DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2014

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2014 performance budget. Our programs will touch the lives of almost 116 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2014. We take our role very seriously, as our oversight responsibilities impact millions of vulnerable citizens and continue to grow dramatically. We now have an opportunity to help millions of additional Americans access affordable, quality health care through new provisions governing private health insurance enacted in the Affordable Care Act. These provisions include important new consumer protections, and, beginning in 2014, will prevent insurers from denying anyone coverage, or charging them more for coverage, based on their health condition. In addition to implementing these reforms, we propose further improvements in our existing programs that directly contribute to significant savings and deficit reduction.

Through better care for individuals, better health for the population, and lower cost through improvements, CMS remains committed to strengthening and modernizing the nation's health care system. This budget request reflects our commitment to the Medicare, Medicaid and CHIP programs, while highlighting progress toward the establishment of new Health Insurance Marketplaces and protection programs. In an unprecedented effort, we will make affordable health insurance available to millions of Americans through the implementation of the Health Insurance Marketplace in 2014.

Our resource needs are principally driven by workloads that grow annually and by our role in leading national efforts to improve efficiency, health care quality and access to care, not just for our traditional beneficiaries, but for all Americans. Our FY 2014 Program Management request reflects an increase over the FY 2012 enacted level but one that is consistent with the magnitude and complexity of the new programs and provisions CMS is tasked with implementing. Wherever possible, CMS will leverage its experience and existing systems and programs to achieve efficiencies and avoid duplication of effort.

This budget also highlights progress on key CMS performance measures that represent our agency's broad purview and our commitment to strengthening and modernizing the nation's health care system.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2014 performance budget.

Marilyn Tavenner

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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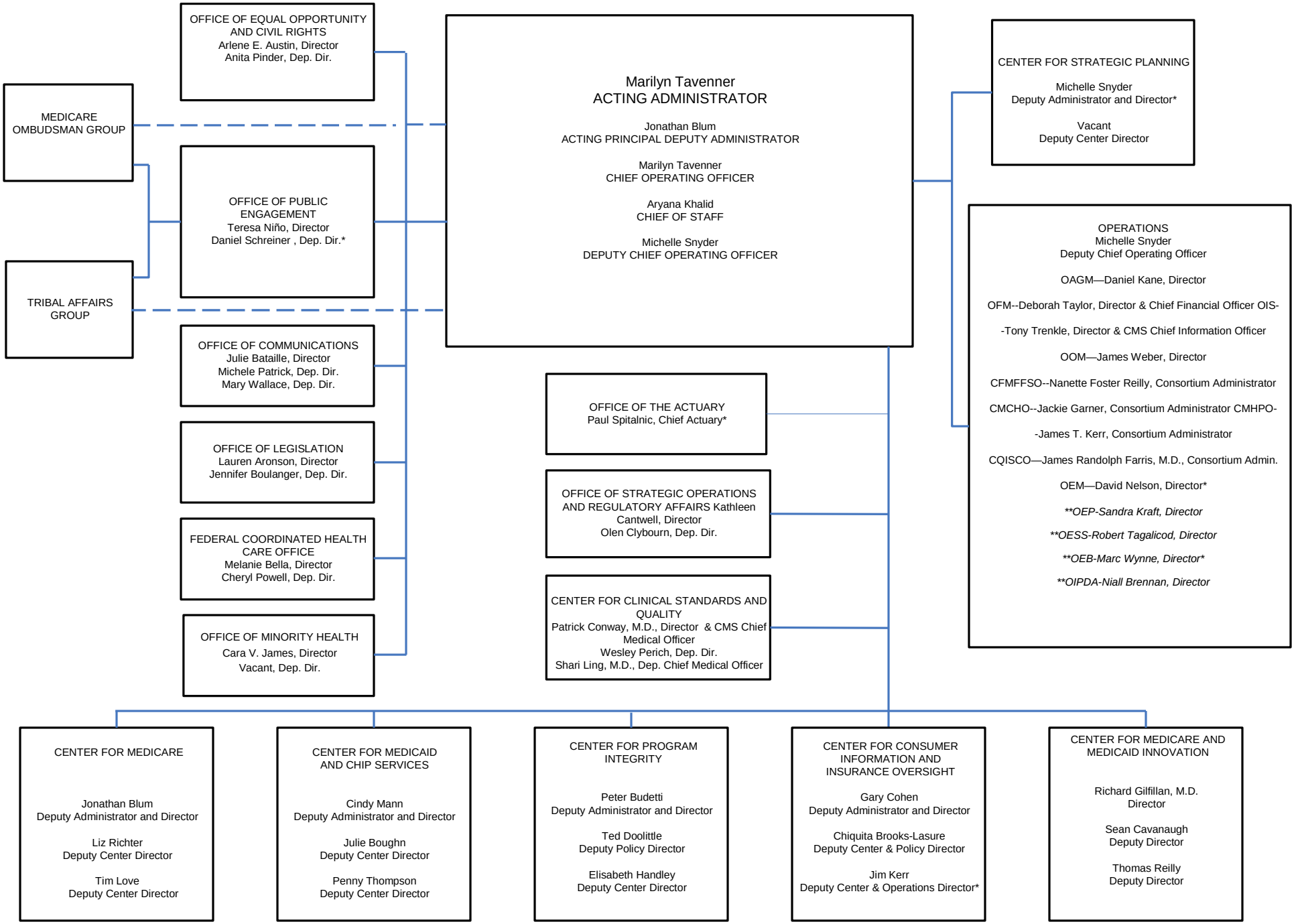
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
As of April 1, 2013
*** Acting**
****Reports to Office of Enterprise Management**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (DHHS). The creation of CMS (previously the Health Care Financing Administration) in 1977 brought together, under unified leadership, the two largest Federal health care programs—Medicare and Medicaid. In 1997, the Children's Health Insurance Program (CHIP) was established to address the health care needs of uninsured children.

Over the past decade, legislation has significantly expanded CMS' responsibilities. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) added a prescription drug benefit. In 2005, the Deficit Reduction Act (DRA) created a Medicaid Integrity Program to address fraud and abuse in the Medicaid program. The Tax Relief and Health Care Act of 2006 (TRHCA) established a physician quality reporting program, quality improvement initiatives and enhanced CMS' program integrity efforts through the expansion of the Recovery Audit Contractor (RAC) program. The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA) continued physician quality reporting and extended the CHIP, Transitional Medical Assistance (TMA), and other programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended and expanded the physician quality reporting program and established an electronic prescribing incentive program. It also established a value-based purchasing for end-stage renal disease services. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) improved outreach, enrollment, and access to benefits within the Medicaid and CHIP programs, and mandated development of child health quality measures and reporting for children enrolled in Medicaid and CHIP. The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act") provided investments for technological advances, including health information technology and the use of electronic health records, along with prevention and wellness activities. In March 2010, the President signed into law the Affordable Care Act (ACA). The legislation contains numerous provisions which impact CMS' traditional role as the overseer of Medicare, Medicaid, and CHIP including: a major expansion of the Medicaid program; a two-year extension of CHIP; the establishment of a new Federal Coordinated Health Care Office in CMS to improve care for beneficiaries who are eligible for both Medicare and Medicaid; the gradual elimination of the Medicare prescription drug coverage gap; payment reform; quality improvement incentives; and the creation of a CMS Innovation Center to explore different care delivery and payment models in Medicare, Medicaid, and CHIP.

In January 2011, CMS became responsible for the implementation of the Affordable Care Act's consumer protections and private health insurance provisions. These provisions contain new coverage options for previously uninsured Americans with pre-existing conditions; reimbursement for employers to help pay part of the cost of providing health benefits for early retirees, their spouses and dependents; new requirements regarding the market conduct of private health care insurers; and new consumer outreach and education efforts to help consumers assess their options and determine their eligibility for public health programs. By 2014, CMS will work with States to create new competitive Health Insurance Marketplaces and provide millions of Americans with access to affordable healthcare coverage.

CMS remains the largest purchaser of health care in the United States. Our programs combined currently pay almost one-third of the Nation's health expenditures. For 46 years, these programs have helped pay the medical bills of millions of older and low-income Americans. In FY 2014, we expect to serve almost 116 million Medicare, Medicaid and CHIP beneficiaries, more than one-in-three Americans. With the implementation of the Affordable Care Act provisions, CMS has the opportunity to provide affordable health care to millions of additional Americans.

CMS outlays more benefits than any other Federal agency and we are committed to administering our programs as efficiently and effectively as possible. In FY 2014, benefit outlays for our traditional programs are expected to total $901.1 billion. Non-benefit costs, which include administrative costs such as Program Management, the Federal share of Medicaid State and local administration, the Health Care Fraud and Abuse Control account (HCFAC), the Quality Improvement Organizations (QIO), and the new insurance market reforms, among others, are estimated at $35.5 billion or 3.9 percent of total benefits. CMS' non-benefit costs are small when compared to Medicare benefits and the Federal share of Medicaid and CHIP benefits. Remarkably, discretionary Program Management costs are less than one percent of these benefits.

Mission

CMS envisions itself as a major force and trustworthy partner for the continual improvement of health and healthcare for all Americans.

Overview of Budget Request

CMS requests funding for its five annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, Payments to the Health Care Trust Funds (PTF) and beginning in FY 2014, Reduced Cost Sharing for Individuals Enrolled in Qualified Health Plans (Cost Sharing Reductions). The table at the end of this section displays our FY 2013 and FY 2014 requests for these accounts.

Within Program Management, funding will enable CMS to implement enhancements and expansions in its traditional health care programs—Medicare, Medicaid, and CHIP—as well as new activities related to the Marketplaces, insurance market reform and oversight, and consumer information. This request will allow CMS to maintain statutory and near-policy survey frequencies in the Nation's health care facilities. CMS' request also includes funding for State High-Risk Pool grants. Major initiatives and activities within each of these accounts are discussed in more detail below.

Key Initiatives

- <u>Federal Marketplaces</u>

  CMS' program level request for the Marketplaces totals $2.0 billion in FY 2014, to support the first year of program operations. This program level consists of a request for $1.5 billion in discretionary Program Management resources, and $450.0 million in anticipated user fee collections. This funding will be used to implement several key activities including eligibility, enrollment and appeals services; outreach and education;

plan oversight; Small Business Health Option Program (SHOP) and employer support; Information Technology (IT) systems; and financial management.

- Shared Services

  CMS requests $83.5 million to develop scalable, reusable solutions for multiple business processes. Through targeted investments in shared Master Data Management, Business Rules, Enterprise Portal and Enterprise Identity Management, CMS will realize larger economies of scale, elimination of redundant capabilities, increased data reliability and improved governance. Our request is needed to improve the delivery and efficiency of health care through the implementation of an agile, flexible environment that provides secure, easy access to authoritative data for health care providers, payers, beneficiaries and consumers.

- Competitive Bidding

  CMS' FY 2014 request includes $73.9 million to continue Durable Medical Equipment (DME) Competitive Bidding in 100 metropolitan statistical areas. In addition to maintaining current operations, this request will fund Round 2 and national mail order re-competes and systems development, as required by law.

  The Competitive Bidding program will produce significant savings to the Medicare program. Net savings are projected to total $1.1 billion in 2014, and $25.8 billion over the ten-year period, beginning in 2014.

- Proposed Law

  CMS' request includes $400.0 million in proposed law funding to implement the Agency's mandatory legislative proposals. CMS will utilize this funding to implement systems changes and process improvements needed to generate additional savings, improve efficiencies and enhance program integrity in a timely manner.

  CMS' request also includes a proposal to extend the funding for MIPPA section 183, Consensus-Based Entity, at $10 million per year from FY 2014 through FY 2017 in order to focus on performance measurement. In addition, CMS proposes to extend the funding for ACA section 3014, Quality Measurement, at $20 million per year from FY 2015 through FY 2017. These extensions will allow CMS to continue support for a consensus-based entity who will develop multi-stakeholder groups and facilitate the stakeholder groups' input on the endorsement and use of endorsed and non-endorsed quality measures for reporting performance information.

  CMS' FY 2014 request includes two proposals for new user fees: a Survey and Certification Revisit Fee and a fee for the expanded sharing of Medicare data with qualified entities. The Revisit Fee will provide CMS a greater ability to revisit poor performers while creating an incentive for facilities to ensure continuing quality of care. This fee will be phased in over a number of years to avoid disruption to ongoing facility activities. Fees for expanded data sharing will allow CMS to broaden qualified entities' use of Medicare data for activities such as fraud prevention, care coordination practice improvement and other value-added analyses.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2012 Enacted	FY 2014 Request	FY 2014 +/- FY 2012
Program Management	$3,820.1	$5,217.4	+$1,397.2
HCFAC – Discretionary	$309.8	$311.0	+$1.2
Grants to States for Medicaid	$270,724.4	$284,208.6	+$13,484.2
Payments to Health Care Trust Funds	$230,741.4	$255,185.0	+$24,443.6
Cost Sharing Reductions	$0.0	$3,977.9	+$3,977.9
Grand Total [1/]	**$505,595.7**	**$548,899.9**	**+$43,304.2**

[1/] Totals may not add, due to rounding.

FY 2014

Program Management

CMS requests $5,217.4 million in Program Management funds, an increase of $1,397.2 million over the comparable FY 2012 enacted level. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and CHIP and to implement health insurance reforms, such as the Marketplace. Effective implementation of the Affordable Care Act (ACA) is a top Administration priority. CMS' requested investment in FY 2014 for ACA implementation is critical to expanding health care coverage to millions of Americans and in controlling the growth in health care costs.

- Program Operations:

  CMS' budget request for Program Operations totals $4,011.2 million in FY 2014, a $1,403.2 million increase over the comparable FY 2012 enacted level. This request includes $1,457.4 million for the Marketplace. This funding is needed to ensure first-year Marketplace operations as planned for FY 2014.

  The majority of the Program Operations account funds CMS' traditional Medicare operations. This funding level will allow CMS to process over 1.2 billion fee-for-service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), continue work on the new International Classification of Diseases (ICD-10) coding system, maintain our 1-800 call centers, oversee Part C and D plans, and to provide outreach and education

to millions of beneficiaries and consumers. Further, the FY 2014 request includes funding for Medicaid and CHIP operations, and for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

Program Operations also includes funds for many provisions enacted in the Affordable Care Act. These provisions enhance all three existing health care programs—Medicare, Medicaid, and CHIP—and includes funding for the operation of the new consumer information and private market insurance reform and oversight programs.

- Federal Administration:

  CMS requests $771.8 million in FY 2014, about the same funding level as the comparably-adjusted FY 2012 enacted level. The FY 2014 request includes $634.0 million to support 4,635 direct FTEs, an increase of 280 FTEs over actual FY 2012 FTE consumption levels. Our payroll estimate assumes a 1.0 percent civilian and military cost of living allowance (COLA) in 2014.

  This request also supports administrative information technology, communication, utilities, rent and space requirements, as well as administrative contracts and inter-agency agreements.

- Survey and Certification:

  CMS requests $412.4 million in FY 2014, a $37.2 million increase over the FY 2012 enacted level. Of this amount, $368.1 million will support direct survey costs, $11.3 million will support additional costs related to direct surveys, and $32.9 million will be used for surveyor training, Federally-directed surveys and information technology. In FY 2014, CMS will begin surveys of Community Mental Health Centers for the first time. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and allows for near-policy level survey frequencies at other types of facilities.

  Approximately 92 percent of the requested funding will go to State survey agencies for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, organ transplant facilities and End-Stage Renal Disease (ESRD) facilities. This request supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics and ambulatory surgery centers. The budget also supports contracts to strengthen quality improvement and national program consistency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

- State High-Risk Pool Grants:

  CMS requests $22.0 million for High-Risk Pools in FY 2014, a $22.0 million decrease from the FY 2012 enacted level. High-Risk Pool grants to States help individuals with pre-existing conditions access affordable health care coverage. Our FY 2014 request provides resources to States to fund operational losses incurred in FY 2013 and to fund remaining bonus grants in FY 2014.

Health Care Fraud and Abuse Control

CMS requests $640.0 million in additional HCFAC funding in FY 2014, $311.0 million in ongoing discretionary funding and $329.0 million in proposed mandatory funding. The additional funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, and CHIP. This includes ongoing investments in state-of-the-art analytic technology to detect and prevent improper payments; measures to reduce the improper payment error rate, including focused pre-payment review, aggressive representation at cases before administrative law judges, and staffing to implement corrective actions; support for Medicare Strike Forces, used to identify and prosecute fraudulent providers; increased provider and supplier site visits; fraud hot lines and increased beneficiary outreach.

Grants to States for Medicaid

The FY 2014 Medicaid request totals $284.2 billion, an increase of $13.5 billion above the FY 2012 level. The majority of this increase is attributed to the ACA Medicaid expansion in FY 2014. This appropriation consists of $177.9 billion for FY 2014 and $106.3 billion in an anticipated advance appropriation from FY 2013. These funds, together with a $22.0 billion projected unobligated end-of-year balance from FY 2013 and a $0.3 billon anticipated offsetting collection for Medicare Part B premiums, will finance $306.5 billion in estimated obligations in FY 2014. These obligations consist of:

- $283.3 billion in Medicaid medical assistance benefits;
- $2.4 billion for benefit obligations incurred but not yet reported;
- $16.5 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.3 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2014 request for Payments to the Health Care Trust Funds account totals $255.2 billion, an increase of $24.4 billion above the FY 2012 level. Our FY 2014 request is driven by increases for the Federal share of Medicare Part B payments and increases for the prescription drug benefit. The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the Trust Funds for amounts, initially borne by the trust funds, to which they are entitled under law. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds, including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, benefits for uninsured annuitants, and administrative costs, including program integrity activities that are properly chargeable to the General Fund.

Reduced Cost Sharing for Individuals Enrolled in Qualified Health Plans

The FY 2014 request for Reduced Cost Sharing for Individuals Enrolled in Qualified Health Plans is $4.0 billion in the first year of operations for Health Insurance Marketplaces, also known as Exchanges. CMS also requests a $1.4 billion advance appropriation for the first quarter of FY 2015 in this budget to permit CMS to reimburse issuers who provided reduced cost-sharing in excess of the monthly advanced payments received in FY 2014 through the cost-sharing reduction reconciliation process.

Conclusion

CMS' FY 2014 request for its five annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, Payments to the Health Care Trust Funds, and Cost-Sharing Reductions—is $548.9 billion in FY 2014, an increase of $43.3 billion above the FY 2012 level. This request includes funding for a new appropriation for reduced cost-sharing provided to individuals enrolled in plans through the Marketplaces, beginning in 2014.

CMS' FY 2014 President's Budget request totals $5.2 billion for Program Management, a $1.4 billion increase over the comparably-adjusted FY 2012 enacted level. This funding will allow CMS to operate the Marketplace as planned in FY 2014, continue its traditional activities in the Medicare, Medicaid, and CHIP programs and implement many other provisions enacted in FY 2010 as part of the Affordable Care Act.

This budget request invests $640.0 million in additional HCFAC funding in FY 2014, $311.0 million in ongoing discretionary funding and $329.0 million in proposed mandatory funding, an increase of $330.2 million over the FY 2012 enacted level. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

CMS remains committed to finding efficiencies within base workloads, to safeguarding its programs, and to providing beneficiaries, stakeholders, and health care consumers with the highest possible levels of service.

OVERVIEW OF CMS PERFORMANCE

The CMS FY 2014 performance plan includes a proposal of 40 goals (66 performance measures). We continue to track many of the measures included in the FY 2013 plan, with new FY 2014 targets consistent with the President's goals and priorities. Some performance measures were retired due to consistent annual success or to focus on new CMS responsibilities, challenges and strategic priorities. Our plan is structured to reflect our mission: *The Centers for Medicare & Medicaid Services is a major force and trustworthy partner in the continual improvement of health and health care for all Americans.* Our measures are also linked to the Department of Health and Human Services' (HHS) Strategic goals to Strengthen Health Care and Increase Efficiency, Transparency, and Accountability of its programs. Many of our performance goals will be featured in the consolidated HHS FY 2014 Online Performance Appendix.

Consistent with the Government Performance and Results Act of 1993 (GPRA), CMS has focused on identifying a set of meaningful, outcome-oriented performance measures that highlight fundamental program purposes and focus on the Agency's role as a steward of taxpayer dollars. The FY 2014 targets, along with most recent reporting on key measures, are outlined in the Outcomes and Outputs Table at the end of each related program discussion. Our plan is being revised to reflect the requirements of the GPRA Modernization Act of 2010, which amplify some aspects of the original 1993 law.

To comply with the GPRA Modernization Act of 2010, CMS is developing a rigorous, integrated, data-driven performance management process, which includes regular progress reviews of its priorities by CMS leadership. The GPRA performance measures represent CMS' vast purview and were developed with input from senior agency leaders, the HHS Strategic Plan, and from other administrative priorities and legislative mandates. CMS uses performance data to inform decisions made by program managers and senior leadership in managing its programs and resources. The Chief Performance Officer is positioned in the office of CMS' Chief Operating Officer to better coordinate and monitor performance management across the agency. CMS is improving its internal performance management process to ensure that performance information is used to drive key program decisions and to inform strategic and policy direction.

HHS has identified a limited number of FY 2012 – FY 2013 agency priority goals that are an Administration focus. CMS is leading a collaborative effort with its HHS partners in the Office of the Assistant Secretary for Health, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality, "To improve patient safety: By September 30, 2013, reduce the national rate of healthcare-associated infections by demonstrating significant, quantitative and measurable reductions in hospital-acquired central line-associated bloodstream infections and catheter-associated urinary tract infections." CMS is also a partner on the HHS Health Information Technology Priority Goal to increase the number of eligible providers receiving CMS Medicare and Medicaid incentive payments for the successful adoption or meaningful use of certified Electronic Health Record (EHR) technology, and is a contributor to the tobacco cessation priority goal led by the Office of the Assistant Secretary for Health.

CMS is undertaking a major initiative to implement the Affordable Care Act. With this responsibility comes the opportunity to collect data and develop goals that measure our progress toward meeting the challenges offered by health care reform. We currently have measures to track the progress made toward developing Health Insurance Marketplaces, also

known as Exchanges, expanding Medicaid coverage, and increasing the number of young adults covered under their parents' employer-sponsored health insurance plan. For FY 2014, we have introduced new measures to "Reduce the Growth of Health Care Costs While Promoting Better Health and Health Care Quality Through Delivery System Reform" and "To Protect Individual and Small Businesses from Potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review Program". In FY 2014 and later years, CMS intends to collect information on consumer choice of health insurance plans and eligibility for advance premium tax credits and cost-sharing reductions in the Federal Marketplace. In addition, in FY 2014 CMS will track enrollment in private health insurance – including Marketplace enrollment - and Medicaid to inform the Department's overall tracking of the percent of the population that remains uninsured

Performance measurement results provide valuable information about the success of CMS' programs and activities. CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of our performance measures also provides a method of clear communication of CMS programmatic objectives to our partners, such as States and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges represented by our performance goals and are optimistic about our ability to meet them.

Discretionary All-Purpose Table (Comparable)
The Centers for Medicare & Medicaid Services
Dollars in Thousands

Program	FY 2012 Enacted 1/	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Program Operations	$2,658,900	$2,675,173	$4,011,200	$1,352,300
Federal Administration	$772,963	$777,694	$771,800	($1,163)
State Survey & Certification	$375,203	$377,500	$412,353	$37,150
Research 2/	$21,160	$21,289	$0	($21,160)
High-Risk Pool Grants 3/	$0	$44,269	$22,004	$22,004
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$3,828,227**	**$3,895,925**	**$5,217,357**	**$1,389,130**
High-Risk Pool Grants 3/	$44,000	$0	$0	($44,000)
Subtotal, Appropriation/BA Current Law (Mandatory; 0511)	**$44,000**	**$0**	**$0**	**($44,000)**
Comparability Adjustment (SHIP Transfer to ACL) 4/	($52,115)	($52,434)	$0	$52,115
Subtotal, Appropriation/BA Current Law (Disc. + Mand.; 0511)	**$3,820,112**	**$3,843,491**	**$5,217,357**	**$1,397,245**
MIPPA (Mandatory; P.L. 110-275)	$38,000	$3,000	$3,000	($35,000)
Affordable Care Act (ACA; Mandatory; P.L. 111-148/111-152)	$75,000	$75,000	$75,000	$0
ATRA (Mandatory; P.L. 112-240)	$0	$17,500	$0	$0
Total, Appropriation/BA Current Law (0511)	**$3,933,112**	**$3,938,991**	**$5,295,357**	**$1,362,245**
Proposed Law Appropriation (Mandatory) 5/	$0	$0	$410,000	$410,000
Total, Appropriation/BA Proposed Law (0511)	**$3,933,112**	**$3,938,991**	**$5,705,357**	**$1,772,245**
Est. Offsetting Collections from Non-Federal Sources:				
User Fees, C.L.	$240,200	$190,254	$641,075	$400,875
Recovery Audit Contracts, C.L.	$310,000	$310,000	$310,000	$0
Subtotal, New BA, Current Law	**$4,483,312**	**$4,439,245**	**$6,246,432**	**$1,763,120**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2011) 6/	$265,368	$167,159	$0	($265,368)
Program Level, Current Law (0511)	**$4,748,680**	**$4,606,404**	**$6,246,432**	**$1,497,752**
Proposed Law User Fees 7/	$0	$0	$0	$0
Program Level, Proposed Law (0511)	**$4,748,680**	**$4,606,404**	**$6,656,432**	**$1,907,752**
Affordable Care Act (ACA; P.L. 111-148/111-152):				
Section 2701 Adult Health Quality Measures	$60,000	$60,000	$60,000	$0
Section 10323 Medicare Coverage/Environmental Health Hazards	$302	$1,000	$1,000	$698
Total, ACA Appropriation/BA C.L. (Mandatory; 0509) 8/	**$60,302**	**$61,000**	**$61,000**	**$698**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):				
Section 4103 Medicare Incentives	$100,000	$100,000	$100,000	$0
Section 4201 Medicaid Incentives	$40,000	$40,000	$40,000	$0
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 8/	**$140,000**	**$140,000**	**$140,000**	**$0**
Total, Program Management Appropriation/BA, P.L. (All Sources)	**$4,133,414**	**$4,139,991**	**$5,906,357**	**$1,772,943**
Total Prog. Mgt. Program Level, Proposed Law (All Sources)	**$4,948,982**	**$4,807,404**	**$6,857,432**	**$1,908,450**
HCFAC Discretionary	**$309,790**	**$311,686**	**$311,000**	**$1,210**
Non-CMS Administration 9/	**$2,174,000**	**$2,199,000**	**$2,107,000**	**($67,000)**
CMS FTEs:				
Direct (Federal Administration)	4,355	4,746	4,635	280
Reimbursable (CLIA, CoB, RAC)	103	124	124	21
Subtotal, Program Management FTEs	**4,458**	**4,870**	**4,759**	**301**
Affordable Care Act (Mandatory)	23	38	43	20
ARRA Implementation (Mandatory)	133	152	161	28
Total, Program Management FTEs, Current Law	**4,614**	**5,060**	**4,963**	**349**
Program Management, Proposed Law	0	0	0	0
Total, Program Management FTEs	**4,614**	**5,060**	**4,963**	**349**
Affordable Care Act (Mandatory)	248	445	481	233
HCFAC Mandatory	188	214	214	26
HCFAC Discretionary	133	172	172	39
Medicaid Integrity (State Grants; Mandatory)	79	95	100	21
QIO	138	174	182	44
Total, CMS FTEs 10/	**5,400**	**6,160**	**6,112**	**712**

1/ The FY 2012 column is shown as enacted, net of rescissions, transfers and reprogrammings.
2/ In FY 2014, CMS proposes to fund activities previously funded through the Research line through the Program Operations line.
3/ In FY 2012, the High-Risk Pool grants are considered a CHIMP and rebased as mandatory once an appropriations bill is enacted.
4/ Reflects the comparable transfer of the SHIP program to the Administration for Community Living (ACL) in FY 2014.
5/ CMS' FY 2014 request includes $400.0 million in administrative funding to implement the health care proposals in the President's budget, along with $10.0 million to extend funding for MIPPA section 183, Consensus-Based Entity.
6/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.
7/ CMS' FY 2014 request includes proposals for two new user fees: a Survey and Certification Revisit Fee, and a Qualified Entity Data Fee. In FY 2014, CMS assumes that if collections occur, the amounts collected would be negligible.
8/ Includes ACA and ARRA mandatory funds included within the CMS Program Management account. Excludes transfers of discretionary budget authority (BA). BA amounts are scored in the first year of availability.
9/ Includes funds for the SSA, DHHS/OS, and the Medicare Payment Advisory Commission (MedPAC).
10/ The FY 2012 column reflects actual FTE consumption and does not include 16 FTE funded by the ACA Implementation Fund.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Current Law Appropriations Language
Centers for Medicare & Medicaid Services
Program Management

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed $5,217,357,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That the Secretary is directed to collect fees in fiscal year 2014 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare & Medicaid Services, not to exceed $5,217,357,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act;	Provides an appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
	Eliminates the separate language provision specifying a two-year period of availability for Healthcare Integrated General Ledger Accounting System development activities.

Program Management

Language Analysis

Language Provision	Explanation
Provided further, That the Secretary is directed to collect fees in fiscal year 2014 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act:	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.
	Eliminates a specific language provision earmarking funds for the State High-Risk Pool program in FY 2014. Funding for the State High-Risk Pool program is included in the reference to Title XXVII of the Public Health Service Act, above.

CMS Program Management
Amounts Available for Obligation

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Request
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,835,476,000	$3,895,925,000	$5,217,357,000
Across-the-board reductions (L/HHS)	-$7,249,000	$0	$0
Subtotal, Appropriation (L/HHS)	$3,828,227,000	$3,895,925,000	$5,217,357,000
Comparable transfer to (ACL):	-$52,115,000	-$52,434,000	$0
Subtotal, adjusted trust fund discr. appropriation	$3,776,112,000	$3,843,491,000	$5,217,357,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$44,000,000	$0	$0
Subtotal, Appropriation (L/HHS)	$44,000,000	$0	$0
MIPPA (PL 110-275)	$35,000,000	$0	$0
ACA (PL 111-148/152)	$25,302,000	$26,000,000	$26,000,000
ATRA (PL 112-240)	$0	$17,500,000	$0
Subtotal, trust fund mand. appropriation	$104,302,000	$43,500,000	$26,000,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund mand. appropriation	$104,302,000	$43,500,000	$26,000,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$110,000,000	$110,000,000	$110,000,000
Subtotal, trust fund mand. appropriation	$113,000,000	$113,000,000	$113,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$51,474,000	$50,000,000	$50,000,000
Coordination of benefits user fees	$51,090,000	$35,000,000	$35,000,000
MA/PDP user fees	$65,800,000	$70,400,000	$71,100,000
Revisit user fees	$3,000	$0	$0
Sale of data user fees	$9,028,000	$7,119,000	$7,240,000
Provider enrollment user fees	$29,729,000	$27,735,000	$27,735,000
Marketplace user fees	$0	$0	$450,000,000
Recovery audit contracts	$287,197,000	$310,000,000	$310,000,000
Subtotal, offsetting collections 1/	$494,321,000	$500,254,000	$951,075,000
Unobligated balance, start of year	$1,180,941,000	$1,129,515,000	$383,254,000
Unobligated balance, end of year	-$1,129,515,000	-$383,254,000	-$311,771,000
Prior year recoveries	$18,927,000	$0	$0
Unobligated balance, lapsing	-$73,211,000	$0	$0
Total obligations 1/, 2/	**$4,484,877,000**	**$5,246,506,000**	**$6,378,915,000**
American Recovery and Reinvestment Act (ARRA):			
Trust Fund Mandatory Appropriation:			
ARRA (PL 111-5)	$0	$0	$0
Mandatory Appropriation:			
ARRA (PL 111-5)	$140,000,000	$140,000,000	$140,000,000
Unobligated balance, start of year	$167,874,000	$167,136,000	$141,016,000
Unobligated balance, end of year	-$167,136,000	-$141,016,000	-$140,868,000
Prior year recoveries	$1,038,000	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$141,776,000**	**$166,120,000**	**$140,148,000**

1/ Current law display. Excludes the following amounts for reimbursable activities carried out by this account: FY 2012: $34,850,000. Reflects actual budget authority in FY 2012, comparably adjusted, as opposed to enacted values.

2/ Excludes funding provided by the American Recovery and Reinvestment Act (ARRA; PL 111-5).

CMS Program Management
Summary of Changes

2012	
Total estimated budget authority 1/	$3,820,112,000
(Obligations) 1/	($3,814,770,000)
2014	
Total estimated budget authority 1/	$5,217,357,000
(Obligations) 1/	($5,217,357,000)
Net Change	**$1,397,245,000**

	2012 Estimate FTE	2012 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Pay Raise				$5,037,000
2. Annualization of Pay Raise				$769,000
3. Additional Day of Pay				$2,211,000
Subtotal, Built-in Increases 1/				**$8,017,000**
B. Program:				
1. Program Operations		$2,607,984,000		$1,639,863,000
2. Federal Administration	4,355	$771,764,000	280	$52,649,000
3. State Survey & Certification		$375,203,000		$38,746,000
Subtotal, Program Increases 1/				**$1,731,258,000**
Total Increases 1/				**$1,739,275,000**
Decreases:				
A. Built-in:				
1. Rent and Mortgage				($543,000)
Subtotal, Built-in Decreases 1/				**($543,000)**
B. Program:				
1. Program Operations		$2,607,984,000		($236,647,000)
2. Federal Administration		$771,764,000		($60,088,000)
3. State Survey & Certification		$375,203,000		($1,596,000)
4. Research 2/		$21,160,000		($21,160,000)
5. State High-Risk Pools		$44,000,000		($21,996,000)
Subtotal, Program Decreases 1/				**($341,487,000)**
Total Decreases 1/				**($342,030,000)**
Net Change 1/				**$1,397,245,000**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and obligations from mandatory funds, except State High-Risk Pools, user fees and reimbursable agreements. The FY 2012 base has been adjusted by -$52.1 million for comparability purposes.

2/ In FY 2014, ongoing research activities will be funded from the Program Operations line.

American Recovery and Reinvestment Act (ARRA):

2012	
Total estimated budget authority	$140,000,000
(Obligations)	($141,776,000)
2014	
Total estimated budget authority	$140,000,000
(Obligations)	($140,148,000)
Net Change	**$0**

	2012 Estimate FTE	2012 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Pay Raise				$235,000
2. Additional Day of Pay				$67,000
B. Program:				
1. Medicare and Medicaid HIT	133	$140,000,000	28	$3,993,000
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT		$140,000,000		($4,295,000)
Net Change				**$0**

CMS Program Management

Budget Authority by Activity

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Request
1. Program Operations	$2,663,935	$2,675,173	$4,011,200
MIPPA (PL 110-275)	$38,000	$3,000	$3,000
ACA (PL 111-148/152)	$20,000	$20,000	$20,000
ATRA (PL 112-240)	$0	$17,500	$0
Comparability Adjustment	-$50,916	-$51,203	$0
Enacted Rescission	-$5,035	$0	$0
Subtotal, Program Operations	**$2,665,984**	**$2,664,470**	**$4,034,200**
(Obligations)	($2,806,243)	($2,723,015)	($4,034,200)
2. Federal Administration	$794,465	$777,694	$771,800
ACA (PL 111-148/152)	$60,000	$60,000	$60,000
Reprogramming	-$20,000	$0	$0
Comparability Adjustment	-$1,199	-$1,231	$0
Enacted Rescission	-$1,501	$0	$0
Subtotal, Federal Administration	**$831,765**	**$836,463**	**$831,800**
(Obligations)	($778,900)	($940,612)	($865,983)
3. State Survey & Certification	$355,876	$377,500	$412,353
ACA (PL 111-148/152)	$0	$0	$0
Reprogramming	$20,000	$0	$0
Enacted Rescission	-$673	$0	$0
Subtotal, State Survey & Certification	**$375,203**	**$377,500**	**$412,353**
(Obligations)	($386,448)	($415,040)	($449,893)
4. Research, Demonstration & Evaluation	$21,200	$21,289	$0
ACA (PL 111-148/152)	$55,302	$56,000	$56,000
Enacted Rescission	-$40	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$76,462**	**$77,289**	**$56,000**
(Obligations)	($33,157)	($623,316)	($55,760)
5. High-Risk Pool Grants	$44,000	$44,269	$22,004
Enacted Rescission	$0	$0	$0
Subtotal, High-Risk Pool Grants	**$44,000**	**$44,269**	**$22,004**
(Obligations)	($44,000)	($44,269)	($22,004)
6. User Fees 1/	**$207,124**	**$190,254**	**$641,075**
(Obligations)	($208,036)	($190,254)	($641,075)
7. Recovery Audit Contracts 1/	**$287,197**	**$310,000**	**$310,000**
(Obligations)	($228,093)	($310,000)	($310,000)
Total, Budget Authority 1/, 2/, 3/	**$4,487,735**	**$4,500,245**	**$6,307,432**
(Obligations) 2/, 3/	**($4,484,877)**	**($5,246,506)**	**($6,378,915)**
FTE 3/	**4,481**	**4,908**	**4,802**

1/ Reflects actual budget authority (BA) and staffing in FY 2012, comparably adjusted, as opposed to enacted values.

2/ FY 2012 excludes $34,850,000 for other reimbursable activities carried out by the Program Management account.

3/ Reflects CMS' current law request.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$140,000**	**$140,000**	**$140,000**
(Obligations)	**($141,776)**	**($166,120)**	**($140,148)**
FTE	**133**	**152**	**161**

CMS Program Management
Authorizing Legislation

	FY 2013 Amount Authorized	FY 2013 Enacted	FY 2014 Amount Authorized	FY 2014 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite		
- Section 1115 1/	$2,000,000	$2,000,000		
b) P.L. 92-603, Section 222	Indefinite	Indefinite		
c) P.L. 90-248, Section 402	Indefinite	Indefinite		
d) Social Security Act, Title XVIII	Indefinite	Indefinite		
2. Program Operations:				
Social Security Act, Titles XI, XVIII, XIX and XXI	Indefinite	Indefinite	Indefinite	Indefinite
a) Social Security Act, Title XI				
- Section 1110			Indefinite	Indefinite
- Section 1115 1/			$2,000,000	$2,000,000
b) P.L. 92-603, Section 222			Indefinite	Indefinite
c) P.L. 90-248, Section 402			Indefinite	Indefinite
d) Social Security Act, Title XVIII			Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. High-Risk Pool Grants:				
Trade Act of 2002; High-Risk Pool Funding Extension Act of 2006	Indefinite	Indefinite	Indefinite	Indefinite
6. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
7. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003	2/	2/	2/	2/
8. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
9. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
10. Marketplace:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
11. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0
American Recovery and Reinvestment Act (ARRA):				
1. ARRA Implementation:				
American Recovery and Reinvestment Act of 2009 (PL 111-5)	$140,000,000	$140,000,000	$140,000,000	$140,000,000

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2014.
2/ Limits authorized user fees to an amount computed by formula.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2005				
Trust Fund Appropriation:				
Base	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,696,402,000
Rescissions (P.L. 108-447)	$0	$0	$0	($23,555,000)
Subtotal	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,672,847,000
2006				
General Fund Appropriation:				
DRA (PL 109-171)		$0	$0	$0 $38,000,000
Trust Fund Appropriation:				
Base	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,170,927,000
Rescissions (P.L. 109-148/149)	$0	$0	$0	($91,109,000) Transfers
(P.L. 109-149)		$0	$0	$0 $40,000,000
DRA (PL 109-171)		$0	$0	$0 $36,000,000
Subtotal	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,155,818,000
2007				
Trust Fund Appropriation:				
Base	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,141,108,000
TRHCA (PL 109-432)	$0	$0	$0	$105,000,000
Subtotal	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,246,108,000
2008				
General Fund Appropriation:				
MMSEA (PL 110-173)		$0	$0	$0 $60,000,000
Supplemental (PL 110-252)		$0	$0	$0 $5,000,000
Trust Fund Appropriation:				
Base	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,207,690,000
Rescissions (P.L. 110-161)	$0	$0	$0	($56,038,000) MMSEA
(PL 110-173)		$0	$0	$0 $55,000,000
MIPPA (PL 110-275)		$0	$0	$0 $20,000,000
Subtotal	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,226,652,000
2009				
General Fund Appropriation:				
CHIPRA (PL 111-3)		$0	$0	$0 $5,000,000
Trust Fund Appropriation:				
Base	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,305,386,000
MIPPA (PL 110-275)		$0	$0	$0 $182,500,000
Subtotal	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,487,886,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)		$0	$0	$0 $140,000,000
Trust Fund Appropriation (ARRA):				
ARRA (PL 111-5)		$0	$0	$0 $2,000,000
2010				
General Fund Appropriation:				
ACA (PL 111-148/152)		$0	$0	$0 $251,600,000
Trust Fund Appropriation:				
Base **1/**	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,470,242,000
MIPPA (PL 110-275)		$0	$0	$0 $35,000,000
ACA (PL 111-148/152)		$0	$0	$0 $95,300,000
Subtotal	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,600,542,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)		$0	$0	$0 $140,000,000
2011				
General Fund Appropriation:				
MIPPA (PL 110-275)		$0	$0	$0 $3,000,000
ACA (PL 111-148/152)		$0	$0	$0 $60,000,000
MMEA (PL 111-309)		$0	$0	$0 $200,000,000
Trust Fund Appropriation:				
Base **1/**	$3,646,147,000	$3,470,242,000	$3,470,242,000	$3,470,242,000
Rescissions (P.L. 112-10)	$0	$0	$0	($6,940,000) MIPPA (PL
110-275)		$0	$0	$0 $35,000,000
ACA (PL 111-148/152)		$0	$0	$0 $527,750,000
Subtotal	$3,646,147,000	$3,470,242,000	$3,470,242,000	$4,026,052,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)		$0	$0	$0 $140,000,000
2012				
General Fund Appropriation:				
MIPPA (PL 110-275)		$0	$0	$0 $3,000,000
ACA (PL 111-148/152)		$0	$0	$0 $110,000,000
Trust Fund Appropriation:				
Base **1/**	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,879,476,000
Rescissions (P.L. 112-74)	$0	$0	$0	($7,249,000) MIPPA (PL
110-275)		$0	$0	$0 $35,000,000
ACA (PL 111-148/152)		$0	$0	$0 $25,302,000
Subtotal	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,932,529,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)		$0	$0	$0 $140,000,000
2013				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Trust Fund Appropriation:				
Base **2/**	$4,820,808,000	$0	$4,370,112,000	$3,895,925,000
ATRA (PL 112-240)	$0	$0	$0	$17,500,000
ACA (PL 111-148/152)	$0	$0	$0	$26,000,000
Subtotal	$4,820,808,000	$0	$4,370,112,000	$3,939,425,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2014 3/				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000

1/ High-Risk Pools are considered a CHIMP and rebased as mandatory once an appropriations bill is enacted.
2/ The FY 2013 Appropriation column reflects the FY 2013 annualized CR level.
3/ Reflects the FY 2014 current law request.

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	Appropriations in FY 2014

CMS Program Management has no appropriations not authorized by law.

Program Management
Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' traditional programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), as well as the insurance Marketplace, new private health insurance provisions and consumer protections enacted by the Affordable Care Act. The FY 2014 request includes funding for CMS' four Program Management line items: Program Operations, Federal Administration, Medicare State Survey and Certification, and State High Risk Pools.

The table below and the subsequent narrative on the following language provide additional summary-level information on each of the line items in the FY 2014 request.

Program Management Summary Table
($ in millions)

Line Item	FY 2012 Enacted	FY 2014 Request	FY 2014 +/- FY 2012
Program Operations	$2,608.0	$4,011.2	$1,403.2
Federal Administration	$771.8	$771.8	$0.0
Survey & Certification	$375.2	$412.4	$37.2
Research	$21.2	$0.0	-$21.2
State High Risk Pools	$44.0	$22.0	-$22.0
Program Management 1/	**$3,820.1**	**$5,217.4**	**$1,397.2**
FTEs – Federal Administration	4,355	4,635	280

1/ Numbers may not add, due to rounding. Numbers are comparably adjusted to include $44 million for High-Risk Pools and to remove $52 million for the SHIP transfer to ACL in the FY 2014 budget.

FY 2014 Request

Program Management: CMS' FY 2014 Program Management request totals $5,217.4 million, a $1,397.2 million increase over the comparable FY 2012 enacted level.

- Program Operations:

  CMS' budget request for Program Operations totals $4,011.2 million in FY 2014, a $1,403.2 million increase over the comparable FY 2012 enacted level. This request includes $1,457.4 million for the Marketplace, excluding user fees. This request will allow CMS to continue to effectively administer Medicare, Medicaid, CHIP, and to implement health insurance reforms such as the Marketplace.

  The majority of the Program Operations line funds CMS' traditional Medicare operations. This funding level will allow CMS to process over 1.2 billion fee-for-

service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), continue work on the new ICD-10 coding system, maintain our 1-800 call centers, oversee Part C and D plans, and to provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2014 request includes funding for Medicaid and CHIP operations and ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

Program Operations also includes funds for many provisions enacted in the Affordable Care Act. These provisions enhance all three traditional health care programs—Medicare, Medicaid, and CHIP—as well as funding for the operation of the consumer information and private insurance market programs.

- Federal Administration:

  CMS requests $771.8 million in FY 2014, about the same as the FY 2012 enacted level. The FY 2014 request includes $634.0 million to support 4,635 direct FTEs, an increase of 280 FTEs over the FY 2012 consumption level. Our FY 2014 request also funds other objects of expense for ongoing activities and ACA implementation efforts. CMS' FY 2014 request includes $70.0 million to support the Marketplace.

- Survey and Certification:

  CMS requests $412.4 million in FY 2014, a $37.2 million increase over the FY 2012 enacted level. Of this amount, $368.1 million will support direct survey costs, $11.3 million will support additional costs related to direct surveys, and $32.9 million will be used for surveyor training, Federally-directed surveys and information technology. In FY 2014, CMS will begin surveys of Community Mental Health Centers. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and allows for near-policy level survey frequencies at other types of facilities.

- State High Risk Pools:

  CMS' FY 2014 request for State High Risk Pools totals $22.0 million, a $22.0 million reduction from the FY 2012 enacted level. This activity provides grants to States to help individuals with pre-existing conditions access affordable coverage.

Program Management Proposed Law Summary

The CMS budget request includes proposed appropriations totaling $410.0 million in FY 2014. Of this amount, $400.0 million would be requested through a General Fund appropriation to implement the Administration's health care proposals. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our discretionary request. The remaining $10.0 million for the FY 2014 portion of CMS' quality initiative would be funded through mandatory offsetting collections from the HI and SMI Trust Funds.

CMS' FY 2014 request also includes proposals for two new user fees. The authority to implement the new user fees will be requested through authorizing language proposals, not appropriations language. These proposals are described in more detail below:

Mandatory General Fund Appropriation ($400,000,000)

CMS requests $400.0 million in mandatory funds needed to implement the health care proposals contained in the President's Budget. Taken together, this request will allow the Administration to realize additional efficiencies, make further reductions in waste and improve the nation's health care system beyond the reforms put in place through the Affordable Care Act. In order to achieve reforms proposed, CMS will utilize this funding to implement significant systems and process changes needed to realize the proposed savings in a timely manner.

Quality Initiative ($10,000,000)

CMS proposes to extend the funding for MIPPA section 183, Consensus-Based Entity, at $10 million per year from FY 2014 through FY 2017 in order to focus on performance measurement. In addition, CMS also proposes to extend the funding for ACA section 3014, Quality Measurement, at $20 million per year from FY 2015 through FY 2017. These extensions will allow CMS to continue support for a consensus-based entity who will develop multi-stakeholder groups and facilitate the groups' input on the endorsement and use of endorsed and non-endorsed quality measures for reporting performance information.

Proposed User Fees ($0)

CMS' FY 2014 request includes two proposals for new user fees: a Survey and Certification Revisit Fee and a fee for the expanded sharing of Medicare data with qualified entities. The Revisit Fee will provide CMS the authority to charge providers user fees to recover the full-cost of Medicare revisit surveys. Revisit surveys are conducted to verify that deficiencies cited during initial certification, recertification or substantiated complaint surveys have been corrected. Revisit Fees will allow CMS a greater ability to revisit poor performers while creating an incentive for facilities to ensure continuing quality of care. This fee would be phased in over a number of years to avoid disruption.

Fees for expanded data sharing would allow CMS to broaden the scope of Medicare data released to Medicare physicians and other providers. Qualified entities' use of Medicare data would be broadened for activities such as fraud prevention, care

coordination, practice improvement and other value-added analyses. Under this proposal, data would be made available to a qualified entity for a fee equal to the cost of providing this data, and would provide flexibility in statutory authority for the qualified entities.

Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Budget Request
Program Operations	$2,663,935	$2,675,173	$4,011,200
Rescission	($5,035)	$0	$0
Comparability Adjustment 1/	($50,916)	($51,203)	$0
Mandatory Appropriation, Proposed Law 2/	$0	$0	$410,000
Appropriation, Net, Proposed Law	$2,607,984	$2,623,970	$4,421,200
Federal Administration	$794,465	$777,694	$771,800
Rescission	($1,501)	$0	$0
Reprogramming	($20,000)	$0	$0
Comparability Adjustment 1/	($1,199)	($1,231)	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$771,765	$776,463	$771,800
State Survey & Certification	$355,876	$377,500	$412,353
Rescission	($673)	$0	$0
Reprogramming	$20,000	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$375,203	$377,500	$412,353
Research, Demonstration & Evaluation	$21,200	$21,289	$0
Rescission	($40)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$21,160	$21,289	$0
State High-Risk Pool Grants 3/	$44,000	$44,269	$22,004
Rescission	$0	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$44,000	$44,269	$22,004
Discretionary Appropriation, Net	**$3,776,112**	**$3,843,491**	**$5,217,357**
Mandatory Appropriation, Net 3/	**$44,000**	**$0**	**$0**
Mandatory Appropriation, Proposed Law	**$0**	**$0**	**$410,000**
Total Appropriation, Proposed Law 4/	**$3,820,112**	**$3,843,491**	**$5,627,357**

1/ Reflects the comparable transfer of the SHIP's to the ACL in Fiscal Years 2012 and 2013.

2/ Reflects the separate $400.0 million general fund appropriation needed to implement the proposals contaned in the President's Budget, along with $10.0 million in first-year funding for the quality initiative.

3/ In FY 2012, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill is enacted. In FY 2013, the risk pools are considered discretionary for display purposes, as an FY 2013 appropriation had not yet been enacted at the time this submission was prepared. In FY 2014, CMS requests these resources as discretionary.

4/ In addition, CMS is proposing two new user fees for facility revisit surveys and expanded sharing of Medicare data with qualified entities.

Program Operations

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Budget Request	FY 2014 +/- FY 2012
BA	$2,658,900,000	$2,675,173,000	$4,011,200,000	+1,352,300,000
Comparability Adjustment 1/	$(50,916,000)	$(51,203,000)	$0	+50,916,000
Adjusted BA 2/	$2,607,984,000	$2,623,970,000	$4,011,200,000	+1,403,216,000

1/ The FY 2012 Enacted and FY 2013 Annualized CR levels include a comparability adjustment to reflect the FY 2014 request to transfer funding for the State Health Insurance Assistance Program (SHIP) from CMS to the Administration for Community Living (ACL).

2/ The FY 2012 Enacted and FY 2013 Annualized CR Program Operations funding levels do not include $21.2 million and $21.3 million respectively for Research, Demonstrations, and Evaluation funded from the Program Operations account in the FY 2014 Budget.

Medicare Authorizing Legislation – Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395 and the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Medicaid Authorizing Legislation – Social Security Act, Title XIX, Section 1901

Children's Health Insurance Program Authority Legislation – Social Security Act, Title XXI

Research, Demonstration, and Evaluation Authorizing Legislation – Social Security Act, Sections 1110,1115,1875 and 1881(a); Social Security Amendments of 1967, Sec 402; Social Security Amendments of 1972, Sec 222.

Affordable Care Act Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152).

FY 2014 Authorization – One Year/Multi-Year
Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

CMS is responsible for administering and overseeing three of the Nation's largest

ongoing health care programs. These programs include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with end-stage renal disease (ESRD); the Medicaid program, also established in

1965, for low-income families and aged, blind, and disabled individuals; and the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels.

In addition, CMS is responsible for setting up the new Federal Marketplace (Marketplace), also known as the Exchange, for each State that elects not to establish a State-based Marketplace (SBM) program. The Marketplace will serve a population that is different from the beneficiaries with whom CMS usually interacts. The Marketplaces will operate complex eligibility and enrollment processes that are highly automated and communicate with other Federal agencies. The Marketplace will allow individuals and small businesses to pool their purchasing power and compare health plan options with both the Federally-facilitated and State-based Marketplaces beginning enrollment on October 1, 2013.

CMS is also responsible for administering and overseeing insurance oversight included in the Affordable Care Act (ACA). Some of our new responsibilities include:

- Ensuring compliance with new insurance market rules, such as the Patient's Bill of Rights;
- Helping States review unreasonable rate increases and overseeing new Medical Loss Ratio rules;
- Providing oversight for the Federal Marketplace and compiling data for www.HealthCare.gov.

CMS works closely with governors and the State insurance commissioners, consumers, and stakeholders to ensure the new law best serves the American people.

Program Description and Accomplishments

Medicare

Established in 1965, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 19 million in 1966 to 53.1 million beneficiaries expected in FY 2014. Medicare benefits, that is, the payments made to providers for their services, are permanently authorized. They are explained more fully in the Medicare Benefits chapter in the "Other Accounts" section of this book. The Medicare administrative expenses discussed in this chapter are funded annually through the Program Management appropriation. CMS uses these funds primarily to pay contractors to process providers' claims, to fund beneficiary outreach and education, to maintain the information technology (IT) infrastructure needed to support various claims processing systems, and to continue programmatic improvements such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS), the administrative simplification provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the tenth revision of the International Classification of Diseases (ICD-10), and others.

- **Medicare Parts A and B**

The original Medicare program reflected a fee-for-service approach to health insurance and consisted of two parts: Part A or Hospital Insurance, financed primarily by payroll taxes; and Part B or Supplemental Medical Insurance, which provides optional coverage for a monthly premium.

- **Medicare Parts C and D**

Part C, also known as Medicare Advantage (MA), offers comprehensive Part A and B medical benefits in a managed care setting through private health care companies. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits. In FY 2014, CMS estimates 15 million beneficiaries will enroll in MA plans.

Medicare Part D provides voluntary prescription drug coverage. Most Medicare beneficiaries, including nearly 12 million low-income beneficiaries in 2014, receive comprehensive prescription drug coverage, either through a standalone prescription drug plan (PDP), a joint MA-prescription drug plan (MA-PDP), an employer-sponsored drug plan, or other creditable coverage. In FY 2014, approximately 39 million beneficiaries will receive Part D benefits, including approximately 37 million enrolled in a Part D private plan and 2 million who receive benefits through the Retiree Drug Subsidy.

Medicaid and CHIP

Authorized under title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed jointly by States and the Federal Government that has provided health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. The ACA provided states the option of expanding eligibility for Medicaid to adults with incomes below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. In addition, Medicaid also provides community based long-term care services and supports to seniors and individuals with disabilities, as well as institutional care and long-term care services. As a result, Medicaid programs vary widely from State to State. The grants made to States for the Federal share of Medicaid services and State administration of this program are appropriated annually. They are explained in further detail in the Medicaid chapter, located within the “Mandatory Appropriations” section of this book. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid operating systems, contracts, and intra-agency agreements such as Part D retail surveys, contract support for newly eligibles and IT management systems.

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a Federal-State matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program was the largest single expansion of health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children who are less than 19 years of age. CHIP grants to States are explained further in the CHIP chapter, located within the “Other Accounts” section of this book.

Health Care Market Reform

CMS is responsible for setting up the Federal Marketplace in States that elect not to set up their own Marketplace. The Marketplace will give tens of millions of Americans and small businesses access to affordable coverage. Implementation of the Federal Marketplace is an unprecedented effort for CMS. CMS' FY 2014 Program Management request includes $1,527 million in appropriated funding for the Marketplaces, along with $450 million in projected user fee collections to fully fund the Marketplaces at a program level totaling $1.9 billion.

CMS, in close collaboration with the Departments of Labor and Treasury, is also responsible for ensuring compliance with the new insurance market rules enacted in the ACA. CMS is implementing the new medical loss ratio rules, reviewing large health insurance rate increases in States without an effective rate review program, and providing guidance and oversight for the new Marketplaces. CMS will set up new competitive private Marketplaces for tens of millions of Americans and small businesses needing access to affordable coverage. Finally, CMS compiles and maintains data for an internet portal providing information for consumers on insurance options.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 122 million beneficiaries in FY 2014. The funding request for Research includes projects that cannot legally be funded in the CMS Innovation Center (with ACA section 3021 funding).

Funding History (Non-Comparable)

FY 2009	$2,265,715,000
FY 2010	$2,335,862,000
FY 2011	$2,325,801,000
FY 2012	$2,658,900,000
FY 2013	$2,675,173,000

Budget Request: $4,011.2 Million

CMS' FY 2014 budget request for Program Operations is $4,011.2 million, an increase of $1,403.2 million above the FY 2012 comparably adjusted Enacted Level. This request will allow CMS to continue to effectively administer Medicare, Medicaid, and CHIP, and to implement health insurance reforms, such as the Federally-facilitated Marketplace.

Program Operations

(Dollars in Millions)

Activity	FY 2012 Enacted Level[1]	FY 2013 Annualized CR	FY 2014 Budget Request	FY 2014 +/- FY 2012
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$956.843[1]	$1,022.312	$1,029.515	+72.672
FFS Operations Support	$51.680	$51.617	$48.472	-3.208
Claims Processing Investments	$81.928	$77.946	$81.292	-0.636
DME/Part B Competitive Bidding	$8.945[2]	$27.215	$73.864	+64.919
Contracting Reform	$30.094	$30.056	$21.485	-8.609
II. Other Medicare Operational Costs				
Accounting & Audits	$162.143	$139.427	$134.480	-27.663
QIC Appeals (BIPA 521/522)	$60.549	$66.230	$68.928	+8.379
HIPAA Administrative Simplification	$26.776	$26.222	$26.776	+0.000
ICD-10/5010	$55.600	$39.310	$27.998	-27.602
Research, Demo, & Evaluation	$21.160[3]	$21.159	$23.156	+1.996
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	$12.817	$13.831	$23.690	+10.873
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$78.422	$75.809	$78.303	-0.119
Oversight & Management	$127.558	$117.927	$887.524	+759.966
V. Health Care Quality				
Health Care Improvement Initiatives	$142.775	$120.480	$99.012	-43.763
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$248.565[4]	$261.896[4]	$268.969	+20.404
Provider Outreach	$29.900	$28.688	$24.632	-5.268
Consumer Outreach	$81.937	$191.646	$573.817	+491.880
VII. Information Technology				
IT Investments	$451.452	$333.358	$519.287	+67.835
TOTAL	**$2,607.984**	**$2,623.970**	**$4,011.200**	**+1,403.216**

[1] The FY 2012 enacted level does not include $50.0 million used for claims processing from The Medicare & Medicaid Extender's Act, P.L. 111-309. The program level for Ongoing Ops is $1,006.8 million.

[2] The FY 2012 enacted level and FY13 CR level do not include funding for DMECB from section 154 of the Medicare Improvements for Patients and Providers Act, P.L. 110-275. MIPPA contributed $57.1 million in FY12 to Competitive Bidding for a program level of $66.0 million and $10.6 million in FY 2013 for a program level of $37.8 million.

[3] The FY 2012 enacted level and FY 2013 CR level for Research, Demonstration, and Evaluation are only shown for comparable purposes – the FY 2012 and FY 2013 RD&E funding is provided under a separate PPA.

[4] The FY 2012 enacted level (-$50.9 million) and FY13 CR level (-$51.2 million) include a comparability adjustment for the National Medicare Education Program (NMEP) to reflect the FY 2013 request to transfer funding for the SHIP from CMS to the ACL.

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

This category reflects the Medicare contractors' ongoing fee-for-service (FFS) workloads, which include processing claims, enrolling providers in the Medicare program, handling provider reimbursement services, processing appeals, responding to provider inquiries, educating providers about the program, and administering the participating physicians/supplier program (PARDOC). These activities are described in more detail below.

- *Bills/Claims Payments* – The Medicare contractors are responsible for processing and paying Part A bills and Part B claims correctly and timely. Currently, almost all providers submit their claims in electronic format - 99.8 percent for Part A and over 97.5 percent for Part B.

- *Provider Enrollment* - CMS and its Medicare contractors are responsible for both enrolling providers and suppliers into the Medicare program and ensuring that they continue to meet the requirements for their provider or supplier type. The enrollment process includes a number of verification processes to ensure that Medicare is only paying qualified providers and suppliers. In addition, the Medicare program requires that all new enrollees or those making a change in enrollment obtain Medicare payments by electronic funds transfer.

- *Provider Reimbursement Services* – Medicare Part A providers are required to file a cost report on an annual basis. In addition to determining the payment amount for items paid on cost, the cost report is used to finalize prospective payment system (PPS) add-on payments such as graduate medical education (GME), indirect medical education (IME), disproportionate share hospital (DSH), and bad debt payments. The contractors' provider reimbursement area performs several activities, most requiring substantial manual effort, including:

    - Conducting rate reviews to establish and adjust interim reimbursement rates for add-on payments;
    - Performing quarterly reviews when the provider has elected to be paid on a bi-weekly basis, in lieu of actual claims payments;
    - Conducting reviews of payments to all hospice providers to determine if the hospice exceeded the aggregate or inpatient cap;
    - Maintaining files of provider-specific data (such as the DSH adjustment) to calculate the provider's claims payment;
    - Maintaining systems such as the provider statistical and reimbursement system (PS&R) which contains all of the claims information needed to settle cost reports; and the system for tracking audit and reimbursement (STAR) which tracks the cost report through final settlement;
    - Making determinations regarding a hospital's provider-based status, which affects the amount of reimbursement the hospital is entitled to receive;
    - Reporting and collecting provider overpayments; and,
    - Identifying delinquent debt and referring debts to Treasury for collection.

- *Medicare Appeals* – The statutorily mandated Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse contractor determination, including coverage and payment decisions. There are five levels in the Medicare Part A and Part B appeals process starting with the Medicare Administrative Contractor (MAC) and ending with judicial review in Federal District Court.

  The first level of appeal begins at the Medicare contractor with a redetermination of the initial decision. MAC personnel not involved in the original determination make the decision to determine if it should be changed and handle any reprocessing activities. MACs generally issue a decision within 60 days of receipt of an appeal request. This workload is impacted by changes in Medicare policy, medical review strategies, and Medicare Integrity Program directives. A significant number of claims are denied based on an apparent lack of medical necessity. Approximately 90 percent of appellants are suppliers and physicians.

  In FY 2012, the MACs processed 3.2 million redeterminations. In FY 2013, the MACs expect to process approximately 3.5 million redeterminations. In FY 2014, CMS anticipates the MACs will process 3.8 million redeterminations, reflecting higher than normal growth in the number of redeterminations as seen in prior fiscal years.

  The second level of appeal is a reconsideration performed by a Qualified Independent Contractor or QIC. These costs are not part of this Ongoing Operations section, and will be discussed later in this chapter.

- *Provider Inquiries* – CMS coordinates communication between Medicare contractors and providers to ensure consistent responses. To accomplish this, CMS requires the Medicare contractors to maintain a Provider Contact Center (PCC) that can respond to telephone and written (letters, e-mail, fax) inquiries. The primary goal of the PCC is to deliver timely, accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices are designed to help providers understand the Medicare program and, ultimately, bill for their services correctly.

  In FY 2012, contractors responded to almost 39 million telephone inquiries and 600,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. The contractors utilized Interactive Voice Response (IVR) systems to automate approximately 70 percent of their telephone inquiries. CMS estimates receiving 34.2 million telephone inquiries in FY 2014 and a slight increase in the IVR utilization rate. Utilization of the IVR frees up customer service representatives to handle the more complex questions. CMS has made a number of efforts that contribute to decreased volume in FFS provider calls to MAC contractors' toll free lines. These efforts include:

  - Major improvements in education beginning in 2005, including major new lines of educational products associated with FFS Medicare;
  - Improved CMS and MAC contractor websites that host Medicare information;
  - Improved outreach to FFS providers through national and local provider association partners, expanded MAC contractor provider electronic mailing lists and expanded CMS provider electronic email lists;
  - Increased number of MAC contractor provider Internet portals for claims-related transaction information; and,

- Improved training of MAC contractor call center Customer Service Representatives.

The following table displays provider toll-free line call volumes from FY 2009 through FY 2014 (estimated):

Provider Toll-Free Service Call Volume
(Call Volume in Millions)

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Completed Calls	50.1	44.4	41.1	38.8	35.7	34.2

CMS believes the FFS related call volume will decline through FY 2014 allowing CMS to absorb inquiries related to the implementation of Medicare related ACA provisions and allowing CMS to provide better service for more complex calls.

- *Participating Physician/Supplier Program (PARDOC)* – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who "participate" in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows. Every year, the MACs are instructed to furnish participation enrollment materials to providers. The open enrollment period runs from November 15 through December 31 of each year. CMS has made more information available at http://www.medicare.gov about physicians participating in Medicare. The National Participating Physician Directory includes the providers' medical school and year of graduation, any board certification in a specialty, gender, hospitals at which they have admitting privileges, and any foreign language capabilities. In 2012, 685,211 physicians "participated" out of 705,568 enrolled physicians (97.1%), and out of a total of 1,146,342 physicians, LLPs, and NPPs, 1,101,560 participated (96.1%).

- *Provider Outreach and Education* – The goal of Provider Outreach and Education is to reduce the Medicare error rate by helping providers manage Medicare-related matters on a daily basis and properly bill the Medicare program. The Medicare contractors are required to educate providers and their staffs about the fundamentals of the program, policies and procedures, new initiatives, and significant changes including any of the more than 500 change requests that CMS issues each year. They also identify potential issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing (CERT) data, and the Recovery Audit Program data.

  CMS encourages its contractors to be innovative in their outreach approach and to use a variety of strategies and methods for disseminating information including using print, Internet, telephone, CD-ROM, educational messages on the general inquiries line, face-to-face instruction, and presentations in classrooms and other settings.

- *Enterprise Data Centers* – The Enterprise Data Centers (EDC) are the foundation that supports all CMS production data center operations. Traditionally, the Medicare contractors either operated their own data centers or contracted out these services. As part of CMS' contracting reform initiative, CMS reduced the number of data centers from more than one dozen separate small centers to three large EDCs. CMS manages these contracts. CMS has achieved administrative efficiencies from this consolidation. It will also deliver greater performance, security, reliability, and operational control. In addition, the new EDC infrastructure gives CMS flexibility in meeting current and future data processing challenges. This flexibility is critical as the FFS claims workloads continue to grow and Medicare claims processing applications require a more stable environment.

Budget Request: $1,029.5 Million

The FY 2014 budget request for Ongoing Operations is $1,029.5 million, an increase of $72.7 million above the FY 2012 Enacted Level. The FY 2012 Enacted level does not include $50.0 million used for claims processing from The Medicare & Medicaid Extender's Act, P.L. 111-309. CMS' FY 2014 request is $22.7 million above the FY 2012 program level for ongoing operations.

CMS' request supports a projected 1.5 percent increase in claims volume from the current FY 2013 projections. Workloads are projected to increase by 2.5 percent or 23.6 million claims as compared to FY 2012.

This request allows the contractors to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements.

In FY 2014, CMS' contractors expect to:

- process over 1.2 billion claims
- handle 3.8 million redeterminations
- answer 34.2 million toll-free inquiries

The following table displays claims volumes and unit costs for the period FY 2009 to FY 2014. The unit costs reflect the total funds provided to our contractors in the Ongoing Operations line for claims processing, data centers, appeals, inquiries, enrollment, outreach and education, provider reimbursement, and PARDOC workloads. CMS has maintained its unit cost over the last several years. We remain committed to achieving efficiencies in our fee-for-service operations.

Claims Volume and Unit Costs
(FYs 2009 – 2014)

Volume (in millions)	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Estimate**	**FY 2014 Estimate**
Part A	191.4	195.2	199.1	207.3	210.0	213.0
Part B	992.2	979.5	989.8	1,011.9	1,014.4	1,029.8
Total	**1,183.6**	**1,174.7**	**1,188.9**	**1,219.2**	**1,224.4**	**1,242.8**
Unit Cost (in dollars)						
Total	**$0.85**	**$0.89**	**$0.87**	**$0.83**	**$0.83**	**$0.83**

Fee-for-Service Operations and Systems Support

CMS offers several critical services supporting the Medicare fee-for-service program. Some of these include:

- *Printing and Postage:* This contract provides for the printing and postage costs associated with direct billing of Medicare Part A, Part B and Part D Income-Related Monthly Adjusted Amount (IRMAA) premiums for beneficiaries who may not receive a monthly Social Security Administration (SSA), Office of Personnel Management (OPM), or Railroad Retirement Board (RRB) benefit check from which the premiums are deducted and are not part of a State Buy-in Agreement or Formal Group Payer Arrangement.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens* - Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides funding to eligible providers for furnishing emergency health services to undocumented and certain other aliens. Through a contractor, CMS performs provider enrollment, claims processing, payment, program integrity, customer service, and other activities which support the program.

- *Internal Controls Assessment* - The Office of Management and Budget Circular A-123 requires that CMS establish and maintain internal controls over financial reporting, rigorously assess these controls, and submit a statement of assurance on these controls.

- *Medicare Beneficiary Ombudsman* - The legislative mandate for the creation of a Medicare Ombudsman (MMA Section 923) requires the Medicare Beneficiary Ombudsman to provide assistance to Medicare beneficiaries with handling their inquiries, complaints, grievances, and appeals. The Ombudsman's office also

provides recommendations for improvement in the administration of the Medicare program.

Budget Request: $48.5 Million

The FY 2014 budget request for fee-for-service operations support is $48.5 million, a decrease of $3.2 million below the FY 2012 Enacted level. The activities that make up this request are as follows:

- *Printing and Postage*: $7.4 million. This funds CMS' ongoing FFS printing and postage needs.

- *Home Health Initiatives*: $3.9 million. This funding will enable CMS to continue to monitor case-mix growth in the home health industry and monitor for suspect billing patterns which may require immediate Home Health PPS changes.

- *Provider Internet Transaction Pilots:* $3.8 million. This funding would support maintenance and expansion of MAC provider portals for claims related transactions, and continued compliance with associated security documents and processes.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $3.7 million. CMS doesn't anticipate a change in funding from FY 2012 to FY 2014. This request funds payments to eligible providers for emergency health services provided to undocumented aliens. Contracting support is necessary to operate the program and process payments quarterly.

- *Actuarial Services & Contract Audits*: $3.6 million. This request supports contracts assisting the Actuary in providing cost estimates for various demonstrations and other issues required by provisions of the law. In addition, this funding will be used to enter into agreements with the Defense Contract Audit Agency, as well as contracts with support contractors to aggressively address any backlogged audit efforts.

- *A-123 Assessment*: $2.0 million. Funding supports a Certified Public Accountant (CPA) firm to conduct a rigorous assessment of the CMS internal controls over financial reporting, which is required by the Office of Management and Budget (OMB) Circular A-123 (Management's Responsibility for Internal Control). This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors. The CMS requests an increase in FY 2014 funding due to expected higher fees for incorporating the review and testing of the Marketplace which are expected to go live in 2014.

- *Medicare Beneficiary Ombudsman*: $1.9 million. Funding is required to adequately fulfill the mandate of Section 923 of MMA to assist people with Medicare with all aspects of the Medicare program and to develop and report recommended improvements to the administration of the Medicare program in the Medicare Ombudsman annual report to the Secretary and Congress.

- *Other Operational Costs:* $22.2 million. This request supports some of the activities involving program monitoring, provider validation, satisfaction surveys, and many other various FFS administrative functions.

Claims Processing Investments

CMS' claims processing systems currently process over 1.2 billion Part A and B claims each year, and these systems are a major component of our overall information technology costs. The claims processing systems receive, verify, and log claims and adjustments, perform internal claims edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The request covers ongoing systems maintenance and operations. The main systems include:

- *Part A, Part B and DME Processing Systems* – The contractors currently use standard systems for processing Part A, Part B, and DME claims. Historically, the contractors used one of several different processing systems. A few years ago, CMS converted the Medicare contractors to one of three selected standard systems. This has provided a more controlled processing environment and reduced the costs of maintaining multiple systems.

- *Common Working File (CWF)* – This system verifies beneficiary eligibility and conducts prepayment review and approval of claims from a national perspective. The CWF is the only place in the claims processing system where full individual beneficiary information is housed.

- *Systems Integration Testing Program* – CMS conducts systems testing of FFS claims processing systems in a fully-integrated, production-like approach that includes data exchanges with all key systems. This investment allows CMS to monitor and control system testing, costs, standardization, communication, and flexibility across systems.

Budget Request: $81.3 Million

The FY 2014 budget request for claims processing investments is $81.3 million, a decrease of $0.6 million below the FY 2012 Enacted level.

Competitive Bidding

- *Competitive Bidding for Part B Drugs* - Section 303(d) of the MMA established the Competitive Acquisition Program (CAP) for Part B Drugs. The CAP is an alternative to the average sales price (or "buy and bill") method used to supply drugs that are administered incident to a physician's services. Major activities associated with this requirement have included ongoing claims processing (including post payment review as mandated by the Tax Relief and Health Care Act of 2006), conducting appeals and dispute resolution, carrying out vendor enrollment, and conducting various educational activities for vendors and physicians who obtain drugs through them.

This program's 2013 contract implementations have been postponed and the CAP remains on hold. CMS has made a provision for an upcoming round of vendor bidding in CY 2014.

- *DME Competitive Bidding* – Section 302(b)(1) of the MMA authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007. MIPPA and the ACA expanded the number of MSAs by 91 areas for a total of 100 MSAs and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016.

Budget Request: $73.9 Million

The FY 2014 budget request for competitive bidding is $73.9 million, an increase of $64.9 million above the FY 2012 Enacted Level.

- *Competitive Bidding for Part B Drugs:* $1.0 million, an increase of $0.9 million above the FY 2012 Enacted Level.

- *DME Competitive Bidding:* $72.9 million, an increase of $64.0 million above the FY 2012 Enacted Level. FY 2014 reflects a significant increase over FY 2012 due to the increase in activities related to Round 2 and national mail order competitions and the exhaustion of funds authorized in MIPPA to initiate the DME Competitive Bidding Program. CMS is required by law to re-compete contracts for the DMEPOS Competitive Bidding Program at least once every three years. Therefore in FY 2014, the Competitive Bidding Implementation Contractor will expand operations to begin re-competition of the Round 2 and national mail order competitions. This will require CMS to update and maintain the bidding operational processes which includes education of providers, suppliers and beneficiaries. The Competitive Bidding Program also requires CMS to update and maintain the bidding system along with the bid evaluation system that is used to evaluate the bids and assists CMS in the awarding of contracts to the winning bidders. In addition to conducting these competitions, CMS must continue to conduct the oversight and maintenance periods for the Round 2, national mail order, and Round 1 Re-compete competitions.

  The DMEPOS competitive bidding program saved the Medicare fee-for-service program approximately $202 million in its first year of operation, and according to current Office of the Actuary estimates, the program is projected to save the Medicare Part B Trust Fund $25.8 billion between 2014 and 2023, with an additional $17.2 billion in savings for beneficiaries during that same period.

<u>Contracting Reform</u>

Medicare contracting reform changes the face of the traditional Medicare program by integrating Parts A and B contracting under a single contract authority, known as a Medicare Administrative Contractor or MAC, using competitive acquisition procedures

under the Federal Acquisition Regulation (FAR), and enabling a re-engineering of business processes. Following are the major funding requirements for this effort:

- *IT Systems* - Contractor Management Information System (CMIS), maintenance and enhancements for the electronic change management portal (eChimp) system, and the Common Electronic Data Interchange (CEDI) system. The CMIS is an application that allows CMS to effectively manage, monitor, and report on the performance of its Medicare fee-for-service contractors. CMIS is a web based analytical application that has been deployed on the CMS net. The eChimp system is used by CMS, Medicare FFS Contractors, and MACs to support the Fee for Service Change Management Process. This support includes online forms for the MACs to report the functions involved in reviewing and implementing the requirements in the change requests and an electronic approval process. The CEDI front-end system provides a single front-end solution for the submission of electronic claims-related transactions for Medicare durable medical equipment suppliers. This standardization allows greater efficiencies in inbound and outbound EDI exchange.

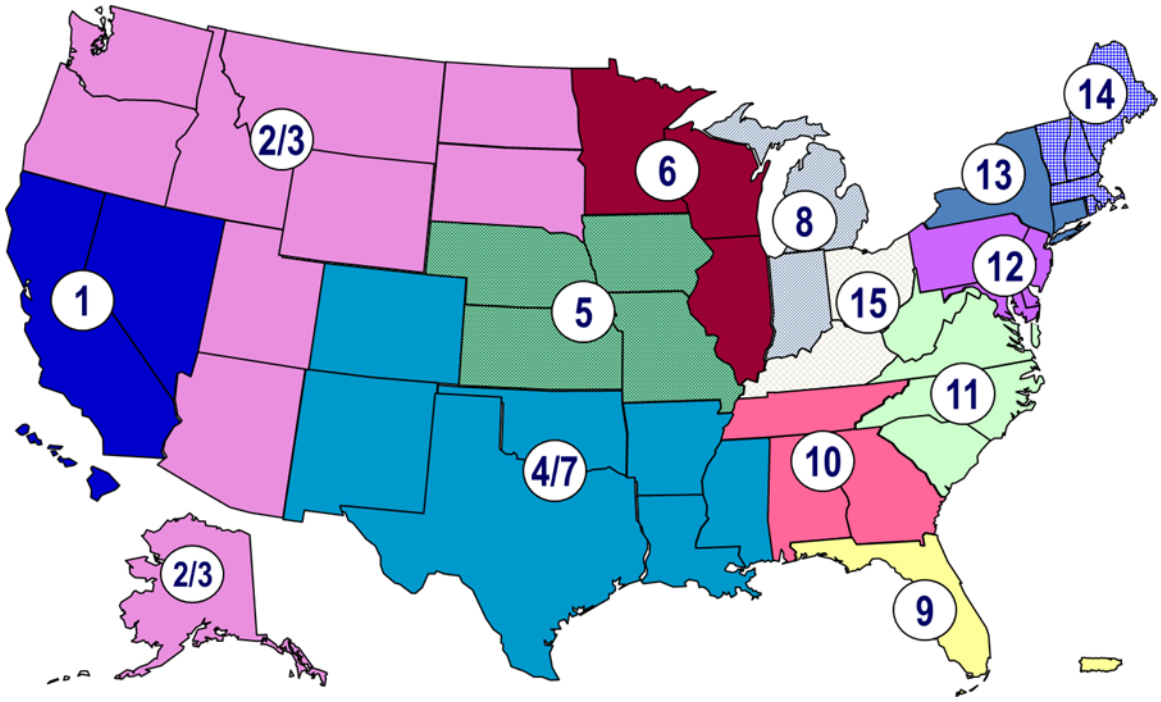
- *Contracting Support* - Funding will be used to obtain expert procurement, audit, and implementation support for CMS' operations under the Medicare Contracting Reform provision (Section 911) of MMA. Even though the first round of MAC procurements was largely completed by the beginning of FY 2012 (October 1, 2011), the MMA also stipulates that the MAC contracts are to be competitive contracts which are re-competed a minimum of every 5 years. CMS continues to plan and implement this "second generation" of MAC procurements.

  CMS began to develop detailed acquisition plans and solicitation documents for the "second generation" contracts in FY 2009. CMS has completed and implemented three out of four "second generation" DME MAC contract awards, and the fourth DME MAC "second generation" contract (DME Jurisdiction C) will be implemented by the end of April 2013. In addition, CMS is now in the process of procuring "second generation" A/B MAC contracts.

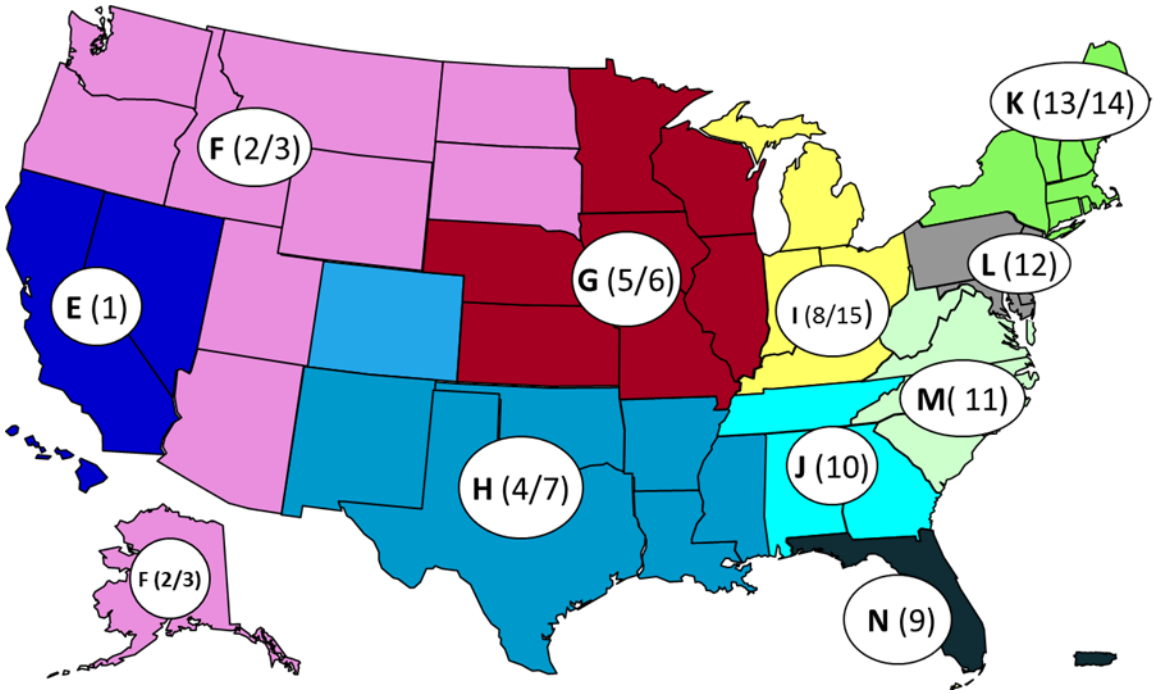
  On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of procurements. Through a series of incremental actions, CMS plans to reduce the number of A/B MACs from fifteen to ten by 2017. The first of the consolidated jurisdictions to be awarded and implemented were A/B MAC Jurisdictions F (a consolidation of the former A/B MAC Jurisdictions 2 and 3) and H (a consolidation of the former A/B MAC Jurisdictions 4 and 7). In the fourth quarter of FY 2012, CMS awarded the final "first round" A/B MAC contract (A/B MAC Jurisdiction 6) and three additional "second round" A/B MAC contracts (A/B MAC Jurisdictions 5, E, and L). Most of these recent contract awards were pending implementation as of the end of CY 2012.

  This FY 2014 request provides for implementation support, audit support, and expert support required to settle a number of legacy (FI/carrier) contract termination claims, and implementation funding for the Round II MAC contracts for Jurisdictions, K, N, J and M (formerly Jurisdictions; 13 & 14; 9; 10; and 11). The funds are needed to ensure the continued success of CMS' Medicare Contracting Reform effort.

The following map presents the A/B MAC jurisdictions as of the first quarter of FY 2013.



The following map presents the ten consolidated A/B MAC jurisdictions that CMS intends to establish by 2017.



Budget Request: $21.5 Million

The FY 2014 budget request for contracting reform is $21.5 million, a decrease of $8.6 million below the FY 2012 Enacted Level. This request includes funding for MAC implementation and transition costs as a result of re-competes, implementation and audit expertise, and three IT systems.

Contracting Reform is expected to produce large Trust Fund savings primarily due to making more accurate payments as a result of combining A/B workloads under one MAC. For the five year period FY 2012 – FY 2016, the CMS actuary estimated trust fund savings for Medicare contracting reform in the amounts of $620.0 million in FY 2012, $660.0 million in FY 2013, $730.0 million in FY 2014, $780.0 million in FY 2015, and $840.0 million in FY 2016 respectively.

- *IT Systems:* $6.9 million, a decrease of $0.9 million below the FY 2012 Enacted Level. This budget request continues the efficiencies produced by the Contractor Management Information System (CMIS), eChimp system and Common Electronic Interchange System (CEDI).

- *MAC Transition Costs:* $14.6 million, a decrease of $7.7 million below the FY 2012 Enacted Level. This funding will provide for any required transition costs when CMS replaces incumbent MACs with new contractors, either due to the statutory re-competes or for performance reasons. This funding allows for the smooth transition of Medicare contract activities from one Medicare contractor to another, and ensures continuity of Medicare claims operations. CMS anticipates that all of the currently-pending MAC contract awards enumerated above will be made by late FY 2013 or during FY 2014, and most of the legacy contract termination expenses that are projected will also be closed-out during FY 2014.

II. OTHER MEDICARE OPERATIONAL COSTS

Program Description and Accomplishments

<u>Accounting and Audits</u>

- *Healthcare Integrated General Ledger and Accounting System (HIGLAS)* - HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting and replaces the existing separate accounting/payment systems for Medicare and Medicaid. The main objective of this effort is to leverage the use of commercial off the shelf (COTS) software in the Federal government to increase automation, increase efficiency, and maximize economies of effort to centralize management. This will save millions of taxpayer dollars that fund Medicare and Medicaid each year, while eliminating redundant and inefficient / ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (DHHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with DHHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of DHHS.

HIGLAS implementation will yield significant improvements and benefits to the Nation's Medicare program which will strengthen the Federal government's fiscal management and program operations/management of the Medicare program. HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS is a critical success factor in ensuring DHHS meets FFMIA compliance requirements. The transition of Medicare contractors to HIGLAS enables CMS to resolve material weaknesses identified in the CFO audits related to the accounting of Federal dollars. Through the implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the implementation of administrative program accounting functions at CMS central office, CMS continues to make progress in achieving the goals tracked by DHHS and OMB.

The HIGLAS effort has significantly improved the ability of CMS to perform Medicare accounting transactions. These improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare contractor overpayments. Moreover, HIGLAS implementation has resulted in better internal financial controls across Medicare contractor operations. Implementation of HIGLAS has a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. From the beginning of HIGLAS implementation in May 2005 through FY 2012, CMS estimates that $507 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes.

During FY 2013, HIGLAS plans to roll out the remaining internal CMS Administrative Program Accounting functionality to HIGLAS. CMS will also continue supporting the production and application maintenance of HIGLAS in FY 2013. CMS expects to begin analysis for Durable Medical Equipment Medicare Administrative Contractors (DMACs) and continue conducting analysis and begin development efforts to incorporate the Federal Marketplace accounting to HIGLAS.

- *CFO/Financial Statement Audits* - The CFO/Financial Statement Audits include the annual audit required by the Chief Financial Officers (CFO) Act of 1990. This legislative mandate ensures CMS financial statements are reasonable, that our internal controls are adequate, and that CMS complies with laws and regulations. Our goal is to maintain an unqualified audit opinion, which indicates that our financial statements present fairly in all material respects, the financial position, net costs, social insurance, changes in net position, budgetary resources, and financing of CMS.

Budget Request: $134.5 Million

The FY 2014 budget request for HIGLAS and the CFO audit is $134.5 million, a decrease of $27.7 million below the FY 2012 Enacted Level. In FY 2014, CMS will

support the production and application maintenance of HIGLAS, as well as support future system enhancements, upgrades, and/or initiatives.

- *HIGLAS*: $124.2 million. This request supports operations and maintenance costs including payment to the entity that performs data processing and hosts the HIGLAS application (including hardware and software maintenance), payment for the disaster recovery hot site and continuity of operations support, development and implementation of quarterly software releases to update HIGLAS for changes in two Medicare claims processing and payment rules systems, shared system maintainer costs related to changes made to enable HIGLAS interfaces, HIGLAS production help desk, and HIGLAS technical and analytical services. This budget request is also attributable to the planning and analysis efforts associated with transitioning the DMACs to HIGLAS, as well as future system enhancements, upgrades, and initiatives. During this time period, HIGLAS will continue with planning for a major software upgrade to align with Departmental requirements. In addition, HIGLAS capabilities must be expanded to incorporate Federal Marketplace accounting.

HIGLAS Costs - FY 2011 through FY 2014
(Dollars in Millions)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2014 Request
Development, Modernization & Enhancement	$35.6	$33.9	$11.2	$8.5
Operations & Management	$118.3	$118.2	$118.3	$115.7
Total	$153.9	$152.1	$129.5	$124.2

- *CFO/Financial Statement Audits:* $10.3 million. The cost of the audit is funded through an interagency agreement between CMS and the Department. The request is based upon the General Services Administration (GSA) rate schedules and federal audit requirements.

Qualified Independent Contractor Appeals (QIC)

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with qualified independent contractors (QICs) to adjudicate second level appeals of adverse claims determinations. For Medicare fee-for-service activities, CMS currently contracts with one Administrative QIC (AdQIC), two QICs performing Medicare Part A reconsideration activities, and three QICs performing Medicare Part B reconsideration activities. CMS also contracts with an evaluation and oversight contractor to perform annual evaluations of the QICs' compliance with contract and regulatory requirements.

Generally, QICs must process Medicare Parts A & B claim appeals within 60 calendar days of the date the QIC receives a timely filed reconsideration request.[5] In accordance with 42 CFR §405.970(c), if a QIC is unable to complete the appeal within the mandated

[5] Each time a party submits additional evidence after the request for reconsideration is filed, the QIC's 60 day decision making timeframe is extended by up to 14 days for each submission.

timeframe, then it must notify the appellant that it cannot timely complete the appeal and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge (ALJ).

In addition to processing reconsiderations, the QICs also prepare and ship case files to the ALJs for pending hearings. QIC Medical Directors and other staff also participate at ALJ hearings to discuss and/or clarify CMS coverage and payment policies. The AdQIC receives all completed fee-for-service Medicare ALJ cases and acts as the central repository for these cases. It also forwards any effectuation information to the MACs so they can issue payments to appellants. The AdQIC also maintains a website with appeals status information for both the QIC and ALJ levels of appeal, so appellants can easily check the status of their appeal request. Finally, the AdQIC provides data and other information to CMS for quality control purposes.

Another important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). The MAS' goal is to support the appeals process for the FFS, Medicare Advantage, and Prescription Drug Programs. The MAS enhances workflow tracking and reporting capabilities and supports the processing of all second level appeals. CMS maintains the system and implements all necessary system changes.

Budget Request: $68.9 Million

The FY 2014 budget request for QIC appeals (BIPA section 521) is $68.9 million, an $8.4 million increase above the FY 2012 Enacted Level. $63.2 million are QIC costs, an increase of $8.2 million above the FY 2012 Enacted Level. $5.7 million are Medicare Appeals System costs, an increase of $0.2 million above the FY 2012 Enacted Level.

The number of appeals has consistently increased every year over the last several years, with a significant increase in FY 2012. The largest appeals increases in FY 2012 involved Part A and Part B (non-durable medical equipment (DME)) claims. CMS is seeing another substantial increase early in FY 2013 in Part A appeals and DME appeals. The workload chart below contains the projections for FY 2013 and FY 2014.

With well over 100 million claims denied each year, it is difficult to pinpoint a single cause for the appeals increase seen in FY 2012 and into FY 2013. However, CMS believes the following factors and initiatives have, at least in part, caused these increases:

- Growth in the beneficiary population, which has resulted in a corresponding increase in claims submissions;

- Increased provider familiarity with appeals rights and procedures, making them more comfortable with appealing their claim denials. There may also be incentive for some providers to appeal overpayments since doing so allows the provider to delay recoupment of the overpayment until the appeal reaches the ALJ level.

- Increased program integrity efforts and medical review initiatives to ensure proper claims payment. The implementation of the Fraud Prevention System, along with increased efforts in traditional methods to review and edit claims to

detect improper payments, increases the number of claims denials that will be appealed;

- Significant increase in Part A appeals (approximately 50% of one QIC's non-Recovery Audit workload) due to appeals from State Medicaid Agencies for home health claims that were previously part of a CMS/SMA third party liability demonstration; and

- Large legal settlements that impact CMS' interpretation of coverage policies and allow appellants to have appeals re-reviewed based on the new interpretation.

The following chart summarizes historical QIC appeals and anticipated appeal workload levels for the upcoming fiscal years:

QIC Appeals Workload[6]

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
QIC Appeals	456,849	494,077	520,221	758,921	916,752	1,054,265
% Increase	11.0%	8.1%	5.3%	45.9%	20.8%	15.0%

HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange. Several of the budgeted HIPAA activities for which CMS is responsible include:

- *National Provider Identifier (NPI) & National Plan and Provider Enumeration System (NPPES)* – HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. CMS was delegated the responsibility to build a system, known as the NPPES, which assigns NPIs and processes NPI applications. It also makes subsequent changes to the data of enumerated providers. Providers are required to keep their NPPES data current by submitting timely updates. CMS estimated that there are approximately 2.3 million covered health care providers who must obtain NPIs and approximately 3.7 million non-covered providers who may be eligible and apply for NPIs. Currently, over 3.4 million NPIs have been assigned and over 3.3 million changes have been applied to the NPPES records of enumerated providers.

[6] The second level appeals activities noted in the above chart do not include Recovery Audit Program appeals. That workload is being tracked, reported, and funded separately.

- *HIPAA Claims-Based Transactions* – HIPAA requires the Medicare program to respond to electronic requests for eligibility information from providers and health care institutions using the adopted standard. Medicare built the Health Eligibility Transaction System (HETS) which provides eligibility information to fee-for-service providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims.

- *HIPAA Electronic Data Interchange (EDI)* – This project supports the monitoring and management of Medicare fee-for-service contractor compliance with HIPAA EDI requirements. These activities support contractor oversight and include: data collected from files uploaded by contractors to the web site, reports generation, website Help Desk support for contractors and CMS central office, ad-hoc reporting, compliance investigation, reporting, and trouble-shooting.

- *HIPAA Outreach, Enforcement, Gap Analysis Pilot* – This project includes outreach programs for covered entities and other affected organizations, as well as complaint enforcement efforts:

    - Enforcement activities consist of investigating contractor activity to review, providing analysis and tracking complaints. The enforcement contract includes maintenance of the website for electronic submission of complaints; assistance with evaluating technical complaints; and managing the correspondence to and from complainants and the entities against which the complaint is filed. The Administrative Simplification Enforcement Tool (ASET) is a web-based application that provides online complaint filing and management to parties who wish to file a complaint. Enforcement also includes a HIPAA Identification Tracking System (HITS) tool which compiles statistics and generates reports for use in managing the complaint process. The system currently has information on 1,200 complaints.

    - Conducting a gap analysis of the updated version of the HIPAA technical standards (new in 2013). CMS must undertake pilot testing of upcoming X12 version 6020 prior to its adoption to eliminate many of the production issues experienced across the industry with previous HIPAA standard implementations. These issues, such as varying interpretation of field requirements by payers, inconsistent front-end system edits, and other variations, result in claims rejections, reimbursement delays and/or other costly adjudication problems and implementation delays.

Budget Request: $26.8 Million

The FY 2014 budget request for HIPAA Administrative Simplification is $26.8 million, the same as the FY 2012 Enacted Level. This includes funding for the following activities:

- *NPI & NPPES*: $8.3 million. At this level, CMS can comply with current NPI requirements, continue its current enumeration workload, and conduct the following ongoing activities:

    - Resolution and correction of data inconsistencies between NPPES and the IRS. The NPI Enumerator works with providers whose data do not

match IRS' records in order to resolve issues. This work is an ongoing part of CMS' responsibility for ensuring the inclusion of accurate, correct data in NPPES.
    - Dissemination of the monthly NPPES file. CMS is required by Federal Notice to make this file available via the Internet each month.
    - Utilization of SSA's Death Master File by the NPI Enumerator to verify the death of providers who have been assigned NPIs, deactivate those NPIs, and pass this information on to the Medicare provider/supplier enrollment system.

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $11.1 million. CMS provides institutions and other health care providers with beneficiary eligibility information. This systems application is considered mission critical as it provides eligibility information on a real-time basis as well as assists in determining how Medicare should be billed for the services rendered. The FY 2014 request will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA EDI standard.

- *HIPAA Outreach, Enforcement, Compliance Reviews, Pilot*: $7.4 million. Contractor support will be needed to complete IT system requirements, develop regulations, and conduct training, outreach and education. CMS's goal is to reduce the clerical burden on patients, providers, and health plans by reducing the amount and complexity of forms and data entry required prior to or at the point of care. The industry has requested that CMS conduct more outreach to assist in understanding the new policies that are being published, and the Regional Offices require greater support from Central Office. The gap analysis pilot will help in the adoption of an updated version of the standard when the time comes and the Review Committee is established to make its recommendations to the Secretary.

ICD-10 and Version 5010 Regulations

- *Background*: The Health Insurance Portability and Accountability Act requires CMS, along with the entire U.S. health care industry, to transition to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9) code set. CMS published a final rule on January 16, 2009.

  The new ICD-10 code set will accommodate new procedures and diagnoses, provide greater specificity of diagnosis-related groups and preventive services, permit more rigorous program integrity efforts and improved reimbursement for medical services. The U.S. is the only "big seven" nation not yet transitioned from ICD-9 to ICD-10, which hampers our ability to share diagnosis and other health information, such as pandemic data, with other countries.

- *ICD-10 and other Health Care Initiatives*: ICD-10 is essential to achieving Affordable Care Act (ACA) initiatives, specifically in the areas of fraud, waste, and abuse prevention, and to move the current volume-based system to a value-based purchasing system. ICD-10 data also may be instrumental in various provider incentive programs such as meaningful use of certified electronic health record (EHR) technology and quality measures determined by CMS. The more detailed

nature of the ICD-10-CM and ICD-10-PCS codes will enhance the provider's ability to document that they have met the stringent quality measure criteria to receive incentive payments.

- *Current ICD-10 Status*: The January 2009 ICD-10 final rule called for industry compliance with ICD-10 on October 1, 2013, a pushback of two years from the October 2011 date in the ICD-10 proposed rule. This was in response to industry comments that they needed additional compliance time. From lessons learned in the January 2012 implementation of the Version 5010 standard, (a prerequisite for the use of the ICD-10 codes), CMS industry survey results, and industry feedback, we estimate that as many as 25 percent of providers could not achieve compliance with ICD-10 by the October 1, 2013 date, which translates into more than 5 million rejected claims a week. Rejected claims could result in suspension of reimbursements, leading to a possible shutdown of provider operations. This would negatively impact patient access to care, which is the overriding concern.

  The Secretary announced on February 15, 2012 that there would be a further delay in the October 1, 2013 ICD-10 compliance date. After much industry feedback and analysis, the Department proceeded with a proposed rule which included a provision to push the ICD-10 compliance date for all HIPAA covered entities from October 1, 2013 to October 1, 2014. This delay timeframe took into consideration the timing of other initiatives, the investments already made by the industry's "early adopters" of ICD-10, and the need for thorough testing and preparation on the part of all industry segments.

  On August 24, 2012, the final rule *Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier*; *Addition to the National Provider Identifier Requirements*; and a *Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD 10 CM and ICD 10 PCS) Medical Data Code (CMS-0040-F)* made final a one-year proposed delay – from Oct. 1, 2013, to Oct. 1, 2014 – in the compliance date for use of new codes that classify diseases and health problems.

The chart below shows the major differences between ICD-9 and ICD-10 codes:

	ICD-9	ICD-10
Diagnosis Codes		
Number of Characters	3-5 Alphanumeric	3-7 Alphanumeric
Number of Codes	15,000	68,000
Procedure Codes		
Number of Characters	3-4 Numeric	7 Alphanumeric
Number of Codes	4,000	72,000

Budget Request: $28.0 Million

The FY 2014 budget request for ICD-10/Version 5010 is $28.0 million, a decrease of $27.6 million below the FY 2012 Enacted Level. The decrease reflects that the majority of system designs and coding development will have been completed by FY 2014.

- *IT System Costs*: $22.3 million. This request supports systems conversions, including updating Medicare Fee for Service core processing systems, and all downstream and front-end systems.

- *Code Policy*: $1.5 million. This request supports all activities associated with updating CMS processes, policy changes and code analysis for national coverage determinations, and quality measures.

- *Training, Outreach & Education*: $1.3 million. This request supports the development and implementation for industry education and outreach, coding training for CMS and related personnel, state Medicaid agencies, MACS, Medicare Advantage plans, ICD-10 website maintenance, materials development, and national provider webinars.

- *Planning Requirements*: $2.9 million. This request supports program management activities, monitoring component progress, and compliance tracking.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at a reasonable cost. CMS develops, implements, and evaluates a variety of research and demonstration projects, in addition to maintaining and building the necessary data and information products that support both internal and external research. These activities cannot be funded under ACA section 3021.

CMS continues to invest in the Medicare Current Beneficiary Survey (MCBS), demonstrations and other research activities as key tools for monitoring, evaluating and improving how care is delivered and financed under Medicare and Medicaid.

- *Medicare Current Beneficiary Survey* – The MCBS is a continuous, multipurpose, in-person survey of a representative sample of the Medicare population. The MCBS is designed to aid the Centers for Medicare & Medicaid Service's (CMS) administration, monitoring and evaluation of the Medicare program, and is also widely used for research and analytics outside of CMS by health services researchers and policy analysts. The survey is focused on health care use, cost and sources of payment and comprehensively captures beneficiaries whether aged or disabled, living in the community or facility, or served in managed care or fee-for-service.

  The MCBS is uniquely positioned to provide information and insight into the Medicare population that is unavailable via any other CMS (or non-CMS) data or information source. With over 20 years of continuous data collection to-date (over 1 million interviews), the MCBS is the most comprehensive and complete survey in existence on the Medicare population. As the definitive survey for the Medicare population, MCBS enables CMS to determine sources of payment for all medical services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; develop reliable and current information on the use and cost of services not covered by Medicare (such as coverage gaps in the prescription drug

benefit and long-term care); ascertain all types of health insurance coverage and relate coverage to sources of payment; and monitor the financial effects of changes in the Medicare program. Additionally, the MCBS is the only source of multi-dimensional person based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the Medicare program. The MCBS captures both Medicare-covered and non-Medicare services, payments and information. The MCBS has been used both internally and externally in research and development activities, resulting in over 700 research and/or policy-related publications to date.

The MCBS data is of importance to: decision-makers for crafting legislation; the Congressional Budget Office (a prime user of our MCBS data) in developing legislative estimates; actuaries for compiling the annual Trustees' Report as well as calculating figures in the National Health Accounts; and, internal CMS researchers, policy analysts, and external researchers projecting the consequences of alternative policies for the Medicare population and the Medicare budget. Foundations such as Kaiser, R W Johnson, and the Commonwealth Fund also use MCBS data for policy analyses.

- *Demonstrations* – CMS plans, designs, conducts, and monitors demonstrations to test potential improvements in Medicare coverage, expenditures, delivery, access and quality of care. CMS translates research and concepts into demonstrations, performs evaluations and applies knowledge gained to program improvements. The demonstrations are real-world tests that yield real-world impacts of potentially new policy approaches on beneficiaries, providers and program expenditures. Past demonstration projects have influenced almost every major new payment system and/or method, the evolution of the Medicare managed care program, and delivery system and benefits decisions.

  In FY 2014 CMS will perform the following demonstrations:

  - Acute Care Episode Demonstration: The Acute Care Episode (ACE) Demonstration is testing the effect of bundling Part A and B payments for episodes of care as opposed to payment by individual service to improve the coordination, quality, and efficiency of that care. Building upon the experience of prior bundled payment demonstrations, the ACE Demonstration has been instrumental in refining bundled payment methodologies and in developing an electronic bundled payment claims processing system with national applicability. Implemented for specified cardiac and orthopedic procedures in five health care systems between 2009 and 2010, the demonstration continues to have four active sites, all of which have been accepted into the Bundled Payment for Care Improvement (BPCI) initiative to be initiated later this year. Until that time, the ACE sites will continue to enhance and refine their bundled payment practices and procedures for incorporation into the BPCI initiative.

  - Medicare Health Care Quality Demonstration: The Medicare Health Care Quality Demonstration is mandated by section 1866C of the Social Security Act, as added by section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Broadly stated, the goals of the Demonstration are to: improve patient safety; enhance quality; increase efficiency; and reduce scientific uncertainty and the unwarranted variation in medical practice that results in both

lower quality and higher costs. Four sites were chosen (each with a different intervention and evaluation plan). Two sites – North Carolina Community Care Network (NC-CCN) and Indiana Health Information Exchange (IHIE) – have recently ended intervention activities while the other two sites – Meridian Health System and Gundersen Lutheran Health System – continue to enroll beneficiaries. FY2014 funds are required to conduct evaluation activities for all four sites, with final reports and claims data analysis being conducted for the NC-CCN and IHIE, and primary data collection (including site visits), claims analysis, and report generation for the two active sites. These evaluation activities are designed to examine the impact of the demonstration on cost, quality, and utilization of Medicare services.

- Frontier Community Health Integration Demonstration: This demonstration was originally authorized by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and was reauthorized by the Affordable Care Act with minor revisions. The demonstration was created to accomplish multiple goals: 1) to ensure the adequacy of reimbursement to eligible CAHs; 2) to work with Medicaid on innovative reimbursement strategies; 2) to streamline survey and certification methods; and, 4) to explore other avenues for regulatory reform. Hospitals in 4 states (Montana, Wyoming, North Dakota, and Alaska) are eligible for the demonstration. CMS anticipates that this demonstration will begin implementation in FY2014. The funds will be used for finalizing the design of the model through a research contractor and for the costs of Medicare Administrative Contractors to implement the payment changes that would be associated with the model.

In 2011 and 2012, CMS continued to test for potential improvements in Medicare by designing, implementing, and evaluating demonstrations with interventions and/or changes to Medicare in the following key areas: Health Information Technology (IT), Care Coordination/Disease Management/ Prevention, Value-Based Purchasing, Payment/Delivery System, Medical Homes, and other areas. CMS released numerous demonstration evaluation reports in 2012, including:

- Senior Risk Reduction Program – Year 1 report
- Home Health Pay for Performance Demonstration – Final report
- Post-Acute Care Payment Reform Demonstration – Final report, Report to Congress
- Hospital-Acquired Condition - Present on Admission Program – Environmental Scan, Evidence-Based Guidelines, Incremental Reimbursement /Cost of a Hospital-Acquired Conditions, Readmissions due to a Hospital-Acquired Condition, State Government Tracking of Hospital-Acquired Conditions, Strategy to Examine Spillover Effects and Unintended Consequence, Accuracy of Coding of Hospital-Acquired Conditions, Report to Congress

Other demonstration evaluation reports released under the program management research agenda may be found at http://www.cms.gov/Reports/Reports/list.asp

- *Other Research* – Other research activities include various projects aimed at maintaining and building the necessary data and information products to support both internal and external research, and various types of evaluation research (i.e.,

program evaluations, prospective payment systems evaluation, refinement and monitoring).

CMS continues to develop, enhance and administer multiple initiatives aimed at providing important data products and information key to research efforts. One such tool is the chronic conditions warehouse (CCW). The CCW houses CMS data that are easily linked, at the individual patient level, for all Medicare and Medicaid claims data, eligibility data, nursing home and home health assessments, and CMS beneficiary survey data. This data warehouse transforms and summarizes this administrative health insurance information into research data files, thus providing researchers all the information they need to conduct studies focused on improving the quality and cost of care provided to chronically ill beneficiaries. In addition, the CCW project supports the CCW Website (www.ccwdata.org) which includes documentation on the various data sets available via the CCW and provides a number of static data tables related to the Medicare and Medicaid population as well as an interactive Chronic Conditions Dashboard.

Another tool CMS makes available to external and internal researchers is the Research Data Assistance Center (ResDAC). ResDAC develops and enhances the capabilities/expertise of the overall health services research community by providing insight and education into CMS data and data systems. The purpose of the ResDAC is to increase the number of researchers skilled in accessing and using CMS data for research studies, which in turn may lead to improvements in the Medicare and Medicaid programs and add value to current CMS activities. The ResDAC operates a help desk and a website resource which handles over 3,000 requests per year.

- *Historically Black Colleges University and Hispanic Serving Institutions Research Grant Programs* – The Research program meets the crosscutting research needs of the wider health research community through grant programs that establish partnerships with Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs) researchers. These grants assist researchers in conducting health services research that supports the CMS mission and our diverse beneficiary population by presenting new paradigms, strategies, and tactics to reduce health care disparities and better the health of African American and Hispanic American populations. The HBCU grant program was established in 1995 and the HSI grant program was established in 1999.

Budget Request: $23.2 million

The FY 2014 budget request for Research, Demonstration, and Evaluation is $23.2 million, an increase of $2.0 million above the FY 2012 Enacted Level.

- *MCBS*: $15.8 million, the same as the FY 2012 Enacted Level request level. CMS will make all efforts to maintain the same level of operations for the MCBS, however cuts in content or sample size may be necessary to offset flat-lined funding with rising annual costs.

- *Demonstrations*: $1.0 million, a decrease of $1.1 million below the FY 2012 Enacted Level request level due to demonstrations that have expired since 2012.

This funding will support the Acute Care Episode, the Medicare Health Care Quality demonstrations, and Frontier Community Integration demonstration.

- *Other Research*: $5.8 million, an increase of $2.9 million above the FY 2012 Enacted Level request level. This funding supports efforts that build and improve CMS' health service research, data and analytical capacity, as well as program evaluations. These activities include, for example, the Chronic Condition Warehouse (CCW), Research Data Assistance Center (ResDAC) and CER Public Use Data Files and Medicaid Analytic Data.

- *HBCU/HSI Research Grants*: $0.6 million, an increase of $0.2 million above the FY 2012 Enacted Level request level. These grants support the crosscutting research needs of the wider health research community.

III. MEDICAID & CHIP INITIATIVES

Program Description and Accomplishments

Medicaid and CHIP Operations

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP).

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families, pregnant women, people of all ages with disabilities, and people who require long-term care services and supports, who all should receive coordinated, quality care. The average enrollment for Medicaid is expected to be 65.7 million in FY 2014, about 21 percent of the U.S. population.

Congress has recently passed several pieces of legislation that have impacted Medicaid. The ACA provided states the option of expanding eligibility for Medicaid to all legal adult residents with incomes below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014; states have the option to expand coverage earlier. Several provisions of the Affordable Care Act provide substantial new funding for developing a Medicaid adult quality measurement program to complement the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In addition, the law includes other provisions that expand the Federal-State partnership in disease prevention and quality improvement in health care.

CHIP was created through the BBA of 1997 to address the fact that at the time nearly 11 million American children - one in seven - were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly $40 billion over ten years, beginning in FY 1998, to create CHIP - the largest health care investment in children since the creation of Medicaid in 1965. The original CHIP budget authority expired September 30, 2007, but was extended by Congress through March 31, 2009 in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007. On February 4, 2009, CHIPRA was enacted reauthorizing CHIP and extending funding through FY 2013. The ACA provided additional funding for CHIP through 2015.

Beginning in FY 2013, CMS requested to fully fund Medicaid and CHIP operations in Program Operations. The requested funding will be used to carry out the following priority activities for Medicaid and CHIP:

- *Affordable Care Act (ACA) Implementation* – The ACA changes how income-based eligibility is determined for applicants to the Medicaid and CHIP programs. CMS published a new Medicaid eligibility regulation in FY 2012, closely aligned with eligibility rules for the Federal Marketplace, under which States will use a Modified Adjusted Gross Income (MAGI) basis for determining eligibility. Under the new eligibility rules, States will develop new eligibility policies and convert their existing income-based eligible population thresholds to MAGI-based thresholds.

  The ACA also enables States to expand their existing Medicaid programs to cover individuals with incomes up to 133% of the FPL. For States that expand their Medicaid programs, the Federal government will cover 100% of the medical assistance costs for newly eligible populations for CYs 2014 through 2016, after which the level of assistance gradually phases down to 90% in CY 2020 and beyond. CMS and states will implement methodologies that distinguish newly eligible populations from previously eligible populations.

  In FY 2014, CMS will be working closely with States as they implement the MAGI-based methodologies, perform the MAGI conversions and calculate and implement the appropriate Federal Medical Assistance Percentage (FMAP) rates for their Medicaid and CHIP populations.

- *Program Integrity and Financial Management* – Financial management and program management activities are critical to the Medicaid program, particularly as the program grows with the ACA expansion in 2014. Managed care is already the predominant delivery system for State Medicaid and CHIP programs, and its growth is expected to accelerate in FY 2014. Not only will the newly eligible populations likely be served through managed care plans, States continue to expand managed care to more and more vulnerable populations needing long-term care services. To that end, CMS will continue to improve its managed care oversight and monitoring activities begun in FY 2013, including focus on the intersection between managed care and long-term care services. CMS will also engage more intensively with States to obtain complete managed care encounter data, both for supporting program analyses and to ensure that Medicaid and CHIP beneficiaries are able to access high quality health care.

CMS will also continue to advance the modernization of Medicaid and CHIP business processes through continued development and implementation of the MACPro system for automating the submission and review processes for State Plans and Waivers and completing the implementation of a new process and system for collecting Medicaid and CHIP operational data from States.

- *Medicaid Moving Forward and State Health Reform Initiatives* – Within the existing Medicaid program, considerable authority exists for CMS to approve innovations in health care delivery in States. These can take the form of amendments to the existing State plan or as waivers to current Federal Medicaid policy. These State proposals often affect health care delivery to hundreds of thousands to millions of beneficiaries and impact Federal funding in the hundreds of millions to billions of dollars. Each of these proposals must be carefully reviewed, negotiated and then evaluated to determine outcomes. CMS also processes State Plan Amendments (SPAs), waiver applications, and other State-initiated requests. CMS expects to receive hundreds to thousands of these types of proposals in FY 2014.

  The ACA and other legislation mandates establishing outcomes-based performance measurement in Medicaid and CHIP. In FY 2014, CMS will be working with States to establish and implement quality measurement programs for both children and adults, and begin collecting quality measures from States.

Budget Request: $23.7 Million

The FY 2014 budget request for Medicaid and CHIP operations is $23.7 million, an increase of $10.9 million above the FY 2012 Enacted Level. Funding in this section includes support for certain administrative activities necessary to operate Medicaid and CHIP. Information on benefit dollars for these programs can be found in the chapters titled “Medicaid” and “CHIP” later in this book.

- *State Communication and Outreach*: $7.9 million. There are several projects underway to prepare for the 2014 expansion in Medicaid. CMS will be working in conjunction with states to design the programs, tools and systems needed to ensure that high-performing health insurance programs are in place and are equipped to handle the fundamental changes brought about by the Affordable Care Act. A stakeholder communication strategy is imperative to maintain partnerships with States and keep them informed as implementation materials are developed, tested and implemented. Support is also needed to keep beneficiaries informed via websites.

- *Increased Match Rates for Expansion Populations*: $4.2 million. CMS is responsible for all implementation, State training and technical review of State-based processes and plans for this activity. With contractor support, CMS will obtain statistician assistance with the development of State methodologies for the applying and increased FMAP. In addition, the implementation contract will provide technical guidance and support to assist States in identifying and developing methodologies in accordance with the required time frames. The associated implementation contract activities could include onsite staff support for States, compiling and analyzing data for States and assisting States with completion of documents for submission.

- *Survey of Retail Prices*: $3 million. This request funds the monthly survey of retail community pharmacy prescription drug prices and the generation of publicly available pricing databases. These databases will afford State Medicaid agencies a valid array of covered outpatient drug prices, from ingredient costs paid by retail community pharmacies to those prices available to the consumer. The State agency can use this information to compare their own pricing methodologies and payments to those derived from this survey.

- *Medicaid Managed Care Oversight*: $3 million. Many States are now moving to enroll their highest cost populations into managed care arrangements. CMS expects the growth in managed care delivery systems to reach upwards of 80% of Medicaid beneficiaries nationwide by 2014. This funding will be used to ensure that the increased use of managed care delivery systems for Medicaid is based on prudent and accountable purchasing strategies at the State level and results in quality care and positive health outcomes for all Medicaid beneficiaries, including vulnerable populations needing long-term care services.

- *1115 Demonstration Management and Transparency Support*: $2.0 million. The number of section 1115 demonstration submissions has grown significantly and the trend is expected to continue. In addition, the ACA required the Secretary to implement a process to allow public comment and notice on the submissions. The breadth and complexity of the submissions is a significant challenge as States both confront significant State budget challenges and desire to reform their health care delivery systems through Medicaid authorities. Funds will be used to obtain contractor support in reviewing and evaluating 1115 demonstration submissions and to maintain the web site that is used to support the public commenting capability.

- *Implementation of Medicaid Primary Care Rates and Medicaid Access Regulation*: $1.8 million. Contractor support is needed to provide technical assistance to States to help ensure that States accurately determine difference between both their 2009 fee-for-service and managed care rates in order to determine the appropriate differential which is eligible for 100% Federal matching funds in compliance with the Affordable Care Act. Contractor support is also needed to provide technical support to states as they implement final regulations under development which would create a standardized and transparent process for states to follow as they assure that Medicaid services under the state plan are available at least to the same extent those services are provided to the general population in geographic areas. While this requirement has been long-standing in the Medicaid statute, CMS has yet to define the framework that will guide states in meeting their ongoing obligation to demonstrate and monitor beneficiary access to care.

- *Project Analysis and Testing of MAGI Conversion Methods and Development of Statistical Methods & Models for FMAP*: $1.0 million. Contractor support is needed to provide technical assistance for States who will be submitting MAGI conversion plans for eligibility, converting income standards for eligibility groups for eligibility purposes, and FMAP purposes, submitting income conversion plans to CMS for review, submitting FMAP methodology documents for CMS for

review, and submitting State plan amendments to reflect new income standards for review.

- *Access to Care*: $0.8 million. To comply with the Americans with Disabilities Act, these funds will support the "Community Integration Campaign". This campaign will engage Medicaid participants who are aged and/or disabled, advocacy groups, and staff from across the Department to gather information and create an action plan to ensure that all Medicaid participants are served in the most integrated setting appropriate. In addition, the funds will be used to implement the new statutory authority under the Affordable Care Act which will allow States to implement health home delivery models that transform the way care is provided and coordinated for Medicaid individuals with chronic conditions.

IV. HEALTH CARE PLANNING AND OVERSIGHT

Program Description and Accomplishments

CMS administers and oversees private health plans including Medicare Advantage (MA) (Part C) and Medicare prescription drug benefit (Part D) programs as well as private insurance market reform and oversight activities established under the ACA.

The following material elaborates on the systems, management, and review activities needed to run these programs.

Part C and D Information Technology (IT) Systems Investments

CMS maintains several major systems needed to run the Parts C and D programs.

These systems include:

- *Medicare Advantage Prescription Drug Payment System (MARx)* – This system supports the Medicare Modernization Act (MMA) Title I and Title II requirements for beneficiary enrollment and calculation of payments. The MARx also supports the Premium Withhold System (PWS).

- *Medicare Beneficiary Database Suite of Services (MBDSS)* – This project contains beneficiary demographic and entitlement information. The MBDSS stores Low Income Subsidy (LIS) beneficiary status. It also derives Part D eligibility periods, processes State Files for the State Phase Down Billing System and deeming process, deems beneficiaries eligible for LIS, and assigns LIS beneficiaries to a Part D drug plan.

- *Drug Data Processing System (DDPS)* – This system collects the prescription drug event (PDE) data for each Medicare Part D claim and is used to generate invoices to prescription drug manufacturers for the coverage gap discount program (CGDP).

- *Payment Reconciliation System (PRS)* – This system takes prospective payment data from MARx, the PDEs from DDPS, and direct and indirect remuneration (DIR) reports from the Health Plan Management System (HPMS) to calculate final reconciliation payments for Part D sponsors.

- *Integrated Data Repository (IDR)* – The IDR stores data from multiple CMS systems and programs for analytic and operational purposes.

- *Retiree Drug Subsidy System* – This system collects sponsor applications, drug cost data, and retiree data, and processes this information in order to pay retiree drug subsidies to plan sponsors. This system supports drug plan sponsors' participation in the Retiree Drug System program through data center hosting, hardware/software maintenance, system technical support, data/database administration and system security testing.

- *Risk Adjustment System* – This system uses demographic and diagnostic data to produce risk adjustment factors to support payments to MA and Part D plans.

Budget Request: $78.3 Million

The FY 2014 budget request for Parts C and D IT Systems Investments is $78.3 million, a decrease of $0.1 million below the FY 2012 Enacted Level. This request supports steady state Parts C and D IT system operations.

Oversight and Management of Health Plans

- *Medicare Parts C and D* - Oversight and management activities needed to run the Part C and Part D programs include obtaining actuarial estimates, reviewing bids from the prescription drug and MA plans, approving new plan applicants for the new contract year, reviewing formularies and benefits, monitoring current plan performance, reconciling prior year plan payments, and expanding and supporting Part D enrollment of low-income beneficiaries. Much of the Parts C and D oversight and management activities require contractor support.

  Oversight and management also includes Part C and Part D appeal reviews. CMS contracts with an independent reviewer to conduct reconsiderations of adverse MA plan determinations and coverage denials made by Medicare Advantage and PDP plans. This review stage represents the second level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs).

The Parts C&D appeals workloads history is presented below:

QIC Appeals Workload for Parts C/D – FY 2009 through FY 2014
(Appeals in Hundreds)

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Part C Appeals	61,625	62,420	64,843	92,365	93,000	111,000
Part D Benefit Appeals	20,733	18,958	13,872	14,879	25,000	30,000
Part D LEP appeals	40,728	35,246	31,332	36,472	45,000	50,000

Legislation has added many new activities that impact Parts C and D such as closing the Part D coverage gap, improving formularies, improving the system for handling Parts C and D complaints, reducing wasteful dispensing, and improving the Part D Medicare Therapy Management program.

- *Insurance Market Reform* – The Affordable Care Act includes several provisions that reform the private health insurance market. Between FYs 2010 and 2013, CMS released several significant rules related to these reforms, including regulations on new market reforms that go into effect in 2014. These regulations implement provisions relating to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, essential health benefits (EHB), and catastrophic plans. CMS continues to release technical sub-regulatory guidance related to these rules as well as the market rules that went into effect in 2010. Additional details on these regulations and related guidance can be found at: http://cciio.cms.gov/resources/regulations/index.html. Moving into FY 2014, CMS will be focused on working with states to ensure that these rules are being enforced and that consumers are benefiting from the changes included in the Affordable Care Act.

- *Medical Loss Ratio (MLR)* – The Affordable Care Act requires health insurance issuers offering group or individual coverage to submit an annual report to the Secretary on the proportion of premium revenue spent on clinical services and quality improvement activities, also known as the medical loss ratio (MLR). The MLR rules require insurance companies to spend at least 80 or 85 percent, depending on the market, of their premium dollars on reimbursement for clinical services to enrollees and on quality improvement activities or pay a rebate to their customers if they fail to meet these standards. Insurers submitted their first annual report detailing their spending on health care and quality improvement activities in June 2012. Any insurer not meeting its MLR was required to provide a rebate to policyholders by August 1, 2012. The annual reports, including information on issuer's rebate payments, are available to the public on the HHS website.

- *Rate Review* – Since September 2011, issuers seeking rate increases of 10 percent or more have been required to submit their proposed rate increase for review. These rates then undergo an actuarial review by either a state, or, if a state is unable to review the proposed increases, then CMS. Information on these proposed rate increases as well as any justifications for increases found to be unreasonable are made available to the public on Healthcare.gov. Beginning with rates that going into effect in 2014, the Affordable Care Act requires that the Secretary, in conjunction

with the states, “monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.” To assist in this monitoring function, CMS released final rules that adds a reporting threshold for any rate increase above zero as well as amends the standards for health insurance issuers and states regarding reporting, utilization, and collection of data for the program. Those increases above 10 percent would continue to undergo an actuarial review for reasonableness. CMS also updated the data template used to collect information on rate increases. The new template allows states and CMS to review for the rating rules that go into effect in 2014 as well as to review rates for the reasonableness of the proposed increases. A copy of the rules and updated data template can be found at: http://cciio.cms.gov/resources/regulations/index.html.

- *Health Insurance Marketplaces* – The Health Insurance Marketplaces, also known as the Affordable Insurance Exchanges, sets up a new competitive private health insurance market, giving tens of millions of Americans and small businesses access to affordable coverage. The Marketplace will allow individuals and small businesses to pool their purchasing power and compare health plan options. If a State elects not to establish a State-based Marketplace, CMS must establish a Federal Marketplace in that State and perform all Marketplace functions. These functions include:

    - Determining consumers’ eligibility for a number of health insurance programs and facilitating enrollment;
    - Reviewing health plan benefits and rates in order to certify qualified health plans (QHPs);
    - Establishing a separate Marketplace for small employers, called the Small Business Health Option Program (SHOP); and,
    - Developing the back-end infrastructure for organizing the Health Insurance Marketplace.

  In establishing a Federal Marketplace, CMS will work with interested States to perform these functions, through State Partnerships and Cooperative Agreements.

  In addition to operating a Federal Marketplace in States that opt not to establish their own, CMS will have responsibilities on behalf of all Marketplaces, such as developing quality improvement and transparency standards, determining eligibility for advanced payment of the premium tax credits, performing eligibility appeals, and conducting certification and oversight.

  In addition to the Marketplace, the ACA establishes two transitional risk-sharing programs, reinsurance and risk corridors, as well as a risk adjustment program which will operate on an ongoing basis. These programs are sometimes referred to in aggregate as premium stabilization programs, or the “3Rs.” States that operate a State Based Marketplace will have the opportunity to operate a risk adjustment program with Federal guidelines on methodology. In States that do not operate a risk adjustment program, CMS will operate the program. HHS has developed uniform reinsurance parameters and States have the flexibility to supplement these parameters with additional contributions. Risk corridors are a temporary Federal program that will be operated solely by HHS.

  Other financial management activities include the implementation of refundable premium tax credits and non-refundable cost-sharing reductions for individuals

enrolling in QHPs. CMS will work with other Federal agencies such as Treasury and the Social Security Administration to verify eligibility for these programs. CMS is responsible for developing these insurance affordability programs and for operating them for and for operating on behalf of all States.

CMS published several Marketplace-related regulations in 2012: a final rule setting forth standards for the reinsurance, risk corridors, and risk adjustment programs, the Exchange Final Rule, and a final rule related to the data collection and recognition of accrediting entities. CMS also published proposed rules on market reforms, rate review and wellness, and on essential health benefits. Additionally, in early December 2012, CMS published the draft Notice of Benefit and Payment Parameters, which included additional technical detail regarding the premium stabilization programs, and standards for administering the advance payment of premium tax credits, and cost sharing reductions, and included several provisions on the SHOP.

In 2013, CMS released proposed rules that included Marketplace eligibility and enrollment provisions, including appeals, and coverage exemptions and minimum essential coverage. CMS also finalized the essential health benefits, market reforms, and Notice of Benefit and Payment Parameters regulations in this year.

CMS released several Marketplace-related guidance documents in 2012, including an illustrative list of the largest three small group products in each State, a list of Frequently Asked Questions (FAQs) on essential health benefits, a list of FAQs on Marketplaces, Market Reforms, and Medicaid, and a bulletin on actuarial value and cost sharing reductions. Additionally, CMS released bulletins on verification of employer-sponsored coverage, risk adjustment, and reinsurance.

Additional details on Marketplace-related regulations and guidance can be found at http://cciio.cms.gov/resources/regulations/index.html.

Budget Request: $887.5 Million

The FY 2014 budget request for Oversight and Management is $887.5 million, an increase of $760.0 million above the FY 2012 Enacted Level.

- *Medicare Parts C and D*: CMS requests $65.6 million, a $6.8 million increase above the 2012 Enacted Level. This funding supports the on-going Medicare Part C and Part D reconsideration contracts, audits, actuarial reviews, and estimates of Medicare Advantage and Prescription Drug Plans. It also funds new initiatives such as closing the Medicare Part D coverage gap, reforming MA plan payments, and making improvements to Part D plan operations.

- *Insurance Market Reform, Oversight, Medical Loss Ratio (MLR) and Rate Reviews*: CMS requests $18.4 million, an increase of $3.8 million above the FY 2012 Enacted Level, to fund ongoing compliance and enforcement activities and new work associated with the implementation of the 2014 market rules.

- *Operations and Management of Marketplaces*: CMS requests $803.5 million, an increase of $755.8 million above the FY 2012 Enacted Level. In addition, CMS

expects to collect and expend an additional $150 million in user fees to fully fund Marketplace Operations.

- Eligibility & Enrollment: A minimum function of the Marketplace is to determine eligibility for enrollment in a qualified health plan through the Marketplace and for insurance affordability programs (advance payments of the premium tax credits (APTC), cost-sharing reductions (CSR), Medicaid and CHIP). In those States that do not elect to establish their own Marketplace, or who opt to partner with CMS to operate the Marketplace, CMS will handle eligibility and enrollment.

  CMS must reconcile enrollment records across issuers and Federal and State-run Marketplaces in order to ensure that applicants are enrolled accurately, and that they are not enrolled in coverage and receiving tax credits and cost-sharing reductions through more than one Marketplace.

  CMS also has responsibilities for eligibility and enrollment activities on behalf of all Marketplaces, such as establishing an appeals process for appeals in the individual and SHOP markets, as well as certain appeals by employers appealing their notice of potential tax liability sent by the Marketplace. CMS will also adjudicate appeals for decisions made by the Marketplace regarding exemptions from the shared responsibility payment.

  In addition, eligibility support staff will handle mail intake, process paper applications, review verification documentation, and resolve complex issues for Federally-facilitated and State Partnership Marketplaces. CMS will also access external source of income data that will provide for more accurate eligibility determinations.

  Additionally, the FY 2014 Budget request reflects the cost of printing and mailing a number of paper notices to the applicant population should they request paper notices (and not electronic notices).

- Health Plan Benefit and Rate Review, Management, and Oversight: In FY 2014, CMS will focus activity under the Federal Marketplace on continuing to qualify new health plans to be members of a Marketplace across both the individual and small group markets. Although QHPs will already have been certified in FY 2013 for the 2014 benefit year, CMS expects that new plans will seek certification for the 2015 benefit year. Once QHPs have been certified, CMS will annually engage in the work of re-certifying and potentially de-certifying plans. CMS is tasked with QHP issuer oversight in the Federal Marketplace. In conjunction with States, CMS will monitor the performance and compliance of Federal Marketplace issuers, and work with issuers and their respective states to address any areas of concern.

- Payment & Financial Management: In order to fully implement the Marketplace and three market stabilizing programs (reinsurance, risk corridors, and risk adjustment) in 2014, CMS will provide support to educate stakeholders about critical program-related information. Throughout FY 2014, CMS will collect data through the use of a distributed approach to support risk adjustment and reinsurance payments and charges that will occur in FY 2015.

To ensure the integrity of programs that redistribute tens of billions of dollars, CMS must have robust systems to audit and/or validate user fees, calculations of cost-sharing reductions, advance payment of premium tax credits, reinsurance, risk corridors, and risk adjustment, carefully track operational data and metrics (e.g. reinsurance payments, payment parameters, audit methodology, populations, etc.) across the three market stabilizing programs and the Marketplaces, as well as to implement and maintain a fraud surveillance program to prevent and detect fraud, waste, and abuse. CMS will use proactive measures including data mining techniques and other analytic activities to detect anomalies that may be indicators of fraudulent activity.

- SHOP & Employer: In FY 2014, CMS will operate Federally-facilitated SHOP (FF-SHOP) Marketplaces for States that do not elect to build their own.

  In FY 2014, SHOP activities will focus on developing and coordinating the capacity to provide SHOP-specific technical assistance to States, analyzing small group markets in each State and conducting SHOP-specific issuer and broker training.

  To accomplish the required provisions of the Affordable Care Act, CMS will establish a toll-free line to help SHOP employers and employees with questions about health insurance coverage through the Marketplace program. The call center will assist SHOP employers and employees looking for and comparing health plans to enroll in a health plan that meets their needs and budgets. SHOP employers will need customer service assistance with benefit administration activities, such as changing employee employment status and setting up accounts for eligible employees within the organizations.

  CMS will be coordinating with and leveraging the infrastructure of the existing 1-800-MEDICARE call center to provide this service. CMS' request assumes this coordination.

- Marketplace Quality Review: Quality activities for FY 2014 will include the development of the statutorily-mandated QHP-specific quality rating, enrollee satisfaction survey system and quality improvement strategy metrics for all Marketplaces. For the quality rating, this will include planning the beta test making refinements to the quality rating measure set based on input from testing, providing technical assistance to States and issuers, and implementing a process for reviewing alternative quality rating methodologies developed by State-based Marketplaces. For the survey, providing technical assistance to issuers and Marketplaces, and planning for the beta test, providing training and oversight to survey vendors, and developing and testing a child-only survey. Quality activities will also include setting requirements for certification for QHPs in the Marketplace including that health plans be accredited.

- State Grants, Technical Assistance, & Oversight: CMS will utilize policies, procedures and processes for on-going oversight and monitoring of State-based Marketplaces (SBMs) and Partnership Marketplace activities. CMS conditionally approved 18 SBMs and 7 Partnerships for January 2014. Many States will continue to work toward a SBM or Partnership Marketplace for the following plan year FY 2015

V. HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality Improvement Initiatives

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value based purchasing (VBP) programs and other CMS health care quality initiatives. In FY 2014, CMS plans to perform activities that achieve the development of a coordinated quality improvement strategy aimed at adjusting payments to providers and suppliers based on quality performance, increasing availability of information on performance, and sharing in savings with providers who meet efficiency targets while also providing high quality care.

Examples of these initiatives include:

- *VBP Initiative, End Stage Renal Disease (ESRD)* – CMS' request supports the ESRD value based purchasing initiative including the development, implementation and organizational support authorized by MIPPA 153c and support for the development of performance models, standards, and public reporting. CMS will reduce ESRD payments by up to 2 percent to dialysis providers and facilities that fail to meet a total performance score with respect to certain specified performance measures. We successfully implemented the FY 2012 ESRD-QIP program by paying dialysis facilities based on their quality of care. CMS successfully provided facility outreach and education, calculated measure rates and performance scores, awarded several contracts to monitor and evaluate the program and any unintended consequences for the FY 2012 program.

- *Development of Quality Measures* – CMS is required by the ACA to develop quality measures for use in evaluating Medicare programs. The funding will be used for the development and maintenance of quality measures needed for the implementation and ongoing support for efforts that require new quality reporting programs, new payment reduction programs, new value-based purchasing programs, new requirements to existing quality reporting programs, new measure development, and new support for quality measures. In FY 2012, funding was used to support the maintenance of 18 hospital outcome measures and the development of 4 new hospital outcome measures, the maintenance of 16 nursing home measures, the development of 2 new nursing home outcome measures, the maintenance of 96 Home Health quality measures, and the development of 2 new Home Health measures. The FY 2012 funding was also used to support the calculation of 21 different hospital measures that are used in the Hospital Value Based Purchasing Program, Hospital Compare, and the Hospital Readmission Reduction program. This funding also supported the maintenance of 33 measures for the Medicare Shared Savings Program.

- *Medicare Shared Savings Program* – On October 20, 2011, CMS released rule establishing a Shared Savings Program in which provider groups and suppliers who agree to meet quality standards can be eligible to share in the cost-savings they achieve through the Medicare program. The final rule stipulates that groups of providers from Accountable Care Organizations (ACOs) will be held accountable for the efficiency and quality of care rendered to at least 5,000 Medicare beneficiaries.

ACOs will qualify to share in savings generated for Medicare by meeting 33 quality benchmarks. Some ACOs may be subject to shared losses. This provision requires notice and comment rule making and significant contract support to accept and review program applications from ACOs, assist with claims data analysis and reports, calculate shared savings payment, measure quality performance and conduct follow-up monitoring to guard against inappropriate avoidance of beneficiaries and their care. In 2012, CMS announced 114 new ACOs. In January 2013, 106 ACOs were added to the program. CMS modified existing program monitoring, CAHPS, and Program Analysis contracts. In addition, in FY 2012 funds were used for data sharing, database support, help desk, testing, ACO portlet hosting, storage and licensing contracts.

- *Physician Feedback Improvements* – CMS must provide reports to physicians that compare their resource use among Medicare fee-for-service patients with that of similar physicians or groups of physicians. Because value is comprised of cost and quality, CMS also includes indicators of clinical quality in the feedback reports. The reports to be produced and disseminated in FY 2014 build on lessons learned from the reports produced in FY 2012 and FY 2013. The FY 2014 reports will incorporate refinements to align, and eventually consolidate physician reporting efforts to provide more comprehensive reports to physicians and thus increase CMS' operating efficiency.

- *VBP Initiative, Payment Modifier* – The ACA established a value-based payment modifier under the Part B Physician Fee Schedule and requires the Secretary to publish the performance period and measures of cost and quality of care that will be used to adjust physician payments under the modifier. Statute requires the modifier to be phased in starting in 2015 so that, by 2017, all participating physicians are subject to the modifier, which will apply to each payment physicians' receive under .the Physician Fee Schedule. CMS established initial cost and quality measures, as well as the initial performance period in the CY 2012 Physician Fee Schedule Final Rule and finalized policies in the CY 2013 Physician Fee Schedule to begin implementation of the value-based payment modifier by applying it to certain groups of physicians in 2015. The FY 2014 funding request includes critical funding necessary to both continue implementation of the value-based payment modifier and ensure CMS meets the statutory requirement to apply the modifier to all physicians by 2017. Specifically, FY 2014 funding will provide contractor support to create value scores that reflect important aspects of physician practice, patient outcomes and the efficient use of health care resources.

- *VBP Initiative, Hospital Value Based Purchasing* – ACA mandates the Hospital Value-Based Purchasing Program (HVBP), which provides value based incentive payments to hospitals based on their performance on specific measures. Section 1886(o)(2)(B)(ii), as added by section 3001 of the Affordable Care Act, requires inclusion of measures of Medicare spending per beneficiary in the Hospital VBP Program. CMS finalized the inclusion of the Medicare spending per beneficiary measure in the Hospital VBP Program, in the FY 2013 Inpatient Prospective Payment System (IPPS) Final Rule. The measure includes Medicare Part A and Part B payments. In order to perform the calculation of the measure so that Medicare spending can be compared across disparate geographic regions, all included payments must be standardized to remove differences attributable to geographic payment policies such as wage index and geographic practice cost

index. The FY 2014 request would provide funds for the existing contract tasked with the refinement of the standardization methodology used for the MSPB measure under the Hospital VBP Program, the Center for Strategic Planning and the Physician Value Modifier program to account for changes in CMS payment policy.

- *Hospital Readmission Reduction Program* – The ACA requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning October 1, 2012. The provision also requires the Secretary to make readmission rates for a hospital publicly available. In addition, the provision directs the Secretary to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations not later than two years after enactment. In FY 2013 and FY 2014 CMS will continue to administer payment adjustments for hospitals pursuant to this provision in ACA. CMS will calculate hospital specific readmission rates, calculate the hospital specific payment adjustment factor for excess readmissions and engage in rulemaking to maintain the current measures.

- *Medicare Data for Performance Measurement (ACA Section 10332)* - The ACA added a new subsection to Section 1874 of the Social Security Act, requiring that the Secretary establish a process to allow for the use of standardized extracts of Medicare Parts A, B, and D claims data by Qualified Entities (QEs) to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use.

Budget Request: $99.0 Million

The FY 2014 budget request for health care quality improvements is $99.0 million, a decrease of $43.8 million below the FY 2012 Enacted Level. This request will be used to implement the quality initiatives described above, and will support efforts to develop quality measures, conduct data analysis and validation, develop reporting infrastructure, apply appropriate risk adjustment methodologies, determine appropriate payments, make shared savings calculations, provide help desk support, conduct program monitoring, and support Value Based Purchasing programs.

- *VBP Initiative, End Stage Renal Disease (ESRD)*: $53.5 million. Funding is needed to implement the data validation work, which includes multiple data sources and to procure an analytics contactor as we move to an enterprise architecture information system. Additional technical support for providers is needed as the number of measures grows to include collection of patient experience of care and healthcare associated infection data.

- *Development of Quality Measures*: $11.2 million. The FY 2014 funding request is for development and maintenance of quality measures that support quality reporting programs and new measure development. In FY 2014, CMS will use this funding to develop a composite measure of Hospital Acquired Conditions for the Section 3008 Hospital Acquired Condition Payment Reduction Program and the Section 3001 Hospital Value Based Purchasing Program; to maintain existing and develop new Home Health Quality Measures, as well as to develop new Home Health Quality Measures, and to maintain existing Nursing Home Quality Measures and to develop new Nursing Home quality measures. The funding will

be used to calculate different hospital measures that will be used in the Hospital Inpatient Quality Reporting Program, the Hospital Readmissions Reduction Program and Hospital Compare. In addition, CMS will continue development of a patient experience of care survey for dialysis facilities, start development of risk-standardized mortality and readmission measures, maintain current anemia management measures, start development of pediatric measures, start development of an iron therapy measure, and measures assessing serum calcium and serum phosphorus concentrations. The FY 2014 funding will also support the refinement and maintenance of measure sets that will be used in CMS various quality programs and their associated methodologies.

- *Medicare Shared Savings Program*: $13.5 million. This request funds the automation review and the screening of ACO applications. Help desks will assist ACOs with inquiries on program operation. CMS must maintain and refine infrastructure to assign beneficiaries, calculate shared savings payments, assist with claims data analysis, develop and analyze reports, distribute reports and data files to ACOs and monitor the inappropriate avoidance of at risk beneficiaries and the potential under/over utilization of care. This includes compliance reviews and audits, leveraging ACO data to identify anomalies and potentially harmful trends; working with the Center for Program Integrity (CPI) to monitor ACO participants. Funding is required to expand and maintain ongoing operations as well as to leverage efficiencies from our initial investment in program implementation and collaborate with other CMS components. There are currently 220 ACOs that participate in the Medicare Shared Savings Program. A new application cycle began in 2013 with a new cohort of ACOs starting in January 2014.

- *Physician feedback reports and payment adjustments:* $10.0 million. The FY 2014 request would provide contractor support to develop and implement a registration module for Physician Quality Reporting System (PQRS) and Value Based Payment Modifier (VBPM) initiatives. Increasing report production and dissemination to physicians and physicians groups will require significant systems development and infrastructure to develop reports and calculate cost and quality measures. In addition, production and dissemination of a large number of reports requires significant outreach to the stakeholders to help them understand methodologies and to obtain feedback on additional ways to provide meaningful and actionable information in these reports. Our existing support contract will continue to develop reports for the expanding feedback program and will provide research and development to support the methodology used in the feedback reports including incorporating episode based costs, and the creation of a value-based payment modifier (ACA Section 3007).

- *VBP Initiative, Payment Modifier:* $4.6 million. CMS is in the process of implementing the value-based payment modifier; first applying it to certain physician groups beginning in 2015 and eventually to all physicians under the Physician Fee Schedule by 2017. To do so, we must simulate various options to construct the value-based payment modifier, provide physicians with information on the quality and cost of care delivered to their Medicare FFS beneficiaries, and continue to develop and disseminate reports for the expanding feedback program (section 3003).

- *VBP Initiative, Hospital Value Based Purchasing*: $0.5 million. Funding supports data standardization, analysis, and calculation of the Medicare spending per beneficiary measure to be included in hospitals Total Performance Score (TPS), on which hospital VBP payments must be based. CMS intends to seek National Quality Forum endorsement of the measure. Funding would be required for ongoing maintenance of the measure and its endorsement.

- *Hospital Readmission Reduction Program*: $0.7 million. The ACA requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning October 1, 2012. Funding is required to expand the methodologies used to identify hospitals with high rates of readmissions. CMS will make readmission rates for hospitals publicly available. Funding is also needed to expand the types of conditions considered under this policy in future years as required by the law. In FY 2014 CMS will continue to administer payment adjustments for hospitals pursuant to the ACA provision. CMS will calculate hospital specific readmission rates, calculate the hospital specific payment adjustment factor for excess readmissions and engage in rulemaking to maintain the current measures.

  CMS anticipates expanding the readmissions measures in 2015, so beginning in FY 2014, contractors will assist CMS with the rulemaking activities needed to expand these measures.

- *Medicare Data for Performance Measurement:* $5.0 million. CMS will procure the services of contractor staff to support three major areas: program management, data preparation and distribution, and technical assistance.

VI. OUTREACH AND EDUCATION

Program Description and Accomplishments

National Medicare Education Program (NMEP)

The National Medicare Education Program (NMEP) educates Medicare beneficiaries and their caregivers so they can make informed health care decisions. The program is comprised of five major activities including: beneficiary materials, the beneficiary contact center (BCC) or 1-800-MEDICARE, internet services, community-based outreach, and program support services.

- *Beneficiary Materials* - This request supports the printing and mailing of the *Medicare & You* handbook. The *Medicare & You* handbook satisfies numerous legal mandates including BBA Section 1851 (d) and MMA Section 1860(d) to provide print information to current and newly eligible beneficiaries about Medicare coverage options and available services, including plan comparison information for Medicare Advantage and prescription drug plans. The handbook is updated annually, and mailed to all current beneficiary households each fall. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

The costs associated with this funding line are printing/postage for the monthly mail contract (English and Spanish handbook to new enrollees), printing/postage for the October mailing (English and Spanish handbook to all current beneficiary households), large print English and Spanish handbooks, freight (shipping the handbook to local mail facilities, thus saving on postage costs), and on-site quality monitoring by Government Printing Office personnel.

The chart below displays the actual number of *Medicare & You* handbooks distributed for FYs 2009 -2012 and the estimated distribution for FYs 2013 - 2014. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

The *Medicare & You* Handbook Yearly Distribution
(Handbooks Distributed in Millions)

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Number of Handbooks Distributed	43.1	43.6	39.3	40.8	42.1	43.5

**The FY 2011 Actual decrease is due to increased efficiencies realized by improvements to the process used in identifying opportunities to consolidate beneficiary mailing addresses.*

- *1-800-MEDICARE/Beneficiary Contact Center (BCC)* – The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. This line provides beneficiaries with responses to both general and claim-specific Medicare questions. CSRs respond to inquiries including, but not limited to: Authorizations, Benefit Periods, Claims (including denials, filing or status), Election Periods, Deductibles, Coverage, Eligibility and Enrollment, Complaints, Plan Compares, Prescription Drug Benefit Enrollment and Disenrollment, Appeal Status, etc. Beneficiaries can also use 1-800 MEDICARE to report fraud allegations. CMS is using the information from beneficiaries' complaints in important ways. For example, CMS is generating weekly "fraud complaint frequency analysis reports" that compile provider-specific complaints and flag providers who have been the subject of multiple fraud complaints for a closer review. CMS has also developed the capability to map shifts and trends in fraud allegations reported to 1-800-MEDICARE over time, using geospatial maps and sophisticated data tools. These tools will allow CMS to gather more information from 1-800-MEDICARE calls for data analysis purposes

  1-800 MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800 MEDICARE while seeking to preserve the efficiencies and cost-effectiveness. Additionally, CMS uses a variety of quality assurance technologies and services to ensure that the responses provided are accurate and complete and continue to maintain excellent customer service.

The following table displays call volume experienced from FY 2009 through the FY 2014 estimate. In FY 2014, CMS expects to receive 27.0 million calls to the 1-800 MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system. Approximately 30 percent of the calls are handled completely by IVR.

1-800-MEDICARE/Beneficiary Contact Center Call Volume
(Call Volume in Millions)

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Number of Calls	25.9	25.6	25.3	25.6	26.0	27.0

- *Internet* - The Internet budget funds three websites:

  The http://www.cms.gov website is the Agency's public website for communicating with providers, professionals, researchers, and the press on a daily basis. It supports a variety of critical CMS initiatives, including outreach and education, delivery of materials to stakeholders electronically, and data collection.

  The http://www.medicare.gov website is the Agency's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools. These tools enable Medicare beneficiaries and their caregivers to obtain information on their benefits, plans, and medical options. The Medicare Plan Finder, Hospital Compare, Nursing Home Compare, and the Medicare Eligibility tool are included under this activity. The website serves as an effective and efficient communication channel and provides self-service options for U.S. citizens, beneficiaries, and caregivers.

  Beneficiaries also have access to the http://www.mymedicare.gov website to review and update their online account. Beneficiaries can log into mymedicare.gov, a secure website, and check their claims within 24 hours of the processing date. In addition, beneficiaries can use the website to view upcoming available preventive services, a Medicare Summary Notice or enrollment information as well as update their email address and add emergency contact information. Beneficiaries also can generate an On-the-Go Report which allows them to download personalized health information and share with their healthcare providers. Additionally, beneficiaries are able to download their personalized information using Blue Button.

In FY 2014, CMS estimates 285.0 million page views to http://www.medicare.gov, approximately a two-percent increase in traffic from the page views anticipated in FY 2013. CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and we continue to implement more self-service features for beneficiaries to use, maximizing their health and quality of care decisions.

www.Medicare.gov Page Views
(Page Views in Millions)

	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimate	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Number of http://www.medicare.gov Page Views	231.4	236.1	241.0	270.0	277.5	285.0

Note: CMS migrated to a new web analytics system in FY 11. Some of the benefits of this new system include increased visibility into user behavior and timelier access to web statistics. The migration to the new system has caused a re-baselining of our web statistics as the new tool measures page views differently. By all other metrics (for example online enrollments, number of completed transactions, system measures, (CPU memory) and others), traffic is consistent with the 2% + growth we have noted in previous years. Beginning in FY 12 and beyond, we anticipate this new baseline number will grow at a rate consistent with past years.

- *Community-Based Outreach* - Historically, CMS has administered and conducted community based outreach programs, including the State Health Insurance Assistance Program (SHIP), collaborative grassroots coalitions, and national, local, multi-media training and partnership building efforts that provide assistance at the local level. The SHIP will remain with CMS in FY 2014. CMS anticipates that the SHIP will serve over 2.2 million Medicare beneficiaries through one-on-one counseling and reach approximately 5 million total persons through public and media outreach.

- *Program Support Services* - This activity includes the multi-media Medicare education campaign, assessment activities, and consumer research. In addition, it funds the *Medicare & You* handbook support activities such as electronic and composition support, translation services, and production of the handbook and other NMEP materials in formats such as Braille and audio.

  The Multi-Media Medicare Education Campaign raises beneficiary awareness about the coverage options, benefits and services available through Medicare. It is designed to help people with Medicare and those who help them (caregivers including family and friends, information intermediaries and others) maximize the use of their Medicare benefits to maintain their health, resulting in healthier beneficiaries and lower costs for Medicare. The campaign also promotes Medicare's official information sources including 1-800-MEDICARE, medicare.gov, mymedicare.gov, Medicare & You Handbook, SHIPS, and other localized partners and resources.

National Medicare Education Program Budget Summary

(Dollars in Millions)

NMEP Category	Funding Source	FY 2012 Enacted Level	FY 2013 Annualized CR	FY 2014 President's Budget	Description of Activity in FY 2013
Beneficiary Materials	Total	$51.6	$44.8	$47.6	National Handbook with comparative information in English and Spanish (national & monthly mailing); initial enrollment packages to new beneficiaries; targeted materials only to the extent that funding is available after payment of the Handbook.
	Program Management	$33.6	$26.8	$29.6	
	User Fees	$18.0	$18.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	Total	$220.4	$237.4	$233.1	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives for 12 months. Includes funding previously allotted to FFS Medicare contractors for claims-related inquiries.
	Program Management	$168.3	$185.0	$180.0	
	User Fees	$52.1	$52.4	$53.1	
Internet	Total	$26.6	$22.8	$31.4	Maintenance and updates to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.
	Program Management	$23.8	$22.8	$31.4	
	QIO	$2.8	(TBD)	(TBD)	
Community-Based Outreach	Total	$1.8	$3.7	$5.0	Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to people with Medicare in their communities.
	Program Management	$1.8	$3.7	$5.0	
Program Support Services	Total	$21.1	$23.5	$22.9	A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, Audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as LIS.
	Program Management	$21.1	$23.5	$22.9	
	QIO	-	-	-	
	Total	**$321.5**	**$332.3**	**$340.0**	
	Program Management	**$248.6**	**$261.9**	**$268.9**	
	User Fees	**$70.1**	**$70.4**	**$71.1**	
	QIO	**$2.8**	(TBD)	(TBD)	

Budget Request: $269.0 Million

The FY 2014 Program Management budget request for NMEP is $269.0 million, an increase of $20.3 million above the FY 2012 Enacted Level. The following bullets highlight activities funded under the Program Management request:

- *Beneficiary Materials:* The FY 2014 budget request for Beneficiary Materials is $29.6 million, a decrease of $4.0 million below the FY 2012 Enacted Level. The majority of the budget request funds the cost of the *Medicare & You* handbook. This estimate is based on historical publication usage data and current market prices for printing and mailing. The unit cost of producing the handbook is approximately $0.93.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The FY 2014 budget request for 1-800-MEDICARE/BCC activities is $180.0 million, an increase of $11.7 million above the FY 2012 Enacted Level. This request supports a call volume estimated at 27.0 million calls in FY 2014, 1.4 million more calls than reflected in the FY 2012 Enacted Level. CMS expects to operate at no more than a 5-minute ASA in FY 2014, consistent with current policy.

  This request covers the costs for the operation and management of the BCC including the customer service representatives'(CSR) activities, print fulfillment, plan dis-enrollment activity, quality assurance, an information warehouse, content development, CSR training, and training development.

- *Internet*: The FY 2014 budget request for Internet is $31.4 million, an increase of $7.6 million above the FY 2012 Enacted Level. These funds will be used for ongoing maintenance costs, renewing software licenses, redesigning the http://www.cms.hhs.gov website to make it more user friendly, providing database support, as well as support for the Part D prescription drug plan and fall enrollment period requirements. This includes expanded Agency programs, ongoing security and testing, and monitoring activities. This funding supports ongoing efforts to increase beneficiary self-service via online channels and provide beneficiaries with expanded, easy to understand Medicare information through interactive tools, including an interactive electronic tool for the *Medicare & You* handbook. This includes expanding MyMedicare.gov services to provide integrated health management capabilities. CMS believes it is especially important to provide sufficient funding to activities that increase beneficiary self-service online. Because services accessed online are generally much less resource intensive than services accessed in person or via telephone, providing funds now to increase beneficiaries' use of online tools will reduce costs in the future.

- *Community-Based* Outreach: The FY 2014 budget request for Community-Based Outreach is $5.0 million, an increase of $3.2 million above the FY 2012 Enacted Level.

- *Program Support Services:* The FY 2014 budget request for Program Support Services is $22.9 million, an increase of $1.8 million above the FY 2012 Enacted Level. This project provides funding for support of the National Medicare

Education Program (NMEP) and includes: producing accessible materials for low vision/blind and disabled beneficiaries (audio tape, Braille and large print and e-reader designs), electronic and composition support for the *Medicare &You* (M&Y) Handbook, mail file creation for the statutory September mailing of the M&Y Handbook, NMEP consumer research and assessment (including consumer testing of the Medicare & You handbook), a publication ordering web site for partners, support for the Advisory Panel on Outreach and Education (APOE), and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

In addition to the Program Management request, the NMEP will receive approximately $71.1 million in user fees bringing the total funding level for NMEP to $340.0 million.

Provider Outreach

- *Provider Toll-Free Service* – Per section 1874(A) (g) (3) of the Social Security Act, CMS is required to offer a toll-free telephone service to providers. CMS maintains toll-free numbers for general provider inquiries and questions about enrollment, electronic claims, and Medicare secondary payer issues. The costs of the toll-free lines and support contracts are included in this category. The costs of answering the inquiries, including customer service representatives, are included in Ongoing Operations under Provider Inquiries. In FY 2012, the number of provider toll-free calls continued to drop, and we expect lower call volume for provider toll-free service to continue through 2014. Several factors contributed to this decline: enhancements to contractors' IVR systems and portals enable an increasing number of provider inquiries and providers' claims-related transactions to be handled via self-service; improvements in both CMS and contractors' websites, resulting in the availability of more information for providers that is easily accessible; improvements in CMS provider educational products, provider training, and outreach to providers; and more/improved training of CSRs, resulting in more efficient handling of provider telephone inquiries. CMS will continue these improvement activities into FY 2013 and FY 2014.

- *National Provider Education, Outreach, and Training* - National provider education, outreach, and training ensures consistency in educational tools, resources, training, campaigns, products, and materials needed by Medicare FFS providers and their billing and practice administration staff. Educational products, branded as part of the Medicare Learning Network® (MLN) include MLN Matters® national articles, MLN publications, web-based training courses, billing guides, CD-ROMs/DVDs, and National Provider Calls. Contractors and CMS Regional Offices are required to use MLN products in their outreach efforts.

  National Provider Calls are conducted throughout the year and deliver timely, accurate information about the Medicare program to Medicare FFS providers and suppliers. These live forums allow up to 20,000 participants to stay informed of program changes and ask questions of CMS subject matter experts. All calls are recorded and transcribed to extend their value and reach to the provider community. Podcasts and video slideshow presentations of many calls are developed to further the reach.

CMS also manages an accredited comprehensive Continuing Education (CE) Program. Over the last 2 years, the interest in CE has increased substantially and has necessitated an expansion of the current CE program. We are currently working toward accrediting a total of 40+ educational activities from across all CMS components (at this point in time we have approximately 20 accredited educational activities).

- *Federal Coverage and Payment Coordination* - The purpose of the Office is to coordinate within CMS as well as with external partners to more effectively integrate benefits under the Medicare and Medicaid programs and to improve the coordination between the Federal Government and States for individuals eligible for benefits under both programs in order to ensure that such individuals get full access to the items and services to which they are entitled.

Budget Request: $24.6 Million

The FY 2014 budget request for Provider Outreach is $24.6 million, a decrease of $5.3 million below the FY 2012 Enacted Level.

- *Provider Toll-Free Service*: $7.9 million. This request maintains steady state operations of the toll-free service.

- *National Provider Education, Outreach, and Training*: $8.5 million. Funding will support the development and dissemination of Medicare fee-for-service (FFS) educational information on Medicare policy and operations. This also supports fulfillment activities related to requests for hard copy products and national provider calls.

  CMS also requests funding to establish practical communications with a wide variety of physicians and allied health providers to reach beneficiaries in more remote locations across the country. This will be accomplished by developing tools for practitioners to use during office visits and other settings where messages and information regarding benefits and changes impacting beneficiaries can be shared and reinforced.

- Federal Coverage and Payment Coordination: $8.2 million. Funding will support contracts to perform:

  - Technical Assistance to States;
  - Technical Assistance to Providers;
  - Analytics Support;
  - Communicating with Medicare-Medicaid Enrollees;
  - Develop Quality Measures and Tools Development;

<u>Consumer Outreach</u>

- *Consumer Information & Outreach for the Health Insurance Marketplace* – Consumer information and outreach efforts are necessary to educate individuals on their health insurance options and responsibilities, increase awareness on access to affordable coverage, and assist consumers in making informed health care decisions. CMS is

responsible for consumer outreach and education activities in the Federal Marketplace. This work involves planning and developing consumer support resources and educational materials, including a consumer call center operated in conjunction with 1-800-Medicare. Outreach efforts must cast a wide net and target various segments of the population, including the uninsured and historically hard to reach populations. Effective and extensive outreach is critical to enrolling a diverse risk pool in the initial years of Marketplace operations.

- *Consumer Assistance* – Section 1311(i) of the Affordable Care Act established a grant program whereby Marketplaces will provide grants to entities and individuals to serve as Marketplace Navigators. HHS is required to award grants in FY2013 and beyond in States where the Federal government will operate a Federal Marketplace and in those States who opt for the State Partnership Marketplace. Navigators will assist consumers in understanding insurance affordability programs, comparing and selecting QHP's, and interacting with QHP issuers, State agencies, and the Federal Marketplace. CMS will also support other forms of in-person enrollment assistance in addition to navigator grantees.

- *Consumer Appeals* - The ACA provides consumers with the right to refute adverse benefit determinations made by their insurance company. In FY 2014, CMS will continue to fund and operate a Federal external review program for consumers in States that do not have an external review process that meets the minimum protections established by the Appeals regulation or the standards established by the Secretary through guidance. This program will also be open to self-insured non-Federal public employee health plans if they choose to participate. Through the Office of Personnel Management (OPM), CMS established and operated an interim federal external review program in FY 2011, expanded and operated a Federal external review program in FY 2012, and will continue to operate the Federal external review program through FY 2013 and beyond.

- *HealthCare.gov* - The ACA requires the establishment of a web portal, now www.HealthCare.gov, through which individuals and small businesses can identify affordable health insurance options that may be available to them, and can obtain information related to such options. The educational portal also makes it easy for consumers and small businesses to compare health insurance plans in both the public and private sectors and find other important health care information from more than 10,000 private insurance plans nationwide, representing actual options in every State. Consumers can use the data to obtain information about options specific to their life situations and local communities, and starting in fall 2013 consumers can use the site to enroll in the new Health Insurance Marketplaces, also known as Exchanges. The website provides the public with ways to search and compare private plans, learn more about coverage and benefits, and serves as a resource on the ACA and how it may affect different individuals.

- *Summary of Benefits and Coverage (SBC)* – All plans and issuers providing health insurance coverage to consumers are required to provide summaries of benefits, specific information regarding coverage, and a glossary of medical insurance terms to consumers. This will allow consumers to make informed comparisons of health insurance options by providing consumers with equivalent information on all

available coverage options. The coverage fact labels (CFLs) facilitate comparison of the level of protection provided by different plan or coverage options.

- *Indian Health Care* – CMS will conduct studies and other activities designed to implement new authorities and create the fullest opportunities for American Indians and Alaska Natives (AI/ANS) to access all CMS programs. ACA aids Indian Health programs by providing additional community services.

- *Issuer Data Collection and Management* – The Rate Benefit Information System (RBIS) and Health Insurance Oversight System (HIOS) systems managed by CMS, feed data into HealthCare.gov, Oversight efforts, the FFEs, and serve as an important analytical resource for the Department. The information collected defines the universe of approved products displayed to consumers and tracked for other purposes, and the detailed information assists consumers in accessing high-quality public and private health coverage via HealthCare.gov. The funds will be dedicated to evaluating the information against external sources, for assessing the overall quality and completeness of the information, and for combining and comparing this data with other sources including internal information on appeals and consumer assistance. Analytics to combine and understand the overlap and connections across data also will help to inform decisions made regarding the best service to consumers, including informing the Department regarding the implementation of Section 2715 of the ACA.

Budget Request: $573.8 Million

The FY 2014 budget request for consumer outreach is $573.8 million, an increase of $491.9 million above the FY 2012 Enacted Level. CMS expects to collect and expend $300 million in user fees to support Marketplace-specific information and outreach. The total program level for all activities requested in Consumer Outreach is $873.8 million.

- *Consumer Information & Outreach for Marketplaces*: $553.9 million. This request funds consumer outreach efforts, the implementation of the Federal Marketplace consumer contact center, and Marketplace Navigators.

  The funding for FY 2014 will support consumer outreach and education activities for open enrollment as well as some general educational and awareness targeted outreach. These funds will also be used to assess CMS' success in the Marketplace's initial enrollment period and provide baseline for the first open enrollment in fall 2013. The impact assessments are necessary for lessons learned for continuous quality improvement of our communication and outreach activities.

  Traditional forms of consumer engagement will be used to raise awareness of insurance coverage options available, but program enrollment will be driven by grassroots activities and partner engagement. Reaching a broad audience of uninsured and eligible consumers will require collaborating with a diverse range of external organizations that have direct contact and influences with the target audiences.

  CMS will establish a toll-free line to help consumers with questions about health insurance coverage through the Federal Marketplace. The call center will open

in June 2013 to start answering general questions ahead of the first open enrollment period in October 2013. The Marketplace Contact Center will assist individuals looking for and comparing health plans to find out if they are eligible for advance premium tax credits or cost-sharing reductions or other insurance affordability programs, and help them enroll in a health plan that meets their needs and budget.

CMS will award Navigator grants to Federal and State Partnership Marketplaces in FY 2014 for Navigators who will assist individuals in the open enrollment period for the 2015 plan year and throughout the year. Navigators also serve an outreach function and may specifically target communities of interest, such as those with low English literacy, or tribes, though Navigators must serve all individuals requesting assistance with Marketplace enrollment. Funding will also support the cost of an IAA with ACF to administer the grants to the Navigators. Other forms of in-person enrollment assistance may be available to individuals applying for Marketplace coverage.

- *Consumer Appeals*: $10.3 million. Funding supports an interagency agreement with OPM to facilitate and contract with an independent review organization to conduct external appeals. This estimate is based on the FEHBP appeals rate of 0.03% with a base population of consumers in fully-insured plans and self-funded non-federal governmental plans in States without a compliant external appeals process. As of February 2013, plans and issuers in 10 States and 5 territories without a compliant external appeals process were using the Federal External Review Process.

- *HealthCare.Gov*: $3.8 million. Funding supports ongoing maintenance costs including renewing software licenses, providing database support, maintaining back-end support systems to collect plan and rate review data, continuing security and testing, and monitoring to continue providing this communication channel to U.S. Citizens. Website maintenance involves a multitude of activities to ensure private insurance plan information is accurate and up-to-date on a regular basis and to ensure the public has access to timely and accurate resources to assist with private insurance plan comparisons, understanding insurance and rate changes, comparing coverage providers, and learning how various parts of the ACA may impact their health care insurance benefits and coverage.

- *Summary of Benefits and Coverage (SBC)*: $2.5 million. Funding allows CMS to continue to fund a contractor to maintain and update the coverage facts labels (CFLs) on HealthCare.gov. The maintenance and updating of the CFLs require the work of a contractor with specialized experience with similar data. Additionally, funding would expand the number of coverage facts labels available for consumer use in FY 2014. With the current set of CFLs, consumers are able to compare health insurance coverage options and potential out-of-pocket costs for one episode of care; however, with an expanded list of CFLs, consumers will be able to compare additional scenarios, leading to increase understanding of the coverage they purchase. In addition, CMS will also provide Navajo translations in 2014. Funding will additionally cover consumer testing of the SBC

as well as education and outreach efforts in coordination with the Office of Communications, such as webinars, PSAs, and educational materials.

- *Indian Health Care*: $1.7 million. Outreach and training for Native Americans can be challenging due to geographic isolation, the need for culturally appropriate outreach materials, differing processes and protocols, and other difficulties due to social and economic limitations. The AI/AN population suffer higher rates of health disparities compared to the general population and health care reform offers an opportunity to improve the lives of our native people. Thus, funding for outreach activities is vital to ensure Native Americans are aware and can access new programs.

- *Issuer Data Collection and Management*: $1.6 million. Funding will support efforts to evaluate the data collected for the Plan Finder portal on healthcare.gov and to complete the SBC templates against external sources, for assessing the overall quality and completeness of the information, and for combining and comparing this data with other sources including internal information on appeals and consumer assistance. Funding will additionally cover the costs of doing analytical work on the data collected thus far, including analyses on expanded data from the Marketplaces and other collection efforts.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Enterprise IT Activities

Enterprise IT activities encompass CMS' critical systems that support ongoing operations, primarily the consolidated information technology infrastructure contract (CITIC). The CITIC data center contract supports the day-to-day operations and maintenance activities of CMS' enterprise-wide infrastructure, including managing the mainframe, network, voice and data communications, as well as backing up CMS' mission critical applications and managing CMS' hardware and software. Other enterprise IT activities include:

- Ongoing enterprise activities: Facilitates and supports all application needs, such as enterprise-wide identity management and standards development, with the unique requirements of the given application coming from the Application/Business Owner's pool of resources, software licenses, help desk support, production support, security, software development and testing, cloud computing pilot, unified communications, enterprise web services platform, and enterprise data warehouse and analytics.

- The Medicare Data Communications Network: Supports transaction processing and file transmission through a secure telecommunications network.

- Hardware maintenance and software licensing: Consists of ongoing safeguarding maintenance and software application certification.

- Development and Maintenance of Mission Critical Database Systems: Includes databases that house the data required by the CMS business community to perform its core functions.

- Modern Data Environment: Transitions CMS from a claims-centric data warehouse orientation to a multi-view data warehouse orientation capable of integrating data on beneficiaries, providers, health plans, and claims. Without this repository, CMS must extract data from different locations, often resulting in inconsistent and slow answers to queries and costly analyst intervention.

- CMS enterprise data and database management investment: Allows for the addition of databases, the establishment of consistent application of data policies and processes; and heightens data security as CMS moves to the Enterprise Data Center environment. CMS plans to increase the number of applications that use the "individuals authorized access to CMS computer systems (IACS)" system to authenticate users and meet HSPD-12 requirements. This provides greater security for data and systems, and accelerates the retirement of the Enterprise User Administration (EUA).

- The Enterprise Information Technology Fund: Supports Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Infrastructure Investments

This section includes several key IT infrastructure projects, which are:

- Infrastructure Investments: CMS will prepare technical infrastructure (i.e., hardware capacity, network connectivity, and software) to accommodate the development, integration, testing, validation and Integrated Data Repository (IDR) environments, as well as high availability and corresponding disaster recovery for implementation. Funding is also needed for contractor support for infrastructure upgrades and project management, additional CPU capacity to support application growth resulting from legislative changes to existing systems, expansion of IDR platform by 20 terabytes, growth of mid-tier and mainframe direct access storage device (DASD) to support growth of databases (20 terabytes), and network connectivity for up to 50 new business partners.

- The Virtual Call Center strategy: This critical project has greatly increased the overall efficiency and effectiveness of the 1-800-MEDICARE call center. Through this project, CMS is able to standardize the management of the Medicare beneficiary call center operations with best practice technology and

process improvements, allowing for greatly improved customer service. The call center strategy provides efficient and timely service using the latest technology and support functions.

- The Web Hosting project: This project covers the transitions of MMA web-hosted applications to an Enterprise Data Center (EDC). These applications include the Medicare Advantage Prescription Drug Payment System, Premium Withhold System, The Medicare Beneficiary Suite of Systems, and the Risk Adjustment System. The EDCs are designed to support the increased security and reliability that are required in the long term. The Baltimore Data Center (BDC), which currently houses these systems, cannot sustain these growing workloads, and maintaining these systems at the BDC greatly increases the risk of system failure.

CMS ACA IT

This request supports Marketplace implementation and other IT needs.

- Data Warehousing: Provides data analysis and technical expertise to enable CMS to host data, conduct data mining and data analysis functions for the Marketplaces.

- The IT Security Project: Supports all the IT security needs of the Marketplaces, focusing on oversight, user protections, risk mitigation and adherence to federal IT regulations.

- The Project Management Office & Governance Project: Provides the tools needed to develop and gather business requirements, perform key governance activities, provide project management leadership and facilitate lifecycle management needs of the Federally Facilitated Marketplace build out. The Enterprise Architecture Project supports the cloud computing environment for the Federally Facilitated Marketplace. The IT Operations Project supports CMS Identity Management solutions needed for the Marketplaces IT Infrastructure.

- The CMS Healthcare Insurance Marketplace IT Investment (HIX): Provides a platform for organizing the Health Insurance Marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits, services, and quality. HIX fulfills key provisions of the ACA and aligns with the HHS Strategic Goal: Transform Health Care. FY 2014 activities will continue to focus on operational readiness reviews, completing Marketplace interfaces, and implementation of the Federal Marketplace and data services hub, which services all Marketplaces.

IT Shared Services

CMS will continue to create operational efficiencies while reducing long-term costs through the adoption of enterprise IT services in conjunction with Departmental

investment strategies. This will lead to increased economies of scale through centralization of data, infrastructure and business applications. The shared service strategy will reduce costs associated with redundant development of capabilities and increase reliability, consistency, and repeatability of service outcomes. Shared services will also improve customer satisfaction through timely delivery and assessment of services that will be measured rigorously through performance management. Shared services will also implement the "architect before investment" principle that will promote better government practices.

Budget Request: $519.3 Million

The FY 2014 budget request for information technology investments supporting all Program Operations is $519.3 million, an increase of $67.8 million above the FY 2012 Enacted Level. This category includes four major IT investment activities.

- *Enterprise IT Activities*: $222.9 million, a $6.7 million decrease from the FY 2012 Enacted level. This funding is needed to continue IT activities which support improvements in the effectiveness and efficiency of CMS program management operations. These activities provide the operational support to manage the Agency's data environment for mission critical and enterprise-wide CMS IT strategies. One such area is the Baltimore Data Center (BDC), which supports all facets of CMS business operations. CMS has maximized the Agency-wide approach of utilizing cost effective technology to decrease this funding in FY 2014.

- *Infrastructure Investments*: $33.7 million, a $1.9 million dollar increase from the FY 2012 Enacted level. Funding is needed to continue to support the activities of the virtual call center strategy as well as the web hosting project. This funding will also include several crosscutting projects such as Enterprise Architecture, Requirements, Data Services Management, Enterprise Services and Infrastructure for new legislative mandates. System Modifications will also be performed on the Me.2icaid Budget and Expenditure System, the Children's Health Insurance Program Budget and Expenditure systems, Medicaid Management information system, Medicaid IT Architecture System, Medicare Administrative issue Tracking and Reporting of Operations and Complaints Tracking Module. In addition changes will be made to the Provider Enrollment and Chain Ownership System, National Plan and Provider Enumeration System and the Provider Statistical and Reimbursement Redesign to accommodate changes in legislation.

- *CMS ACA IT*: $179.2 million, a $9.5 million increase over the FY 2012 Enacted level. Funding is needed to cover extensive systems changes required by multiple ACA provisions including continued support of the Enterprise IT Projects that will enable the comprehensive development of the Marketplace IT Infrastructure; hardware/software needs and network connectivity; system enhancements, new reports, additional variance analysis; data extracts; validating business and system needs; updating websites; system and security documentation; additional capacity; standardizing key elements of Medicaid business operations, inter-agency information Marketplaces, trading partner data formats, and program performance measures; and enhancing capability to share existing Medicaid standards, models, and business services. The development of

the Federal Marketplace, support for State Based Marketplaces and other IT supported ACA initiatives requires a robust and agile environment to succeed. In addition, the final stages of the data services hub build out will occur in FY 2014, including system testing and integration testing with other Federal departments.

- *IT Shared Services*: $83.5 million, a $63.1 million increase over the FY 2012 Enacted level. CMS has initiated an Enterprise Shared Services (ESS) program. This funding will continue to fund the mission to achieve higher levels of overall business effectiveness and cost efficiency. CMS will continue to achieve substantial cost savings and operational efficiencies by creating shared IT capabilities to meet common business needs across multiple programs and business processes.

  There are several business drivers for CMS to create enterprise shared services:

  - The scope and scale of business needs are creating the need for more complex and cross-program IT solutions;
  - Creating unique systems for each program requirement is challenging because of legislative timelines and the resulting operational efficiencies; and
  - The Office of Management and Budget (OMB) PortfolioStat M-12-10

  The mission of the ESS Program is to deliver on-time, on-budget shared services that meet business requirements, accelerate implementation timeframes, and maximize the value of IT investments. There are four shared services strategies being implemented;

  1. Master Data Management (MDM) - MDM creates a suite of data records and services that will allow CMS to link and synchronize beneficiary, provider and organization data to multiple disparate sources. This effort results in a single, trusted authoritative data source.

  2. Enterprise Identity Management (EIDM) - EIDM will enable individuals to use a single online identity (e.g. user ID) for engaging in business with CMS that meets all Federal security requirements. There are two components of EIDM: a Remote Identity Proofing Service that uses a third party to vet the identity of a potential user and a Multi Factor Authentication solution that assigns and manages online credentials.

  3. Enterprise Portal - The Enterprise Portal is a central preferred channel for beneficiaries, providers, organizations and States to receive CMS information, products and services. The enterprise portal will present consistent Web pages to users to access CMS services.

  4. Business Rules Enterprise Services (BRES) - Business rules provides a framework for automating and managing decision logic and routines for CMS programs (e.g. provider and beneficiary cross check for Accountable Care Organizations program).

  The key elements of our ESS implementation included foundational work in FY 2011 and FY 2012 to define and develop the initial shared services. In FY 2013, the shared services will gradually become operational. Once in

production, the shared services will support key agency initiatives. In FY 2014, onboarding of new users will continue, as well as development of sharing system enhancements.

Throughout the implementation of shared services, CMS has employed a strong governance structure to ensure business owners have input into the future priorities and direction of the program. This approach values close alignment of business needs with IT solutions with the goals of consolidation, efficiency and value.

Performance Measurement

CMS has a vast purview in its responsibility for administering and overseeing three of the Nation's largest ongoing health care programs: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS is also responsible for setting up the new Federal Marketplace (Marketplace) for each State that elects not to establish a State-based Exchange (SBE) program. Because we cannot measure every possible activity that CMS oversees, we have developed representative performance measures that focus on the larger outcomes that these programs seek to achieve.

MCR9 Ensure Beneficiary Telephone Customer Service: Beneficiary telephone customer service is a central part of CMS' customer service function. The Beneficiary Contact Center (BCC) uses a Quality Call Monitoring process is used by the Beneficiary Contact Center (BCC) to evaluate each Customer Service Representative's (CSR's) performance in responding to Medicare beneficiary telephone inquiries. The BCC is responsible for evaluating and scoring each CSR's monthly performance in handling telephone inquiries using the quality standards of privacy act (45 C of Federal Regulations, Subtitle A 5b), knowledge skills, and customer skills. The BCC has exceeded the FY 2012 targets of 90 percent for each standard by a minimum of three percentage points. Despite exceeding targets in previous reporting years, CMS will continue to maintain the quality standards target levels at 90 percent for FY 2014. In order to increase contact center quality target levels, contact centers would need to hire additional staff responsible for quality assurance monitoring and coaching which would require additional resources that are better utilized elsewhere.

MCR12 Maintain CMS' Improved Rating on Financial Statements: CMS met its FY 2012 target of maintaining an unqualified opinion. During FY 2012, the auditors could not express an opinion on the financial condition of the CMS Statement of Social Insurance as of January 1, 2012, or the CMS Statement of changes in Social Insurance Amounts. CMS reflected in the projections of the social insurance program the direct impact, but not the secondary impacts, if any, of productivity adjustments and reductions in Medicare payment rates for physician services mandated in the Affordable Care Act and current law. Due to these limitations, the auditors were unable to obtain sufficient evidential support for the amounts presented in the statement of social insurance. For FY 2012, CMS remains substantially compliant with the Federal Financial Management Improvement Act. CMS' its financial systems are be integrated in accordance with OMB Circular A-127, Financial Management Systems. As of September 2012, CMS has 99 percent of total Medicare program payments accounted for in HIGLAS, the official financial system of record. The FY 2014 target is to maintain an unqualified opinion.

MCR20 Implement the International Classification of Diseases (ICD)-10: On September 5, 2012, HHS published in the Federal Register a final rule, CMS-0040-F, which included a provision to delay ICD-10 for one year, until October 1, 2014. Our goal was to find a delay timeframe that takes into consideration the timing of other initiatives, the investments already made by the industry, and the need for thorough testing and preparation on the part of all industry segments.

CMS is measuring activities towards transitioning to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set, and has met most of its FY 2012 targets, as reflected in the table at the end of this chapter. ICD-10 implementation can be successful only if all industry segments are prepared to make the transition to ICD-10 at

the same time and industry feedback indicated that many providers would not be able to meet the October 1, 2013, deadline. This would potentially result in serious impacts to patient care: some providers may not get paid and be forced to close down operations, adversely affecting patient access to care, or ask patients to pay up front for medical services. While we understand that a prolonged delay could be costly, the overwhelming concern must be for patient access to quality medical care.

FY 2013 will see the continuation of many FY 2012 activities, with a drop-off in ICD-10 conversion activities and a ramping up of testing activities, outreach, and readiness monitoring. All these activities will provide impacted CMS business areas with the support mechanisms to ensure timely and efficient CMS, contractor and industry transition to the new code set by October 1, 2014.

MCR21 Effectively Manage Information Technology (IT) Systems and Investments to Minimize Risks and Maximize Returns: CMS has four FY 2014 performance measures representing effective management of CMS IT systems and investments to minimize risks and maximize returns. CMS ensures that IT investments are managed effectively by adhering to the Expedited Life Cycle (XLC) framework, by conducting post-implementation reviews, and making sure that CMS IT systems have a formal Authority to Operate (ATO) and are included in a vulnerability management program. CMS met two of its FY 2012 targets: (1) Federal Information System Management Act (FISMA) systems scanned and monitored by a vulnerability management system, and (2) the percent of IT projects that have adapted to the XLC framework. We exceeded our FY 2012 Post Implementation Review (PIR) target of 12 PIRs with an actual of 16 PIRs. The PIR targets will be reflected in percentages going forward. We conducted 8 PIRs in 2011 and 16 in 2012. This represents 47 percent and 53 percent, respectively, of all projects that were candidates for PIRs during that time period. In FY 2013, our goal is to complete PIRs for 60 percent of new IT implementation projects that have been in operations for up to 12 months, and increase the target to 65 percent in 2014. It is more realistic to base our projections on the percentage of candidate PIRs completed rather than to strive to reach a numerical target because the number of systems moving through the life cycle during any given year is variable, making it impossible to accurately predict the number of systems that will be good candidates for the PIR.

We did not meet our FY 2012 target of 90 percent of CMS FISMA systems ATO based on defining the number of CMS FISMA systems for the following reasons:

(1) In the FISMA system inventory list, there are systems that did not fully follow the lifecycle; some either went into production prior to getting an ATO, and others still do not have an ATO. These systems may have followed parts of the lifecycle, but they did not fully complete it properly.

(2)The influx of systems from ACA created a large backlog of current and future systems that needed Security Control Assessments (SCAs) at one time. CMS does not have the resources to test them all at once.

MCR22 Improve the Accuracy of Medicare Physician Fee Schedule Payments: The purpose of this measure is to achieve more accurate pricing under the Medicare physician fee schedule, consistent with CMS' goal of moving to a value driven health care system. The Medicare Physician Fee Schedule (PFS) is a payment system used to pay practitioners for Medicare services. In this process, each service is assigned a unique code and a relative value unit (RVU), which helps Medicare determine the payment for the services. Like other payment systems, the Medicare PFS is not perfect

and is vulnerable to mispricing. In order to achieve CMS' goal of moving to a value driven health care system, it is imperative to have a payment system that provides accurate payment for the services rendered. The Affordable Care Act directed the Secretary of Health and Human Services to establish a systematic process for identifying and reviewing potentially misvalued services. This measure aims to quantify CMS' progress in determining which services under the Medicare PFS are misvalued and in setting the appropriate values for those services.

Originally, CMS set the baseline for this analysis as the number of codes previously identified through the potentially misvalued codes initiative, which began in 2008. CMS planned to have reviewed 20 percent of the identified potentially misvalued codes in 2012 and an additional 20 percent in both CY 2013 and CY 2014, achieving review and appropriate valuation of 60 percent of the baseline. However, in CY 2012, CMS exceeded target of 20 percent by reviewing 78 percent of codes identified between 2008 and 2011. The number of codes CMS identified as potentially misvalued through 2011 was approximately 1,167. From the start of the misvalued code initiative in 2008 through the end of 2012, CMS reviewed 911 codes.

The identification and review of misvalued codes is an ongoing process with an expanding baseline, and CMS believes that should be reflected in the construction of the goal. As such, CMS has revised the baseline and targets for this goal going forward. Each year, CMS will identify a new cohort of potentially misvalued codes. The new target will be to review 40 percent of the cohort of newly identified codes one year after identification, and 20 percent of that cohort each additional year, reviewing 100 percent of the codes in that cohort within four years. Furthermore, each year there will be an additional cohort for which CMS will also review 40 percent in year one, and 20 percent each additional year.

MCR26 Reduce All-Cause Hospital Readmission Rate for Medicare Beneficiaries:
In order to reduce Medicare expenditures and improve quality of care, CMS has chosen to measure preventable Medicare inpatient hospital readmissions. A "hospital readmission" occurs when a patient, who has recently been discharged from a hospital (within 30 days), is once again readmitted to a hospital. Discharge from a hospital is a critical transition point in a patient's care, and incomplete handoffs at discharge can lead to adverse events for patients and avoidable rehospitalizations. CMS established the Hospital Readmissions Reduction Program which began in FY 2013, which would reduce a portion of Medicare's payment amounts to certain hospitals based on the hospital's excess Medicare readmissions in the conditions included in the program. In addition to the Hospital Readmissions Reduction Program, CMS leverages efforts of other programs to reduce hospital readmissions. Among these is the Partnership for Patients (PfP) to reduce preventable complications during a transition from one care setting to another which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations (ACOs), which must report on 33 quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program.

CMS targets reduction of all-cause Medicare hospital readmissions by one percent per year by 2015, beginning with a baseline of 18.7 percent on CY 2010 data set in FY 2012. Based on CY 2011 fee-for-service and Medicare Advantage inpatient claims data, the Medicare all-cause hospital readmission rate is estimated to be 18.6 percent, which

falls slightly below the 2013 target of 18.5 percent. Much of this slight short fall is due to rounding (the CY 2011 rate before rounding was 18.561 percent). We note that although hospital specific readmission data was publicly available in 2011 on the Hospital Compare website, many of CMS' endeavors aimed at reducing hospital readmissions (discussed above) were not fully developed or implemented until after CY 2011, which is the period for assessing the 2013 target for this goal. Despite not successfully achieving the 2013 target, we believe we will meet or exceed the 2014 target for this goal as the data used to assess future targets will include admissions data that reflects hospitals' experiences under and in response to CMS' efforts aimed at reducing hospital readmissions. The readmission rate will be updated annually through FY 2015.

MCR27 Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Among Eligible Professionals (EP) and Hospitals (text on FY 2014 targets is pending): CMS has performance measures to promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals and hospitals. CMS is measuring the number of eligible professionals, eligible hospitals and eligible Critical Access hospitals receiving Medicare and Medicaid EHR Incentive Payments for the successful demonstration of meaningful use. Additionally, CMS measured the number of eligible professionals and hospitals receiving Medicaid EHR Incentive Payments for adopting, implementing, or upgrading (AIU) their EHR. This measure supports the HHS Priority Goal to improve health care through adoption or meaningful use of health information technology, which aims by September 30, 2013, to increase the number of eligible providers who receive an incentive payment from the Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology to 230,000. For more information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs. CMS has also set FY 2014 targets based on previous performance and future projections at this point in time.

MCR28 Reduce Healthcare-Associated Infections: Healthcare-associated infections (HAIs) are a significant cause of morbidity and mortality in the United States. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death, and catheter-associated urinary tract infections (CAUTI) are among the most common. Research has shown that a significant portion of these infections can be prevented. This HAI Agency Priority Goal, led by the Centers for Medicare & Medicaid Services, with the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and the Office of the Assistant Secretary for Health, tracks and monitors hospital activity to reduce the national rate of HAIs by demonstrating significant, quantitative and measurable reductions in hospital-acquired CLABSI and CAUTI.

National Healthcare Safety Network (NHSN) 6-month CLABSI data was calculated at 0.561 Standardized Infection Ratio (SIR), which shows progress in CLABSI reduction for the October 2011-March 2012, and is ahead of the midway goal target September 2012) of 0.60 SIR or a 12.5 percent reduction. Less progress has been observed for CAUTI at a SIR of 0.953, which is attributable at least in part to the fact that reporting for CAUTI increased dramatically since the baseline period. The midway target for CAUTI is 0.85 SIR or a 10 percent reduction.

CLABSI and CAUTI FY 2011 data prior to the Agency Priority Goal period are 0.59 and 0.93 SIR, respectively. We had already reduced CLABSI by 18 percent from

baseline. Less progress has been observed for CAUTI, which we attribute at least partially to a change in measurement strategy. Final FY 2012 data is currently being reviewed and will be available in May. We plan to continue efforts to reduce CLABSI and CAUTI in our nation's hospitals by leveraging programmatic efforts across the Department toward HAI prevention and reduction, and will set FY 2014 targets consistent with the Federal Steering Committee for the Prevention of HAIs "National Action Plan to Prevent HAIs: Roadmap to Elimination" 2020 targets due out late in 2013. We are on track to meet the goal of reducing CLABSI by 25 percent and CAUTI by 20 percent by the end of FY 2013 over the FY 2010 Standardized Infection Ratios of .68 and .94, respectively. For more information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs.

MCR29 Protect the Health of Medicare Beneficiaries by Implementing the First Value-Based Purchasing Program: End-Stage Renal disease Quality incentive Program: In order to promote high-quality dialysis services, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary to implement an End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) that will result in payment reductions to dialysis facilities that do not meet or exceed a total performance score. Payment reductions, up to 2 percent, apply to payments for renal dialysis services furnished on or after January 1, 2012, and are specific to the payment year based on specific performance standards

Through rulemaking, CMS established performance standards for the selected measures, performance periods, and a methodology for assessing the total performance of each facility. In addition, as part of this program, CMS develops procedures for making performance information available to the public, as well as procedures for ensuring that facilities have an opportunity to review information before public release. The first payment year (PY) of the QIP (2012), was outlined in two rules, which were published in the Federal Register in 2010 and 2011, and included assessment on three measures (two related to anemia management and one on dialysis adequacy). The PY 2013 and PY 2014 QIP were established by a rule published in the Federal Register in November 10, 2011, and included additional areas of evaluation (vascular access type, infection monitoring, mineral metabolism monitoring, and patients' experience of care survey administration). The PY 2015 QIP was finalized in the Federal Register on November 9, 2012. It added new measures for anemia management, and replaced the dialysis adequacy measure with one that includes adult hemodialysis patients, adult peritoneal dialysis patients and pediatric in-center hemodialysis patients. For future years of the program, CMS aims to strengthen the QIP by evaluating facilities on a wider range of measures covering more topic areas. For example, CMS is currently developing measures to assess fluid weight management, on transplantations, iron management, and transfusions, and additional measures on bone mineral metabolism.

PHI1 Percent of Required Individual Health Plans Reporting Data that is Accurate and Displayed on HealthCare.gov: CMS tracks the HealthCare.gov website's success in capturing market data for use by its target audience. By tracking the percent of State-authorized plans that are reporting an accurate representation of their products, CMS is able to understand the completeness of the data it offers to the public. HealthCare.gov helps expand the visibility and use of health insurance coverage information, empowering individual consumers and small businesses to make informed decisions when purchasing coverage. In FY 2012, 80 percent of required individual health plans reported accurate data on HealthCare.gov, falling short of our target of 85 percent.

Feedback from issuers has indicated that this is due to difficulties in summarizing the plans by the tools originally provided, due to technical issues regarding the timing of submissions, and efforts which were put into reporting on small group insurance details. CMS has already begun to implement changes to address these issues. Submission windows have been extended, instruments have been re-designed to reflect other emerging reporting standards and CMS will be reaching out to those issuers who have not reported details to help issuers come into compliance. Our FY 2014 target is for 85 percent of plans to report on HealthCare.gov.

PHI2 Increase the Number of Young Adults Ages 19 to 25 Who Are Covered as a Dependent on Their Parent's Employer-sponsored Insurance Policy: To extend health insurance coverage to a segment of the American population that is disproportionately uninsured, CMS is monitoring the implementation of a regulation that allows adult children to remain on their parents' employer-sponsored health insurance plans through age 26. In FY 2011, 9.5 million young adults were covered under this regulation, exceeding our target of 8.4 million. CMS' goal is to increase the number of adult children covered as dependents on a parent's employer-sponsored insurance policy to 9.7 million by FY 2014. CMS plans to use audits to monitor compliance with the requirements that issuers offer coverage for young adults ages 19 to 25.

PHI3 Protect Individual and Small Businesses from Potentially Unreasonable Health Insurance premium Increases through the Effective Rate Review Program: The Affordable Care Act brings an unprecedented level of scrutiny and transparency to health insurance rate increases in the individual and small group markets through the creation of an Effective Rate Review program. This program will protect individual and small businesses from potentially unreasonable health insurance premium increases. In every State, large, proposed rate increases will be evaluated by independent experts to assess whether the increases are based on reasonable cost assumptions and solid evidence. Reasonableness determinations can lead to lower implemented rate increases. CMS has begun to measure how the Effective Rate Review program has assisted States in improving their capabilities to review requested rate increases. Our FY 2014 target is to increase the percentage of submissions where issuers reduce the implemented rate increase as a result of Effective Rate Review to 60 percent.

PHI4 Increase the Proportion of Legal Residents under Age 65 covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion: CMS tracks progress toward setting up Health Insurance Marketplaces (Exchanges) to ensure that millions of individuals estimated to gain insurance through Marketplaces will have the ability to enroll beginning in October 2013. We met our FY 2012 target to award all qualifying applications for Establishment Grants within 60 days of receiving the application. Our 2014 target is to "establish" individual Marketplaces and Small Business Options Programs in 50 States and the District of Columbia. Programs are considered to be "established" if consumers are enrolling in a qualified health plan and if advance premium tax credit and cost sharing reduction payments are made to issuers on behalf of eligible enrollees.

Please see the Performance Measurement section and the Output and Outcomes Table in the Medicaid chapter for additional information about the Medicaid Expansion measures PHI4.2 and PHI4.3.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MCR9.1a: Quality Standards: Minimum of 90% pass rate for Adherence to Privacy Act (Outcome)	FY 2012: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1b: Quality Standards: Minimum of 90% expectations for Customer Skills Assessment (Outcome)	FY 2012: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1c: Quality Standards: Minimum of 90% meets expectations for Knowledge Skills Assessment (Outcome)	FY 2012: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.3: Minimum of 90% pass rate for the Customer Satisfaction Survey (Outcome)	FY 2012: 93% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR12: Maintain an unqualified opinion	FY 2012: Maintain an unqualified opinion (Target Met)	Maintain an unqualified opinion	Maintain an unqualified opinion	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2013: ICD-10 Industry Compliance Level and State Medicaid program readiness baselines updated. Target: Update Industry Compliance Level and State Medicaid program readiness baselines in December 2012 (Target Met) FY 2013: External ICD-10 outreach and communications continued. Target: Continue external ICD-10 outreach and communications on October 1, 2012 and ongoing (Target Met)	Continue external ICD-10 outreach and communica-tions by October 1, 2011 and ongoing Update ICD-10 industry compliance level and State Medicaid program readiness baselines by December 1, 2011. Update ICD-10 industry compliance level and State Medicaid program readiness baselines by May 1, 2012	Continue the external outreach and communica-tions of the International Classification of Diseases (ICD-10) Update ICD-10 industry compliance Level and State Medicaid program readiness baselines Complete CMS implementation of ICD-10	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MCR21.1: Percent of CMS Federal Information System Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. (Outcome)	FY 2012: 78% Target: 90% (Target Not Met)	90%	90%	Maintain
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution (Outcome)	FY 2012: 100% Target: 100% (Target Met)	100%	100%	Maintain
MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (EXL) framework (Outcome)	FY 2012: 100% Target: 90% (Target Exceeded)	90%	95%	+5%
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) (Outcome)	FY 2012: 16 PIRs (or 53%) Target: 12 PIRs (Target Exceeded)	12 PIRs	65%	N//A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MCR22: Review potentially misvalued codes and unreviewed misvalued codes (Outcome)	FY 2012: 78% Target: Review 20% of potentially misvalued codes identified 2008 to 2011 (Target Exceeded)	Review 20% of potentially misvalued codes identified 2008 to 2011	Review 20% of unreviewed potentially misvalued codes identified 2008 to 2011, 20% of potentially misvalued codes identified in 2012, and 40% of potentially misvalued codes identified in 2013	N/A

MCR26: Reduce all-cause hospital readmission 1% over previous year's target Baseline: 18.7% (CY 2010 data)	FY 2013: 18.6%[7] Percent Target: 18.5% (Target Not Met but Improved)	Set Baseline	18.3%	N/A
MCR27.1: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use for Medicare	FY 2012: 93,652 Target: 34,350 (Target Exceeded)	34,350	205,000	+170,650

[7] Based on CY 2011 data

MCR27.2: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under	FY 2012: 1,874 Target : 5,600 (Target Not Met)	5,600	18,000	+12,400
MCR27.3: Increase number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicare	FY 2012: 1,474 Target: 650 (Target Exceeded)	650	3,700	+3,050
MCR27.4: Increase number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicaid	FY 2012: 316 Target : 815 (Target Not Met)	815	1,100	+285
MCR27.5: Increase number of Eligible Professionals receiving EHR incentive payments for Adopt/Implement / Upgrade (AIU) under the Medicaid incentive program	FY 2012 : 58,334 Target: 38,135 (Target Exceeded)	38,135	82,300	+44,165

MCR27.6: Increase number of Eligible Hospitals receiving EHR incentive payments for Adopt/Implement / Upgrade (AIU) under the Medicaid incentive program	FY 2012: 2,484 Target : 450 (Target Exceeded)	450	3,600	+3,150
MCR28.1 Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013. (Outcome)	FY 2012: Results are being reviewed Target: 12.5% (Pending)	12. 5%[8]	TBD	N/A
MCR28.2 Reduce by 20 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2013. (Outcome)	FY 2012: Results are being reviewed Target: 10% (Pending)	10%[9]	TBD	N/A
MCR29.1: Develop drafts and final ESRD QIP rules for payment years (PY) 2014 through 2016	FY 2013: PY 2015 final rule published. Target: Publish PY 2015 final rule (Target Met)	Publish PY 2015 final rule	Publish PY 2016 final rule	N/A

[8] The Standardized Infection Ratio (SIR) for FY 2010 is 0.68. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.68 x 0.875). Projected FY 2013 SIR calculation (0.68 x 0.75).

[9] The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

MCR29.2: Implementation of ESRD QIP payment reduction (to meet statutory requirement)	FY 2013: Payments adjusted for facilities not meeting performance standards (based on 2011 claims data) Target: Adjust payment for facilities not meeting performance standards (based on 2011 claims data) (Target Met)	Adjust payment for facilities not meeting performance standards (based on 2010 claims data)	Adjust payments for facilities not meeting performance standards (based on 2012 claims data)	N/A
MCR29.3: Obtain monitoring and evaluation contractor and implement monitoring strategy	FY 2011: Acumen awarded monitoring and evaluation contract on September 29, 2011. Target: Procure contractor (Target Met)	No target in FY 2012	Target Discontinued	N/A
PHI1: Increase percent of required individual health insurance market plans reporting data that is accurate and displayed on HealthCare.gov	FY 2012: 80% Target: 85% (Target not met)	85%	85%	Maintain
PHI2**:** Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy	FY 2011: 9.5 million Target: 8.4 million (Target Exceeded)	8.7 million	9.7 million	1,000,000

PHI3: Increase the percentage of submissions where issuers reduce the implemented rate increase as a result of Effective Rate Review.	FY 2012: 50% Baseline	Baseline 50%	60%	+10 percentage points over baseline
PHI4.1: Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Affordable Insurance Exchanges and Implementing Medicaid Expansion*	FY 2012: Awarded all qualifying applications for Establishment Grants within 60 days of receiving the application Target: Award all qualifying applications for Establishment Grants within 60 days of receiving the application (Target met)	Awarded all qualifying applications for Establishment Grants within 60 days of receiving the application	Establish Individual and Small Business Health Options Program Exchanges in 50 States +DC	N/A

*Medicaid Expansion measures (PHI4.2 and PHI4.3) are included in the Medicaid chapter.

Program Operations Discontinued Measures

Measure	FY	Target	Result
MCR3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	*2012*	74%	Feb 28, 2013
	2011	73%	74%
	2010	72%	75% (Target Exceeded)
	2009	71%	73% (Target Exceeded)
	2008	65%	75% (Target Exceeded)
	2007	64%	69% (Target Exceeded)
MCR3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	*2012*	63%	Feb 28, 2013
	2011	62%	63%
	2010	61%	65% (Target Exceeded)
	2009	60%	62% (Target Exceeded)
	2008	46%	69% (Target Exceeded)
	2007	45%	68% (Target Exceeded)

Performance Measure MCR3.1b, 3.1c

These measures are being retired. CMS has consistently met or exceeded targets for these measures and rates appear to have stabilized at a relatively high level of awareness, given the standard outreach campaigns.

Measure	FY	Target	Result
MCR10.1: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for Fiscal Intermediaries	*2012*	95%	99.8%" (Target Exceeded)
	2011	95%	99.5% (Target Exceeded)
	2010	95%	99.8% (Target Exceeded)
	2009	95%	99.7% (Target Exceeded)
	2008	95%	99.8% (Target Exceeded)
MCR10.2: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for Carriers	*2012*	95%	99.5% (Target Exceeded)
	2011	95%	99.1% (Target Exceeded)
	2010	95%	99.0% (Target Exceeded)
	2009	95%	99.4% (Target Exceeded)
	2008	95%	98.9% (Target Exceeded)
MCR10.3: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for Medicare Administrative Contractors	*2012*	95%	99.8% (Target Exceeded)
	2011	95%	99.5% (Actual)
	2010	95%	98.7% (Historical Actual)
	2009	95%	99.6% (Historical Actual)
	2008	95%	99.2% (Historical Actual)

Performance Measures MCR 10.1, 10.2, 10.3

While CMS will continue to monitor this activity, these measures are being retired after FY 2012. This goal has been featured since the FY 2000 budget justification. There has been demonstrable success at exceeding goal targets with consistent results over 99 percent.

Federal Administration

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 Request	FY 2014 +/- FY 2012
BA	$772,963,000	$777,694,000	$771,800,000	-$1,163,000
Comparability Adjustment [1/]	-$1,199,000	-$1,231,000	$0	$1,199,000
FTE	4,355	4,746	4,635	280

[1/] Comparably adjusted for the SHIP transfer to ACL in FY 2012 and FY 2013.

Authorizing Legislation – Reorganization Act of 1953
FY 2014 Authorization – One Year
Allocation Method - Various

Program Description and Accomplishments

CMS oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), the nation's largest health insurance programs. We also oversee benefits for consumers and employers through the Federal Marketplace, the Pre-existing Condition Insurance Program (PCIP), the Early Retirement Reinsurance Program (ERRP), and State High-Risk Pools. CMS is responsible for setting up the new Federal Marketplace (Marketplace) for each State, also known as Exchanges, that elects not to establish a State-based Exchange (SBE) program. In addition, CMS is responsible for enforcing new rights and greater accountability for consumers and providers in the private health insurance market, and we disseminate an unprecedented level of consumer information regarding coverage options. As the largest purchaser of health care in the United States, CMS expects to serve almost 116 million beneficiaries in our traditional programs and millions of new consumers in the private insurance market in 2014.

The Federal Administration account funds the majority of CMS' staff and operating expenses for routine activities such as planning, implementing, evaluating and ensuring accountability in a variety of health care financing programs. Remaining staff are funded through different budget accounts and are not included in the Federal Administration request.

CMS currently employs approximately 5,400 Federal Full-Time Equivalents (FTEs) working in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; ten regional offices located throughout the country, and three anti-fraud field offices located in Miami, Los Angeles, and New York. Employees in Baltimore, Bethesda and Washington write health care policies and regulations; set payment rates; develop national operating systems for a variety of health care programs; provide funding for the Medicare contractors and monitor their performance; develop and implement customer service improvements; provide education and outreach to beneficiaries, consumers, employers and providers; implement guidelines to fight fraud, waste, and abuse; and assist law enforcement agencies in the prosecution of fraudulent activities. Regional Office employees provide services to Medicare contractors; accompany State surveyors to hospitals, nursing homes, labs, and other

health care facilities to ensure compliance with CMS health and safety standards; assist States with Medicaid, CHIP and other health care programs; and conduct outreach and education activities for health care providers, beneficiaries, and the general public. We also have staff in our fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program.

The funds in this account pay for: employee compensation and benefits, and other objects of expense including rent, utilities, information technology, contracts, supplies, equipment, training, and travel. These categories are discussed below, in more detail.

Personnel Compensation and Benefits:

CMS' personnel compensation and benefits expense includes costs for: civilian and Commissioned Corps, or military, pay; other personnel compensation including awards, overtime, unemployment compensation, and lump-sum leave payments; and fringe benefits for civilian and Commissioned Corps personnel. Civilian benefits include Agency contributions for both Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) retirement systems, Federal Insurance Contribution Act (FICA) taxes, Federal Employees Government Life Insurance (FEGLI) life insurance expenses, and Federal Employees Health Benefits (FEHB) health insurance payments. Commissioned Corps benefits include housing and subsistence payments, FICA contributions, continuation payments, dislocation pay, cost-of-living allowances while abroad, and uniform allowances. CMS' total staffing and associated payroll expense is funded through several line items and accounts, including: Federal Administration, Health Care Fraud and Abuse Control (HCFAC), State Grants and Demonstrations, direct appropriations from recent legislation, Clinical Laboratory Improvement Amendment (CLIA) User Fees, Coordination of Benefits (CoB) User Fees, and other reimbursable efforts including Recovery Audit Contractors (RAC) activities. This section discusses direct staffing and payroll requirements associated with only the Federal Administration line.

CMS' staffing level and related compensation and benefits expense is largely workload-driven. Over the last decade, CMS' core workloads have increased dramatically due to major legislative and Secretarial initiatives. These include the completion of activities mandated by the Health Insurance Portability and Accountability Act (HIPAA); the Balanced Budget Act (BBA); the Ticket to Work and Work Incentives Improvement Act (TWWIIA); the Balanced Budget Refinement Act (BBRA); the Benefits Improvement and Protection Act (BIPA); the Trade Act; the Medicare Modernization Act (MMA); the Deficit Reduction Act (DRA); the Tax Relief and Health Care Act (TRHCA); the Medicare, Medicaid and SCHIP Extension Act (MMSEA); the Medicare Improvements for Patients and Providers Act (MIPPA); the Children Health Insurance Program Insurance Reauthorization Act (CHIPRA); the American Recovery and Reinvestment Act (ARRA); the Medicare and Medicaid Extenders Act; and, the Affordable Care Act (ACA). In addition, CMS is responsible for the concurrent implementation of a number of Secretarial priorities, including quality improvement, value-based purchasing, price transparency, consumer choice, e-health initiatives, and enhanced beneficiary outreach.

Other Objects

CMS' Other Objects expense includes rent, communication, and utilities; the mortgage for the Central Office building loan; CMS' share of the Department's Service and Supply Fund; administrative services; Information Technology (IT); inter-agency agreements (IAs); supplies and equipment; administrative contracts and intra-agency agreements; training; travel; printing; and postage.

Most of these costs—including rent, communications, utilities; the Central Office building loan; and CMS' share of Departmental costs such as the Service and Supply Fund; Office of General Counsel support; and the Federal Protective Services contracts—are determined by the Department or another government agency and are not negotiable. Other costs—including IT infrastructure costs, building maintenance, and most of our inter- and intra-agency agreements—are essential for carrying out our mission as a government agency.

CMS' FY 2014 request has been prepared in accordance with Executive Order 13589, Promoting Efficient Spending.

- Rent, Communication & Utilities

This category funds rent and building operational costs for our offices in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; the ten Regions; and the three anti-fraud field offices Miami, New York, and Los Angeles. Costs include space rental, utilities, grounds maintenance, snow removal, cleaning, trash removal, and office relocations. These costs are non-negotiable. The General Services Administration (GSA) calculates the charge and informs CMS of the amount it must pay. Most of the items in this category reflect contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal. Other items, such as utilities, increase every year due to inflation.

- Building Loans

This category provides funding to pay the GSA for the principal and interest on 44 construction loans for our headquarters facility in Baltimore, Maryland. The 30-year loan for CMS' Central Office headquarters building will be paid in full in 2025. In addition, CMS must pay the building loan for the San Francisco Regional Office.

- Service and Supply Fund

This category funds CMS' share of the Department of Health and Human Services' (DHHS) Program Support Center (PSC) expenses. These services include payroll, financial management, and e-mail systems used throughout the Department; regional mail support; small business operations; web communication; support provided to the Office of the Secretary's audit resolution staff; and other services related to the administrative support of our daily operations. The PSC provides a wide range of administrative and technical services to the Department's Operating Divisions, allowing these divisions to concentrate on their core mission objectives, and to eliminate duplication of functions, thus achieving economies of scale.

- Administrative Services

This category funds contracts for activities that support the daily operation of CMS' Central, Regional and anti-fraud field offices including building and machine maintenance and repairs, employee medical and health services, space enhancements and transportation costs for shipping and receiving Agency documents. This category also includes expenses needed to comply with the American Disabilities Act, such as interpreting services, closed-captioning services, personal assistance fees, and adaptable furniture. In addition, the cost of heating and cooling the Central Office data center 24 hours-a-day, 7 days a week, is included here. While the Rent, Communication and Utilities category covers most standard-level utility charges, the data center utility cost is over and above the GSA standard-level user charge for this activity and must be paid separately.

- Information Technology (IT)

This category funds CMS' administrative system operations, including telecommunications, systems security, Continuity of Operations Planning (COOP) and disaster recovery, videoconferencing, web hosting, satellite services, and a portion of the Baltimore data center costs. It also covers the costs of several systems that support grants and contract administration as well as financial management, data management, and document management services.

- Inter-Agency Agreements

This category funds several interagency agreements (IAs), that is, contractual arrangements for goods or services with other agencies outside the Department, including:

  - An IA with the Department of Labor for administering and paying CMS' annual share of worker's compensation benefits resulting from a workplace injury or death of an employee. These benefit payments are required by law; and,

  - An IA with the Office of Personnel Management (OPM) for background investigations of new employees and contractor personnel.

- Supplies and Equipment

This category funds general everyday office supplies and materials for CMS employees, including new and replacement furniture, office equipment and small desktop-related IT supplies.

- Administrative Contracts and Intra-Agency Agreements

This category funds over 100 small administrative contracts and intra-agency agreements (i.e., contractual arrangements for goods or services with other agencies within the Department of Health and Human Services). These essential operational services include:

  - Legal services with the Office of General Counsel (OGC): CMS reimburses the OGC for the legal services and guidance it provides on ethics activities and on

legislative, programmatic, and policy issues related to CMS' programs. This contract allows CMS to implement policies and run its programs. In FY 2012, CMS paid about $12.2 million for these services. OGC calculates the charge and informs CMS of the amount it must pay.

- Tribal Training and Outreach: In support of HHS' priorities, CMS is committed to working with the Tribal governments to improve the health care of American Indians and Alaska Natives (AI/ANs). Several contracts enable CMS to continue its work with the Indian Health Service (IHS) to provide ongoing outreach and education to AI/ANs, facilitate AI/AN enrollment in CMS' programs, enhance our relationship with the IHS and the Tribes, and conduct satellite training for providers in remote areas. The satellite activity is designed to break down cultural barriers and reach out to the tribal populations who are geographically isolated. Using satellite broadcasts, CMS can provide specialized interactive training to Indian health care providers, efficiently and cost-effectively. To date, CMS has provided support for satellite installation at 120 Tribes and Urban Indian health facilities.

- Security services with the Department of Homeland Security (DHS): This contract pays the DHS for the Federal Protective Service (FPS) agents who provide security guard services to our facilities and employees. Presidential Decision Directive 63 and Homeland Security Presidential Directive 7 classify CMS as a Critical Infrastructure Facility. The Department of Justice has classified CMS as Level IV facility (on a scale where Level I is the lowest vulnerability and Level V is the highest). These ratings require that specific security measures be in place.

- Training

This category supports continuous learning, with special emphasis on leadership and management development. In addition to technical, professional, and general business skills, CMS is committed to enhancing leadership skills and management development for non-managers and offering continuous learning for managers. This category also pays certifications to keep staff, such as actuaries, contract specialists, financial managers, nurses, and other health professional specialists, current with their skills. In addition, funds are required for ongoing core courses for employees such as Reasonable Accommodation, Alternative Dispute Resolution, and Equal Employment Opportunity (EEO) and Whistle Blower Protection.

- Travel

Most of CMS' travel is comprised of on-site visits to contractors, States, healthcare facilities, and other providers. Since CMS administers its programs primarily through contractors or third parties, site visits are critical to managing and evaluating these programs and to ensuring compliance with the terms and conditions of contracts and cooperative agreements. Site visits also allow CMS to ensure that our beneficiaries and consumers are receiving quality care and that providers are not engaged in fraudulent practices. A few examples of CMS site visits include:

- Conducting performance reviews of Medicare Administrative Contractors (MACs) and remaining fiscal intermediaries and carriers who handle the administrative processes needed to run the Medicare fee-for-service program. These contractors are located throughout the country and CMS staff must travel to their locations.

Reviews and oversight ensure that the contractors are carrying out their responsibilities properly, in accordance with CMS policies and regulations. CMS has always conducted on-site performance reviews, but now that the new MACs can earn incentive payments, these reviews are critical to ensuring that the incentives are appropriate.

- Working with the States on Medicaid and CHIP issues. CMS staff travels to the States to develop and implement new applications for Medicaid eligibility systems, provide systems training, review quality improvement activities, provide technical assistance, ensure compliance with statutory and regulatory changes and requirements, identify innovations and best practices, and investigate Medicaid financial/reimbursement issues in preparation for the CFO audits.

- Overseeing the Medicare Survey and Certification process for healthcare facilities, such as nursing homes, to ensure that these facilities are not only following the State guidelines, but also complying with federal guidelines.

- Printing and Postage

The largest expense in this category (90%) is for printing notices in the Federal Register and Congressional Record. The law requires CMS to publish regulations that adhere to notice and comment rulemaking procedures. Historically, one major piece of new authorizing legislation involving CMS's programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

The remaining printing requests include funding needed for postage meters for routine correspondence and printing of required reports, such as the CMS Financial Report.

Funding History

2009	$641,351,000
2010	$696,880,000
2011	$685,806,000
2012	$772,963,000
2013	$777,694,000

Non-comparable values.

Budget Overview and Supported Activities

FY 2014 Request ($771.8 million):

Personnel Compensation and Benefits ($634.0 million): The FY 2014 estimate includes $634.0 million to support 4,635 direct FTEs, a $53.5 million (+280 FTE) increase over the FY 2012 enacted level. This staffing level is necessary to help us implement private market insurance reforms, including the Federal Marketplace, maintain and improve our traditional programs in light of significant beneficiary population growth, and to improve program integrity. FY 2014 marks the first full year of Marketplace operations and other market reforms. Our payroll estimate assumes a 1.0 percent pay increase for civilians and the Commissioned Corps in 2014.

Rent, Communication & Utilities ($23.5 million): Our FY 2014 request fully funds rent, communications and utilities at $23.5 million, a -$0.5 million decrease from the FY 2012 enacted level.

Building Loans ($10.9 million): The FY 2014 request for building loans is $10.9 million. This estimate remains the same as the FY 2012 enacted level.

Service and Supply Fund ($23.1 million): The FY 2014 Service and Supply Fund request totals $23.1 million, a $6.9 million increase over the FY 2012 enacted level.

Human Resources Support ($0.0 million): CMS' FY 2014 request assumes that ongoing human resources support will be absorbed into routine Agency operations. As a result, we no longer request separate funding for this activity. Staffing, the largest cost component of this activity, is absorbed within our payroll request.

Administrative Services ($9.6 million): The FY 2014 Administrative Service estimate is $9.6 million, a -$0.6 million decrease from the FY 2012 enacted level.

Administrative Information Technology ($28.9 million): The FY 2014 Administrative IT estimate is $28.9 million, a -$14.0 million decrease below the FY 2012 enacted level.

Inter-Agency Agreements ($3.8 million): The FY 2014 estimate in this category is $3.8 million, a $0.3 million increase over the FY 2012 enacted level.

Supplies and Equipment ($1.2 million): The FY 2014 request for supplies and equipment is $1.2 million, the same as the FY 2012 enacted level.

Administrative Contracts and Intra-Agency Agreements ($23.0 million): The FY 2014 request for Contracts and Intra-Agency Agreements totals $23.0 million, a -$20.7 million reduction from the FY 2012 enacted level.

Training ($3.3 million): The training estimate for FY 2014 is $3.3 million, a -$10.1 million decrease from the FY 2012 enacted level.

Travel ($7.1 million): The travel estimate for FY 2014 totals $7.1 million, a -$5.2 million decrease compared to the FY 2012 enacted level.

Printing and Postage ($3.4 million): The printing and postage estimate for the FY 2014 request totals $3.4 million, a -$1.0 million decrease from the FY 2012 enacted level.

Federal Administration Summary
(Dollars in thousands)

Objects of Expense	FY 2012 Enacted	FY 2014 Request	FY 2014 +/- FY 2012
Personnel Compensation	$580,565	$634,029	$53,464
Rent, Communications and Utilities	$24,000	$23,457	-$543
Central Office Loan	$10,900	$10,900	$0
Service and Supply Fund	$16,200	$23,133	$6,933
BHRC Human Resources	$9,700	$0	-$9,700
Administrative Services	$10,200	$9,583	-$617
Administrative IT	$42,853	$28,893	-$13,960
Inter-Agency Agreements	$3,523	$3,788	$265
Supplies and Equipment	$1,183	$1,180	-$3
Administrative Contracts and Intra-Agency Agreements	$43,635	$22,961	-$20,674
Training	$13,380	$3,312	-$10,068
Travel	$12,363	$7,125	-$5,238
Printing and Postage	$4,461	$3,439	-$1,022
Subtotal, Non-Pay Objects of Expense	$192,398	$137,771	-$54,627
Total, Federal Administration 1/	**$772,963**	**$771,800**	**-$1,163**

1/ Non-comparable display.

Medicare Survey and Certification

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$375,203,000	$377,500,000	$412,353,000	$37,150,000

Authorizing Legislation - Social Security Act, title XVIII, section 1864
FY 2014 Authorization - One Year
Allocation Method – Contracts

Program Description and Accomplishments

In order to secure quality care for the elderly, one of the Nation's most vulnerable populations, CMS requires that all facilities seeking participation in Medicare and Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two territories. Utilizing over 6,500 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards. In FY 2012, about 87 percent of Medicare participating nursing home facilities were cited for health deficiencies. The average number of health deficiencies per standard survey was approximately six. Similarly, 77 percent of dialysis facility surveys resulted in deficiency citations in FY 2012, 53 percent of hospital surveys, and 47 percent of HHA surveys. In FY 2012 approximately 57% of ambulatory surgical centers (ASCs) were cited for infection control deficiencies, as CMS has continued its efforts to address this serious issue. These examples illustrate the profound importance of regular, comprehensive inspections of health care facilities, as well as timely and effective investigation of complaints.

Twenty recent reports (2010-2012) from the Government Accountability Office (GAO) and the Office of Inspector General (OIG) highlight the need for Federal oversight to ensure quality of care. At various times, the GAO has placed areas of survey and certification oversight, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement. Recent reports from the OIG focused on adverse events in hospitals and ASCs. We are therefore implementing a variety of the OIG recommendations to strengthen survey and certification oversight, such as improvements in infection control, adverse event reporting, and strengthening provider internal quality assessment and performance improvement systems. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to ensuring Federal dollars support only quality care.

<u>Direct Survey Costs</u>

Direct Survey costs represent the funding provided directly to States to perform surveys and complaint investigations and to support associated program costs. Two facility types have statutorily mandated survey frequencies: each individual nursing home must be surveyed at least every 15 months and on average all nursing homes every 12 months, and each home health agency must be surveyed at least every 3 years. Survey frequencies for all other facility types are determined by policy and funding levels. Direct survey costs are affected primarily by

the number of Medicare-participating providers and the onsite survey time required. The number of providers continues to increase, with home health agencies, ambulatory surgical centers, and dialysis facilities growing the fastest in number (increasing by 76 percent, 54 percent, and 37 percent respectively between FY 2002 and FY 2012).

In addition to the cost of conducting surveys, Direct Survey costs also include Other Direct Survey costs, which support State program costs. These costs include support for the Minimum Data Set (MDS), which contains data information to improve nursing home projects. This information also supports the Outcome and Assessment Information Set (OASIS), which serves as the backbone of the home health prospective payment system. Examples of other Direct Survey costs also include emergency preparedness and validation surveys to assess the adequacy of State surveys and those of CMS-approved accrediting organizations (required by law in the case of non-long term care facilities and accrediting organizations).

Survey frequencies for non-statutorily mandated facilities improved after 2009, but frequency has recently been decreasing (in some cases to intervals longer than once every ten years between surveys for some providers), due to a growing number of facilities, growth in complaint visits, and demands to survey more facility types. Reduced survey frequencies have consequences. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various Ambulatory Surgical Centers (ASCs), potentially affecting more than 50,000 people. A CMS pilot in 2008 found that 57 percent of randomly-selected ASCs were cited for deficiencies in infection control practice. ASCs account for approximately 43 percent of all same-day (ambulatory) surgery in the United States, amounting to about 15 million procedures every year and have been among the fastest growing provider types participating in Medicare. In 2010, CMS, with assistance from the 2009 Recovery Act, expanded the pilot's initiative to all States to increase awareness of proper infection control practices among ASCs, improve the ability of surveyors to identify problems in infection practices, and ensure corrective action by ASCs to remedy problems and prevent future serious infections. To maintain appropriate oversight and address widespread problems in infection control, CMS also increased the survey frequency for ASCs to every 3 years in 2010, and standardized the average frequency at once every 4 years thereafter.

In recent years, CMS improved standards and survey processes for many types of providers, especially dialysis facilities (ESRD), ASCs, hospices, home health, organ transplant centers, and nursing homes. In FY 2008, CMS began phasing in onsite surveys of all organ transplant centers in the U.S. and enforcing outcome standards if patient deaths or graft failure exceed 150 percent of the risk-adjusted expected number. Patient survival for all types of organ transplants has improved, with the greatest improvements achieved in programs that entered into System Improvement Agreements with CMS. Since 2008, dialysis facilities have also been surveyed in accordance with substantially improved ESRD regulations. CMS has increasingly used statistical information to review outcomes as well as focus more attention on facilities whose performance data indicate a higher risk of poor patient outcomes. Nursing home survey processes have been improved through clarified surveyor guidance (such as guidance on surveying for the use of unnecessary medications), further development and deployment of the Quality Indicator Survey (QIS), and continued focus on the nursing homes judged to have the highest risk of poor quality of care (through the CMS *Special Focus Facility* (SFF) initiative). A 2012 analysis of nursing homes identified for special attention from 2005-2011 through the SFF initiative found that such nursing homes came into compliance with CMS requirements 50 percent more quickly compared the comparison of candidate facilities that were not surveyed with the same frequency.

Individuals in nursing homes are a particularly vulnerable population. Consequently, CMS places a high priority on ensuring nursing home quality. Funding for Nursing Home Oversight Improvement Program (NHOIP) activities is included in direct survey costs, as these activities have become a standard part of nursing home survey procedures. NHOIP activities are intended to improve survey processes through targeted mechanisms such as investigating complaints which allege actual harm within 10 days, imposing immediate sanctions for facilities found to have care deficiencies that involve actual patient harm, staggering inspection times to include a set amount begun on weekends and evenings, and additional surveys of facilities with a history of persistent serious problems (i.e., the CMS *SFF* initiative).

Support Contracts and Information Technology

Support Contracts

Of the several categories of support contract costs, surveyor training comprises the largest single category. The training program is essential to ensure that State surveyors both understand Federal regulations and maintain accurate and consistent interpretation of federal law and regulations. The training funds enable CMS to develop an increasing array of online course material and other innovative training methods to more efficiently train surveyors and maximize the value of training expenditures.

Federally-directed surveys constitute the second largest category of support contracts. These surveys either directly assist States, substitute for State surveys in certain specialized areas (such as organ transplant hospitals or psychiatric hospitals), or assist CMS Regional Offices in conducting comparative surveys designed to check the accuracy and adequacy of surveys done by States.

NHOIP activities that are funded as support contracts include implementing an improved survey process; understanding and addressing survey variations across States; maintaining the Medicare and Medicaid MDS; and publicly reporting nursing home staffing and other information on CMS' *Nursing Home Compare* website. Other critical Survey and Certification support contracts include, but are not limited to, the Surveyor Minimum Qualifications Test and other efforts to ensure national program oversight and consistency.

CMS is increasingly using performance data to direct survey attention to higher risk areas, prepare for surveys, and track provider progress. For example, CMS uses performance information to assure that onsite surveys are conducted – every year – for at least the 10 percent of dialysis facilities that CMS and the States consider to be at highest risk for poor quality of care or safety. Similarly, CMS now makes extensive use of risk-adjusted patient outcome data for organ transplant programs. As a consumer service, CMS also maintains a *Five Star Quality Rating System* for nursing homes, with results updated monthly on the *CMS Nursing Home Compare* website, one of CMS' most-visited websites.

Information Technology

CMS maintains several information technology systems that are necessary for survey and certification activities. The Online Survey, Certification, and Reporting System (OSCAR) and Federal Oversight/Support Survey System (FOSS) are, respectively, the State and Federal

workload database systems that are essential to the daily operation of the Survey and Certification program. Both of these systems are in the process of being redesigned to integrate with other essential IT systems. The OSCAR system enhancements will upload and convert the data from the current system to the new Quality Improvement and Evaluation System (QIES) through the use of the Certification and Survey Provider Enhanced Reports (CASPER). The OSCAR system is scheduled to be retired in 2015. The QIES system records and tracks more information on the Survey and Certification process and quality of healthcare for over 240,000 Medicare, Medicaid, and Clinical Laboratory Improvement Amendments (CLIA) providers. Although the OSCAR system is being redesigned, the legacy system must be maintained until QIES and CASPER are fully developed. The FOSS redesign will integrate the database into Automated Survey Processing Environment (ASPEN) which is essential in gathering the data from survey results.

CMS is implementing an improved data-driven standard survey system to be used in the certification of nursing homes that participate in the Medicare and Medicaid programs. The QIS was developed in response to concerns identified by CMS, GAO, and OIG regarding the current survey process. The concerns focus on achieving greater consistency in how compliance with Federal requirements is assessed for the 15,800 Medicare and Medicaid nursing homes that must be surveyed each year. The new QIS process uses both off site and on site information to develop computer generated quality of care indicators, comparing delivery of care with national norms. The QIS requires surveyors to use computers on site during the survey as the survey team gathers information, generates quality of care indicators and identifies those areas that are triggered for investigation in the second stage of the survey. Approximately 5,000 State and Federal surveyors will require training on the new survey process. Training is extensive and is conducted with contractor assistance. 26 States are either now in the process of, or have completely transitioned to, the QIS. In the meantime, CMS continues to run two survey processes, the traditional survey process and the QIS survey process.

Funding History

FY 2009	$293,128,000
FY 2010	$346,900,000
FY 2011	$361,276,000
FY 2012	$375,203,000
FY 2013	$377,500,000

Budget Request

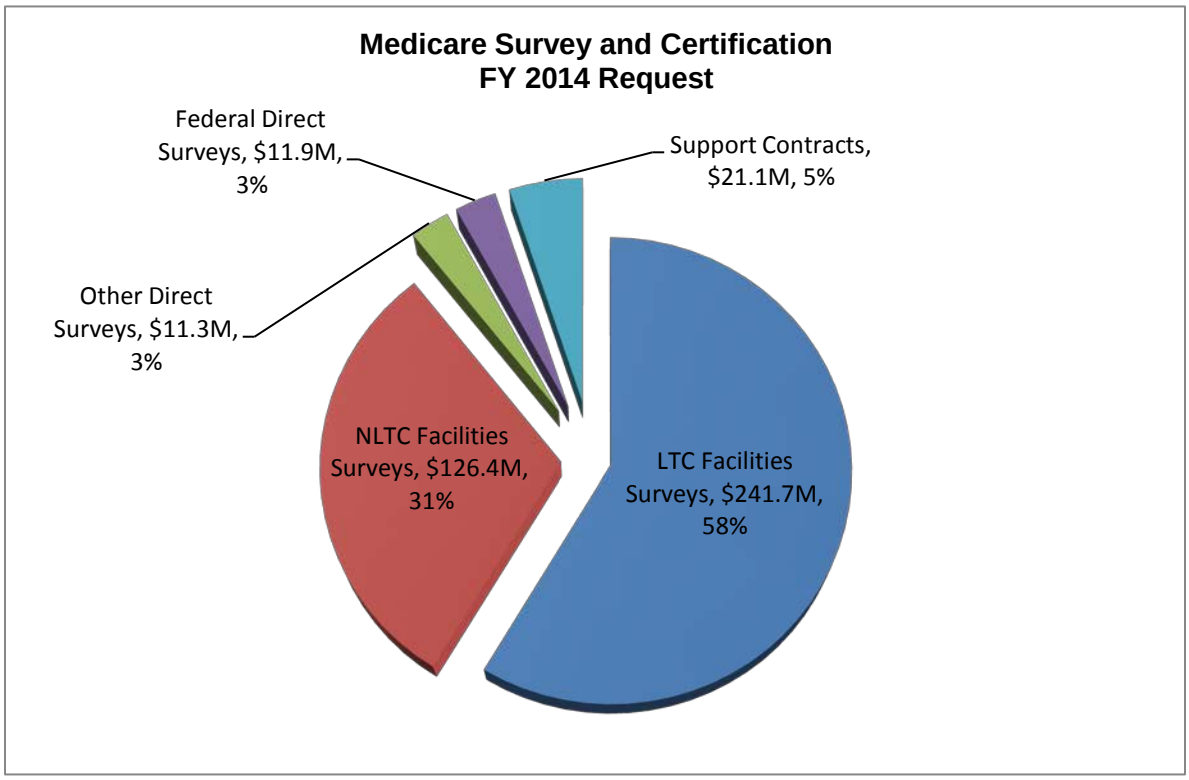
CMS' FY 2014 request for Medicare Survey and Certification is $412.4 million, a $37.2 million increase over the FY 2012 Enacted Level. Key cost drivers are the cumulative impact of new responsibilities (such as transplant hospitals, organ procurement organizations, advanced diagnostic imaging, and community mental health center surveys), implementing GAO and OIG recommendations for improvements to oversight and survey processes (but which resulted in longer onsite survey time, such as the increased time to conduct QIS surveys and a 32% increase in dialysis facility survey time after improved standards were put in place), continued growth in the number of facilities, expanded quality of care requirements, inflation, and the end of furloughs and salary freezes in most States (resulting in catch-up surveyor labor costs).

To contain costs in the face of a greater survey workload, CMS is undertaking many initiatives

to make survey processes even more efficient and effective. Increasing oversight and coordination with CMS-approved accrediting organizations is one such initiative. Efficiency initiatives include redesigning the procedures for ESRD and organ transplant hospital surveys to take a more risk-based approach and reduce average onsite survey time. Fewer full surveys of accredited hospitals will be conducted following a complaint investigation that finds Condition-level deficiencies, in favor of more focused surveys of particular areas of concern. Nursing home sprinkler status and compliance history will be weighted more heavily in determining the amount of onsite survey time spent evaluating compliance with the life safety code, so the amount of survey attention can be calibrated more closely to the degree of predicted risk.

As described below in more detail, $368.1 million of this amount will support State direct survey costs, $11.3 million will support additional costs related to State direct surveys, and $32.9 million will be used for direct surveys by CMS National Contractors (non-State), support contracts, and information technology.

Approximately 92 percent of the requested funding will go to State survey agencies. This funding will be used for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, organ transplant facilities and ESRD facilities. Compared with recent FY2012 survey rates, the request supports more frequent surveys of certain providers or suppliers, such as dialysis facilities, hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, ambulatory surgery centers and community mental health centers. The request will therefore promote performance that more closely aligns with CMS policy and past practice. The budget also includes funding for continued program support contracts to strengthen quality improvement and national program consistency, make oversight of accrediting organizations more effective, and implement key recommendations made by the Government Accountability Office (GAO) and Office of the Inspector General (OIG). In FY2014 HHS proposes a revisit survey user fee. The proposal provides CMS with the ability to revisit providers that have been cited for deficiencies and confirm that they have restored their services to substantial compliance with CMS requirements. Thus, the fee would only apply to providers or suppliers that have had serious quality of care or safety deficiencies, and would create an incentive for facilities to correct the problems in a timely and effective manner. To enable providers good opportunity to plan, the revisit user fee would be phased-in over a multi-year period and no significant revenue would be anticipated from the fee until FY2015. Prior experience with a revisit user fee in FY2007 demonstrated its feasibility, and the multi-year phase-in approach proposed by HHS should make a future fee even more feasible.



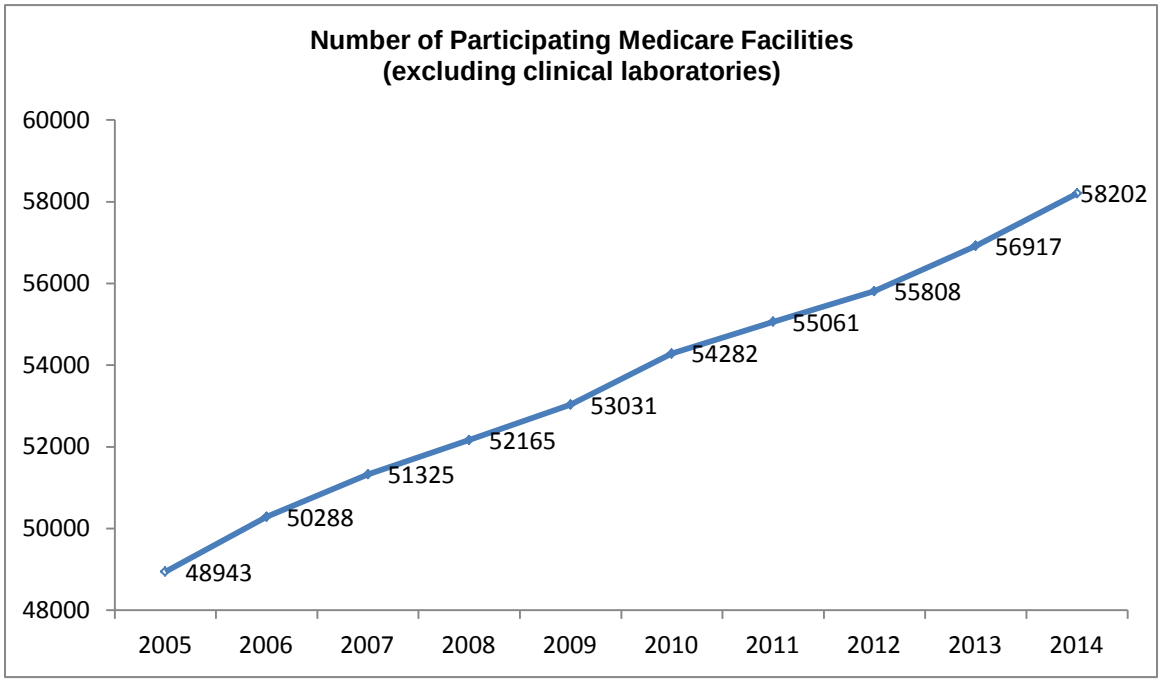
State Direct State Survey Costs - $368.1 million

The FY 2014 request includes $368.1 million for State direct survey costs. This funding will enable CMS to meet statutory survey frequencies as well as near CMS policy levels frequencies for non-statutory facilities.

Conditions of Participation (COPs) for Community Mental Health Centers (CMHCs) have been published in proposed form, with the final regulation scheduled for FY2013. The COPs will promote improvements in the quality of care at CMHCs by setting minimum quality and safety of care standards that CMHCs will have to meet in order to enter and maintain enrollment as a Medicare provider. CMHC surveys are expected to begin during FY 2014.

As shown in the pie chart above, the direct survey budget includes resources to survey most provider types, with the majority of the budget funding long-term care facility surveys (i.e., SNFs and dually-certified SNF/NFs).

Between FY 2012 and the end of FY 2014, the number of Medicare-certified facilities to be surveyed will have increased 4.3% percent, from 55,808 to 58,202 facilities in FY 2014, as shown in the following graph, excluding clinical laboratories.



Direct Survey Costs (Dollars in Millions)

Provider Type	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Skilled Nursing Facility (SNF)	$12.9	$13.9	$14.1
SNF/NF (dually-certified)	$195.8	$222.7	$227.6
Home Health Agencies	$29.9	$32.1	$32.4
Non-Accredited Hospitals	$17.7	$10.9	$17.5
Accredited Hospitals	$18.8	$24.5	$30.3
Ambulatory Surgery Centers	$8.0	$9.9	$11.1
ESRD Facilities	$15.1	$14.6	$19.6
Hospices	$6.3	$5.4	$8.5
Outpatient Physical Therapy	$1.8	$0.9	$1.5
Outpatient Rehabilitation	$0.3	$0.1	$0.2
Portable X-Rays	$0.2	$0.2	$0.3
Rural Health Clinics	$1.8	$1.6	$2.3
Transplant Centers	$3.4	$0.8	$1.6
Community Mental Health Centers	$0.0	$0.0	$1.1
Subtotal, Direct Survey Costs	**$312.0**	**$337.6**	**$368.1**
Other Direct Survey Costs	$17.0	$11.3	$11.3
Total, Direct Surveys [1]/	**$329.0**	**$348.9**	**$379.4**

[1] Total may not add due to rounding.

CMS' FY 2014 request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. CMS continues to advance efforts to address healthcare associated infections (HAI) across all providers. The request continues the enhanced survey process in ASCs to target infection control deficiencies with an average survey frequency that meets policy level of every 4 years.

The following chart includes updated frequency rates for FY 2013 and FY 2014.

Type of Facility	Recert. Level FY 2012 Actual	Recert. Level FY 2013 Annualized CR	Recert. Level FY 2014 President's Budget
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 4 Years	Every 5 Years	Every 3.4 Years
Accredited Hospitals	2% Year	1.2% Year	2.5% Year
ESRD Facilities	Every 4.3 Years	Every 5 Years	Every 3.5 Years
Organ Transplant Facilities	Every 6.1 Years	Every 7 Years	Every 6 Years
Ambulatory Surgical Center	Every 4.5 Years	Every 4.5 Years	Every 4 Years
Community Mental Health Centers	Not Funded	Not Funded	Every 6 Years
All Other Non-LTC Facilities 1/	Every 7 Years	Every 10 Years	Every 6 Years

1/ All other Non-LTC facilities includes: hospices, outpatient physical therapy & rehab, x-rays, and rural health clinics

In FY 2014, CMS expects to complete approximately 24,253 initial and recertification inspections, as shown in the Surveys and Complaint Visits table, below. In addition, CMS estimates 55,425 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2014 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of pressure ulcers in nursing homes. In October 2010, all nursing homes began submitting nursing home clinical assessment data using the MDS, version 3.0; therefore, CMS rescaled and rebased the measure. Additional information about Survey and Certification performance measures is included in the performance section of this chapter.

Survey and Complaint Visit Table

	FY 2013 Annualized CR Level				
Type of Facility	**Projected # Fac. (Beg of FY)**	**Total Recert. Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	816	816	30	808	1654
SNF/NF (dually-certified)	14295	14460	127	42275	56862
Home Health Agencies	10625	2925	29	1525	4479
Accredited Hospitals	4545	53	0	4495	4548
Transplant Centers	*264*	15	12	10	37
Non-accredited Hospitals	1712	342	4	735	1081
Hospices	4375	353	6	582	941
Outpatient Physical Therapy	2624	262	37	9	308
Outpatient Rehabilitation	415	42	5	5	52
Portable X-Rays	565	57	21	5	83
ESRD Facilities	5685	1137	263	765	2165
Rural Health Clinics	3885	389	215	40	644
Ambulatory Surgery Centers	5470	767	5	99	871
CMHC	0	0	0	0	
Total	**55,276**	**21,618**	**754**	**51,353**	**73,725**

	FY 2014 President's Budget				
Type of Facility	**Projected # Fac. (Beg of FY)**	**Total Recert. Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	816	816	30	880	1726
SNF/NF (dually-certified)	14295	14460	120	45750	60330
Home Health Agencies	10625	2925	90	1550	4565
Accredited Hospitals	4545	113	0	4515	4628
Transplant Centers	264	44	12	12	68
Non-accredited Hospitals	1712	507	68	1010	1585
Hospices	4620	588	52	615	1255
Outpatient Physical Therapy	2624	437	29	10	476
Outpatient Rehabilitation	415	69	5	4	78
Portable X-Rays	565	94	30	4	128
ESRD Facilities	5685	1624	238	905	2767
Rural Health Clinics	3885	648	215	40	903
Ambulatory Surgery Centers	5470	863	56	120	1039
CMHC	660	0	120*	10	25
Total	**56,181**	**23,188**	**1065**	**55,425**	**79,678**

** All surveys of existing CMHCs are here considered initial surveys under the new Conditions of Participation.*

Other State Direct Survey Costs - $11.3 million

The FY 2014 direct survey cost estimate also includes $11.3 million in other direct survey costs for several continuing activities. Examples of such activities include:

- MDS State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects
- OASIS State program costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support
- Validation Support, including conducting validation surveys of the non-long-term care accredited facilities; home health agencies, ASCs, and hospices.

Federal Direct Surveys and Support Contracts and Information Technology - $32.9 million

Federal Direct Surveys - $11.8 million

CMS will engage in a small number of national contractors (in lieu of or with States) to conduct certain surveys on behalf of CMS in areas that are highly specialized or so small in number that States have difficulty maintaining infrequently-used expertise. The contractors also assist States or federal surveyors in emergencies or in responding to special challenges. Contractors are used for some surveys of organ transplant hospitals, psychiatric hospitals, ESRD facilities, and nursing homes.

Support Contracts and Information Technology - $21.1 million

Support contracts and information technology, managed by CMS, constitute $21.1 million of the FY 2014 request.

Support Contracts

The FY 2014 request for support contracts totals $19.1 million. One of the largest categories in support contracts continues to be surveyor training and fulfilling the statutorily-required training mandates of sections 1819, 1919, and 1891 of the Social Security Act. Implementing more efficient and effective training of surveyors is an area that has a high return on investment. Through web-based and case-study training, surveyors can gain the skills necessary to perform proficiently, while providing quality care for beneficiaries. CMS is developing an increasing array of web-based trainings in order to reduce travel expenses. The FY 2014 request will also continue to provide funds for maintenance and continued improvement of the CMS *Nursing Home Compare* website and *Five Star Quality Rating System* for nursing homes. The FY 2014 budget supports CMS efforts to increase the use of performance data in focusing survey attention as efficiently as possible. The budget supports the CMS partnership efforts to improve dementia care and reduce the use of anti-psychotic medications in nursing homes.

Information Technology

The IT funding request for FY 2014 is $2.0 million. The IT funding level is slightly lower than the FY 2013 President's budget request because we anticipate no longer funding activities related to the maintenance of the OSCAR system and expect to transition to the CASPER system in FY

2013, with only Clinical Laboratory functions not yet transitioned off of OSCAR.

This FY 2014 request includes $0.5 million for the continued implementation of the IT portion of the QIS. These funds support the ongoing system support and maintenance for current and future states implementation to the QIS process. IT expenses are incurred for systems work, regardless of the number of States.

Performance Measurement

CMS uses performance measures to support our mission and to inform the decision-making process. CMS evaluates the performance of State survey agencies and ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements via Federal Validation Surveys. CMS' State Performance Standards System (SPSS) tracks measures such as adequacy of documentation, promptness of reporting survey results and quality of surveys, as well as conformance with expected survey frequencies. For example, the percentage of nursing homes surveyed at mandated 15-month maximum survey intervals has increased from about 97.0 percent in 2002 to 99.2 percent in 2012, and the percent of home health agencies surveyed at the mandated minimum 3-year frequency rose from 92.0 percent in 2002 to 99.7 percent in 2012. Measures under the Government Performance and Results Act (GPRA) include the following.

MSC1 Decrease the Prevalence of Pressure Ulcers in Nursing Homes: CMS measures quality of care and other survey and certification activities in nursing homes to assess the effectiveness of State surveys. Measure MSC1 is clinically significant and is closely tied to the care given to beneficiaries. The CMS Regional Offices (ROs) have taken the lead in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative. New survey guidance and follow-up with States has increased the focus on pressure ulcer reduction.

The prevalence of pressure ulcers in nursing homes is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers. Nonetheless, a decrease in the prevalence of pressure ulcers of even 0.1 percentage points represents more than 1,000 fewer nursing home residents with a pressure ulcer. The success of the efforts can be attributed to greater collaboration between State survey agencies and Quality Improvement Organizations and the national Advancing Excellence in America's Nursing Homes campaign.

In October 2010, all nursing homes began submitting nursing home clinical assessment date using the Minimum Data Set (MDS), version 3.0, an upgrade from version 2.0. The pressure ulcer measure was affected by the changes in the MDS; therefore, CMS had to rescale and rebase the measure beginning in FY 2011. The new FY 2011 baseline is 7.1 percent. In prior years, we measured pressure ulcers in Stages 1 through 4 for all long-stay nursing home residents. For FY 2011 reporting and beyond, we will track the prevalence of pressure ulcers, Stage 2 and greater, in high-risk, long-stay residents. In FY 2012, the actual reported prevalence of Stage 2 and greater pressure ulcers among high risk residents was 6.5 percent, exceeding our target of 6.9 percent. Our FY 2013 and FY 2014 targets are 6.9 percent.

MSC2 Percentage of States that Survey Nursing Homes at Least Every 15 Months and MSC3 Percentage of States that Survey Home Health Agencies at Least Every 36 Months: CMS has performance measures to assess whether CMS and our survey partners are meeting the core statutory obligations for carrying out surveys with routine frequency. Although 99.2 percent of all nursing homes were surveyed within the statutory 15-month timeframe, CMS did not meet its FY 2012 target of 97 percent of States completing all surveys, as only 83 percent of States achieved 100 percent. In addition, only 83 percent of States surveyed all home health agencies at least every 36 months, missing the FY 2012 target of 95 percent. The primary factor affecting the ability to meet the FY 2012 targets was State employee furloughs and hiring freezes, which prevented surveyors from completing their required surveys. The FY 2014 targets are for 97 percent of States to survey nursing homes at least every 15 months and

for home health agencies to survey at least 96 percent at least every 36 months. This methodology requires a State to comply with 100 percent of its surveys, and the metric is, therefore, sensitive to States achieving this absolute bar. In order to assist States, CMS must ensure that proper operational controls, such as training and regulations, are in place. CMS also issues annual instructions to States, which update the agency's policies, priorities, and the statutory survey frequency requirements to meet these targets.

MSC4 Decrease the Percentage of Long-Stay Nursing Home Residents who have Experienced One or More Falls with Major Injury: We are also developing a new measure to decrease the percentage of long-stay nursing home residents who have experienced one or more falls with major injury. Estimates of the number of falls in nursing homes vary widely and this will be the first large-scale measurement of injurious falls in the nursing home population. The FY 2012 baseline is 3.3 percent and our 2014 target is 3.1%. While not all falls are preventable, there are effective strategies that nursing homes can use to not only reduce injuries in fall-prone individuals, but also increase strength and balance for all nursing home residents. While increasing efforts to reduce injurious falls in nursing homes, we will work to ensure that this is achieved without undesired actions to limit residents' mobility (e.g. through increased use of physical restraints). CMS, in partnership with nursing homes, has achieved significant progress in reducing the use of physical restraints in nursing homes. In 1999, when CMS began reporting on physical restraints, the prevalence of physical restraints in nursing homes was 17 percent; the most recent data from 2011 now indicate the prevalence has decreased to 2 percent, representing an important and permanent change in the practice of care in this country's nursing homes. Although we discontinued our annual performance goal to reduce the prevalence of restraints in nursing homes after FY 2010, we will continue to carefully monitor this metric and educate providers about the negative consequences of restraint and side-rail use. We will also evaluate how well nursing homes assess residents for risks of falls and incorporate strategies for reducing the risk of serious injury.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MSC1: Decrease the prevalence of pressure ulcers in nursing homes	FY 2012: 6.5% (Target Exceeded)	6.9%	6.9%	Maintain
MSC2: Percentage of States that survey 100% of nursing homes at least every 15 months	FY 2012: 83% Target: 97% (Target Not Met)	97%	97%	Maintain
MSC3: Percentage of States that survey 100% of Home Health Agencies at least every 36 months	FY 2012: 83% Target: 95% (Target Not Met)	96%	96%	Maintain
MSC4: Decrease the percentage of long-stay nursing home residents who have experienced one or more falls with major injury.	FY 2012: Baseline = 3.3%	Baseline	3.1%	N/A

Survey and Certification Discontinued Measure

Performance Measure MCR 8

Measure	FY	Target	Result
MCR8: Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds for those States that fail to complete all statutorily-required surveys	*2012*	92%	100% (Target Exceeded)
	2011	90%	100% (Target Exceeded)
	2010	80%	100% (Target Exceeded)
	2009	75%	100% (Target Exceeded)
	2008	70%	75% (Target Exceeded)

Performance Measure MCR 8

This measure is being retired. The targets that were set for this goal have been exceeded in each of the years the goal has been in effect. Procedures and processes are in place to ensure that those States that do not fully deliver the required workload each year will incur a reduction
in funding based on the average cost to perform the specific workload they failed to achieve.

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State High-Risk Pools

Program	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
State High-Risk Pools	$44,000,000	$44,269,000	$22,004,000	($21,996,000)

Authorizing Legislation - Trade Act of 2002 (P.L. 107-210) and the State High-Risk Pool Funding Extension Act of 2006 (P.L. 109-172).

Allocation Method - Grants

Program Description and Accomplishments

Title II, Division A, of the Trade Act of 2002 (P.L. 107-210) amended the Public Health Service Act by adding section 2745, which sought to support the creation and initial operation of qualified high-risk pools to assist "high-risk" individuals who may find private health insurance unavailable or unaffordable and are therefore at risk for being uninsured. Qualified high-risk pools provide health insurance coverage that does not impose any preexisting condition exclusion to all Health Insurance Portability and Accountability Act of 1996 (P. L. 104-191) eligible individuals. In general, high-risk pools are operated through state-established non-profit organizations, or directly by States, which contract with private insurance companies or administrators to collect premiums, administer benefits, and pay claims.

In FY 2006, section 6202 of the Deficit Reduction Act (P.L.109-171) and State High-Risk Pool Funding Extension Act of 2006 (P.L. 109-172) extended the funding of grants under section 2745 of the Public Health Service Act by authorizing and appropriating $15 million for seed grants to assist States to create and initially fund qualified high-risk pools and $75 million for grants to help fund prior year operational losses and current year bonus grants for supplemental consumer benefits to the existing qualified high-risk pools. CMS awarded grants to 36 States in FY 2006 and 5 States in FY 2007. These funds were included in the CMS mandatory State Grants and Demonstrations account. The Consolidated Appropriations Act of 2008 (P.L. 110-161) appropriated $49.1 million for high-risk pools for FY 2008 in the CMS discretionary Program Management account. In FY 2009, $75 million was appropriated for the high-risk pools grant program through the Omnibus Appropriation Act, 2009 (P.L. 111-8). On December 16, 2009, the Consolidated Appropriations Act, 2010 (P.L. 111-117) appropriated $55 million for FY 2010.

The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) extended funding through September 30, 2011 and appropriated $54.9 million for the grant program. On December 23, 2011, President Obama signed into law the Consolidated Appropriations Act, 2012 (Public Law 112-74) which provided $44.0 million for the grant program in FY 2012.

With enrollment in excess of 227,000[1] enrollees as of December 31, 2012, high-risk pools have provided a mechanism for high-risk individuals to maintain continuous coverage prior to January 1, 2014 when the Affordable Care Act's insurance market reforms take full effect.

The table on the following two pages displays the FY 2012 grant appropriations awarded by State.

FY 2012 Operational and Bonus Grants by State

State	Operation Losses	Bonus Grant	Total Award Amount	Bonus Grant Category
Alabama Health Insurance Plan	$733,715	$0	$733,715	N/A
Alaska Comprehensive Health Insurance Association	$449,652	$246,308	$695,960	Premium Holiday
Arkansas Comprehensive Health Insurance Plan	$705,009	$379,227	$1,084,236	Disease Management & Low-Income Premium Subsidy
CoverColorado	$1,191,515	$630,152	$1,821,667	Premium Reduction
Connecticut Health Reinsurance Association	$599,780	$324,466	$924,246	Premium Holiday
Idaho Individual High Risk Reinsurance Pool	$543,488	$295,075	$838,563	Supplemental Consumer Benefits
Illinois Comprehensive Health Insurance Plan	$1,827,325	$961,301	$2,788,626	Premium Relief
Indiana Comprehensive Health Insurance Association	$1,004,692	$534,485	$1,539,177	Disease Management & Low-Income Premium Subsidy
Iowa Comprehensive Health Association	$636,415	$0	$636,415	N/A
Kansas Health Insurance Association	$582,418	$315,446	$897,864	Disease Management
Kentucky Access	$841,436	$449,931	$1,291,367	Disease Management
Louisiana Health Plan	$757,798	$407,435	$1,165,233	Disease Management & Expanded Consumer Benefits
Maryland Health Insurance Plan	$1,493,735	$785,565	$2,279,300	Low-Income Premium Subsidy
Minnesota Comprehensive Health Association	$1,690,592	$885,760	$2,576,352	Low-Income Premium Subsidy
Mississippi Comprehensive	$738,510	$396,519	$1,135,029	Disease

[1] The Annual Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis Report, published by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), provides the total number of State High-Risk enrollees.

State	Operation Losses	Bonus Grant	Total Award Amount	Bonus Grant Category
Health Insurance Risk Pool Association				Management & Expanded Consumer Benefits
Missouri Health Insurance Pool	$866,239	$463,277	$1,329,516	Low-income Premium Subsidy
Montana Comprehensive Health Association	$564,894	$305,708	$870,602	Premium Subsidy & Disease Management
Nebraska Comprehensive Health Insurance Pool	$652,726	$351,080	$1,003,806	Premium Reduction
New Hampshire Health Plan	$496,410	$270,382	$766,792	Low-Income Premium Subsidy
New Mexico Medical Insurance Pool	$902,030	$480,174	$1,382,204	Low-Income Premium Subsidy
North Carolina Health Insurance Risk Pool	$1,188,206	$631,786	$1,819,992	Low-Income Premium Subsidy
Comprehensive Health Association of North Dakota	$469,025	$256,068	$725,093	Premium Reduction
Oklahoma Health Insurance High Risk Pool	$700,743	$377,284	$1,078,027	Premium Reduction
Oregon Medical Insurance Pool	$1,196,168	$632,214	$1,828,382	Expanded Consumer Benefits - Medication
South Carolina Health Insurance Pool	$784,079	$420,954	$1,205,033	Premium Reduction
South Dakota Risk Pool	$445,716	$244,193	$689,909	Extended Customer Benefits - to help offset the out-of-pocket medical expenses
Texas Health Insurance Risk Pool	$3,889,734	$2,039,340	$5,929,074	Premium Reduction
Utah Comprehensive Health Insurance Pool	$698,135	$375,069	$1,073,204	Premium Reduction
Washington State Health Insurance Pool	$877,536	$469,254	$1,346,790	Premium Reduction
Wisconsin Health Insurance Risk-Sharing Plan	$1,374,679	$723,547	$2,098,226	Disease Management & Low-Income Premium Subsidy
Wyoming Health Insurance Pool	$445,600	$0	$445,600	N/A
Totals	**$29,348,000**	**$14,652,000**	**$44,000,000**	

Funding History

FY 2009	**$75,000,000**
FY 2010	**$55,000,000**
FY 2011	**$54,890,000**
FY 2012	**$44,000,000**
FY 2013	**$44,269,000**

Budget Request

CMS requests $22.0 million in discretionary funding for this activity in FY 2014, a $21.9 million decrease from the FY 2012 enacted level. This request provides grants to States to help offset the operational losses incurred during the prior fiscal year and bonus grants to States to fund consumer benefits, premium subsidy programs or chronic disease management programs in FY 2014.

Grantees rely on Federal funding to offset their prior year operational losses and in some cases to provide low-income subsidies and premium reductions to many individuals who may not be able to afford, or may be denied, healthcare coverage in the current year. Additionally, there are 28 States that use grant funding to operate disease and care management initiatives to address care coordination. This FY 2014 request will provide funding for the state high-risk pool program as pools transition to the Health Insurance Marketplace in 2014.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $177,872,985,000 to remain available until expended.

For making, after May 31, 2014, payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2014 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2015, $103,472,323,000 to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $177,872,985,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the authorized advance appropriation of $106.3 billion for the first quarter of FY 2014. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
For making, after May 31, 2014, payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2014 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.	This section provides indefinite authority for payments to States in the last quarter of FY 2014 to meet unanticipated costs including budget authority to the Vaccines for Children's program for payments on behalf of States.

Medicaid

Language Analysis

Language Provision	Explanation
For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2015, $103,472,323,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of FY 2015 to ensure continuity of funding for the Medicaid program including the Vaccines for Children program in the event a regular appropriation for FY 2014 is not enacted by October 1, 2014
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Medicaid Program
Appropriation
Amounts Available for Obligation
(dollars in thousands)

	2012 Actual	2013 Current Law	2014 Estimate
Appropriation Annual	$270,724,399	$269,405,279	$284,208,616
Appropriation Indefinite	0	0	0
Unobligated balance, start of year	407,762	21,091,365	21,951,882
Unobligated balance, end of year	-21,091,365	-21,951,882	0
Recoveries of Prior Year Obligations	20,185,635	0	0
Collections/Refunds	687,259	645,000	300,000
Total Gross Obligations	$270,913,690	$269,189,762	$306,460,498
Offsetting Collections Medicare Part B QI Program	-602,303	-645,000	-300,000
Obligations Incurred but not Reported	-1,091,446	-1,959,000	-2,369,000
Total Net Obligations	$269,219,941	$266,585,762	$303,791,498

Medicaid Program
Summary of Changes
(dollars in thousands)

2014 Estimated Budget Authority		$284,208,616
2013 Budget Authority Request from PB 2013		$269,405,279
Net Change		$14,803,337
Explanation of Changes	FY 2013 Current Base Budget Authority	FY 2014 Change From Base Budget Authority
Program Increases		
Legislation and Administrative Actions	$6,014,000	$25,613,000
Fraud control Units	237,200	3,400
Obligations Incurred But Not Reported	1,359,500	1,009,500
Vaccines for Children Program	4,271,015	22,368
State and Local Administration	13,437,866	2,548,582
Financial Management Reviews	-297,000	115,000
Total Program Increases	$25,022,581	$29,311,850
Program Decreases		
Medical Assistance Payments	$258,806,000	-$6,906,000
State Certification	230,280	-4,213
Unobligated Balance Carry Forward	-14,653,582	-7,298,300
Offsetting Collections from Medicare Part B premiums	0	-300,000
Total Program Decreases	$244,382,698	-$14,508,513
TOTAL	$269,405,279	$14,803,337

Medicaid Program
Authorizing Legislation

	FY 2013 Amount Authorized	FY 2013 Current Law	FY 2014 Amount Authorized	FY 2014 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$265,798,023,000	Indefinite	$279,915,233,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,607,256,000		$4,293,383,000
Total Appropriations		$269,405,279,000		$284,208,616,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2004	176,753,583,000	176,753,583,000	182,753,583,000	182,753,583,000	
2005	177,540,763,000	177,540,763,000	177,540,763,000	177,540,763,000	
2006	215,471,709,000	215,471,709,000	215,471,709,000	215,471,709,000	
2007	200,856,073,000	------	------	168,254,782,000	1/
2008	206,885,673,000	206,887,673,000	206,885,673,000	206,885,673,000	
2009	216,627,700,000	------	------	254,890,065,000	2/
2010	292,662,503,000	292,662,511,000	292,662,511,000	292,662,511,000	
2011	259,933,181,000	------	------	258,365,747,000	3/
2012	270,724,399,000	------	------	270,724,399,000	
2013	269,405,279,000				
2014	284,208,616,000				

1/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
2/ Includes $38,262.4 million under indefinite authority.
3/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.

Medicaid
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Medical Assistance Payments (MAP)	$248,606,307	$247,442,000	$283,345,000	$35,903,000
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$1,091,446	$1,959,000	$2,369,000	$410,000
Vaccines for Children	$4,000,453	$3,607,256	$4,293,383	$686,127
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$17,215,485	$16,181,506	$16,453,115	$271,609
Obligations (gross)	$270,913,690	$269,189,762	$306,460,498	$37,270,736
Unobligated Balance, Start of Year	-$407,762	-$21,091,365	-$21,951,882	$860,517
Unobligated Balance, End of Year	$21,091,365	$21,951,882	$0	-$21,951,882
Recoveries of Prior Year Obligations	-$20,185,635	$0	$0	$0
Appropriation Budget Authority (gross)	$271,411,658	$270,050,279	$284,508,616	$14,468,337
Collections	-$687,259	-$645,000	-$300,000	$345,000
Total Budget Authority (net)	$270,724,399	$269,405,279	$284,208,616	$14,813,337
Indefinite Authority	$0	$0	$0	$0
Advanced Appropriation	-$86,445,289	-$90,614,082	-$106,335,631	-$15,721,549
Annual Appropriation	$184,279,110	$178,791,197	$177,872,985	-$918,212

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5

FY 2013 Authorization - Public Law 111-148, Public Law 111-152, Public Law 112-74, Public Law, 112-175

Allocation Method - Formula Grants

Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government that provides health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. The Affordable Care Act (P.L. 111-148 and P.L 111-152), extends, at the State's option, Medicaid eligibility to non-elderly individuals with family incomes up to 133 percent of the Federal poverty level (FPL), with the Federal government paying most of the costs of coverage starting in calendar year (CY) 2014. In addition, Medicaid provides home and community-based services and supports to seniors and individuals with disabilities, as well as institutional long-term care services. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State.

In general, most individuals who are eligible for cash assistance under the Supplemental Security Income (SSI) program, or who meet the categorical income and resource requirements of the former Aid to Families with Dependent Children (AFDC) cash assistance program as it existed on July 16, 1996, must be covered under State Medicaid programs. Other Federally-mandated coverage groups include low-income pregnant women and children and qualified Medicare beneficiaries who meet certain income and/or eligibility criteria. At their option, States may expand these mandatory groups or cover additional populations including the medically needy. Medically needy persons are those who do not meet the income standards of the other categorical eligibility groups, but incur large medical expenses such that when subtracted from their income, fall within eligibility standards.

Medicaid covers a broad range of services to meet the health needs of beneficiaries. Federally-mandated services for categorically-eligible Medicaid beneficiaries include hospital inpatient and outpatient services, home health care, laboratory and x-ray services, physician services, and nursing home care for individuals age 21 or older. Commonly offered optional services for both categorically- and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, and services in intermediate care facilities for individuals with intellectual disabilities. The Early and Periodic Screening Diagnostic and Treatment mandate within the Medicaid program requires the provision of comprehensive health screenings and medically necessary services authorized under section 1905(a) of the Social Security Act to individuals from birth to age 21. In addition, States may elect to offer an array of home and community-based services to individuals with disabilities, individuals who are aging or individuals with chronic conditions through a variety of waivers and funding opportunities.

Medicaid payments are made directly by States to health care providers or health plans for services rendered to beneficiaries. Providers must accept the State's payment as full recompense. By law, Medicaid is the payer of last resort. If any other party, including Medicare, is legally liable for services provided to a Medicaid beneficiary, that party generally must first meet its financial obligation before Medicaid payment is made.

The signing of the Affordable Care Act ushered in major improvements in health care coverage, cost and quality for all Americans. Under the law, Medicaid is the mechanism by which affordable coverage is provided to the lowest income Americans. To accomplish this, Medicaid eligibility is expanded and simplified, with the Federal government paying most of

the new coverage costs. Beyond these eligibility and financing changes, the new law improves access to home and community-based services, enhances the Federal commitment to assuring program integrity, and makes other program improvements.

The American Recovery and Reinvestment Act (ARRA), (P.L. 111-5) was signed into law on February 17, 2009. ARRA contains Medicaid provisions to provide protections for Native Americans and Alaskan Natives under Medicaid and CHIP, and funding for administration and incentive payments to promote the adoption and meaningful use of health information technology (HIT).

Medicaid Integrity Program

The Medicaid Integrity Program, though not funded from the Medicaid appropriation, supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. This program represents the most significant single, dedicated investment the Federal government has made in ensuring the integrity of the Medicaid program. Further discussion of the Medicaid Integrity Program can be found in the Medicaid Integrity section located in the State Grants and Demonstrations chapter.

Vaccines for Children Program

The Vaccines for Children (VFC) program is 100 percent Federally-funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention. This program allows vulnerable children access to lifesaving vaccines as a part of routine preventive care, focusing on children without insurance, those eligible for Medicaid, and American Indian/Alaska Native children. Children with commercial insurance that lack an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, Federally-purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention provides funding to 61 State and local public health immunization programs that include all 50 States, six city/urban areas, and five U.S. territories and

protectorates. Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities and intermediate care facilities for individuals with intellectual disabilities ensures that Medicaid beneficiaries are receiving quality care in a safe environment. In order to secure quality care for the Nation's most vulnerable populations, CMS requires that certain facilities seeking participation in Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two other territories. Utilizing more than 6,500 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards.

Medicaid Fraud Control Units (MFCUs)

Medicaid Fraud Control Units (MFCUs) are required by law to be established for all States operating a Medicaid program, unless the State receives a waiver from the Secretary. The MFCUs investigate State law violations of Medicaid fraud and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities. The MFCU must be part of or coordinate with an office with statewide prosecutorial authority, such as the State Attorney General's office.

Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Prior to 1982, 99 percent of Medicaid recipients received coverage through fee-for-service arrangements. The passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997 made it easier for States to develop managed care delivery systems thereby significantly increasing the number of Medicaid recipients enrolled in managed care organizations. As of July 1, 2011 over 74 percent of all Medicaid beneficiaries (just over 42 million) in 47 States, the District of Columbia, and Puerto Rico were enrolled in some type of managed care plan. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization of services, contain costs, improve access to services, and achieve greater continuity of care. Increasingly, States are using managed care to provide acute, primary, and behavioral health services, as well as long-term services and supports, to older individuals, individuals with disabilities and individuals with chronic conditions.

Prior to the passage of the Balanced Budget Act of 1997, States primarily used section 1915(b) waivers or section 1115 research and demonstration waivers to develop innovative managed care delivery systems. Section 1915(b) waivers are used to enroll beneficiaries in mandatory managed care programs; provide additional services via savings produced by managed care; create a "carve out" delivery system for specialty care, e.g., behavioral health; and/or create programs that are not available statewide. Section 1115 demonstrations allow States to test programs that vary in size from small-scale pilot projects to statewide demonstrations and test new benefits and financing mechanisms.

The Balanced Budget Act of 1997 added section 1932 of the Social Security Act and increased State flexibility to enroll certain Medicaid groups on a mandatory basis (with the exception of special needs children, Medicare beneficiaries, and Native Americans) into managed care through a State plan amendment. The Deficit Reduction Act of 2005 has enabled States to mandate enrollment for certain non-exempt populations in benchmark and benchmark-equivalent benefit plans under section 1937 of the Social Security Act. If a State opts to implement the alternative benefit packages under section 1937, the State may also use a managed care delivery system to provide the services.

As Medicaid managed care programs continue to grow, CMS remains committed to ensuring that high-quality, cost-effective health care is provided to Medicaid beneficiaries. CMS' efforts include evaluating and monitoring demonstration and waiver programs, enhancing information systems, and providing expedited review of State proposals. CMS has begun implementing a strategic plan to significantly expand its oversight and monitoring activities of Medicaid managed care programs. Key elements include expanded technical

assistance to States, more extensive and routine program reviews, identification and remediation of managed care payment anomalies, and formalizing managed care policy.

Section 1115 Demonstrations

Under section 1115 authority, many States have significantly restructured their Medicaid and/or CHIP programs in the areas of eligibility, benefits, service delivery systems, and financing with the goal of expanding health insurance coverage to lower income, vulnerable populations. Since the enactment of the Affordable Care Act, an increasing number of States are initiating efforts through 1115 waivers to promote delivery system reform in anticipation of the new health coverage options starting in 2014. States have sought section 1115 demonstrations to expand health care coverage to the low-income uninsured and test innovative approaches in health care service delivery. Currently, CMS has many active demonstrations, many of which will need to be considered for renewal by December 31, 2013. Most demonstrations are statewide and include the majority of the Medicaid population in the state. The most current fiscal data available indicates the Federal share of obligations for 1115 demonstrations in FY 2012 was $57.5 billion:

- 41 statewide health care reform demonstrations in 31 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Washington, and Wisconsin) and the District of Columbia.

- 4 non-Statewide health reform demonstrations (Illinois, Louisiana, Missouri and Ohio) and

- 17 demonstrations specifically targeted to family planning (Alabama, Arkansas, Florida, Georgia, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, North Carolina, Oregon, Pennsylvania, Washington, and Wyoming).

CMS plans to provide States with technical assistance to aid with the transition of demonstration populations into coverage options available in 2014 and, to support management of key section 1115 deliverables, such as quality evaluation reports, in all active demonstrations to ensure that these initiatives are evaluated appropriately in the context of determining demonstration program changes necessary in 2014 and beyond.

Some statewide demonstrations expand health coverage to the uninsured, and others test new methods for delivering health care services. Many of the demonstrations include low-income families and the Temporary Assistance for Needy Families (TANF)-related populations, and some include older individuals and individuals with disabilities. Although the demonstrations vary greatly, many of the demonstrations recently considered by CMS include provisions to dramatically improve States' health care delivery systems in ways that support the goals of the Affordable Care Act to provide better, lower cost care for Medicaid beneficiaries.

Recipients

The following table reflects the estimated annual Medicaid enrollment in number of person-years, which represents full-year equivalent enrollment, receiving Federal Medical Assistance. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment (Person-Years in Millions) /1

	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2013
Aged	5.1	5.2	5.4	0.2
Disabled	9.5	9.6	9.7	0.1
Adults	13.7	13.7	20.2	6.5
Children	28.2	27.9	29.4	1.5
Territories	1.0	1.0	1.0	0
Total	57.5	57.4	65.7	8.3/1

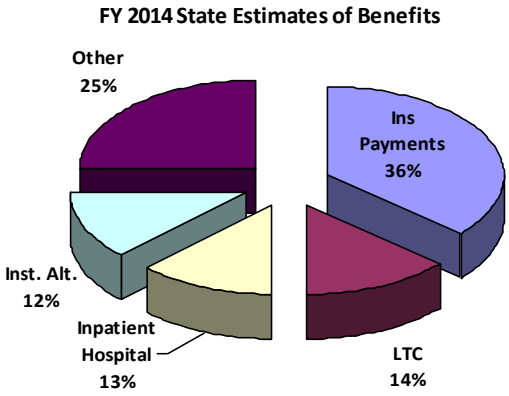
1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2014, 65.7 million of the projected 322.4 million in the total U.S. population, will be enrolled in Medicaid for the equivalent of a full year during FY 2014. In FY 2014, Medicaid will provide coverage to more than one out of every five children in the nation.

CMS projects that in FY 2014, children and non-disabled adults under age 65 will represent 77 percent of the Medicaid population, but account for approximately 40 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments and Medicaid beneficiaries in the Territories. In contrast, older individuals and individuals with disabilities are estimated to make up about 23 percent of the Medicaid population, yet account for approximately 60 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services

As displayed in the table on the following page, the State estimates for medical assistance payments increased from $261.5 billion for FY 2013 to $268.7 billion for FY 2014.



Health insurance payments are the largest Medicaid benefit service category. These benefit payments are comprised primarily of premiums paid to Medicaid managed care plans. These services are estimated to require $96.4 billion in funding for FY 2014 representing 36 percent of the State-submitted benefit estimates for FY 2014. The second largest FY 2014 Medicaid category of service is institutional long-term care services. It is composed of nursing facilities and intermediate care facilities for individuals with intellectual disabilities. The States have submitted FY 2014 estimates totaling $36.3 billion or about 14 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2014 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($33.7 billion or 13 percent), followed by institutional alternative services such as home health, personal care, and other home and community-based services ($33.0 billion or 12 percent). Together these four benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for 75 percent of the State-estimated cost of the Medicaid program for FY 2014.

Estimated Benefit Service Growth, FY 2013 to FY 2014
November 2012 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2013	Est. FY 2014	Dollar Growth	Annual Percent Growth	Percent Of State Estimate Growth
Health Insurance Payments (Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums)	$86,729,661	$96,436,740	$9,707,079	11.2%	135.4%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$31,696,986	$32,966,329	$1,269,343	4.0%	17.7%
Other (Targeted case management, hospice, all other services, and collections)	$24,167,988	$22,698,335	-$1,469,653	-6.1%	-20.5%
Long-Term Care (Nursing facilities, intermediate care facilities for the intellectually disabled)	$36,237,212	$36,346,556	$109,344	0.3%	1.5%
Outpatient Hospital	$9,834,778	$9,082,120	-$341,592	-3.6%	-4.8%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$5,762,715	$6,124,910	$362,195	6.3%	5.1%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$35,257,771	$33,655,880	-$1,601,891	-4.5%	-22.3%
Physician/Practitioner/Dental	$13,015,409	$13,279,879	$264,470	2.0%	3.7%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$8,700,215	$8,594,506	-$105,709	-1.2%	-1.2%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$9,393,665	$9,055,185	-$338,480	-3.6%	-4.7%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$261,519,897	$268,691,545	$7,171,648	2.7%	100.0%

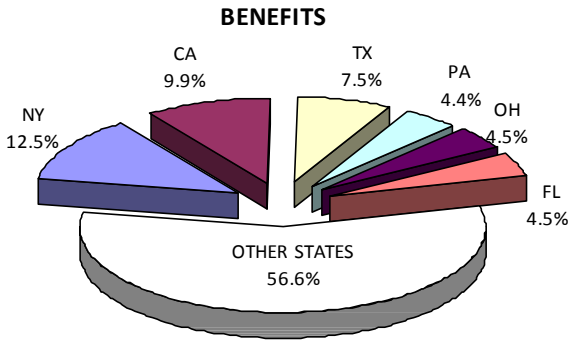
Note: This table reflects current law estimates.

Distribution of Medicaid Monies

The total FY 2014 State-submitted estimates for Medicaid are $281.6 billion, composed of $268.7 billion for Medicaid medical assistance payments and $12.9 billion for State and local administration.

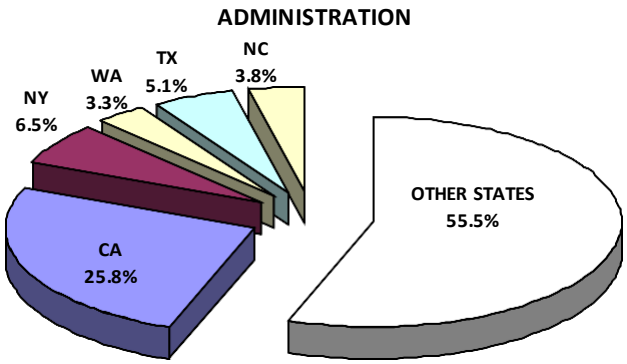
Distribution of Benefit Monies

As displayed, New York, California, Texas, Pennsylvania, Ohio, and Florida account for $116.8 billion, or over 43 percent, of the State-submitted estimates for benefits for FY 2014. Ten States represent over 55 percent of these estimates.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2014 State and local administration represents about 4.6 percent of the total State-submitted estimates for Medicaid costs for FY 2014. As displayed, California, New York, Washington, Texas, and North Carolina account for $5.7 billion or more than 44 percent of the FY 2014 estimates for State and local administration. Ten States represent over 58 percent of these estimates.



Funding History (Appropriation)

FY 2009	$254,890,065,000 1/
FY 2010	$292,662,511,000
FY 2011	$259,933,181,000 2/
FY 2012	$270,724,399,000
FY 2013	$269,405,279,000 3/

1/ Includes $38,262.4 million in indefinite funding authority.
2/ Full year continuing resolution appropriation provided indefinite funding authority.
3/ Pending requested appropriation.

Budget Request

CMS estimates its FY 2014 appropriation request for Grants to States for Medicaid is $284.2 billion, an increase of $14.8 billion relative to the FY 2013 level of $269.4 billion. This appropriation is composed of $177.9 billion in monies for FY 2014 and $106.3 billion in authorized advance appropriation monies for FY 2014.

The request reflects estimated end of year FY 2013 unobligated balance carried forward to FY 2014 of $22.0 billion[1/] and an estimated $300.0 million in offsetting collections from Medicare Part B for qualified individuals. Resources will fund $306.5 billion in anticipated FY 2014 Medicaid obligations. These obligations are composed of:

- $283.3 billion in Medicaid medical assistance benefits;
- $2.4 billion for benefit obligations incurred but not yet reported;
- $16.5 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $4.3 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

This submission is based on projections from State-submitted estimates and the CMS' Office of the Actuary (OACT) using Medicaid expenditure data as recent as the first quarter of FY 2013. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2014 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $303.8 billion in FY 2014. This represents an increase of 14.0 percent relative to the estimated net outlay level of $266.6 billion for FY 2013. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 14.5 percent during this time

period. Medical Assistance Payments

(MAP)

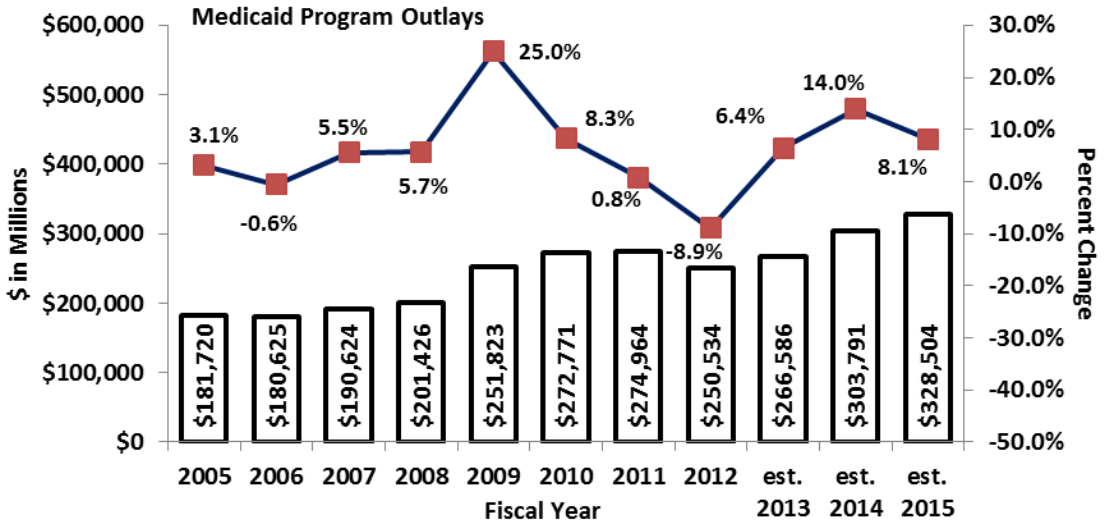
In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2012 State estimates. These adjustments reflect actuarial estimates, legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2012 State estimates for MAP in FY 2014 are the first State-submitted estimates for FY 2014. Typically, State estimation error is most likely to occur early in the budget cycle because States are most interested with their current year budget and have not yet focused on their projections for the Federal budget year.

/1 The Budget request was developed prior to enactment of the FY 2013 full year continuing resolution (P.L.113-6). Under the CR, Medicaid will not have any anticipated carry-forward into FY 2014.

OACT developed the MAP estimate for FY 2014. Using the last three quarters of FY 2012 State-reported expenditures as a base, expenditures for FY 2013 and FY 2014 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by the OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the November 2012 State-submitted estimates.



Factors Impacting Medicaid Expenditure Growth

Medicaid program cost growth accelerated with a sharp increase in enrollment resulting from a downturn in the economy, as well as growth in medical prices and utilization. Medicaid capitation premiums and payments to hospitals were among the most significant sources of expenditure growth. The growth in the last several years has abated as enrollment growth has slowed and as the Federal government and the States took steps to curb the growth of Medicaid expenditures.

Additionally, with the advent of the Medicare Part D benefit in 2006, spending on prescription drugs decreased as those costs shifted to Medicare. Thus, spending in 2006 actually decreased 0.6 percent. Medicaid spending grew modestly in FY 2007 and FY 2008; however, actual FY 2009 spending showed a larger increase compared to FY 2008 spending, driven by managed care, inpatient hospital care, nursing facilities, home and community-based waivers, and prescription drugs, as well as child and adult enrollment increases tied to the unemployment rate.

Federal Medicaid spending grew much faster than total Medicaid spending in FY 2009 due to the substantially higher Federal match rate provided in ARRA. The match rate increase and continued faster enrollment growth led to relatively strong growth in Federal Medicaid spending in FY 2010, although this rate grew only slightly faster than total Medicaid

spending. After the first quarter of FY 2011, the ARRA temporary increases in the Federal match rates were phased down to lower levels in the second and third quarters, leading to slower growth in Federal Medicaid spending for FY 2011 and a decline in Federal spending for FY 2012. In addition, enrollment growth is also expected to slow as the economy expands and employment levels increase following the end of the recession.

In March 2010, President Obama signed the Affordable Care Act which will usher in major improvements to health care coverage, cost and quality for all Americans. The largest change occurs in 2014 including the expansion of Medicaid eligibility at the State's option to persons under age 65 with incomes under 133 percent of the Federal Poverty Level (with a 5 percent income disregard). Federal Medicaid spending is projected to increase in FY 2014 due to large increases in enrollment among newly eligible individuals whose medical assistance expenditures will be reimbursed at 100 percent Federal match for 2014 through 2016 after which it gradually phases down to 90 percent for 2020 and beyond. As enrollment increases associated with the eligibility expansion are anticipated to continue through 2016, expenditures are projected to continue to grow relatively faster in FYs 2015 and 2016 as well.

In 2013 and 2014, CMS will be working with States to implement sections 1413 and 2201 of the Affordable Care Act which simplifies Medicaid eligibility starting in 2014. Section 1413 directs the Secretary to establish a streamlined eligibility and enrollment system for individuals to apply for and be enrolled in an insurance affordability program including Medicaid, CHIP and Basic Health Program (if applicable), as well as, enrollment in a qualified health plan. Section 2201 establishes simplified and coordinated Medicaid and CHIP eligibility and enrollment processes, under which States will use modified adjusted gross income (MAGI) based standards to determine eligibility for most populations. State Medicaid and CHIP agencies are making the necessary changes to their eligibility verification procedures to align with these provisions.

CMS has and will continue to provide extensive technical assistance, policy guidance and training to eligibility staff, providers, stake holders, consumer advocates and others on the new eligibility rules, policies and procedures in order to prepare for 2014. For many of the individuals newly eligible for enrollment in Medicaid and CHIP, this will be the first time they will have access to health coverage. These individuals will need access to information and education to so they can understand their health insurance options.

In the next year, CMS intends to take the following actions to promote and facilitate the expansion of Medicaid and CHIP:

- Offer a model online application for States to use to implement the Medicaid and CHIP eligibility simplifications in coordination with eligibility determinations for premium tax credits and cost sharing reductions available through the Health Insurance Marketplace effective in 2014.

- Provide a series of training opportunities (such as webinars, conferences, etc.) to State Medicaid and CHIP agencies on implementing of new business practices, data systems and staff training on the new Affordable Care Act eligibility changes.

- Provide States flexibilities to further simplify the outreach, enrollment, and retention processes and to address expected increases in enrollment that will result when the 2014 Affordable Care Act changes begin to take effect.

Please refer to the Program Management chapter for more information.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Recent Legislation (Estimated FY 2014 costs are $760 million)

American Taxpayer Relief Act of 2012
(P.L. 112-240)

- Extension of the Medicaid Express Lane Eligibility Option

  The express lane eligibility (ELE) option authorized by CHIPRA allows state Medicaid programs to use data from other programs in making income eligibility determinations for children. The authority to use the ELE was scheduled to expire on September 30, 2013. This provision will extend the ELE authority for one additional year through September 30, 2014.

- Extension of Transitional Medical Assistance (TMA)

  TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This provision extended the TMA program from January 1, 2013 through December 31, 2013.

- Extension of the Qualified Individual (QI) Program

  The Qualified Individual (QI) program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. In addition, QI beneficiaries are deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. This provision extended the QI program from January 1, 2013 through December 31, 2013.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2014 savings are $182 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $182 million in FY 2014. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure State compliance with Federal regulations governing Medicaid and State financing. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific

high-risk areas, and other ongoing oversight and enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2014 estimate of $2.4 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2013 to September 30, 2014. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Vaccines for Children (VFC) Program

The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. In addition to the health benefits of vaccines, they also provide significant economic value. A 2011 economic evaluation found that for each birth cohort vaccinated against 13 childhood diseases (diphtheria, *haemophilus influenzae* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella) over 20 million cases of disease and over 42,000 deaths are prevented over the lifetime of children born in any given year, and result in an annual cost savings of $13.6 billion in direct medical costs. An estimated $10.20 is saved in direct medical costs for each $1 invested in vaccines for VPDs.

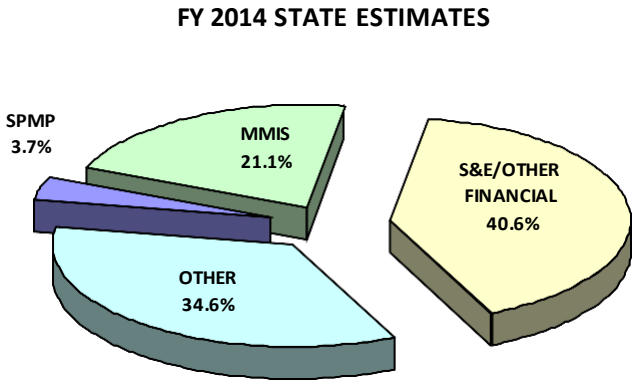
The current FY 2014 estimate for the VFC program is $4.3 billion, which is $686.1 million above the FY 2013 estimate. This estimate includes vaccine-purchase contract costs and related costs, such as costs of vaccine ordering and distribution on behalf of States. The net increase includes an increase for vaccine purchase and a decrease for vaccine management business improvement plan contractual support. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget is used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of States; immunization grantee vaccine management activities, quality assurance and quality improvement site visits to VFC enrolled providers, immunization coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2014, based on recent actual data and the November 2012 State estimates, CMS estimated the Federal share of State and local administration costs to be $16.5 billion. This estimate is composed of $16.0 billion for Medicaid State and local administration and $.5 billion in additional funds for Medicaid State survey and certification and State Medicaid fraud control units.

State and Local Administration

In November 2012 the States estimated the Federal share of State and local administration outlays to be $12.9 billion for FY 2014. State and Local Administration monies provide funding for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing activities; skilled professional medical personnel (SPMP); salaries, fringe benefits, training; and other State and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.



CMS adjusted the FY 2014 State-submitted estimates of $12.9 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when States submitted estimates. In addition, the State estimates were adjusted to reflect improvements to Medicaid eligibility determination systems and the enrollment activities and administrative costs associated with implementing the ACA. These estimates were also adjusted to reflect the estimated costs of providing incentives to eligible providers and hospitals for the adoption and meaningful use of electronic health records (EHR), described further below. After these adjustments, the FY 2014 estimate for State and local administration is $16.0 billion.

- Electronic Health Records, (EHR) Administration FY 2014 estimate is $2.2 billion for provider incentives payments and $181.4 million for State and Local Administration to administer the incentives program)

  To encourage adoption and meaningful use of electronic health records (EHRs), Medicaid will provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced Federal financial participation (FFP) of 100 percent for incentive payments to providers for the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for State and local administrative expenses associated with administering the incentive payments.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for individuals with intellectual disabilities in FY 2014 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2014 estimate for Medicaid State survey and certification is $240.6 million. This represents an increase of $10.3 million above the current FY 2013 estimate of $230.3 million. This increased funding level includes monies to support increasing workload requirements (i.e. increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 21,000 Medicaid participating facilities with nearly 22,000 health and life safety code annual certifications, as well as over 48,000 complaint survey investigations; and direct State survey costs associated with nursing home quality.

State Medicaid Fraud Control Units (MFCUs)

In FY 2014, State Medicaid fraud control unit operations are currently estimated to require $226.1 million in Federal matching funds. This represents an increase of $3.9 million over the FY 2013 funding level of $222.2 million. Forty-nine States and the District of Columbia participate in the program. Estimated increases are due to increases in staff and related expenses as MFCUs invest resources into curtailing Medicaid fraud and patient abuse and neglect.

The MFCU's mission is to investigate and prosecute provider fraud in State Medicaid programs as well as patient abuse and neglect in health care facilities. In FY 2012, States reported $2.9 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs. In addition to other significant accomplishments by the MFCUs in prosecuting patient abuse and detecting and deterring fraud, this translates to a return on investment (ROI) of $13.48 per $1 expended by the Federal and State Governments for MFCU operations.

Impact of Proposed Legislation

1. Rebase Future Disproportionate Share Hospital (DSH) Allotments

   As the number of uninsured people decreases due to the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of DSH funding needed. Legislation has extended DSH reductions through FY 2022, but in FY 2023, allotments revert to levels that had been in effect prior to the Affordable Care Act. This proposal would determine future allotments off states' actual DSH allotments reduced by ACA.

   Five-year budget impact: $0

2. Begin ACA Disproportionate Share Hospital (DSH) Reductions, One Year Later, in FY 2015

   As states continue working to reduce their uninsured populations, this proposal begins the DSH payment reductions one year later, in FY 2015. Instead, the payment reductions currently scheduled for FY 2014 would be spread over FY 2016 and FY 2017.

   Five-year budget impact: $0

3. Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates

   Through the DME Competitive Bidding Program, Medicare is in the process of implementing innovative ways to increase efficiency for DME payments, expecting to save Medicare more than $25.8 billion, and Medicare beneficiaries approximately $17.2 billion, over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting federal reimbursement for a state's Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services.

   Five-year budget savings: $1.8 billion

4. Clarify Medicaid Drug Rebate and Payment Definitions and Calculations

   The Budget includes a number of proposals that clarify and improve the way Medicaid determines the Average Manufacturer Price (AMP) and Federal Upper Limits (FUL). These proposals clarify the definition of brand drugs, remove brand-name and authorized generic drug prices from the FUL and brand rebate calculations, and correct the rebate formula for new drug formulations.

   Five-year budget savings: $3.7 billion

5. Expand State Flexibility to Provide Benchmark Benefit Packages

   States currently have the option to provide certain populations with alternative benefit packages called benchmark or benchmark-equivalent plans in place of the benefits covered under a traditional Medicaid state plan. This proposal provides states the flexibility to allow benchmark-equivalent benefit coverage for non-elderly, non-disabled adults with income that exceeds 133 percent of the federal poverty level.

   Five-year budget impact: $0

6. Extend Transitional Medical Assistance (TMA) through CY 2014
   The TMA program extends Medicaid coverage for at least 6 months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. This proposal extends authorization and funding of the TMA program through December 31, 2014. States that adopt the

Medicaid expansion will be able to opt out of TMA, consistent with a Medicaid and CHIP Payment and Access Commission recommendation. Current law extends this program through December 31, 2013.

Five-year budget costs: $1.1 billion

7. Extend the Qualified Individuals (QI) through CY 2014

   The QI program provides states 100 percent federal funding to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. This proposal extends authorization and funding of the QI program through December 31, 2014. Current law extends this program through December 31, 2013.

   Five-year budget costs: $590 million

8. Establish hold harmless for Federal poverty guidelines

   To protect access to programs, including Medicaid, for low-income families and individuals, this proposal would treat the Consumer Price Index for All Urban Consumers (CPI-U) adjustment for the poverty guidelines consistent with the treatment of the annual cost of living adjustments for Social Security Benefits. The poverty guidelines would only be adjusted when there is an increase in the CPI-U, not a decrease in CPI-U.

   Five-year budget impact: $0

9. Integrate the Appeals Process for Medicare-Medicaid Enrollees (Medicaid impact)

   Different provisions of the Social Security Act govern the Medicare and Medicaid appeals processes; therefore, each program has different requirements related to timeframes and limits, amounts in controversy, and levels of appeals. These sometimes conflicting requirements can result in confusion for beneficiaries and inefficiencies and administrative burdens for states and providers. This proposal provides the Secretary the authority to implement a streamlined appeals process for Medicare-Medicaid beneficiaries by allowing for more efficient integration of program rules and requirements.

   Five-year budget impact: $0

10. Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries (Medicaid impact)

    This proposal would allow CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed. This plan would serve as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. Under current law, these beneficiaries are assigned at random to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under this proposal, the plan would be paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries

during this period. A current demonstration has shown the proposed approach to be more efficient and less disruptive to beneficiaries, but is set to expire at the end of calendar year 2014.

Five-year budget impact: $0

11. Expand Medicaid Fraud Control Unit (MFCU) Review Additional Care Settings

A MFCU's investigation or prosecution of abuse and neglect does not always qualify for federal matching funds in a variety of settings in which a beneficiary may be victimized in the course of receiving health care services. This limitation was logical when the MFCU program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting, but has become outmoded as the delivery and payment for health services has shifted to in-home and community-based settings.

Five-year budget savings: $30 million

12. Strengthen Medicaid Third-Party Liability

Medicaid is the payer of last resort, and this proposal would affirm Medicaid's position by strengthening third-party liability under Medicaid to improve states' and providers' abilities to receive third-party payments for beneficiary services, as appropriate. This proposal allows states to delay payment of costs for prenatal and preventive pediatric claims when third parties are responsible to the extent beneficiary access to care is not negatively impacted; allows states to collect medical child support where health insurance is available from a non-custodial parent; and allows Medicaid to recover costs from beneficiary liability settlements.

Five-year budget savings: $680 million

13. Track High Prescribers and Utilizers of Prescription Drugs in Medicaid

States are currently authorized to implement prescription drug monitoring activities, but not all states have adopted such activities. Under this proposal, states will be required to monitor high risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes to improve Medicaid integrity and beneficiary quality of care.

Five-year budget savings: $720 million

14. Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States

Manufacturers are required to report a list of their covered outpatient drugs to CMS for Medicaid prescription drug coverage under current federal law. Some manufacturers improperly report items that are not covered by Medicaid. This

proposal requires full restitution to states for any covered drug improperly reported by the manufacturer on the Medicaid drug coverage list.

Five-year budget savings: $8 million

15. Enforce Manufacturer Compliance with Drug Rebate Requirements

    This proposal would allow CMS to conduct regular audits and surveys of drug manufacturers to ensure compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective.

    Five-year budget impact: $0

16. Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage

    Current law requires manufacturers to list their prescription drugs with the FDA, but not all drugs on the market are properly listed. This proposal would require electronic listing of drugs with the FDA in order to receive Medicaid coverage and thereby align Medicaid drug coverage requirements with Medicare drug coverage requirements.

    Five-year budget impact: $0

17. Increase Penalties for Fraudulent Noncompliance on Rebate Agreements

    Under Medicaid drug rebate agreements, drug manufacturers are required to report accurate information. This proposal would increase penalties collected from drug manufacturers that knowingly report false information under their drug rebate agreements for the calculation of Medicaid rebates.

    Five-year budget impact: $0

18. Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP

    Federal regulations prohibit federal funds from being used as the state share for Medicaid unless authorized in federal law. By codifying this principle in statute, this proposal would prevent states from using federal funds to pay the state share of Medicaid or CHIP, unless specifically authorized under law.

    Five-year budget impact: $0

19. Consolidate Redundant Error Rate Measurement Programs

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

    Five-year budget impact: $0

20. Retain a Portion of Recovery Audit Contractor Recoveries to Implement Actions That Prevent Fraud and Abuse

Under current law, CMS can use the Recovery Audit Contractor (RAC) program recovery funds to administer the RAC program but cannot use these funds to implement corrective actions, such as new processing edits and provider education and training, to prevent future improper payments. This proposal addresses this funding restriction.

Five-year budget savings: $40 million

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

CMS is committed to protecting Medicare, Medicaid, and all other federal health care programs from potentially fraudulent providers. This proposal would expand the current authority to exclude individuals and entities from federal health programs if affiliated with a sanctioned entity by: eliminating the loophole in the current law that allows an officer, managing employee, or owner of a sanctioned entity to evade exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity.

Five-year budget savings: $0 million

22. Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers

In an effort to protect beneficiaries from illegal distribution of beneficiary identification numbers, this proposal would strengthen penalties for the knowing distribution of Medicare, Medicaid, or CHIP beneficiary identification or billing privileges.

Five-year budget savings: $0 million

23. Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees (Medicaid impact)

Beginning in FY 2014, this proposal would extend the SSI for qualified refugees under the Elderly and Disabled Refugees Act for two years.

Five-year Medicaid budget cost: $24 million

24. Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicaid impact)

This proposal would modify the length of exclusivity on brand name biologics to encourage faster development of generic biologics while retaining appropriate incentives for research and development for the innovation of breakthrough products. Effective in 2014, it would award brand biologic manufacturers seven years of exclusivity rather than 12 years under current law and prohibit additional periods of exclusivity for brand biologics due to minor changes in product formulations, a practice often referred to as “ever greening.”

Five-year budget savings: $50 million

25. Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicaid impact)

    Beginning in FY 2014, this proposal would increase the availability of generic drugs and biologics by authorizing the Federal Trade Commission (FTC) to prohibit "pay for delay" agreements between brand and generic pharmaceutical companies that delay entry of generic drugs and biologics into the market. In these agreements, a brand name company settles its patent law suit by paying the generic firm to delay entering the market.

    Five-year budget savings: $1.0 billion

26. Modernize Child Support (Medicaid impact)

    This proposal would prohibit States from recouping Medicaid birthing costs directly from a noncustodial parent. Fewer than 10 States still collect birthing costs, some in just a few counties. Most States believe the practice discourages the participation of pregnant women in Medicaid, and is inconsistent with Medicaid cost-sharing requirements. This practice means that child support orders are set beyond the ability of noncustodial parents to pay them and that less child support goes directly to families to meet their basic needs. Research finds that imposing birthing costs on noncustodial parents substantially reduces both child support payments and formal earnings for the fathers and families that already struggle in securing steady employment and coping with economic disadvantage. This proposal would be effective in FY 2015.

    Five-year budget impact: $0

27. Prisoner Data for Improper Payments (Medicaid impact)

    The Budget proposes to increase Federal and State access to information contained in the Social Security Administration's (SSA's) Prisoner Update Processing System (PUPS), which contains Federal, State, and local prisoner data.

    Five-year budget impact: $0

MEDICAID PROGRAM

Proposed Law
Dollars in Thousands

Legislative Proposal	FY 2014
Rebase Future Disproportionate Share Hospital (DSH) Allotments	$0
Begin ACA Disproportionate Share Hospital (DSH) Reductions in FY 2015	$360,000
Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates	-$250,000
Clarify Medicaid Drug Rebate and Payment Definitions and Calculations	-$411,000
Expand State Flexibility to Provide Benchmark Benefit Packages	$0
Extend Transitional Medical Assistance (TMA) Through CY 2014	$480,000
Establish Hold Harmless for Federal Poverty Guidelines	$0
Integrate the Appeals Process for Medicare-Medicaid Enrollees (Medicaid impact)	$0
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries (Medicaid impact)	$0
Expand Medicaid Fraud Control Unit (MFCU) Authority Review to Additional Care Settings	-$5,000
Strengthen Medicaid Third-Party Liability	-$100,000
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid Strengthen Medicaid Third-Party Liability	-$50,000
Require Manufacturers that Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	-$1,000
Enforce Manufacturer Compliance with Drug Rebate Requirements	$0
Require Drugs be Electronically Listed with FDA to Receive Medicaid Coverage	$0
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	$0
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	$0
Consolidate Redundant Error Rate Measurement Programs	$0
Retain a Portion of Recovery Audit Contractor Recoveries to Implement Actions That Prevent Fraud and Abuse (Medicaid impact)	$0
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities (Medicaid impact)	$0
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers (Medicaid impact)	$0
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees (Medicaid	$11,000

Impact)	
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicaid impact)	$10,000
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicaid impact)	-$170,000
Modernize Child Support (Medicaid Impact)	$0
Prisoner Data For Improper Payments (Medicaid Impact)	$0
SUBTOTAL	**-$126,000**
Extend the Qualified Individuals (QI) Program through CY 2014 (Medicaid Part B Transfer)	$405,000
TOTAL	$279,000

FY 2013 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	Difference +/- 2014
Alabama	$4,449,073	$3,868,295	$3,948,547	$80,252
Alaska	923,647	903,464	960,342	56,878
Arizona	5,791,413	6,012,030	6,061,532	49,502
Arkansas	3,558,608	3,228,304	3,393,627	165,323
California	28,047,760	33,038,381	30,050,657	-2,987,724
Colorado	2,521,861	2,688,130	2,639,248	-48,882
Connecticut	3,359,024	3,305,323	3,901,442	596,119
Delaware	874,890	867,722	895,073	27,351
District of Columbia	1,559,468	1,650,505	1,773,318	122,813
Florida	10,834,635	11,726,955	12,553,752	826,797
Georgia	6,153,684	5,903,411	5,885,947	-17,464
Hawaii	834,588	841,897	881,108	39,211
Idaho	1,177,221	1,313,436	1,357,615	44,179
Illinois	7,111,553	7,342,706	7,329,626	-13,080
Indiana	5,205,355	5,046,072	5,607,615	561,543
Iowa	2,156,259	2,305,914	2,349,613	43,699
Kansas	1,649,795	1,643,190	1,662,046	18,856
Kentucky	4,334,765	4,330,106	4,587,818	257,712
Louisiana	5,246,734	4,600,044	4,588,703	-11,341
Maine	1,618,018	1,543,487	1,533,151	-10,336
Maryland	3,968,555	4,257,845	4,369,226	111,381
Massachusetts	7,041,214	7,195,771	7,316,268	120,497
Michigan	8,889,577	9,109,191	9,310,739	201,548
Minnesota	4,679,605	4,815,169	5,237,487	422,318
Mississippi	3,799,483	3,819,220	3,466,530	-352,690
Missouri	5,827,091	5,815,956	6,008,470	192,514
Montana	687,618	719,753	748,641	28,888
Nebraska	1,085,993	1,083,170	1,104,948	21,778
Nevada	1,071,192	1,133,066	1,213,247	80,181
New Hampshire	666,780	687,387	716,723	29,336
New Jersey	5,736,239	5,956,958	7,395,361	1,438,403

FY 2013 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	Difference +/- 2014
New Mexico	2,675,871	2,700,195	2,909,675	209,480
New York	28,391,280	32,993,896	34,495,561	1,501,665
North Carolina	8,576,362	8,714,029	9,244,891	530,862
North Dakota	462,176	460,383	458,357	-2,026
Ohio	10,734,663	11,630,374	12,474,987	844,613
Oklahoma	3,127,782	3,304,601	3,438,048	133,447
Oregon	3,080,954	3,410,220	4,175,639	765,419
Pennsylvania	11,918,827	11,800,286	12,163,757	363,471
Rhode Island	1,133,514	1,103,400	1,167,380	63,980
South Carolina	3,422,344	3,514,228	3,521,016	6,749
South Dakota	505,288	502,410	513,761	11,351
Tennessee	6,387,082	6,779,258	7,385,036	605,778
Texas	17,541,559	20,831,020	20,872,459	41,439
Utah	1,507,169	1,410,720	1,491,614	80,894
Vermont	828,055	934,525	920,321	-14,204
Virginia	3,745,735	4,054,732	7,266,901	212,169
Washington	4,723,818	4,372,927	4,922,824	549,897
West Virginia	2,194,989	2,308,223	2,260,244	-47,979
Wisconsin	4,636,985	4,705,262	4,620,878	-84,384
Wyoming	148,215	313,461	308,134	-5,327
Subtotal	**256,604,366**	**272,597,047**	**280,459,903**	**7,862,856**
American Samoa	9,901	12,224	12,224	0
Guam	14,640	24,994	24,749	-245
Northern Mariana Islands	5,047	17,118	17,118	0
Puerto Rico	333,505	1,025,547	1,058,182	32,635
Virgin Islands	16,312	42,677	42,677	0
Subtotal	**379,405**	**1,122,560**	**1,154,950**	**32,390**
Total States/Territories	**256,983,771**	**273,719,607**	**281,614,853**	**7,895,246**
Survey & Cert	207,628	230,280	240,600	10,320

FY 2013 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	Difference +/- 2014
Fraud Control Units	215,973	222,201	226,067	3,866
Vaccines For Children	4,000,453	3,607,256	4,293,383	686,127
Medicare Part B Transfer	602,303	645,000	705,000	60,000
Incurred But Not Reported	1,091,446	1,959,000	2,369,000	410,000
Undistributed	7,812,117	-11,215,582	17,259,595	28,475,177
TOTAL RESOURCES	**$270,913,691**	**$269,167,762**	**$306,708,498**	**$37,540,736**

[1] Represents current law baseline projections of obligations.

Medicaid Program Budget Authority by Object (Dollars in Thousands)

	2013 Estimate	2014 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$265,798,023	$279,915,233	$14,117,210
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,607,256	$4,293,383	$686,127
Total Budget Authority	$269,405,279	$284,208,616	$14,803,337

Medicaid Program
Medicaid Requirements
(Dollars in Thousands)

	2013 Estimate	2014 Estimate
November 2012 State Estimates	$273,719,607	$281,572,176
CMS Estimates		
State Certification	230,280	240,600
Fraud Control Units	222,201	226,067
Total Unadjusted Estimates	$274,172,088	$282,038,843
Legislation	$1,080,000	$760,000
State and Local Administration	3,557,427	3,105,817
Obligations Incurred But Not Reported	1,959,000	2,369,000
Financial Management Reviews	-159,000	-182,000
Medical Assistance Payments	-15,027,009	-14,075,455
Total Adjustments	-$8,589,582	$20,128,272
Vaccines For Children Program	$3,607,256	$4,293,383
Current Law Requirement	269,189,762	306,460,498
Unobligated Balances		
Start of Year	-21,091,365	-21,951,882
End of Year	21,951,882	0
Recoveries	0	0
Gross Budget Authority	$270,050,279	$284,508,616
Offsetting Collections	-645,000	-300,000
Appropriation/Net Budget Authority	$269,405,279	$284,208,616

Performance Measurement

Medicaid covers a wide range of health services for eligible beneficiaries, including low-income families with dependent children, pregnant women, children and aged, blind and disabled individuals. To measure performance in the Medicaid program and to reflect recent legislation, CMS has goals to represent the populations who receive Medicaid coverage. We have several measures to track quality of and access to care for children and we measure children's enrollment in Medicaid. We have also begun to develop a measure set to track quality of care provided to adults and we measure the number of Medicaid beneficiaries who receive home and community-based services. In addition, we measure the percentage of section 1115 Demonstration budget neutrality reviews completed to ensure that State demonstrations maintain the requirement to not create new costs for the Federal government.

CHIP3.3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid: States submit quarterly and annual statistical forms, which report the number of children under age 19 enrolled in Medicaid, separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3), which provides CHIP funding through September 30, 2013, provides options to facilitate enrollment and retention of children in health coverage. The Affordable Care Act provides CHIP funding through FY 2015 and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

Enrollment in CHIP or Medicaid should be viewed in the context of overall children's enrollment in both programs. Many factors will affect enrollment in CHIP and Medicaid, including States' economic situations, programmatic changes, and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In prior years, we set separate targets for Medicaid and CHIP. Beginning in FY 2013, we will track combined Medicaid and CHIP enrollment. The FY 2014 target is to increase CHIP and Medicaid enrollment to 46,617,385 children, (Medicaid: 38,083,596/CHIP: 8,533,789), nearly 25 percent more children than were covered in FY 2008**.** Our FY 2014 combined target is based on our assumption that we will enroll approximately 3.1 million more children than in FY 2011, our most recent result. The increase is expected due to a combination of population increases, loss of employer-sponsored insurance and extensive outreach to enroll children who are eligible, but unenrolled, in light of the Affordable Care Act coverage expansions.

MCD4 Percentage of Beneficiaries who Receive Home and Community-Based Services: Because there is evidence that home and community-based services (HCBS) are more cost effective than institutional care for some beneficiaries, CMS has a measure to increase the percentage of beneficiaries who received HCBS. The Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and support in the community, including a new State Plan option for States to provide HCBS; improvements to an existing State Plan option to provide HCBS; additional financial incentives for States to rebalance the provision of long-term care to include HCBS; an extension of and improvements to the "Money Follows the Person Rebalancing Demonstration" (MFP); and an extension of the "spousal impoverishment" protections to people who receive HCBS.

The percentage increase of HCBS waiver enrollment remains low as compared to prior years in response to updated Medicaid Statistical Information System (MSIS) enrollment information that demonstrates a downward trend in the growth of persons enrolled in HCBS waivers. This trend is due in large part to State budget deficits that reduce the capacity of State governments to appropriate additional funds to serve new waiver participants. The much slower than expected growth in HCBS can also be attributed to slower than expected transitions of persons from institutions to the HCBS waivers as part of the MFP demonstration. Given the approximate two-year lag in the recovery of State budgets post-recession, growth in enrollment may be difficult. Although enrollment increased by 19 percent between FY 2008 and FY 2009, we expect little growth in the next few years. In addition, the latency of State's data submissions has resulted in a delay in reporting results for FY 2010. Our FY 2014 target is to maintain enrollment between FY 2013 and FY 2014.

MCD5 Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed: CMS measures the percentage of section 1115 demonstration budget neutrality reviews completed out of the total number of operational demonstrations that have scheduled, targeted, budget reviews. Under section 1115 of the Social Security Act, the HHS Secretary has the authority to grant waivers to allow States to test innovative reforms such as new health care delivery systems. State demonstrations are generally held to a standard of budget neutrality, meaning that the demonstration should not create new costs for the Federal government. The result for percentage of targeted reviews completed has been 100 percent since FY 2006. In FY 2011, CMS completed 100 percent of the scheduled reviews. All were found to be budget neutral. The FY 2012, FY 2013 and FY 2014 targets are to complete 98 percent of the targeted budget neutrality reviews to help ensure the demonstrations are operating within the agreed upon budget neutrality limits.

MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary State collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and States, CMS developed and published a core set of twenty-four children's quality measures. While the use of the core set is voluntary for States, CMS encourages all States to use and report on the core set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP populations. In FY 2011, 84 percent of States reported on at least one quality measure, exceeding the CMS target to work with States to ensure that 70 percent of States report on at least one quality measure in the core set of measures. The FY 2014 target is to work with States to ensure that 90 percent of States report on at least eight measures in the CHIPRA core set of quality measures.

CMS will continue to work with our Technical Assistance and Analytic Support contracting team to provide States with specific clarifications on measurement collection questions; hold all-state webinars around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance, we target

States that are already reporting multiple measures, as well as those that are just beginning to understand how to collect and report the measures. Further, as our technical assistance program continues to mature, we are also expanding the scope of our technical assistance to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

MCD7.1 Increase the National Rate of Low Income Children and Adolescents, who are Enrolled in Medicaid, who Receive Any Preventive Dental Service: Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the single most preventable common chronic disease of childhood. CMS has performed State dental program reviews focused on practices and innovations that have successfully increased utilization of dental care services in those States. Some of the innovations include: partnerships and collaboration among State partners and stakeholders; collaboration with dental schools and loan repayment programs; increased reimbursement and simplified administrative processes. CMS is committed to providing technical assistance to States as they work to reach this goal. The FY 2011 national baseline for Medicaid is 44 percent. The FY 2014 Medicaid target is to increase the national rates of preventive dental service to 50 percent, 6 percentage points over the FY 2011 baseline.

MCD8 Improve Adult Health Care Quality Across Medicaid: The Affordable Care Act called for the establishment of an adult quality measures program in Medicaid. Similar to the children's quality goal, this goal focuses on creating a core set of adult quality measures for voluntary use by States to report the core measures in a standardized manner. Through a partnership with the Agency for Healthcare Research and Quality, CMS developed an initial set of core measures that were published in the *Federal Register*. CMS has also worked with States over the past year to help them prepare to report data on the measures. Our FY 2014 target is to work with States to ensure that 65 percent of States report on at least five quality measures in the core set of quality measures for adults in Medicaid. CMS will work to provide technical assistance to States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid. In future years, CMS will establish quantifiable goals that target increased State reporting of the adult quality measures.

PHI4.2/4.3 Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion: The Affordable Care Act (ACA) makes significant improvements to the Medicaid and CHIP Programs through the creation of a seamless system of coverage. The ACA expands access to Medicaid for certain low-income adults in States that take up the option, simplifies Medicaid and CHIP eligibility rules and processes, and ensures coordination between Medicaid, CHIP and the newly-established health Insurance Marketplace.

Our new 2014 targets are for 100 percent of States to be using streamlined application to enroll individuals in Medicaid and CHIP by January 2014. We have also targeted that 100 percent of States to have an approved implementation Advanced Planning Document (APD) for enhanced funding for eligibility and enrollment systems that have a dynamic electronic application by June 2014. Technology enables the online application process to offer a number of advantages over a paper process. Made available on an interactive web

site, the online application will feature a dynamic or “smart” process that poses questions to the applicant based on the responses to previous questions and available verification information

This process ensures that only relevant questions are asked and any non-relevant questions do not appear on the application. A dynamic electronic application will populate relevant data and entries as the individual completes the application. Based on the information already entered, and available data sources, the application will automatically complete some information for the individual.

Please see the Performance Measurement Section and the Outputs and Outcomes table in the Program Operations narrative for additional information about the Marketplace performance measure (PHI4.1).

Key Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2014 Target	FY 2014 +/- FY 2013
CHIP3.3 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid and CHIP	Combined Target begins FY 2013 FY 2011: 43,542,385 children (CHIP: 7,970,879/ Medicaid: 35,571,506) Historical Actual	+22% over baseline 45,592,385 children (CHIP:8,346,152 /Medicaid: 37,246,233)	+25% over baseline 46,617,385 children (CHIP: 8,533,789/ Medicaid: 38,083,596)	N/A
MCD4 Percentage of Beneficiaries who Receive Home and Community-Based Services	FY 2009*: 19% over prior FY Target: 3% over prior FY (Target Exceeded)	Maintain over prior FY	Maintain over prior FY	Maintain
MCD5 Percentage of Section 1115 demonstration budget neutrality reviews completed	FY 2011: 100% Target 98% (Target Exceeded)	98%	98%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2014 Target	FY 2014 +/- FY 2013
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2011: 84% of States reported on at least one quality measure Target: 70% of States report on a least one quality measure (Target exceeded)	Work with States to ensure that 85 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA core set of quality measures	+10 percentage points/+3 States
MCD7.1 Increase the national rate of low income children and adolescents, who are enrolled in Medicaid, who receive any preventive dental service.	FY 2011: 44% National Baseline	48%	50%	+2 Percentage Points over baseline
MCD8 Improve Adult Health Care Quality Across Medicaid	FY 2012: Target Met Target: Publish initial core set of adult quality measures in the Federal Register. (Target Met)	Work with States to ensure that 60 percent of States report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 65 percent of States report on at least five quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	N/A
PHI4.2: Percentage of States Using Streamlined Application to Enroll Individuals in Medicaid and Children's Health Insurance Program.	New for 2014	New for 2014	100%	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2014 Target	FY 2014 +/- FY 2013
PHI4.3 Percentage of States with an Approved Implementation Advanced Planning Document (APD) for Enhanced Funding for Eligibility and Enrollment Systems that have a Dynamic Electronic Application	New for 2014	New for 2014	100%	N/A

*FY2010 Data is still being compiled for MCD4.

Medicaid Discontinued Measure

Measure	FY	Target	Results
CHIP3.2: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid	*2012*	+17% over FY 2008 35,033,500 children	March 31, 2013
	2011	+11% over FY 2008 33,236,910 children	+18.8% 35,571,506 children (Target exceeded)
	2010	Historical actual	34,441,217 children (+15% over FY 2008) (Historical Actual)**
	2009	N/A	32,292,253 children (+7.8% over FY 2008) (Historical Actual)
	2008	Baseline	29,943,162 children

CHIP 3.2: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid

In prior years, we set separate targets for Medicaid and CHIP. As discussed above, beginning in FY 2013, we will track combined Medicaid and CHIP enrollment in order to provide a fuller picture of children's access to health care coverage; therefore, we are discontinuing measure 3.2.

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Payments to the Health Care Trust Funds

Appropriations Language

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, ***[****$251,359,000,000****]*** *$255,185,000,000.*

In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary. *Note.—A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Resolution, 2013 (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.*

Payments to the Health Care Trust Funds

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $255,185,000,000.	Provides a one-year appropriation from general revenues to make the HI and SMI Trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match, and provides resources for the Part D prescription drug benefit program in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds

Amounts Available for Obligation

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Estimate
Appropriation: Annual	$230,741,378,000	$234,266,378,000	$255,185,000,000
Indefinite Annual Appropriation, for SMI Premium Match	---	---	--
Indefinite Annual Appropriation, for Part D Benefits	---	---	---
Lapse in Supplemental Medical Insurance	-12,787,019,000	--	--
Lapse in General Revenue Part D: Benefits	-6,556,592,000	---	--
Lapse in General Revenue Part D: Federal Administration	-80,745,000	---	--
Lapse in Program Management	-11,132,000	---	---
Lapse in Transfer for HCFAC Reimbursement	-298,101,000	-184,378,000	---
Lapse in Quinquennial Adjustment	---	---	---
Adjustment from Expired Accounts *(FY09-11 HCFAC, FY11 PM – non-add)*	*170,927,000*	---	---
Total Obligations	$211,007,789,000	$234,082,000,000	$255,185,000,000

Payments to the Health Care Trust Funds

Summary of Changes

2013 Appropriation

Total Budget Authority (Annualized CR) - $234,266,378,000

2014 Estimate

Total Budget Authority - $255,185,000,000

Net Change, Total Appropriation - + $20,918,622,000

Changes	FY 2013 Annualized CR	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance (SMI)	$181,351,000,000	+ $13,214,000,000
Indefinite Annual Appropriation, SMI	---	---
Hospital Insurance for Uninsured Federal Annuitants	228,000,000	(24,000,000)
Program Management Administrative Expenses	750,000,000	+569,000,000
General Revenue for Part D (Drug) Benefit	51,245,000,000	+7,351,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---
General Revenue for Part D Federal Administration	382,000,000	(9,000,000)
Part D: State Low-Income Determination	---	---
Reimbursement for HCFAC	310,378,000	(182,378,000)
Net Change	$234,266,378,000	+ $20,918,622,000

Payments to the Health Care Trust Funds

Budget Authority by Activity (Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Estimate
Supplementary Medical Insurance (SMI)	$178,041,000	$181,351,000	$194,565,000
Indefinite Annual Appropriation, SMI	---	---	---
Hospital Insurance for Uninsured Federal Annuitants	262,000	228,000	204,000
Program Management Administrative Expenses	222,000	750,000	1,319,000
General Revenue for Part D Benefit	51,431,000	51,245,000	58,596,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
General Revenue for Part D Federal Administration	475,000	382,000	373,000
Part D: State Low-Income Determination	---	---	---
Reimbursement for HCFAC	310,378	310,378	128,000
Total Budget Authority	$230,741,378	$234,266,378	$255,185,000

Payments to the Health Care Trust Funds

Authorizing Legislation

	2013 Amount Annualized CR	2013 Budget Estimate	2014 Amount Authorized	2014 Budget Request
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$234,266,378,000	$234,359,000,000	N/A	$255,185,000,000
Total Budget Authority	$234,266,378,000	$234,359,000,000	N/A	$255,185,000,000

Annual Budget Authority by Activity

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Estimate	FY 2014 +/- FY 2013
BA	$230,741,378,000	$234,266,378,000	$255,185,000,000	+$20,918,622,000

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. This account has no sources of funds - rather, it is a source of funds to the HI and SMI trust funds. These payments make the Medicare trust funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to general funds under current law, including amounts due the SMI Trust Fund with the general fund contribution for the cost of the Part B and Part D programs.

Through this appropriation, the trust funds are made whole for:

Hospital Insurance for Uninsured Federal Annuitants: This includes costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

This appropriation also reimburses the HI Trust Fund for:

Program Management Administrative Expenses: This includes that portion of CMS' administrative costs, initially borne by the Hospital Insurance Trust Fund, which is properly chargeable to general funds, e.g., Federal administrative costs for the Medicaid program, and for the Center for Consumer Information and Insurance Oversight (CCIIO).

Health Care Fraud and Abuse Control (HCFAC) account: The HCFAC program pays for program integrity activities for Original Medicare, Medicare Advantage, Medicare Part D, Medicaid, and the Children's Health Insurance Program. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance trust funds, which are properly chargeable to the general funds.

This appropriation also includes the Federal Contribution for SMI. This reflects a Federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is currently set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

Finally, as a result of enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this account includes General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these new Medicare Prescription Drug Account costs. Most of these activities started in FY 2006.

Funding History

The appropriated funding history for Payments to the Health Care Trust Funds is represented in the chart below:

FY 2009	$195,383,000,000
FY 2010	$207,286,070,000
FY 2011	$229,464,000,000
FY 2012	$230,741,378,000
FY 2013	$234,266,378,000

Budget Request

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2014 estimate of $204 million for Hospital Insurance for Uninsured Federal Annuitants is $24 million less than the FY 2013 estimate of $228 million.

Program Management Administrative Expenses

The FY 2014 estimate of $1.3 billion to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare Trust Fund activities, is $569 million more than the FY 2013 estimate of $750 million. CCIIO administrative increases primarily represent the implementation costs of the marketplaces.

Federal Contribution for SMI

The estimate of $194.6 billion for the FY 2014 Federal Contribution for SMI is a net increase of $13.2 billion over the FY 2013 estimate of $181.4 billion. The cost of the Federal match continues to rise from year to year because of beneficiary population and program cost growth.

General Revenue for Part D (Benefits)

The FY 2014 estimate of $58.6 billion for General Revenue for Part D (Benefits) is $7.4 billion more than the FY 2013 estimate of $51.2 billion. Much like the SMI Federal Contribution, this benefit contribution rises with Part D Prescription Drug program population and cost growth.

General Revenue for Part D Federal Administration

The FY 2014 estimate of $373 million for General Revenue for Part D Federal Administration is $9 million less than the FY 2013 estimate of $382 million.

General Revenue for Part D State Eligibility Determinations

The FY 2014 estimate for General Revenue Part D State Eligibility Determinations is $0.

Reimbursement for HCFAC

The FY 2014 estimate of $128 million for Reimbursement for HCFAC is $182 million less than the FY 2013 estimate of $310 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI trust funds, but which are properly chargeable to the general funds. The FY 2014 request reflects lower estimated non-trust fund liabilities, relative to the continued funding level of FY 2013.

Permanent Budget Authority

(Dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 Estimate	FY 2014 +/- FY 2013
Tax on OASDI Benefits	$18,643,000	$14,387,000	$18,877,000	+ $4,490,000
SECA Tax Credits	17	---	---	---
HCFAC, FBI	131,872	135,036	137,872	2,836
HCFAC, Asset Forfeitures	20,371	23,000	23,000	0
HCFAC, Criminal Fines	1,389,127	1,126,215	1,140,856	14,641
HCFAC, Civil Penalties and Damages: Administration	18,208	20,200	20,900	700
Total BA	$20,202,594	$15,691,451	$20,199,628	+ $4,508,177

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. In addition, the following permanent indefinite appropriations associated with Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: FBI funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D). FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and again are permanent indefinite appropriations from the general funds, transferred to the HI Trust Fund.

Payments to the Health Care Trust Funds

Budget Authority by Object

	FY 2012 Appropriation	FY 2013 Annualized CR	FY 2014 Request
Grants, subsidies and contributions: Non-Drug	$178,041,000,000	$181,351,000,000	$194,565,000,000
Indefinite Annual Appropriation	---	---	---
Grants, subsidies and contributions: Drug	51,431,000,000	51,245,000,000	58,596,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
Insurance claims and indemnities	262,000,000	228,000,000	204,000,000
Administrative costs-General Fund Share	1,007,378,000	1,442,378,000	1,820,000,000
General Revenue Part D: State Eligibility Determinations	---	---	---
Total Budget Authority	$230,741,378,000	$234,266,378,000	$255,185,000,000

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Reduced Cost Sharing for Individuals Enrolled In Qualified Health Plans

Appropriations Language

For carrying out, except as otherwise provided, sections 1402 and 1412 of the Patient Protection and Affordable Care Act (Public Law 111-148), such sums as necessary. For carrying out, except as otherwise provided, such sections in the first quarter of fiscal year 2015 (including upward adjustments to prior year payments) $1,420,000,000.

Language Provision	Explanation
For carrying out, except as otherwise provided, sections 1402 and 1412 of the Patient Protection and Affordable Care Act (Public Law 111-148), such sums as necessary.	Funding for payments made to Qualified Health Plan (QHP) issuers to reduce cost sharing for eligible enrollees beginning in January of 2014. Provides indefinite authority to avoid shortfalls.
For carrying out, except as otherwise provided, such sections in the first quarter of fiscal year 2015 (including upward adjustments to prior year payments) $1,420,000,000.	Funding to cover the first quarter payments made to Qualified Health Plan (QHP) issuers to reduce cost sharing for eligible enrollees beginning in October of 2014, including reconciliation of FY 2014 cost-sharing payments to issuers.

Reduced Cost Sharing for Individuals Enrolled In Qualified Health Plans

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Budget Authority	-	-	3,977,893	3,977,893
Outlays	-	-	3,977,893	3,977,893

Appropriations – Funding Available for Obligation

Authorizing Legislation – Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

Allocation Method - Direct Federal

Program Description and Accomplishments

Section 1402 of the Patient Protection and Affordable Care Act (P.L. 111-148) provides for reductions in cost sharing for certain individuals enrolled in qualified health plans purchased on the Exchanges, also known as Health Insurance Marketplaces, beginning in 2014. Section 1412 of the Patient Protection and Affordable Care Act (P.L. 111-148) provides for the advance payment of these reductions to issuers. This assistance helps eligible low- and moderate-income qualified individuals and families afford the out-of-pocket spending associated with health care services provided through Marketplace-based qualified health plan coverage. Issuers receive payments to cover the amount of cost sharing they would have otherwise received from enrollees.

Budget Request ($3,978 million)

CMS requests an appropriation in order to ensure adequate funding to make payments to issuers to cover reduced cost-sharing in FY 2014. This request is comparable to other appropriated entitlements such as Medicaid. The $3,978 million request reflects current estimates by the CMS Office of the Actuary for cost-sharing reduction payments that will be made to issuers beginning in January 2014 when Marketplace coverage begins. Because this is a new program and estimates are subject to variability in the actual amount needed, CMS is requesting an indefinite appropriation for FY 2014 to cover the costs of payments for reduced cost-sharing if they exceed preliminary estimates.

The advance appropriation for the first quarter of FY 2015 will ensure timely payments are made to issuers at the beginning of the fiscal year. It will also permit CMS to reimburse issuers who provided reduced cost-sharing in excess of the monthly advanced payments received in FY 2014 through the cost-sharing reduction reconciliation process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Appropriations Language
Centers for Medicare & Medicaid Services
Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, $311,000,000, to remain available through September 30, 2015, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $251,420,650 shall be for the Centers for Medicare and Medicaid Services Program Integrity Activities, including administrative costs, to conduct oversight activities for the Medicare program including, but not limited to, Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act and for activities described in section 1893 of such Act and for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities, of which $29,789,675 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which $29,789,675 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2014 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, $311,000,000, to remain available through September 30, 2015, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which $251,420,650 shall be for the Centers for Medicare and Medicaid Services Program Integrity Activities, including administrative costs, to conduct oversight activities for the Medicare program including, but not limited to, Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act and for activities described in section 1893 of such Act and for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities,	Provides funding, including administrative costs, for the Medicare Integrity Program; and funding for Medicaid and CHIP program integrity activities.
of which $29,789,675 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act,	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which $29,789,675 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.

Health Care Fraud and Abuse Control
(dollars in thousands)

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY2012
Discretionary /1				
CMS Program Integrity	$250,442	$251,976	$251,420	$978
Medicare Integrity(non-add)	*$219,463*	*$220,807*	*$214,117*	*($5,346)*
Medicaid Integrity(non-add)	*$30,979*	*$31,169*	*$37,303*	*$6,324*
OIG	$29,674	$29,855	$29,790	$116
DOJ	$29,674	$29,855	$29,790	$116
Subtotal, Discretionary	$309,790	$311,686	$311,000	$1,210
Mandatory /1				
CMS Program Integrity **/1 2**	$863,129	$1,025,126	$1,059,991	$196,862
Additional Medicare Integrity(non-add)	--	*$141,750*	*$166,516*	*$166,516*
Additional Medicaid Integrity(non-add)	--	*$19,330*	*$11,910*	*$11,910*
FBI **/2**	$131,872	$135,036	$137,872	$6,000
OIG **/1 2**	$196,090	$269,784	$278,030	$81,940
Additional OIG(non-add)	--	*$73,485*	*$77,751*	*$77,751*
DOJ Wedge **/1 2**	$61,225	$130,039	$135,355	$74,130
Additional DOJ(non-add)	--	*$68,749*	*$72,823*	*$72,823*
HHS Wedge **/2**	$37,505	$37,544	$38,306	$801
Subtotal, Mandatory	$1,289,821	$1,597,529	$1,649,554	$359,733
Total Funding	**$1,599,611**	**$1,909,215**	**$1,960,554**	**$360,943**

/1 For FY 2014, the Budget proposes to continue to provide $311 million for CMS, OIG, and DOJ through discretionary appropriations. The Budget also proposes to provide a dedicated, dependable source of additional mandatory funding beginning in FY 2013.
/2 Mandatory HCFAC funding includes Mandatory base and additional mandatory funding.

Authorizing Legislation - Social Security Act, Title XVIII, Section 1817K

FY 2014 Authorization – Public Law 104-191

Allocation Method – Other

OVERVIEW

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse.

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides a stable stream of mandatory funds. In FY 2009, discretionary funding was appropriated to increase program integrity efforts and the discretionary appropriation was authorized to be available for obligation over two fiscal years beginning in FY 2010. In FY 2011, in a show of bipartisan support for combating health care fraud, waste, and abuse, and in recognition that program integrity efforts are paying off, the Budget Control Act of 2011 created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. Despite enactment of these multi-year discretionary cap adjustments, annual appropriations bills have not provided the full amount of program integrity funding authorized in BBEDCA. Billions of dollars in savings over the next ten years from curtailing improper payments will not be realized if consistent, additional funding for program integrity is not provided. The Budget proposes to continue to provide the base funding of $311 million for HHS and DOJ through discretionary appropriations in FY 2014 and provide a dedicated, dependable source of additional mandatory funding beginning in FY 2013 that will ensure HHS and the Department of Justice (DOJ) have the resources that they need to conduct necessary program integrity activities and make certain that only the right people receive the right payment for the right reason at the right time.

With the receipt of discretionary funds, HCFAC has been able to expand its activities to include strengthened program integrity activities in Medicare Advantage and Medicare Part D; program integrity staffing and support; funding for program integrity initiatives; preventing excessive payments; and program integrity oversight efforts. In addition, HCFAC funds have allowed CMS to carryout traditional HCFAC actions such as medical review and provider audits.

Additionally, CMS is also committed to fighting fraud, waste and abuse in the Medicaid program. The Medicaid Integrity Program protects Medicaid by strengthening the national Medicaid audit program, and enhancing Federal oversight, support and technical assistance of state Medicaid programs. The Medicaid Integrity Program activities enhance the Federal-State partnership.

HCFAC has been steadily growing since it began in 1997 and this investment in fraud fighting resources is paying dividends. The HCFAC account has returned over $23.0 billion to the Medicare Trust Funds since the inception of the Program in 1997. The return on investment (ROI) from various HCFAC activities ranges from nearly $8 to $1 expended for audit, investigative, and prosecutorial work performed by the Department of Health and Human Services Office of Inspector General (HHS/OIG) and the Department of Justice (DOJ) to $14 to $1 for the Medicare Integrity Program's activities. The ROI for the HCFAC program over the last three years (2010-2012) is $7.90 for every $1.00 expended, which is $2.50 higher than the average ROI for the life of the HCFAC program since 1997. Due to the fact that the annual ROI can vary from year to year depending on the number of cases that are settled or adjudicated during that year, DOJ and HHS use a three-year rolling average.

CMS is committed to working with law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the

Medicare Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. In 2009, the Strike Forces were reorganized under the Health Care Fraud Prevention and Enforcement Action Team (HEAT). HEAT consolidated the fraud efforts of the DOJ's Civil Division and U.S. Attorneys' Offices, the HHS/OIG, the Food and Drug Administration, and CMS.

In addition, CMS has been working with its private and public partners to build better relationships and increase coordination. CMS has co-hosted a series of regional fraud prevention summits on health care fraud, bringing together Federal and State officials, law enforcement experts, private insurers, health care providers, and beneficiaries. CMS also participates in the Healthcare Fraud Prevention Partnership, launched in July 2012 by HHS and DOJ, which is a collaboration of the Federal government, private health insurers, and other health care and anti-fraud groups and associations to combine the best health care fraud prevention and detection efforts in the public and private arena.

In 2010, the passage of the Affordable Care Act (ACA) provided an additional $350 million over ten years and an inflationary adjustment to the mandatory base. In addition, the ACA also provided a comprehensive set of tools to strengthen CMS' program integrity efforts. This funding has allowed CMS to develop and implement activities to prevent and find fraud such as the following:

- Enhanced Provider Screening – Risk-based screening of categories of providers for Parts A and B before enrolling in Medicare.
- National Site Visit Contractor Procurement – This contract has been awarded to conduct all site visits (except for durable medical equipment suppliers) to increase efficiency and standardization of the site visits.
- Enrollment Revalidation Project – CMS has embarked on an ambitious project to revalidate the enrollments of all 1.5 million existing Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements.
- Termination of Medicaid Providers – The ACA requires States to terminate relationships with Medicaid providers or suppliers who have been revoked by Medicare or terminated for cause by another State's Medicaid program or Children's Health Insurance Program (CHIP). Similarly, under current authority, Medicare may also revoke providers or suppliers that have been terminated by State Medicaid agencies or CHIP. To support State efforts to share such information, CMS implemented a web-based application that allows States to share information regarding terminated providers and view information on Medicare providers and suppliers that have had their billing privileges revoked for cause.
- Law Enforcement Access to Data – CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. The IDR is currently populated with seven years of historical Medicare Parts A, B, and D paid claims, along with pre-payment data for Medicare Parts B and DME beginning with FY 2012.

CMS has been implementing the antifraud provisions of ACA since its enactment. Four major final rules have been published dealing with a number of important requirements including: provider screenings enhancements, National Provider Identifier (NPI) requirements on enrollment applications, physician ordering and recordkeeping requirements, recovery audit contractor programs for Medicaid, payment suspensions, and face-to-face encounters.

CMS has published four final rules implementing additional face-to-face requirements and transparency provisions:

- November 4, 2011: CMS published a Final rule to implement section 6407(d).
- February 1, 2013: CMS issued a final rule to implement section 6002.
- April 27, 2012: CMS published a Final rule outlining requirements that enrollment in Medicare was required for physicians who order or certify DMEPOS, HHA, IDTF and Clinical Laboratory services, that adequate records associated with the order must be maintained by both the provider/supplier of service and the ordering/certifying physician, and the records must be produced upon demand.
- November 16, 2012: CMS published a final rule to implement section 6407.

CMS has targeted four major program areas to carry out its mission to strategically identify, evaluate, and target resources and projects. These areas are Prevention, Detection, Recovery, and Transparency & Accountability. Elements of the program areas are defined as follows:

Prevention -- Increase CMS' capability to stop fraudulent claims before they are paid by enhancing existing processes and increasing predictive analytic capabilities.

Detection -- Foster collaboration with HEAT, components of HHS, DOJ, States and other stakeholders with a shared interest in the integrity of the national health care system.

Recovery -- Identify and recover overpayments to reduce improper payments. CMS will continue to work with partners, including the OIG, DOJ, state agencies for survey and certification, and state Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

Transparency and Accountability -- Develop and deploy a comprehensive program integrity communication plan to share key messages and information with internal and external stakeholders. Performance measures are also being developed to evaluate operations and outcomes against other CMS reporting activities.

Funding History

FY 2009	$	1,358,683,000
FY 2010	$	1,483,683,000
FY 2011	$	1,707,995,000
FY 2012	$	1,599,611,000
FY 2013	$	1,909,215,000

Budget Request

The FY 2014 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2014 budget request is $1.96 billion, $360.9 million above the FY 2012 Enacted Level.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include both traditional methods such as Medical Review (MR), Benefit Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education, as well as new innovative approaches to preventing fraud, such as predictive analytics in both claims processing and provider enrollment. This new approach is moving CMS beyond "pay and chase" and includes the use of a variety of in-house personnel, contractor, law enforcement, and auditors to analyze, investigate, and prosecute individuals committing fraud, waste, and abuse.

Some of the specific steps CMS is taking under current authorities and resources involve more stringent scrutiny of applicants seeking to bill the Medicare program, more aggressive application of payment suspensions, oversight of Medicare Advantage (MA) and Part D Prescription Drug Plans (PDPs), and testing new methods to detect and deter potential fraudulent behaviors at both the pre-enrollment stage as well as after suppliers are enrolled in the Medicare program.

In FY 2014, the major initiatives CMS will be funding under the MIP account include, but are not limited to, provider audit, Medicare Secondary Payer Review, Medical Review, data matching, provider education & outreach, and error rate measurement. These activities will be discussed in more detail throughout this section.

CMS Program Integrity Budget Request

The FY 2014 CMS discretionary request level of $251.4 million will fund the activities listed in the table at the end of this chapter. Those activities, as well as the mandatory funded activities, are described in more detail, as follows:

I. <u>Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D:</u>

<u>Medicare Drug Integrity Contractors (MEDICs)</u>: Approximately 13 million beneficiaries are enrolled in the Medicare Advantage (MA) program and nearly 32 million beneficiaries are covered by a Prescription Drug (PD) Sponsoring Organization (SO). CMS has a fiduciary responsibility to safeguard these programs and the Medicare Trust Funds from fraud, waste and abuse (FWA).

In 2013 and 2014, CMS plans to have the NBI MEDIC focus on the continual development and improvement of their data analysis capabilities to proactively fight FWA. In order for the NBI MEDIC to improve on their ability to perform data analysis by building potential fraud detecting profiles and algorithms, the NBI MEDIC must have the resources to increase their ability to store, mine and manipulate data. Also, CMS intends to enhance the NBI MEDICs effectiveness by increasing program; oversight, vulnerability detection, and FWA audits of SOs.

<u>Part C and D Contract/Plan Oversight:</u> Oversight efforts emphasize the assessment of whether an entity is qualified to contract with Medicare. One such way to determine the qualifications of an entity is through the Health Plan Management System (HPMS). HPMS is a web-enabled information system that supports the ongoing business operations of the MA and Part D programs. HPMS software modules collect data for and manage the following MA and Part D

plan enrollment and compliance processes: application, formulary, bid and benefit package submissions, marketing material reviews, plan monitoring and oversight, marketing surveillance, complaints tracking, medication therapy management, plan connectivity, financial reporting, financial and plan bid audits, plan surveys, operational data feeds for enrollment, payment, and premium withhold, and data support for the Medicare & You handbook and the medicare.gov website.

In FY 2014, CMS will continue implementation of an audit redesign initiative in HPMS, to integrate the MA and Part D audit functions and establish new workflows for audit scheduling, recording of audit findings, uploading of supporting documentation in a centralized repository, automated letters, and corrective action plan submission and monitoring. Beginning in March 2013, both CMS and MA and Part D plans will use this functionality to enter audit data upload supporting files and documentation, and track the status of an audit via data views and reports. Following the initial phase, CMS will automate other parts of this process, including full integration of the monitoring worksheets as online tools, utilization of systematic risk assessment mechanisms, and automated sampling of universe files.

CMS will also develop a new Network Management Module to further integrate health service delivery and retail pharmacy automated reviews and perform additional network reviews for renewing networks, plan benefit package-specific networks and other specialized networks, such as provider-specific networks.

Monitoring, Performance Assessment, and Surveillance: This category emphasizes the day-to-day use of plan-reported, CMS data, and data received from outside sources to ensure accurate payment and compliance with program requirements. Technical, clinical, compliance and enforcement audit support is provided to assist CMS in conducting Part C and Part D audits. More specifically, clinical experts conduct program and compliance audits, ensure a sponsor's readiness to participate in the Part C and Part D programs, and conduct compliance program effectiveness audits and core performance audits for parent organizations. In 2012, CMS revamped its program audit strategy in response to suggestions from the Office of the Inspector General (OIG). This new strategy ensures that all Part C and Part D sponsors are audited within a five-year period, which requires CMS to conduct approximately 40 audits on an annual basis.

In FY 2012, CMS conducted 40 program audits of sponsors, whereas only 11 program audits were conducted in 2011. Further, CMS increased the scope of its audits to better evaluate whether beneficiaries are receiving access to the care and medication to which they are entitled in the Part C and D programs.

Program Audit: Sections 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of the MAOs and PDPs offering plans. These audits enable CMS to review and assess previously submitted information to ensure compliance with program requirements. During the audits, auditors review costs associated with the Medicare Advantage and Prescription Drug programs, identify internal control deficiencies, and make recommendations for compliance with Medicare regulations and accurate reporting to CMS. Some of the specific areas of review include plans' solvency; related party transactions; administrative costs; direct medical costs; and Part D costs and payments, including direct and indirect remuneration and true out-of-pocket costs. To meet the one-third audit requirement, CMS conducts approximately 250 audits of MAOs and Part D sponsors per year.

In response to IPIA of 2002, as amended by IPERA of 2010, CMS enhanced its efforts to address improper payments. One such activity promotes the integrity of risk adjusted Part C payments to MA organizations through risk adjustment data validation (RADV), a rigorous payment validation process which measures the payment error estimates at the national and contract level. Diagnosis data submitted by plans is validated to check for incorrect reporting of diagnoses which can lead to overpayments and underpayments. RADV involves conducting medical record reviews, estimating contract level payment errors with the intent of conducting payment recovery, and implementing an appeals process. Error rate targets for the Part C program are described in more detail in the Performance Measurement section near the end of this chapter.

Compliance and Enforcement: CMS provides audit compliance training, technical assistance, education, and outreach to the managed care industry, MA plans, PDPs, and audit assistance contractors. These training, education, and outreach models extend to internal and external stakeholders via webinars, compliance conferences, and on-line training sessions.

In addition, IT infrastructure plays a large role in supporting CMS' efforts of compliance and enforcement to safeguard the Trust Funds. For example, the Risk Adjustment System produces the risk adjustment factors to calculate beneficiary level payments. The factors are created by analyzing the history of diagnoses for each beneficiary and executing statistical models to adjust the risk experienced by each plan with regard to each individual beneficiary. Multiple risk adjustment factors are generated for each Medicare beneficiary that supports both the payments to MA and Part D plans.

Likewise, the Medicare Advantage Prescription Drug (MARx) application is the enterprise system of record supporting daily nationwide operations of the Medicare Part C and Part D programs. MARx primary system functions include processing transactions for enrollment/disenrollment of Medicare beneficiaries into/from Part C and Part D health plans, and calculating monthly capitated payments to Part C and Part D plans. Under CMS' current Enterprise Systems Development (ESD) model, MARx requires three separate IT support service contracts which include the following: (1) systems development and maintenance, (2) testing services, and (3) business operations services.

II. Program Integrity Staffing & Support:

Oversight Staffing, Administration, and Field Office Rapid Response: This funding includes staffing for CMS' Central Office and three field offices in areas of the country that are highly vulnerable of fraud, waste, and abuse in Medicare and Medicaid (New York City, Los Angeles, and Miami). The staff possesses the required skill sets to perform detailed analytic work, contractor oversight, and policy development relating to all of CMS' program integrity activities. In addition, this funding also provides support services for IT infrastructure, data communications, security, and administrative services.

III. Program Integrity Initiatives:

Automated Provider Screening (APS): In FY 2011, CMS initiated pilot projects using advanced statistical methodologies and multiple data sources to develop models to identify providers that either do not meet eligibility requirements or pose an elevated risk to the Medicare program. These pilots are being used to develop and enhance the APS tool that was launched on December 31, 2011. For FY 2014, estimates for production take into account the volume and complexity of enhancements required to more fully automate the manual checks performed by

the Medicare Administrative Contractor's (MACs) provider enrollment specialists and facilitate their use of the system during the enrollment process, as well as enhance the predictive models to assess the potential risk of fraud.

1-800-MEDICARE Integration: In an effort to fight fraud, waste, and abuse in the Medicare and Medicaid programs, suspected fraud can be reported to both the OIG Hotline and 1-800-MEDICARE. The consolidation of the OIG Hotline and 1-800-MEDICARE complaints into the Next Generation Desktop began in FY 2012; which will isolate and identify aberrant behaviors/trends in a more timely fashion.

In an effort to track fraud complaints, CMS will create visual representations of such complaint volumes through "heat maps" to help investigators target priorities and identify "hot spots." This effort supports the strategic objective of targeting interventions based on risk. CMS will test the value of producing these reports and sharing them with contractors. As calls come into 1-800-MEDICARE, data will be geographically displayed, which will allow CMS to quickly see shifts in fraud calls over time and to drill down by various parameters such as claim type, geographic location, and fraud type, and to listen to the actual call if necessary. CMS is also exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE. These updated processes will help CMS to more quickly and efficiently examine and address waste, fraud, and abuse issues.

Case Management System: CMS will continue to test ways to manage and track the leads that are sent to the Zone Program Integrity Contractors (ZPICs)/ Program Safeguard Contractors (PSCs). Leads can be from multiple sources, including complaints, tips, and data analysis. CMS intends to enable ZPICs/PSCs to prioritize the high-risk leads while providing national outcome tracking and measuring. CMS expects initial development and implementation of the system to occur during FY 2014, and more complex features, functionality, and a national roll-out is planned in FY 2015. During FY 2014, funding will be used for the planning, research, and initial data collection activities necessary to support the development and implementation of the system as well as for analysis of the data initially received.

Technology and Strategic Decision Support: This project will capitalize on the investment in multiple technologies and pilot programs. CMS is engaging and planning multiple pilots (enhanced provider screening tools, provider profiles to improve analytic model performance, and social network analysis to test innovative strategies) to prevent and detect fraud, waste, and abuse. This project will create the infrastructure to provide key strategic support for each pilot project, while maintaining a high-level vision for such pilots. This effort will identify vulnerabilities to be addressed at the policy level, as well as prevent duplication of effort through tracking. Such a support structure will facilitate the dissemination of pilot results, and permit CMS to quickly interpret and integrate the pilot results into fraud, waste, and abuse activities. CMS is also evaluating innovative technologies for implementation, and the system would be able to perform comparisons and evaluations of the potential technology solutions. This tool will also be used to conduct analysis of risk and development of rules for provider screening.

Moving forward, this project will dovetail with the Case Management System and readily provide metrics reflecting the results of these efforts. CMS' broad performance metrics initiative will facilitate legislative and regulatory reporting, and institutionalize CMS transparency and accountability. Continued support for this project throughout FY 2013 and FY 2014 is crucial to accomplishing this goal.

Beneficiary Fraud Outreach and Fraud Early Warning System (FEWS): Educating and empowering Medicare health care consumers to identify, report, and prevent Medicare fraud is an essential strategy in the arsenal of fraud-fighting efforts. The activities proposed in this project achieve this goal in a cost-effective manner by leveraging existing programs and partnerships and utilizing 1-800-Medicare and Next Generation Desktop (NGD) complaint databases to develop a FEWS to warn beneficiaries and their caregivers and prevent additional losses. This project consists of a number of activities to engage beneficiaries in fighting fraud.

IV. Prevent Excessive Payments:

Fraud System Enhancements: This project will continue to develop and enhance existing benefit integrity automated controls based on data analysis and changing IT infrastructure requirements.

In FY 2014, data analysis of system enhancements to improve detection and prevention will continue to streamline and enhance the benefit of information technology investment.

Command Center: In FY 2012, CMS established the Command Center as the center for excellence for detection and investigation, driving program integrity innovation and improvement. The Command Center is a paradigm shift in the way CMS conducts its program integrity work by supporting multi-party working sessions among Federal program staff, contractors, and law enforcement to identify emerging fraud schemes, develop approaches to address priority issues, and resolve leads from the Fraud Prevention System faster. The Fraud Prevention System applies predictive analytic technology to Medicare claims prior to payment to identify aberrant and suspicious billing patterns.

The Command Center has hosted collaborative sessions in which CMS staff, anti-fraud contractors, law enforcement partners, and other federal partners have participated since it opened in July 2012, involving not only participants from CMS, but OIG, FBI, State OIG, State Agencies, Contractors, and other Federal Agencies. Significant outcomes have already been achieved.

The FY2014 ongoing funding will be necessary to support this effort to effectively share and present findings, display data, and make determinations and decisions on a system-wide basis across various fraud detection and prevention efforts.

Medical Review: Medical Review activities can be conducted either pre-payment or post-payment, and serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the appropriate conditions. CMS, currently, only conducts complex medical review on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements. In addition, CMS also conducts prepayment medical reviews to prevent improper payments from being made. Both types of medical reviews help reduce the Medicare FFS error rate. Additional funding would support an increased level of prepayment review on those claims that local or national data suggest are leading to Medicare improper payments.

Fraud Prevention System: Since the June 30, 2011 implementation of the Fraud Prevention System (FPS), CMS has been using sophisticated algorithms to screen all Medicare fee-for-service claims nationwide to identify providers that are exhibiting patterns of behavior suggestive of fraud. These algorithms are developed by teams that include data analysts, law enforcement, policy experts, and clinicians. The ZPICs/PSCs use the resulting leads to identify

potential fraud, find improper payments, determine overpayments and establish edits through the MAC to resolve the improper payments.

As cited in the First Year Report to Congress, the FPS prevented or identified $115.4 million in payments, generated leads for 536 new investigations, and augmented information for 511 pre-existing investigations. CMS continues to add new models to the FPS and refine existing models to better prevent and detect fraud, waste, and abuse.

In addition to using the FPS system, in FY 2014, ZPICs and PSCs will continue to participate in Command Center Missions, at which CMS leadership, ZPIC/PSC representatives, CMS Contracting Officer Representatives (CORs), predictive modeling experts, and clinicians work collaboratively with the ZPICs/PSCs on model development, investigative techniques, resolving specific leads, and training opportunities.

Benefit Integrity: Benefit Integrity (BI) activities deter and detect Medicare fraud through concerted efforts with the CMS, OIG, DOJ, and other CMS partners. Nearly all of the BI funding is directed to the Zone Program Integrity Contractors/Program Safeguard Contractors (ZPICs/PSCs) in various geographical zones throughout the United States. In FY 2014, ZPICs/PSCs will continue to conduct proactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement, a major component of BI activities. ZPICs/PSCs also evaluate and investigate beneficiary complaints that indicate fraud and support law enforcement as during the development and prosecution of cases.

CMS has implemented FPS, which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The ZPIC/PSCs are utilizing this new anti-fraud tool to move our program integrity strategy beyond a “pay and chase” approach to a focus on prevention. The FPS generates a prioritized list of leads for ZPIC/PSCs to review and investigate Medicare fraud in their designated region. When suspect behavior or billing activity is identified, the ZPIC/PSCs perform specific program integrity activities. Complementing the ZPIC/PSCs’ traditional activities, ZPIC/PSCs are now using FPS as an additional source of leads to prevent, identify, and investigate fraud. The FPS screens claims data before payment is made, allowing the ZPIC/PSCs to rapidly implement administrative actions, such as prepayment review, revocation, or payment suspension, as appropriate.

The continuum from detection to prosecution of fraudulent activity requires complete coordination with CMS, its contractors, and law enforcement partners. The ZPIC/PSCs meet on a regular basis with the OIG and DOJ staff to share information on active cases and new leads. CMS participates in fraud task forces, educational sessions and formal meetings to review the status of cases, and discuss identified fraud schemes. In addition, the ZPICs/PSCs frequently perform medical review or data analysis for cases initiated by OIG or the FBI.

Additionally, the ZPIC/PSCs currently have multiple task orders, including special projects and supporting many of the antifraud initiatives in the Field Offices, including HEAT activities. Field office probes/initiatives are prioritized among ZPIC/PSC basic program integrity work. In FY 2014, funding will be used for ZPIC/PSCs to perform data analysis projects and to support immediate and real-time requests of from the field offices special projects. The additional support is needed for these field offices located in HEAT and other high fraud areas. The field offices have notably strengthened the revocation process by improving the manner in which substantiating documentation is obtained

Provider Audit: Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report.

In FY 2012, approximately 42,000 Medicare cost reports were accepted by the FIs and MACs, and tentative settlements were completed for 20,000 cost reports. In addition, approximately 21,000 Desk Reviews were completed, and 3,000 Audits. CMS completed contractor monitoring activities on all MACs during the year and plan to maintain similar levels of effort in FY 2013 and FY 2014.

Medicare Secondary Payer: The Medicare Secondary Payer (MSP) effort ensures that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on the proper order of payers, and makes sure that Medicare only pays for those claims where it has primary responsibility for payment of health care services for Medicare beneficiaries. When mistaken Medicare primary payments are identified, recovery actions are undertaken.

During FY 2012, CMS began implementing a new MSP contracting strategy to fully integrate pre-payment coordination of benefits activities with MSP debt recovery activities. An MSP Integration Contract and MSP Systems Contract are already fully operational while a Business Program Operations Contract and an MSP Recovery Contract will be transitioned in FY 2013. During FY 2013, significant enhancements will be implemented to take advantage of combined MSP operations. Once complete, the public will have one primary point of contact for all MSP coordination of benefits and recovery activities.

Medicare-Medicaid Data Match Project (Medi-Medi): Medi-Medi, authorized by the Deficit Reduction Act of 2005 (DRA), is a voluntary partnership between CMS and participating States where data is collected and analyzed from both programs with the intent of detecting fraud, waste, and abuse that may otherwise go undetected in each program. The One PI system, which is discussed later in this chapter, will be integral in this program. The Medicare and Medicaid programs share many common beneficiaries and providers, matching claims identifies billing patterns that may be indicative of potential fraud, waste or abuse that may not be evident when provider billings from either program are viewed in isolation. Analysis performed in the Medi-Medi program can reveal trends that are not evident in claims data from each program alone, making the Medi-Medi program an important tool in identifying and preventing fraud. The Medi-Medi program has grown to 19 states. CMS will continue to expand this program in FY 2014.

CMS is in the process of developing a comprehensive strategy and contracting plan for the Medi-Medi program with a focus on encouraging state participation. Through this strategy we plan to reduce provider and state audit burden, provide better access to improved data, and establish better collaboration between the Medicare and Medicaid investigations and audits. The Medi-Medi program will become increasingly more effective as more states participate. Through the additional states' participation, the Medi-Medi program will be able to further Federal-State collaboration in analyzing trends to identify potential fraud, waste, and abuse in the Medicare and Medicaid programs throughout the country. CMS has partnered with some of the larger states in the country as it relates to expenditures; the 19 states that are in the Medi-Medi program account for a majority of total Medicaid expenditures. At least 13 additional states have expressed an interest in participating. CMS is also working to identify ways the program can be improved and be more beneficial to states.

V. Program Integrity Oversight Efforts:

Enhanced Provider Oversight: In addition to the on-going revalidation effort, CMS will continue to expand and refine proactive data analysis to ensure provider enrollment records are accurate. Multiple CMS contractors are performing the on-going systematic analysis of provider enrollment records at a national level. The initial phases of this project revealed that vulnerabilities may exist with inconsistent data between PECOS, the National Plan and Provider Enumeration System (NPPES), and the claims processing systems. The data analysis is being performed in conjunction with the revalidation initiative, and it will identify discrepant data that the MACs will then use to initiate appropriate actions to reconcile the various systems. As of October 2012, the implementation of this project has produced significant results including revocation of over 12,000 enrollments and the deactivation of over 100,000 billing numbers.

In FY 2014, CMS will sustain the level of effort necessary to continue the project. This includes identifying additional screening requirements and expanding the current program infrastructure to take an increasing number of administrative actions as the project continues. This project will enable CMS to identify minor and major operational changes necessary to eliminate program vulnerabilities, and evaluate the effect of national implementation. CMS will also focus mainly on the use and enhancement of new additional provider enrollment screening tools and program safeguards (i.e. APS, FPS data).

Overpayments and Payment Suspension: On November 19, 2008, CMS published a final rule with comment titled, “Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Final Rule" in the Federal Register. In part, this regulation permits CMS or its designated contractor to deny additional Medicare billing privileges to an owner of an enrolling provider or supplier or a physician or non-physician practitioner who has an existing overpayment or is currently under payment suspension. This project would implement two of the provisions of this rule (424.530(a)(6) – overpayments and 424.530(a)(7) – payment suspensions) in FY 2013 and FY 2014.

In FY 2013, CMS is developing instructions and implementing a standardized process for Medicare contractors to deny Medicare billing privileges if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing overpayment that has not been repaid in full at the time an enrollment application is filed. This includes denying new enrollments or change of ownership applications from a current owner of an enrolling provider or supplier or a physician or non-physician practitioner.

In FY 2014, CMS expects this process for denying enrollment applications when an overpayment exists to be fully operational and implemented. In addition, CMS will develop instructions and implement a process to deny Medicare billing privileges if the current owner of an enrolling provider or supplier or the enrolling physician or non-physician practitioner has been placed under a Medicare payment suspension.

Durable Medical Equipment Initiatives: Durable Medical Equipment (DME) continues to pose a high risk of fraud to the Medicare Program. Through the DME Stop Gap Project, initiated in 2009, ZPICs/PSCs have increased site visits and interviews of DME suppliers, providers, and beneficiaries receiving DME products in high billing areas for DME supplies and products. In FY 2014, additional funds are necessary to support increased site visits to, and interviews of, suppliers, doctors and patients that have been identified as potentially suspicious.

In November 2006, CMS approved 10 national accreditation organizations that determine if DMEPOS suppliers meet the quality standards under Medicare Part B for accreditation, as required for all DMEPOS suppliers. As of July 12, 2012, there are 60,194 Medicare enrolled accredited DMEPOS suppliers nationwide.

This funding request will allow us to continue these validation efforts.

Compromised Numbers Checklist (CNC): Since 2010, CMS has been developing and refining a national database of Medicare provider and beneficiary identification numbers known or suspected to be compromised. In FY 2013, CMS will complete the process of redefining the entries in the CNC database to facilitate its incorporation into the Fraud Prevention System (FPS) and other program integrity predictive analytics. In addition to assigning risk levels (high, medium, low) to each beneficiary Health Insurance Claim Number (HICN) and provider National Provider Identifier/Provider Transaction Access Number (NPI/PTAN), the ZPICs/PSCs are re-categorizing each of the HICNs and NPIs/PTANs by designating the specific reason code which best defines why the number was considered compromised and eligible to be entered into the database. The CNC is accessible to and periodically updated by the ZPICs/PSCs and the MEDIC, and is used to identify investigative leads, implement claims processing edits, and share corrective actions taken against individuals. This database has helped CMS identify false front providers and other providers submitting claims for stolen or compromised beneficiaries and stolen or compromised rendering or ordering providers, and implement timely corrective actions such as revoking their Medicare billing privileges, resulting in significant savings to the Medicare Trust Fund.

CMS will continue to focus on developing and refining a more robust process to provide comprehensive data quality validation and to include additional information on the providers and beneficiaries that are included in this database. The expectation is that the database will continue to grow as new compromised numbers are identified and added. Since the redesign is scheduled to be completed in February 2013, the funding request for FY 2014 will support ongoing maintenance.

National Supplier Clearinghouse: The National Supplier Clearinghouse (NSC) activity is a continuing contractual arrangement for the NSC's receipt, review and processing of applications from organizations and individuals seeking to become suppliers of DMEPOS in the Medicare program. This process includes conducting on-site visits, enumeration of the DMEPOS supplier and implementing safeguards to ensure only legitimate suppliers enter and/or remain in the Medicare program. In FY 2014, CMS plans to implement a new fraud and abuse index of risk (FAIR) and to transition to a new contractor, if applicable.

One PI Data Analysis: One PI is a web-based portal that provides centralized access to multiple analytical tools and data sources, in order to fight fraud, waste and abuse in Medicare and Medicaid. Through this investment, CMS will continue to train and support a multitude of contractors and law enforcement users for using these tools and data to fight fraud, waste, and abuse.

Through this investment CMS will also continue to test matching of Medicaid data from 11 pilot States with the historical Medicare Parts A, B, and D and provider enrollment data in the IDR. The investment will also promote the efficient expansion of the agency's Medi-Medi data match project and data sharing requirements as required in the DRA of 2005 and Section 6402a of the ACA.

One PI provides access to current and historical Medicare data that is used to develop and refine predictive analytic models prior to integration into the Fraud Prevention System (FPS). Analysts and investigators also rely on the data available via One PI to develop leads identified in the FPS.

Fraud & Abuse Customer Service Initiative: In FY 2014, funding would support a regional fraud hotline and associated investigative team in the State of Florida. Well-trained, bilingual staffs triage calls, as well as acknowledge receipt of complaints in writing and refer potentially fraudulent providers to the investigations team at the ZPIC. A dedicated investigative team at the ZPIC responds within 24 hours to any calls that are considered to be appropriate (i.e., an immediate response could very likely lead to an administrative action against a fraudulent provider/supplier). The fraud hotline number is printed on Medicare Summary Notices (MSNs) and sent monthly for Medicare Parts A and B.

This project also allows CMS to work with the Administration on Community Living, through the Senior Medicare Patrol program, to conduct beneficiary outreach and education in high vulnerability areas so that beneficiaries understand the types of fraud that occur and how to read their MSN to better detect potentially fraudulent billings. This project funds the dedicated South Florida fraud hotline and associated investigative team.

Health Care Fraud Prevention & Enforcement Action Team (HEAT) Support / Strike Force Teams: The first Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse among Durable Medical Equipment (DME) suppliers and Human Immunodeficiency Virus (HIV) infusion therapy providers in South Florida. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of these efforts and increased appropriated funding for the HCFAC program from Congress and the Administration, DOJ and HHS expanded the Strike Force to include teams of investigators and prosecutors in a total of nine cities – Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Baton Rouge, LA; Tampa, FL; Chicago, IL; and Dallas, TX.

Recent accomplishments of the HEAT initiative can be found in the FY 2012 HCFAC Annual Report.[1] The funding request for FY 2014 will allow CMS to continue its joint efforts with law enforcement to support the HEAT initiatives and Strike Force cities.

Healthcare Fraud Prevention Partnership (HFPP): One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care system. As part of this initiative, CMS launched the Healthcare Fraud Prevention Partnership with OIG, DOJ, FBI, private health insurance companies, and other health care and anti-fraud groups and associations. In order to ensure a coordinated nationwide health care anti-fraud and abuse strategy, CMS is implementing a partnership structure that will achieve the following:

- exchange health care fraud and abuse information;
- identify innovative measures to detect and prevent health care fraud and abuse; and
- educate the public on health care fraud and provide prevention measures.

[1] https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf

CMS' efficacy in identifying and preventing fraud, waste and abuse will be significantly enhanced by developing relationships and working together with private insurers and other stakeholders with a similar goal. In FY 2013, we began to share information and membership will begin to grow including the development of strategic plans for the Partnership and the Trusted Third Party. In FY 2014, CMS plans to award the comprehensive Trusted Third Party contract and continue to expand the membership of the Partnership and anticipates that the information exchange will be more sophisticated, requiring increased systems capacity and access.

Appeals Initiatives: In FY 2013, CMS developed a workgroup to improve the appeals process to reduce the number of Medicare contractor decisions that are overturned. In FY 2014 CMS will expand the presence of the Program Integrity contractors at Administrative Law Judge (ALJ) hearings so that they can present CMS's reasoning for the determination being appealed. CMS will also provide additional training and outreach programs for the ALJs and Medicare contractors in order to ensure there is a proper understanding of CMS policies and regulations.

In FY 2014, CMS will improve ZPIC claims decisions tracking to better understand potential vulnerabilities in the review and analysis of different claims and different regions. The data that is collated pursuant to this tracking will allow CMS to work with the individual ZPIC contractors to address areas that are having a high overturn rate and to react accordingly. Additionally, it will also provide CMS with a snapshot of success cases that they may be able to put into a best practices document and disseminate it to the other ZPIC contractors for them to implement.

CMS' Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) activities for Medicare fee-for-service (FFS) Parts A & B claims. CMS currently contracts with two QICs to perform Medicare Part A reconsideration activities, and three QICs to perform Medicare Part B reconsideration activities. Historically, the QICs have participated as "non-party participants" in approximately 10 percent of ALJ hearings. CMS anticipates that by invoking party status in more hearings, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Funds expenditures.

During FYs 2012 & 2013, funding has been provided to the QICs to participate in ALJ hearings as a party. FY 2014 funds will support continued activities and efforts in QIC participation.

Probable Fraud Measurement Pilot: CMS is estimating the rate of probable fraud in Medicare fee-for-service payments for home health agencies (HHAs). CMS designated HHAs as having a "high" categorical risk in the final rule on the implementation of ACA screening provisions [CMS-6028-FC amending adding 42 CFR 424.518]. The funding for the pilot has been used to obtain contractor support to facilitate the study design, use investigators who currently work with CMS' program integrity contractors to conduct site visits and interviews, and provide data analysis support.

A statistically valid estimate of the rate of fraud in Medicare, Medicaid, or other health care programs does not currently exist. A credible measure of probable fraud will provide insight into the scope of the fraud problem in Medicare and therefore provide a metric against which to judge the current and future program integrity policies and activities. The work will also inform predictive analytics, thereby supporting the strategic objectives of transitioning to prevention (rather than relying only on "pay and chase") and targeting interventions based on risk.

CMS began working on Phase I of the pilot in August 2012. Phases II- IV of the pilot, in which CMS will complete the pre-test pilot with 130 cases and then the full-scale HHA pilot with 2,030

cases, will take place during FY 2013 and FY 2014. CMS also anticipates that additional funding will be needed in FY2014 as the pilot is expanded to the Durable Medical Equipment service area.

Provider Outreach and Education: Provider Outreach and Education (POE) funding is used by the Medicare Fee-for-Service claims processing contractors (Medicare Administrative Contractors, fiscal intermediaries and carriers) to educate Medicare providers and their staffs about the fundamentals of the Medicare program, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such mechanisms as provider inquiries, claim submission errors, medical review data, CERT data and Recovery Audit Contractor data. The primary goal of the POE program is to reduce the CERT error rate by giving Medicare providers the timely and accurate information they need to understand the Medicare program, be informed about changes and correctly bill Medicare claims. Medicare contractors utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms such as educational events and webinars.

Provider Enrollment, Chain and Ownership System: Provider Enrollment, Chain and Ownership System (PECOS) is the national enrollment system for Medicare providers and suppliers. Providers and suppliers submit one or more enrollment forms to CMS either via paper or electronically in PECOS. Medicare providers and suppliers may also use PECOS to view and update their existing information. PECOS centralizes the enrollment data collected from the forms into one system and is used by Medicare contractors to enter, update, and review data. Increased funding in this category will be used to enhance the usability to align with regulations, statutes and agency needs; and provide training to the Medicare contractors and the provider and supplier community. In addition, the consolidation and redesign of enrollment forms and PECOS enhancements will streamline the process; reduce the amount of paperwork processed, and provide clearer guidance to providers on what they need to submit.

In FY 2014, key PECOS updates are focused on improving customer service, increased connectivity within CMS, and greater data integrity.

Comprehensive Error Rate Testing: The Medicare Fee-for-Service (FFS) program is identified as at risk for significant improper payments.

As part of the original IPIA compliance efforts, and to help all Medicare FFS contractors to better focus review and education efforts, CMS established the Comprehensive Error Rate Testing (CERT) program to randomly sample and review claims submitted to Medicare. The CERT program produces Medicare FFS national improper payment rates specific to contractor, service type, and provider type. Independent reviewers review a systematic random sample of claims identified after they are accepted into the claims processing system at carriers, fiscal intermediaries, and MACs.

These sampled claims are then followed through the system to their final disposition. The independent reviewers perform medical review on claims that contractors paid or denied to ensure that the payment decision was appropriate.

CMS needs precise, timely sub-national estimates of billing and payment errors in order to manage the Medicare program properly. The sub-national estimates include contractor groups,

specific contractors, types of providers, and services. The data from the reviews must provide a robust source of information for identification of aberrant billing.

During FY 2014, CMS expects to accomplish the following:

- Measure and report improper payments in Medicare FFS high-risk areas as required by the Executive Order on Improper Payments;
- Gather all documents for CERT reviews;
- Maintain a web site describing the status of CERT processing;
- Partner with the OIG to insure the integrity of the CERT program;
- Participate in the Electronic Submission of Medical Documentation (esMD) for CERT to allow CERT contractors to accept documents electronically;
- Conduct a system test & evaluation (ST&E) review on each of the CERT contractors' systems as required and providing contractors with additional funding to meet the information technology security requirements, if necessary; and
- Develop the national improper payment report.

VI. Medicaid Program Integrity Initiatives:

Payment Error Rate Measurement (PERM) in Medicaid and CHIP: The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), requires heads of Federal agencies to: annually review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, submit those estimates to Congress, and submit a report on actions the Agency is taking to reduce improper payments. The Medicaid and CHIP programs are identified as at risk for significant erroneous payments. PERM enables States to identify the causes of improper payments in their claims payment systems and eligibility processes, and to address them with the appropriate corrective actions. CMS created a 17 State rotation cycle so that CMS will review improper payments in each State once every 3 years and estimate a national improper payment rate annually.

The PERM final rule (75 FR 48816) was published on August 11, 2010 and was effective September 10, 2010. This final rule implements provisions from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 with regard to the PERM program. Section 601 of CHIPRA prohibits HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is effective. In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempts CMS from completing a 2011 CHIP improper payment rate. Therefore, HHS did not report an improper payment rate for FY 2009 in the FY 2010 Agency Financial Report (AFR). HHS resumed measuring CHIP improper payments with the FY 2011 PERM cycle which, was reported in 2012.

CMS reported in the FY 2012 Agency Financial Report a three-year rolling national error rate for Medicaid of 7.1 percent (or $19.2 billion) in estimated improper payments, which represents a decrease from the three-year rate reported in FY 2011 of 8.1 percent (or $21.9 billion). As mentioned above, CMS commenced the CHIP error rate measurement in 2011 and reported the single-year FY 2012 national CHIP error rate in the FY 2012 Agency Financial Report, which was 8.2 percent (or $0.7 billion) in estimated improper payments.

During FY 2014, CMS expects to accomplish the following:

- Measure and report improper payments in Medicaid high-risk areas as required by the Executive Order on Improper Payments;

- Gather all documents for PERM reviews;
- Maintain a web site describing the status of PERM processing;
- Provide support to States, as needed, to conduct targeted reviews on areas at risk for improper payments (i.e., Mini-PERMs, which are voluntary smaller scale measurements of state improper payments during years when a State is not being measured under PERM);
- Prepare to use the Medicaid and CHIP Business Information Solutions (MACBIS) data from States for PERM;
- Participate in the Electronic Submission of Medical Documentation (esMD) for PERM to allow PERM contractors to accept documents electronically;
- Conduct a system test & evaluation (ST&E) review on each of the PERM contractors' systems as required and provide contractors with additional funding to meet the information technology security requirements, if necessary;
- Conduct ongoing provider education and outreach to educate providers on medical documentation requirements in order to decrease documentation errors. Create and disseminate educational materials to be distributed to states and providers in order to decrease error rates;
- Develop a state policy database to collect states' policies for PERM;
- Research alternatives for harmonizing PERM and MEQC improvements; and
- Develop the national improper payment report.

CMS recently incorporated additional efforts to decrease improper payments in States. This includes collaborating with other Medicaid audit entities; conducting in-person meetings with States to discuss their improper payments identified through PERM and the States' corrective action plans; and coordinating quarterly best practices calls to allow States to exchange strategies for decreasing improper payments. In addition, CMS conducts annual site visits to the 17 States involved in the current cycle measurement for the PERM program. During the site visits, CMS educates the States regarding PERM requirements and identifies any State-specific issues that may hinder an accurate error rate measurement. This proactive measure helps CMS achieve a more accurate error rate for the Medicaid and CHIP programs.

National Correct Coding Initiative (NCCI): The goal of this statutory program is to protect Medicaid funds by reducing the number of improperly paid Medicaid claims through the use of standard methodologies, which include edits for state Medicaid claims. This initiative was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payments of Medicaid claims. Procedure-to-Procedure (PTP) edits are automated prepayment edits that prevent improper payments when certain codes are submitted together. In addition to the PTP edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System / Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a single date of service for a single beneficiary. MUEs specify the number of times a procedure can be performed on the same beneficiary on the same date of service by the same provider without denying payment of all UOS on the claim line. New edits are continually developed in the NCCI program for states to use to screen Medicaid claims for codes that should not be submitted together and for UOS that should not exceed a certain limit on one claim line for that code.

State Readiness, Enrollment and Eligibility: Under the Affordable Care Act, states will be required to implement significant and substantial changes to their Medicaid programs, including: eligibility determinations, plan management, financial management, customer service, and integration with new affordable insurance programs from health insurance exchanges. The

GAO has identified Medicaid as a program at significant risk for overpayments[2]. Eligibility is the major contributor to the payment error rate in Medicaid, as calculated by CMS. Implementation of the changes required by the Affordable Care Act presents an opportunity to address some of the long-standing problems identified in the PERM process through simplified business rules, automated verifications of submitted data, modernized systems, and associated changes in other areas of the Medicaid program. Additionally, the Act presents some significant challenges and opportunities in ensuring that changes in FMAP for the newly eligible Medicaid population are implemented by states in accordance with the statute and regulations. In order to ensure proper implementation of these and other changes, CMS has developed a technical assistance model to work closely with states as they implement the new requirements. A contractor will support both, the teams in the model as well as provide necessary short-term resources who can work directly with states.

Medicaid & CHIP Business Information Solutions (MACBIS): Transforming the Medicaid and CHIP data enterprise (MACDE) is necessary to complete the requirements in the Affordable Care Act, to significantly boost program integrity efforts, and improve performance and accountability of the Medicaid and CHIP programs for our beneficiaries and other key stakeholders. MACBIS will enable performance data to be derived from one source. Investments in this capability will be shared among the IT solutions within the CMS Data Enterprise and the MACBIS program portfolio.

Combining key State program data, provider information and claims and encounter data under a common data model, data dictionary and integrated data environment will allow for new methods to fight fraud, waste and abuse. In addition, these data sets present opportunities to detect fraudulent patterns that may not be evident when billings for either program are viewed in isolation as well as offer comparative analytics across state lines. These efforts will also support the data needs of the Medi-Medi Program, the Medicare Program Integrity (PI) Group and Medicaid Integrity Group (MIG). The data will provide the opportunity for referral of well documented cases to both Federal and State Law Enforcement. Improper payments (both overpayments and underpayments) related to potentially fraudulent behavior can be identified in both the Medicare and Medicaid programs.

During FY 2012, CMS made significant investments in the development, implementation of a new Medicaid and CHIP data environment within the Baltimore Data Center to host key program and operational data, the integration of two primary systems described below, and new State-based data exchange and portal interfaces. We expect the systems described below will also serve as the primary data sources for the CMS quality reporting and performance measurement capacities for Medicaid and CHIP.

1. Operations Data (TMSIS): The Transformed Medicaid and CHIP Statistical Information System (TMSIS) - granular-level operational claims, provider and enrollment data; and
2. MACPro: The aggregate level Medicaid and CHIP program (MACPro) data to facilitate efficient adjudication of the State plan, waiver, and other administrative actions submitted to CMS by States for approval. MACPro will also host data templates to support the collection of key administrative and program data.

With these investments, CMS achieved the following in 2012:

- completed a 10-State pilot to test an expanded operational data set (Transformed MSIS);

[2] See GAO, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States,* **GAO-12-288T** (Washington, D.C.: December 7, 2011).

    - tested an expanded data dictionary and data exchange mechanism with States for MSIS submittals;
    - built a new data quality tool to review the completeness and quality of State MSIS submittals upon receipt; and
    - developed a plan to launch national implementation of TMSIS in 2014.
- created a comprehensive Medicaid and CHIP Enterprise Data Model that documents metadata and business relationships for all current and anticipated business needs for Medicaid and CHIP so that CMS may effectuate a data governance board and structured change control process;
- worked with States and other stakeholders to develop of a comprehensive, phased, multi-year approach for the development of the new MACPro and TMSIS systems that will also address the continued operation, and eventual transition of Medicaid and CHIP legacy systems to new integrated platforms;
- documented business rules to enable data integration across MACPro, TMSIS, as well as other key provider, quality and performance initiatives;
- established an enterprise portal to support State/stakeholder data exchanges for key program data and future collection of program (MACPro), operational (TMSIS), performance and quality data;
- engaged in systems development to provide electronic adjudication of eligibility and Alternative Benefit Plan State plan amendments in MACPro. The table below references all functionality to be released in 2013;
- created technical guides for the MACPro system that will offer State and CMS users on-line access to current CMS policy guidance as it applies to the structured MACPro state plan and waiver templates;
- designed an operational work plan and budget to ensure the rest of the State plan and waiver actions are automated and incorporated into MACPro by 2015, as well as bring in other program and administrative reporting requirements by 2016; and
- initiated planning with key CMS health reform staff to provide necessary state plan eligibility data to healthcare.gov.

Current planning and budget estimates for FY 2013 and FY 2014 assume fundamental systems operations which will include data exchanges with other agency data sources. The Medicaid and CHIP programs are continuing to evolve and MACBIS must be flexible and responsive to the needs of the key stakeholders. Moreover, FY 2014 implementation represents significant change to the existing legacy processes which will be streamlined and updated to be more efficient and to allow the program to be managed more effectively.

The infrastructure build and integration of legacy systems involve significant costs in FY 2014 and through the project lifecycle. As business requirements of those legacy systems are compared and integrated with new and future business needs, it is necessary to purchase and apply new technologies to support all needs of this program and to develop modular services that incorporate existing legacy functionality and future business requirements which will allow for an orderly retirement of those legacy systems and data exchanges.

Expected outcomes for FY 2013 and FY 2014 are detailed below:

Investment	FY 2013	FY 2014
TMSIS	• Scalable platform for all states to submit their TMSIS data for purposes of analytical analysis based on the ORNL prototype and	• Technical Assistance to all states to complete the national rollout • Enhance CMCS Data Engine for

	the 10-State pilot lessons learned • Begin National Rollout strategy with States for preparing them to provide T-MSIS data by January 1, 2014. • Operation and Maintenance of MSIS	Medicaid and CHIP for integration with other Agency data sources • Operation and Maintenance • Begin transition of legacy systems and data exchanges into TMSIS and begin retirement
MACPRO	• Process Medicaid and CHIP Eligibility SPAs • Collection of Adult Quality Measures • Collection of key Performance metrics • Process HITECH APDs • Operation and maintenance	• Process remaining SPAs • Add financial management processes • Collect additional Quality measures and program information • Implemented remaining APDs • Add pharmacy processes • Operation and maintenance
Quality	• Incorporation of HIE • Complete business/systems requirements and finalize workplan for system builds/data infrastructure to support Medicaid and CHIP quality in MACPro and TMSIS • Incorporate adult quality measures (2701) into TMSIS • Begin initial collection of adult quality measures (2701) in MACPro	• Ability to formulate a comprehensive view of the impact of our programs on beneficiary outcomes
Performance Measures	• Identify and include Eligibility and Enrollment measures • Identify and include Provider Enrollment Claims Processing measures	• Integrate States' business processes areas that relate closely to the performance of states' IT systems • Enhance consumer experience • Enhance access to care measures

VII. Affordable Care Act:

ACA Section 6002- National Physician Payment Transparency Program- Open Payments: This Section is split-funded between mandatory and discretionary funding. The discretionary request in the table at the end of this chapter is for the estimated share covered by Medicaid. This rule finalized the provisions that require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. CMS will post that data to a public website. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests. This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers.

This new reporting will apply to applicable manufacturers and GPOs. These organizations, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication. Data collection will begin on August 1, 2013. Applicable manufacturers and applicable GPOs will report the data for August through December of 2013 to CMS by March 31, 2014 and CMS will release the data on a public website by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process. This process of reporting and public posting will be an annual process.

During FY 2014, CMS will continue to develop the technical capabilities for registration, data submission, data review and dispute and reporting capabilities for public posting. The public website will also be prepared for public posting and public query into the data. In order to verify the accuracy of the data and that it is matched to the correct covered recipient (physician or teaching hospital), CMS will engage with a technical contractor to monitor and validate the data prior to public posting. Communications, outreach and education are also vital to this program as there are millions of potential users of the system whom must be educated about the program and rules of participation.

Section 6402 - Enhanced Medicare and Medicaid Program Integrity Provisions: This provision provides enhanced Medicare and Medicaid program integrity provisions. These provisions include new data and systems requirements and safeguards as well as additional HCFAC funding. The primary goals of this legislation are as follows:

1. Integrate claims and payment data into the Integrated Data Repository (IDR) from Medicare, Medicaid, CHIP, the Veteran's Administration, the Department of Defense, the Social Security Administration, Indian Health Services and Contract Health Services programs.
2. Prioritize the inclusion of new data sources into the IDR.
3. Develop interagency agreements for matching and sharing the data in the IDR.
4. Provide access to law enforcement while maintaining data security.

During FY 2014, CMS will continue to develop the data and business context for this section. Through this work, CMS will begin framing what source data is to be collected from each Federal healthcare data partner, develop a logical data model, identify the types of queries needed to support business analysis, develop information product specifications and scenarios for their use, and develop a proposal that addresses the need to uniquely identify patients and providers across organizations. Project management and joint application development work are necessary to implement this requirement. CMS will be expanding the data elements included in the IDR. This expansion will increase the workload currently being performed on existing data which includes various methods of proactive data analysis including predictive modeling which is designed to prevent payments to fraudulent providers and suppliers and to detect identity theft of beneficiary and provider information.

Section 6411 - Expansion of Recovery Audit Contractors for Parts C & D and Medicaid – In order to expand the RAC program to Medicare Parts C & D, a variety of projects have been implemented, including, but not limited to: project management and implementation activities; contract actions- recovery audit contractor, data validation contractor (validate RAC results), appeals contractor; systems development; and outreach planning and implementation which includes the development of the Parts C & D RAC website.

- *Project Management and Implementation Activities:* This project will support the rapid implementation timeframe and multifaceted strategic approach needed to operationalize these programs. Specifically, this includes analyzing different approaches to meet statutory requirements; preparing options papers; reviewing, compiling, summarizing, and analyzing industry comments; assisting with planning and implementation; and developing and carrying out messaging, communication, stakeholder engagement, and outreach activities.

- *Recovery Audit Contractor (RAC):* The RAC is responsible for the examining Medicare Part C and D Sponsoring Organizations to determine improper payments related to various audit issues.

- *Data Validation Contractor (DVC):* The DVC is responsible for verifying and validating improper payment determined by the RAC and the RAC's accuracy rate.

- *Appeals Contractor:* The appeals contractor will be necessary for any RAC-identified improper payment that is appealed by the Sponsor, and any subsequent support required by CMS throughout the process, including Federal Court cases.

- *System Development:* For the purposes of the RAC, the DVC, and Appeals Contractors properly tracking their progress, the Payment Recovery Interface System (PRIS) has been developed. The PRIS system will allow these contractors to coordinate their efforts during the recovery audit process.

- *RAC Website*: Provides seamless open communication between CMS and the Sponsoring Organizations. The website will be a means for issuing guidance to the organizations as well as provide further information to CMS' contractors.

As of March 15, 2013, States have made progress in implementing their Medicaid RAC programs. Forty-four (44) States and D.C. have Medicaid RAC programs in place. CMS has also granted implementation delay exceptions, to the January 1, 2012 implementation date, to several States that were unable to execute contracts with Medicaid RAC vendors by the required effective date. Additionally, CMS granted three (3) States time-limited implementation delays. In those cases, CMS approved requests from those States requesting up to two years to implement a Medicaid RAC program. Lastly, CMS has granted five territories complete exceptions from establishing Medicaid RAC programs, and fourteen States have requested other types of exceptions to the Final rule.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. Each of the 56 FBI field offices has personnel assigned specifically to investigate health care fraud matters. With national health care expenditures projected to exceed $2.8 trillion dollars in FY 2012, it is especially important to coordinate all investigative efforts to combat the significant fraud and abuse within the health care system.

The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as HHS/OIG, the FDA, the DEA, the Defense Criminal Investigative Service, the Office of Personnel Management, the Internal Revenue Service, state Medicaid Fraud Control Units, and other state and local agencies. On the private side, the FBI is actively involved in the Fraud Prevention Partnership, an effort to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. These efforts will enable members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud. In addition, the FBI maintains significant liaison with private insurance national groups, such as the

National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, other professional associations, and private insurance investigative units.

In FY 2012, the FBI initiated 817 new health care fraud investigations and had 2,835 pending investigations. Investigative efforts produced 1,096 criminal health care fraud convictions and 909 indictments and informations. In addition, investigative efforts resulted in the operational disruption of 329 criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 83 HCF criminal enterprises.

FBI Budget Request

The FY 2014 FBI budget includes mandatory funding in the amount of $137.9 million, an increase of $6.0 million above the FY 2012 Enacted Level. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year CPI-U Annual Averages and Percent Change.

OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in health-care-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. In FY 2012, OIG's oversight efforts, approximately 80 percent of which are supported by HCFAC funding, resulted in 778 criminal actions and 367civil actions. Further, OIG's oversight efforts resulted in approximately $6.9 billion in expected recoveries, including civil or administrative settlements and civil judgments related to Medicare, Medicaid, and other Federal, State, and private health care programs.

OIG Budget Request

The FY 2014 OIG budget includes $200.3 million in base mandatory funding. The FY 2014 Budget also proposes an additional mandatory investment of $77.75 million for OIG and the FY 2014 discretionary request is $29.8 million, $0.12 million above the FY 2012 Enacted Level. This request will support the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and related program integrity efforts.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The Department of Justice's litigating components (United States Attorneys, Criminal Division, Civil Division, and Civil Rights Division) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

DOJ Budget Request

The FY 2014 DOJ budget estimate includes $62.5 million in base mandatory funding, which is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations. The FY 2014 Budget also proposes an additional mandatory investment of $72.8 million for DOJ, and the DOJ discretionary request for FY 2014 is $29.8 million, $0.12 million above the FY 2012 Enacted Level.

HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING PROJECTS

Program Description and Accomplishments

In addition to MIP, CMS also uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2013, negotiated amounts were $37.5 million for distribution among HHS components and $61.3 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding.

The HHS portion of the wedge awards, $37.5 million, funded the following activities during FY 2013:

CMS Medicaid Financial FTE ($12.5M): These Funding Specialists work in the field to review proposed Medicaid State Plan reimbursement amendments, develop financial management reviews, research state Medicaid financing policy and practices, and promote proper state Medicaid financing methods prior to implementation. An estimated $128 million in questionable reimbursement was averted in FY 2012 due to the funding specialists' preventive work with States to promote proper state Medicaid financing. Additionally, CMS removed an estimated $895 million (with approximately $451 recovered and $444 million resolved) of approximately $7.8 billion identified in questionable Medicaid costs.

Office of the General Counsel (OGC) ($8.9M): OGC primarily uses HCFAC funds in support of litigation and enforcement activities that assist in the recovery of program funds. Some highlights of OGC's HCFAC activities include: coordinating Federal, State, and local law enforcement programs to control fraud and abuse in public and private health care plans; participating in investigations and litigation relating to the delivery of and payment for health care services; facilitating the enforcement of the provisions authorizing exclusions, civil monetary penalties, criminal prosecutions, administrative penalties, and other statutes applicable to health care fraud and abuse (including those statutes addressing poor quality of care); and providing guidance to the health care industry and consumers regarding waste, fraud and abuse in health care programs. OGC works to prevent the wrongful disbursement of program funds by providing active legal counsel regarding False Claims Act cases, Medicare Secondary Payer recoveries, the defense of CMS' suspension of payments, and coordination with the Department of Justice and law enforcement. In FY 2012, OGC specifically continued its efforts to implement pertinent anti-fraud provisions of the Affordable Care Act, and supported DOJ litigation efforts that recovered over $2.6 billion in False Claim Act cases, including several against pharmaceutical manufacturers.

Administration for Community Living (ACL) SMP Support ($3.4M): This funding supports infrastructure, technical assistance, and the other SMP program support and capacity-building activities designed to enhance the effectiveness of state-wide SMP programs.

Administration for Community Living (ACL) SMP Grants ($7.3M): In FY 2013, the Secretary has provided this funding to enable the provision of grants to help more than 50 Senior Medicare Patrol (SMP) programs fight Medicare fraud in high fraud States. This will enable the program to expand its capacity to reach more beneficiaries.

Food and Drug Administration (FDA) Pharmaceutical Fraud Pilot Program (PFPP) ($3.4M): This program began in the second half of FY 2010 and is designed to detect, prosecute, and prevent pharmaceutical fraud. In addition to pharmaceutical fraud, the PFP program investigates fraudulent activity involving FDA-regulated medical devices and biological products such as vaccines. The PFP utilizes a proactive approach to opening investigations by identifying fraud schemes through intra-agency coordination and other methods of surveillance. With continued PFP funding, FDA is pursuing ongoing and initiating new criminal investigations, including off-label promotion, manufacturing fraud, clinical trial and application fraud and other falsified data matters unique to FDA. In FY 2012, FDA's second full fiscal year of PFP funding, FDA initiated 18 criminal investigations, obtained two criminal convictions and conducted one training seminar.

HHS Wedge Budget Request

The FY 2014 HHS Wedge request includes mandatory funding of $38.3 million, which is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations.

Performance Measurement

Please note: For more information about the Medicare Fee-for-Service, Parts C and D, and Medicaid/CHIP payment error rates, please see the FY 2012 HHS Agency Financial Report, Other Accompanying Information at http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf

MIP1 Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program: We have made progress on our efforts to reduce the Medicare Fee-for-Service (MFFS) error rate over the years; however, at a rate of 8.5 percent, we did not meet our FY 2012 target of 5.4 percent. Beginning with the FY 2012 reporting period, HHS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. In addition, HHS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services. (It is important to capture the impact of these changes on the targets and results in order to report the most accurate improper payment rate possible.) As a result of these factors, we have revised our FY 2013 target from 5.0 percent to 8.3 percent, and set our FY 2014 target at 8.0 percent. CMS is continuing to pursue strategies directed at specific regions, providers, and error types; including developing new data analysis procedures to identify payment aberrancies and using that information to preemptively stop improper payments. CMS is also directing Medicare contractors to develop local efforts to lower the error rate by developing plans that address problems that result in errors.

Initiatives aimed at reducing Medicare FFS improper payments include:

- CMS implemented two demonstration projects to test the ability of these programs to reduce the incidence of improper payments in the future: Recovery Audit Prepayment Review and Prior Authorization of Power Mobility Devices.
- CMS is increasing and improving medical review through the detection of and focus on services, supplies, providers and suppliers that are at high risk for improper payments.
- CMS and its contractors conduct ongoing education to inform providers about the importance of submitting thorough and complete documentation.
- CMS implemented the ability to accept medical records electronically through the Electronic Submission of Medical Documentation (ESMD) program.
- CMS developed comparative billing reports to help Medicare contractors and providers analyze administrative claims data.
- CMS continuously develops new data analysis strategies to prevent improper payments.
- CMS updates review manuals, as needed, to clarify requirements for reviewing documentation. These clarifications promote uniform interpretation of the policies across all medical review entities involved in the Medicare FFS program.

While many successful initiatives to reduce the improper payment rate have been implemented, the factors contributing to the improper payment rate are complex. It also should be noted that many of CMS' significant corrective payment actions will not show up until future measurement periods.

MIP5 Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program and MIP6 Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program: In FY 2012, CMS fell short of its target of 10.4 percent with an actual Part C error rate of 11.4 percent. The root cause of improper payments in the Part C program reported in FY 2012 is due entirely to administrative and documentation errors. The majority of the payment error estimate was due to insufficient documentation to support the diagnoses submitted by the plans, as measured by the Risk Adjustment Payment Error (RAE) estimate. The error rate estimate for the RAE increased slightly for FY 2012 due to a decrease in the submission of physician attestations for records that lack proper signatures or credentials. The remainder of the payment error in the program is related to transfer of data, interpretation of data and payment calculations, as reflected in the Medicare Advantage Prescription Drug Payment System Error Estimate. The FY 2014 target is to reduce the Part C error rate to 10.4 percent.

The Part D composite payment error rate amount is the sum of the payment error amounts for five component measures divided by the CY 2012 total Part D payments. The root cause of all improper payments in the Part D program reported in FY 2012 is administrative and documentation errors. In FY 2012, we reported a result for Part D of 3.1 percent, exceeding our target of 3.2 percent. The FY 2014 target for the Part D error rate is 3.0 percent.

MIP7 Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data: In their efforts to fight fraud, waste, and abuse in the Medicare program, the HEAT Strike Forces have utilized near real-time, CMS systems data to examine claims payment data for aberrancies, to identify suspicious billing patterns/trends, and to conduct surveillance on target providers and suppliers under investigation for potentially fraudulent practices. The purpose of this measure is for CMS to increase the number of law enforcement personnel with training and access to CMS program integrity data systems and applications. CMS met its FY 2012 target of training 100 percent of Law Enforcement referred

for training and access, and will continue to offer and expand training for additional strike force law enforcement personnel in FY 2014.

MIP8 Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment and Payment Safeguard Actions: In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate, and reasonable services for beneficiaries. This goal is aimed at measuring CMS' ability to target high risk providers and suppliers effectively. To reflect statutorily mandated changes in CMS fraud prevention work and because of difficulties and anomalies in the reporting systems and data systems, CMS has redesigned this goal to reflect our direct fraud identification and prevention work—the National Fraud Prevention Program (NFPP). This goal aligns with provisions of the Affordable Care Act and the Small Business Jobs Act (SBJA) which added new requirements to use advanced predictive analytics to identify high risk providers. With funding authorized in the SBJA, CMS developed the Fraud Prevention System (FPS) which allows for better tracking of administrative actions against high risk providers and suppliers.

Our predictive analytics work using FPS will focus on activities in areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. Our goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

Our FY 2012 baseline is from the first year of the FPS (July 2012) at a rate of 27 percent of Medicare providers and suppliers (identified through predictive analytics) as high risk that received an administrative action. We have set our FY 2013 and FY 2014 targets at a rate of 31 percent and 36 percent, respectively. CMS is partnering with HHS' Office of General Counsel and the Office of Inspector General, the Department of Justice, and the Federal Bureau of Investigation to implement the full spectrum of administrative actions, including those that result from referrals to law enforcement. Instances of potential fraud identified through predictive analytics are referred to law enforcement for additional civil and criminal remedies which are powerful tools to assist CSM to protect the integrity of the Medicare Trust Fund.

MIP9.1 Estimate the Payment Error Rate in the Medicaid Program (previously MCD1.1): The Medicaid three-year weighted average national error rate reported in the 2012 AFR was based on error rate data reported in 2010, 2011, and 2012. The current reported three-year rolling error rate (as reported in the 2012 AFR) is 7.1 percent. The 2012 AFR also reported weighted national error components rates, which are as follows: Medicaid FFS: 3.0 percent, Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent. It is important to note that the 17 States measured and reported on in the 2012 AFR were the same States measured and reported on in the 2009 AFR. The Medicaid error rate for these States dropped from 8.7 percent in 2009 to 5.8 percent in 2012, causing the three-year rolling error rate to decrease. The re-measurement of this group of States reflects the impact of effective corrective actions implemented to decrease improper payments associated with eligibility errors. Specific corrective action strategies implemented included leveraging technology and available databases to obtain eligibility verification information without client contact; and providing additional caseworker training, particularly in areas determined by the Payment Error Rate Measurement (PERM) review to be error-prone.

MIP9.2 Estimate the Payment Error Rate in the Children's Health Insurance (CHIP) (previously MCD1.2): For the CHIP PERM, CMS was required by Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to develop and publish a new final regulation. CHIPRA prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is in effect. Therefore, CMS temporarily suspended the CHIP PERM reviews. In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempted HHS from reporting a 2011 CHIP improper payment rate. As a result, CMS did not report a national improper payment rate for CHIP in the 2009 through 2011 AFRs. CMS resumed CHIP measurement and published a single-year national CHIP error rate in the 2012 AFR of 8.2 percent. The current CHIP error rate (as reported in the 2012 AFR) is 8.2 percent. The 2012 AFR also reported national error components rates, which are as follows: CHIP FFS: 6.9 percent, CHIP managed care: 0.1 percent; and CHIP eligibility: 5.8 percent. In the 2013 AFR, we will report a 2-year weighted average national CHIP error rate and in the 2014 AFR, we will report the first three-year weighted average baseline national CHIP error rate. Setting out-year target rates for CHIP is not possible until all States have been measured and a national CHIP baseline is established. The CHIP baseline and 2015-2017 targets will be reported in the 2014 AFR.

MCR19 Reduce Provider Burden by Increasing the Identification Rate of an Improper Payment by the Recovery Auditors When Additional Documentation is Requested from Providers: As mandated by Section 302 of the Tax Relief and Health Care Act of 2006, CMS implemented the MFFS Recovery Audit Program in all 50 States to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The Affordable Care Act expands the Recovery Audit Contractor Program to Medicaid, Medicare Advantage, and Medicare Part D. A decreasing overall appeal overturn rate means an increasing level of accuracy in recoveries obtained due to contractor auditing. As part of a demonstration to identify underpayments and overpayments, our FY 2008 appeals overturn rate was 8.2 percent, reported in FY 2010, almost two years after the end of the demonstration. After completion of the demonstration, CMS applied best practices and lessons learned to the national program. Our FY 2011 target was to develop the baseline and future targets for the appeals overturn rate; however, as we measured FY 2010 and FY 2011, we learned that the rate was 2.4 and 2.7 percent, respectively. These rates are significantly lower than the demonstration rate, and show that the changes CMS made were effective in ensuring that only valid claims are denied by the Recovery Auditors. As a result of this low baseline, CMS no longer feels that this measure is appropriate for this program given we have a high level of accuracy.

For FY 2013 and FY 2014, we will target reducing provider burden by increasing the identification rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers. We set an FY 2012 baseline of 28.6 percent for FY 2013 and 2014 targets to increase that rate each year by five percent over the previous year. We continued to report on the FY 2012 target which was measured at 2.1 percent, further confirming our decision to change targets going forward.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Outcome)	FY 2012: 8.5%[3] Target: 5.4% (Target Not Met but Improved)	5.4%	8%	+2.6%
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program	FY 2012: 11.4% Target: 10.4% (Target Not Met)	10.4%	10.4%	Maintain
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program	FY 2012: 3.1% Target: 3.2% (Target Exceeded)	3.2%	3.0%	-.2%

[3] Beginning with the 2012 report period, HHS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. In addition, HHS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MIP7: Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data at 100% of the LE personnel referred up to approximately 200 LE personnel annually.	FY 2012: 100% Target: 100%[4] (Target Met)	100%	100%	Maintain
MIP8 Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Outcome)	FY 2012: 27%[5] (Target Not In Place)		36%	N/A

[4] CMS trained 190 new LE.

[5] The previously established FY 2012 target of 15% is no longer relevent. It was set in 2010 when the HHS Strategic Plan was being developed. It has been changed to more accurately reflect the changes in statutorily directed work of CMS in fraud prevention and detection. This also applies to the FY 2015 target of 25% set when the HHS Strategic Plan was being developed in 2010. 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MIP9.1: Estimate the Payment Error Rate in the Medicaid Program (Outcome)	FY 2012: 7.1% Target: 7.4%[6] (Target Exceeded)	7.4%	6%	-1.4%
MIP9.2: Estimate the Payment Error Rate in the Children's Health Insurance Program (CHIP) (Outcome)	FY 2012: 8.2% Target: Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States (Target Met)	Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States	Report rolling average error rate in the 2014 Agency Financial Report	N/A

[6] Previously 6.4% as MCD1.1 in the FY 2013 HHS OPA. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
MCR19: FY 2014: Reduce provider burden by increasing the identification rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers	FY 2012: 28.6% (Baseline)	N/A	Increase the Recovery Auditor identification rate by 5% over the previous year	N/A
FY 2012: Decrease the appeal overturn rates at the first level of appeal for overpayments identified by the Recovery Audit Program	FY 2012: 2.1% - Appeals overturn rate (in favor of provider) Target: At or below FY 2011 appeals overturn rate (Target Met)	At or below FY 2011 appeals overturn rate	N/A	N/A

FY 2014 CMS HCFAC Funding Request
(dollars in thousands)

Project or Activity	FY 2014 Discretionary Request	FY 2014 Additional Mandatory Request	FY 2014 Total Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D			
Medicare Drug Integrity Contractors (MEDICs)	$23,000	$0	$23,000
Part C & D Contract/Plan Oversight	$30,865	$0	$30,865
Monitoring, Performance Assessment, and Surveillance	$66,676	$0	$66,677
Program Audit	$41,183	$0	$41,183
Compliance and Enforcement	$28,047	$0	$28,047
Total	**$189,772**	**$0**	**$189,772**
II. Program Integrity Staffing & Support			
Oversight Staffing, Administration, and Field Office Rapid Response	$9,288	$24,910	$34,198
Total	**$9,288**	**$24,910**	**$34,198**
III. Program Integrity Initiatives			
Automated Provider Screening (APS)	$0	$11,512	$11,512
1-800 Medicare Integration	$0	$2,200	$2,200
Case Management System	$0	$7,000	$7,000
Technology and Strategic Decision Support	$0	$3,500	$3,500
Beneficiary Fraud Outreach and Fraud Early Warning System	$0	$1,700	$1,700
Total	**$0**	**$25,912**	**$25,912**
IV. Prevent Excessive Payments			
Fraud System Enhancements	$0	$1,100	$1,100
Command Center	$0	$1,000	$1,000
Benefits Integrity	$0	$4,068	$4,068
Medical Review	$0	$30,000	$30,000
Fraud Prevention System (FPS)	$4,858	$0	$4,858
Total	**$4,858**	**$36,168**	**$41,026**
V. Program Integrity Oversight Efforts			
Enhanced Provider Oversight	$0	$5,100	$5,100
Overpayment/Payment Suspension	$0	$5,000	$5,000
Durable Medical Equipment (DME) Initiatives	$10,200	$0	$10,200
Compromised Numbers Checklist (CNC)	$0	$315	$315
National Supplier Clearinghouse (NSC)	$0	$20,000	$20,000
One PI Data Analysis	$0	$16,024	$16,024
Fraud & Abuse Customer Service Initiative	$0	$7,300	$7,300
HEAT Support / Strike Force	$0	$2,000	$2,000
Healthcare Fraud Prevention Partnership (HFPP)	$0	$3,900	$3,900
Appeals Initiatives	$0	$14,887	$14,887
Probable Fraud Measurement Pilot	$0	$5,000	$5,000
Total	**$10,200**	**$79,526**	**$89,726**

FY 2014 CMS HCFAC Funding Request
(dollars in thousands)

Project or Activity	FY 2014 Base Request	FY 2014 Additional Mandatory Request	FY 2014 Total Request
VI. Medicaid Program Integrity Initiatives			
Payment Error Rate Measurement (PERM)	$18,000	$2,000	$20,000
National Correct Coding Initiative	$0	$774	$774
State Readiness, Enrollment and Eligibility	$0	$5,000	$5,000
Medicaid and CHIP Business Information Solutions (MACBIS)	$19,303	$1,136	$20,439
ACA Section 6002: Physician Ownership Interests	$0	$3,000	$3,000
Total	**$37,303**	**$11,910**	**$49,213**
HCFAC Summary			
Total Medicare Integrity	**$214,117**	**$166,516**	**$380,634**
Total Medicaid Integrity	**$37,303**	**$11,910**	**$49,213**
Total CMS Funding Request	**$251,420**	**$178,426**	**$429,847**

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Clinical Laboratory Improvement Amendments of 1988

	FY 2012 Enacted	FY 2013 Base	FY 2014 President's Budget	FY 2014 +/- FY 2013 Base
BA	$43,000,000	$50,000,000	$50,000,000	$0
FTEs	68	82	84	2

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

FY 2014 Authorization - One Year

Allocation Method – Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA strengthens quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens to diagnose, prevent, or treat illness or impairment. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 19,133 laboratories during the FY 2012-2013 survey cycle.

Laboratories exempt from routine Federal inspections include those performing waived tests only, laboratories in which specified practitioners perform only certain microscopic tests, laboratories accredited by approved independent accrediting organizations, and laboratories in States that approve or license clinical laboratories under their own standards. Waived laboratories perform only simple testing and are not generally subject to CLIA requirements, with the exception of following manufacturers' instructions and paying applicable certification fees. Laboratories which are accredited, or which operate in exempt States, are inspected by the accrediting organization or the State at the same frequency as CMS-certified laboratories, namely every 2 years. The accrediting organizations and exempt States have standards considered equal to or more stringent than those required under the CLIA statute. Laboratories that are subject to Federal surveys (those performing nonwaived testing) can choose to be surveyed either by CMS or by one of the six CMS-approved private accrediting organizations. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Currently, 231,630 laboratories are registered with the CLIA program. Approximately 194,402 or 83.9 percent, of these laboratories are classified as waived or provider-performed microscopy laboratories and are not subject to routine onsite inspection. The largest number of laboratories, physician office laboratories (POLs), account for approximately 116,358, or 50.2 percent, of the laboratories registered under the CLIA program. Approximately 97,699 or 83.9 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of 2.5 percent for the FY 2012-2013 survey cycle.

Effective October 31, 2003, the authority for CLIA test categorization was transferred to the Food and Drug Administration (FDA), which enables laboratory device manufacturers to submit applications to only one agency for both device approval and categorization. CMS, the Centers for Disease Control (CDC), the FDA, and the States remain focused on the mission to improve the accuracy of tests administered in our Nation's laboratories, thereby improving health care for all. CMS, the CDC, and the FDA have reevaluated the program, procedures, responsibilities, and time lines to continually achieve greater efficiencies, while ensuring that requirements reflect the current standard of practice in laboratory medicine. By being flexible and results-oriented, the CLIA program has remained successful in the dynamic health care environment.

Budget Request

The FY 2014 CLIA budget request for CMS is $50 million. The CLIA program is a 100-percent user fee-financed program. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories. CMS then sets the national survey workload at 100 percent of the laboratories to be inspected in a two-year cycle. Workloads projected for the FY 2012-2013 cycle include surveys of 19,133 non-accredited laboratories, State validation surveys of 785 accredited laboratories, and approximately 1,338 follow-up surveys and complaint investigations.

Performance Measurement

CLIA2: Improve Laboratory Safety by Measuring the Outcome of Delivering Educational Materials Prior to an Educational Survey -The Clinical Laboratory Improvement Amendments (CLIA) ensure the quality of laboratory testing by requiring that all laboratories are certified by HHS and meet the CLIA provisions. The CLIA provisions are based on the complexity of tests performed by laboratories. CLIA imparts an exemption or a Certificate of Waiver (CW) of quality provisions to laboratories that perform only simple tests. "Simple" in this context refers to simple laboratory examinations and procedures that have an insignificant risk of an erroneous result, including those that employ methodologies that are so simple and accurate as to render the likelihood of erroneous results by the user negligible, or the Secretary of HHS has determined the test poses no unreasonable risk of harm to the patient if performed incorrectly.

Because of the significant growth of waived tests and laboratories, CMS developed a survey of the nations' waived laboratories. The surveys were designed to educate laboratories on sound laboratory practice, to gather information for CMS, to ensure that

personnel conduct in laboratories is protecting patient safety, to determine laboratories' regulatory compliance and to ensure that CW laboratories are not performing more than simple tests. In general, surveys measure whether a lab is in full compliance with CLIA regulations as they pertain to waived testing laboratories.

Survey data has continually substantiated that a significant percentage of these waived laboratories have pre- and post-testing issues, are not performing Quality Control as instructed by the manufacturer, and that testing personnel are not familiar with and are less trained in good laboratory practice compared to personnel in non-waived labs. Additionally, these surveys have brought to light that some laboratories are performing testing beyond the scope of their certificate (i.e. non-waived testing), which can lead to potential patient harm.

Analysis of a FY 2010 sample of 20 States showed that only 18 percent of CW laboratories were in full compliance with CLIA regulations and in FY 2011, only 32 percent of CW laboratories in the same 20 States were in full compliance.

On January 23, 2012, we implemented a pilot to study the laboratories in the same 20 States to measure the impact of distributing educational materials prior to surveys with the aim of increasing the number of laboratories that are in full compliance with CLIA provisions. As of October 19, 2012, a total of 726 CW laboratories, from the 20 states selected to participate in this study, were sent the "READY, SET, TEST" booklet. This represents 41 percent of the total number of laboratories that were surveyed overall as part of the CW project. In total, 1,758 CW laboratories were identified for a survey (as of July, 2012, there were 153,568 registered CW laboratories). Of the 726 CW laboratories noted above, 318 (44 percent) received a Letter of Congratulations.

We are pleased to report that we met our expectations for success. Based on the percentage of Letters of Congratulations provided to waiver laboratories in full compliance with CLIA provisions for fiscal year 2011 (33 percent) compared to the percentage of Letters of Congratulations for fiscal year 2012 (44 percent) we report over a 33 percent increase from 2011 to 2012. We therefore conclude that educational materials, like the "READY, SET, TEST" booklet, are well received by laboratories and serve as an effective means of improving the quality of laboratory testing. However, we recognize that additional efforts are still needed to further raise the compliance rate and will continue to pursue efforts to improve performance.

The FY 2014 target is to increase the number of States that that are in full compliance with CLIA by 2 percent over the FY 2013 actual. We remain cautious in our expectations to achieve greater than a 2 percent increase over FY2012 because of the variability that exists with CW laboratories, high staff turnover, the limitations of human resources to train personnel and monetary considerations. Also, it is important to note that the laboratories surveyed in FY 2012 will not be the same group of laboratories surveyed in FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/- FY 2013 Target
CLIA2: Increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA provisions.	FY 2012 44% (Target Exceeded)	+2% over FY 2012	+2% over FY 2013	+2%

Quality Improvement Organizations

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate
BA	$372,800,000	$458,600,000	TBD

Authorizing Legislation - Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended.

Allocation Method – Contracts

The Quality Improvement Organization (QIO) 10th Statement of Work (SOW) began August 1, 2011 and will end July 31, 2014. The 10th SOW will expand on work started in the 9th SOW with a particular focus on Clinical Quality Improvement and Value Based Purchasing.

The 10th SOW major themes are: Beneficiary and Family Centered Care, Improve Individual Patient Care, Integrating Care for Populations and Improving Health for Populations and Communities.

Beneficiary and Family Centered Care activities will emphasize mandatory review activity and quality improvement. Mandatory review includes utilization review, quality of care review (including beneficiary complaints), review of beneficiary appeals of certain provider notices, and reviews of potential anti-dumping cases. Emphasizing quality improvement, Beneficiary and Family Centered Care in the 10th SOW will engage in more active evaluation of program activities and will benefit from more highly advanced reporting and tracking systems. It is estimated that QIOs will review substantially more cases in the 10th SOW, including an estimated increase in beneficiary complaints resulting from increased outreach to beneficiaries concerning their appeal and complaint rights under the QIO program.

The Improve Individual Patient Care efforts will address major areas of patient harm where evidence on how to improve safety and a record of QIO success exists. This work will be predicated on the reduction of patient harm that is more likely a result of the patient's interaction with the health care system than an attendant disease process. QIO activities for this theme will focus on four major topics: reducing healthcare-associated infections in hospitals, reducing health care acquired conditions in the nursing home setting, reducing adverse drug events and supporting quality improvement reporting initiatives through QIO outreach.

Integrating Care for Populations and Communities is a strategic Aim where QIOs are bringing together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions. QIOs implement community-based projects that help make process improvements to address issues in medication management, post-discharge follow-up, and plans of care for patients who move across health care settings. Communities that join QIOs in this initiative to integrate care for populations and communities will contribute to the goal of a three-year, 20% national reduction in readmissions within 30 days of hospital discharge.

The Improve Health for Populations and Communities efforts will emphasize evidence-based and cost-effective care proven to prevent and/or slow the progression of disease. QIO work will impact health care programs, polices, practices, community norms, and linkages and will

produce higher quality of care for Medicare beneficiaries and cost savings. Over time, as disease is mitigated and its progression slowed through preventive measures such as early testing, immunization, and effective and timely intervention, the Nation will see a healthier Medicare population emerge. This downstream impact will be most evident in the reduction of chronic kidney disease (CKD) and a decrease in the rate of progression to kidney failure. QIOs will also continue to improve the use of electronic health records (EHRs) for care management and prevention by working to promote, and assist physicians with, quality reporting.

Program Description and Accomplishments Section

QIOs are Medicare contractors that work in each state and territory to improve quality of care by collaborating with providers and responding to beneficiary concerns. Today, QIOs work under a three-year contract, called a Statement of Work (SOW). The 10th SOW aims to protect beneficiaries from harm, reduce hospital-acquired conditions, enhance quality reporting, lower readmissions, and promote screening tests that can prevent potentially life-threatening conditions. The current 10th SOW (August 2011- July 2014) totals approximately $1.6 billion.

The improved oversight of the program and increased competition for sub national projects found in the 9th and 10th SOWs are providing improved outcomes and value. CMS will continue to build on the success from our innovative management approach.

Budget Overview

The QIO 11th SOW will begin on August 1, 2014. HHS and CMS are currently consulting with stakeholders regarding how the new SOW framework will be structured. The 11th SOW will implement several changes to the program as enacted in the Trade Adjustment Assistance Extension Act of 2011 (the "Trade Law"), which gave CMS flexibility to expand QIO contracts to a larger geographic scope and an expanded pool of contractors, ensuring that beneficiaries are served by organizations with the best experience and the most relevant skills, and extended the SOW contract period from three years to five years.

CMS is also working on the programmatic content of the QIO Program going forward, which will align the 11th SOW with the Secretary's National Strategy for Quality Improvement in Health Care (the National Quality Strategy).

Funding History

FY 2009	$535,400,000
FY 2010	$175,400,000
FY 2011	$1,018,955,000
FY 2012	$372,800,000
FY 2013	$458,600,000

Performance Measurement

CMS uses performance measures to support its mission and to inform the decision-making process. The following performance measures touch on the themes of the 10th SOW as well as our efforts to improve oversight of the QIOs.

QIO1 - Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those who Receive an Annual Vaccination for Influenza: For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend annual vaccination against influenza. While CMS improved over the previous year, the FY 2011 influenza result of 82.5 percent, for beneficiaries residing in a long term care facility, did not exceed the FY 2011 target of 86 percent. Nationally, there is a 6 percentage point improvement from the FY 2010 results of 76.5 percent. Over the past few years, there has been a national decline of influenza immunization rates seen from 2008 to 2010 reported among the Medicare Current Beneficiary Survey (MCBS) Facility, MCBS Community, and the CDC's Behavior Risk Factor Surveillance System Community data. As a result of the QIO 10th SOW Improving Health for Populations and Communities Aim, eligible professionals will increase Medicare beneficiaries' understanding and utilization of the influenza immunization. Through the use of the Physician Quality Reporting System, electronic health records, this Aim will engage the participating professionals by implementing care management and tracking, and improving their patients' receipt of the influenza vaccine. Participating eligible professionals will utilize their electronic health records to facilitate immunization practices, document vaccination recommendations, and improve compliance with recommendations, allowing them to use decision support tools to improve quality of care, care coordination and better engagement of patients and families in making health care decisions.

QIO3 - Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol Testing: CMS is committed to improving care for its diabetic beneficiaries by increasing the rate of hemoglobin A1c (HbA1c) and cholesterol (LDL) testing. Multiple studies have demonstrated a relationship between well controlled blood sugars as measured by HbA1c and protection against the development and/or progression of the devastating complications of diabetes. Cardiovascular complications of diabetes are common and cause heart attacks, strokes and lower extremity amputations. Cardiovascular disease is the number one cause of death for diabetic patients. CMS improved over the previous year; however, the agency fell just short of CY 2011 targets of 88.5 percent (HbA1c) and 83.1 percent (LDL) at rates of 87.93 percent and 82.05 percent, respectively. Recent evidence suggests that HbA1c is not as powerful a target as is effective blood pressure and lipid management in averting macro-vascular events and disease. CMS will continue to track this goal and consider it for modification as evidence emerges.

QIO4 - Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection: According to the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs), surgical site infections (SSIs) are the second leading cause of HAIs (the first is catheter-associated urinary tract infections). Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection. The reduction in the incidence of SSI that is expected to result from improvement in the timing of antibiotic prophylaxis will primarily benefit Medicare beneficiaries through reduced morbidity and mortality. An additional benefit will be reduced need for and cost of re-hospitalization for treatment of infections. CMS surpassed the FY 2011 target of 95.5 percent to end at a rate of 97.8 percent. To achieve targets, the agency has continued to emphasize the

performance measures of the Surgical Care Improvement Project in the Improve Individual Patient Care Aim of the QIO 10th SOW. CMS uses the performance measures for continued accountability through public reporting (Hospital Inpatient Quality Reporting - IQR), and these measures were integrated into the hospital value-based purchasing program established by section 3001 of the Affordable Care Act beginning in FY 2013.

MCR28 - Reduce Healthcare-Associated Infections: The QIOs play an important role in the Agency Priority Goal to reduce Central Line-Acquired Bloodstream Infections and Catheter-Acquired Urinary Tract Infections. For more information, please see Measure MCR28.1 and 28.2 in the Performance Measurement Section under the Program Operations chapter.

QIO5 - Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis: Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD) with approximately 372,000 Medicare beneficiaries receiving this treatment. The three current types of vascular access are: arteriovenous fistula (AVF), catheter, and graft. For many ESRD patients, an AVF is the preferred type of vascular access due to lower rate of infection and clot formation, resulting in greater longevity than other types of vascular access.

Reporting from October 2011 through April 2012 indicates achievement of 60.6%of the FY 2012 target of 60.5 percent; however, there is a delay in full year's data reporting. CMS will await final and complete FY 2012 data and report as soon as it is available.

Based on results to date, CMS' FY 2013 and FY 2014 targets reflect a continuation of improvement from 2011 while acknowledging that performance is progressing towards maintaining previous achievements.

QIO6 - Improve Oversight of Quality Improvement Organizations: The purpose of this goal is to ensure that CMS' efforts in overseeing the QIOs are aligned with the performance targets in the QIO 10th SOW. These targets are important as they are designed to measure improvements in the quality of care for Medicare beneficiaries at a national level. QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The 9th SOW ended July 31, 2011, and represented a change from previous QIO contracts since it held all QIOs accountable for meeting specific, predefined performance targets under four major themes. CMS was successful in improving QIO 9th SOW oversight by conducting routine quarterly monitoring of the metrics, and requesting immediate correction of identified problems. Under the 10th SOW, which began August 1, 2011, QIOs will be evaluated on achievement associated with meeting the "Drivers" performance expectations and contract monitoring evaluation targets; for FY 2012, CMS has achieved all four of its targets. The "Drivers" for performance are: a) Supporting and Convening Learning and Action Networks, b) Providing Technical Assistance, and c) Care Reinvention through Innovation Spread Model.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
QIO1 Increase influenza immunization (nursing home subpopulation) (Outcome)	FY 2011: 82.5% Target: 86% (Target Not Met but Improved)	84%	85%	+1%
QIO3.1 Increase hemoglobin A1c (HbA1c) testing rate (Outcome)	FY 2011: 87.93% Target: 88.5% (Target Not Met but Improved)	89.5%	90.5%	+1%
QIO3.2 Increase cholesterol (LDL) testing rate (Outcome)	FY 2011: 82.05% Target: 83.1% (Target Not Met but Improved)	84.1%	86%	+1.9%
QIO4 Increase percentage of timely antibiotic administration (Outcome)	FY 2011: 97.8% Target: 95.5% (Target Exceeded)	98%	99%	+1%
QIO5 Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis (Outcome)	FY 2011: 59.8% Target: 58% (Target Exceeded)	60.5%	61%	+0.5%
QIO6.5a Improve Health for Populations and Communities (Outcome)	FY 2012: 100% of pertinent QIOs achieved the recruitment goals. Target: New for 10th SOW - 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4) (Target Met)	New for 10th SOW - 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	80% of the QIOs will meet the overall performance expectations for the 10th SOW	N/A

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
QIO6.5b Improve Individual Patient Care (Outcome)	FY 2012: 100% of the QIOs have achieved the recruitment goals by the 12th month (quarter 4) per CMS requirements. Target: New for 10th SOW - 100% of the recruitment goals by the 12th month (quarter 4) (Target Met)	New for 10th SOW - 100% of the recruitment goals by the 12th month (quarter 4)	80% of the QIOs will meet expectations towards the overall 10th SOW targets for Urinary Catheter Utilization Rates, CLABSI, CAUTI, CDI, pressure ulcer prevention treatment practices and reduction of adverse drug events.	N/A
QIO6.5c Integrate Care for Populations and Communities (Outcome)	FY 2012: 92% of the QIOs met the 12th month (quarter 4) 1-4 (interim) performance expectations. Target: New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) 1-4 (interim measure) performance expectations (Target Exceeded)	New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) 1-4 (interim measure) performance expectations	80% of the QIOs will meet the overall performance expectations for the 10th SOW	N/A
QIO6.5d Beneficiary and Family Centered Care (Outcome)	FY 2012: 97% of the QIOs met the 12th month performance expectations. Target: New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) performance expectations (Target Exceeded)	New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) performance expectations	80% of the QIOs will meet the overall performance expectations	N/A

Medicare Benefits
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Outlays	$549,311,000	$590,152,000	$603,848,000	+$13,696,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process. Estimates are based on the FY 2014 President's Budget.

Authorizing Legislation - Title XVIII of the Social Security Act
FY 2014 Authorization - Indefinite
Allocation Method - Direct Federal

Program Description and Accomplishments

Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Enacted in December 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), P.L. 108-173, was designed to improve and modernize the Medicare program, including the addition of a prescription drug benefit. Based on current efforts to implement the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5, Medicare added significant new funding and incentives for physician and hospital expansion in electronic health records and quality information in FY 2011. Implementation of these ARRA provisions builds on Medicare's ongoing transformation into an active purchaser of high quality services. In addition, the Affordable Care Act of 2010 (P.L.111-148) created a number of changes that will improve the Medicare program. While full implementation is expected to take several years, many beneficial aspects of the law have already been implemented.

Medicare processes over one billion fee-for-service (FFS) claims every year and is the Nation's largest purchaser of health care (and within that, of managed care). Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and the Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to an estimated 53.6 million beneficiaries in FY 2014.

The Medicare Hospital Insurance program, also known as Medicare Part A or HI, is normally provided automatically to people age 65 and over who qualify for Social Security benefits. This program is also extended to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital care, as well as skilled nursing, home health, and hospice care; and is financed primarily through payroll taxes paid by workers and employers. While the taxes paid each year are used mainly to pay benefits for current beneficiaries, funds not currently needed to pay benefits and related expenses are held in the HI Trust Fund and invested in U.S. Treasury securities.

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home

health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. Beneficiaries who choose the optional Part B coverage are subject to monthly premium payments. About 93 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI Trust Fund, and invested in U.S. Treasury securities.

The Medicare Advantage (MA) program, also known as Medicare Part C, created in 2003 by the MMA, is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join an MA plan, if they are entitled to Part A and enrolled in Part B, and if there is a plan available in their area. Those who are eligible for Medicare because of ESRD may join an MA plan only under special circumstances. All MA plans are currently paid a per capita payment, and generally must provide all Medicare covered services. Further, MA plans assume financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services to beneficiaries, such as vision and dental benefits, which are not available under Part A or Part B; many also offer Part D coverage of prescription drugs in addition to medical benefits. MA plans have an estimated 14.9 million enrollees in FY 2014.

The Prescription Drug Benefit Program, also created by the MMA, is funded through the SMI Trust Fund, and provides for an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A or Part B. Beneficiaries who qualify for both Medicare and Medicaid ("dual eligibles") automatically receive the Medicare drug benefit. The statute also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and qualified low-income beneficiaries. In general, coverage for this benefit is provided under private prescription drug plans, which offer only prescription drug coverage, or through Medicare Advantage plans which integrate prescription drug coverage with the general health care coverage they provide to Medicare beneficiaries. In addition, plan sponsors of employer and union plans offering a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the retiree drug subsidy program to fund some of their costs. Part D benefits are funded through premiums paid by beneficiaries, general fund subsidies, and specified payments from states. Enrollment in Part D plans is estimated to be 39 million in FY 2014, including 36.7 million enrolled in Part D plans and 2.3 million who receive benefits through the retiree drug subsidy. The Affordable Care Act authorized a rebate program for those applicable beneficiaries who reached the coverage gap before the end of the 2010 calendar year. In addition it offers a discount for prescription drugs in 2011 and beyond, to applicable beneficiaries who reach the coverage gap before the end of each calendar year after 2010.

Outlays History

FY 2009	$497,635,667,000
FY 2010	$518,948,805,000
FY 2011	$557,732,000,000
FY 2012	$549,311,000,000
*FY 2013	$590,152,000,000
*Estimate Under Current law	

Budget Estimates

The budget estimates for Medicare benefits for FY 2014, by trust fund account, are shown in the following table.

	FY 2014	+/- from FY 2013
HI	$278,131,000,000	+$4,397,000,000
SMI – Part B	$254,250,000,000	+$1,372,000,000
SMI – Part D	$71,467,000,000	+$7,927,000,000
Total	$603,848,000,000	+$13,696,000,000

Note that Part C, Medicare Advantage, is funded by the HI and SMI trust funds.

The estimate for FY 2014 is an increase of $13,696,000,000 from FY 2013. This increase is due to higher enrollment, and increasing medical service utilization and costs.

Performance Measurement

The performance measures below represent activities to support the four Medicare programs and to inform the decision-making process.

MCR1 Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive: CMS has monitored FFS and MA access to care and prescription drugs as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Because the drug benefit is now well established, the prescription drug access measures are retired beyond FY 2012. We exceeded both FY 2012 targets regarding access to prescription drugs. As the Affordable Care Act is implemented, we will continue to include measures to monitor FFS and MA access to care in order to maintain the same high rates for our beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: "Percent of persons with FFS (or MA Plans) report they usually or always get needed care right away as soon as they thought they needed it." CMS met or exceeded our FY 2012 targets reflecting beneficiary experience in FFS and MA access to care in 2011. For FY 2014, we want at least 90 percent of beneficiaries surveyed to report that they have access to care in the MFFS and MA programs.

MCR23 Reduce the Average Out-of-Pocket share of Prescription Drug Costs While in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non Low- Income Subsidy (LIS) Medicare Beneficiaries Who Reach the Gap and Have No Supplemental Coverage in the Gap: CMS will measure the success of the Affordable Care Act Coverage Gap Discount Program, which reduces the amount Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap, by measuring the average percent of drug costs beneficiaries must pay while in the coverage gap. Discounts are provided through a combination of rebate checks for 2010, and significant manufacturer discounts and increased Medicare coverage according to a predetermined scale for years 2011 through 2020. To reflect current analysis using baseline data and applying the discounts that will be available to beneficiaries in 2011 through 2015, CMS set the FY 2012 target at 58 percent, the FY 2013 target at 55 percent, and the FY 2014 target at 53 percent. FY 2011 data just received reflect an average of 57 percent of drug costs paid in the coverage gap.

MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit: CMS will measure the number of Medicare Annual Wellness Visits (AWVs) to demonstrate success in increasing beneficiary awareness and utilization of this benefit, which was first available January 2011. The Affordable Care Act added this benefit with no copayments or other cost-sharing on the part of the beneficiary if the doctor or other health care provider accepts assignment. The AWV includes elements that focus on (1) assessing health risks, (2) furnishing personalized health advice and referrals, as appropriate to health education and preventive counseling services, and (3) creating a screening schedule for the next five to ten years and a list of risk factors and conditions as well as ongoing and/or recommended interventions. CMS developed the baseline with CY 2011 data of 2.3 million beneficiaries, and set the CY 2013 target at 2.8 million. CMS would like to get another year's data for stability, and plan to set future targets once CY 2012 data are available in June 2013.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2014 Target	FY 2014 Target +/-FY 2013 Target
MCR1.1a Maintain or exceed percent of beneficiaries in Medicare fee-for-service (FFS) who report access to care (Outcome)	FY 2012: 90% Target: 90% (Target Met)	90%	90%	Maintain
MCR1.1b Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care (Outcome)	FY 2012: 91% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR23 Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap (Outcome)	FY 2011: 57% (Historical Actual)	55.0%	53.0%	-2%
MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Outcome)	FY 2012: 2.3 million[1] Target: Set baseline (Baseline)	2.8 million	TBD	N/A

[1] CY 2011 data. The actual number of beneficiaries receiving an AWV was 2,335,992 million. Please note that this number could change, although very slightly, as old claims are submitted.

Medicare Benefits Discontinued Measures

Measures	*FY*	Target	Result
MCR1.2a: Percent of beneficiaries in FFS who report access to prescription drugs. Baseline: 91% (FY 2007)	*2012*	91%	93% (Target Exceeded)
	2011	91%	93% (Target Exceeded)
	2010	91%	91% (Target Met)
	2009	90%	91% (Target Exceeded)
	2008	90%	91% (Target Exceeded)
MCR1.2b: Percent of beneficiaries in MA who report access to prescription drugs. Baseline: 93% (FY 2007)	*2012*	91%	95%
	2011	91%	95% (Target Exceeded)
	2010	91%	93% (Target Exceeded)
	2009	91%	93% (Target Exceeded)
	2008	91%	93% (Target Exceeded)

Performance Measure MCR 1.2a, 1.2b

The measures are being retired. Targets were set to maintain or exceed already high standards in each of the satisfaction measures on an annual basis. CMS has either met or exceeded its targets each year for these two measures. Given the high rates of satisfaction, it is challenging to increase the satisfaction scores further**.**

Children's Health Insurance Program

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate
State allotments (CHIPRA of 2009, P.L. 111-3) ; P.L 111-148)	$14,982,000,000	$17,406,000,000	$19,147,000,000
Total Budget Authority for State Allotments	**$14,982,000,000**	**$17,406,000,000**	**$19,147,000,000**
CHIP Performance Bonus Payments [1] (P.L. 111-3)	$1,060,742,000	$351,559,000[2]	$4,704,531,000[2]
Child Health Quality Improvement (P.L. 111-3)	$45,000,000	$45,000,000	$45,000,000
Total Budgetary Resources	**$16,087,742,000**	**$17,802,559,000**	**$23,896,531,000**
Total Outlays	**$9,065,230,099**	**$9,897,126,000**	**$9,992,506,000**

[1] Funding levels reflect carry-forward balances from prior years and rescissions enacted in each current year and do not represent new appropriations.
[2] This figure represents the amount available if the Continuing Appropriations Act (P.L. 112-175) is annualized.

FY 2014 Authorization – Public Law 111-148
Allocation Method - Formula Grants

Authorizing Legislation - The Balanced Budget Act of 1997 (BBA) (P.L. 105-33), the Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113), the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3), and the Patient Protection and Affordable Care Act (P.L. 111-148)

Child Enrollment Contingency Fund

(The Child Enrollment Contingency Fund is set up as a separate interest-bearing account in the United States Treasury Department)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate
Child Enrollment Contingency Fund	$2,093,294,642	$2,092,718,000	$1,995,782,000
Interest Estimate	$53,010	$3,064,000	$3,502,000
Total Budgetary Resources	**$2,093,347,652**	**$2,095,782,000**	**$1,999,284,000**
Total Outlays	**$204,937**	**$125,108,000**	**$100,000,000**

FY 2012 - FY 2014 figures reflect carry-forward balances from previous year and do not represent new appropriations.

Authorizing Legislation - The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3).

Program Description and Accomplishments

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a Federal-State matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program was the largest single expansion of health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States have the option to expand Medicaid (title XIX) coverage, set up a separate CHIP program, or have a combination of Medicaid expansion and separate CHIP programs.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44 billion through FY 2013 to maintain State programs and to cover more insured children. More recently, the Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $28.8 billion in budget authority over the baseline.

Since September 1999, all States, Territories, Commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review States' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibility to make innovative changes. As of July 31, 2012, CMS has approved a total of 449 amendments to CHIP plans.

In addition to increased funding for States, CHIPRA created several new programmatic features of the CHIP program. A few of the major provisions include:

- CHIP Performance Bonus Payments – The CHIP Performance Bonus Payments were created as an incentive for States to enact policies that promote enrollment and retention of eligible children. States receive bonus payments for the increase on a per child basis equal to a portion of the State's annual Medicaid per capita expenditure on children. In order to receive a performance bonus payment, States must implement 5 of 8 enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation and in future years any unobligated national allotments, unexpended State allotments, and excess funds beyond the aggregate cap for Child Enrollment Contingency Fund amounts may be transferred to this account.

- Child Health Quality Improvement in Medicaid and CHIP – Section 1139A of the Social Security Act (the Act) requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. Other CHIPRA requirements include developing a standardized reporting format that encourages States to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the State plan under Medicaid or CHIP, and several grants and contracts to develop and test these quality measures. A total of $225 million ($45 million per year for FYs 2009-2013) was appropriated for the Secretary to carry out these activities. Funds for these activities are available until expended. This initiative is also discussed in the performance measurement section of this chapter.

The current status of Child Health Quality Improvement activities in Medicaid and CHIP include:

CHIPRA Pediatric Quality Measures Program:

- A State Health Official Letter was issued February 14, 2011 outlining the initial core set of children's health care quality measures and reporting guidance. Since spring 2012, CMS and the Agency for Healthcare Research and Quality (AHRQ) have been collaborating to identify an improved core set of children's health care quality measures, as required by CHIPRA. AHRQ's Subcommittee to the National Advisory Committee will recommend to CMS additional measures for potential inclusion in and retirement from the core set. CMS currently has an (Interagency Agreement) IAA with AHRQ to use a Subcommittee of AHRQ's Advisory Committee for the purposes of identifying recommendations to CMS on improvements to the Children's Core Set. At this time, we have funding to renew the IAA with AHRQ through FY 2014. CMS released the first set of improvements to the Core Set in a January 2013 State Health Official Letter which outlined the updates to the Child Core Set, including the retirement of one measure and the addition of three new measures (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf).

- Over the past two years CMS has held multiple technical assistance calls, webinars and released issue briefs for states to provide clarification and guidance about collecting and reporting the Child Core Set measures.

- To increase the number of States consistently collecting, reporting, and using the initial core set of children's health care quality measures, CMS established the "Technical Assistance and Analytic Support Program" with an award of a contract to Mathematica Policy Research in May 2011. State data derived from the voluntary core measures are part of the Secretary's Report on the Quality of care for Children in Medicaid and CHIP (link to 2012 report: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf) published annually.

- On March 1, 2011, CMS, in collaboration with the AHRQ, awarded $55 million dollars in four year cooperative agreement grants to seven Centers of Excellence with diverse talents and expertise that will advance and improve measures of healthcare quality for children. In 2011 and 2012, the Centers of Excellence received measurement development assignments covering child and adolescent health measurement priority topics such as: care coordination, content and follow-up of well care visits, sickle cell, functional status, readmissions, cost and efficiency. The Centers of Excellence will continue to develop measures over the next two years on a rolling basis. Likewise, the Office of the National Coordinator, working through an IAA with CMS, will continue to develop a small set of measures and electronically specifying measures in the core set for inclusion in future stages of the HITECH (Health Information Technology for Economic and Clinical Health) meaningful use program.

- A contract was awarded to RTI International on April 15, 2011 to establish a Coordinating and Technical Assistance Center that will coordinate and disseminate information on the work of the Centers of Excellence. Since that time, RTI has assisted AHRQ in creating workgroups based on shared topics of interest relevant to measurement development (e.g. data aggregation, identify racial and ethnic disparities, data informatics).

- The first national planning meetings for the Centers of Excellence, the National Coordinating and Technical Assistance Center, and two State Medicaid CHIPRA quality demonstration grantees were held April 2011 and September 2012. The Centers of Excellence meet monthly via conference call to discuss measurement issues and to hear about early challenges and updates from each other.

CHIPRA Electronic Health Record Program:

- Working through an IAA with CMS, the AHRQ awarded a $5 million contract to Westat to develop a children's model EHR (Electronic Health Record) format. Children's model EHR format prototype development was completed in March 2012 and the format was released publically in February 2013 (http://www.ahrq.gov/news/newsroom/press-releases/2013/childehrpr.html). The format includes a minimum set of data elements and applicable data standards that can be used as a blueprint for EHR developers seeking to create a product that can capture the types of health care components most relevant for children. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting.

- Two CHIPRA Quality Demonstration Grantees, Pennsylvania and North Carolina, are working to evaluate the impact of the Children's Model EHR Format.

CHIPRA Quality Demonstration Grants:

- CMS awarded the first $20,000,000 in demonstration grants to ten States on February 22, 2010. All grantees continue to meet expectations and were awarded fourth year demonstration awards in February 2013.

- As outlined in the Special Terms and Conditions, all grantees are required to submit web-based semi-annual progress reports. The first web-based report was submitted to CMS on August 1, 2011. Grantees will continue to submit web-based semi-annual progress reports through the end of the grant program.

- CMS continues to host monthly all-grantee calls. CMS staff facilitates the calls and Grantees present early successes and challenges on topics identified by the Grantees. The 2012-2013 call topics include asthma management best practices, integration of electronic health records to

support medical home transformation, improving access to oral health; and methods for engaging patients in their care and self-management.

- For the second year, in June 2012, Grantees presented posters on early successes and lessons learned from their Demonstrations at the Annual CMS Medicaid/CHIP Quality Conference in Baltimore.

- The National Evaluation of the CHIPRA Quality Demonstrations is led by Mathematica Policy Research and funded by CMS through an interagency agreement with the Agency for Healthcare Research and Quality. National evaluation activities for 2012 include site visits to all 10 Grantee states. The National Evaluation launched its website, which is hosted by the AHRQ website, in August 2012. In early 2013, the National Evaluation team released its first evaluation highlight, entitled "How are CHIPRA demonstration States approaching practice-level quality measurement and what are they learning?" (http://www.ahrq.gov/policymakers/chipra/demoeval/highlights/highlight01.pdf). Over the next year, the National Evaluation team will continue to work with AHRQ and CMS to develop additional evaluation highlights.

- Child Enrollment Contingency Fund – This fund is used to provide supplemental funding to States that exceed their allotment due to a higher-than-expected child enrollment in CHIP. A State may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and its average monthly child enrollment exceeds its target average number of enrollees for the fiscal year.

  The fund received an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2015, Section 2104(n) of the Act appropriates the amount necessary to make payments to eligible States, but not to exceed 20 percent of the total annual allotment appropriation for CHIP. Any amounts in excess of the aggregate cap will be made available for CHIP Performance Bonus Payments. Also, the contingency fund will be invested in interest bearing securities of the United States. The income derived from these investments constitutes a part of the fund. The fund accrued a total of $53,010 in interest in FY 2012 and is estimated to accrue $3,064,000 in FY 2013. To date, only one state (Iowa) has received shortfall funds through the Contingency Fund.

Performance Measurement

CMS is committed to improving quality of care and to increasing enrollment of eligible children in the CHIP program, as illustrated by our efforts to track and improve performance in those areas. Our past efforts have resulted in dramatic improvement in States' reporting of CHIP health quality performance information.

MCD6 Improve Children's Health Quality Across Medicaid and CHIP through Implementation of the CHIPRA Quality Initiatives: While State reporting on the core set of quality measures is voluntary, CMS is encouraging all States to use and report on the core set in order to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures specific to Medicaid and CHIP programs. CMS exceeded the FY2011 target of 70 percent of states reporting at least one or more of the initial core set of children's health care quality measures, with 84 percent of states meeting this target. CMS is working with states to increase the number of

measures that each states report in order to reach the FY2012 target of 80 percent of states reporting at least five measures in the CHIPRA core set of quality measures. CMS' FY 2014 target is to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA core set of quality measures, which is an increase over the FY 2013 target of 85 percent of states reporting seven measures.

We will continue to work with our Technical Assistance and Analytic Support contracting team to provide States with specific clarifications on measurement collection questions; hold all-state webinars around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance, we target States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. Further, as our technical assistance program continues to mature, we will also be expanding the scope of our technical assistance to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

MCD7.2 Increase the National Rate of Low Income Children and Adolescents who are Enrolled in CHIP, Who Receive Any Preventive Dental Service: This measure seeks to improve access to and utilization of oral health care services for children enrolled in CHIP. Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the single most preventable common chronic disease of childhood. CMS has performed State dental program reviews focused on practices and innovations that have successfully increased utilization of dental care services in those States. Some of the innovations include: partnerships and collaboration among State partners and stakeholders; collaboration with dental schools and loan repayment programs; and increased reimbursement and simplified administrative processes. CMS is committed to providing technical assistance to States to lead to a higher level of confidence in the data that will be used to report an FY 2012 baseline in late 2013. CMS has established an FY 2013 target to increase the national rate of preventive dental service by 2 percentage points over the FY 2012 baseline and an FY 2014 target to increase the national rates of preventive dental service by 4 percentage points over the FY 2012 baseline.

CHIP3.3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid: States submit quarterly and annual statistical forms, which report the number of children under age 19 enrolled in Medicaid, separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year. CHIPRA, which provides CHIP funding through September 30, 2013, provides options to facilitate enrollment and retention of children in health coverage. The Affordable Care Act provides CHIP funding through FY 2015 and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

Enrollment in CHIP or Medicaid should be viewed in the context of overall children's enrollment in both programs. Many factors will affect enrollment in CHIP and Medicaid, including States' economic situations, and programmatic changes, and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In prior years, we set separate targets for Medicaid and CHIP. Beginning in FY 2013, we will track combined Medicaid and CHIP enrollment. The FY 2014 target is to increase CHIP and Medicaid enrollment to 46,617,385 children, (Medicaid: 38,083,596/CHIP: 8,533,789), nearly 25 percent more children than were covered in FY 2008**.** Our FY 2014 combined

target is based on our assumption that we will enroll approximately 3.1 million more children than in FY 2011, our most recent result. The increase is expected due to a combination of population increases, loss of employer-sponsored insurance and extensive outreach to enroll children who are eligible, but unenrolled in light of the Affordable Care Act coverage expansions.

State Allotment Funding History

FY 2005	$4,082,400,000
FY 2006	$4,365,400,000
FY 2007	$5,690,000,000
FY 2008	$6,640,000,000
FY 2009	$10,602,000,000
FY 2010	$12,518,000,000
FY 2011	$13,459,000,000
FY 2012	$14,982,000,000
FY 2013	$17,406,000,000
FY 2014	$19,147,000,000
FY 2015	$21,061,000,000

Budget Request

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) authorized and appropriated $40 billion for CHIP allotments to States, Territories, Commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113) authorized and appropriated additional funding for CHIP allotments to Commonwealths and Territories. The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) authorized funding for States, Commonwealths, and Territories in the amount of $17,406,000,000 in FY 2013. Under this appropriation, funding to States increased by $44.0 billion above the baseline over five years. Additional provisions added through CHIPRA include Performance Bonus Payments, the Child Enrollment Contingency Fund, and Child Health Quality Improvement in Medicaid and CHIP (discussed earlier in this chapter). Information regarding additional provisions provided by CHIPRA can be found in the State Grants and Demonstrations chapter. In addition to CHIPRA, the Affordable Care Act extends Federal funding for CHIP through FY 2015, appropriating $19,147,000,000 in FY 2014 and $21,061,000,000 in FY 2015.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2013 Target	FY 2014 Target	FY 2014 Target +/-FY 2013 Target
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2011: 84% of States reported on at least one quality measure Target: 70% of States report on at least one quality measure in the CHIPRA core set of quality measures (Target exceeded)	Work with States to ensure that 85% of States report on at least seven quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA core set of quality measures.	N/A
MCD 7.2 Increase the national rate of low income children and adolescents, who are enrolled in the Children's Health Insurance Program (CHIP), who receive any preventive dental service	FY 2012: Set Baseline Results available October 2013	+2 percentage points above baseline	+4 percentage points over baseline	+2 percentage points over baseline
CHIP3.3 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid	Combined target begins FY2013 FY 2011: 43,542,385 children (CHIP: 7,970,879/ Medicaid: 35,571,506) Historical Actual	+22% over baseline 45,592,385 children (CHIP:8,346,152/ Medicaid: 37,246,233)	+25% over baseline 46,617,385 children (CHIP: 8,533,789/ Medicaid: 38,083,596)	+1,025,000 children

CHIP Discontinued Measures

Measure	FY	Target	Result
CHIP3.1: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP	*2012*	+11% over FY 2008 8,179,012 children	March 31, 2013
	2011	+9% over FY 2008 8,031,642 children	+8.1% over FY 2008 7,970,879 children (Target not met)
	2010	+5% over FY 2008 7,736,903 children	+4.6% over FY 2008 7,705,723 children (Target not met)
	2009	+1% over FY 2008 7,442,164 children	+5% over FY 2008 7,717,317 children
	2008	6,732,000 children	+11% over baseline 7,368,479 children (Target Exceeded) (New baseline established FY 2009)
	2007	N/A	7,100,000 children (Historical Actual)
	2006	Set Baseline	6,600,000 children (Baseline)

Performance Measures CHIP 3.1

CHIP 3.1 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP:

In prior years, we set separate targets for Medicaid and CHIP. As discussed above, beginning in FY 2013, we will track combined Medicaid and CHIP enrollment in order to provide a fuller picture of children's access to health care coverage; therefore, we are discontinuing measure 3.1

FY 2013 MANDATORY STATE/FORMULA GRANTS
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(dollars in thousands)

STATE	Total FY 2012	FY 2013	FY 2014 Estimate	Difference +/- 2013 Col D - C
A	B	C	D	E
Alabama	$168,108	$162,846	$169,269	$6,423
Alaska	$21,005	$20,558	$21,369	$811
Arizona	$64,635	$25,392	$26,393	$1,001
Arkansas	$95,364	$103,118	$107,185	$4,067
California	$1,314,260	$1,296,015	$1,347,135	$51,120
Colorado	$130,420	$131,841	$137,666	$5,825
Connecticut	$32,686	$41,328	$42,959	$1,631
Delaware	$14,162	$15,738	$16,359	$621
District of Columbia	$12,611	$14,867	$15,921	$1,054
Florida	$339,812	$359,047	$373,209	$14,162
Georgia	$250,874	$282,709	$294,317	$11,608
Hawaii	$34,803	$25,809	$26,872	$1,063
Idaho	$37,945	$35,957	$37,376	$1,419
Illinois	$285,132	$275,566	$286,435	$10,869
Indiana	$98,664	$144,858	$150,572	$5,714
Iowa	$115,252	$92,496	$96,144	$3,648
Kansas	$58,771	$55,399	$57,584	$2,185
Kentucky	$135,474	$147,886	$153,719	$5,833
Louisiana	$195,190	$171,875	$178,906	$7,031
Maine	$37,038	$31,479	$32,720	$1,241
Maryland	$176,289	$160,475	$166,804	$6,329
Massachusetts	$330,784	$330,876	$343,927	$13,051
Michigan	$126,248	$54,797	$56,958	$2,161
Minnesota	$21,392	$32,082	$33,347	$1,265
Mississippi	$167,658	$176,877	$183,854	$6,977
Missouri	$117,629	$122,948	$127,798	$4,850
Montana	$40,144	$59,390	$61,733	$2,343
Nebraska	$50,106	$42,464	$44,248	$1,784
Nevada	$25,129	$31,454	$32,695	$1,241
New Hampshire	$13,380	$18,195	$18,913	$718
New Jersey	$618,026	$640,184	$665,436	$25,252
New Mexico	$258,655	$124,226	$129,553	$5,327
New York	$556,754	$579,751	$602,619	$22,868
North Carolina	$401,229	$304,201	$316,911	$12,710
North Dakota	$16,064	$17,311	$18,151	$840

FY 2013 MANDATORY STATE/FORMULA GRANTS
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(dollars in thousands)

Ohio	$290,093	$336,051	$349,306	$13,255
Oklahoma	$126,870	$114,193	$119,403	$5,210
Oregon	$95,355	$143,895	$149,571	$5,676
Pennsylvania	$335,890	$305,718	$317,776	$12,058
Rhode Island	$31,669	$39,507	$41,065	$1,558
South Carolina	$102,467	$98,283	$102,340	$4,057
South Dakota	$21,119	$19,438	$20,259	$821
Tennessee	$145,620	$200,235	$208,133	$7,898
Texas	$882,578	$891,518	$936,060	$44,542
Utah	$67,820	$62,494	$65,511	$3,017
Vermont	$6,934	$13,037	$13,551	$514
Virginia	$184,004	$186,576	$194,039	$7,463
Washington	$47,620	$96,942	$101,067	$4,125
West Virginia	$43,069	$48,276	$50,180	$1,904
Wisconsin	$107,215	$103,003	$107,066	$4,063
Wyoming	$10,443	$10,764	$11,188	$424
Subtotal	$8,860,459	$8,799,945	$9,161,572	$361,627
Commonwealths and Territories				
American Samoa	$1,253	$1,302	$1,353	$51
Guam	$4,360	$4,532	$4,711	$179
N. Mariana Islands	$899	$934	$971	$37
Puerto Rico	$103,911	$132,660	$137,892	$5,232
Virgin Islands	$0	$0	$0	$0
Subtotal	$110,423	$139,428	$144,927	$5,499
TOTAL	$8,970,882	$8,939,373	$9,306,499	$367,126

Note: Obligations remain available for Federal payments for two years.

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State Grants and Demonstrations

(Budget Authority Dollars in Thousands)

Program	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$0	$0	$0	$0
Subtotal – TWWIIA	**$0**	**$0**	**$0**	**$0**
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Alternatives to Psychiatric Residential Treatment Facilities for Children	$0	$0	$0	$0
Money Follows the Person (MFP) Demonstration[1]	$448,900	$448,900	$448,900	$0
MFP Research & Evaluations[2]	$1,100	$1,100	$1,100	$0
Medicaid Transformation Grants	$0	$0	$0	$0
Medicaid Integrity Program[3]	$78,334	$80,214	$81,899	$1,685
Subtotal – DRA	**$528,334**	**$530,214**	**$531,899**	**$1,685**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment[4]	$0	$0	$0	$0
Application of Prospective Payment System	$0	$0	$0	$0
Subtotal – CHIPRA	**$0**	**$0**	**$0**	**$0**
Affordable Care Act				
Medicaid Emergency Psychiatric Demonstration Project	$0	$0	$0	$0
Medicaid Incentives for Prevention of Chronic Diseases	$0	$0	$0	$0
Subtotal – Affordable Care Act	**$0**	**$0**	**$0**	**$0**
Appropriations/BA	**$528,334**	**$530,214**	**$531,899**	**$1,685**

[1] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012.
[2] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012.
[3] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U.
[4] P.L. 111-148 extended the availability of these funds through FY 2015.

Authorizing Legislation - Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170; Medicare Modernization Act of 2003, Public Law 108-173; Deficit Reduction Act of 2005, Public Law 109-171; Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3; Affordable Care Act, Public Law 111-148 together with Public Law 111-152

Allocation Method - Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The grants assist in providing State-infrastructure support and services to targeted populations. Targeted populations include working individuals with disabilities, undocumented aliens, and other eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight to combat fraud, waste and abuse, improving the effectiveness and efficiency in providing Medicaid, establishing alternate non-emergency service providers, and modernizing Medicaid programs to be more sustainable while helping individuals achieve independence. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two new programs: an outreach grant program to increase children's enrollment and retention in Medicaid and the Children's Health Insurance Program (CHIP), and transition grants for the application of the Medicaid prospective payment system for services provided by Federally-qualified health centers and rural health clinics. The Affordable Care Act established two new programs, the Medicaid Emergency Psychiatric Demonstration Project and Incentives for Prevention of Chronic Diseases in Medicaid and extended existing programs.

Funding History

FY 2009	$632,763,000
FY 2010	$621,763,000
FY 2011	$807,816,000
FY 2012	$528,334,000
FY 2013	$530,214,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration programs, determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT GRANT PROGRAMS

Program Description and Accomplishments

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA - P.L. 106-170) established two grant programs starting in FY 2001: the Medicaid Infrastructure Grants and the Demonstration to Maintain Independence and Employment (DMIE). By statute, funding for new grant awards for the DMIE program ended on September 30, 2009.

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants (MIG), section 203 of the TWWIIA, provides funding to States to build the infrastructure necessary to support working individuals with disabilities. These infrastructures include:

- Increased outreach on Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs on Medicaid and other work incentives.

A major goal of the program is to support the expansion of Medicaid coverage for workers with disabilities (also known as “Medicaid buy-in”). With this infrastructure funding, States make systemic changes to help individuals with disabilities gain employment and retain their health care coverage. These changes include, but are not limited to, creating Medicaid buy-in programs and enhancing State personal assistance service programs.

Through FY 2010, a total of 50 entities (49 States and the District of Columbia) had been approved for Medicaid Infrastructure Grants. Thirty-seven of these States had created Medicaid buy-in programs for working adults with disabilities. As of December 2010, there were approximately 150,000 workers receiving Medicaid benefits under the buy-in options. A total of 18 States applied for and received 2011 MIG continuation grant awards. Twenty-five States and the District of Columbia received new 2011 MIG competitive grant awards. FY 2011 marked the final year for this program.

Budget Overview

The Medicaid Infrastructure Grant Program (section 203) was authorized for 11 years beginning in fiscal year 2001 with an appropriation of $150,000,000 for the first 5 years. Beginning in FY 2006, the funding level is tied to the consumer price index for all urban consumers (CPI-U). Of the $42.8 million appropriated for FY 2007, $35.6 million had been granted to the States as of July 30, 2007. Of the $44 million appropriated for FY 2008, $40.3 million had been granted to States. Of the $45 million appropriated in FY 2009, $64.5 million had been granted to States (which included $19.5 million in carryover funding from previous years). In FY 2010, section 203 of TWWIIA authorized and appropriated $46 million, $74.6 million was granted to States (which includes 28.6 million in carryover funding from previous years). In FY 2011, section 203 of TWWIIA authorized and appropriated $46.5 million for 100 percent Federally-funded Medicaid Infrastructure Grants to States. There is no new appropriation for this activity.

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Grant Awards*
Alabama	$3,625,000	$500,000	$500,000	$750,000
Alaska	$3,675,000	$750,000	$700,000	$750,000
Arizona	$500,000	$750,000	$750,000	$750,000
Arkansas	$1,544,950	$682,000	$745,116	$633,556
California	$10,099,274	$2,640,006	$4,028,900	$3,166,715
Colorado	$500,000	$0	$750,000	$743,328
Connecticut	$14,510,205	$4,631,665	$7,260,844	$5,666,161
DC	$3,400,860	$750,000	$750,000	$750,000
Delaware	$1,000,000	$0	$0	$0
Florida	$1,650,000	$750,000	$750,000	$750,000
Georgia	$1,125,000	$0	$0	$500,000
Hawaii	$2,000,000	$750,000	$750,000	$750,000
Idaho	$1,625,000	$500,000	$750,000	$750,000
Illinois	$3,725,001	$500,000	$500,000	$500,000
Indiana	$2,450,000	$750,000	$1,443,000	$1,443,000
Iowa	$5,533,450	$744,000	$750,000	$750,000
Kansas	$4,815,277	$750,000	$959,627	$1,139,136
Kentucky	$500,000	$0	$0	$0
Louisiana	$3,600,000	$750,000	$1,700,000	$900,000
Maine	$4,702,003	$750,000	$870,000	$750,000
Maryland	$2,525,440	$600,000	$750,000	$750,000
Massachusetts	$14,236,084	$5,600,409	$6,353,521	$4,993,868
Michigan	$2,262,000	$750,000	$1,320,000	$1,320,000
Minnesota	$14,256,400	$5,434,648	$6,089,210	$4,605,603
Mississippi	$500,000	$0	$0	$0
Missouri	$3,125,000	$0	$0	$0
Montana	$1,000,000	$750,000	$750,000	$750,000
Nebraska	$4,175,000	No-cost extension	$750,000	$750,000
Nevada	$4,175,000	$500,000	$750,000	$750,000
New Hampshire	$7,033,998	$1,480,863	$2,357,893	$2,033,304
New Jersey	$3,775,000	$500,000	$1,754,890	$1,482,451
New Mexico	$5,356,068	$1,592,000	$1,540,000	$1,500,000
New York	$1,811,689	$5,992,413	$5,992,413	$4,710,037
North Carolina	$2,349,339	$600,000	$600,000	$750,000
North Dakota	$359,177	$750,000	$750,000	$750,000
Ohio	$2,786,416	$500,000	$500,000	$653,500
Oklahoma	$1,045,053	$0	$0	$0
Oregon	$4,373,563	$750,000	$935,000	$1,500,000
Pennsylvania	$2,946,470	$5,327,141	$5,327,000	$4,187,133
Rhode Island	$3,625,000	$750,000	$750,000	$750,000
South Carolina	$1,799,647	$0	$0	$0
South Dakota	$3,500,000	$500,000	$581,289	$520,600
Texas	$1,500,000	$750,000	$750,000	$750,000
Utah	$4,225,000	$750,000	$750,000	$750,000
Vermont	$4,505,000	$750,000	$750,000	$750,000
Virginia	$3,500,000	$750,000	$750,000	$750,000
Washington	$3,100,000	$750,000	$750,000	$750,000
West Virginia	$3,625,000	$750,000	$750,000	$750,000
Wisconsin	$22,253,336	$9,881,187	$12,846,137	$7,635,582
Wyoming	$2,050,000	$750,000	$750,000	$750,000
TOTAL	**$202,355,700**	**$64,456,332**	**$79,904,840**	**$67,083,974**

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Program Description and Accomplishments

Authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA), Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, provides funding to hospitals, physicians, and ambulance suppliers for their un-reimbursed costs of furnishing emergency health services to undocumented and certain other aliens. Payment of Section 1011 funds is limited to services required by section 1867 of the Social Security Act (Emergency Medical Treatment and Labor Act (EMTALA))[5] and related services. Section 1011 provided $250 million per year during each of Federal fiscal years 2005 through 2008.

As of February 2013, Section 1011 provided funding to a total of 2,265 hospitals, 49,505 physicians, and 537 ambulance providers. Since inception of the program in May 2005 through February 2013, Section 1011 has disbursed $945.4 million in provider payments, in response to 1,431,271 payment requests.

Providers may seek reimbursement for emergency services provided to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa. Eligible hospitals include hospitals with EMTALA obligations (generally, Medicare-participating hospitals that have emergency departments), including critical access hospitals and Indian Health Service facilities, whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as described in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Eligible physicians include doctors of medicine, doctors of osteopathy, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, doctors of optometry, chiropractors or doctors of dental surgery. Eligible ambulance suppliers include State-licensed providers of ambulance services.

Budget Overview

Section 1011 of the MMA appropriated $250 million per year during each of FYs 2005 through 2008. Individual State allocations, for each year of appropriation, are based on data provided by the Department of Homeland Security (DHS). Two-thirds of total funds ($167 million) were allocated to all 50 States and the District of Columbia, based on their relative percentages of the estimated total number of undocumented aliens nationwide. The remaining one-third ($83 million) was allocated to the six States with the largest number of DHS undocumented alien apprehensions. Funds appropriated shall remain available until expended.

[5] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals participating in Medicare to medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those having an emergency condition, regardless of an individual's method of payment or insurance status.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Program Description and Accomplishments

Section 6043 of the DRA enacted Emergency Room Co-Payments for Non-Emergency Care. This provision added a new subsection 1916A(e) to the Social Security Act and provided funding in the amount of $50 million in Federal grant funds to States. This funding provides State options to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver. This provision also added a new subsection 1903(y) authorizing Federal grant funds for States to use for the establishment of alternative non-emergency service providers, or network of such providers. States were encouraged to apply for grant funds to implement projects that would create new primary care access points (such as additional evening and weekend hours or new primary care sites closely located to large hospitals), target chronic disease management and outreach to high-emergency department users, utilize mental health triage nurses, and use health information technology to streamline and support emergency department referrals to the beneficiaries' medical homes.

States may not use funds as the State's share of the Medicaid program costs or to supplement disproportionate share hospital (DSH) payments. Grant applicants are limited to the 51 State Medicaid agencies and the Medicaid agencies in the Federal territories.

Budget Overview

The DRA made available a total of $50,000,000 over four years (FY 2006-2009) for the establishment of alternate non-emergency service providers or networks of such providers to provide non-emergency care. CMS released one solicitation on August 15, 2007 available for all four years (FY 2006, FY 2007, FY 2008, and FY 2009). On April 17, 2008, Emergency Room Diversion Grants were awarded to 20 State Medicaid agencies, for a total of 29 projects (Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, and Washington). Priority was given to applicants targeting medically-underserved areas whose emergency department utilization rate for non-urgent issues exceeded the State average and to those States who proposed collaboration with local community hospitals. The grants help to align States with CMS efforts to avoid unnecessary emergency room visits through improved physician care and implementation of strategies to slow spending growth while maintaining and even improving access to coverage.

On April 13, 2010, all 20 grantees were granted a 12 month no-cost-extension to spend down their remaining grant funds and to complete their projects. The goal for the extension period was to provide the grantees additional experience delivering the full array of services within the program structure they have been developing. The grantees needed additional time to develop a sustainable base for emergency department diversion services. Grant extensions also increased improvement in beneficiary satisfaction in relationships and access to their primary care medical home. The grant extension allowed grantees to collect, measure, and evaluate behavior changes by trending Medicaid claims history before and after redirection management.

In FY 2011, a third no-cost-extension was requested and approved for North Carolina and Pennsylvania to spend-down their remaining unobligated funds totaling $1,032,600.00. For

both States, the grant ended on January 14, 2012. The final Progress Report for the State of North Carolina was submitted to CMS on September 30, 2011, and the State of Pennsylvania submitted their final Progress Report on April 11, 2012.

On March 21, 2012, CMS held a teleconference with grantees to discuss a CMS Draft Report on the results of the ER Diversion Grant program, based on final reports submitted by the States. Twenty-three grantees representing 13 of the 20 participating States took part in the in the teleconference. Attendees discussed with CMS various ER diversion strategies implemented during the performance period, including urban versus rural approaches. Towards the end of the teleconference, a grantee suggested—and all agreed—that CMS would design and provide a single page template for each of the 20 States to complete as a high level summary on the strategies, findings and sustainability of their individual grant programs. Three States: Colorado, Indiana, and Tennessee submitted additional report information or clarifications advocating a more positive review of their respective results in the summary report, which CMS agreed were pertinent to the final draft report.

CMS anticipates posting individual State summaries with the final ER Diversion report on Medicaid.gov by April 2013.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVE TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Program Description and Accomplishments

Over the last decade, psychiatric residential treatment facilities (PRTFs) have become the primary provider for children and youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities, States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to institutional care which would provide services that would enable children and youth to be diverted from institutionalization or transition out of PRTFs back to their homes and with their families.

Section 6063 of the DRA addressed this issue by authorizing up to ten States to develop demonstration programs that provide home and community-based waiver services to youth as alternatives to institutionalization in PRTFs. To participate in this demonstration, Medicaid eligible individuals must be 21 years of age or younger and require the need for a PRTF level of care as defined in the State's Medicaid State plan.

This demonstration program has been evaluated and has improve or maintain functional outcomes for children and youth participating in the demonstration. The common theme across all state grantees is that children and youth with the highest level of needs at baseline benefited the most from participating in the Demonstration waiver. These children showed the most improvement, across the most domains, and over the most follow-up periods. The demonstration was also cost effective. The savings have been consistent across all state grantees and through all waiver years, with waiver costs averaging less than 50 percent of the comparable institutional costs. These findings are quite positive and reflect the need for a more permanent format for HCBS mental health programs for

children and youth. A Report to Congress is due to be released in May 2013 which will contain additional details.

The ten participating States submitted a 5-year, web-based 1915(c) demonstration waiver application as the grant implementation plan. Nine States have approved 1915(c) demonstration waivers. While Florida was awarded a grant, due to budget cuts in the State, Florida rescinded their grant and their grant award was returned to the demonstration grant appropriation. All nine States with approved waivers have provided waiver services 3,875 children and youth as of September 30, 2011. It is estimated that approximately 6,000 children and youth will be served by the end of the demonstration.

The table below shows the total five year commitment for the grant awards funded in FY 2007-2011 by State.

Budget Overview

The DRA provided ten States with up to $218 million for a period of five years (appropriations through FY 2011) to develop demonstration programs. One million dollars of the project funding is made available for required interim and final evaluation reports.

CMS has made awards totaling $194 million to participating States for the demonstration project period less the rescission by Florida of $2.1 million, leaving a total awarded to States of over $191.9 million. CMS also awarded a contract for the national evaluation in April 2007 for $904,422 and a modification in the amount of $93,690 in FY 2008 totaling $998,112.

The DRA authorized and appropriated $37 million for FY 2008, $49 million in FY 2009, $53 million in FY 2010, and $57 million in FY 2011. CMS also provided grant funding matching the increased FMAP provided for in the American Reinvestment and Recovery Act (ARRA) of 2009 during the recovery period. States received their final supplemental funding award in September 2011 that covered the period October 1, 2011 through September 30, 2014. Funding provided in FY 2011 is available to serve children and youth in FY 2012 and claims for services provided in FY 2012 will require funding from the FY 2011 appropriation through FY 2014 (federal assistance is available for up to two years from the date of service for claims).

State	Total PRTF Appropriation	Original Program Funding Commitment	FY 07-11 Supplemental Awards
AK		$8,927,571	$7,165,217
IN		$25,139,967	$41,652,061
MT		$5,184,455	$8,848,070
MS		$56,603,183	$63,396,017
VA		$18,705,337	$5,580,920
KS		$17,978,247	$5,940,574
MD		$10,410,333	$30,441,069
SC		$22,808,864	$9,226,436
GA		$22,614,239	$19,708,997
Totals	**$218,000,000**	**$188,372,196**	**$191,959,361**

Some States received larger supplemental awards to serve additional children and youth as they amended their 1915(c) demonstration waiver unduplicated counts.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of Section 6071 of the DRA, as amended by Section 2403 of the Affordable Care Act, States now have new options to rebalance their long-term support programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve independence. Specifically, the MFP demonstration supports State efforts to:

- Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
- Transition individuals from institutions who want to live in the community.
- Implement a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

The demonstration provides for enhanced Federal Medical Assistance Percentage (FMAP) for 365 days for qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. Eligibility for participation in the demonstration was modified by the Affordable Care Act. Individuals must reside in a qualified institution for at least 90 days before they transition to the community, with the exception that any days an individual resides in an institution solely for the purpose of short-term rehabilitative services for which payment is limited under

Medicare are excluded. In addition, States must continue to provide community-based services after the 365 day demonstration period for as long as the individual needs community services and is Medicaid eligible.

The table on the following page shows all grant awards that were made in FY 2007-FY 2012. The Affordable Care Act amended the Deficit Reduction Act by extending MFP grant demonstration through FY 2016 and included $2.25 billion additional funding to allow continuation of existing demonstrations and participation by new States. A grant solicitation for non-participating States was released Feburary 8, 2012. Three states submitted applications on August 8, 2012 and CMS awarded three new grants totaling $7,956,443 on September 30, 2012. The additional 2012 grantees are: Alabama, Montana, and South Dakota.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.75 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. The provision appropriated $250 million for FY 2007, $300 million in FY 2008 and $350 million in FY 2009, $400 million in FY 2010, $450 million in each of fiscal years 2011 and 2012. Section 2403 of the Affordable Care Act of 2010 amends the Deficit Reduction Act providing $450 million in each fiscal year from 2012-2016, totaling an additional $2.25 billion. States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50 percent of the State share, capped at 90 percent. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and four additional fiscal years. This allows States to expend MFP funding awarded in FY 2016 through FY 2020.

CMS has also provided the grantees grant funding matching the increased FMAP provided for in the Recovery Act of 2009 for service claims for the allowable nine fiscal quarters and is reflected in the chart below.

Of the original DRA appropriation of $1.75 billion, $2.4 million was made available to carry out technical assistance and quality assurance activities and $1.1 million per year for evaluation and reporting to Congress. In addition, Section 2403 of the Affordable Care Act authorizes $1.1 million from each year's appropriation in FY 2012 through FY 2016 that may be used to carry out evaluation and a required report to Congress.

As of December 2012, CMS obligated $1,110,718,981 in grants to 45 States and the District of Columbia. Grantees have transitioned over 26,000 individuals as of January 2012. The 45 participating States and DC have proposed to transition an additional 47,550 individuals out of institutional settings through 2016. As grantees continue to make progress in implementing their projects, there continues to be additional opportunity to seek supplemental funding for program expansion.

Money Follows the Person Rebalancing Demonstration			
State Name	***Cumulative Award Total*** (FY2007 - FY2012)	***Budget Projections*** (FY2007 - FY2020)	***Total Project Funds*** (cumulative award plus budget projections)
Alabama	$3,949,097	$23,223,302	$27,172,399
Arkansas	$15,196,469	$10,641,818	$25,838,287
California	$41,595,564	$74,911,975	$116,507,539
Colorado	$2,243,424	$68,279,881	$70,523,305
Connecticut	$43,112,567	$149,775,260	$192,887,827
District of Columbia	$21,593,213	$85,151,488	$106,744,701
Delaware	$3,504,849	$5,702,762	$9,207,611
Florida	$4,203,999	$31,544,853	$35,748,852
Georgia	$49,113,901	$63,893,164	$113,007,065
Hawaii	$4,791,841	$10,436,627	$15,228,468
Idaho	$2,720,369	$6,738,574	$9,458,943
Iowa	$18,771,647	$27,455,106	$46,226,753
Illinois	$14,902,910	$61,592,254	$76,495,164
Indiana	$19,135,222	$39,294,760	$58,429,982
Kansas	$21,274,346	$29,742,026	$51,016,372
Kentucky	$46,582,264	$144,067,500	$190,649,764
Louisiana	$15,047,246	$40,754,008	$55,801,254
Maine	$2,026,949	$7,794,270	$9,821,219
Maryland	$66,840,544	$118,862,416	$185,702,960
Massachusetts	$26,001,872	$112,621,106	$138,622,978
Michigan	$29,267,149	$89,146,809	$118,413,958
Minnesota	$20,262,703	$173,990,885	$194,253,588
Mississippi	$4,705,517	$35,735,420	$40,440,937
Missouri	$26,275,983	$25,024,984	$51,300,967
Montana	$2,684,302	$1,306,478	$3,990,780
North Carolina	$11,889,656	$41,919,419	$53,809,075
North Dakota	$8,707,820	$24,407,191	$33,115,011
Nebraska	$8,979,536	$24,067,460	$33,046,996
Nevada	$2,628,084	$9,754,061	$12,382,145
New Hampshire	$7,159,772	$17,279,245	$24,439,017
New Jersey	$32,430,928	$18,358,603	$50,789,531
New Mexico*	$595,839	$0	$595,839
New York	$43,278,648	$87,371,208	$130,649,856
Ohio	$91,536,185	$179,531,102	$271,067,287
Oklahoma	$17,637,095	$21,781,385	$39,418,480
Oregon	$40,269,191	$50,730,455	$90,999,646

Money Follows the Person Rebalancing Demonstration			
State Name	***Cumulative Award Total*** (FY2007 - FY2012)	***Budget Projections*** (FY2007 - FY2020)	***Total Project Funds*** (cumulative award plus budget projections)
Pennsylvania	$28,425,121	$57,610,486	$86,035,607
Rhode Island	$3,617,749	$23,717,505	$27,335,254
South Carolina	$1,804,806	$3,963,690	$5,768,496
South Dakota	$1,323,044	$4,985,133	$6,308,177
Tennessee	$21,966,250	$117,266,863	$139,233,113
Texas	$175,848,250	$279,023,574	$454,871,824
Vermont	$3,139,867	$15,839,084	$18,978,951
Virginia	$25,978,265	$49,674,839	$75,653,104
Washington	$58,551,913	$104,475,425	$163,027,338
West Virginia	$1,832,168	$20,953,050	$22,785,218
Wisconsin	$17,314,847	$37,668,170	$54,983,017
Total	**$1,110,718,981**	**$2,628,065,674**	**$3,738,784,655**

NOTE: States may exceed their original request for funding by exceeding their benchmarks and transitioning additional participants into home and community-based services.
*New Mexico rescinded the grant in Jan 2012

MEDICAID TRANSFORMATION GRANTS

Program Description and Accomplishments

This program is authorized by Section 6081 of the DRA which added another subsection, 1903 (z) to title XIX of the Social Security Act. This section provided new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates through health information technology, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual Payment Error Rate Measurement program, implementing medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and developing methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Grantees must report on cost savings, use of the grant funds and any clinical improvements in beneficiary health status, as appropriate.

There is no requirement for State matching funds in order to receive payments for transformation grants.

Budget Overview

The DRA authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008. CMS released a State Medicaid Director Letter/Grant Solicitation to States on July 25, 2006. On January 25, 2007, CMS awarded 32 Medicaid Transformation Grants to 26 States totaling $97,040,144. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $52,959,856. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

The primary focus of these projects is for the States to adopt innovative methods to improve the effectiveness and efficiency in providing Medicaid through the development, implementation and the use of electronic health records (EHR), Health Information Exchanges (HIE), electronic clinical decision support tools, and e-prescribing programs in an effort to reduce healthcare costs and improve overall patient quality.

Table A and Table B on the following pages lists all of the Medicaid Transformation Grants awarded in the two rounds of applications.

Table A: FY 2007 Medicaid Transformation Grants, Round 1

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Alabama	Together for Quality - Health Information Systems (HIE/EHR)	$7,587,000	Health Information Technology
Arizona*	Medicaid Health Information Exchange and Utility Project	$11,749,500	Health Information Technology
Arkansas	Electronic Verification of Proof of Citizenship	$285,513	Fraud, Waste & Abuse
Connecticut	Health Information Exchange and e-Prescribing	$5,000,000	Quality & Health Outcomes
District of Columbia	Comprehensive Medicaid Integration (HIE/EHR)	$9,864,000	Health Information Technology Quality & Health Outcomes
Florida	GenRx Expansion (e-Prescribing)	$1,737,861	E-Prescribing
Hawaii*	Open Vista ASP Network (HIE/EHR)	$3,188,535	Health Information Technology Quality & Health Outcomes
Illinois	Predictive Modeling System	$4,849,200	Quality & Health Outcomes Fraud, Waste & Abuse

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Indiana*	Medicaid Estate Recovery Centralization and Automation Project	$124,880	Health Information Technology Medicaid Estate Recovery
Kansas	Using Predictive Modeling Technology to improve Preventive Health Care in the Disabled Medicaid Population	$906,664	Quality & Health Outcomes
Kentucky	Health Information Partnership (HIE/EHR)	$4,987,583	Health Information Technology
Maryland	Automated Fraud and Abuse Tracking	$576,228	Fraud, Waste & Abuse
Massachusetts	Secure Verification of Citizenship through Automation of Vital Records	$3,950,440	Citizenship
Michigan	One Source Credentialing	$5,208,759	Quality & Health Outcomes
Michigan	Expansion of Vital Records Automation and Integration into Medicaid	$3,929,317	Citizenship
Minnesota	Communication and Accountability for Primary Care Systems (HIE/EHR)	$2,843,340	Quality & Health Outcomes
Mississippi*	As One - Together for Health (HIE/EHR)	$1,688,000	Health Information Technology
Montana*	Enhancing EHR - Clinical Decision Making	$1,481,152	Quality & Health Outcomes
New Jersey	Medical Information for Children (HIE/EHR)	$1,516,900	Health Information Technology
New Mexico	e-Prescribing	$855,220	e-Prescribing
New Mexico	Electronic Health Record Project	$712,301	Health Information Technology
North Dakota	Web-based Electronic Pharmacy Claim Submission Interface	$75,000	e-Prescribing
Rhode Island*	IT Infrastructure Transformation	$725,253	Fraud, Waste & Abuse
Tennessee	E-Prescription Pilot Project	$674,204	e-Prescribing
Texas	Electronic Health Passport for Foster Care	$4,000,000	Health Information Technology
Utah	Developing a Pharmacotherapy Risk Management System with an Electronic Surveillance Tool	$2,881,662	Risk Management
West Virginia	Healthier Medicaid Members through Personal Responsibility	$917,560	Quality & Health Outcomes
West Virginia	Healthier Medicaid Members through a Stronger Medicaid Program	$1,731,680	Health Information Technology
West Virginia	Healthier Medicaid Members through Health Systems Improvement (HIE/EHR)	$3,895,730	Health Information Technology

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
West Virginia	Healthier Medicaid Members through Applied Technology	$1,766,280	Health Information Technology
West Virginia	Healthier Medicaid Members through Enhanced Medication Management	$4,287,110	Health Information Technology Quality & Health Outcomes
Wisconsin*	Health Information Exchange Initiative	$3,043,272	Health Information Technology
	Round 1Total Funding Awarded	$97,040,144	

*Received MT Grants in both Round 1 and Round 2

Table B: FY 2007 Medicaid Transformation Grants, Round 2

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Arizona*	Transparency - Value Driven Decision Support Tool Box	$4,411,300	Health Information Technology Quality & Health Outcomes
Arkansas	Touch: Telemedicine Outreach Utilizing Collaborative Health Care (Neonatal Outcomes)	$1,458,826	Quality & Health Outcomes
Delaware	Delaware e-Prescribing Pilot	$1,018,065	e-Prescribing
Georgia	Health Information Transparency Website	$3,929,855	Health Information Technology
Hawaii*	Enhanced Electronic Health Record and Information Exchange	$1,815,000	Health Information Technology
Indiana*	Health Information Exchange Services to Improve the Effectiveness and Efficiency in Providing Medical Assistance Under Medicaid	$1,294,689	Health Information Technology Quality & Health Outcomes
Mississippi*	A Healthy Mississippi - Moving Forward Enhancing Program Integrity	$1,750,700	Fraud, Waste & Abuse
Missouri	Web-Based Tool for Home and Community Based Services	$1,940,175	Health Information Technology Quality & Health Outcomes
Montana*	Improving Lien and Estate Recoveries	$601,126	Medicaid Estate Recovery
Nevada	Building Value Through a Nevada Medicaid Data Warehouse	$29,207	Health Information Technology
North Carolina	Neonatal Outcomes Improvement Project	$1,019,550	Quality & Health Outcomes
Ohio	Neonatal Outcomes Improvement Project	$2,154,948	Quality & Health Outcomes

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Oklahoma	Online Enrollment Process	$6,146,640	Health Information Technology
Oregon	The Health Record Bank of Oregon (HIE)	$5,500,093	Health Information Technology Quality & Health Outcomes
Pennsylvania	Implementing Predictive Modeling For High Risk Populations	$4,811,320	Risk Management
Puerto Rico	Reduction of Fraud and Abuse through Validation of Demographic and Socioeconomic Data with the Use of Electronic Data Exchanges	$4,267,231	Fraud, Waste & Abuse Health Information Technology
Rhode Island*	Medicaid Health Information Exchange Integration Initiative	$2,765,265	Health Information Technology Quality & Health Outcomes
Washington	Second Generation Fraud and Abuse Detection System	$5,948,000	Fraud, Waste & Abuse
Wisconsin*	Health Care Quality and Patient Safety - Value Driven Health Care Initiative	$2,097,866	Health Information Technology Quality & Health Outcomes
	Round 2 Total Funding Awarded	$52,959,856	
	Total 2007 Medicaid transformation Grant Awards	$150,000,000	

*Received MT Grants in both Round 1 and Round 2

In FY 2010, CMS approved 32 no-cost extensions through March 31, 2011 for 24 States to spend-down their remaining unobligated funds totaling $44,347,657 and to complete their projects. In FY 2011, a third no-cost-extension was requested and approved for the following States to spend-down their remaining unobligated funds totaling $3,434,245.20: Mississippi, Missouri, North Carolina and Rhode Island.

In FY 2012, the State of Mississippi requested and received approval for a fourth no-cost-extension for 12 months for the FY 2007 Medicaid Transformation Grant, “A Healthy Mississippi – Moving Forward Enhancing Program Integrity”. This extension request covers the period of April 1, 2012 through March 31, 2013 for the expenditure of approximately $606,000 of unobligated funds remaining in this grant. The purpose of this extension is to allow the State of Mississippi the time and means to perform a thorough eligibility review, a program integrity evaluation, and allow sufficient time to complete a comprehensive final report.

As of February 2013 all Medicaid transformation grants have been closed with the exception of Mississippi. CMS is waiting for final reports from Alabama, Delaware, District of Columbia, Mississippi, New Mexico, North Carolina, Rhode Island, and Utah.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, Section 6034 of the DRA (P.L. 109-171) established the Medicaid Integrity Program in Section 1936 of the Social Security Act (SSA). With the passage of this legislation, Congress provided CMS with increased resources to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program. The Medicaid Integrity Program represents CMS' first national strategy to detect and prevent Medicaid fraud, waste, and abuse, but other Medicaid program integrity activities are funded out of the Health Care Fraud and Abuse Control Program (HCFAC) and are discussed in the HCFAC chapter of this document.

The DRA provided CMS with the authority to hire 100 full-time equivalent employees to provide support to states. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste, and abuse beginning in FY 2006. The first CMIP was published in July 2006, and covered FYs 2006 to 2010. The most recent CMIP was released in June 2009 and covers FYs 2009-2013.

Congress mandated that CMS enter into contractual agreements with eligible entities to do the following:
Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
Audit claims, including cost reports, consulting contracts, and risk contracts;
Identify overpayments; and
Conduct education of State or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

The contractors that perform these functions are known as Medicaid Integrity Contractors (MICs). In December 2007, CMS awarded umbrella contracts for both the Review MICs and Audit MICs. The contractors began conducting provider reviews and audits in September 2008. In collaboration with the United States Department of Justice, CMS also established the Medicaid Integrity Institute to provide state employees with a comprehensive program of course work encompassing numerous aspects of Medicaid program integrity.

The Medicaid Integrity Program has achieved a number of clear successes since the start of the program in 2006. The Medicaid Integrity Institute (MII) has repeatedly been praised by states, Congress, the Government Accountability Office (GAO), and Medicaid and CHIP Payment and Access Commission (MACPAC) as making a substantial contribution to state efforts to combat fraud and improper payments. The MII has trained 3,383 state employees from all 50 states through 82 courses from its inception in 2008 through the end of FY 2012, with 919 state staff participating in 19 courses in FY 2012 alone. Former students have reported $31 million in cost avoidance and identified overpayments as the direct result of training received at the MII. In FY 2013, CMS will enhance the educational opportunities provided through MII by expanding course offerings, providing distance learning through monthly webinars to train even more state program integrity staff, and issuing the first Certified Program Integrity Professional designation for state program integrity staff who successfully complete certification requirements. In addition, MII supports a secure, web-based information sharing system that all states use to exchange documents, questions

and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance.

Since 2007, the Medicaid Integrity Group (MIG), which runs the Medicaid Integrity Program, has conducted triennial comprehensive state program integrity reviews, which assess each state's Medicaid program integrity vulnerabilities and best practices. The MIG has reviewed every state (including Puerto Rico and the District of Columbia) at least once, with 44 states having been reviewed twice. Comprehensive reviews were conducted for 18 states in FY 2012, and the MIG expects to conduct 14 state program integrity reviews in FY 2013 as part of its transition to a quadrennial review cycle. The MIG will also implement a new review system to make the reviews more empirical, more likely to identify opportunities for technical support, and less burdensome on the states. The MIG hosted conference calls to discuss program integrity issues and best practices, issued guidance on policy/regulatory issues, and published annual reports of program integrity best practices that have been of considerable value to states.

The Medicaid Integrity Program provides additional support to states through technical assistance from MIG staff and the activities of Education MICs. For example, the MIG has provided personnel and other resources to serve as "boots on the ground" to carry out targeted antifraud actions in cooperation with state Medicaid staff. The MIG also assists in the education of providers and beneficiaries on program integrity efforts by employing Education MICs to develop materials, conduct training, and encourage Medicaid beneficiaries to report fraud, waste, abuse, and criminal activities.

The State Program Integrity Assessment (SPIA) is an annual activity to collect State Medicaid program integrity data, develop profiles for each state based on those data, determine areas to provide states with technical support and assistance, and develop measures to assess states' performance in an ongoing manner. Through SPIA, states and CMS are able to gauge their collective progress in improving the overall integrity of the Medicaid program. For FY 2012, MIG conducted SPIA data collection covering FY 2010 data. For FY 2013, MIG is redesigning SPIA data collection to address concerns, raised by the GAO, which led to the suspension of the data collection in FY 2013 (for FY 2011 data). The redesign will develop and test a design that reduces duplication of data collection with other CMS reporting mechanisms, reduces the reporting burden on the states, eliminates the time lag in reporting SPIA data, and institutes more rigorous validation of data to prevent the reporting of erroneous information.

One major area has not been as successful as anticipated: the National Medicaid Audit Program (NMAP). In early 2010, CMS determined through internal analysis, environmental assessments, parallel discussions with stakeholders, and reviews of contractor performance that the initial auditing model of the Medicaid Integrity Program required fundamental changes in how it conducts its work in order to effectively support states in their efforts to combat fraud, waste, and abuse in their Medicaid programs. As a result, over the course of the past two years, CMS has made changes in the NMAP and initiated a redesign of the Medicaid Integrity Program. The redesign plan for the Medicaid Integrity Program will recognize the increasing penetration of Medicaid managed care, anticipated growth in enrollment in the Medicaid program, the influence of new State Medicaid Recovery Audit Contractors, as well as the need to eliminate redundant and inefficient practices.

An integral change in the redesign will be the new focus on collaborative auditing projects with the states. The new approach moves away from traditional stand-alone federal audits that relied on post-payment data intended largely for research purposes, and moved to using more timely claims data residing with each state's Medicaid Management Information System (MMIS). Collaborative audits have proven to be an effective way to coordinate federal and state audit efforts and resources to better meet states' needs, resulting in more timely and accurate audits. Since the earliest collaborative audits were assigned to the MICs in January 2010 through the end of FY 2012, the MIG developed 218 collaborative audits with 22 states that represent 60 percent of Medicaid spending. In FY 2012, collaborative audits identified an average overpayment of $254,000 versus an average of $143,000 for traditional audits. CMS expects to have collaborative projects with 30 states by the end of FY 2013, and will continue to work collaboratively with states to develop audits in FY 2014.

In parallel, CMS is reconfiguring how to best review and audit Medicaid providers through our contractors. This reconfiguration comprises expanding that review to include improved oversight of managed care entities, improved identification of audit targets like high-risk providers serving both Medicare and Medicaid beneficiaries, overhauling CMS' contractor structure, and enhanced support and assistance to states. The redesign approach also has significant dependencies on the Medicaid data strategy and information technology infrastructure in conjunction with the Center for Medicaid and CHIP Services.

Budget Overview

The DRA appropriated $5 million in FY 2006, $50 million in FYs 2007 and 2008 respectively, and $75 million in FY 2009 and each year thereafter for the Medicaid Integrity Program. Beginning in FY 2011, Section 1303(b)(3) of P.L. 111-152 adjusts this funding by the percentage increase in the CPI-U annually. The FY 2011 appropriation was $76.3 million, and the appropriation for FY 2012 is $78.3 million. The FY 2013 appropriation is $78.3 million with a current CPI-U adjustment of 2.5 percent bringing the total request to $80.3 million. The FY 2014 appropriation is $80.2 million with a CPI-U adjustment of 2.1 percent bringing the total request to $81.9 million. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

Section 201 of CHIPRA provided $100 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Affordable Care Act increased the appropriation to $140 million. These programs will conduct outreach and enrollment efforts designed to increase the enrollment and participation of children who are eligible for Medicaid or CHIP but not enrolled.

<u>Outreach and Enrollment Grants</u>

The grants are proposed to target geographical areas with high rates of eligible but unenrolled children, including children who reside in rural areas; or racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment.

Of the $100 million provided by section 201 of CHIPRA, $80 million was appropriated for the Outreach and Enrollment Grants. The first $40 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40 million in Federal funds across 41 States and the District of Columbia. On August 18, 2011 CMS awarded the remaining $40 million in grant funds to 39 grantees across 23 States. These grants, entitled CHIPRA Outreach and Enrollment Grants – Cycle II encouraged applicants to take a more systematic approach to outreach, enrollment and retention. Grantees are focusing on five specific areas that have been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

CMS expects to award a third round of Outreach and Enrollment Grants in June 2013 from the $32 million appropriated through the Affordable Care Act. These grants will build on the successes of the first two cycles of CHIPRA grants and then further promote outreach and enrollment activities encouraged by the Affordable Care Act.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Outreach to Indian Children

The authorizing statute for the program sets aside ten percent of appropriations to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible American Indian and Alaska Native children in Medicaid and CHIP. On April 15, 2010, CMS awarded 41 grants for a total of $9,902,105. CMS expects to award a second round of Outreach and Enrollment Grants to organizations serving Indian children in late 2013 from the $4 million appropriated through the Affordable Care Act. These grants will also build on the successes on the first round of grants for the outreach to Indian children but will further complement outreach and enrollment activities promoted by the Affordable Care Act.

National Enrollment Campaign

The statute set aside 10 percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. To date, the campaign has focused on a call to action and providing technical assistance to States, grantees, and other groups to help enroll more children in Medicaid and CHIP and keep them covered. The campaign, referred to as the, Connecting Kids to Coverage National Campaign, seeks to create opportunities for families to sign up their eligible children and motivate parents to enroll and renew their coverage. Additionally, the campaign is building a set of activities that can be easily replicated or adapted in multiple state and community settings by providing outreach guides and tool kits to support these efforts.

In addition to developing general campaign materials that can be used throughout the campaign, there are three waves of outreach to engage national, State and local partners to reach out to families with eligible children and teens: Winter Wave (February to March, 2013), Allergies and Asthma (April to May, 2013) and Back-to-School (July to August, 2013). The waves are designed to focus on enrollment and retention of coverage and are adaptable so that they can be used in a variety of settings. Each wave features events, collateral materials and earned media. The Back-to-School wave coincides with the debut of open enrollment for Exchanges and Medicaid expansion in October, 2013.

States with the largest number of uninsured, eligible children are targeted for Campaign activities in 2013. As a result, the following 10 markets in 6 states are targeted: California: Fresno and Riverside/San Bernardino; Florida: Orlando and Tampa; Georgia: Atlanta/Atlanta Suburbs; New York: Capital District (e.g., counties surrounding Albany); Ohio: Cincinnati and Youngstown; Texas: Dallas and Houston.

Activities to date have included a "Hoops for Health" 3-on-3 basketball tournament, Outreach and Enrollment Health Fair, Valentine's Day themed Family Fun Day, as well as other interactive events. Numerous events are planned throughout the 2013 campaign outreach period.

CMS continues to provide grantee and partner training activities, including technical assistance to States through a variety of strategies, including on-going Webinars and providing supplemental toolkit materials.

CMS is in the process of launching a Connecting Kids to Coverage National Campaign television and radio public service announcement with messaging framed around giving parents the peace of mind and security that comes from knowing they can find quality, affordable health coverage for their children. Core messages are aimed at educating families about the availability and affordability of health coverage, the valuable benefits offered (e.g., check-ups, hospital visits, emergency services, prescriptions, etc.) and how to get coverage.

Budget Overview

CHIPRA appropriated a total of $100 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the Affordable Care Act provided an additional $40 million in fiscal year 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, ten percent is set-aside for the national enrollment campaign and another ten percent is for Indian outreach. CMS awarded $40 million in FY 2009 for outreach grants and approximately $10 million in FY 2010 for general outreach to Indian children. CMS awarded an additional $40 million of the remaining grants funds on August 18, 2011. Work on the National Enrollment Campaign is on-going. The original contract, awarded in June 2009, ended in July 2012 and hada total contract value of $6.377 million. A total of $7.970 million will be used for campaign efforts between FY 2012 and 2015. CMS awarded a FY 2012 contract for $2.437 million in August 2012; this contract will build upon existing campaign efforts. The remaining funding combined with the ACA appropriation (approximately $5 million) will be applied to on-going efforts to enroll eligible children in FY13 and FY14. FY15 will be used as an administrative close down year.

APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Program Description and Accomplishments

Section 503 of CHIPRA establishes transition grants to States to apply in their CHIP programs the prospective payment system (PPS) established under section 1902(bb) of the Social Security Act to services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs). State CHIP programs that contract with FQHCs are required to

develop a prospective payment system or an alternative payment methodology (APM) agreed to by the FQHCs and RHCs to pay for these services provided to CHIP beneficiaries.

The CHIPRA transition grants will provide funding to States that operate a either a separate CHIP or combination CHIP (i.e., has both a separate CHIP and a Medicaid expansion) to assist them in transitioning to a PPS for the FQHC/RHC payments. The goals of this grant appropriation will be to assist States in applying the PPS requirements for this purpose as required by CHIPRA.

Budget Overview

The statute appropriated $5 million for fiscal year 2009. In June 2010, a total of five grants were awarded. However, one grantee declined the award. The four grantees in 2010 to 2011 were: California, Michigan, Colorado, and Pennsylvania, representing $1,934,345 of the appropriated funds. CMS released a second solicitation on January 11, 2012 for another round of these transition grants. On July 1, 2012, CMS awarded the second round of grants to three states: Montana ($500,000), Iowa ($200,000), and Pennsylvania ($426,170), for a combined total of $1,126,170 in grant funding. After all awards, a total of $1,939,485 still remains unawarded from the appropriation.

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Section 2707 of the Affordable Care Act authorizes a demonstration project where selected States may provide payment under the State Medicaid plan under Title XIX of the Social Security Act (SSA) to an institution for mental disease that is not publicly owned or operated and is subject to the requirements of section 1867 of the SSA for Medicaid beneficiaries aged 21 to 64 who require medical assistance to stabilize an emergency psychiatric medical condition, defined as expressions of suicidal or homicidal thoughts or gestures or is determined to be dangerous to themselves or others. The demonstration project shall be conducted for a period of three consecutive years. Each eligible State shall be paid an amount each quarter equal to the FMAP of expenditures in the quarter. An evaluation of the demonstration shall be conducted to determine the impact on Medicaid beneficiaries and the health and mental health service system.

On August 9, 2011, a solicitation to participate in the demonstration was distributed to all State Medicaid Directors. Application proposals from the States were received by October 14, 2011. CMS announced the final selection of eleven States and the District of Columbia on March 12, 2012. Participants in the Demonstration are: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, West Virginia and the District of Columbia.

Budget Overview

Section 2707 authorized and appropriated $75 million beginning in fiscal year 2011 to carry out this section. The funds appropriated for this demonstration are available until all funds are expended or until December 31, 2015.

MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES

Section 4108 of the Affordable Care Act authorizes CMS to provide grants to States to provide incentives to Medicaid beneficiaries who successfully participate, complete, and maintain healthy behaviors by meeting the specific targets of a comprehensive, evidence based, widely available, and easily accessible program designed to help individuals achieve one or more of the following:

1. Ceasing the use of tobacco products
2. Controlling or reducing their weight
3. Lowering their cholesterol
4. Lowering their blood pressure
5. Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

The Funding Opportunity Announcement (FOA) was released to States on February 23, 2011 and grants were awarded to New York, Texas, Hawaii, Minnesota, New Hampshire, California, Montana, Nevada, Wisconsin, and Connecticut on September 13, 2011. Funding for the second year of the grants was awarded for the period of September 13, 2012 through September 12, 2013. CMS awarded an implementation contract on September 26, 2011. The implementation contractor is responsible for providing technical assistance to grantees on implementation and operation of the program; monitoring implementation and providing reports to CMS on grantee progress; facilitating collaboration and learning among grantees; and supporting the Federal evaluation contractor's efforts to assess the outcomes of the program. The period of performance for this contract is from September 27, 2011 through September 26, 2016. The evaluation contract was awarded May 1, 2012. The period of performance for this contract is from May 1, 2012 through April 30, 2017.

Budget Overview

Section 4108 authorized and appropriated $100 million over a five-year period beginning calendar year 2011 to carry out this section. Amounts appropriated for this program shall remain available until expended.

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Affordable Insurance Exchange Grants

(dollars in thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Total Obligations	$1,655,000	$2,751,000	$1,343,000	-$1,408,000
Outlays	$167,000	$1,457,000	$2,061,000	+$604,000

Authorizing Legislation – Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)
Allocation Method – Direct Federal, Competitive Grant, and Co-operative Agreements

Program Description and Accomplishments

The Affordable Care Act (ACA) gives States the option of establishing a Health Insurance Exchange. These Exchanges must facilitate the purchase of qualified health plans (QHPs), provide for the establishment of a Small Business Health Options Program (SHOP) designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered through the SHOP, and meet other requirements specified in 1311(d) of the ACA and in the Exchange final rule (77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, and 157)). A Federally-facilitated Exchange (FFE) or State-Partnership Exchange (SPE) will operate in those States that elect not to pursue a State-based Exchange (SBE).

Exchanges will provide millions of Americans and small businesses access to affordable health insurance coverage. By January 1, 2014, Exchanges will help individuals and small employers better understand their insurance options, and assist them to shop for, select, and enroll in high-quality, competitively-priced private health insurance plans. The Exchanges will also facilitate receipt of tax credits to offset premium costs and cost-sharing assistance, as well as help eligible individuals enroll in other Federal or State insurance affordability programs. By providing one-stop shopping, Exchanges will make purchasing health insurance easy and understandable, giving individuals and small businesses access to increased options and greater control over their health insurance purchases.

Section 1311 of the ACA provides such sums as necessary to enable the Secretary to award grants to States to support their role in establishing Exchange. Grants may be awarded through December 31, 2014 for all Exchange models. Grant funds are available for permissible and approved Exchange establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment and start-up year. Funding can also be used to support States that wish to transition from a SPE or FFE to an SBE. States may continue to spend grant funding in 2015 and beyond. Territories that commit to establishing an Exchange may also receive grant funding.

CMS has used a phased approach to provide States with funding for implementing Exchanges. In 2010 and 2011, CMS awarded Exchange Planning Grants to 49 States and the District of Columbia. Exchange Planning grants assisted States with initial planning activities related to the implementation of the Exchanges in key areas, including background research, stakeholder involvement, governance, program integration, technical infrastructure and business operations. In 2011, CMS also awarded initial Exchange Grants (similar to planning) to four Territories that indicated intent to establish an Exchange.

In February 2011, CMS awarded Early Innovator funding to six States and one consortium of States to develop Exchange Information Technology (IT) systems that would serve as models for other States. This approach reduced the need for each State to “reinvent the wheel” and aided States in Exchange establishment by accelerating the development of Exchange IT systems. There are currently four Early

Innovator States (Maryland, Massachusetts, New York, and Oregon) that are actively participating in this process. Kansas, Oklahoma and Wisconsin are not active.

In 2011 and 2012, CMS awarded Exchange Establishment Grants to 34 States and the District of Columbia. These grants provided States with support for establishment of Exchange IT systems, outreach and education, necessary testing and improvement, as well as other activities related to the establishment of the Exchange. These additional activities include the development of major business processes such as plan management, eligibility and enrollment, and financial management.

States have used these monies to make demonstrable progress toward Exchange establishment. In January 2013, CMS conditionally-approved 17 States and the District of Columbia as SBEs. These States are: California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. Three States are conditionally approved as Partners: Arkansas, Delaware, and Illinois. In March, CMS conditionally-approved SPE in Iowa, Michigan, New Hampshire and West Virginia.

Funding History

The fiscal year obligations for each year are listed below. Section 1311(a) of the Affordable Care Act appropriated such sums as are necessary for the Secretary to award grants under this account.

FY 2010	$49,321,679
FY 2011	$478,373,712
FY 2012	$1,655,000,000
FY 2013	TBD

Budget Overview ($1.3 Billion)

Overall estimates of spending in the Exchange grant program have increased since the FY 2013 President's Budget, due to increased experience in establishing Exchanges at the State level. Programmatic decisions such as covering start-up year expenses and the Partnership Model proposed in the Exchange regulation (i.e., *Establishment of Exchanges and Qualified Health Plans [CMS-9989-P]*, July 2011), permitted additional numbers of States to participate in Exchange development.

States will use grant funding to undertake critical activities, including procuring contracts for IT systems development and consultancy services, and performing the necessary analysis to ensure the Exchanges are on-track to begin full operations by January 2014. Other examples of State activities:

- Developing, implementing, and testing of the IT infrastructure, including systems for:
    - Eligibility and premium tax credit determination;
    - Web portal design;
    - Data security and back-up systems;
    - Accounting and financial systems;
    - Interfaces with other partners such as State Medicaid agencies;
- Developing advertising, marketing, and outreach campaigns;
- Analyzing and implementing key policy and operational processes;
- Ensuring capabilities are in place to provide assistance to individuals and small businesses;
- Procuring vendor assistance to enroll individuals in plans, call centers, and financial systems;
- Finalizing eligibility and premium tax credit determination guidelines; and

- Hiring key executives, including chief information officer, chief financial officer, and chief executive officer to oversee operations and policy development.

The budget also funds CMS activities to support State establishment of Exchanges. These administrative costs include an estimated 63 full-time equivalent staff to serve as project officers, grants management staff, technical assistance teams and leadership to oversee State progress toward achieving milestones under their cooperative agreements. Funding will also be used for contracts to provide technical assistance to States on Exchange business functions (e.g., eligibility, plan management) and to help States use their grant funding to implement programmatic components that are in line with Federal policy.

Performance Measurement

State Affordable Insurance Exchanges are a keystone of the health insurance reform. CMS has a performance measure to track the agency's progress towards setting up the Exchange in every state. This measure supports the CMS strategic plan measure of increasing the proportion of residents with health insurance by ensuring that the millions of individuals estimated to gain access to insurance through Exchanges will have the ability to enroll for coverage that begins in 2014.

CMS funds States planning to establish Exchanges through a series of grant applications. A core performance measurement, as part of the Government Performance and Results Act of 1993 (GPRA), is that awards for qualifying applicants are made within 60 days of receipt of an application. Timely and accurate processing of these funding applications requires review of the State plan to ensure that the State is on track for certification, as well as review of the funding request to ensure that it is appropriate given the planned activities.

In addition, CMS tracks the performance of this program to ensure that funds are used for authorized purposes through information received from recipients of Cooperative Agreement funding. This information has included project status, implementation activities initiated, accomplishments, barriers, and lessons learned. Such performance includes submission of the State's progress toward the Exchange Activities in its Work Plan.

CMS monitors a State's progress towards setting up an Exchange through the Establishment Review process. The Establishment Review process is a three-part series of reviews (i.e., planning, design, and implementation) that align with the Blueprint for Approval of SBE and SPE. This review is focused around thirteen core areas of Exchange functionality. These core areas include legal authority and governance, consumer and stakeholder engagement and support, plan management, eligibility and enrollment, financial management, and SHOP. The Establishment reviews track progress towards completion of an Exchange build and incorporate all eight of the CMS Enterprise Life Cycle Stage gate reviews. Currently, CMS is monitoring progress towards implementation, which will culminate with the Implementation Review. Such reviews have been successful in ensuring ongoing support to States, providing technical assistance, and monitoring progress.

Please see Output and Outcomes table in Progress Operations narrative for additional information.

Grants Table

Affordable Insurance Exchange Grants (93.525) (ObliQations in thousands of dollars)			
State or Territory	FY 2012 Actual	FY2013 (estmated)	FY 2014 (estmated)
Alabama	8,772		
)\Iaska			
)\ri2ona	29,877		
Arkansas	26,461		
California	196,480	673,705	
Colorado	61,438		
Connecticut	108,900	2,141	
Delaware	3,400	8,537	
District of CoiLmbia	72,985		
Florida			
Georgi•			
Hawaii	76,256		
Idaho	20,377		
Illinois	32,861		
Indiana			
Iowa	34,377	6,845	
Kansas			
Kentucky	62,320	182,708	
Louisiana			
Maine			
Maryland	123,049		
Massachusetts	62,219	80,226	
Michigan	9,849	30,668	
Minnesota	68,675	39,326	
Mississippi			
Missouri			
Montana			
Nebraska	5,482		
Nevada	69,709		
New Hampshire		894	
New Jersey	7,897		
New Mexico	34,279		
New York	143,971	185,822	
North Carolina		73,961	
North Dakota			
Ohio Oklahoma			
Oregon			
Pennsylvania	8,878	238,263	
Rhode Island	33,832		
South Carolina	58,516	9,251	
South Dakota			
ennessee	5,880		
oxas Utah	8,110		
Vermont			
Virginia		1,000	
Washington	122.269	6,685	
West Virginia		4,320	
Wisconsin	127,852		
omng			
American Samoa			
Guam			
Northern Mariana Islands			
Puerto Rico			
Freely Aooociated States			
Virgin Islands			
India n Tribes			
Undistributed			
Total			
		∎ 1,153,480	[2] 1,292,000
	1,624,971	2,697,832	1,292,000

S500 or less or 0.005 percent or less.

' Exchange Grants are distributed based on state grart applications and reflect individual states' needs for establishing Exchanges. Current totals show grants awarded through February 2013.

Funding awards are based on applications therefore we cannot predict the award amount per

Pre-Existing Condition Insurance Plan Program

(Dollars in thousands)

	FY 2012 Enacted	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Budget Authority	-	-	-	-
Gross Outlays	$1,599,000	$2,355,000	$983,000	($1,372,000)
Offsetting Collections	($98,000)	($199,000)	($46,000)	$153,000
Total Net Outlays	$1,501,000	$2,156,000	$937,000	($1,219,000)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), Section 1101

Allocation Method – Contracts

Program Description and Accomplishments

In July 2010, the Secretary launched the Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to uninsured individuals who have been denied coverage by private insurance companies due to a pre-existing condition. The PCIP program will serve as a temporary bridge until the Affordable Insurance Exchanges become operational on January 1, 2014 and provide more options for individuals with pre-existing conditions. At that time, insurance companies will be barred from discriminating against Americans because of pre-existing conditions. The interim final rule implementing this program was published on July 30, 2010.

Funding for this unique, temporary Federal program is limited to $5 billion to pay claims and administrative costs that are in excess of the premiums collected from enrollees in the program. The Affordable Care Act provides the Secretary of HHS broad authority to manage program funding so that expenditures do not exceed the appropriated level, including explicit authority to stop taking enrollment applications. CMS obligates funding for each state-based entity that has contracted to operate PCIP, and separately for the Federally run PCIP. Per Section 1101 of the Affordable Care Act, CMS is required to establish oversight procedures, including appeals procedures and protections against fraud, waste, and abuse. CMS awarded a support services contract in FY 2012 to support these activities and efforts are currently underway to review compliance with contractual and regulatory requirements in the state-run and federally- run PCIP programs.

Eligibility and Benefits

An individual is eligible to enroll in a PCIP if he or she:

(1) Is a citizen or national of the United States or is lawfully present in the United States as determined in accordance with section 1411 of the Affordable Care Act;

(2) Has not been covered under creditable coverage, as defined in section

2701(c)(1) of the Public Health Service Act as of the date of enactment, during the six-month period prior to the date on which he or she is applying for coverage through the PCIP; and,

(3) Has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

Additionally, an individual must be a resident of a State that falls within the service area of a PCIP.

Individuals who enroll in a PCIP are entitled to limited out-of-pocket costs. A plan's average share of total allowable costs must be at least 65 percent and enrollee out-of- pocket expenses cannot exceed the amount available to individuals with a high deductible health plan linked to a health savings account (this amount is currently $6,250).

All PCIP programs cover a wide range of health benefits, including primary and specialty care, hospital care, diagnostic testing, prescription drugs, home health and hospice care, skilled nursing, preventative health, and maternity care. The benefits reflect services most commonly covered by existing State High Risk pools (based on a survey conducted by the National Association of State Comprehensive Health Insurance Plans (NASCHIP) in 2009). Premiums are capped at 100 percent of the standard individual market rate in the State. By law, premiums charged in the pool may vary only on the basis of age (by a factor not greater than four to one).

CMS announced the temporary suspension of enrollment in all PCIP programs on February 15, 2013. This step will reduce the rate of growth in program expenditures and strengthen PCIP's position to continue covering enrollees during 2013, after which individuals will be able to transfer to the new Affordable Insurance Marketplaces as of January 1, 2014.

State-administered PCIP Programs

HHS signed contracts with twenty-seven States to operate their own State PCIP programs. Many of these programs began accepting applicants on July 1, 2010. CMS is responsible for ensuring each State performs necessary functions to design, implement, and operate a PCIP program within the amounts obligated.

Federally-administered PCIP Program

For those States choosing not to operate their own PCIP program, HHS established the Federal PCIP program on July 1, 2010. The Federal PCIP program began operating in twenty- three States and the District of Columbia in October 2010. HHS entered into agreements with the U.S. Office of Personnel Management (OPM) and the U.S. Department of Agriculture's National Finance Center (NFC) to run the program. The Government Employees Health Association (GEHA) administers the health plan benefits for the Federal PCIP program.

Funding History

FY 2010	$5,000,000,000

Budget Overview

In FY 2014, CMS will continue paying claims and administrative costs (in excess of the premiums collected from enrollees in the program) at a diminishing rate, given that the program ends on December 31, 2013. Enrollees will also begin to transition to the Affordable Insurance Marketplaces as necessary during the first open enrollment period, beginning October 1, 2013, for coverage beginning January 1, 2014, when insurers will be barred from discriminating against Americans because of pre- existing conditions. CMS will continue to monitor and audit the State-administered PCIP programs, working with contractors to use anti-fraud detection methods related to providers and enrollees, similar to those employed in their commercial products. During FY 2014, CMS will also be closing out contracts and interagency agreements, continuing to pay claims for dates of service prior to December 31, 2013, and reconciling funds provided to both State-administered PCIP programs, OPM, NFC and GEHA once PCIP coverage ends in order to begin the close-out of the program.

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Early Retiree Reinsurance Program

(dollars in thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Budget Authority	-	-	-	-
Net Outlays	$1,926,000	$72,000	$23,000	(-$49,000)

Authorizing Legislation - PPACA, Section 1102

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Contract Application

Program Description and Accomplishments

The Early Retiree Reinsurance Program (ERRP) was created to address the gradual erosion over the last 20 years in the number of employers and other employment-related health plan sponsors providing health coverage to early retirees. Early retirees often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable and inaccessible. Additionally, rising health care costs have made it difficult for employers to provide high quality, affordable health insurance for workers and retirees while also remaining competitive in the global marketplace. The proportion of large employers offering retiree coverage has declined by half in just 20 years, dropping from 68 percent in 1988 to 26 percent in 2011. Health insurance premiums in the individual market for older Americans are over four times more expensive than they are for young adults and the deductible these enrollees pay is, on average, almost four times that for a typical employer-sponsored insurance plan.

ERRP provides needed financial help for employer-based plans to continue to provide valuable coverage and financial relief to plan participants. ERRP provides reimbursement to approved sponsors of certified plans providing health benefits to early retirees, their spouses, and surviving spouses and dependents equal to 80 percent of the actual cost of health expenses paid for an individual between a cost threshold (originally $15,000) and cost limit (originally $90,000). The cost threshold and cost limit are adjusted each year by linkage to the Medical Care Component of the Consumer Price Index. ERRP reimbursement can be used to reduce employer health care costs, provide premium relief to workers and families, or both. Analysis of data as of February 2012 from a voluntary survey of plan sponsors, who had received ERRP funds, indicates that over 19.1 million plan participants have already, or will have, benefitted from the ERRP program, either directly or indirectly as their plan sponsors apply the ERRP funds to offset the plan's increased costs, plan participants' costs, or both.

The Affordable Care Act appropriated $5 billion for this program. It became effective on June 1, 2010, pursuant to the interim final rule published on May 5, 2010.

In October 2010, sponsors with approved applications began to receive reinsurance payments. CMS approved applications from sponsors from all sectors of the economy and from all areas of the country. Sponsors of certified plans include entities such as businesses, schools and other educational institutions, religious groups, unions, and local governments, and non-profit organizations. In FY 2012, ERRP paid out all of the funds initially planned to go to participating plan sponsors and also initiated the overpayment collection process. Overpayment collection activities continued into FY 2013 and recovered funds were used to pay plan sponsors, in the order reimbursement requests were received. These operations will continue into early-mid FY 2014, pending the availability of recovered funds. Only reimbursement requests received prior to the program sunset date, January 1, 2014, may be considered for reimbursement.

Funding History

FY 2010	$5,000,000,000

Budget Overview ($23 million)

In FY 2014, CMS will continue its program integrity work to audit the claims submitted by plan sponsors. If ERRP recoups any funds from program integrity related work, ERRP will redistribute such funds as new reimbursements to sponsors with pending reimbursement requests (received prior to the program sunset date and in the order received). Other program operations will include system maintenance, technical support, responding to inquiries, and financial reporting. In addition, during FY 2014 ERRP will continue the program closeout activities (e.g., discontinuing certain operations, systems, and support contracts) initiated in FY 2013.

Consumer Operated and Oriented Plan Program and Consumer Operated and Oriented Plan Program Contingency Fund

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Appropriation (rescission)	-$400,000	-$2,278,545	-	$2,278,545
X0118 Account (10% Transferred to the X0524 Account)				
Net Outlays	$37,813	$253,833	$175,047	-$78,786
X0524 Account (10% Transferred from the X0118 Account)				
Net Outlays	-	$30,281	$55,036	$24,755
Total Outlays	$37,813	$284,114	$230,083	- $54,031

Authorizing Legislation - Patient Protection and Affordable Care Act (ACA), Public Law 111-148, Title I, section 1322, and Public Law 111-152.

Allocation Method – Direct Loans and Contracts

Appropriating Legislation: Patient Protection and Affordable Care Act, Public Law 111-148, Title I, section 1322, and Public Law 111-152. Amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10, Title VIII, section 1857, the Consolidated Appropriations Act, 2012, Public Law 112-74, Division F, Title V, section 524, and the American Taxpayer Relief Act of 2012, Public Law 112-240, Title VI, Subtitle C, section 644.

Program Description and Accomplishments

The Affordable Care Act required HHS to establish the Consumer-Operated and Oriented Plan (CO-OP) Program to foster the creation of CO-OPs that will offer non-profit qualified health plans in the individual and small group health insurance markets. The program provided Start-up loans (repayable in 5 years) for start-up costs and Solvency loans (repayable in 15 years) to meet State reserve and solvency requirements to support the development of CO-OPs. Priority for the award of loans was given to applicants that will offer Qualified Health Plans (QHPs) on a State-wide basis, use an integrated care model, and have significant private support. If no health insurance issuer applies within a State, the Secretary may use funds to encourage the establishment of qualified issuers within the State or the expansion of a qualified issuer from another State to the State with no applicants.

A 15-member GAO-appointed Federal Advisory Committee was established as required by statute for the purpose of making recommendations to the Secretary on program implementation. The Committee issued a final report to the Secretary with recommendations for establishing the program in April 2011. The CO-OP Program issued a final rule on governing the award of loans and the operation of the CO-OP program in December 2011.

Award of CO-OP Loans

CMS made Start-up and Solvency loans to 24 organizations operating in 24 states (AZ, CO, CT, IA, IL, KY, LA, MA, MD, ME, MI, MT,NE, NJ, NM, NY, NV, OH, OR, SC, TN, UT, VT, and WI) to encourage the establishment of member-operated, qualified non-profit health insurance issuers within each State. To solicit applications from organizations, the CO-OP Program published a Funding Opportunity Announcement in July 2011 (revised in December 2011). Applications were accepted on a quarterly basis, with the first round being received in October 2011, and with additional quarterly rounds through December 31, 2012.

The CO-OP Program contracted externally for expert objective reviews of the loan applications. The expert reviewers provided recommendations on awarding loans to the CMS Selection Committee, which made the final awards. CMS made initial loan awards in February 2012 and continued to accept applications and award loans in FY 2013. With the passage of the American Taxpayer Relief Act of 2012, CMS retains the ability and funding to assist and oversee the existing CO-OPs.

Loan Servicing and CO-OP Monitoring

CMS has begun disbursing Start-up and Solvency loan funds and established an infrastructure to support the awarding and monitoring of CO-OP funding. Start-up loan funds are disbursed in installments based on loan disbursement schedules that reflect the specific business plan of each CO-OP. Disbursements are contingent upon documented completion of key milestones in the business plan. Solvency loan funds are disbursed as needed to meet State licensing and solvency reserve requirements.

CO-OPs have made significant progress towards achieving their key milestones such as contracting with key vendors, establishing claims and enrollment systems, and building their provider networks. Several CO-OPs have achieved licensure or conditional licensure. In addition, CO-OPs are developing their applications for QHP certification in the Exchanges.

During FY 2013, CMS will continue to actively monitor the loan portfolio and support the development of the CO-OPs towards the goal of participating in the initial open enrollment of the Affordable Insurance Marketplaces. CO-OP monitoring includes regular calls with an Account Manager, financial reporting, audits, and increased oversight as required. In FY 2012, the CO-OP Program contracted with a vendor for the provision of technical assistance to CO-OPs. In September 2012, the CO-OP Program also began conducting site visits to provide technical assistance to CO-OPs.

Funding History

FY 2010	$6,000,000,000
FY 2011	-$2,200,000,000
FY 2012	-$400,000,000
FY 2013	-$2,278,544,723

The American Taxpayer Relief Act of 2012 rescinded $2.3 billion of the $3.4 billion appropriated for this program, leaving just $253 million in a contingency fund (x0524) for oversight and assistance to existing loan entities.

Unobligated Balance January 2, 2013	**$2,531,716,358.56**
90% Rescinded	**$2,278,544,722.70**
10% Transfer to Contingency Fund	**$253,171,635.86**

Budget Overview

FY 2014 Administrative Funding for CO-OP Program

The program will continue to require contract-funded technical assistance to program staff and CO-OPs as the CO-OPs build up enrollment in their health plans. Program efforts will also continue towards the development of internal IT systems to establish loan servicing systems and monitor performance. The program staff will provide program management, oversight of contractors, and ensure program integrity. Funding for program integrity allows CMS to adequately identify, prevent, and prosecute fraud, abuse and/or misuse of CO-OP funds. CMS will continue to support program integrity by monitoring activities of recipient organizations, collecting documentation, conducting site visits, and engaging vendors for audits. Based on the scale of loans for this program, CMS must ensure that loan recipients meet quality and performance standards, engage in proper use of Federal funds, and reinvest profits to the benefit of the members. The CO-OP loan program requires account management, program controls, and program integrity activities.

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Health Insurance Rate Review Grants

(dollars in thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate	FY 2014 +/- FY 2013
Budget Authority	-	-	-	-
Outlays	22,000	100,000	80,000	-20,000

Authorizing Legislation - PPACA, Section 1003, Section 2794 of the Public Health Service Act

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Application for Grants

Program Description and Accomplishments

In 2010, HHS established a $250 million program of multi-year grants to States, the District of Columbia, and the U.S. territories to enhance their health insurance rate review process. Per the Affordable Care Act, no State qualifying for a grant shall receive less than $1 million or more than $5 million for a single grant year. Each grant recipient will establish a process for annual review of "unreasonable" rate increases and provide the Secretary with information about trends in premium increases in health insurance coverage. The final rate review regulation promulgated in the spring of 2011 provides federal guidance on the definition of "unreasonable" rate increases, as well as guidance on the processes and justification that grantees must follow in reviewing rate increases. In fall 2011, this final rule was amended to clarify the rate review requirements that apply to health insurance plans sold through associations. Finally, a final rule was published in the winter of 2013 that amended the standards that apply to "Effective Rate Review" programs.

FY 2010

Cycle I grants for FY 2010 were awarded on August 9, 2010. $51 million was made available to States in FY 2010, for which 46 States applied and were awarded $1,000,000 each.
Grant funding for the first cycle of the Health Insurance Rate Review Grant Program is used to:

1. Enhance the current rate review process in the States;
2. Report data to the Secretary on premium trends; and,
3. Implement the optional provision to provide funding to data centers to assist collecting, analyzing, and sharing fee schedule data with the public and other partners. Grants limit funding for data centers to five percent of the total award.

FY 2011

In FY 2011, grant funding was reopened to the U.S. territories and CMS awarded each of the five U.S. territories a $1,000,000 Rate Review Grant Award. In August 2011, 28 States and the District of Columbia applied for and received a total of $109 million in Cycle II, Phase I grants. As in Cycle I, Cycle II grants will be used to further enhance a recipient's rate review process, building upon their accomplishments in Cycle I and working towards the continued improvement

of an "Effective Rate Review program" as outlined in federal regulation. The Cycle II grant funding opportunity provided States with multiple opportunities, or phases, to apply for funding.

In order to be eligible for and receive Cycle II funding, a State must demonstrate that it either: (i) already meets the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle II grant funds, it will have the resources to meet those criteria within the twelve month period following the receipt of the Notice of Grant Award. Further, a State will have to demonstrate in its quarterly reports that it is continuing to develop or enhance its effective rate review program.

In addition to a Baseline Grant Award, two additional segments of funds are also available under the Cycle II grants. "*Workload"* funds are available to States based on population and the number of health insurance issuers in the State. While the rate review regulations do not require that States have the authority or ability to disapprove rates in order to be considered a State with an Effective Rate Review program, the "*Performance"* funds are available to those States that have the authority to disapprove unreasonable rate increases. States with such authority may also have larger workloads and therefore have higher resource needs.

Some States will be eligible for and awarded both the "*Workload*" and the "*Performance*" funds.

FY 2012

Cycle II of the Rate Review Grants Program continued in Fiscal Year 2012, with Phase II. A total of $8 million was awarded to one State and three territories on September 21, 2012.

FY 2013

In fiscal year 2013, the Cycle II Funding Opportunity Announcement (FOA) was amended to establish a new funding opportunity. During the most recent application period, one state applied for and received a $2 million award. In addition, the amended FOA extended the project period for Cycle II Phase IV to two years. This lengthened project period will permit States to develop sustainable enhancements to their rate review programs. Finally, the amendment permitted previous Cycle II funding recipients to re-apply for Cycle II funding in Phase IV if they achieved specific financial milestones and could benefit from further financial support.

Funding History

FY 2010	$250,000,000

Budget Overview ($80 million)

CMS projects that $100 million will be outlayed in FY 2013 and an additional $80 million will be outlayed in FY 2014. The funding authorized in FY 2014 will continue to support the distribution of grants to States so that States, in collaboration with HHS, can expand upon the rate review activities initiated in the earlier phases of the grant program. Funding will be used by States, territories, and the District of Columbia to increase their capacity to review and analyze rate filings, publish rate filings, audit filers, educate consumers, and build infrastructure to enhance and improve rate review. The grant funding will increase transparency in the health insurance market and will discourage insurers from implementing unreasonable premium increases.

Center for Medicare and Medicaid Innovation

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Current Law	FY 2014 Estimate
BA	$0	$0	$0
Obligations	$780,506	$1,312,500	$1,412,400

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010, Section 3021

Allocation Method - Contracts, Cooperative Agreements, Grants

Program Description and Accomplishments

The Center for Medicare and Medicaid Innovation (Innovation Center), established by Section 3021 of the Affordable Care Act of 2010 (ACA), tests new payment and service delivery models to deliver better care, better health, and reduced costs through improvement to Medicare, Medicaid, and Children's Health Insurance Program (CHIP). The Secretary of Health and Human Services has statutory authority to expand successful Innovation Center models through rulemaking.

The Innovation Center is an integral part of the Centers for Medicare & Medicaid Services (CMS) efforts to transform itself from a claims payer in a fragmented care system into a health care partner in a more integrated health care environment, working collaboratively with the health care community toward continual improvement and better value for our health care dollars. The goal, as CMS envisions it, is a people-centered health care system where beneficiaries receive the right care in the right setting at the right time all the time—where health dollars are spent efficiently, thereby reducing significantly the rate of spending growth, and where clinical and delivery system "best practices" are diffused rapidly.

Since its official launch in November 2010, the Innovation Center has systematically consulted with a wide array of partners and stakeholders. The Innovation Center's strategy for engaging stakeholders includes extensive outreach including Open Door Forums, participation in conferences, and listening sessions with targeted groups. The Innovation Center also co-sponsored the first-ever Care Innovations Summit, bringing together leaders in health care innovation from across the country. In addition, the Innovation Center has developed a robust online presence by creating and maintaining a website at http://innovations.cms.gov/ and using a variety of communications platforms to provide information on Innovation Center activities and allow innovators to share their observations and ideas. To supplement these activities, the Innovation Center has collaborated with professional societies, news media, and other organizations to spread knowledge and to disseminate the improvements in payment and service delivery that have the potential to produce better health care and better health at lower cost.

All of these strategies for public engagement contribute to the Center's open, collaborative process for the development and selection of new models to test. Suggestions for new models can come from a range of sources, including unsolicited ideas received from the

public, responses to specific funding opportunities, and models recommended for consideration in the statute. The Innovation Center has used this input to launch a series of tests of new health care payment and service delivery models, while continuing to solicit new suggestions and proposals. The Innovation Center's portfolio of new models to test will continue to grow as compelling ideas surface and are developed.

This portfolio currently includes the following initiatives launched under Section 3021 authority, and will include funding information for each model program as it becomes available.

Partnership for Patients: CMS has dedicated up to $800million, including up to $500 million in Innovation Center funding, to test models to reduce hospital-acquired conditions and to reduce preventable readmissions through improved transitions in care. This public-private partnership supports the efforts of physicians, nurses and community-based organizations to make care safer and better coordinate patients' transitions from hospitals to other settings. Through 26 Hospital Engagement Networks, the Innovation Center supports the dissemination of proven methods for dramatically reducing both harm caused in hospitals and preventable hospital readmissions. To date, more than 8,400 organizations have joined the Partnership for Patients and pledged to support its goals, and over 3,700 hospitals are working to meet these goals. The partnership has the potential to save thousands of lives and reduce millions of preventable injuries and complications over the next three years. The Partnership for Patients has set two ambitious goals for all U.S. hospitals by the end of 2013: 1) reduce preventable all-cause harm by 40 percent, and 2) reduce hospital readmissions by 20 percent. In collaboration with the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and Office of the Assistant Secretary for Health, the Partnership for Patients is also helping achieve the HHS Agency Priority Goal to reduce central line-associated bloodstream infections and catheter-associated urinary tract infections. An important part of the Partnership is the Community-Based Care Transitions program, authorized by Section 3026 of the Affordable Care Act, which provides financial assistance to community-based organizations working closely with hospitals and other health care providers to improve transitions in care and reduce preventable rehospitalizations.

Health Care Innovation Awards: The Innovation Center is providing almost $900 million in funding to applicants to implement the most compelling new ideas to deliver better health, better care, and lower cost through improvement to people enrolled in Medicare, Medicaid, and CHIP, particularly those with the highest health care needs. The objectives of the Health Care Innovation Awards are to engage a broad set of innovation partners to identify and test new payment and service delivery models and to rapidly train and deploy a new workforce to meet the demands of our changing health care system. CMMI announced awards to 107 organizations in Spring 2012, covering all 50 states.

Pioneer Accountable Care Organizations (ACO): The Pioneer ACO model is designed to test the ability of health care providers to rapidly transition to a population-based model of care. Thirty-two provider organizations were selected for this model, which is intended to be complementary to the Medicare Shared Savings Program, and the first performance year began in January 2012.

Advance Payment ACO Model: The Advance Payment Model provides support to certain ACOs, such as physician-based and rural ACOs, that have the potential to deliver better care at lower costs but need access to seed capital in order to invest in care coordination

infrastructure. Designed for organizations participating in the Medicare Shared Savings Program (MSSP), the Advance Payment Model tests whether providing up-front payments to providers, to be repaid through the shared savings that participating ACOs earn, will increase participation in the Shared Savings Program, allow ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and increase the amount of Medicare savings. Thirty-five ACOs participating in MSSP have been selected for this model.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: This demonstration will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs, testing the impact that additional financial support has on FQHCs' ability to transform their practices into Patient-Centered Medical Homes (PCMHs). More specifically, the goal of the demonstration is for its participants to achieve NCQA Level 3 recognition as Patient Centered Medical Homes (PCMH). This entails a practice transformation process that strengthens both infrastructure, including information technology systems, and the quality of care; ultimately improving the health of the patients and the overall quality of care offered. In evaluating this model, the Innovation Center will consider the impact of cost and quality of care for Medicare beneficiaries. Currently, there are 491 FQHCs participating in this Demonstration, which includes a semi-annual assessment to demonstrate progress toward achieving NCQA recognition.

State Demonstrations to Integrate Care for Dual Eligible Individuals: The Innovation Center and the Medicare-Medicaid Coordination Office awarded design contracts to fifteen States to design new approaches to better coordinate care for Americans enrolled in both the Medicare and Medicaid programs – beneficiaries sometimes described as "dual eligibles." Based on the design proposals, these States are eligible for awards of additional implementation support funding via separate cooperative agreements. All approved State demonstrations will establish new methods of payment and care integration for Medicare and Medicaid's most vulnerable and most costly beneficiaries.

Financial Alignment Initiative: The Innovation Center, in collaboration with the CMS Medicare-Medicaid Coordination Office, is providing new opportunities for States to implement payment and service delivery reforms to better coordinate care for Medicare-Medicaid enrollees. Twenty-six states have submitted proposals to pursue one of two models: (1) a capitated managed care model or (2) a managed fee-for-service model. Implementation of financial alignment models will begin in 2013. As indicated above, the Innovation Center and the Medicare-Medicaid Coordination Office awarded design contracts to fifteen States to design new approaches to better coordinate care for this population, many of which are pursuing these models. As of March 27th, CMS has approved capitated models in Massachusetts, Ohio, Illinois, and California and a fee-for-service model in Washington.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: The Innovation Center, in collaboration with the Medicare-Medicaid Coordination Office, has launched a new demonstration focused on reducing preventable inpatient hospitalizations among residents of nursing facilities. CMS competitively selected seven independent organizations that, in partnership with CMS, will provide enhanced clinical services to people in approximately 150 nursing facilities. Participants were announced in fall of 2012, and the first sites began serving beneficiaries in February 2013.

Bundled Payments for Care Improvement: The Innovation Center will test four models of episode-based (bundled) Medicare payments. Under the current fee-for-service (FFS) system, separate FFS payments to numerous providers for a single episode of care may result in fragmentation of care and duplication of services. Payment models that provide a single bundled payment to providers for an entire episode of care, and that hold the same group of providers accountable for the cost, quality, and patient outcomes of that episode, may spur hospitals, physicians, and other providers to better coordinate care, improve quality of care, and reduce costs. CMS has developed four distinct models of bundling payments, varying by the types of health care providers involved and the services included in the bundle. In January 2013, CMS announced the participants in Model 1, which tests bundled payments for acute care hospital stays. Phase 1, a data and shared learning phase of the bundled payment models 2-4 was also launched in January 2013; Phase 2, in which providers will be at risk for providing discounts to Medicare, will be launched later in 2013.

Comprehensive Primary Care (CPC) initiative: This CMS-led, multi-payer initiative fosters collaboration between public and private payers to strengthen primary care. Health plans which cover only a small segment of a primary care practice's total patient population have historically struggled to provide enough resources to support the transformation of primary care practices in proving higher-quality, more coordinated care. The CPC initiative will attempt to break through this historical impasse by inviting payers to join together with Medicare to invest in primary care. Seven markets have been chosen for investments by CMS and 497 practices are participating in the Initiative, representing a total of 2,347 providers serving an estimated 315,000 Medicare fee-for-service beneficiaries.

Strong Start for Mothers and Newborns: The Innovation Center is pursuing two complementary strategies as part of a national initiative to improve birth outcomes. First, the Innovation Center partnered with providers and hospitals to improve perinatal safety by reducing early, elective deliveries prior to 39 weeks. Second, the Innovation Center is testing three models of enhanced prenatal care services for women enrolled in Medicaid or CHIP who are at high risk for having a preterm birth. Awardees were announced in February 2013.

State Innovation Models: The State Innovation Models initiative will support the development and testing of state-based models for multi-payer payment and delivery models that deliver high-quality health care and improve health system performance for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Awards were announced in February 2013.

Comprehensive End-Stage Renal Disease (ESRD) Care: The new Comprehensive ESRD Care initiative will test the effectiveness of a new payment and service delivery model for Medicare beneficiaries with ESRD. Through the initiative, CMS will enter into agreements with groups of health care providers and suppliers called ESRD Seamless Care Organizations who will work together to provide beneficiaries with a more patient-centered, coordinated care experience. Participating organizations must include at least a dialysis facility, a nephrologist, and one other Medicare provider or supplier. These participating organizations will assume clinical and financial responsibility for a group of beneficiaries with ESRD, and those organizations that are successful in improving beneficiary health outcomes and lowering the per capita cost of care for beneficiaries will have an opportunity to share in Medicare savings with CMS.

Innovation Advisors Program: Supporting individuals who can test, implement and refine new models to drive delivery system reform is a crucial component of transforming the health care system. In December 2011, CMS selected 73 individuals through a competitive process to become Innovation Advisors. These individuals support the Innovation Center's goals in a number of ways: utilizing their knowledge and skills in their home organization or area in order to improve health, improve care, and lower cost through continuous improvement; working with other local organizations or groups in driving delivery system reform; developing new ideas or innovations for possible testing of diffusion by the Innovation Center; and building durable skills in system improvement throughout their area or region.

Funding History (Budget Authority)

FY 2010	$5,000,000
FY 2011	$10,000,000,000
FY 2012	$0
FY 2013	$0

Section 3021, amending Section 1115A of the Social Security Act, provides $10 billion in budget authority for activities initiated in fiscal years 2011 through 2019, with not less than $25 million to be made available each year for the design, implementation, and evaluation of innovative payment and service delivery models.

Operational Activities

The process of model testing generally requires the following operational activities:

- Data Sharing
- Implementation assistance
- Learning & diffusion activities, including Advanced Development Learning Sessions;
- Payment administration and/or reconciliation
- Performance monitoring and evaluation

The appropriation also supports Innovation Center operational activities that are not specific to each model, including:

- Establishing and evaluating the effectiveness of learning systems that facilitate the testing of models and the rapid and widespread diffusion of best practices and validated service delivery and payment models;
- Harvesting best practice models and identifying need gaps for designing new innovations in care delivery improvement and sustainability;
- Assessment of planning, design, and business process requirements for an information systems environment;
- Project management support; and
- Operations management and oversight.

Finally, appropriated funding is used for routine administrative costs at the Innovation Center, including personnel and benefits.

Performance Measurement

The Center for Medicare and Medicaid Innovation was tasked with testing new payment and service delivery models to deliver better care, better health, and reduced cost through program improvement. During the development of models, the Innovation Center builds on the ideas received from stakeholders and consults with clinical and analytical experts, as well as with representatives of relevant Federal agencies.

CMMI1: Reduce the Growth of Health Care Costs while Promoting Better Health and Health care Quality through Delivery System Reform: Delivery system reform will potentially include a very broad array of interventions, but this measure will initially focus on Accountable Care Organizations (ACOs), which are groups of physicians, providers and suppliers that work together to coordinate care for beneficiaries with original Medicare fee-for-service health coverage. These ACOs enter into agreements with CMS, taking responsibility for the quality of care they provide to Medicare beneficiaries in return for the opportunity to share in savings realized through care improvement. For FY 2014, we will aim to increase the number of Medicare beneficiaries who have been aligned with ACOs and increase the number of physicians participating in ACOs. In addition, we will develop a baseline for a measure to increase the percentage of ACOs that share in savings. Data for this measure will be collected and aggregated across the following initiatives: Medicare Shared Savings Program, Pioneer ACO model, Advance Payment ACO model and the Physician Group Practice Transition demonstration. This measure represents efforts across CMS, not just CMMI, to promote better health and health care quality through delivery system reform. In the coming year, we will continue to identify additional performance measures to meaningfully highlight CMMI and other delivery system reform activities.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/- FY 2013 Target
CMMI1.1 Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations:	FY 2013 Baseline Available April 2013	N/A	TBD Target set when FY 2013 baseline is available	N/A
CMMI1.2 Increase the number of physicians participating in an Accountable Care	FY 2013 Baseline	N/A	TBD Target set when FY 2013 baseline is available	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/- FY 2013 Target
Organizations:	Available April 2013			
CMMI1.3 Increase the percentage of Accountable Care Organizations that share in savings	FY 2014 Baseline Available September 2014	N/A	Collect FY 2012 and FY 2013 data on savings and measures of quality to determine shared savings to develop baseline.	N/A

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Information Technology

(Dollars)

Funds Source	FY 2012 Enacted	FY 2013 Base	FY 2014 President's Budget	FY 2014 Request +/- FY 2012 Enacted
Program Operations	$ 1,002,966,000	$ 855,699,000	$ 1,034,570,000	$ 31,604,000
Federal Administration	46,616,000	32,229,000	32,656,000	(13,960,000)
Survey & Certification	3,614,000	1,925,000	1,984,000	(1,630,000)
Subtotal, Program Management Appropriation	**$ 1,053,196,000**	**$ 889,853,000**	**$ 1,069,210,000**	**$ 16,014,000**
Coordination of Benefits (COB) User Fee	$ 8,015,000	$ 7,074,790	$ 6,904,715	$ (1,110,285)
CLIA User Fees	4,500,000	4,750,000	4,400,000	(100,000)
ESRD Network	1,200,000	1,200,000	1,400,000	200,000
Program Integrity (MIP/HCFAC)	152,066,187	118,430,207	115,158,553	(36,907,634)
ARRA/Hitech	85,883,179	95,552,452	92,950,000	7,066,821
Quality Improvement Organizations 1/	200,474,058	189,265,789	195,957,444	(4,516,614)
Subtotal, Additional Funding Sources	**$ 452,138,424**	**$ 416,273,238**	**$ 416,770,712**	**$ (35,367,712)**
Total, CMS IT Portfolio	**$ 1,505,334,424**	**$ 1,306,126,238**	**$ 1,485,980,712**	**$ (19,353,712)**

1/ QIO estimates are currently being developed for the 10th scope of work

Program Description and Accomplishments

As shown in the table above, CMS's information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, and the HCFAC and QIO programs. IT activities support various programs that CMS oversees, including Medicare, Medicaid, CHIP, the Affordable Care Act provisions, Private Insurance Market and associated quality-assurance and program safeguards. This chapter provides an overview of IT activities funded and discussed in various other parts of this budget submission. Additional information can be found in those specific narratives. Further information on specific IT projects can be found within the Exhibit 53 and CMS Exhibit 300s, which can be viewed at:

http://www.itdashboard.gov/portfolios/agency=009,bureau=38

CMS Program Management Appropriation

CMS's IT investments support a broad range of business operational needs, as well as implementing provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. The following investments are organized similarly to the exhibit 300 portfolios, with an explanation of the type of investments in each.

Program Operations

IT Investment portfolios and activities include:

- *Beneficiary Enrollment and Plan Payment, and Beneficiary E-Services* includes the Medicare Advantage enrollment and plan payment systems such as the premium withhold system, risk adjustment system, and the Medicare Advantage Prescription Drug Payment System (MARx). Our public internet sites www.cms.hhs.gov, www.medicare.gov, and the virtual call center operations are also included.

- *Data Management Operations* supports the beneficiary enrollment database; Medicare beneficiary database suite of systems; and CMS enterprise data administration.

- *Claims Processing* operates and maintains the Medicare fee-for-service claims processing systems and the Common Working File (CWF), a major component of the Medicare claims adjudication function.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* includes development, operational, and maintenance costs for CMS's financial management system.

- *Modernized IT Infrastructure* includes Enterprise Data Centers (EDCs), providing a standardized infrastructure and network platform to process over 1 billion FFS claims.

- *Infrastructure* provides the IT business platforms for CMS and includes the Consolidated Information Technology Infrastructure Contract (CITIC), which maintains numerous Medicare program applications, CMS mid-tier and mainframe operations at the CMS data center; and ongoing systems security activities at Medicare contractors.

- *Claims Interoperability and Standards* provides for the continued standardization of certain electronic transactions required by HIPAA-enacted administrative simplification provisions.

- *Other Investments* includes:

  ICD-10 and Version 5010 **-** ICD-10 is the biggest change in American health care standard coding systems in over 30 years. As discussed in the Program Operations section of this budget submission, ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code. Also, in order to implement ICD-10, the current version of the HIPAA transactions was updated from version 4010 to 5010. Version 5010 accommodates the increased field space required for the ICD-10 code sets. The FY 2014 request also includes funds for HIPPA Version 3, which is the next iteration of the electronic data standards adopted by the secretary of HHS.

- *Authentication - Individuals Authorized Access to the CMS Computer Services (IACS)* - hardware and software services to control access to a growing number of web-based applications, while accommodating more users.

Federal Administration

The Federal Administration portion of the Program Management appropriation funds a variety of IT activities that support CMS's IT infrastructure and daily CMS operations, including:

- Voice and data telecommunication costs;
- Web-hosting and satellite services;
- Ongoing systems security activities across the CMS enterprise; and
- Systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

In addition, the service and supply fund activity within the Federal Administration line item includes CMS' share of costs for HHS enterprise activities, including payroll and email services.

Survey and Certification

The Survey and Certification line item in CMS' Program Management budget provides IT funding primarily for operation and maintenance of systems that approximately 6,500 State surveyors use to track and report the results of healthcare facility surveys. The FY 2014 request supports the continued implementation of the Quality Indicator Survey (QIS), an initiative that will utilize information technology to support quality improvements in the survey process.

Additional IT Funding Sources

Part D Coordination of Benefits (COB) and CLIA User Fees

A portion of the COB user fees will be used to fund Part D systems. CLIA user fees are collected to fund the Information Technology portion of the CLIA program.

End Stage Renal Disease (ESRD) network

With the passage of the Medicare Improvements for Patients and Providers Act of 2008, CMS has launched the first End Stage Renal Disease Pay-for-Performance Program. Section 153 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the establishment of a quality incentive payment program for ESRD providers, effective January 1, 2012. A portion of IT funding will support this activity.

Program Integrity (HCFAC/MIP)

IT funding from the Medicare Integrity Program (MIP) budget within the HCFAC account pays for a portion of CWF operating costs, as well as the ongoing operations and

maintenance of systems related to audit tracking, Medicare secondary payer work, medical review, and other benefit integrity activities. Examples of MIP-funded systems include the fraud investigation database and the Medicare exclusion database. This funding also includes MIP- Discretionary systems costs and the One-PI system.

Quality Improvement Organizations

IT activities funded from the QIO program budget include the QIO Standard Data Processing System (SDPS), the Quality Improvement & Evaluation System (QIES), and QIO-related operations at the CMS data center and other sites.

Budget Request

CMS Program Management Appropriation

The FY 2014 level for Program Management Information Technology is $1.06 billion. This request is a $16 million increase from the FY 2012 Enacted level. The demand on the CMS IT portfolio continues to grow with the enactment of the Affordable Care Act and the implementation of the private insurance market. The Program Operations line within Program Management will fund extensive systems changes, enhancements and development of new systems for these new program areas. These changes include hardware/software purchases, enhanced network connectivity, and new reporting features. These funds will also support data extraction, validation of business and system needs, website redesigns, system and security documentation and additional capacity for storage.

Additionally, these funds will also support the development of shared services. In FY 2014, CMS will continue to implement the Agency's and Department's approach to shared services. Shared IT services include common IT applications and infrastructure technologies that deliver specific capabilities to multiple business units. Shared services are reusable and scalable while reducing costs, redundancies and required governance.

The shared service strategy will reduce costs associated with development of duplicative capabilities. It will increase reliability and promote better government practices that will be measured rigorously through performance and earned value management.

There are four shared services strategies being implemented:

Master Data Management (MDM) - MDM comprises processes, policies, and tools that consistently define master data. MDM links and aggregates beneficiary, provider, program, and organization data from multiple disparate sources across the agency creating a trusted authoritative data source.

Enterprise Identity Management (EIDM) - EIDM provides remote identity proofing (confirming persons are who they say they are) via a single sign-on, while meeting federal security requirements.

Enterprise Portal - The Enterprise Portal provides a framework for integrating information and processes onto a single platform and entry point for beneficiaries, providers, organizations, and States to receive CMS information, products, and services.

Business Rules Enterprise Services (BRES) - Business rules describe the operations, definitions and constraints that apply to CMS systems enterprise-wide.

In addition, the Program Operations funds will provide for IT needs related to insurance market oversight and Affordable Insurance Exchanges. These funds will specifically support tools for consumer support, infrastructure investments, an enrollment system for exchanges, a data collection system for insurance and market oversight, and data reporting tools for Medical Loss Ratio oversight.

The Program Management IT Portfolio supports numerous investments, mostly through program operations. Some of the larger investments in program management are Enterprise Identity Management, Healthcare Integrated General Ledger (HIGLAS), Health Information Technology for Economic & Clinical Health (HITECH), Information management, HIPPA Claims based transaction/ICD-10, Master Data Management and Infrastructure (ongoing operations and data center management). The larger investments represent about 70 percent of the total program operations spending. Some of the other investments are Part A claims processing, Coordination of Benefits, Disaster Recovery, Physician Feedback Program, Drug and Durable Medical Equipment claims.

The Program Management IT also supports funding in Federal Administration to accommodate workloads triggered by the Affordable Care Act and information technology related to the administration of operations within CMS.

CMS is also committed to developing an IT reduction plan according to the FY 2014 IT Budget Reduction and Reinvestment Initiative. We look forward to working with the Office of Management and Budget in an effort to maximize operational efficiency and cost effectiveness.

Additional Sources of IT Funding for CMS Programs

The HCFAC and the QIO programs are funded primarily with mandatory dollars and operate on separate budget cycles from CMS's discretionary Program Management appropriation. The FY 2014 estimates for mandatory accounts will be refined as CMS proceeds through the budget cycle.

The other areas of IT spending are estimates and are subject to change as CMS continues the Information Technology Investment Review Board (ITIRB) process.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Resource Summary

	Budget Outlay Estimates ($ in Millions)		
	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate
Drug Resources by Decision Unit and Function:			
Medicaid Treatment	$ 2,600	$ 2,800	$ 3,700
Medicare Treatment	900	920	970
Total	$ 3,500	$ 3,720	$ 4,670
Drug Resources by Decision Unit:			
Centers for Medicare & Medicaid Services			
Total	$ 3,500	$ 3,720	$ 4,670
Drug Resources Personnel Summary			
Total FTEs (direct only)	0	0	0
Drug Resources as a Percent of Budget			
Total Agency Budget (in Billions)	$810	TBD	TBD
Drug Resources Percentage	0.4	TBD	TBD

Program Summary

Mission

The Centers for Medicare & Medicaid Services' (CMS) envisions itself as a major force and trustworthy partner for the continual improvement of health and healthcare for all Americans.

Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of ONDCP by continuing to meet the challenges of providing drug abuse treatment care benefit payments to eligible beneficiaries.

ONDCP and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) co-sponsored recently completed research to determine what the total Federal drug treatment outlays under Medicaid were in CY 2008, and what those estimates could tell us about equivalent spending in FY 2011. The estimates displayed in the resource table were developed by the CMS Office of the Actuary (OACT) based on the research results.

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2014 CMS budget submission to the Congressional Appropriations Committees includes a budget decision unit (Resource Summary table).

However, because CMS has not been tasked with a drug control initiative for which budgetary resources are sought from the Congress, our resource summary reflects outlay estimates.

Methodology

Medicaid Estimate

These projections were based on the estimates in "Medicaid Substance Abuse Treatment Spending: Findings Report"1, which was written at the request of ASPE and the Office of National Drug Control Policy (ONDCP).

The projections relied on the estimates of substance abuse treatment expenditures within core services (inpatient and outpatient hospital services, residential care services, prescription drugs, and substance abuse treatment services provided through managed care plans) for CY 2008 by state, service, and eligibility category. OACT developed estimates for FY 2011 using the growth rate of expenditures by state, service, and eligibility category from the CMS-64, the Annual Person Summary files from the Medicaid Statistical Information System, and the estimates of enrollment growth consistent with the President's FY 2014 Budget.

OACT projected expenditures for FYs 2012 through 2014 using the FY 2011 estimates and the projected growth rate in Medicaid expenditures from the President's FY 2014 Budget. The projections include the impacts of the Affordable Care Act, most notably the Medicaid eligibility expansion in 2014.

Medicare Estimate

The estimates of Medicare spending for the treatment of substance abuse are based on the FY 2014 President's Budget baseline. These projections reflect estimated Part A and Part B spending and are based on an analysis of historical fee-for-service claims through 2011, using the primary diagnosis code[2] included on the claims. The historical trend of substance abuse spending was used to make projections into the future.

An adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage plans, since their actual claims are not available. It was assumed that the proportion in costs related to substance abuse treatment was similar for beneficiaries enrolled in Medicare Advantage plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Part D of Medicare because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat substance abuse are also used to treat other conditions.

Budget Summary

The total drug control outlay estimate for the CMS is $4,670 million, a net increase of $950 million above the FY 2013 outlay estimate. This estimate reflects Medicaid and Medicare benefit outlays for substance abuse treatment.

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[1] Bouchery E, Harwood R, Malsberger R, Caffery E, Nysenbaum J, and Hourihan K, "Medicaid Substance Abuse Treatment Spending: Findings Report," Mathematica Policy Research, September 28, 2012.

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 disease categories.

Medicaid
FY 2014 outlay estimate: $3,700 million
(Reflects $900 million increase from FY 2013)

Medicaid is a means-tested health care entitlement program financed by States and the Federal government. States have considerable flexibility in structuring their Medicaid programs. Medicaid mandatory services include substance abuse services for detoxification and treatment for substance abuse needs identified as part of early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21 years of age. Additional Medicaid substance abuse treatment services may be provided as optional services.

Medicare
FY 2014 outlay estimate: $970 million
(Reflects $50 million increase from FY 2013)

Medicare provides hospital, supplemental medical and prescription drug insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance abuse treatment benefits payments are made for Medicare Part A inpatient hospital care, Medicare Part B outpatient treatment, Medicare Part B preventative substance abuse treatment, and Medicare Part D prescription drugs for substance abuse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

CMS Program Management
Budget Authority by Object Class

	2012 Base	2014 Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$432,001,000	$465,506,000	$33,505,000
Other than full-time permanent (11.3)	$11,162,000	$11,831,000	$669,000
Other personnel compensation (11.5)	$6,231,000	$7,680,000	$1,449,000
Military personnel (11.7)	$9,668,000	$12,635,000	$2,967,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$459,062,000**	**$497,652,000**	**$38,590,000**
Civilian benefits (12.1)	$116,522,000	$129,868,000	$13,346,000
Military benefits (12.2)	$4,981,000	$6,509,000	$1,528,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$580,565,000**	**$634,029,000**	**$53,464,000**
Travel and transportation of persons (21.0)	$12,363,000	$7,125,000	($5,238,000)
Transportation of things (22.0)	$0	$0	$0
Rental payments to GSA (23.1)	$24,000,000	$23,457,000	($543,000)
Communication, utilities, and misc. charges (23.3)	$300,000	$305,000	$5,000
Printing and reproduction	$4,161,000	$3,134,000	($1,027,000)
(24.0) Other Contractual			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$1,797,694,000	$2,985,639,000	$1,187,945,000
Purchase of goods and services from government accounts (25.3)	$3,523,000	$3,788,000	$265,000
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$21,160,000	$23,156,000	$1,996,000
Medical care (25.6)	$1,290,263,000	$1,397,640,000	$107,377,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$3,112,640,000**	**$4,410,223,000**	**$1,297,583,000**
Supplies and materials (26.0)	$1,083,000	$1,080,000	($3,000)
Equipment (31.0)	$100,000	$100,000	$0
Land and Structures (32.0)	$10,900,000	$10,900,000	$0
Investments and Loans (33.0)	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$74,000,000	$127,004,000	$53,004,000
Interest and dividends (43.0)	$0	$0	$0
Refunds (44.0)	$0	$0	$0
Total Non-Pay Costs	**$3,239,547,000**	**$4,583,328,000**	**$1,343,781,000**
Total Budget Authority by Object Class	**$3,820,112,000**	**$5,217,357,000**	**$1,397,245,000**

American Recovery and Reinvestment Act (ARRA):			
Personnel compensation:			
Full-time permanent (11.1)	$13,939,000	$17,020,000	$3,081,000
Other personnel compensation (11.5)	$223,000	$267,000	$44,000
Civilian benefits (12.1)	$3,566,000	$4,736,000	$1,170,000
Other Contractual Services:			
Other services (25.2)	$122,272,000	$117,977,000	($4,295,000)
Total Budget Authority by Object Class	**$140,000,000**	**$140,000,000**	**$0**

CMS Program Management
Salaries and Expenses

	2012 Base	2014 Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$432,001,000	$465,506,000	$33,505,000
Other than full-time permanent (11.3)	$11,162,000	$11,831,000	$669,000
Other personnel compensation (11.5)	$6,231,000	$7,680,000	$1,449,000
Military personnel (11.7)	$9,668,000	$12,635,000	$2,967,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$459,062,000**	**$497,652,000**	**$38,590,000**
Civilian benefits (12.1)	$116,522,000	$129,868,000	$13,346,000
Military benefits (12.2)	$4,981,000	$6,509,000	$1,528,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$580,565,000**	**$634,029,000**	**$53,464,000**
Travel and transportation of persons (21.0)	$12,363,000	$7,125,000	($5,238,000)
Transportation of things (22.0)	$0	$0	$0
Rental payments to Others (23.2)	$0	$0	$0
Communication, utilities, and misc. charges (23.3)	$300,000	$305,000	$5,000
Printing and reproduction (24.0)	$4,161,000	$3,134,000	($1,027,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$1,797,694,000	$2,985,639,000	$1,187,945,000
Purchase of goods and services from government accounts (25.3)	$3,523,000	$3,788,000	$265,000
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$21,160,000	$23,156,000	$1,996,000
Medical care (25.6)	$1,290,263,000	$1,397,640,000	$107,377,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$3,112,640,000**	**$4,410,223,000**	**$1,297,583,000**
Supplies and materials (26.0)	$1,083,000	$1,080,000	($3,000)
Total Non-Pay Costs	**$3,130,547,000**	**$4,421,867,000**	**$1,291,320,000**
Total Salary and Expense	**$3,711,112,000**	**$5,055,896,000**	**$1,344,784,000**
Direct FTE	**4,355**	**4,635**	**280**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$13,939,000	$17,020,000	$3,081,000
Other personnel compensation (11.5)	$223,000	$267,000	$44,000
Civilian benefits (12.1)	$3,566,000	$4,736,000	$1,170,000
Other Contractual Services:			
Other services (25.2)	$122,272,000	$117,977,000	($4,295,000)
Total Salary and Expense	**$140,000,000**	**$140,000,000**	**$0**
Direct FTE	**133**	**161**	**28**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2012 Actual	2013 Estimate	2014 Estimate
Office of the Administrator			
Direct FTEs	16	15	14
Reimbursable FTEs	0	0	0
Subtotal	16	15	14
Office of Minority Health			
Direct FTEs	6	6	6
Reimbursable FTEs	0	0	0
Subtotal	6	6	6
Center for Medicare			
Direct FTEs	648	679	663
Reimbursable FTEs	5	6	7
Subtotal	653	685	670
Center for Medicaid and CHIP Services			
Direct FTEs	281	308	301
Reimbursable FTEs	2	0	0
Subtotal	283	308	301
Center for Program Integrity			
Direct FTEs	5	4	4
Reimbursable FTEs	0	0	0
Subtotal	5	4	4
Center for Strategic Planning			
Direct FTEs	11	12	11
Reimbursable FTEs	0	0	0
Subtotal	11	12	11
Center for Medicare and Medicaid Innovation			
Direct FTEs	37	24	24
Reimbursable FTEs	0	0	0
Subtotal	37	24	24
Center for Consumer Information and Insurance Oversight			
Direct FTEs	226	295	288
Reimbursable FTEs	0	0	0
Subtotal	226	295	288
Center for Clinical Standards and Quality			
Direct FTEs	197	214	209
Reimbursable FTEs	29	40	42
Subtotal	226	254	251
Office of Federal Coordinated Health Care			
Direct FTEs	21	27	27
Reimbursable FTEs	0	0	0
Subtotal	21	27	27
Office of Public Engagement			
Direct FTEs	104	112	110
Reimbursable FTEs	0	0	0
Subtotal	104	112	110
Office of Communications			
Direct FTEs	161	176	172
Reimbursable FTEs	0	0	0
Subtotal	161	176	172
Office of the Actuary			
Direct FTEs	83	82	80
Reimbursable FTEs	0	0	0
Subtotal	83	82	80

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2012 Actual	2013 Estimate	2014 Estimate
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	130	144	141
Reimbursable FTEs	0	0	0
Subtotal	130	144	141
Office of Equal Opportunity and Civil Rights			
Direct FTEs	31	32	32
Reimbursable FTEs	0	0	0
Subtotal	31	32	32
Office of Legislation			
Direct FTEs	41	47	46
Reimbursable FTEs	0	0	0
Subtotal	41	47	46
Office of Acquisition & Grants Management			
Direct FTEs	168	178	174
Reimbursable FTEs	2	2	2
Subtotal	170	180	176
Office of Enterprise Management			
Direct FTEs	125	155	151
Reimbursable FTEs	0	0	0
Subtotal	125	155	151
Office of Financial Management			
Direct FTEs	248	265	258
Reimbursable FTEs	26	30	27
Subtotal	274	295	285
Office of Information Services			
Direct FTEs	396	437	426
Reimbursable FTEs	3	4	4
Subtotal	399	441	430
Office of Operations Management			
Direct FTEs	273	299	292
Reimbursable FTEs	0	0	0
Subtotal	273	299	292
Consortia			
Direct FTEs	1,149	1,233	1,204
Reimbursable FTEs	36	42	42
Subtotal	1,185	1,275	1,246
Total, CMS Program Management FTE 1/	**4,458**	**4,870**	**4,759**
Total, CMS Military Staffing (Non-Add) 1/	*114*	*124*	*124*
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE 1/	**133**	**152**	**161**

1/ FY 2012 reflects actual FTE consumption. Reflects discretionary Program Management staffing, except for ARRA staffing.

Average GS Grade

FY 2010	**13.4**
FY 2011	**13.4**
FY 2012	**13.3**
FY 2013	**13.3**
FY 2014	**13.3**

CMS Program Management Detail of Positions

(Dollars in Thousands)

	2012 Actual	2013 Base	2014 Budget
Subtotal, EX	0	0	0
Total - Exec. Level Salary	$0	$0	$0
Subtotal	77	77	77
Total - ES Salaries	$13,072	$13,105	$13,220
GS-15	539	590	576
GS-14	688	754	736
GS-13	2,022	2,215	2,162
GS-12	772	846	826
GS-11	223	244	238
GS-10	1	1	1
GS-9	208	227	222
GS-8	12	13	12
GS-7	83	91	89
GS-6	16	17	17
GS-5	17	18	18
GS-4	11	12	12
GS-3	4	5	4
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,595	5,032	4,912
Total - GS Salary 1/	$433,758	$480,936	$477,225
Average GS grade 1/	13.3	13.3	13.3
Average GS salary 1/	$94.398	$95.576	$97.155

1/ Reflects direct discretionary and user fee financed staffing within the Program Management account.

Federal Employment Funded by the Patient Protection and Affordable Care Act, P.L. 111-148

Center for Medicare & Medicaid Services

Program	Section	FY 2011			FY 2012			FY 2013			FY 2014		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated													
Health Insurance Consumer Information	1002		2			0			0			0	
Pre-existing Condition Insurance Plan Program	1101		13			18			16			16	
Reinsurance for Early Retirees	1102		2			4			12			12	
Affordable Choices of Health Benefit Plans	1311	Such Sums	28		Such Sums	44		$2,750,521,000	62		Such Sums	63	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP)	1322	-$2,200,000,000	1		-$400,000,000	6		-$2,278,500,000	0		$0	0	
CO-OP Contingency Fund	1322/644	$0	0		$0	0		$253,000,000	25		$0	22	
Adult Health Quality Measures	2701	$60,000,000	2		$60,000,000	5		$60,000,000	11		$60,000,000	11	
Medicaid Emergency Psychiatric Demonstration	2707	$75,000,000	0			0			0			0	
Quality Measurement	3014	$20,000,000	2		$20,000,000	4		$20,000,000	9		$20,000,000	10	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021	$10,000,000,000	68			163			309			347	
Independence At Home Demonstration	3024	$5,000,000	0		$5,000,000	3		$5,000,000	3		$5,000,000	4	
Community Based Care Transitions	3026	$500,000,000	0			2			3			4	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			2			2			2	
Medicaid Incentives for Prevention of Chronic Disease	4108	$100,000,000	0			1			2			2	
Community Prevention and Wellness	4202		0			1			2			2	
Graduate Nurse Education	5509		0		$50,000,000	1		$50,000,000	1		$50,000,000	2	
Sunshine Act	6002		0			0		$16,050,000	2		$1,024,000	2	
LTC National Background Checks	6201		2			3			5			6	
Provider Screening & Other Enrollment Requirements/1	6401		5			8		$5,000,000	13			13	
Enhanced Medicare/Medicaid Program Integrity Provisions/1	6402	$10,000,000	2		$10,000,000	2		$13,000,000	2		$3,000,000	2	
Expansion of the Recovery Audit Contractor Program/1	6411		2			2		$3,300,000	2		$3,783,000	2	
Termination of Provider Participation under Medicaid/1	6501		0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323	Such Sums	0		Such Sums	2		$0	2		Such Sums	2	
Total ACA Direct Appropriated FTEs			**129**			**271**			**483**			**524**	

/1 From FY 2011 through FY 2016, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

Physicians' Comparability Allowance (PCA) Worksheet

DHHS: Centers for Medicare and Medicaid Services

Table 1

		PY 2012 (Actual)	CY 2013 (Estimates)	BY 2014* (Estimates)
1) Number of Physicians Receiving PCAs		39**	42	45
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		39	42	45
4) Average Annual PCA Physician Pay (without PCA payment)		$151,038	$151,038	$151,038
5) Average Annual PCA Payment		$25,795	$25,795	$25,795
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position			
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	39**	42	45

** FY 2012 totals were generated on August 15, 2012 prior to the end of the fiscal year. Please note that this number is subject to change.

*FY 2013 data will be approved during the FY 2014 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Additional physician categories have not been designated by CMS.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

The maximum amount of PCA varies depending on the GS level, the number of years as a Government physician, if they sign a one year or multi-year contract, board certified and mission-specific which is a factor based on the physician's duties that are directly related to the strategic mission and goals of CMS. The maximum for less than 24 months as a Government Physician is $14,000 and for more than 24 months as a Government Physician is $30,000. Each time that the physician is eligible for a new contract, the package is reviewed to see if they meet the criteria for additional money due to the number of years as a Government Physician.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

In order to attract and retain highly skilled and qualified Medical Officers, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) and Physician's and Dental Pay (PDP.) CMS Medical Officers are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. Positions recruited and filled by Medical Officers require the knowledge and skills of a licensed physician to perform such duties as, evaluation of medical technology, Medicare coverage decisions, advising the Regional Offices on Medicare coverage and claims, women and children's health issues, managed and long term care coverage decisions, hospital and physician reimbursement and payment policy.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

With the implementation of the Affordable Care Act, CMS had to set up several new program offices to implement new programs. We have established additional Medical Officer positions and quickly filled vacated Medical Officer positions for very specific needs. Many of these positions were also supervisory positions. PCA and PDP pay systems were used as a recruitment tool to fill these highly specialized positions. Without this recruitment and retention allowance CMS would not be able to attract and retain highly qualified physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

This question is not applicable to CMS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Item

Food Allergies- In the United States, a patient visits an emergency department every three minutes for the treatment of a food related allergic reaction. The Committee believes that proper management of food allergies could improve patient outcomes, reduce costs, and decrease the incidence of preventable death. The Committee encourages CMS to consider food allergy patients in other disease management pilot programs.

Action Taken or To be Taken

CMS appreciates the importance of proper management of food allergies. The Center for Medicare and Medicaid Innovation (Innovation Center) was created by the Affordable Care Act to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. Currently, the Innovation Center does not have any initiatives specifically focusing on disease management for beneficiaries with food allergies. CMS will keep the management of food allergies in mind as it further develops the Innovation Center's portfolio of initiatives.

Item

Community First Choice Option- The Committee commends CMS on the completion of the final rule for the implementation of the Community First Choice Option. The Committee directs CMS to provide information to State Medicaid Directors about the availability of the Community First Choice Option as a way to help States meet their obligations to expand opportunities for home and community based services for people with disabilities under the Supreme Court's decision in Olmstead v. L.C. and the Americans with Disabilities Act.

Action Taken or To be Taken

In April 2012, CMS issued an informational bulletin announcing the publication of the final regulation for the Section 1915(k) Community First Choice State Plan option (CFC). After the publication of the final regulation on May 7, 2012, CMS provided information about the new CFC option at various stakeholder events, including the National Home and Community-Based Services Conference held September 2012. CMS has provided and continues to provide focused technical assistance to States on how the CFC benefit can support States in their efforts to meet their obligations under the ADA and the Supreme Court's decision in Olmstead v. L.C. and to expand the available options of home and community services options.

Additionally, in a May 2012 notice of proposed rulemaking defining home and community-based settings, we indicated that the Medicaid program can provide an important opportunity to obtain Federal funding that supports compliance with the ADA, section 504 of the Rehabilitation Act, and Olmstead through the provision of services through the CFC benefit. We are currently engaged in finalizing this regulation that will set the standard of the characteristics that settings must have to be considered home and community-based for the purposes of services provided under the CFC state plan option, as well as sections 1915(i) and 1915(c) of the Social Security Act. In August 2012, CMS approved California's state plan amendment to add the CFC benefit to its Medicaid program, making it the first in the country. There are three additional amendments currently under review.

CMS plans to issue a State Medicaid Director's letter in spring of 2013 to announce the availability of a web-based format for submission of CFC State plan amendments. This format

will include a technical guide to provide additional guidance to states on proper implementation of the CFC benefit.

Item
Continuous Oxygen Therapy- The Committee continues to encourage innovative and more cost-effective methods for treating hard-to-heal wounds. The Committee appreciates CMS' interest in commissioning a technology assessment through AHRQ to review evidence on continuous oxygen delivery.

Action Taken or To be Taken
Due to resource and operational constraints with the current process for acquiring technology assessments through AHRQ, CMS has been unable to commission a technology assessment to review the evidence on continuous oxygen therapy for hard-to-heal wounds. CMS is currently exploring potential alternatives for commissioning technology assessments.

Item
Health Insurance Literacy- The Committee recognizes that to most effectively implement PPACA in medically underserved and at-risk communities, individuals with limited literacy and numeracy skills will need special attention. The Committee encourages CMS to work with experts to develop effective programs to educate these consumers on their rights and resources available to help them access insurance coverage.

Action Taken or To be Taken
CMS recognizes the importance of outreach and education to inform all consumers about their new rights under the Affordable Care Act and new resources available to help them access insurance coverage, particularly through the new federally-facilitated Federal Marketplaces.

CMS outreach efforts are two-pronged: 1) to build a major collaborative network from the grassroots to the national level to expand education and outreach prior to the start of enrollment in Marketplaces; and 2) to ensure access to health care coverage for communities traditionally underserved by the current private health insurance market.

CMS has been meeting with consumer groups, disability groups, and others representing communities traditionally underserved by the current private health insurance market to solicit input as CMS develops guidelines related to meaningful access standards for the Marketplaces.

The unprecedented nature of the Affordable Care Act includes a variety of new rights for consumers and new transparency requirements for the insurance industry, and creates a new marketplace in which individuals and small businesses can purchase insurance. The convergence of these changes will require collaborative efforts across federal departments, private and public sectors, and with state and local government partners. To begin this coordination, CMS has organized workgroups that meet regularly to strategize on content development, outreach and education, data sharing, and other topics, provide updates on projects, and enlist support of stakeholders. The CMS Regional Offices (RO) are playing an important role in reaching out to private and public sectors in preparation of the Federal Marketplace rollouts. ROs have been trained on the Summary of Benefits and Coverage (SBCs), the Federal; Appeals program for consumers, and other initiatives as a "train the trainer" approach to meet the objective of consumer education.

Usability and health literacy issues have been high priorities for us as we work to develop all aspects of the consumer experience, from the website to the applications for coverage to the

call center. CMS is using research-based best practices to ensure that everyone in our target audience can access our programs and services, and to make that experience as simple and seamless as possible.

CMS will provide consumer support to help individuals and families determine their eligibility for different coverage options and to help them apply for a plan through the marketplace. CCIIO has made progress in establishing the Navigator program whose grantees are required to provide assistance and services in a manner that is culturally and linguistically appropriate and in ways that are accessible to people with disabilities

Starting in the summer 2012, CMS began conducting usability research among diverse consumers, including those who are uninsured, to test messages and concepts related to the marketplace. In addition, in November 2012, CMS conducted usability testing among low literacy and Spanish-speaking consumers on their understanding of cost sharing insurance concepts and the SBC. The findings from that research will also inform the recommendations CMS makes for changes to the SBC.

CMS has also developed a strategic outreach plan to help promote the new Health Insurance Marketplaces and Medicaid expansion to the uninsured and others who would benefit from its use. The plan uses a research-based approach to segment audiences and build appropriate motivational messages, including those for vulnerable populations and those from different cultural backgrounds. CMS is applying the same techniques that helped it increase Medicare drug coverage from 25% to 90% and a multi-tiered effort that resulted in a million children being enrolled each year during the first five years of the Children's Health Insurance Program (CHIP).

A key to achieving our goal is establishing metrics to monitor success in communications, outreach and customer service. Metrics will continue to be developed and refined with iterations of the plan but will include measures such as online applications process, call volume and top topics and usage rate of translation line.

Item

HIGLAS- The Committee requests that the fiscal year 2014 budget justification include lessons learned in the implementation of this program that may serve as a guide for other similar efforts to implement automated systems using commercially available software in the Federal Government.

Action Taken or To be Taken

The Healthcare Integrated General Ledger Accounting System (HIGLAS) is being implemented to support the DHHS mission, meet fiduciary responsibilities, and ensure compliance with legislative and regulatory mandates. The use of a Commercial Off The Shelf (COTS) package greatly reduces the time between project start-up to system implementation for a system/functionality and the risk associated with "building" a custom solution.

Several lessons can be gained from this experience. For example, the use of a COTS package supported rigorous Change Management which helped control possible "scope creep." Specific effort was made to ensure that the scope of work was not expanded outside of the COTS functionality unless absolutely required to perform mission-critical work. Adherence to the COTS functionality improves ease of system maintenance because changes required by Federal guidance are released by the COTS vendor on a regular basis. Additionally, system security updates and changes are provided by the COTS vendor as a part of regular

maintenance releases. This helps to simplify maintenance efforts, reduce cost, and standardized accounting practices across multiple business partners.

To implement the HIGLAS capabilities, DHHS set up a single Program Office, with oversight of multiple sub-projects, to manage and implement the system through the entire program life cycle. This action provided a single point of responsibility and accountability for the program. This approach also allowed direct access to the COTS vendor when issues surfaced. The program management office reported to both the Business Owner (the Chief Financial Officer), with "dotted line" reporting to the Chief Information Officer. Support for this program has been provided at the Executive-level in an unwavering manner through the entire life of the program.

A dedicated funding source has been provided through the implementation stages. This action ensured that funds were available to complete the effort. Each project, or module, of the implementation had specific deliverables, and the implementation was phased across multiple user communities. This approach protected the integrity of the system, and allowed each "go forward" decision to be made based on the success of multiple preceding activities.

The COTS package assisted in the automation and standardization of debt referral activities and provides for consistent and more efficient collection processes. This functionality is cost-effective due to the nature of the high transaction-volume work, especially related to Medicare healthcare claims.

Additionally, integration with other Federal systems and programs has provided benefits outside of DHHS. For example, DHHS' participation with the Department of the Treasury in the Federal Payment Levy Program allowed recoupment of over $185 million in Federal tax debts, and over $75 million in Federal non-tax debt.

The COTS package allowed us to keep up with changes in Federal Financial policies, and continue mission critical functions. In the future, CMS will use the COTS package to build functionality to support new payment types included in legislation to support laws such as the Affordable Care Act.

Item

Hepatitis Screening- An estimated two-thirds of chronic hepatitis C cases are baby boomers who are currently beginning to enroll in Medicare in large numbers. Viral hepatitis is very costly to treat when diagnosed in the later stages of the disease. The Committee believes that opt-out hepatitis B and C screenings at the Welcome to Medicare physical exam would identify a significant number of beneficiaries with asymptomatic liver disease and reduce Medicare costs overall. The Committee encourages CMS to work with CDC to determine the prevalence of viral hepatitis in the soon-to-enroll Medicare population and to develop a cost-benefit analysis on this type of screening.

Action Taken or To be Taken

CMS' Coverage and Analysis Group has been closely monitoring the recent developments in screening for hepatitis C virus (HCV) and has carefully reviewed the CDC guidance which recommends screening for adults born during 1945 through 1965. The United States Preventive Services Task Force (USPSTF) released revised draft recommendations that recommend screening for HCV infection in adults at high risk, including those with any history of intravenous drug use or blood transfusions prior to 1992 (grade B). The draft recommendations also suggest that "clinicians consider offering screening for HCV infection in adults born between 1945 and 1965" (grade C statement). We note that the statutory requirements for

coverage of additional preventive services established by the Medicare Improvements for Patients and Providers Act of 2008 (Section 1861(ddd) of the Social Security Act) include a three part standard, of which one part is that the service must receive an A or B rating by the USPSTF. Screening for hepatitis B virus (HBV) is not recommended (grade D), although HBV vaccination is covered under Medicare Part B for certain eligible beneficiaries per section 1861(s)(10)(B) of the Social Security Act.

If the USPSTF draft recommendations are finalized without changes in the grades, screening for adults at high risk as noted above is a common subset that CMS may consider for expansion of coverage. It is also a subgroup that the CDC recommends for HCV screening. CMS will work with the CDC to estimate prevalence and incidence of hepatitis B and C infections in the Medicare population and will assess the need and feasibility of a cost-benefit analysis of hepatitis C screening in high risk adults. Funding and the development of a technology assessment procurement process with the CDC would be necessary.

Item

Pediatric Dental Services- Although virtually all dental disease is fully preventable, tooth decay remains the most common chronic illness among children and oral healthcare is the most prevalent unmet healthcare need among children. Currently, 34 States allow dental hygienists to provide dental care outside of a dental office without a prior exam or preauthorization by a dentist. The Committee urges CMS to update Medicaid dental regulations to reflect how dental services are currently delivered in the majority of the country.

Action Taken or To be Taken

Current CMS policy allows States to reimburse for services provided by dental hygienists outside of a dental office without a prior exam or pre-authorization by a dentist. CMS clarified this policy for one State in 2012. To help address any confusion about this policy on the part of State Medicaid agencies, CMS plans to provide a general clarification of the policy through a State Medicaid Director letter in 2013.

Item

Rural Hospital Flexibility- In 1997, Congress created the Medicaid Rural Hospital Flexibility Program for the purpose of improving access to hospitals and other health services for rural residents. For these hospitals that did not meet requirements for a minimum distance to another hospital or critical access hospital [CAH] of more than a 35-mile drive, or a 15-mile drive based on a mountainous terrain or areas with only secondary roads, the program allowed a State to waive the distance requirement for one or more facilities designated as a necessary provider. The Committee requests a list of all CAH facilities grandfathered into the program through the State waiver system.

Action Taken or To be Taken

A response will be provided to the Committee under separate cover.

Item

Vaccinations- The Committee is concerned that the majority of healthcare workers, who are at high risk of contracting infectious disease, do not get regularly recommended vaccinations. In addition, adult vaccination rates are particularly low for minority groups. The Committee supports efforts by CMS to incorporate seasonal influenza vaccination rates into hospital

payment updates and performance metrics and urges CMS to require Medicare-certified hospitals to offer the seasonal influenza vaccine to health care workers.

Action Taken or To be Taken

We recognize that rates of vaccination against seasonal influenza among healthcare workers (HCW) are low, approximately 60-65% in recent years. The majority of hospitals are already required to offer the vaccine to staff, either by their accrediting organization or by State law. We believe that the vast majority of hospitals already offer and provide the vaccine based on CDC, ACIP, and American Hospital Associations recommendations. Evidence indicates that actions associated with greater coverage include a personal reminder from the employer to get vaccinated, vaccination availability at no cost, and vaccination availability on different shifts and over several days.

We share your concerns about the low rates of HCW vaccination against seasonal influenza. We will continue to monitor vaccination rates, and may consider requiring hospitals to offer the vaccine in the future.

The first part of the sentence "*The Committee supports efforts by CMS to incorporate seasonal influenza vaccination rates into hospital payment updates and performance metrics…"* may be referring to the healthcare worker vaccination quality measure and its incorporation into the Hospital Value Based Purchasing (VBP) program since Medicare cannot directly pay for vaccination of healthcare workers: http://www.hhs.gov/ash/initiatives/hai/hcpflu.html

Additionally, CDC is partnering with CMS to develop and pilot test the National Quality Forum (NQF) time-limited influenza vaccination measure in 234 facilities, including acute care hospitals, ambulatory surgical centers, long-term care facilities, outpatient physician practices, and renal dialysis centers. The pilot test was completed in 2011 and the revised measure is currently being reviewed by NQF. CMS is responsible for the Hospital Inpatient Quality Reporting Program (IQR) and published a rule in August 2011 requiring hospital reporting of HCP influenza vaccination coverage following NQF standards, starting in January 2013, for posting on the Hospital Compare website and the FY 2015 payment determination. CMS can consider adding to the hospital value-based purchasing program once the measure is in the IQR program and on Hospital Compare for one year.

CMS has made significant contributions to increasing vaccination rates among minority populations, through the education and outreach activities of the Medicare Part D prescription drug benefit annual open season and the National Medicare Training Program. CMS regional offices host flu clinics and actively promote www.cms.gov/immunizations as a resource along with CMS training materials, developed specifically for minority populations, which are featured prominently in the E-News notices that go to more than 96,000 providers each week. CMS developed Spanish language stories for the newsletters, as well as dual language PSA's that were developed in conjunction with the CDC. CMS also developed a mini-poster in Spanish and English that encourages folks to get their flu vaccination rather than the flu.

Item

Uniform Staffing Data- The Committee encourages CMS to complete its efforts to collect uniform staffing data based on payroll extracts from skilled nursing facilities reimbursed by Medicare and Medicaid. The Committee requests an update from CMS on its progress in the fiscal year 2014 budget justification. Action Taken or To be Taken

Section 6106 of the ACA requires that CMS require nursing homes to electronically report detailed staffing information based on payrolls for each nursing homes, compute quality measures (turnover rates, tenure, resident to staff ratios). Section 6103 requires CMS to post this information, for each nursing home, on the CMS *Nursing Home Compare* website.

CMS tasks involve (a) regulation promulgation, (b) information system design and implementation, (c) technical software specification for payroll system data extracts by nursing homes, (d) data integrity processes, (e) quality measure development, (f) website re-design, (g) required stakeholder involvement processes. The process involves approximately 15,800 nursing homes reporting extensive data on a quarterly basis from all types of nursing homes, ensuring help-desk and technical guidance and assistance to nursing homes, cleaning and reconciliation of data, and posting the data together with meaningful measures on the CMS' *Nursing Home Compare* website.

We have completed considerable preparatory work through in-house staff work and using a small Survey and Certification contract to pilot-test a model for such collection of data. The pilot test has involved a select number of volunteer nursing homes.

Item

Improper Payments- The Committee is encouraged by the work of the Medicare fee-for-service [FFS] Recovery Audit Contractor [RAC] program. While there is clear value in rectifying improper payments, the Committee feels strongly that a larger benefit of the Medicare FFS RAC programs lies in its ability to help potential vulnerabilities, which CMS identifies from RAC reports, allows CMS to make system changes than can prevent improper payments in the future. Unfortunately, in 2010, a GAO report found that CMS has no formal process in place to ensure that RAC-identified vulnerabilities are addressed. The Committee directs CMS to include in its annual report to Congress an accounting of reported vulnerabilities each fiscal year broken down by type of improper payment, including the number of vulnerabilities identified; the financial cost of vulnerabilities report; the number that have been addressed with a change to the system; the number that have a system change identified but are waiting for the change to be made; the number that CMS has decided a system change is unfeasible; and the number that are awaiting CMS review.

Action Taken or To be Taken

CMS has established a process to take corrective actions for program vulnerabilities uncovered by the Medicare Fee-for-Service Recovery Auditors. The Recovery Auditors conduct reviews on claim types that are pre-approved by CMS. These pre-approved review areas are referred to as "issues." If the Recovery Auditors collect over $500,000 on a single issue, CMS adds that issue to the list of program vulnerabilities. These program vulnerabilities are tracked and corrective actions are developed to address the underlying root cause of the improper payment.

Although these issues can be very specific to a service or claim type, there are truly only three major root causes of improper payments the Recovery Auditors identify. These are:

1) services/items were medically unnecessary based on Medicare's coverage policies,
2) the claim was incorrectly coded,
3) other issues such as a duplicate payment or incorrectly billed for bundled services

CMS prioritizes the Recovery Audit identified program vulnerabilities based on dollar amount collected. Changes to Medicare claims processing system are a relatively easy and inexpensive way to correct program vulnerabilities but are effective only in a small number of cases. The

majority of program vulnerabilities cannot be fixed by a systems change. CMS conducts education and outreach efforts to ensure providers understand CMS policies. CMS has issued numerous educational materials including the Quarterly Provider Compliance Newsletters beginning in October 2010. In addition, CMS developed comparative billing reports (CBRs) to help Medicare contractors and providers analyze administrative claims data. CMS distributes approximately 50,000 CBRs each year. CMS also uses the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows Medicare inpatient hospitals to analyze their billing patterns through a comparison to other providers in their state and in the nation. In FY 2012, CMS issued around 20,000 PEPPERs to over 10,000 inpatient facilities. CMS will report the information the Committee requested in the annual Recovery Audit Report to Congress beginning with the FY 2012 report.

Item

Senior Medicare Patrol- The Committee strongly supports the SMP, administered by ACL with historical financial assistance from CMS. The Committee is concerned that the return on investment [ROI] calculation included in the performance metrics of the program does not adequately reflect outcome data on SMP fraud referrals. The Committee requests that a more accurate ROI calculation be developed for this important program. The Committee further directs CMS, ACL, DOJ, and HHS OIG to work to improve the process of informing beneficiaries and volunteers when their tips result in conviction, a recovery, or a change to Medicare policies.

Action Taken or To be Taken

The Senior Medicare Patrol program is operated by ACL and the current ROI for the SMP program was developed between ACL and OIG. Since CMS does not oversee the SMP program, CMS is not in a position to lead the design of a new ROI for the program but will assist ACL, OIG, and others as necessary in any effort to develop a new ROI calculation.

Although CMS is not in a direct position to design ROI for the SMP program, CMS continues to improve the process of informing Medicare beneficiaries and volunteers about the importance of SMP fraud referrals through its support of the State Health Insurance Assistance Program (SHIP), a national program which provides free counseling and assistance to Medicare beneficiaries via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. CMS distributes $50 million in SHIP grants fund programs in 50 states plus DC, Puerto Rico, Guam and the Virgin Islands; these grants support more than 15,000 SHIP counselors nationwide, 57% of which are volunteers. There is significant collaboration between the SHIP and SMP counselors and volunteers. About half of the SHIP counselors are co-located with SMPs and are cross-trained by both entities. SMP often participate in SHIP outreach events to discuss fraud prevention and awareness. Additionally, the National Medicare Training Program at CMS has supported the work of the Senior Medical Patrol programs by training them at national workshops, distributing their materials, inviting them to speak and showing their videos at workshops.

Item

Transparency Reporting- The Committee urges CMS to ensure transparency and accountability through the accurate reporting of transfers of value from drug, device and group purchasing industries to physicians and teaching hospitals. The Committee encourages CMS to finalize procedures to comply with section 6002 of PPACA in time to require data collection in 2013. The Committee supports the statutory goal of posting payment reports information on a public website no later than September 30, 2014.

Action Taken or To be Taken

CMS is committed to achieving the stated transparency and accountability goals of the Section 6002 PPACA legislation. CMS Published the final rule in the Federal Register on February 8, 2013. CMS has begun planning the operational implementation activities necessary to support the industry's collection of data that is required to begin on August 1, 2013, and to meet other deadlines contained in the final rule.