY 2017 Continuing Resolution, for ASPR's Hospital Preparedness Program. The Hospital Preparedness Program works collaboratively with the CDC Public Health Emergency Preparedness program. The Hospital Preparedness Program focuses on incentivizing the private health care sector to prepare and respond while CDC's Public Health Emergency Preparedness program focuses on strengthening the preparedness of the State and local governmental public health. These two programs complement each other to ensure that both the health care delivery system and public health departments are able to prepare for, respond to, and rapidly recover from, disasters. This year, the two programs will implement changes to improve the overall efficiency of each program. These reforms include a greater emphasis on risk assessment, which will direct resources to States and jurisdictions with the greatest need. Additionally, the programs will innovate through competition, funding the most effective preparedness strategies and aligning awardees more closely with program missions to improve the Nation's health. Lastly, the new reforms will use these resources wisely and with accountability by tying continued funds to performance, providing awards to those recipients who are demonstrating results, and improving the overall capabilities of emergency preparedness and response systems.

The FY 2018 Budget maintains $50 million to support the National Disaster Medical System. The National Disaster Medical System consists of approximately 5,000 intermittent Federal employees who stand ready to deploy as trained medical teams to provide essential medical services in communities across the nation when a disaster or public health emergency occurs. Each deployment not only provides trained medical professionals to support the response efforts, but also sends the necessary medical supplies and equipment to ensure the impacted community has the tools necessary to expedite recovery efforts. To improve the efficiency and effectiveness of the program, the National Disaster Medical System has restructured responder requirements and team configurations so that the deployed teams are better able to meet the needs of the States and localities impacted by a disaster.

The FY 2018 Budget maintains ASPR's management of the Medical Reserve Corps by providing $6 million to support these activities, which is the same as the FY 2017 Continuing Resolution. Complementing the National Disaster Medical System, the Medical Reserve

PROGRAM HIGHLIGHT

Pandemic Influenza: H7N9 Response

Since the winter of 2016, a new strain of the H7N9 avian influenza virus, called the Yangtze River Delta lineage, has been circulating among birds in live poultry markets in China. This new lineage has led to more human cases of H7N9 infection in China than any prior H7N9 epidemic wave, with 623 human infections reported as of May 1, 2017. In addition, a growing number of viruses in this lineage have displayed genetic and antigenic changes that indicate greater pathology and greater resistance to current antiviral treatments. While the current risk to the United States public's health posed by these new H7N9 viruses is low, the Department's ongoing influenza risk assessment process has concluded that the pandemic potential is concerning.

To meet pandemic preparedness goals for the new H7N9 viral lineage, BARDA is collaborating with private industry and partners from the Public Health Emergency Medical Countermeasures Enterprise to develop a new H7N9 vaccine for the National Pre-pandemic Influenza Vaccine Stockpile. Using pandemic influenza appropriations, the Department is able to streamline this process by utilizing technology improvements in the development of vaccine seed strains as well as expanded domestic vaccine manufacturing surge capacity to procure vaccine in the event of a pandemic.

Corps consists of over 200,000 volunteers, organized into almost 1,000 community-based groups, ready to serve within their locality to build community resilience through education and prevention activities, improve local preparedness, response, and recovery capabilities, and provide behavioral health support, when necessary. Additionally, the FY 2018 Budget supports ASPR's Office of Emergency Management which manages the necessary assets to support ASPR's response activities while coordinating the logistics necessary to ensure that each of ASPR's preparedness and response efforts have the right resources in the right place at the right time.

PANDEMIC INFLUENZA

The continued emergence of novel influenza viruses with human pandemic potential demonstrates the critical need for pandemic influenza preparedness activities, including the production of influenza countermeasures. Previous investments in domestic influenza vaccine manufacturing facilities and pre-pandemic influenza vaccine stockpiles have successfully increased the Department's capacity to respond to emerging and evolving influenza viruses that pose a significant threat to public health. The FY 2018 Budget continues to invest in this critical capacity within HHS with a total of $207 million, an increase of $135 million above the FY 2017 Continuing Resolution, to support influenza vaccine manufacturing and stockpiling, international preparedness, and the advanced development of novel influenza vaccines, antivirals, and diagnostics. These efforts are supported by BARDA and the Office of Policy and Planning within ASPR and through the Office of Global Affairs. BARDA is currently supporting the manufacturing and stockpiling of a new vaccine in response to the H7N9 avian influenza virus in China, which has caused 623 human infections during its fifth epidemic wave, the largest epidemic wave of the virus to date.

DEPARTMENT-WIDE INFORMATION SECURITY

Security and Strategic Information

The FY 2018 Budget includes $8 million for the Office of Security and Strategic Information. A realignment of $1 million was made from Cybersecurity to the Office of Security and Strategic Information to support cyber threat activities. The Office of Security and Strategic Information keeps Americans safe by integrating and synthesizing information on public health, terrorism, homeland security, and other health threats for HHS activities. The program increases the Department's security awareness by developing and implementing strategies to reduce national security threats. The Office coordinates information sharing and safeguarding not only across HHS, but also with the Director of National Intelligence, other Federal partners, and agencies within the intelligence community.

Cybersecurity

The FY 2018 Budget includes $72 million for the HHS cybersecurity program, $22 million above the FY 2017 Continuing Resolution. The Department's cybersecurity efforts are critical to protecting HHS's mission. The program works to ensure that HHS is able to address the evolving cyber threats and protect the Department's sensitive information. The cybersecurity program will continue its operations to detect, manage, and remediate cybersecurity risks. The cybersecurity program has a unique Federal role, maintaining the security of information for other HHS entities. The activities of the cybersecurity program safeguard the Department's unique data, ranging from FDA's proprietary information, CMS's financial records, and extensive personal health information across the Department. The additional resources will in part be directed to expand HHS's capability to share cybersecurity threat indicators and information across the Federal and private health care spaces to better protect the security of such data.

ABBREVIATIONS AND ACRONYMS

A

ACF	Administration for Children and Families
ACL	Administration for Community Living
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
AWARE	Advancing Wellness and Resiliency in Education

B

BARDA	Biomedical Advanced Research and Development Authority
BRAIN	Brain Research through Advancing Innovative Neurotechnologies

C

CARB-X	Combating Antibiotic Resistant Bacteria Biopharmaceutical Accelerator
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services

D

DPC	Direct Primary Care

F

FDA	Food and Drug Administration
FTE	Full-Time Equivalent
FY	Fiscal Year

H

HCFAC	Health Care Fraud and Abuse Control
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration

I

IHS	Indian Health Service
IT	Information Technology

L

Lifeline	National Suicide Prevention Lifeline
LIHEAP	Low Income Home Energy Assistance Program

M

MACRA	Medicare Access and CHIP Reauthorization Act

N

NIH	National Institutes of Health
NIRSQ	National Institute for Research on Safety and Quality
NMEP	National *Medicare & You* Education Program

O

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

P

PAYGO	Pay-As-You-Go Act of 2010
PHS	Public Health Service

S

SAMHSA	Substance Abuse and Mental Health Services Administration