DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2013

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) 2013 performance budget. Our programs will touch the lives of almost 106 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2013. 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 Americans access affordable, quality health care through strengthened consumer protections and the establishment of private health insurance programs. 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 Affordable Insurance Exchanges and protection programs. In an unprecedented effort for CMS, we will make affordable health insurance available to millions of Americans through the implementation of Affordable Insurance Exchanges in 2014. All State-based and Federally-facilitated Exchanges must be ready to begin initial operations in FY 2013.

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 2013 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 2013 performance budget.

/Marilyn Tavenner/
Marilyn Tavenner

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

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

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As of February 1, 2012
*** Acting**

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OIS--Tony Trenkle, Director & CMS Chief Information Officer

OOM—James Weber, Director

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CMHPO--James T. Kerr, Consortium Administrator

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

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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 at that time--Medicare and Medicaid. In 1997, the Children's Health Insurance Program (CHIP) was established to address the health care needs of uninsured children.

In 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, the most significant expansion of the Medicare program since its inception in 1965. 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 and quality improvement initiatives and enhanced CMS' program integrity efforts through 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 and 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, and prevention and wellness activities. In March 2010, the President signed into law the Affordable Care Act. 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 "donut hole"; and the creation of a CMS Innovation Center to explore different care delivery and payment models in Medicare, Medicaid, and CHIP.

More recently, in January 2011, CMS became responsible for the implementation of the Affordable Care Act's consumer protections and private health insurance provisions. These provisions provide: 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 markets that will operate through Affordable Insurance Exchanges (Exchanges) and provide millions of Americans with access to affordable coverage.

CMS remains the largest purchaser of health care in the United States. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures. For 45 years, these programs have helped pay the medical bills of millions of older and low-income Americans. In FY 2013, we expect to serve almost 106 million Medicare, Medicaid and CHIP beneficiaries, roughly 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 2013, benefit outlays for our traditional programs are expected to total $869.3 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 $30.3 billion or 3.5 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, Program Management costs are about one-half of 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 four annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds (PTF). The table at the end of this section displays our FY 2012 enacted level and FY 2013 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 insurance market reform and oversight, and consumer information. CMS' request includes funding for State High-Risk Pool grants, at a level sufficient to begin scaling down activities in existing risk pools as States transition to operational Exchanges. This request will also allow CMS to maintain statutory and policy-level survey frequencies in the Nation's health care facilities, make ongoing survey process improvements, and to continue to address healthcare-associated infections. Major activities within each of these accounts are discussed in more detail below.

Important New Initiatives:

- *Implement Affordable Insurance Exchanges:* In order to meet the statutory implementation deadline on January 1, 2014, all State- and Federally-facilitated Exchanges must be ready to begin initial operations in FY 2013. With operational capacity in place, health plan bid review and certification must begin by early 2013, followed by processes for initial enrollment later in 2013.

- *Expand Durable Medical Equipment (DME) Competitive Bidding:* CMS is requesting $55.0 million, an increase of $46.1 million above the FY 2012 enacted level. In FY 2013, under the second round, CMS will expand operations to 91 additional Metropolitan Statistical Areas (MSAs), for a total of 100 MSAs, and implement a National Mail Order competition.

  The Medicare program realized an average reduction in allowed charges of 54 percent through the first nine months of the Round 1 Rebid. Lower prices from this expansion will take effect in FY 2013, resulting in $280 million in beneficiary savings. CMS estimates an eight-fold savings associated with this effort in 2013 and nearly $25.7 billion in savings over a ten-year window beginning in 2013.

- *Implement a Robust Package of Legislative Proposals:* CMS' FY 2013 request includes a proposal for $400 million in a direct mandatory appropriation. The funding is for health care proposals in the FY 2013 President's Budget. Taken together, these proposals will provide additional efficiencies, make further reductions in waste, and improve the nation's health care system beyond levels put in place through the Affordable Care Act. We estimate savings of approximately $359 billion over the next ten years from implementation of this plan. CMS will utilize this funding to implement significant systems and process changes needed to realize the proposed savings in a timely manner.

- *Increased Funding for Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA) Program Integrity Adjustments:* The FY 2013 President's Budget includes a proposal to increase the FY 2012 HCFAC discretionary base funding to $311 million, fully offset, and to provide $270 million in additional funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the BBEDCA, as amended.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2012 Enacted	FY 2013 Request	FY 2013 Req. +/- FY 2012
Program Management 1/	$3,820.1	$4,820.8	+$1,000.7
HCFAC – Discretionary 2/	$581.0	$610.0	+$29.0
Grants to States for Medicaid	$270,724.4	$269,405.3	($1,319.1)
Payments to Health Care Trust Funds	$230,741.4	$251,359.0	+$20,617.6
Grand Total	**$505,866.9**	**$526,195.1**	**+$20,328.2**

1/ FY 2012 Program Management levels have been comparably adjusted for the SHIP transfer to the Administration of Aging (AoA).
2/Reflects full-funding for the HCFAC Discretionary cap adjustment in FY 2012.

FY 2013

Program Management

CMS requests $4,820.8 million in Program Management funding, a $1,000.7 million increase over the comparably-adjusted FY 2012 enacted level. This increase reflects additional funds needed to support operational infrastructure and to prepare for open enrollment in the Federally-facilitated Exchanges prior to FY 2014. While the FY 2013 budget environment will be constrained, effective implementation of the Affordable Care Act (ACA) is a top Administration priority. CMS' requested investment in FY 2013 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' FY 2013 budget request for Program Operations totals $3,618.5 million, $1.0 billion more than the comparably-adjusted FY 2012 enacted level. 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 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. The FY 2013 request includes funding for ongoing Medicaid and CHIP operations that previously have been funded through the Federal Administration line.

Beginning in FY 2013, funding for the Medicare Current Beneficiary Survey (MCBS), ongoing demonstrations, and other research activities will be provided within the Program Operations line. These activities were previously funded in the Research, Demonstrations, and Evaluation line item.

Program Operations 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 include the establishment of new consumer information and private insurance market oversight protections and programs. This funding supports the implementation of the Affordable Insurance Exchanges that must be built before 2014, and outreach and education for a new and diverse cohort of consumers.

- Federal Administration:

  CMS requests $793.0 million, an increase of $2.0 million above the comparably-adjusted FY 2012 enacted level. The FY 2013 request includes $631.6 million to support 4,672 direct FTEs. This request reflects a $28.5 million (+136 FTE) increase over the comparable FY 2012 enacted level, due to additional staffing needed to support ACA workloads. Our payroll estimate assumes a 0.5% cost of living adjustment in 2013.

  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 $387.4 million, an increase of $32.1 million above the FY 2012 enacted level. At this level, $340.0 million will support direct survey costs, $15.7 million will support additional costs related to direct surveys, and $31.7 million will be used for support contracts and information technology. This funding maintains statutory and policy level survey frequencies to adequately protect beneficiary quality of care and safety.

  Approximately 91 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 ESRD facilities. This funding also supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics and ambulatory surgery centers. The budget also funds support 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).

- Research, Demonstration, and Evaluation:

  CMS' research agenda has been integrated with the new Innovation Center created under Affordable Care Act to oversee applicable demonstration activity. As a result, the Research line, as a separate Program Management line item account, will be eliminated beginning in FY 2013. Research activities such as the MCBS and certain ongoing

demonstration and evaluation activities will now be funded from the Program Operations line.

- State High-Risk Pool Grants:

  CMS requests $22.0 million, a decrease of $22.0 million below the FY 2012 enacted level. This funding level provides sufficient funding to States as they begin scaling down activities in their existing State High-Risk Pools to transition to operational Exchanges.

  These grants to States help individuals with pre-existing conditions access affordable health care coverage. Additionally, the new Pre-existing Condition Insurance Plan program (PCIP) enacted in the Affordable Care Act offers new coverage options for individuals with pre-existing conditions who have been uninsured for at least 6 months.

Health Care Fraud and Abuse Control

CMS requests $610.0 million in discretionary HCFAC funding in FY 2013, an increase of $29.0 million above the full amount allowed for FY 2012 under the Balanced Budget and Emergency Deficit Control Act (BBEDCA) of 1985, as amended. The FY 2013 budget request includes a proposal to increase the FY 2012 HCFAC discretionary base to $311.0 million, fully offset, and to provide the additional $270.0 million in funding allowed by the cap adjustment, consistent with section 251 (b)(2)(C) of the BBEDCA, as amended.

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; enhancements of Medicaid audits; increased provider and supplier site visits; increased fraud hot lines and beneficiary outreach; and implementation of a robust package of program integrity legislative proposals.

Grants to States for Medicaid

The FY 2013 Medicaid request is $269.4 billion, a decrease of $1.3 billion below the FY 2012 enacted level. This appropriation consists of $178.8 billion for FY 2013 and $90.6 billion in an advance appropriation from FY 2012. These funds, together with a $14.7 billion projected unobligated balance from FY 2012 will finance $284.1 billion in estimated obligations in FY 2013. These obligations consist of:

- $263.7 billion in Medicaid medical assistance benefits;
- $1.4 billion for benefit obligations incurred but not yet reported;
- $14.7 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 2013 request for Payments to the Health Care Trust Funds account—$251.4 billion—reflects an overall increase of $20.6 billion above the FY 2012 enacted level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. 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, HCFAC and other administrative costs that are properly chargeable to the General Fund.

Conclusion

CMS' FY 2013 request for its four traditional annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $526.2 billion in FY 2013, an increase of $20.3 billion above the FY 2012 enacted level.

CMS requests $4.8 billion for Program Management in FY 2013, an increase of $1.0 billion over the comparable FY 2012 enacted level. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs and to also fund many provisions enacted in FY 2010 as part of the Affordable Care Act, including activities for new health insurance protections and programs.

CMS requests $610.0 million in HCFAC discretionary funding, an increase of $29.0 million over the full amount allowed for FY 2012 under the Balanced Budget and Emergency Deficit Control Act (BBEDCA) of 1985, as amended, which will be devoted to maintaining and improving oversight programs related to early detection and prevention, reducing improper payments, and to expanding a variety of activities including ongoing Strike Force efforts.

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 2013 performance plan includes a proposal of 38 goals (63 performance measures). We continue to track many of the measures included in the FY 2012 plan, with new FY 2013 targets consistent with the President's goals and priorities. Some performance measures were retired due to consistent annual success or to focus on significant 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, and many of our performance goals are featured in the new consolidated HHS FY 2013 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 2013 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 will not only retain, but also 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 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. As of April 2011, the Chief Performance Officer (CPO) 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 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 and 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..

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.

FY 2013 Budget by HHS Strategic Goal[1]

(Dollars in Millions)

OPDIV: Centers for Medicare & Medicaid Services

HHS Strategic Goals	FY 2011 Enacted	FY 2012 President's Budget	FY 2013 Planning Level
1.Strengthen Health Care	**863,806.6**	**830,591.4**	**886,565.9**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured	854,957.8	821,440.4	877,820.7
1.B Improve health care quality and patient safety	8,848.8	9,151.0	8,745.2
1.C Emphasize primary and preventative care, linked with community prevention services			
1.D Reduce growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations			
1.F Promote the adoption and meaningful use of health information technology			
2. Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in regulatory sciences to improve food and medical product safety			
2.D Increase our understanding of what works in health and human services			
3. Advance the Health, Safety and Well-Being of the American People			
3.A Promote the safety, well-being, resilience and healthy development of children and youth			
3.B Promote economic and social well-being for individuals, families, and communities			
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness			
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**11,524.4**	**12,222.4**	**12,279.3**
4.A Ensure program integrity and responsible stewardship of resources			
4.B Fight fraud and work to eliminate improper payments	11,524.4	12,222.4	12,279.3

[1] CMS supports additional objectives within Goal 1 and 4.

4.C Use HHS data to improve American health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A Invest in HHS workforce to meet America's health and human service needs today and tomorrow			
5. B Ensure that the Nations health-care workforce meets increased demands.			
5.C Enhance the ability of the public health workforce to improve health at home and abroad			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, state, and local and tribal surveillance and epidemiology capacity			
TOTAL*	**875,331.0**	**842,813.8**	**898,845.2**

Totals may not add due to rounding. Medicare values reflect gross obligations.

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

Program	FY 2011 Enacted 1/	FY 2012 Enacted 1/	FY 2013 Budget Request
Program Operations	$2,325,801,000	$2,658,900,000	$3,618,487,000
Federal Administration	$685,806,000	$792,964,000	$792,964,000
State Survey & Certification	$361,276,000	$355,203,000	$387,353,000
Research 2/	$35,529,000	$21,160,000	$0
High-Risk Pool Grants 3/	$0	$0	$22,004,000
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$3,408,412,000**	**$3,828,227,000**	**$4,820,808,000**
High-Risk Pool Grants 3/	$54,890,000	$44,000,000	$0
Subtotal, Appropriation/BA Current Law (Mandatory; 0511)	**$54,890,000**	**$44,000,000**	**$0**
Comparability Adjustment (SHIP Transfer to AoA)	($52,000,000)	($52,115,000)	$0
Subtotal, Appropriation/BA Current Law (Disc. + Mand.; 0511)	**$3,411,302,000**	**$3,820,112,000**	**$4,820,808,000**
General Fund Allocation	$175,553,000	$0	$0
Subtotal, Appropriation/BA Current Law (Disc. + Mand.; 0511)	**$3,586,855,000**	**$3,820,112,000**	**$4,820,808,000**
MIPPA (Mandatory; P.L. 110-275)	$38,000,000	$38,000,000	$3,000,000
Affordable Care Act (ACA; Mandatory; P.L. 111-148/111-152)	$25,000,000	$75,000,000	$75,000,000
MMEA (Mandatory; P.L. 111-309)	$200,000,000	$0	$0
Total, Appropriation/BA Current Law (0511)	**$3,849,855,000**	**$3,933,112,000**	**$4,898,808,000**
Proposed Law Appropriation (Mandatory)	$0	$0	$400,000,000
Total, Appropriation/BA Proposed Law (0511)	**$3,849,855,000**	**$3,933,112,000**	**$5,298,808,000**
Est. Offsetting Collections from Non-Federal Sources:			
User Fees, C.L.	$215,750,000	$240,200,000	$227,249,000
Recovery Audit Contracts, C.L.	$259,000,000	$310,000,000	$310,000,000
Subtotal, New BA, Current Law	**$4,324,605,000**	**$4,483,312,000**	**$5,436,057,000**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2011) 4/	$284,477,000	$265,368,000	$0
FY 2012 Carryforward Offset 5/	$0	($1,212,000)	$0
Program Level, Current Law (0511)	**$4,609,082,000**	**$4,747,468,000**	**$5,436,057,000**
Proposed Law User Fees	$0	$0	$0
Program Level, Proposed Law (0511)	**$4,609,082,000**	**$4,747,468,000**	**$5,836,057,000**
Affordable Care Act (ACA; P.L. 111-148/111-152):			
Section 1002 Consumer Assistance Grants	$0	$0	$0
Total, ACA Appropriation/BA C.L. (Mandatory; 0111) 6/	**$0**	**$0**	**$0**
Affordable Care Act (ACA; P.L. 111-148/111-152):			
Section 2701 Adult Health Quality Measures	$60,000,000	$60,000,000	$60,000,000
Section 3026 Community-Based Care Transitions	$500,000,000	$0	$0
Section 6201 National Background Checks in LTC Facilities	$0	$0	$0
Section 10323 Medicare Coverage/Environmental Health Hazards	$2,750,000	$4,000,000	$4,000,000
Total, ACA Appropriation/BA C.L. (Mandatory; 0509) 6/	**$562,750,000**	**$64,000,000**	**$64,000,000**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):			
Section 4103 Medicare Incentives	$100,000,000	$100,000,000	$100,000,000
Section 4201 Medicaid Incentives	$40,000,000	$40,000,000	$40,000,000
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 6/	**$140,000,000**	**$140,000,000**	**$140,000,000**
Total, Program Management Appropriation/BA, P.L. (All Sources) 7/	**$4,552,605,000**	**$4,137,112,000**	**$5,502,808,000**
Total Prog. Mgt. Program Level, Proposed Law (All Sources) 7/	**$5,311,832,000**	**$4,951,468,000**	**$6,040,057,000**
HCFAC Discretionary 8/	**$310,377,000**	**$581,000,000**	**$610,000,000**
Non-CMS Administration 7/, 9/, 10/	**$1,994,000,000**	**$2,174,000,000**	**$2,099,000,000**
CMS FTEs:			
Direct (Federal Administration)	4,089	4,536	4,672
Reimbursable (CLIA, CoB, RAC)	105	123	124
Subtotal, Program Management FTEs	**4,194**	**4,659**	**4,796**
Affordable Care Act (Mandatory)	16	37	35
ARRA Implementation (Mandatory)	102	160	161
Total, Program Management FTEs, Current Law	**4,312**	**4,856**	**4,992**
Program Management, Proposed Law	0	0	20
Total, Program Management FTEs	**4,312**	**4,856**	**5,012**
Affordable Care Act (Mandatory)	112	310	394
HCFAC Mandatory	83	201	205
HCFAC Discretionary	79	124	136
Medicaid Integrity (State Grants; Mandatory)	81	100	100
QIO	0	164	164
Total, CMS FTEs	**4,667**	**5,755**	**6,011**
Other Accounts (ACA Implementation Fund/GDM)	528	0	0
Total, FTEs 11/	**5,195**	**5,755**	**6,011**

1/ The FY 2011 and FY 2012 columns are shown as enacted, net of rescissions.
2/ In FY 2013, activities previously funded through the Research line will be funded through Program Operations.
3/ In FY 2011 and FY 2012, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill is enacted.
4/ Reflects remaining no-year and multi-year funding within the traditional Program Management account, excluding user fees.
5/ Reflects an offset from unexpired prior year appropriations needed to ensure the HCFAC Discretionary account meets Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA) requirements for discretionary cap adjustments.
6/ 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. In Fiscal Year 2013, Consumer Assistance Grants will be funded from discretionary resources in the Program Operations line.
7/ These amounts differ from the presentation in the President's Budget, which misclassified mandatory BA as discretionary BA within the trust fund accounts. CMS misclassified approximately $129 million of mandatory funding as discretionary, and the Social Security Administration (SSA) misclassified approximately $161 million of mandatory funding as discretionary.
8/ The President's Budget proposes to increase FY 2012 HCFAC discretionary base funding to $311 million, fully offset, and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the BBEDCA, as amended.
9/ Includes funds for the SSA, DHHS/OS, and the Medicare Payment Advisory Commission (MedPAC).
10/ The FY 2013 Federal budget is offset by $6.706 billion in proposed rescissions to section 2105(a)(3) of the Social Security Act.
11/ The FY 2011 column reflects actual FTE consumption and includes staffing funded from other sources including the ACA Implementation Fund.

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

Discretionary Appropriations

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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 and Medicaid Services, not to exceed **[**$3,879,476,000,**]***$4,820,808,000,* 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 **[**September 30, 2017**]***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 **[**$34,000,000,**]***$11,150,000,* to remain available through September 30, **[**2013**]***2014*, shall be for contract costs for the Healthcare Integrated General Ledger Accounting System: *Provided further*, That the Secretary is directed to collect fees in fiscal year **[**2012**]***2013* 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: **[***Provided further*, That $44,000,000 shall be available for the State high-risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006.**]**

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 and Medicaid Services, not to exceed **[**$3,879,476,000,**]***$4,820,808,000,* 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 new 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 **[**September 30, 2017**]***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.
Provided further, That **[**$34,000,000,**]***$11,150,000,* to remain available through September 30, **[**2013**]***2014*, shall be for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $11,150,000 of this appropriation to be available for obligation over two fiscal years, for the development of the Healthcare Integrated General Ledger Accounting System.

Program Management

Language Analysis

Language Provision	Explanation
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2012**]***2013* 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.
[*Provided further*, That $44,000,000 shall be available for the State high-risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006.**]**	Eliminates a specific language provision earmarking funds for the State High-Risk Pool program in FY 2013. Funding for the State High-Risk Pool program is included in the reference to Title XXVII of the Public Health Service Act above.

Increased Funding for BBEDCA Program Integrity Adjustments

Proposed Law Appropriations Language

Centers for Medicare & Medicaid Services

Program Management

Of the funds made available for Program Management by Public Law 112-10, $1,211,899 are hereby cancelled.

Increased Funding for BBEDCA Program Integrity Adjustments

Program Management

Proposed Law Language Analysis

Language Provision	Explanation
Of the funds made available for Program Management by Public Law 112-10, $1,211,899 are hereby cancelled.	This language provides the offset to additional budget authority provided for the Health Care Fraud and Abuse Control account in FY 2012.

Program Management Proposed Law Summary

The CMS budget request includes a proposed general fund appropriation totaling $400.0 million in FY 2013. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our discretionary request. CMS' Program Management request also includes a -$1.2 million proposal to offset a program integrity budget authority increase in FY 2012. These proposals are described 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. We estimate savings of approximately $359 billion over the next ten years from the implementation of this plan. 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.

Increased Funding for BBEDCA Program Integrity Adjustments (-$1,211,899)

CMS' budget request includes a -$1.2 million proposal to fully offset additional base funding to be provided for the Health Care Fraud and Abuse Control (HCFAC) account in FY 2012 to ensure the HCFAC account meets the requirements for cap adjustment under the BBEDCA. The offset will be taken from unexpired, unobligated funds provided for the Program Management account by Public Law 112-10.

Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
Program Operations	$2,330,462	$2,663,935	$3,618,487
Rescission	($4,661)	($5,035)	$0
Comparability Adjustment 1/	($50,000)	($50,115)	$0
Mandatory Appropriation, Proposed Law 2/	$0	$0	$400,000
Appropriation, Net, Proposed Law	$2,275,801	$2,608,785	$4,018,487
Federal Administration	$687,180	$794,465	$792,964
Rescission	($1,374)	($1,501)	$0
Comparability Adjustment 1/	($2,000)	($2,000)	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$683,806	$790,964	$792,964
State Survey & Certification	$362,000	$355,876	$387,353
Rescission	($724)	($673)	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$361,276	$355,203	$387,353
Research, Demonstration & Evaluation	$35,600	$21,200	$0
Rescission	($71)	($40)	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$35,529	$21,160	$0
State High-Risk Pool Grants 3/	$55,000	$44,000	$22,004
Rescission	($110)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$54,890	$44,000	$22,004
Discretionary Appropriation, Net	**$3,356,412**	**$3,776,112**	**$4,820,808**
Mandatory Appropriation, Net 3/	**$54,890**	**$44,000**	**$0**
Mandatory Appropriation, Proposed Law	**$0**	**$0**	**$400,000**
Total Appropriation, Proposed Law	**$3,411,302**	**$3,820,112**	**$5,220,808**
Discretionary Offset to Budgetary Resources, Proposed Law 4/	**$0**	**($1,212)**	**$0**

1/ Reflects the comparable transfer of the SHIP's to the AoA in Fiscal Years 2011 and 2012.
2/ Reflects the $400.0 million general fund appropriation needed to implement the proposals contained in the President's Budget.
3/ In FY 2011 and FY 2012, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill is enacted. In FY 2013, CMS requests these resources as discretionary.
4/ The President's Budget proposes to increase FY 2012 HCFAC discretionary base funding to $311 million fully offset, and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the BBEDCA, as amended.

CMS Program Management
Amounts Available for Obligation

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,415,242,000	$3,835,476,000	$4,820,808,000
Across-the-board reductions (L/HHS)	-$6,830,000	-$7,249,000	$0
Subtotal, Appropriation (L/HHS)	$3,408,412,000	$3,828,227,000	$4,820,808,000
Comparable transfer to (AoA):	-$52,000,000	-$52,115,000	$0
Subtotal, adjusted trust fund discr. appropriation	$3,356,412,000	$3,776,112,000	$4,820,808,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$54,890,000	$44,000,000	$0
Subtotal, Appropriation (L/HHS)	$54,890,000	$44,000,000	$0
MIPPA (PL 110-275)	$35,000,000	$35,000,000	$0
ACA (PL 111-148/152)	$527,750,000	$29,000,000	$29,000,000
Subtotal, trust fund mand. appropriation	$617,640,000	$108,000,000	$29,000,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund mand. appropriation	$617,640,000	$108,000,000	$29,000,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$60,000,000	$110,000,000	$110,000,000
MMEA (PL 111-309)	$200,000,000	$0	$0
Subtotal, trust fund mand. appropriation	$263,000,000	$113,000,000	$113,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$47,451,000	$43,000,000	$43,000,000
Coordination of benefits user fees	$34,278,000	$48,300,000	$35,000,000
MA/PDP user fees	$71,097,000	$70,100,000	$70,400,000
Revisit user fees	$6,000	$0	$0
Sale of data user fees	$8,592,000	$7,000,000	$7,119,000
Provider enrollment user fees	$4,616,000	$71,800,000	$71,730,000
Recovery audit contracts	$177,625,000	$310,000,000	$310,000,000
Subtotal, offsetting collections 1/	$343,665,000	$550,200,000	$537,249,000
Unobligated balance, start of year	$661,687,000	$1,180,941,000	$226,536,000
Unobligated balance, end of year	-$1,180,941,000	-$226,536,000	-$189,234,000
Prior year recoveries	$11,122,000	$0	$0
Unobligated balance, lapsing	-$62,689,000	$0	$0
Total obligations 1/, 2/	**$4,009,896,000**	**$5,501,717,000**	**$5,537,359,000**
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	$188,025,000	$167,874,000	$113,074,000
Unobligated balance, end of year	-$167,874,000	-$113,074,000	-$60,074,000
Prior year recoveries	$47,000	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$160,198,000**	**$194,800,000**	**$193,000,000**

1/ Current law display. Excludes the following amounts for reimbursable activities carried out by this account: FY 2011: $17,866,000. Reflects actual budget authority in FY 2011, 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/	($3,850,379,000)
2013	
Total estimated budget authority 1/	$4,820,808,000
(Obligations) 1/	($4,820,808,000)
Net Change	**$1,000,696,000**

	2012 Estimate FTE	2012 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. FY 2013 Pay Raise				$2,241,000
2. Annualization of FY 2012 Pay Raise				$57,000
3. Additional Day of Pay				$2,301,000
4. Rent and Mortgage				$949,000
Subtotal, Built-in Increases 1/				**$5,548,000**
B. Program:				
1. Program Operations		$2,608,785,000		$1,189,207,000
2. Federal Administration	4,536	$790,964,000	136	$26,525,000
3. State Survey & Certification		$355,203,000		$34,118,000
Subtotal, Program Increases 1/				**$1,249,850,000**
Total Increases 1/				**$1,255,398,000**
Decreases:				
A. Program:				
1. Program Operations		$2,608,785,000		($179,505,000)
2. Federal Administration		$790,964,000		($30,073,000)
3. State Survey & Certification		$355,203,000		($1,968,000)
4. Research 2/		$21,160,000		($21,160,000)
5. State High-Risk Pools		$44,000,000		($21,996,000)
Subtotal, Program Decreases 1/				**($254,702,000)**
Net Change 1/				**$1,000,696,000**

1/ Reflects 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 2013, ongoing research activities will be funded from the Program Operations line.

American Recovery and Reinvestment Act (ARRA):

2010	
Total estimated budget authority	$140,000,000
(Obligations)	($194,800,000)
2011	
Total estimated budget authority	$140,000,000
(Obligations)	($193,000,000)
Net Change	**$0**

	2012 Estimate FTE	2012 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. FY 2013 Pay Raise				$79,000
2. Additional Day of Pay				$81,000
B. Program:				
1. Medicare and Medicaid HIT	160	$140,000,000	1	$299,000
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT		$140,000,000		($459,000)
Net Change				**$0**

CMS Program Management
Budget Authority by Activity
(Dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
1. Program Operations	$2,330,462	$2,663,935	$3,618,487
MIPPA (PL 110-275)	$38,000	$38,000	$3,000
ACA (PL 111-148/152)	$20,000	$20,000	$20,000
MMEA (PL 111-309)	$200,000	$0	$0
Comparability Adjustment	-$50,000	-$50,115	$0
Enacted Rescission	-$4,661	-$5,035	$0
Subtotal, Program Operations	**$2,533,801**	**$2,666,785**	**$3,641,487**
(Obligations)	($2,569,364)	($2,873,742)	($3,641,487)
2. Federal Administration	$687,180	$794,465	$792,964
ACA (PL 111-148/152)	$60,000	$60,000	$60,000
Comparability Adjustment	-$2,000	-$2,000	$0
Enacted Rescission	-$1,374	-$1,501	$0
Subtotal, Federal Administration	**$743,806**	**$850,964**	**$852,964**
(Obligations)	($684,797)	($957,883)	($869,498)
3. State Survey & Certification	$362,000	$355,876	$387,353
ACA (PL 111-148/152)	$0	$0	$0
Enacted Rescission	-$724	-$673	$0
Subtotal, State Survey & Certification	**$361,276**	**$355,203**	**$387,353**
(Obligations)	($390,265)	($443,937)	($408,121)
4. Research, Demonstration & Evaluation	$35,600	$21,200	$0
ACA (PL 111-148/152)	$507,750	$59,000	$59,000
Enacted Rescission	-$71	-$40	$0
Subtotal, Research, Demonstration & Evaluation	**$543,279**	**$80,160**	**$59,000**
(Obligations)	($47,974)	($631,955)	($59,000)
5. High-Risk Pool Grants	$55,000	$44,000	$22,004
Enacted Rescission	-$110	$0	$0
Subtotal, High-Risk Pool Grants	**$54,890**	**$44,000**	**$22,004**
(Obligations)	($54,890)	($44,000)	($22,004)
6. User Fees 1/	**$166,040**	**$240,200**	**$227,249**
(Obligations)	($133,068)	($240,200)	($227,249)
7. Recovery Audit Contracts 1/	**$177,625**	**$310,000**	**$310,000**
(Obligations)	($129,538)	($310,000)	($310,000)
Total, Budget Authority 1/, 2/, 3/	**$4,580,717**	**$4,547,312**	**$5,500,057**
(Obligations) 2/, 3/	**($4,009,896)**	**($5,501,717)**	**($5,537,359)**
FTE 3/	**4,210**	**4,696**	**4,831**

1/ Reflects actual budget authority (BA) and staffing in FY 2011, comparably adjusted, as opposed to enacted values.

2/ FY 2011 excludes $17,866,000 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)	**($160,198)**	**($194,800)**	**($193,000)**
FTE	**102**	**160**	**161**

CMS Program Management
Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 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. 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

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2013.
2/ Limits authorized user fees to an amount computed by formula.

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

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2004				
Trust Fund Appropriation:				
Base	$2,733,507,000	$2,600,025,000	$2,707,603,000	$2,664,994,000
Rescissions (P.L. 108-199)	$0	$0	$0	($28,148,000)
MMA (PL 108-173)				$1,000,000,000
Subtotal	$2,733,507,000	$2,600,025,000	$2,707,603,000	$3,636,846,000
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	$29,000,000
Subtotal	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,936,227,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2013 2/				
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	$4,820,808,000	$0	$0	$0
MIPPA (PL 110-275)	$0	$0	$0	$0
ACA (PL 111-148/152)	$0	$0	$0	$29,000,000
Subtotal	$4,820,808,000	$0	$0	$29,000,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

1/ Base funding for for High-Risk Pools have since been rebased as mandatory through the CHIMP process.

2/ Reflects 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 2013

CMS Program Management has no appropriations not authorized by law.

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Program Operations

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
BA	$2,325,801,000	$2,658,900,000	$3,618,487,000	+959,587,000
Comparability Adjustment 1/	$(50,000,000)	$(50,115,000)	$0	+50,115,000
Adjusted BA	$2,275,801,000	$2,608,785,000	$3,618,487,000	+1,009,702,000

1/ The FY 2011/2012 funding levels include comparability adjustments to reflect the FY 2013 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

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 2013 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 health care programs. These include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with end-stage renal disease; the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; and the Children's Health Insurance Program or CHIP, established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels.

With the passage of the Affordable Care Act (ACA), CMS is responsible for several major new programs and the creation of new centers and offices within CMS, including

the Center for Medicare and Medicaid Innovation. In FY 2011, CMS also assumed responsibility for the new Center of Consumer Information and Insurance Oversight (CCIIO).

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 52 million beneficiaries expected in FY 2013. 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 2013, CMS approximates 13 million beneficiaries will enroll in MA plans.

Medicare Part D provides voluntary prescription drug coverage. Most Medicare beneficiaries, including over 11 million low-income beneficiaries in 2013, will 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 2013, approximately 38 million beneficiaries will receive Part D benefits, including approximately 35 million enrolled in a Part D private plan and 3 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 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. In addition, Medicaid also provides community based long-term services and supports to seniors and individuals with disabilities, as well as institutional long term 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 administration 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 systems, contracts, and intra-agency agreements.

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. The funding for CHIP included in the Program Operations chapter covers certain administrative expenses such as systems, contracts, and intra-agency agreements.

Health Care Market Reform

CMS, in close collaboration with the Departments of Labor and Treasury, is responsible for ensuring compliance with the new insurance market rules enacted in the ACA. CMS also 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 State-based Affordable Insurance Exchanges. Finally, CMS compiles and maintains data for an internet portal providing information for consumers on insurance options. These activities undertaken by CMS in FY 2010 and FY 2011 were funded through the $1 billion appropriation included in the ACA, and other mandatory appropriations.

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 to expand efforts that improve the efficiency of payment, delivery, access and quality of our health care programs that will serve nearly 106 million beneficiaries in FY 2013.

Funding History

FY 2008	$2,158,906,000
FY 2009	$2,265,715,000
FY 2010	$2,335,862,000
FY 2011	$2,325,801,000
FY 2012	$2,658,900,000

Budget Request: $3,618.5 Million

CMS' FY 2013 budget request for Program Operations total is $3,618.5 million, $1,009.7 million more than the comparably-adjusted FY 2012 enacted level. The majority of the Program Operations account funds CMS' traditional Medicare operations. These activities include processing fee-for-service claims, responding to provider and beneficiary inquiries, overseeing Part C and D plans, providing outreach and education, systems support, and financial management oversight.

The FY 2013 request also includes funding for Medicaid and CHIP operations previously funded through the Federal Administration line, Research, Demonstrations, and Evaluation, and includes provisions enacted in the ACA. These provisions enhance all three existing health care programs - Medicare, Medicaid, and CHIP.

Program Operations

(Dollars in Millions)

Activity	FY 2011 Enacted Level[1]	FY 2012 Enacted Level[1]	FY 2013 President's Budget	FY 2013 +/- FY 2012
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$1,039.883	$956.843[2]	$1,034.289	+77.446
FFS Operations Support	$65.136	$51.680	$51.987	+0.307
Claims Processing Investments	$78.739	$81.928	$84.581	+2.654
DME/Part B Competitive Bidding	$0.100	$8.945	$55.060	+46.115
Contracting Reform	$18.471	$30.094	$21.485	-8.609
II. Other Medicare Operational Costs				
Accounting & Audits	$163.387	$162.143	$139.927	-22.216
QIC Appeals (BIPA 521/522)	$58.487	$60.549	$63.538	+2.989
HIPAA Administrative Simplification	$23.859	$26.776	$39.919	+13.143
ICD-10/5010	$60.208	$55.600	$48.359	-7.241
Research, Demo, & Evaluation	$35.529[3]	$21.160[3]	$24.567	+24.567
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	--	$12.817	$27.763	+14.946
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$73.571	$78.423	$81.127	+2.704
Oversight & Management	$67.044	$151.878	$655.276	+503.398
V. Health Care Quality				
Health Care Improvement Initiatives	$89.300	$163.115	$155.025	-8.090
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$251.389	$249.366	$289.238	+39.872
Provider Outreach	$17.750	$29.900	$27.900	-2.000
Consumer Outreach	$0.000	$57.617	$350.893	+293.276
VII. Information Technology				
IT Investments	$268.477	$431.112	$467.552	+36.441
TOTAL	**$2,275.801**	**$2,608.785**	**$3,618.487**	**+1,009.702**

[1] The FY 2011 and FY 2012 enacted levels include a comparability adjustment of -$50 million for NMEP to reflect the FY 2013 request to transfer funding for the State Health Insurance Assistance Program from CMS to AoA.

[2] The FY 2012 enacted level does not include $50.0M used for claims processing from The Medicare & Medicaid Extender's Act, P.L. 111-309.

[3] The FY 2011 and FY 2012 enacted levels for Research, Demonstration, and Evaluation are only shown for display purposes – the actual Program Ops funding levels are $0 for both years. Funding in FY 2011 and FY 2012 came from the Program Management Research line and are treated as a non-add in the total Program Ops appropriated amounts.

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 (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.
    - 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 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 review 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 2011, the MACs processed approximately 2.76 million redeterminations. In FY 2013, CMS contractors expect to process approximately 3.1 million redeterminations. This reflects a continued steady increase in redeterminations and a 6% increase above the current estimate for FY 2012.

  The second level of appeal is a reconsideration 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 2011, contractors responded to over 41 million telephone inquiries from 2 million providers, and over 400,000 written inquiries as well as rare walk-in inquiries. The contractors utilize Interactive Voice Response (IVR) systems to automate about 68.5 percent of their telephone inquiries. This frees up customer service representatives to handle the more complex questions. CMS believes the call volume will stabilize through FY 2013 assuming no new major legislative changes or initiatives and a minimal impact for implementing DME Competitive Bidding.

- *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 (including the CMS-460, the CMS Announcement and supplemental provider education information) to providers. The open enrollment period runs from November 15 through December 31 of each year.

CMS has made more information available at its http://www.medicare.gov website 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 2011, 628,366 physicians "participated" out of 646,818 enrolled physicians (97.1%), and out of a total of 1,022,909 physicians, LLPs, and NPPs, 981,644 participated (96.0%).

- *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 for 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.

  As part of CMS' vision, all production applications, including Part C/D systems, will be hosted in one of the EDCs. CMS moved the entire FFS claims processing workload to the EDCs in February of 2009. However, specific FFS workloads within the EDCs will continue to be realigned to match contractor transitions that will take place through FY 2011 and early FY 2012. The Part C/D systems migration is still in the preliminary planning phases. The request covers the operations and maintenance costs associated with these three contracts.

Budget Request: $1,034.3 Million

The FY 2013 budget request for Ongoing Operations is $1,034.3 million, an increase of $77.4 million[2/] above the FY 2012 enacted level.

This request allows the contractors to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements. This funding level covers a projected 2.5 percent increase in claims volume from the current FY 2012 estimate as well as maintains the same level of support for provider inquiries regarding new provisions and benefits.

In FY 2013, CMS' contractors expect to:

- process over 1.2 billion claims
- handle 3.1 million redeterminations
- answer 41.0 million provider inquiries

The following table displays claims volumes and unit costs for the period FY 2007 to FY 2013. 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 reduced 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 2007 – 2013)

Volume (in millions)	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Actual**	**FY 2012 Estimate**	**FY 2013 Estimate**
Part A	185.7	187.1	191.4	195.2	200.9	205.9	211.0
Part B	970.0	987.8	992.2	979.5	987.6	1,012.3	1,037.6
Total	**1,155.7**	**1,174.9**	**1,183.6**	**1,174.7**	**1,188.5**	**1,218.2**	**1,248.6**
Unit Cost (in dollars)							
Total	**$0.98**	**$0.87**	**$0.85**	**$0.89**	**$0.87**	**$0.84**	**$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:

- *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. This is a continuing project to operate the program mandated by Section 1011 of the MMA. 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: $52.0 Million

The FY 2013 request for fee-for-service operations support is $52.0 million, an increase of $0.3 million above the FY 2012 enacted level. This level will fund a variety of activities including the following:

- *Planning & Support:* $6.4 million. Funding supports various ACA activities such as the limitation on Medicare exception, Medicare self-referral disclosure, and other support.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $5.0 million. Funding supports steady state operations and quarterly claims processing for the program.

- *Home Health Initiatives*: $4.7 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 HH PPS changes.

- *Contract Surveys and Business Expertise*: $4.6 million. The requested funds are required to maintain the current Medicare contracting reform schedule and meet implementation and procurement deadlines, and measure provider satisfaction for services provided by the contractors.

- *Actuarial Services & Contract Audits*: $3.4 million. This request supports contracts assisting the Actuary in providing actuarial cost estimates for various demonstrations and other issues required by provisions of the law. In addition, funds are requested to perform various contract oversight activities.

- *A-123 Assessment:* $3.0 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.

- *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.

- *Limitation on Recoupment*: $1.7 million. This request funds the ongoing processing of this statutory requirement.

- *Other Operational Costs:* $21.3 million. This request supports some of the activities involving payment adjustments, provider validation, HEDIS performance measurement, and 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: $84.6 Million

The FY 2013 request for claims processing investments is $84.6 million, a $2.7 million increase above the FY 2012 enacted level. The increase in funding level will support an expected 2.5 percent growth in claims volume.

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 2009-2012 implementation was postponed due to contractual issues and the CAP remains on hold. Current activity includes finalizing a number of remaining appeals and claims inquiries as well as adjusting claims that are overturned on appeal at the Administrative Law Judge (ALJ) level.

- *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.

  As required by law, CMS conducted the Round One competition in ten MSAs for ten DMEPOS product categories, and implemented the program on July 1, 2008. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, temporarily delayed the program, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009 in nine MSAs for nine product categories, referring to it as the Round One Rebid. Contracts and prices for the Round One Rebid became effective on January 1, 2011. MIPPA also delayed competition for Round Two in 70 MSAs until 2011 and in additional areas of the country until after 2011. Recent legislation expands the number of Round Two MSAs by 91 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.

  The funding allocated to support the DMEPOS Competitive Bidding Program from MIPPA expires in 2012 and as a result, CMS requests additional funding for the activities associated with completing Round 2 and re-competing the original Round 1 program.

Budget Request: $55.1 Million

- *Competitive Bidding for Part B Drugs:* $0.1 million, the same as the FY 2012 enacted level.

- *DME Competitive Bidding:* $55.0 million, an increase of $46.1 million above the FY 2012 enacted level. In FY 2013, the implementation contractor will expand operations by 91 additional MSAs and implement a National Mail Order competition. The contractor will solicit bids from suppliers, evaluate bids, set prices, and select the winning bidders; conduct a major education campaign; perform monitoring and complaint resolution; maintain and store the bid database; and continue necessary ongoing maintenance in the original MSAs.

  OACT estimates this program will produce substantial savings to the Medicare program. Net Medicare savings are projected to grow from over $400.0 million in 2013, to over $3 billion per year by 2018.

Contracting Reform

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.

- *IT Systems* - Contractor Management Information System (CMIS), maintenance and enhancements for the eChimp system, and the Common Electronic Data Interchange (CEDI) system. The Contractor Management Information System (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 reporting 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 and retrieval of electronic transactions. This standardization allows greater efficiencies in inbound and outbound EDI exchange.

- *Contracting Support* - Funding will be used to obtain expert procurement 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 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. A fourth DME MAC "second generation" contract award for DME Jurisdiction C is undergoing a recomplete in the first quarter of FY 2012. In addition, CMS is now in the process of procuring "second generation" A/B MAC contracts. Therefore, the need for procurement and implementation support will continue beyond October 1, 2011.

This request provides for implementation support, expert support for procurement panels for Jurisdictions E, K, L, N, and J (formerly Jurisdictions 1, 13 & 14, 12, 9 and 10) and accounting system and disclosure statement audits. In addition, this request provides funding for an intra-agency agreement with the Office of General Counsel (OGC) for additional legal support of the MAC procurements as these procurements are high-value, high-risk procurement actions that are subject to bid protests. The funds are needed to ensure the continued success of CMS' Medicare Contracting Reform effort.

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 to ten by 2016. The first of the consolidated jurisdictions to be awarded were Jurisdictions F and H. Please refer to the charts below for additional information.

DME MAC Implementation Plan

DME MAC Region A	Awarded January 2006. Fully operational since July 2006. Contract was re-competed and awarded in March 2011. The award had been protested and the protests were withdrawn.
DME MAC Region B	Awarded January 2006. Fully operational since July 2006. Contract was re-competed and awarded in September 2010.
DME MAC Region C	Awarded January 2006; bid protest activity resolved January 2007. Fully operational since June 2007. A solicitation was posted for the re-compete and proposals are being evaluated. Recompete in progress.
DME MAC Region D	Awarded January 2006. Protest resolved May 2006. Fully operational since October 2006. Contract was re-competed and awarded in February 2011.

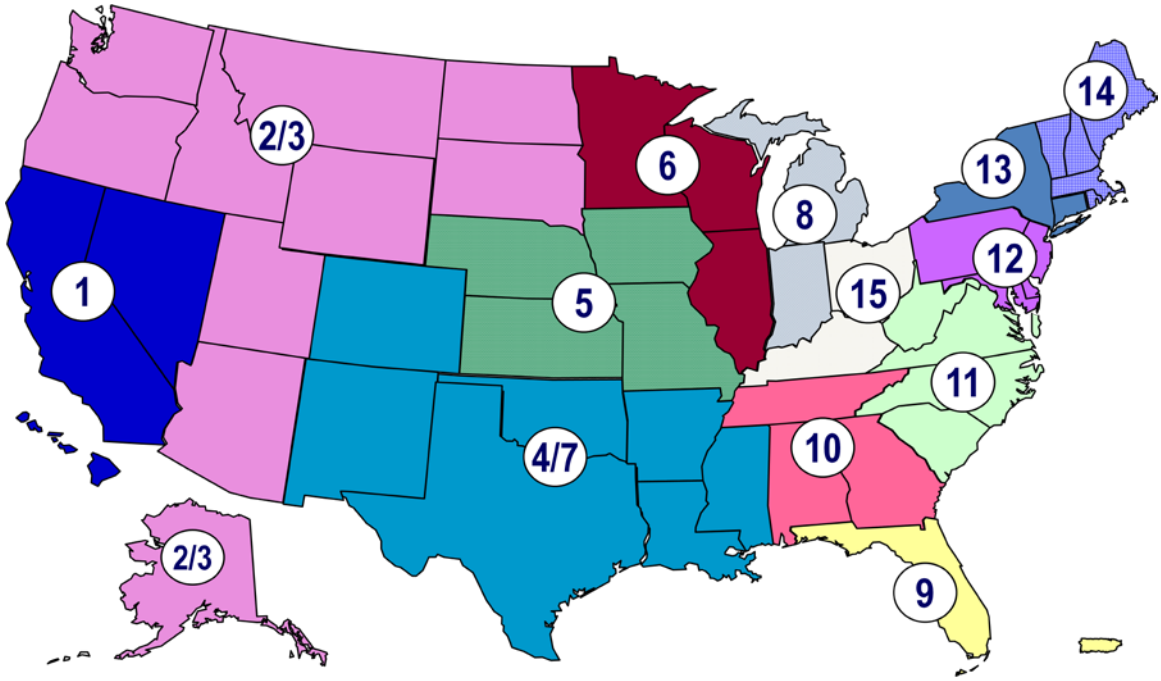
A/B MAC Implementation Plan

Current A/B MAC Jurisdiction	Renamed and/or Consolidated MAC Jurisdiction	Current Status
Jurisdiction 1	**Jurisdiction E**	• J1 was awarded in October 2007 (fully operational). • J1 to be re-named JE. • Solicitation for JE was posted in December 2011. • Proposals are due in for evaluation in January 2012. • Contract slated for award in CY 2012.
Jurisdictions 2 and 3	**Jurisdiction F**	• J2 & J3 are now combined and operational as JF. • JF was awarded in August 2011. • J2 was initially awarded May 2008 and the procurement cancelled following bid protest

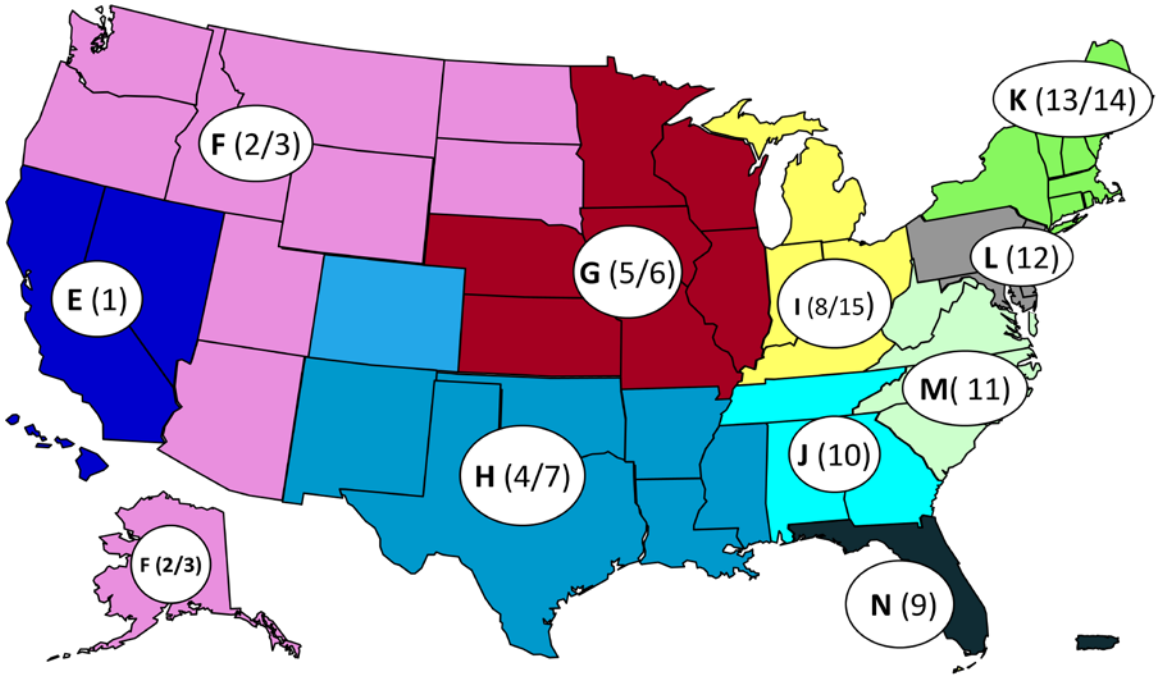
		activity. J2 was then combined with J3 into JF. • J3 was initially awarded in July 2006 and had been fully operational since May 2007. J3 was combined with J2 into JF.
Jurisdiction 5	**Jurisdiction G**	• J5 was initially awarded September 2007. • A solicitation for the re-compete was posted in June 2011 and proposals are currently being evaluated. • An award is anticipated in FY 2012.
Jurisdiction 6		• J6 was initially awarded January 2009, protested and put in corrective action. • A re-solicitation was posted and the contract was awarded in Sep 2011. This contract was protested and is under a stay as of 11/8/2011. • CMS intends to solicit the consolidated JG contract (which will combine J5 & J6) during 2015. • J6 provides for Medicare home health and hospice claims processing requirements.
Jurisdiction 4	**Jurisdiction H**	• J4 & J7 are being consolidated into J H. • CMS awarded the JH contract in November 2011and it was protested. This contract is under a stay as of 11/22/2011. • J4 was initially awarded August 2007. • J7 was initially awarded in June 2008.
Jurisdiction 7		(SEE Jurisdiction 4)
Jurisdiction 8	**Jurisdiction I**	• J8 was initially awarded in January 2009, protested and put in corrective action. • A re-solicitation was posted and award was made in September 2011 and protested. This contract is under a stay as of 11/8/2011. • J8 and J15 will be combined into JI in 2015.
Jurisdiction 15		• J15 was awarded January 2009. Corrective action has been resolved and workload re-awarded in July 2010. It is fully operational. • J8 and J15 will be combined into JI in 2015. • J15 provides for Medicare home health and hospice claims processing requirements.
Jurisdiction 10	**Jurisdiction J**	• J10 was awarded in January 2009 and is fully operational. • It will be renamed JJ and a solicitation will post for this re-compete in late FY 12/early FY13.
Jurisdiction 13	**Jurisdiction K**	• J13 was awarded in March 2008 and is fully operational. • J13 will be consolidated with J14 and re-

		named JK • JK solicitation will be posted in FY 2012.
Jurisdiction 14		• J14 was awarded November 2008 and is fully operational. • J13 will be consolidated with J14 and re-named JK • JK solicitation will be posted in FY 2012. • J14 provides for Medicare home health and hospice claims processing requirements.
Jurisdiction 12	**Jurisdiction L**	• J12 was awarded in October 2007 (corrective action completed). • J12 will be re-named JL • The solicitation for JL was posted in January 2012. • An award is slated for FY 2012/2013.
Jurisdiction 11	**Jurisdiction M**	• J11 was initially awarded January 2009. • The corrective action was resolved and workload re-awarded May 2010. • J11 is fully operational. • J11 will be re-named JM and the solicitation will be posted for JM in FY 2014. • J11 provides for Medicare home health and hospice claims processing requirements.
Jurisdiction 9	**Jurisdiction N**	• J9 was awarded in September 2008 and is fully operational. • J9 will be re-named JN and re-competed in FY 2012-2013.

The following map presents the A/B MAC jurisdictions as of first quarter, FY 2012.



The following map presents the ten consolidated A/B MAC jurisdictions that CMS intends to establish by 2016.



Please note that in transitioning from 15 to 10 A/B MAC jurisdictions, the Jurisdictions will be re-named as indicated in the chart below. Jurisdictions A through D are reserved for DME-MACs.

New Jurisdiction	Old Jurisdiction
E	1
F	2 & 3
G	5 & 6
H	4 & 7
I	8 & 15
J	10
K	13 & 14
L	12
M	11
N	9

Budget Request: $21.5 Million

The FY 2013 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 three IT systems needed to manage and oversee the MACs including the Contractor Management Information System (CMIS), maintenance and enhancements for the eChimp system, and the Common Electronic Data Interchange (CEDI) system.

For the five year period FY 2012 – FY 2016, the CMS actuary estimated trust fund savings 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:* $7.3 million. 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 (Contractor Support):* $14.2 million. Upon the successful implementation from the FI/carrier contracts to MACs, CMS needs to plan for the continuing transition of workloads from an existing MAC to a new MAC in cases where incumbent MACs do not successfully win any re-bids of their contracts. During FY 2012 and 2013, in addition to settling out a number of legacy (FI/carrier) contract termination claims, CMS anticipates implementing MAC contracts for Jurisdiction 5 and Jurisdictions E, K, L, N, and J (formerly Jurisdictions 1, 13 and 14, 12, 9, and 10).

II. OTHER MEDICARE OPERATIONAL COSTS

Program Description and Accomplishments

Accounting and Audits

- *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 and 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 directly supports DHHS efforts to meet compliance goals of FFMIA by encompassing all CMS program dollars (Medicare, Medicaid, Children's Health Insurance Program (CHIP) and administrative program accounting) on HIGLAS by FY 2012. The FFMIA requires each agency to implement and maintain financial management systems that comply with federal requirements and accounting standards. HIGLAS is a critical success factor towards ensuring DHHS meets FFMIA compliance requirements. In addition, transitioning Medicare contractors to HIGLAS enables CMS to resolve a material weaknesses identified in the CFO audits related to the accounting of Federal dollars. Through further implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the continued development and 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/DHHS 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 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 $467 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes.

Since FY 2008, CMS continues to realign its HIGLAS implementation schedule in accordance with the Agency's adjusted MAC implementation schedule and continues to closely and actively monitor/manage efforts in an integrated manner and at the highest levels within the Agency. To date, CMS has deployed HIGLAS at fourteen traditional Medicare fee-for-service contractors and 19 Medicare Administrative Contractor (MACs) sites, achieving greater than 96 percent of total FFMIA compliance including Medicaid and Children's Health Insurance Program federal funding. The HIGLAS project continues to progress on schedule and within budget. The greatest challenge faced by HIGLAS thus far is continuing to ensure that HIGLAS planned transition schedule efforts are fully integrated in concert with the Agency's MAC project implementation efforts. CMS has revised its HIGLAS transition schedule multiple times over the last three years due to the ongoing MAC protest actions.

During FY 2012, HIGLAS will continue moving forward with positive progress in accomplishing the planned MAC transitions to HIGLAS in accordance with the Agency's HIGLAS implementation schedule. CMS currently remains on track with HIGLAS-MAC planned transition activities and expects to meet the Agency's FY 2012 integrated transition schedule. During FY 2012, CMS anticipates reaching 100 percent of FFMIA compliance with the planned transition of 7 additional MAC sites onto HIGLAS, as well as the MSPRC transition to HIGLAS.

In FY 2013, HIGLAS plans to roll out the remaining internal CMS Administrative Program Accounting functionality to HIGLAS. We will also continue supporting the production and application maintenance at the contractor entities that will be utilizing HIGLAS in FY 2013.

- *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 we comply 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: $139.9 Million

The FY 2013 budget request for HIGLAS and the CFO audit is $139.9 million, a decrease of $22.2 million below the FY 2012 enacted level. These efforts are critical to support the Agency's clean opinion on the CFO audit, the "One HHS" goal to improve financial management, the ability of the Department to realize its UFMS goals and objectives, and the ability to meet OMB-mandated Federal Financial Management Improvement Act (FFMIA) compliancy requirements for CMS and HHS.

- *HIGLAS*: $129.4 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 system integration technical and analytical services.

  Upon full implementation of all MAC awards, CMS anticipated that HIGLAS will be implemented in 13 Part A MACs, 13 Part B MACs, 4 DMEs, and 1 RRB.

  In FY 2013, CMS plans to complete all remaining HIGLAS transition activities, and complete development efforts associated with incorporating the remaining internal CMS Administrative Program Accounting functionality onto HIGLAS. The budget request is attributable to HIGLAS transition activities including MAC-HIGLAS transitions, MAC and CMS Enterprise Data Center (EDC) accounting organization merges for HIGLAS and Medicare Customer Information Control System (CICS) regions, HIGLAS system operations and maintenance sustainability costs, and HIGLAS systems integration contract re-compete resource requirements.

HIGLAS Costs - FY 2010 through FY 2013
(Dollars in Millions)

	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Development, Modernization & Enhancement	$35.681	$35.610	$33.936	$11.150
Operations & Management	$125.319	$118.277	$118.207	$118.277
Total	$161.000	$153.887	$152.143	$129.427

- *CFO/Financial Statement Audits:* $10.5 million. The cost of the audit is funded through an interagency agreement between CMS and the Department. The cost of the audit 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.[4] In accordance with 42 CFR §405.970(c), if a QIC is unable to complete the appeal within the mandated 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). A table illustrating the figures regarding the timeliness of QIC activities is provided below.

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.

BIPA Section 522 allows certain beneficiaries in need of an item or service to appeal National Coverage Determinations (NCDs). An NCD is a decision made by CMS controlling the coverage of benefits and services that might be available to Medicare beneficiaries on a national scale. CMS assists with the review and preparation associated with an NCD appeal and ensures that there is a complete and adequate record for any NCD appeal.

Another important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). The MAS' goal is to support the end-to-end 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: $63.5 Million

The FY 2013 budget request for QIC appeals (BIPA sections 521 and 522) is $63.5 million, a $3.0 million increase above the FY 2012 enacted level. As of January 10, 2012, the QICs received 514,234 reconsideration requests in FY 2011[5], an increase of more than 20,000 from FY 2010. CMS requests an increase in funding for the QIC activities as there has been a steady increase in QIC appeal receipts over the past fiscal years (approximately 4% in FY 2011) and CMS anticipates an ongoing increase as the number of beneficiaries in the Medicare program continues to increase in FYs 2012 and 2013.

- *QIC Costs*: $57.9 million, an increase of $2.9 million above the FY 2012 enacted level.

[4] 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.
[5] The second level appeals activities noted in the above chart do not include the Recovery Audit Program appeals. That workload is being tracked, reported, and funded separately.

- *Medicare Appeals System (MAS):* $5.7 million, an increase of $0.1 million above the FY 2012 enacted level.

The following chart details the number of QIC appeals from FY 2008 through FY 2013:

QIC Appeals Workload
(Appeals in Hundreds)

	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
QIC Appeals	411,600	456,849	494,077	514,234[6]	527,090	560,267

The following chart details the percentage of appeals completed timely by type from FY 2007 through FY 2011:

Percent of QIC Appeals Completed by Level
(FY 2007 through FY 2011)

FY	Reconsiderations (2nd Level of Appeal)	
	Part A	Part B
2007	99.90%	72.28%
2008	99.89%	99.69%
2009	99.82%	99.01%
2010	99.96%	99.87%
2011*	99.96%	92.78%

**QIC data updated as of January 9, 2012.*

*In 2011, the QICs received a large unanticipated increase in appeals workload, from increases in Medicare claims and Medical Review efforts, resulting in a 6 percent drop in the timely completion of cases.

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.

[6] FY 2011 Actual represent appeals data as of January 10th, 2012.

It also makes subsequent changes to the data of enumerated providers. Providers are required to keep their NPPES data current by submitting timely updates to NPPES. 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.

- *HIPAA Claims-Based Transactions* – HIPAA requires Medicare to comply with the requirement to respond to electronic requests for eligibility information from providers and health care institutions for Medicare beneficiaries using the adopted standard. Medicare built the H Eligibility Transaction System (HETS) to provide a standard health care eligibility inquiry and response to. The HETS system 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. Methods used to perform these contractor oversight activities 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, Compliance Reviews, Pilots, & Simplification* – This project includes outreach programs for covered entities and other affected organizations, as well as enforcement efforts:

    - Outreach efforts include national roundtable discussions, web support, conferences, educational materials, and HIPAA On-Line, a free, interactive internet-based program that provides timely information to consumers and employers.
    - Enforcement activities consist of investigative contractor activity to support review, analysis and tracking of 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 pilot tests of the HIPAA technical standards (new in 2012).

Budget Request: $39.9 Million

The FY 2013 budget request for HIPAA Administrative Simplification is $39.9 million, an increase of $13.1 million above the FY 2012 enacted level. This includes funding for the following activities:

- *NPI & NPPES*: $9.2 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):* $12.1 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 2013 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, Pilots:* $18.6 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.

ICD-10 and Version 5010 Regulations

To date CMS has made significant progress on its implementation of both Version 5010 and ICD-10. CMS' Medicare Fee for Service program was compliant with the use of the Version 5010 standard by the mandated compliance date of January 1, 2012. The majority of the State Medicaid programs except for a handful were also in various stages of compliance. CMS' Office of E-Health Standards and Services, which has authority delegated from the Secretary to enforce the HIPAA transactions and code sets, allowed for a 90-day enforcement discretion period – until April 1, 2012 – to allow small providers and vendors an opportunity to complete their testing and installations, respectively, without fear of penalty.

Overall, CMS' ICD-10 implementation program is on track to meet the October 1, 2013 compliance date. CMS's ICD-10 Executive Steering Committee meets bi-weekly to discuss the program's progress among all CMS components. Education and training are being offered on an ongoing basis both internally and externally; contractor change requests and requirements are continuing to be developed, and policy, process, and system changes are being made agency-wide, with selected CMS components having already completed their work. Both intra- and inter-system testing of ICD-10 begins in early 2012, with final end-to-end testing anticipated in March/April of 2013.

Reducing health care fraud, waste, and abuse is a major priority of the Administration. Each year that Medicare continues to use the ICD-9-CM code set, the more likely it becomes that claims could be paid inaccurately, potentially leading to increased costs. The ICD-9-CM code set does not provide detailed information concerning a patient's diagnosis, or reflect technologically updated procedures or tests that a provider orders. This makes detailed medical review necessary to detect if a claim was paid improperly. ICD-10 is much more specific, making it easier to determine if a claim was appropriately billed. CMS believes that ICD-10's increased specificity will make it much more difficult for fraud, waste, and abuse to occur. The use of ICD-10 also will allow the United States to share its health care data with other countries in the event of a pandemic.

Both Version 5010 and ICD-10 are foundational to many of the tenets of the Health Information Technology for Economic and Clinical Health Act (HITECH) and the ACA, as they offer improvements to electronic health care transactions and more robust data. This supports the information needs associated with meaningful use, electronic health records, and administrative simplification that will result in cost savings to many industry segments. Changing from a volume-based healthcare system to a value-based system is another central goal of this initiative. Specific and accurate data is vital to the success of a value-based purchasing (VBP) program. The ICD-9-CM code set does not provide the level of specificity needed for VBP, which considers both quality and cost of care over an appropriate period of time. ICD-10 provides very specific information about a patient's diagnosis and the procedures that were performed. As a result, payers can ascertain if additional services were performed because of provider error, leading to cost savings when a payer declines to pay for provider errors.

The ICD-9-CM code set also does not capture new developments in technology, and its usefulness will only continue to diminish as newer technology is introduced. CMS has prolonged the life of ICD-9-CM by placing the codes for new technologies in unrelated chapters of the code book. However, this makes it difficult for medical coders to find these new procedures and compromises the integrity of the code set. Additionally, the implementation of new programs and provisions using ICD-9 codes will lead to an increase in workload.

The process of converting from ICD-9-CM to ICD-10 is a major undertaking that will include revision of instruction manuals, updating of claims processing systems and medical software, outreach and education, and coding and policy analyses. In order to implement ICD-10, the current version of HIPAA transactions must first be upgraded from Version 4010 to 5010 to accommodate the use of the longer ICD-10 codes.

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

History of regulations: On January 16, 2009, HHS published two final rules to adopt updated HIPAA standards. In one rule, HHS adopted ASC X12 Version 5010 and National Council for Prescription Drug Programs Version D.0 for HIPAA transactions. In this rule, HHS also adopted a new standard for Medicaid subrogation for pharmacy claims, known as NCPDP Version 3.0. For Version 5010 and Version D.0, the compliance date for all covered entities was January 1, 2012. The compliance date for the Medicaid subrogation standard was also January 1, 2012, except for small health plans, which will have until January 1, 2013 to become compliant.

In a second rule, HHS adopted the ICD-10-CM for diagnosis coding and the ICD-10-PCS for inpatient hospital procedure coding. These new codes replace the current ICD-9-CM codes for diagnoses and procedures. The compliance date for ICD-10 is October 1, 2013 for all HIPAA covered entities. Version 5010 accommodates space for the longer ICD-10 code sets, and as such, has an earlier compliance date in order to ensure adequate testing time for the industry. These two rules apply to all HIPAA covered entities, including health plans, health care clearinghouses, and certain health care providers.

In 2008, Medicare began a multi-year effort to convert all systems that deal with claims data to the new Version 5010 formats for electronic claims and claims-related transactions, completing a gap analysis of the format changes, and initiating an impact assessment of the Medicare FFS systems that would require modification to accommodate the new data. Modifications to the core systems, the front-end systems, and several downstream systems for Version 5010 have been completed. Medicare Fee-for-Service began accepting claims with Version 5010 in production mode in April 2011. All health care providers were required to be ready to use the new Version 5010 transactions by January 1, 2012.

Medicare and other components within CMS anticipate that modifications to affected CMS systems and business operations for ICD-10 will continue with internal testing occurring during FY 2013. FY 2013 activities include a continuation of industry and State Medicaid program implementation monitoring. All affected components and business operations across CMS also expect that external testing of ICD-10 will occur during FY 2012 and FY 2013 in order to ensure that transactions between trading partners are compliant by the implementation date. All health care covered entities must be ready to accept and receive ICD-10 codes by October 1, 2013.

Budget Request: $48.4 Million

The FY 2013 budget request for ICD-10/Version 5010 is $48.4 million, a decrease of $7.2 million below the FY 2012 enacted level.

- *ICD-10:* $48.4 million, an increase of $4.3 million above the FY 2012 enacted level. In FY 2013, additional funds are needed as CMS intensifies efforts to meet the ICD-10 implementation date of October 1, 2013. FY 2013 represents the bulk of CMS implementation efforts, which include systems conversions and more intense outreach and education. CMS will continue to develop and initiate an industry-wide provider education and outreach strategy; conduct code and policy analysis to update CMS processes that utilize ICD-10 codes; develop and initiate program management support for implementation activities such as monitoring and tracking of industry compliance; initiate updating Medicare FFS core processing systems and CMS downstream and front-end systems that utilize ICD-10 codes. The increase in funding also supports training for CMS and contractor staff, and revisions to manuals and forms.

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 to expand efforts that improve the efficiency of payment, delivery, access and quality of our health care programs that will serve nearly 106 million beneficiaries in FY 2013.

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

- *Medicare Current Beneficiary Survey (MCBS)* – The MCBS is a continuous, multi-purpose survey that represents our Medicare population. The survey's design aids CMS' administration to monitor and evaluate the Medicare program. The survey's focus is on health care use, cost and source of payment. The MCBS is the only comprehensive source of multi-dimensional person-based information about the characteristics of the Medicare population (both managed care and fee-for-service) and their access to and satisfaction with Medicare services. The MCBS provides a unique set of information not available through CMS administrative data, such as self-reported health status and cost and utilization information from non-Medicare payers.

  The MCBS has been used both internally and externally in research and development activities, such as defining CMS risk-adjustment formulas and for evaluating outcomes associated with managed care payments.

  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.

The MCBS is used for program monitoring. For example, CMS researchers monitor the level of prevention to determine how preventive medical care and preventive self-care can be fostered. We also monitor the Part D program interfacing our beneficiary population and CMS to supplement and give meaning to the claims files.

- *Demonstrations* – The Agency 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. CMS evaluates demonstrations and apply 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 2011, 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, and Other areas.

  CMS publicly released numerous demonstration evaluation reports in 2011. A few of those reports include the Rural Hospice Demonstration Report to Congress, the Evaluation of the Electronic Health Records demonstration and the Medicare Gainsharing demonstration Report to Congress on Quality Improvement and Savings. Other demonstration evaluation reports released as part of the program management research agenda may be found at http://www.cms.gov/Reports/Reports/list.asp.

- *Other Research* – Other research projects include program evaluations, prospective payment systems evaluation, refinement and monitoring, and health service research capacity building and improving.

  The program evaluations provide information and statistics on the infrastructure of the health care system and the populations of health care users. CMS presents service and expenditure patterns, variations in costs, quality and access to care. CMS evaluates the impact of potential program changes on beneficiaries and other stakeholders to provide evidence-based knowledge that informs the policy and budget decision-makers before enactment of full-scale program changes.

  The research agenda also incorporates the evaluation of all new and existing prospective payment systems (PPS) as they proceed through stages of implementation, refinement or monitoring. The PPS systems include inpatient psychiatric services, inpatient diagnosis-related groups, home health services,

physician payments, end-stage renal disease (ESRD), inpatient acute care hospital, long-term care and skilled nursing facility.

CMS publicly released numerous reports and studies in 2011 including the Rural PACE Provider Grant Program Report to Congress, the Optimal Pay-for-Performance Scores: How to Incentivize Physicians to Behave Efficiently Using Episode-Based Measures and Medical Home – Assessment of PCMH Instruments. Other reports and studies released as part of the program management research agenda may be found at http://www.cms.gov/Reports/Reports/list.asp.
CMS carries out additional activities that build, support and improve both internal and external health services research capacity. These activities include multiple data collection and dissemination tools, research studies, and grant programs.

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.
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.

- *Real Choice Systems Change (RCSC) Grants* – These grants are no longer funded in FY2012 and 2013. There are programs today that support the goal of transforming long-term care from being institutionally-based and provider-driven to "person-centered" consumer-directed and community-based, through alternative funding vehicles. The Money Follows the Person Rebalancing Demonstration; the Community First Choice Option; the Community Based Care Transitions Program; and incentives provided in the Medicaid FMAP work to create enduring system reform that enable people to live independent lives in the community and work to achieve the same goals of the RCSC Grant program.

- *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: $24.6 million

- *MCBS*: $15.7 million, the same level of funding as the FY 2012 enacted level. CMS will maintain the same level of operations for the MCBS.

- *Demonstrations*: $2.6 million, an increase of $0.5 million from the FY 2012 enacted level. This funding will support the design, implementation and evaluation of the North Dakota Statewide Quality Improvement Network and the Medicare Health Care Quality demonstrations.

- *Other Research*: $5.7 million, an increase of $2.8 million above the FY 2012 enacted level. This funding supports efforts that build and improve CMS' health service research, data and analytical capacity, as well as program evaluations and prospective payment system refinement. 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. 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). In order to carry out these functions, CMS requires funding for certain administrative activities such as contracts, IT systems, and intra-agency agreements. (Information on benefit dollars for these programs can be found in the chapters titled Medicaid and CHIP in this Congressional Justification.) Some of these administrative activities are described below in more detail. Beginning in FY 2012, CHIP and Medicaid operations are funded from CMS Program Operations.

- *Children's Health Insurance Program Reauthorization Act (CHIPRA) Grants* - In 2009, Congress appropriated $100 million in new CHIPRA outreach funding. This amount was increased in FY 2010 by $40 million in the ACA. Of this sum, $80 million was specifically devoted to grants for the enrollment of children into Medicaid and CHIP. CMS awarded $40 million, on September 30, 2009, in outreach grant funds and then subsequently awarded the remaining $40 million on August 18th, 2011. CMS needs to continue to fund the evaluation and administrative support activities related to the initial appropriation of grant funds (the initial $100 million) and now must enhance and expand the existing administrative support activities to support the new cohort of grantees that comprise the additional $40 million in outreach funds grants.

This includes:

- Maintenance and program enhancement of the online reporting system that the grantees are required to use to submit to CMS quarterly and annual reports.
- Continued evaluation of the current grants and writing of the required reports to Congress.
- Evaluation of the additional cohort of grantees that were announced on August 18th, 2011.
- Enhancement of the online reporting system to include the next cohort of outreach grantees.
- Specialized technical assistance to all CHIPRA grants to enhance and support grant outcomes and effectiveness.

- *MACBIS internal and external stakeholder communications and engagement: Medicaid Administration* - The MACBIS (Medicaid and CHIP Business Information Solutions) is a multi-year project designed to transform the Medicaid and CHIP data enterprise. It is necessary to complete the requirements in ACA, to remove redundancy in CMS and the State Medicaid and CHIP operating agencies, to significantly boost program integrity efforts, and to provide the foundation for a data driven culture change improving performance and accountability across the enterprise. The ultimate goal of the MACBIS initiative is to create a fully integrated data environment that will not only represent the single source of Medicaid and CHIP data but will support advanced levels of internal and external controls, including far greater transparency and stakeholder involvement. The transformed system will house the data necessary to meet the business needs of all CMS centers and it will contain a change management structure that will assure equal access to resources and adaptation.

- *Preparing Medicaid Information Systems for Health Information Exchanges and Electronic Health Record (EHR) Technology* - The Medicaid IT Architecture (MITA) initiative is redefining the way that State Medicaid agencies use information technology to reduce Medicaid program costs, improve the quality of Medicaid beneficiary care, and share important health-related information with other State agencies and Federal partners. MITA also promotes the use of healthcare data standards whether mandated by HIPAA legislation or de facto standards driven by industry adoption for both clinical and administrative purposes. MITA is critical to the ability of State's Medicaid agencies to use information technology in coordinating patient care by creating effective linkages between various sources of health information and conducting quality and outcomes measurement via the Medicaid enterprise.

  The next phase of MITA is delivery of data elements that will allow States to begin to implement a new Service Oriented Architecture (SOA) that uses the MITA-defined business and technical services, as well as data definitions, to conduct the business of Medicaid in a way that is aligned with the goals described above. This phase expands upon the creation of use cases, activity diagrams, business relationship mapping, and data models for each of the 79 business processes currently defined by MITA. This includes the continued integration of MITA technical solutions along with MITA business processes to create implementable SOA-based MITA business services. Furthermore, with the additional systems requirements brought on by the American Reinvestment and Recovery Act (ARRA) and the ACA, this phase will

include updating and aligning the MITA architectures so that States can continue to work on implementation and comply with deadlines using the MITA framework and principles.

- *Insure Kids Now Website* - Section 501 of CHIPRA required CMS to increase the capacity of the Insure Kids Now! (IKN) website in the following manner:

    - Annually, every State must report on their dental benefit package;
    - Quarterly, every State must provide an accurate list of all dentists and dental providers within each State who provide dental services to Medicaid and CHIP children; and
    - The hotline must accommodate the increase in calls due to outreach and dental requirements.

  In order to comply with the mandatory annual and quarterly updates for the IKN website, CMS requires funding which was not included in statute. This funding request will allow CMS to make the required updates and maintenance to the IKN website and will also allow us to make quality improvements identified by the GAO in a 2010 report entitled, "Oral Health: Efforts Underway to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns."

- *Outreach Tools* – CMS requests funding to develop a communications strategy to promote the availability of health coverage including the expansion of Medicaid. This will include message development, focus group testing (market segments and general audience) development and production of outreach materials (fliers, posters, palm cards, mailers, public service announcements for television and radio) as well as electronic media (web, social media).

  In addition, webinars will provide training on effective communications strategies and messaging to campaign partners, community stakeholders, consumer advocates, health and human service providers, Federal partners and others.

- *State Enrollment Efforts* – CMS requests funding to develop enrollment tools including:

    - A guide that will describe effective targeted enrollment strategies to expedite enrollment of individuals and families that will be newly eligible for coverage and are already known to States (such as parents of children enrolled in Medicaid and CHIP, adults participating in SNAP and other public benefit programs, individuals covered through waivers and State-funded programs);
    - A communications toolkit which includes messaging, customizable outreach materials and a "how to" section on effective communications strategies that can be used by States;
    - And an application assistance training module that addresses 1) the State health coverage programs (Medicaid, CHIP, Basic Health Program and coverage through an Exchange), 2) application process and, 3) the single, streamlined application. The module can be disseminated to States as well as other partners.

Budget Request: $27.8 Million

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.

- *Contracts and Interagency Agreement's*: $5.3 million. This request provides for a variety of operational activities specific to Medicaid and CHIP programs. These activities, described on the previous page, include CHIPRA outreach grants, MACBIS, and administrative requests to support the MITA initiative.

- *Information Technology:* $8.3 million. This request will aid in funding the National Medicaid Information System, maintaining a database for Medicaid drug rebates, the Insure Kids Now website, and the Medicaid Statistical Information System (MSIS).

- *Outreach Tools and State Enrollment Efforts*: $14.2 million. This includes funding to support State enrollment and outreach, and other changes to the Medicaid and CHIP programs, including enhanced quality improvement programs for nursing home providers, continued provider screening and other enrollment requirements.

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 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 project 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 (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.

- *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: $81.1 Million

The FY 2013 budget request for Parts C and D IT Systems Investments is $81.1 million, an increase of $2.7 million above the FY 2012 enacted level. The increase in funding is due to system upgrades to process Medicare Parts C and D payment computation, maintenance and payment policy updates.

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 C&D appeals workloads history is presented below:

QIC Appeals Workload for Parts C/D
(Appeals in Hundreds)

	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimated Actual	FY 2012 Estimate	FY 2013 Estimate
Part C Appeals	44,166	61,625	62,420	65,000	67,500	70,000
Part D Benefit Appeals	16,541	20,733	18,958	19,000	22,000	23,000
Part D LEP appeals	52,222	40,728	35,246	39,000	43,000	44,500

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. CMS will need additional funding to continue this work in FY 2013.

- *Insurance Market Reform and Oversight* - The Insurance Market Reform and Oversight program focuses on implementing insurance market reforms by setting minimum standards for health coverage in the small group, large group, and individual marketplaces. CMS is planning on releasing notices of proposed rulemaking related to the 2014 insurance market reforms in FY 2012. In FY 2013, CMS is responsible for preparing and issuing final regulations and other guidance needed to implement these new provisions. CMS is also continuing to monitor compliance with earlier market reforms.

- *Medical Loss Ratio* - The ACA 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. Issuers are required to begin submitting their annual reports in June 2012. These reports will be made available to the public on the HHS website.

- *Rate Review* – On May 19, 2011, HHS released a final regulation identifying a threshold above which proposed rate increases are "subject to review". Beginning September 2011, insurers seeking rate increases of 10 percent of more are required to submit summary data about the proposed increases, which CMS posts publically on the HHS website. CMS is currently in the process of establishing State-specific thresholds which will go into effect in September 2012. Proposed increases that are subject to review must undergo a thorough actuarial review by a State with an effective rate review program or by CMS. If the review results in a determination that the increase is unreasonable, and the insurance company chooses to implement the increase, the company must publically justify the increase on both Healthcare.gov and its own website.

- *Affordable Insurance Exchanges* – The Affordable Insurance Exchange (Exchange) program sets up a new competitive private health insurance market, giving tens of millions of Americans and small businesses access to affordable coverage. The Exchanges 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 Exchange, CMS must establish a Federally-facilitated Exchange in that State and perform all Exchange functions. Exchange 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 Exchange for small employers, called the Small Business Health Option Program (SHOP); and,
- Developing the back-end infrastructure for organizing the health insurance marketplace.

In addition to operating a Federally-facilitated Exchange in States that opt not to establish their own, CMS will have responsibilities on behalf of all Exchanges, such as developing quality improvement and transparency standards, determine eligibility for advanced premium tax credits, second-level eligibility appeals, and Exchange certification and oversight.

In addition to establishing Exchanges, 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 policies, or the "3Rs." Reinsurance and risk adjustment are structured as State-run programs with Federal guidelines on methodology, and CMS will run these programs in most States with a Federally-facilitated Exchange. Risk corridors will be operated solely by CMS.

Other financial management activities include the implementation of refundable tax credits and cost-sharing reductions for individuals enrolling in QHPs (also known as insurance affordability programs), and CMS will work with other Federal agencies such as Treasury and the Social Security Administration to verify eligibility for these programs. Additionally, under the proposed Exchange regulations SHOP Exchanges will aggregate employer premiums to minimize the burden on small businesses that could result from multiple premium payments. CMS is responsible for developing these programs and for operating them for States not electing to establish an Exchange.

CMS published several Exchange-related regulations in calendar year 2011. First, proposed regulations on the application, review, and reporting process for waivers for State innovation were published in the Federal Register on March 14, 2011. On July 15, 2011, CMS published two proposed regulations to implement components of the Exchange and health insurance premium stabilization policies. Finally, on August 17, 2011, CMS published a proposed regulation on the eligibility determination process related to enrollment in a qualified health plan or insurance affordability program, and one on eligibility determinations for Medicaid, the Children's Health Insurance Program (CHIP), and other State health coverage programs beginning in 2014. On this same day, the Department of Treasury issued proposed regulations on the premium tax credit.

Further, CMS issued three Exchange-related guidance documents in calendar year 2011. The first published on May 31, 2011, concerns standards for Medicaid and Exchange information technology systems, particularly those used for eligibility determinations. The second, published November 29, 2011, was a question and answer guidance for State Exchange implementation. The third guidance, concerning the determination of the Essential Health Benefits, was issued on December 16, 2011.

Budget Request: $655.3 Million

The FY 2013 budget request for Oversight and Management is $655.3 million, an increase of $503.4 million above the FY 2012 enacted level, primarily due to the beginning of Exchange operations.

- *Medicare Parts C and D*: $65.3 million, an increase of $0.1 million above the FY 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*: $15.4 million, an increase of $0.8 million above the FY 2012 enacted level. In FY 2013, CMS will need to issue final rules and other sub-regulatory guidance related to the 2014 market rules. Additionally, CMS is also responsible for issuing additional guidance related to insurance market reforms published in earlier fiscal years.

- *Operations and Management of Exchanges*: $574.5 million. CMS' funding request for FY 2013 reflects both a larger scope of activities and the significant costs associated with making operational the administrative infrastructure to prepare for open enrollment of the Exchanges in October of 2013. The majority of the operational activities for the Federally-facilitated Exchange will commence in FY 2013 and CMS will also work intensively with State-based Exchanges to ensure they are certified and ready enroll consumers and small businesses in Exchange coverage.

  Implementation of the Federally-facilitated Exchange is an unprecedented effort for CMS. Exchanges will serve a population that is different from the beneficiaries with whom CMS usually interacts, operate complex eligibility and enrollment processes that are highly automated and involve communications with other Federal agencies, and perform a great deal of work that is State-specific rather than uniform throughout the country. For instance, the Exchanges will need to coordinate with State Medicaid agencies related to eligibility for insurance affordability programs, State Departments of Insurance related to certification and oversight of qualified health plans, State Governor's offices for intergovernmental affairs, and the broader issuer community beyond those offering qualified health plans when operating reinsurance and risk adjustment.

  - Eligibility & Enrollment: Exchanges must determine a consumers' eligibility for a number of insurance affordability programs (advanced premium tax credits, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program) based on modified adjusted gross income, and facilitate enrollment into coverage. In those States that do not elect to establish their own Exchange, the Federally-facilitated Exchange is required to perform these functions. CMS also has responsibilities for eligibility and enrollment activities on behalf of all Exchanges, such as development of a unified enrollment form, and conducting second-level eligibility appeals. CMS's funding request for FY 2013 reflects the need to build

operational capacity to perform eligibility determinations, appeals, and enrollment beginning on October 1, 2013.

- Health Plan Benefit and Rate Review, Management, and Oversight: In FY 2013 CMS will focus its resources on supporting certification of issuers and the QHPs they will offer in the Federally-facilitated Exchange. These activities include the review and approval of benefits and rates, and establishing a monitoring and analysis approach to inform issuer and QHP performance in 2014. Additionally, CMS will procure contractor support to assist in the audit and compliance of QHP issuers. CMS staff will focus on conducting health plan reviews and approvals, and preparation of QHP information to display on the insurance web portal.

- Payment & Financial Management: In FY 2013, CMS will implement payment systems for the Federally-facilitated Exchanges, as well as systems to support some State-based Exchange functions. These activities include identifying and preparing for financial risks associated with advanced premium tax credits and cost sharing reductions as well as implementing a reinsurance entity for States that do not operate their own reinsurance. CMS will need support for financial analysis, risk modeling, implementation of the reinsurance entity, development of business processes to track and manage advance payment of premium tax credits, and to put in place the infrastructure needed to adequately prevent fraud, waste, and abuse for the Federally-facilitated Exchange and State-based Exchanges.

- SHOP & Employer: Between now and 2014, CMS must prepare to create Federal SHOP Exchanges for States that do not elect to build their own. In FY 2013, CMS will operationalize support systems to help employers understand insurance selection options for their employees, and provide technical analysis necessary to develop strategies to maximize the SHOP Exchange user experience and other technical support such as drafting standard operating procedures.

- Exchange Quality Review: In FY 2013 CMS needs to issue guidance on the reporting framework, the types of measures collected, and the methodology needed to produce meaningful ratings for public reporting. Additionally, CMS must develop a quality improvement strategy reporting framework, including appropriate measures and an appropriate uniform methodology for evaluation. Finally, CMS must assess Exchange enrollee satisfaction beginning in 2016.

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. This is achieved through value based purchasing programs and other CMS health care quality initiatives. In FY 2013, CMS plans to perform activities that achieve the following: the development of a coordinated quality improvement strategy implementing initiatives 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. ESRD QIP will reduce ESRD payments by up to 2 percent, to dialysis providers and facilities that fail to meet or exceed a total performance score with respect to performance standards established with respect to certain specified measures.

- *Development of Quality Measures* - The Administrator of CMS is required to develop quality measures through contracts for use in programs under the Social Security Act. 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.

- *Medicare Shared Savings Program* - On October 20, 2011, CMS released a final 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. By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform, will help improve the health of individuals and communities while lowering the growth in cost of the system, up to an estimated $470 million over four years. 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 annual rule making and significant contract support to register ACOs, assist with claims data analysis and reports, calculate shared savings payment, and conduct follow-up monitoring to guard against inappropriate avoidance of beneficiaries and their care.

- *Physician Feedback Improvements* - CMS must provide reports to physicians that compare their Medicare fee-for-service patients' resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Because value is comprised of cost and quality, CMS will include indicators of clinical quality in the feedback reports. This phase builds on lessons learned from earlier phases and incorporates 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 statute requires the Secretary to publish the period of performance, measures of resource use and measures of clinical quality that will be used in the value modifier to adjust physician payment during the implementation period 2015-2017. The value modifier is required by statute to be phased in starting in 2015 so that by 2017, all participating physicians are subject to the modifier which will be applied to each Part B payment.

- *VBP Initiative, Hospital Value Based Purchasing* - The Hospital Value-Based Purchasing Program (HVBP), which provides value-based incentive payments to hospitals based on their performance on specific measures, is mandated by the ACA. In FY 2013, CMS plans to use external contractors and internal expertise/resources to implement complex data standardization and calculation tasks to support price standardization as set forth for HVBP.

- *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.

- *Medicare Data Sharing Program* – 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: $155.0 Million

For FY 2013, CMS requests $155.0 million for health care quality improvement initiatives, a decrease of $8.1 million below the FY 2012 enacted level. This funding 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. ESRD was partially funded with MIPPA funds from FY 2008 to FY 2012. In FY 2013, ESRD

must be fully funded from Program Operations. CMS requests funding to maintain operations in FY 2013. Expert contractor support is needed to assist CMS in the development of the systems, methodologies and validation protocols to aid in the development of the performance score to calculate payment for ESRD VBP. Funding also provides support to CMS contractors in the development and testing of the measures and payment adjustment model for this VBP program.

- *Development of quality measures*: $30.0 million. CMS requests funding to maintain the measures used and/or developed in FY 2012. In addition, the funding supports the development of additional new and more complicated outcome or patient experience of care measures in FY 2013 so that these quality programs can be expanded.

- *Medicare Shared Savings Program*: $13.5 million. Funding is required to maintain support contracts to continue to stand-up and operate the Medicare Shared Savings Program. This includes support contracts for data analysis and sharing, financial reconciliation to determine shareable savings or losses, quality measurement and reporting including patient experience of care surveys, program monitoring, application processing, and technical assistance to CMS and ACOs. In 2012, the program is in its early stages of implementation and requires extensive design and development work along with refinement of existing CMS operations in order to support an intensive program, initially for up to 270 ACOs.

- *Physician feedback reports and payment adjustments:* $18.0 million. This funding request reflects continued contractor support to develop reports for the expanding feedback program and to provide research and development to support the methodology used in the feedback reports and the creation of a value-based payment modifier. Significant system development is required for CMS to increase report production and dissemination of reports to over 200,000 physicians in 2013 and to all Medicare Fee-For-Service physicians in 2016.

- *VBP Initiative, Payment Modifier:* $4.6 million. This funding request reflects work that is not covered in our existing contract to develop a value-based modifier that is based on the quality of care furnished compared to cost. This funding is necessary to integrate quality measures used by the Physician Quality and Reporting System into a quality score, per capita and episode-based cost measures into a cost score, and to develop and implement the value-based payment modifier starting in 2015 based on physician performance in 2013.

- *VBP Initiative, Hospital Value Based Purchasing*: $1.0 million. Funding is required to support data standardization work, analysis, and calculation of the Medicare spending per beneficiary ratio, which will be publicly reported on Hospital Compare. In the future, after hospital performance data is displayed for 1 year, this measure will be included in the total-performance score (TPS), on which hospital VBP payments must be based. CMS will calculate and compare hospitals' spending per admission, and this data must be standardized to account for factors such as geographic variation and beneficiary severity of illness. CMS will also calculate a payment exchange function, by which the one

percent base-operating DRG reduction will be redistributed among participating hospitals, based on their performance on specific quality measures. CMS will send hospitals reports notifying them of their Medicare spending per beneficiary measure performance, as well as the estimated, and subsequently the actual payment impact of the Hospital VBP program.

- *Hospital Readmission Reduction Program*: $0.8 million. Funding is essential to fulfill these tasks and implement this provision by the effective date.

- *ACA Shared Services:* $28.6 million. CMS began the process of introducing shared services as scalable, reusable business/technical solutions that serve multiple business processes in FY 2012. CMS will continue that work in FY 2013 as well as bringing new shared services on-board as new functionalities are needed for the ACA.

- *Medicare Data for Performance Measurement (ACA 10332):* $5.0 million. The funds will be used to continue timely implementation and continuing 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. This 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 general and plan comparison information. 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 2008 – 2011 and the estimated distribution for FYs 2012- 2013.

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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
Number of Handbooks Distributed	41.9	43.1	43.6	39.3	40.5	41.7

**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 general inquiries about Medicare.

  Beneficiaries can also use 1-800-MEDICARE to report fraud allegations. CMS is using the information from beneficiaries' complaints in new 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. In addition, CMS has 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. The various parameters include claim type, geographic location, and fraud type. CMS is able to verify the information by listening to the original 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.

  The following table displays call volume experienced from FY 2008 through the FY 2013 estimate. CMS cannot estimate the number of *beneficiaries* that will call 1-800 MEDICARE. CMS can estimate the number of *calls* that will be received in a fiscal year based on a number of factors including historical trends and analysis, growth in the program, and the increase in the Medicare population. In FY 2013, 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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
Number of Calls	27.4	25.9	25.6	25.3	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 receive 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 detect instances of fraud. Beneficiaries can log into mymedicare.gov, a secure website, and check their claims within 24 hours of the processing date. This information is also available through the 1-800-MEDICARE automated system. A fact sheet and informational card have been developed to educate and encourage beneficiaries and caregivers to check their claims frequently and to report any suspicious claims activity to Medicare.

In FY 2013, CMS estimates 612 million page views to http://www.medicare.gov, approximately a two-percent increase in traffic from the page views anticipated in FY 2012. 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 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate
Number of http://www.medicare.gov Page Views	434.0	409.9	553.3	564.4	600.0	612.0

- *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.

CMS proposes to transfer administration of SHIPs, which comprises the bulk of funding for community based outreach, to the Administration on Aging in FY 2013.

- *Program Support Services* - This activity includes the multi-media Medicare education campaign, assessment activities, and consumer research. In addition, it funds *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 2011[7] Enacted Level	FY 2012 Enacted Level	FY 2013 President's Budget	Description of Activity in FY 2013
Beneficiary Materials	Total	$49.0	$51.6	$47.9	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	$31.0	$33.6	$29.9	
	User Fees	$18.0	$18.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	Total	$238.5	$220.4	$252.4	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	$184.0	$168.3	$200.0	
	User Fees	$54.5	$52.1	$52.4	
Internet	Total	$24.4	$26.6	$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	$21.8	$23.8	$31.4	
	QIO	$2.6	$2.8	(TBD)	
Community-Based Outreach	Total	$2.5	$2.6	$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	$2.5	$2.6	$5.0	
Program Support Services	Total	$12.1	$21.1	$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	$12.1	$21.1	$22.9	
	QIO	-	-	-	
	Total	**$326.5**	**$322.3**	**$359.6**	
	Program Management	**$251.4**	**$249.4**	**$289.2**	
	User Fees	**$72.5**	**$70.1**	**$70.4**	
	QIO	**$2.6**	**$2.8**	(TBD)	

[7] The FY 2011/2012 enacted level includes a comparability adjustment of -$50 million for NMEP to reflect the FY 2013 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

Budget Request: $289.2 Million

The FY 2013 Program Management budget request for NMEP is $289.2 million, an increase of $39.9 million above the comparably adjusted FY 2012 enacted level. The following bullets highlight activities funded under the Program Management request.

- *Beneficiary Materials:* The FY 2013 budget request for Beneficiary Materials is $29.9 million, a decrease of $3.7 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 2013 budget request for 1-800-MEDICARE/BCC activities is $200.0 million, an increase of $31.7 million above the FY 2012 enacted level. This request supports a growing call volume estimated at 27 million calls in FY 2013, one million more calls than reflected in the FY 2012 enacted funding level, as well as increases in the complexity of calls and in customer service representatives wage rates as set by the Department of Labor. CMS expects to operate at a 5 minute ASA in FY 2013, consistent with our policy.

  This line item 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 2013 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:* CMS proposes to transfer the SHIPs to the Administration on Aging (AoA) and is not requesting funding in FY 2013 for this activity. Two-thirds of SHIPs are administered by State Agencies on Aging established by the Older Americans Act. As such, streamlining the SHIP

program into AoA is a natural extension of programs authorized under the Older Americans Act.

Below is an historical funding chart for the SHIPs:

SHIP Funding
(Dollars in Millions)

Funding Source	FY 2009 Actual	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Program Management	$45.0	$45.0	$50.0	$50.1	-
MIPPA	$7.5	-	-	-	-
ACA	-	$15.0	-	-	-
Total	$52.5	$60.0	$50.0	$50.1	-

In addition to the SHIPs, collaborative grass roots coalitions and training to numerous community-level organizations, Federal/State/local agencies, providers and others require continued funding in the amount of $5.0 million. This is an increase of $2.4 million above the FY 2012 enacted level.

- *Program Support Services:* The FY 2013 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 $70.4 million in user fees bringing the total funding level for NMEP to $359.6 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. Only the costs of the toll-free lines are included in this category. The costs of answering the inquiries, including customer service representatives' salaries, are included in Ongoing Operations under Provider Inquiries.

  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
- Improved training of MAC contractor call center Customer Service Representatives

The lower call volume should continue through FY 2013 assuming minimal impact for implementing DME Competitive Bidding and that new legislative changes or initiatives (such as the X12N 5010 requirements beginning in January 2012 and the ICD-10 requirements beginning in October 2013) do not drive up the volume. The following table displays provider toll-free line call volumes from FY 2008 through the FY 2013 estimate:

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

	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
Completed Calls	58.2	50.1	44.4	41.1	41.0	41.0

- *National Provider Education, Outreach, and Training* - National provider education, outreach, and training ensure 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 and DVDs. Contractors and ROs 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.

- *Federal Coverage and Payment Coordination* - Section 2602 of the ACA created the Federal Coordinated Health Care Office (FCHCO) to improve care coordination, cost, quality, beneficiary experience and partnerships between the Federal government and States for individuals eligible for benefits under Medicare and Medicaid programs. 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 such programs in order to ensure that such individuals get full access to the items and services to which they are entitled.

Budget Request: $27.9 Million

The FY 2013 budget request for Provider Outreach is $27.9 million, a decrease of $2.0 million below the FY 2012 enacted level.

- *Provider Toll-Free Service*: $9.2 million. The request is the same as the FY 2012 enacted level to maintain the operations of the toll-free service.

- *National Provider Education, Outreach, and Training*: $8.7 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:* $10.0 million. This request is necessary to perform the activities mandated by the ACA for beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles). Funding supports the creation of business intelligence tools, technical assistance to identify and implement best practices addressing coordinating care to beneficiaries, and contracts to conduct needs assessments and gap analysis.

Consumer Outreach

- *Consumer Assistance Programs (CAPs)* - The ACA provides grants to States to establish, expand, or provide support for the establishment of independent CAPs across the country. These programs help consumers navigate their insurance choices and subsidies to find the most affordable health insurance coverage that meets their needs; assist consumers with enrollment into health coverage, including group health plans; collect data on consumer inquiries and complaints to identify problems in the marketplace; educate consumers on their rights and responsibilities, including new protections provided by the ACA; and assist consumers with filing complaints and appeals.

- *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 use the data to obtain information about options specific to their life situations and local communities. 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.

- *Consumer Appeals* - The ACA provides consumers with the right to refute adverse benefit determinations made by their insurance company. In FY 2013, 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 in FY 2013.

- *Summary of Benefits and Coverage* – The ACA, all plans and issuers providing health insurance coverage to consumers will be 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) will 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.

- *Consumer Information & Outreach for Exchanges* – 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 Federally-facilitated Exchange. 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 Exchange operations.

  CMS will also implement an in-person assistance program for the Federally-facilitated Exchange which will be operational leading up to initial open enrollment in October of 2013. This program will be a mechanism to help to ensure that we have a local presence in FFE States and that individual and small businesses can access fair, accurate, and impartial information throughout the application and enrollment process. CMS will conduct outreach and education in regard to Exchanges and insurance affordability programs as well as provide direct and in-person application assistance and referrals.

Budget Request: $350.9 Million

- *Consumer Assistance Programs*: $30.0 million. The CAPs require funding to assist consumers with their health insurance needs. An important part of CAP grant activities includes reporting detailed quarterly data to the Secretary of Health and Human Services on the types of problems and questions consumer experience with their health coverage, and how these problems are resolved. Analysis of this data will help HHS and CMS identify patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. This program is a priority of the Secretary, and it is critical to helping consumers understand, find, and enroll in health insurance. There are few other organizational resources for consumers to obtain assistance with their health insurance.

- *HealthCare.Gov*: $18.2 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.

- *Consumer Appeals:* $9.3 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.

- *Summary of Benefits and Coverage:* $2.0 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. 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, consumer will be able to compare additional scenarios. In addition, CMS will also provide Navajo translations in 2014.

- *Indian Health Care*: $1.9 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 suffers 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.

- *Consumer Information & Outreach for Exchanges*: $289.5 million. Consumer outreach efforts, planning and implementation of the call center.

    - Funding supports advancing a strategic communications plan to inform and educate various segments of the consumer and employer populations that are potentially eligible for insurance coverage through the Federally-facilitated Exchange. Information and outreach will educate consumers on their rights and the resources available to help them access affordable coverage. This includes producing, testing, and distributing consumer education materials, such as fact sheets, brochures, and online advertising campaigns, as well as development and implementation of a consumer call center to handle questions regarding rights, eligibility, and enrollment. Materials must meet accessibility criteria, including production in languages other than English.

    - In addition, funding will support grants to Navigators and in-person enrollment assistance for consumers enrolling in the Federally-facilitated Exchange.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Enterprise IT Activities

Enterprise IT activities encompass CMS' critical systems that supports ongoing operations, primarily the consolidated information technology infrastructure contract (CITIC). The CITIC data center contract provides 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:* Will facilitate and support 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:* The secure telecommunications network that supports transaction processing and file transmission.

- *Hardware maintenance and software licensing:* This is the continuance of safeguarding maintenance and certifying software applications.

- *Developing and maintaining the mission critical database systems* that house the data required by the CMS business community to perform its core functions.

- *The Modern Data Environment*: A cornerstone of the Agency's data environment, will transition 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:* This investment allows for the addition of databases, establishing consistent application of data policies and processes in using CMS' data; and assuring the security of data resources 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:* This 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 also prepare technical infrastructure (i.e., hardware capacity, network connectivity, and software) to accommodate the development, integration, testing, validation and IDR Environments, and high availability and corresponding disaster recovery for implementation. Due to the lead times needed to purchase computing capacity, it is critical to establish contracting vehicles early to avoid implementation delays. 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 DASD to support growth of databases (20 terabytes), 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 service delivery. 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 optimal customer service.

- *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.

- *ACA General IT:* This program consists of projects that support Exchanges implementation and other IT needs. The Data Warehousing project provides data analysis and technical expertise to enable CMS to host data, conduct data mining and data analysis functions for the Exchanges. The IT Security Project supports all the IT security needs of the Exchanges, focusing on oversight, user protections, risk mitigation and adherence to federal IT regulations. The PMO & 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 Exchange build out. The Enterprise Architecture Project supports Cloud computing environment for the Federally Facilitated Exchange. The IT Operations Project supports CMS Identity Management solutions needed for the Exchanges IT Infrastructure. The CMS Healthcare Insurance Exchange IT Investment (HIX) project 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 and services, and quality. HIX fulfills key provisions of the ACA and aligns with HHS Strategic Goal: Transform Health Care. FY 2013 activities will focus on operational readiness reviews, completing Exchange interfaces, implementation of the Federally-facilitated Exchange and data services hub, which services all Exchanges.

Budget Request: $467.6 Million

The FY 2013 budget request for other information technology investments supporting all Program Operations is $467.6 million, an increase of $36.4 million above the FY 2012 enacted level. The increase is primarily attributable to IT needs for ACA. This category includes five major IT investment activities.

- *Enterprise IT Activities*: $219.4 million. Funding is needed to continue IT activities which support CMS' progress in the effectiveness and efficiency of its 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.

- *Infrastructure Investments:* $26.5 million. 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 Medicaid 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:* $221.7 million. 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 Exchange 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 exchanges, 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 Exchange, support for State Based Exchanges 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 2013, including system testing and integration testing with other Federal departments. In FY 2013, CMS will conduct extensive tests for plan management functionality of the Federally-facilitated Exchange IT systems and complete development for the other core Exchange functional areas (eligibility and enrollment, financial management, etc.) in order to be operational and ready for the American consumer by open enrollment on October 1, 2013.

Performance Measurement

Beneficiary telephone customer service is a central part of CMS' customer service function. A CMS 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. During FY 2011 the BCC responded to 500,000 inquiries related to the ACA. The BCC is responsible for evaluating and scoring each CSR's performance in handling four telephone inquiries each month using the quality standards of privacy act, knowledge skills, and customer skills as well as customer satisfaction. The BCC has exceeded the FY 2011 targets of 90 percent for each standard by a minimum of two percentage points. Despite exceeding targets in previous reporting years, we will continue to maintain the quality standards target levels at 90 percent since committing to increase these levels would require additional resources that are better utilized elsewhere.

CMS met its FY 2011 target of maintaining an unqualified opinion. During FY 2011, the auditors could not express an opinion on the financial condition of the CMS Statement of Social Insurance as of January 1, 2011, 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 ACA 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 2011, CMS is still substantially compliant with the Federal Financial Management Improvement Act. CMS considers its financial systems to be integrated in accordance with OMB Circular A-127. Financial Management Systems since as of September 2011, CMS has 96 percent of total Medicare program payments accounted for in HIGLAS, the official financial system of record.

As mandated by Section 302 of the Tax Relief and Health Care Act of 2006, CMS implemented the Recovery Audit Program in all 50 States to identify improper payments made on claims of health care services provided to Medicare beneficiaries. Ongoing monitoring of appeals activity is a key part of the Recovery Audit Program, as it serves as an important gauge of review accuracy. A decreasing overall appeal overturn rate means an increasing level of accuracy in recoveries obtained due to contractor auditing. CMS believes a preliminary appeal rate baseline, reflective of all claim types and appeal levels, will be available in March of 2012. CMS will target a decrease in each year over the previous for FY 2012 and FY 2013.

By October 1, 2013, CMS, along with the entire U.S. health care industry, must transition to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9). The U.S. is the only "big seven" nation not yet transitioned to ICD-10, which hampers our ability to share diagnoses and other information, such as pandemic data, with other countries. We are measuring activities toward this significant accomplishment, and have met our FY 2011 targets and most of those toward FY 2012, as reflected in the table at the end of this chapter. An industry-wide survey was completed in 2011 showing widespread awareness of the ICD-10 compliance dates, but also showing provider concerns about resources for its implementation. As a result, outreach and education efforts will be ramped up and targeted. All these activities will provide impacted CMS business areas with the support to ensure timely CMS, contractor, and industry transition on October 1, 2013.

CMS has four FY 2013 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 Enterprise Performance Life Cycle, by conducting post-implementation reviews, and making sure that CMS IT systems have a formal Authority to Operate and are included in a vulnerability management program. CMS exceeded all four of its FY 2011 targets. These activities protect our key assets and help maintain the public trust in CMS.

CMS has an FY 2013 performance measure to improve the accuracy of Medicare Physician Fee Schedule payments by identifying, reviewing and appropriately valuing 40 percent of potentially misvalued codes (i.e., high expenditure or high cost) under the Medicare Physician Fee Schedule through the potentially misvalued code analysis process.

CMS will measure the success of the new Hospital Readmissions Reduction Program with an FY 2013 performance measure to reduce all-cause hospital readmissions by 5 percent. The rate of readmissions is calculated as the number of Medicare readmissions to the same or another acute-care hospital that occur within 30 days of discharge from an acute care hospital compared to total hospital Medicare admissions for that time period. The numerator will be the number of hospital readmissions to any acute care hospital within 30 days of an acute care hospital discharge. The denominator is the total number of admissions for that time period. The Partnership for Patients (PFP), an initiative under the Department of Health and Human Services, includes a goal to cut hospital readmissions by 20 percent for all hospital patients over the next three years. This performance goal and the PFP goal currently track different populations: this goal is focused on Medicare readmissions while the PFP includes all patients. However, the two goals are aligned in seeking to reduce all-cause readmissions, and will help each other in their effort to reduce readmissions.

CMS has performance measures to promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals and hospitals. We will measure the number of eligible professionals and hospitals receiving Medicare and Medicaid EHR Incentive Payments for the successful demonstration of meaningful use. Additionally, we will measure the number of eligible professionals and hospitals receiving Medicaid EHR Incentive Payments for adopting, implementing, or upgrading their EHR. CMS reported FY 2011 actual, and FY 2012 and FY 2013 targets were set. This measure supports the HHS Priority Goal to improve health care through meaningful use of health information technology.

Reflecting CMS' efforts to improve patient safety and reduce the national rate of healthcare associated infections (HAIs), CMS is introducing a performance measure to make significant reductions in hospital-acquired central line-associated bloodstream infections (CLABSI) and hospital-acquired catheter-associated urinary tract infections (CAUTI) in hospitals by the end of FY 2013. In FY 2010, the standardized infection ratio (SIR) for CLABSI was 0.68 representing the number of infections per 1,000 central line days and 0.94 representing the number of infections per 1,000 urinary catheter days. The SIR is calculated by dividing the actual (observed) infections by the expected infections. By the end of FY 2013, we will combine programmatic efforts across HHS and those of public and private stakeholders to achieve demonstrable improvements in healthcare quality and patient safety through reduction of hospital-acquired CLABSI and

CAUTI by 25 percent and 20 percent, over the FY 2010 SIRs of 0.68 and 0.94, respectively. This initiative is a Department of Health and Human Services (HHS) Priority Goal as an interdepartmental collaboration (with the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Office of the Assistant Secretary for Health,), and is consistent with the HHS Patient Safety Initiative, Partnership for Patients, which aims to improve care and reduce costs for Americans.

Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the Secretary implement an End Stage Renal Disease (ESRD) quality incentive program (QIP) that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. Procedures have been completed for payment adjustments for the first payment year (2012) to individual ESRD facilities based on how well they meet these standards, and final rules have been published for Payment Years 2013 and 2014. CMS finalized three measures as the initial set to represent important indicators of patient outcomes and quality of care during the first program year (2012). CMS plans to add subsequent quality measures and establish additional performance standards that ESRD facilities will need to meet in order to receive full payment for the services they furnish to Medicare beneficiaries. The ESRD QIP is designed to promote high-quality dialysis services at Medicare facilities by linking CMS payments directly to facility performance on quality measures.

CMS tracks a performance measure that indicates 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 order to extend coverage for 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. CMS' goal is to increase the number of adult children covered as dependents on a parent's employer-sponsored insurance policy to 8.8 million by 2013. CMS plans to use audits to monitor compliance with the requirement that issuers offer coverage for young adults ages 19-25.

CMS has a measure to track CMS' progress towards setting up the Exchanges. This measure supports the HHS strategic plan measure of increasing the proportion of residents with health insurance, by ensuring that millions of individuals estimated to gain insurance through Exchanges will have the ability to enroll beginning in 2014.

The FY 2011 process measure tracked the completion of important implementation milestones in each of the 50 States and the District of Columbia. In FY 2011, there was stakeholder consultation performed in 45 States and the District of Columbia. Only five States have not yet engaged with the federal government around Exchanges. In cases in which States opt not, or are unable, to implement their own Exchanges, CMS will complete these milestones as part of establishing a Federally-facilitated Exchange in

that State. CMS revised our measure and future targets to focus on the Federal role in supporting Exchange development.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCR9.1a: (Telephone Customer Service) Quality Standards: Minimum of 90% pass rate for Adherence to Privacy Act	FY 2011: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1b: (Telephone Customer Service) Quality Standards: Minimum of 90% meets expectations for Customer Skills Assessment	FY 2011: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1c: (Telephone Customer Service) Quality Standards: Minimum of 90% meets expectations for Knowledge Skills Assessment	FY 2011: 92% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.3: (Telephone Customer Service) Minimum of 90% pass rate for the Customer Satisfaction Survey	FY 2011: 92% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR12: Maintain an unqualified opinion	FY 2011: Maintain an unqualified opinion (Target Met)	Maintain an unqualified opinion	Maintain an unqualified opinion	N/A
MCR19: Decrease the appeal overturn rates at the first level of appeal for overpayments identified by the Recovery Audit Program	FY 2010: Implemented the Recovery Audit Program in all 50 States and U.S. Territories Target: Implement the Recovery Audit Contractor Program in all 50 States and U.S. Territories (Target Met)	Target below FY 2011 baseline (baseline available March 2012)	Target below previous year	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2012: 1.Continue external ICD-10 outreach and communications Oct 2011 (Target met) 2.Update ICD-10 industry compliance level and State Medicaid program readiness baselines December 2011 (Target met)	1.Continue external ICD-10 outreach and communications Oct. 2011 2.Update ICD-10 industry compliance level and State Medicaid program readiness baselines Dec 1, 2011 and May1, 2012	1.Continue external ICD-10 outreach and communi-cations 2.Update ICD-10 industry compliance Level and State Medicaid program readiness baselines 3. Complete CMS implementation of ICD-10	N/A
MCR21.1: Increase percent of CMS Federal Information System Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. Baseline: 114 out of 311 FISMA Systems (36%) have an active Authority to Operate (ATO) as of 10/2009	FY 2011: 88% Target: 80% Target exceeded	90%	90%	Maintain
MCR21.2: Increase percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution Baseline: 0% in FY 2009	FY 2011: 100% Target: 75% Target exceeded	100%	100%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCR21.3: Increase percent of information technology (IT) projects that have adapted to the Enterprise Performance Life Cycle (EPLC) framework Baseline: 10% in FY 2009	FY 2011: 100% Target: 75% Target exceeded	90%	95%	+5
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) Baseline: 0 PIR in FY 2009	FY 2011: 8 PIRs Target: 2 PIRs Target exceeded	12PIRs	24 PIRs	+12
MCR22: Improve the accuracy of Medicare Physician Fee Schedule payments by identifying, reviewing, and appropriately valuing potentially misvalued codes (i.e. high expenditure or high cost) under the Medicare Physician Fee Schedule (PFS) through the potentially misvalued code analysis process.	New in FY 2012	20%	40%	+20
MCR26: Reduce all-cause hospital readmission rate	New in FY 2012	Set baseline	5%	N/A
MCR27.1: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicare	FY 2011 Actual: 3,700 New in FY 2012	34,350	69,000	+34,650

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCR27.2: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicaid	FY 2011 Actual: 0 New in FY 2012	5,600	25,585	+19,985
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 2011 Actual: 150 New in FY 2012	650	1,000	+350
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 2011 Actual: 150 New in FY 2012	815	1,205	+390
MCR27.5: Increase number of Eligible Professionals receiving EHR incentive payments for Adopt/Imple-ment/Upgrade (AIU) under the Medicaid incentive program	FY 2011 Actual: 6,300 New in FY 2012	38,135	42,735	+4,600
MCR27.6: Increase number of Eligible Hospitals receiving EHR incentive payments for Adopt/Imple-ment/Upgrade (AIU) under the Medicaid incentive program	FY 2011 Actual: 400 New in FY 2012	450	475	+25

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCR28.1: Reduce by 25 percent hospital-acquired central line-associated bloodstream infections (CLABSI) in hospitals by the end of FY 2013	FY 2010 Historical Actual: Standardized Infection Ratio (SIR)=0.68 New in FY 2012	12.5%[8] (SIR=0.60)	25% (SIR=0.51)	+12.5
MCR28.2: Reduce by 20 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) in hospitals by the end of FY 2013	FY 2010 Historical Actual: Standardized Infection Ratio (SIR)=0.94 New in FY 2012	10%[9] (SIR=0.85)	20% (SIR=0.75)	+10
MCR29.1: Develop drafts and final ESRD QIP rules for payment years (PY) 2013, 2014, and 2015	FY 2012: PY 2014 final rule published. Target: Publish PY 2014 final rule (Target Met)	Publish PY 2014 final rule	Publish PY 2015 final rule	N/A
MCR29.2: Implementation of ESRD QIP payment reduction (to meet statutory requirement)	FY 2012: Procedures have been completed and payment reductions will begin January 1, 2012. Target: Adjust payment for facilities not meeting performance standards (based on 2010 claims data) (Target Met)	Adjust payment for facilities not meeting performance standards (based on 2010 claims data)	Adjust payment for facilities not meeting performance standards (based on 2011 claims data)	N/A

[8]The CLABSI rate is the number of infections per 1,000 central line days. 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 CAUTI rate is the number of infections per 1,000 urinary catheter days. 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).

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
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)	Target Discontinued	Target Discontinued	N/A
PHI1: Increase percent of eligible individual health insurance market plans reporting data that is accurate and displayed on HealthCare.gov	FY 2011: 71% Target: 80% (Target not met)	85%	90%	+5
PHI2: Increase number of young adults ages 19 to 25 who are covered as a dependent on their parents' employer-sponsored insurance policy	FY 2010 8.3 million Historical actual	8.7 million	8.8 million	+.1 million
PHI4: Increase the proportion of legal residents under age 65 covered by health insurance by establishing affordable insurance Exchanges and implementing Medicaid expansion	FY 2011 Target: Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process= 50 States+DC Result: 45 States+DC (Target not met)	Award all qualifying applications for Establishment Grants will be awarded within 60 days of receiving the application	1. Release national Federal risk adjustment model 2. Release 2014 payment notice 3. Data sharing agreements for hub use in place with every State 4. Health plans certified in all Federally-facilitated Exchange States	N/A

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Federal Administration

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
BA	$685,806,000	$792,964,000	$792,964,000	$0
Comparability Adjustment 1/	-$2,000,000	-$2,000,000	$0	+$2,000,000
Comparable BA	$683,806,000	$790,964,000	$792,964,000	+$2,000,000
Direct FTEs 2/	4,089	4,536	4,672	+136

1/ Comparably-adjusted for the SHIP transfer to AoA.
2/ The FY 2011 column reflects actual FTE consumption.

Authorizing Legislation – Reorganization Act of 1953
FY 2013 Authorization – One Year
Allocation Method - Various

Program Description and Accomplishments

The Centers for Medicare & Medicaid Services (CMS) oversees three of the nation's largest health care programs: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP); oversees benefits for consumers and employers through the Pre-existing Condition Insurance Program (PCIP), the Early Retirement Reinsurance Program (ERRP), and State High-Risk Pools; enforces new rights and greater accountability for consumers and providers in the private health insurance market; and disseminates an unprecedented level of consumer information regarding coverage options. CMS is the largest purchaser of health care in the United States and expects to serve almost 106 million beneficiaries and consumers in FY 2013. In FY 2011, CMS spent $876 billion on benefits and other costs.

The Federal Administration account funds CMS staff and operating expenses for planning, implementing, evaluating and ensuring accountability in a variety of health care financing programs.

CMS currently employs approximately 5,400 Federal employees 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 new 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 and other direct appropriations, 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 expenses are 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 expenses include rent, communication, and utilities; the mortgage for the Central Office building loan; CMS' share of the Department's Service and Supply Fund; Human Resources; administrative services; Information Technology (IT); inter-agency agreements (IAs); supplies and equipment; administrative contracts and intra-agency agreements; training; travel; and printing and postage.

Most of these costs—including rent, communications, utilities; the mortgage for the Central Office building loan; the CMS share of Departmental costs such as the Service and Supply Fund and Human Resources support; the Office of General Counsel inter-agency agreement; 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 2013 budget request has been prepared in accordance with Executive Order 13589, Promoting Efficient Spending. Spending across CMS for travel and relocation, printing and reproduction, employee IT devices, conferences and the executive motor fleet reflects a 20 percent reduction, cumulatively, from FY 2010 levels.

- 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 General Service Administration (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 for the building loan on the new San Francisco Regional Office facility.

- 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 the personnel, payroll, financial management, and e-mail systems used throughout the Department; regional mail support; EEO complaint investigations; small business operations; web communication; support provided to the Office of the Secretary's audit resolution staff; and other services related to 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 eliminating duplication of functions.

- Human Resources (DHHS)

CMS reimburses the Department for its share of the costs of our Human Resources (HR) support at the Bethesda Operations Center (BOC). In 2007, DHHS developed the "One HHS" initiative to eliminate duplication of effort and achieve economies of scale. As part of this initiative, the Department consolidated personnel activities, previously performed separately by each Operating Division within DHHS, and created centralized human resource activity to service CMS. Our HR activity currently consists of four operational activities: workforce relations, client services, strategic programs, and internal accountability and workforce management:

  - Workforce relations staff advises and consults with managers on employee and labor relations matters, including collective bargaining and employee conduct, performance and disciplinary actions. They also manage the administration of employee benefits, including retirement, health insurance, Federal employees' group life insurance, thrift saving plan, and workers' compensation.

  - Client services staff consults with managers on human resources solutions to workforce issues, especially in the areas of position classification and compensation, strategic recruitment, hiring, and placement.

  - Strategic programs staff advises leadership on strategic human capital planning, human resources program evaluation, and service level agreements. They also develop and implement human resources automation tools and strategies aimed at maximizing efficiency and effectiveness.

  - Internal accountability and workforce management staff develops, implements, and manages internal accountability reviews, identifies ways to improve operations, monitors and evaluates HR management programs and provides policy guidance to HR staff.

- 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/health services, mailroom services, 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 & 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, 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. In addition, Federal Administration IT funding supports the DHHS Service and Supply Fund's e-mail and financial management systems.

- 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:

  - A Department of Labor IA 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;

  - A Department of Justice IA for performing background checks on new job applicants; and,

  - An Internal Revenue Service IA for providing CMS with financial data on corporations, partnerships, and sole proprietorships from its Actuarial Information System. The data provide CMS with critical information on changes in health care spending and on Medicare and Medicaid spending by region and by State.

- 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 2011, CMS paid $10.5 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. This category also funds required ongoing core courses for employees such as Reasonable Accommodation, Alternative Dispute Resolution, and Equal Employment Opportunity (EEO) & 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 fiscal intermediaries, carriers, and Medicare Administrative Contractors, or MACs, 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 single largest expense in this category is printing and mailing Medicare cards, primarily the replacement of lost or damaged cards. CMS mails out over 5 million Medicare cards annually. When Medicare was enacted in 1965, an administrative decision was made to provide Medicare cards to all entitled beneficiaries. The cards identify the individual to providers as a Medicare beneficiary, provide the beneficiary with proof of entitlement, and simplify the administration of the program.

The next largest expense in this category, almost one-fourth of the total, 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. At least 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.

Additionally, CMS is required to print a variety of materials including brochures that help beneficiaries select a health care plan, Medicare lock-in notices informing beneficiaries of their initial enrollment in managed care plans, provider and supplier enrollment forms, and Medicare and Medicaid program guides. Postage costs to mail these materials and other correspondence are also included in this category.

Funding History

2008[1/]	$636,132,000
2009	$641,351,000
2010 [2/]	$696,880,000
2011 [2/]	$685,806,000
2012 [2/]	$792,964,000

[1/] *Includes $5.0 million in Supplemental funding provided by P.L. 110-252.*
[2/] *Non-comparable values.*

Budget Overview and Supported Activities

FY 2013 Request ($793.0 million):

Personnel Compensation and Benefits ($631.6 million): The FY 2013 estimate includes $631.6 million to support 4,672 direct FTEs. This request reflects a $28.5 million (+136 FTE) increase when compared to the comparable FY 2012 enacted level. This increase will help keep up with the growth in the Medicare population, improve program integrity, and implement private insurance reforms. Our payroll estimate assumes a 0.5 percent cost of living adjustment in 2013.

Rent, Communication & Utilities ($24.9 million): Our FY 2013 request fully funds rent, communications and utilities at $24.9 million, which is $0.9 million more than the FY 2012

enacted level. This increase covers the growth in rent and operating costs due to inflation.

Building Loans ($10.9 million): The FY 2013 request for building loans is $10.9 million. This estimate remains the same as the FY 2012 enacted level.

Service and Supply Fund ($16.6 million): The FY 2013 Service and Supply Fund request totals $16.6 million, a $0.4 million increase compared to the FY 2012 enacted level.

Human Resources Support ($10.0 million): The FY 2013 Human Resources support estimate totals $10.0 million, a $0.3 million increase compared to the FY 2012 enacted level.

Administrative Service ($10.6 million): The FY 2013 Administrative Service estimate is $10.6 million, a $0.4 million increase compared to the FY 2012 enacted level.

Administrative Information Technology ($30.8 million): The FY 2013 Administrative IT estimate is $30.8 million, which is $12.1 million less than the FY 2012 enacted level.

Inter-Agency Agreements ($3.5 million): The FY 2013 estimate in this category is $3.5 million, the same as the FY 2012 enacted level.

Supplies and Equipment ($1.2 million): The FY 2013 request for supplies and equipment is $1.2 million, the same as the FY 2012 enacted level.

Administrative Contracts and Intra-Agency Agreements ($26.1 million): The FY 2013 request totals $26.1 million, a $13.0 million decrease compared to the comparable FY 2012 enacted level.

Training ($13.8 million): The training estimate for FY 2013 is $13.8 million, a $0.5 million increase compared to the FY 2012 enacted level.

Travel ($9.2 million): The travel estimate for FY 2013 totals $9.2 million, a $3.1 million decrease compared to the FY 2012 enacted level.

Printing and Postage ($3.6 million): The printing and postage estimate for the FY 2013 request is $3.6 million, a $0.8 million decrease compared to the FY 2012 enacted level.

Federal Administration Summary
(Dollars in Thousands)

Object of Expense	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel Compensation	$603,066	$631,612	$28,546
Rent, Communication & Utilities	$24,000	$24,949	$949
Central Office Loan	$10,900	$10,900	$0
Service/ Supply Fund	$16,200	$16,573	$373
Human Resources	$9,700	$9,990	$290
Administrative Services	$10,200	$10,604	$404
Administrative IT	$42,853	$30,770	-$12,083
Inter-Agency Agreements	$3,523	$3,523	$0
Supplies and Equipment	$1,183	$1,224	$41
Administrative Contracts and Intra-Agency Agreements	$39,135	$26,122	-$13,013
Training	$13,380	$13,849	$469
Travel	$12,363	$9,219	-$3,144
Printing and Postage	$4,461	$3,629	-$832
Subtotal, Other Objects Expense	$187,898	$161,352	-$26,546
Total, Federal Administration 1/	**$790,964**	**$792,964**	**$2,000**

1/ FY 2012 is presented on a comparable basis.

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Medicare Survey and Certification

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
BA	$361,276,000	$355,203,000	$387,353,000	$32,150,000

Authorizing Legislation - Social Security Act, title XVIII, section 1864

FY 2013 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 2010, about 90 percent of Medicare participating nursing home facilities were cited for health deficiencies. The average number of health deficiencies per survey was approximately seven. This demonstrates the profound importance of regular, comprehensive inspections of health care facilities.

Recent reports 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 time, 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. 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.

Direct Survey Costs

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 home health agencies 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 69 percent, 61 percent, and 37 percent respectively between FY 2001 and FY 2010).

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 for 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).

Prior to FY 2010, survey frequencies for many non-statutorily mandated facilities had been longer than once every ten years, due to a growing number of facilities, growth in complaint visits, and demands to survey more facility types. 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 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 type participating in Medicare. In 2010, CMS, with assistance from the 2009 Recovery Act, expanded the pilot's initiative to all States to expand 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. CMS also increased the survey frequency for ASCs to every 3 years in 2010, with assistance from the Recovery Act, to maintain appropriate oversight.

In recent years CMS has improved standards and survey processes for many types of providers, especially dialysis facilities (ESRD), ASCs, hospices, home health, organ transplant centers, and nursing homes. Since late 2007, CMS has conducted onsite surveys of all organ transplant centers in the U.S. and enforced outcome standards if patient deaths or graft failure exceed 150 percent of the risk-adjusted expected number. 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 target facilities whose performance data indicate a higher risk of poor patient outcomes. Nursing home survey processes have been improved through improved 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 initiative).

CMS has worked in recent years to evaluate the performance of state survey agencies and ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements. CMS uses the State Performance Standards System (SPSS), developed in 2002, to track state performance on measures such as adequacy of documentation and promptness of reporting survey results, 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 99.9 percent in 2010, and the percent of home health agencies surveyed at mandated frequencies rose from 92.0 percent in 2002 to 99.9 percent in 2010.

Individuals in nursing homes are a particularly vulnerable population. Consequently, CMS places significant importance 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 two repeat offenders with serious violations per state.

Support Contracts and Information Technology

Support Contracts

There are several categories that comprise support contract costs. Surveyor training has historically comprised the largest single category of support contracts. Training funds ensure that State surveyors are familiar with the Federal regulations and help to improve survey consistency. CMS uses innovative training methods to more efficiently train surveyors and maximize the value of training funds.

Federally-directed surveys have been the second largest category of support contracts. These are either direct surveys that substitute for state surveys (such as in psychiatric hospitals) or comparative surveys designed to check the accuracy and adequacy of surveys done by States. Comparative surveys are done primarily in nursing homes.

NHOIP activities that are funded as support contracts include implementing an improved survey process; understanding survey variations across States; maintaining the Medicare and Medicaid minimum data set (MDS); and publicly reporting nursing home staffing information. Other critical Survey and Certification support contracts include, but are not limited to, life safety code comparative surveys; the Surveyor Minimum Qualifications Test (SMQT); and other efforts to ensure national program oversight and consistency.

CMS is increasingly using information to direct survey attention, prepare for surveys, and track provider progress. For example, CMS uses performance information to assure that onsite surveys are conducted – every year – for 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 OSCAR (Online Survey, Certification, and Reporting System) and FOSS (Federal Oversight/Support Survey System) 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 has developed and 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. This survey system is called the "Quality Indicator Survey" (QIS) and is 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 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, involving CMS contractors. Therefore, CMS is staging national implementation of the QIS as quickly as contracts can be funded and processed. Currently 23 States are either in the process or completely transitioned to the QIS. In the meantime, CMS continues to run two survey processes, the traditional survey process and the QIS survey process, which will ensures a timely transition of systems. In addition, transition to the QIS requires significant technology upgrades to support this refined survey process.

Funding History

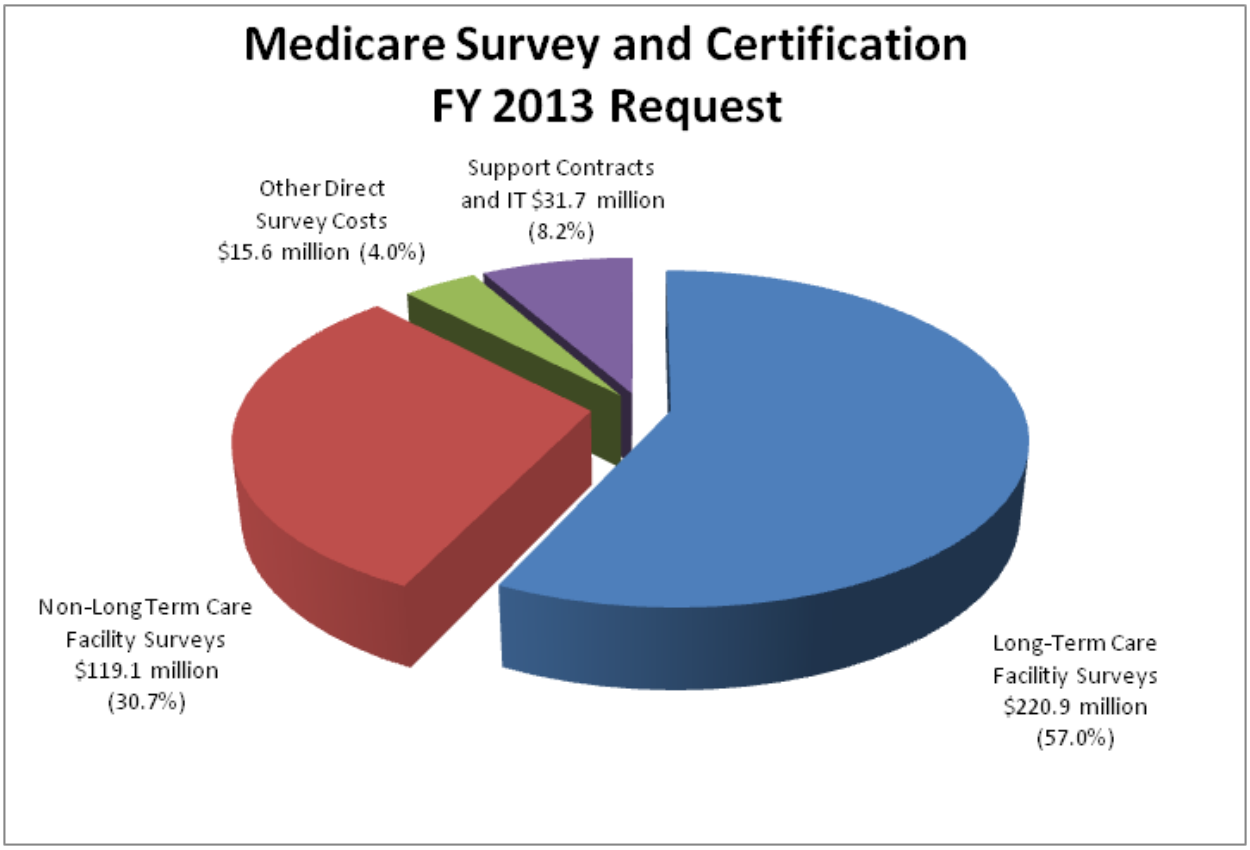
FY 2008	$281,186,000
FY 2009	$293,128,000
FY 2010	$346,900,000
FY 2011	$361,276,000
FY 2012	$355,203,000

Budget Request

CMS' FY 2013 request for Medicare Survey and Certification is $387.4 million, an increase of $32.2 million, or 9.1 percent above the FY 2012 Enacted Level. With facilities' growth, inflation, and longer survey times for certain facilities, this increase is necessary to maintain survey frequencies consistent with statutory and policy requirements. While CMS is still determining the impact of the FY 2012 enacted level, it will be a challenge to maintain current policy survey frequencies. As described below in more detail, $340.0 million of this amount will support State direct survey costs, $15.6 million will support additional costs related to State direct surveys, and $31.7 million will be used for direct surveys by CMS National Contractors (non-State), support contracts, and information technology.

Approximately 91 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. This funding supports less frequent surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics and ambulatory surgery centers. 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).

CMS is also undertaking initiatives to assess and implement methods by which survey processes can be made even more efficient and effective, as well as increasing coordination with CMS-approved accrediting organizations (such as in complaint investigations and communications, consistent with GAO and OIG recommendations).



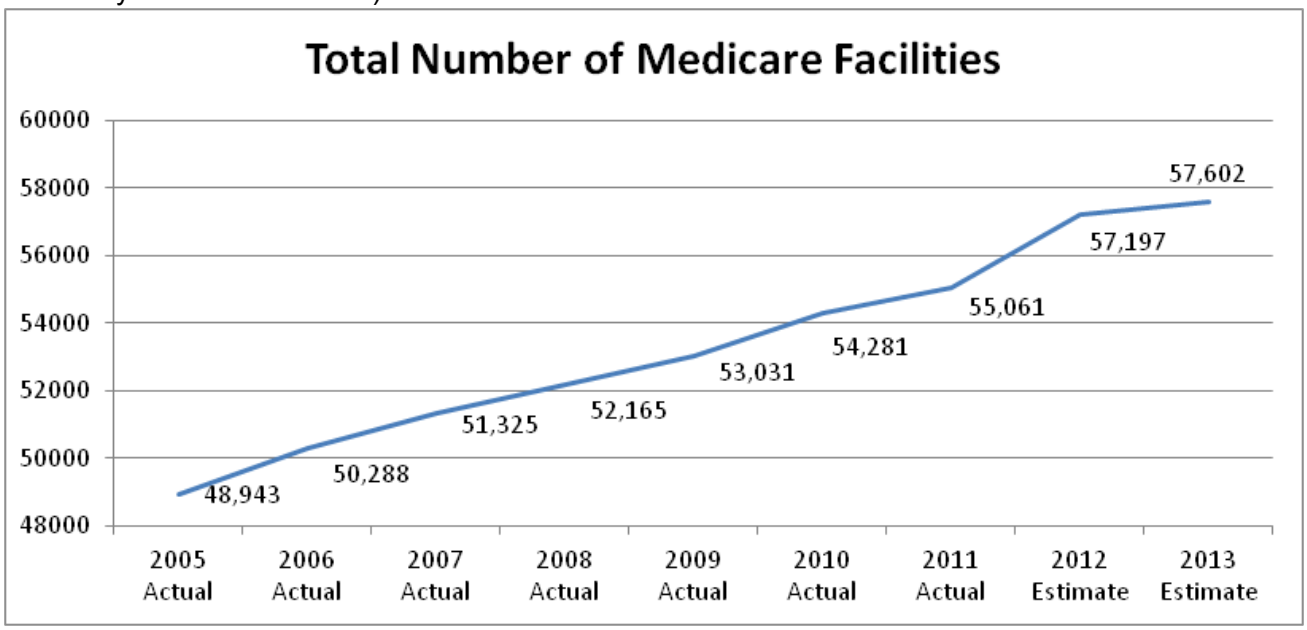
Direct Survey Costs - $340.0 million

The FY 2013 request includes $340.0 million for State direct survey costs. This funding will enable CMS to meet statutory survey frequencies as well as CMS policy levels for non-statutory facilities and allow CMS to continue quality improvement efforts in the surveys of ASCs and accredited hospitals.

We expect to publish Conditions of Participation (COPs) for Community Mental Health Centers (CMHCs). 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. However, we do not expect to begin CMHC surveys until the very end of FY2013 and have therefore not included CMHC survey funds in this budget.

Between FY 2005 and the end of FY 2013, the number of Medicare-certified facilities will have increased by 18 percent, from 48,943 facilities in FY 2005 to an estimated 57,602 facilities in FY 2013, as shown in the following graph.

As shown in the chart below, 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).



Direct Survey Costs (Dollars in Millions) [1]/

Provider Type	FY 2011 Actual	FY 2013 Request
Skilled Nursing Facility (SNF)	$12.9	$12.3
SNF/NF (dually-certified)	$195.8	$208.6
Home Health Agencies	$29.9	$34.1
Accredited Hospitals	$18.8	$21.8
Non-Accredited Hospitals	$17.7	$14.2
Ambulatory Surgery Centers	$8.0	$16.1
ESRD Facilities	$15.1	$18.5
Hospices	$6.3	$8.5
Outpatient Physical Therapy	$1.8	$1.4
Outpatient Rehabilitation	$0.3	$0.3
Portable X-Rays	$0.2	$0.2
Rural Health Clinics	$1.8	$2.3
Transplant Centers	$3.4	$1.7
Community Mental Health Centers	$0.0	$0.0
Subtotal, Direct Survey Costs	**$312.0**	**$340.0**
Other Direct Survey Costs	$17.0	$15.6
Total, Direct Surveys [2]/	**$329.9**	**$355.6**

[1]/ CMS is reviewing FY 2012 direct survey funding within the FY 2012 enacted level.

[2]/ Total may not add due to rounding.

CMS' FY 2013 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). The request continues the enhanced survey process in ASC to target infection control deficiencies, with a survey frequency of every 4 years.

The following chart includes updated frequency rates for FY 2013.

Type of Facility	Recert Level FY 2011 Actual Level ($361.3)	Recert Level FY 2013 Request ($387.4) [1]/
Long-Term Care Facilities	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 3 Years	Every 3 Years
Accredited Hospitals	2% Year	2.2% Year
ESRD Facilities	Every 3 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 3.9 Years
Ambulatory Surgical Center	Every 6 Years	Every 4 Years
All Other Non-LTC Facilities 2/	Every 6 Years	Every 6 Years

1/ CMS is reviewing FY 2012 survey frequencies within the FY 2012 enacted level.

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

In FY 2013, CMS expects to complete approximately 24,800 initial and recertification inspections, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates 51,500 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2013 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of restraints and pressure ulcers in nursing homes. CMS is encouraged by recent downward trends in both measures. In October 2010, all nursing homes began submitting nursing home clinical assessment data using the Minimum Data Set (MDS), version 3.0. The pressure ulcer and restraints measures will be affected by the changes in the MDS; therefore, CMS is rescaling and rebasing both measures. CMS remains committed to reducing the prevalence of restraints and pressure ulcers in nursing homes.

Survey and Complaint Visit Table

	FY 2012 PB 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	36	799	1651
SNF/NF (dually-certified)	14295	14460	141	40192	54793
Home Health Agencies	10950	2712	1038	1595	5345
Accredited Hospitals	4135	109	0	4575	4684
Non-accredited Hospitals	1830	609	101	1025	1735
Transplant Ctrs	267	89	11	10	110
Hospices	3422	490	176	582	1248
Outpatient Physical Therapy	2801	467	45	9	521
Outpatient Rehabilitation	490	82	7	5	94
Portable X-Rays	565	94	20	5	119
ESRD Facilities	5512	1837	256	715	2808
Rural Health Clinics	3775	629	154	40	823
Ambulatory Surgery Centers	5423	943	246	85	1274
CMHC	660	0	25	0	25
Total	**54,941**	**23,337**	**2,256**	**49,637**	**75,230**

	FY 2013 Request				
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	2603	567	1525	4695
Accredited Hospitals	4545	102	0	4495	4597
Non-accredited Hospitals	1712	571	67	735	1373
Transplant Ctrs	264	68	12	10	90
Hospices	4375	588	122	582	1292
Outpatient Physical Therapy	2624	437	37	9	483
Outpatient Rehabilitation	415	69	5	5	79
Portable X-Rays	565	94	21	5	120
ESRD Facilities	5685	1895	263	765	2923
Rural Health Clinics	3885	648	215	40	903
Ambulatory Surgery Centers	5470	863	175	99	1137
CMHC	660	0	25	0	25
Total	**55,936**	**23,214**	**1,666**	**51,353**	**76,233**

Other Direct Survey Costs - $15.6 million

The FY 2013 direct survey cost estimate also includes $15.6 million in other direct survey costs for several continuing activities. Examples of such activities include:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects
- Outcome and Assessment Information Set (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.

Support Contracts and Information Technology - $31.7 million

Support contracts and information technology, managed by CMS, constitute $31.7 million of the FY 2013 request.

Support Contracts

The FY 2013 request for support contracts totals $28.9 million. One of the largest categories in support contracts continues to be surveyor training. 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. The FY 2013 request also includes funding for Federally-directed surveys that substitute for State surveys on psychiatric hospitals, for comparative surveys, and funding for transplant center oversight. The FY 2013 request will also continue to provide funds for the CMS *Nursing Home Compare Program* and *Five Star Quality Rating System*.

Information Technology

The request for FY 2013 includes approximately $2.8 million in IT funding, for activities such as maintenance to the Online Survey, Certification, and Reporting (OSCAR) system and transition to the Certification and Survey Provider Enhanced Reports (CASPER) system. The IT funding level is comparable to the FY 2012 enacted level.

This FY 2013 request includes $0.5 million for the continued implementation of the IT portion of the Quality Indicator Survey (QIS). These funds support the ongoing system support and maintenance for current and future states implementation to the QIS process. In FY 2013, we expect two forms of expansion: (1) expansion within existing States to get to statewide implementation, and (2) adding 3-6 new states, depending on the size of the states. 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. The survey and certification measures provide data to track whether State surveys are performed to comply with statutory requirements and to measure quality of care in nursing homes. We will continue to refine our existing measures and explore new measures in the future.

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. CMS tracks the percentage of States that survey nursing homes every 15 months. CMS did not meet its FY 2010 target of 95 percent, as only 87 percent of States completed the required surveys. In addition, only 81 percent of States surveyed all home health agencies at least every 36 months, missing the FY 2010 target of 90 percent. The primary factor affecting the ability to meet the FY 2010 targets was State employee furloughs, which prevented surveyors from completing their required surveys. The FY 2013 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. To meet these targets, CMS must ensure that proper operational controls, such as training and regulations, are in place. CMS also issues an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements to meet these targets.

In a related activity, we are discontinuing our measure of the 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. The targets originally set for this goal were exceeded in each of the years the goal was reported. 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.

CMS also measures quality of care and other survey and certification activities in nursing homes to assess the effectiveness of State surveys. A measure to decrease the prevalence of pressure ulcers in nursing homes is clinically significant and is closely tied to the care given to beneficiaries. After many years of steady levels, CMS has met or exceeded targets to reduce the prevalence of pressure ulcers in nursing homes in every year since FY 2004, including FY 2010, where we exceeded our target of 8.1 percent with an actual prevalence of 7.4 percent. 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 point 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 will be affected by the changes in the MDS; therefore, CMS will need to rescale and rebase the measure beginning in FY 2011. The FY 2013 target has not yet been determined. Nonetheless, CMS remains committed to reducing the prevalence of pressure ulcers in nursing homes.

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. Data from FY 2012 will be used to establish a baseline and to establish a target for FY 2013.

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 this measure, 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 the GPRA 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 2013 Target	FY 2013 Target +/- FY 2012 Target
MSC1 Decrease the prevalence of pressure ulcers in nursing homes (Outcome)	FY 2010: 7.4% Target: 8.1% (Target Exceeded)	TBD	TBD	Maintain
MSC2 Percentage of States that survey nursing homes at least every 15 months (Outcome)	FY 2010: 87% Target: 95% (Target Not Met)	97%	97%	Maintain
MSC3 Percentage of States that survey HHAs at least every 36 months (Outcome)	FY 2010: 81% Target: 90% (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.(Outcome)	FY 2012: Baseline Available Feb 2013	Baseline TBD	TBD	N/A

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Research, Demonstration and Evaluation

	FY 2011 Enacted	FY 2012 Enacted	FY2013 Budget Request	FY2013 +/- FY2012
BA	$35,529,000	$21,160,000	$0	-$21,160,000
Moved to Program Operations	$0	$0	$24,567,000	+$24,567,000
Adjusted BA	$35,529,000	$21,160,000	$24,567,000	+$3,407,000

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.

FY 2013 Authorization - This line item is eliminated in FY 2013

Allocation Method - Contracts, Competitive Grants, Cooperative Agreements

Program Description and Accomplishments

The Research program's management agenda has been integrated with the new Center for Medicare and Medicaid Innovation (Innovation Center) created under the Affordable Care Act of 2010 (ACA). There are a limited number of Research activities that will continue and will be funded out of the Program Operations line in FY 2013. As a result, the Research line will be eliminated beginning in FY 2013.

Funding for the MCBS and other activities in FY 2013 will be provided from the Program Operations line. The budget request for these activities is included in the Program Operations chapter.

Program Operations Research Crosswalk
(Dollars in Millions)

Topic	FY 2012 Research	FY 2013 Program Operations
MCBS	**$15.7**	**$15.7**
Demonstration Design, Implementation & Evaluation	**$2.1**	**$2.6**
Other Research	**$2.9**	**$5.7**
RCSC Grants	**$0.0**	**$0.0**
HBCU/HSI Research Grants	**$0.4**	**$0.6**
TOTAL (may not add due to rounding)	**$21.2**	**$24.6**

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State High-Risk Pool Grants

	FY 2011 Enacted1/	FY 2012 Enacted1/	FY2013 Budget Request2/	FY2013 +/- FY2012
BA	$54,890,000	$44,000,000	$22,004,000	($21,996,000)

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

1/ In FY 2011 and FY 2012, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill is enacted.
2/ Funding requested through CMS' annual discretionary appropriation.

Allocation Method - Grants

Program Description

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 addresses promotion of qualified high-risk health insurance 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, to all Health Insurance Portability and Accountability Act of 1996 (P. L. 104-191) eligible individuals, health insurance coverage that does not impose any preexisting condition exclusion. In general, high-risk pools are operated through State-established non-profit organizations, many of which contract with private insurance companies 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 operational losses and bonus grants for supplemental consumer benefits to the existing qualified State High-Risk pools. CMS awarded grants to 36 States in FY 2006 and to 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 State High-Risk health insurance pools for FY 2008 in the CMS discretionary Program Management account. In FY 2009, $75 million for High-Risk pools was authorized with the approval of the FY 2009 Omnibus Appropriation Bill (P.L. 111-8). The legislation indicates that no monies are available for seed grants; however, monies are available to fund operational losses and bonus grants to those states that meet the eligibility criteria established in Section 2744 of the Public Health Service Act. On December 16, 2009, the Consolidated Appropriations Act of 2010 (P.L. 111-117) appropriated a total of $55 million for FY 2010 to support the federally qualified State High-Risk pools.

The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) extended funding through September 30, 2011 and appropriated $54.890 million for the

State High-Risk Pool Insurance Program. On December 23, 2011, President Obama signed the Consolidated Appropriations Act, 2012 (Public Law 112-74) which provides $44 million for the State High Risk Pool Insurance Program in FY 2012.

For FY 2013, CMS requests funding for the State High-Risk pools through CMS' annual discretionary appropriation.

Program Description and Accomplishments

With increasing enrollment in excess of 217,000[1] enrollees as of December 31, 2011, the State High-Risk Pool Insurance Program has shown to have economic benefits for the health care system. By bringing these individuals into the ranks of the insured, enrollees' care is now being properly managed, and medical care providers are receiving satisfactory compensation for services rendered. Properly managed care within States that offer the High-Risk Pool Program often reduces overall health care expenses, and the payment to medical providers reduces cost shifting that can occur as a result of uncompensated care.

The table on the following two pages displays the FY 2011 grant appropriations allocated by State.

FY 2011 Operational and Bonus Grants by State

State/Grantee	Operational Losses	Bonus Grant	FY11 Total Grant Amount	Bonus Projects
Alabama – Alabama Health Insurance Plan	$896,534	$0	$896,534	N/A
Alaska - Alaska Comprehensive Health Insurance Association	$561,395	$308,679	$870,074	Low-Income Premium Reduction
Arkansas- Arkansas Comprehensive Health Insurance Plan	$867,951	$478,215	$1,346,166	Disease Management & Low-Income Premium Subsidy
Colorado – Cover Colorado	$1,510,940	$763,088	$2,274,028	Premium Reduction
Connecticut – Connecticut Health Reinsurance Association	$737,080	$417,078	$1,154,158	Perform Outreach to the Uninsured of Connecticut
Idaho – Idaho Individual High Risk Reinsurance Pool	$664,321	$360,373	$1,024,694	Supplemental Consumer Benefits
Illinois – Illinois Comprehensive Health Association	$2,260,445	$1,173,605	$3,434,050	Premium Relief
Indiana – Indiana Comprehensive Health Insurance Association	$1,244,025	$659,922	$1,903,947	Disease Management & Low-Income Premium Subsidy
Iowa – Iowa Comprehensive Health Association	$782,164	$0	$782,164	N/A
Kansas – Kansas Health Insurance Association	$732,308	$401,056	$1,133,364	Disease Management

[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/Grantee	Operational Losses	Bonus Grant	FY11 Total Grant Amount	Bonus Projects
Kentucky – Kentucky Access	$1,040,533	$558,985	$1,599,518	Disease Management
Louisiana – Louisiana Plan	$943,833	$501,717	$1,445,550	Premium Reduction & Expanded Consumer Benefits
Maryland – Maryland Health Insurance Plan	$1,891,210	$960,760	$2,851,970	Low-Income Premium Subsidy
Minnesota – Minnesota Comprehensive Health Association	$2,081,237	$1,158,767	$3,240,004	Low-Income Premium Subsidy
Mississippi – Mississippi Comprehensive Health Insurance Risk Pool Association	$910,029	$494,890	$1,404,919	Disease Management
Missouri – Missouri Health Insurance Pool	$1,220,622	$569,781	$1,790,403	Low income Premium Subsidy Program
Montana – Montana Comprehensive Health Association	$698,429	$384,322	$1,082,751	Disease Management and Low-Income Premium Subsidy allowing for the Expansion of Consumer Benefits
Nebraska- Nebraska Comprehensive Health Insurance Pool	$813,070	$463,154	$1,276,224	Premium Reduction
New Hampshire-New Hampshire Health Plan	$620,183	$332,892	$953,075	Low-Income Premium Subsidy
New Mexico- New Mexico Medical Insurance Pool	$1,124,452	$597,147	$1,721,599	Low-Income Premium Subsidy
North Carolina Health insurance Risk Pool	$1,499,840	$722,259	$2,222,099	Premium Reduction
North Dakota – Comprehensive Health Association of North Dakota	$580,979	$319,607	$900,586	Assisting all CHAND subscribers with their premium costs and other cost sharing requirements.
Oklahoma – Oklahoma Health Insurance High Risk Pool	$877,482	$469,301	$1,346,783	Premium Reduction
Oregon Medical Insurance Pool	$1,496,941	$845,161	$2,342,102	Disease Management & Expanded Consumer Benefits
South Carolina – South Carolina Health Insurance Pool	$552,569	$304,033	$856,602	Expanded Consumer Benefits
South Dakota – South Dakota Risk Pool	$4,865,836	$2,613,301	$7,479,137	Premium Reduction
Texas – Texas Health Insurance Risk Pool	$869,682	$469,638	$1,339,320	Premium Assistance Subsidy (PAS) Program
Utah – Utah Comprehensive Health Insurance Pool	$910,029	$494,890	$1,404,919	Disease Management
Washington – Washington State Health Insurance Pool	$1,070,466	$573,307	$1,643,773	Premium Reduction
Wisconsin- Wisconsin Health Insurance Risk-Sharing Plan	$1,694,494	$862,907	$2,557,401	Disease Management & Low-Income Premium Subsidy
Wyoming – Wyoming Health Insurance Pool	$552,830	$0	$552,830	N/A
Total	**$36,611,629**	**$18,278,371**	**$54,890,000**	

Funding History

FY 2008	**$49,126,500**
FY 2009	**$75,000,000**
FY 2010	**$55,000,000**
FY 2011	**$54,890,000**
FY 2012	**$44,000,000**

Budget Request

CMS is requesting $22.004 million in discretionary funding for this activity in its FY 2013 Program Management account, a decrease of $21.996 million below the FY 2012 enacted level. This funding level provides sufficient funding to States as they begin scaling down activities in their existing State High-Risk Pools to transition to operational Exchanges.

Grantees rely on Federal funding to provide low-income subsidies and premium reductions to many individuals who may not be able to afford or may be denied healthcare coverage. Additionally, there are 28 States that use grant funding to operate disease and care management initiatives to address care coordination. Without those programs, disruption in care may result in complication of health conditions with unintentional costs of care to States as these individuals transition to the Exchanges or other coverage options.

The Affordable Care Act requires States to maintain their existing pools as a condition for participation in the PCIP program. The PCIP program is one of several new options available to people with pre-existing conditions under the Affordable Care Act. As more individuals take advantage of these new changes in the availability of insurance options, enrollment in the existing State High-Risk pools may decrease.

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

Mandatory Appropriations

Medicaid 125
Payments to the Health Care Trust Funds 161

Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$184,279,110,000] *$178,791,197,000* to remain available until expended.

For making, after May 31, [2012] *2013*, payments to States under title XIX 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 [2012] 2013 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 of the Social Security Act for the first quarter of fiscal year [2013,$90,614,082,000] *2014, $106,335,631,000* to remain available until expended.

Payment under such 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, [$184,279,110,000] *$178,791,197,000* to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $90.6 billion for the first quarter of FY 2013 provided under FY 2012 appropriations act. 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, [2012] *2013*, payments to States under title XIX 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 [2012] *2013* 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 2013 to meet unanticipated costs. It makes clear that the language provides budget authority to the Vaccines for Children's program for payments on behalf of States during this time period.

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 of the Social Security Act for the first quarter of fiscal year [2013, $90,614,082,000] *2014, $106,335,631,000* to remain available until expended.	This section provides an advanced appropriation for the first quarter of FY 2014 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for FY 2013 is not enacted by October 1, 2013. It makes clear that the language provides budget authority to the Vaccines for Children program during the first quarter of a fiscal year.
Payment under such 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)

	2011 Actual	2012 Current Law	2013 Estimate
Appropriation Annual	$86,789,382	$270,724,399	$269,405,279
Appropriation Indefinite	171,576,365	0	0
Unobligated balance, start of year	17,006,270	407,762	14,653,582
Unobligated balance, end of year	-407,762	-14,653,582	0
Recoveries of Prior Year Obligations	20,039,400	9,464,147	0
Collections/Refunds	832,389	320,000	0
Total Gross Obligations	$295,836,044	$266,262,726	$284,058,861
Offsetting Collections Medicare Part B QI Program	-703,327	-320,000	0
Obligations Incurred but not Reported	-117,310	-1,359,500	-1,359,500
Total Net Obligations	$295,015,407	$264,583,226	$282,699,361

Medicaid Program
Summary of Changes
(dollars in thousands)

2013 Estimated Budget Authority		$269,405,279
2012 Enacted		$270,724,399
Net Change		-$1,319,120
Explanation of Changes	FY 2012 Enacted Budget Authority	FY 2013 Change From Base Budget Authority
Program Increases		
Fraud Control Units	$226,085	$11,115
Vaccines for Children Program	4,030,996	240,019
Legislation and Policy Actions	2,885,507	3,128,493
MAP	251,001,000	7,805,000
State and Local Administration	11,043,445	1,337,845
Offsetting Collections from Medicare Part B for Qualified Individuals	-165,000	165,000
Obligations Incurred But Not Reported	1,359,500	0
State and Local Administration Financial Adjustment	394,266	662,310
Total Program Increases	$270,775,799	$13,349,782
Program Decreases		
State Certification	$238,600	-$8,320
Financial Management Reviews	-290,000	-7,000
Unobligated Balance Carry Forward	0	-14,653,582
Total Program Decreases	-$51,400	-$14,668,902
TOTAL	$270,724,399	-$1,319,120

Medicaid Program
Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$ 266,715,339,00	Indefinite	$265,134,264,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$4,009,060,000		$4,271,015,000
Total Appropriations		$270,724,399,000		$269,405,279,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2003	158,692,155,000	158,692,155,000	158,692,155,000	164,550,765,542	1/
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	2/
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	3/
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	4/
2012	270,724,399,000	------	------	270,724,399,000	
2013	269,405,279,000				

1/ Includes $5,858.6 million under indefinite authority.
2/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
3/ Includes $38,262.4 million under indefinite authority.
4/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.

Medicaid

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Medical Assistance Payments (MAP)	$277,682,645	$246,009,000	$263,693,000	$17,684,000
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$117,310	$1,359,500	$1,359,500	$0
Vaccines for Children	$3,952,677	$4,009,060	$4,271,015	$261,955
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$14,083,412	$14,885,166	$14,735,346	-$149,820
Obligations (gross)	$295,836,044	$266,262,726	$284,058,861	$17,796,135
Unobligated Balance, Start of Year	-$17,006,270	-$407,762	-$14,653,582	-$14,245,820
Unobligated Balance, End of Year	$407,762	$14,653,582	$0	-$14,653,582
Recoveries of Prior Year Obligations	-$20,039,400	-$9,464,147	$0	$9,464,147
Appropriation Budget Authority (gross)	$259,198,136	$271,044,399	$269,405,279	-$1,639,120
Collections	-$832,389	-$320,000	$0	$320,000
Total Budget Authority (net)	$258,365,747	$270,724,399	$269,405,279	-$1,319,120
Indefinite Authority	-$171,576,365	$0	$0	$0
Advanced Appropriation	-$86,789,382	-$86,445,289	-$90,614,082	$344,093
Annual Appropriation	$0	$184,279,110	$178,791,197	-$5,487,913

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

FY 2012 Authorization - Public Law 111-117, Public Law 111-226, Public Law 111-148, Public Law 111-152, Public Law 112-10, Public Law 112-74

Allocation Method - Formula Grants

Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid is 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, older individuals, and people who are blind or disabled. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L 111-152), together known as the Affordable Care Act, expands Medicaid eligibility by 2014 or earlier at the State's option to adults under age 65 with incomes up to 133 percent of the Federal poverty level (FPL). In addition, Medicaid provides coverage for long-term care services and supports, including institutional services and home and community-based services and supports to older individuals and individuals with disabilities. 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 Supplemental Security Income (SSI) or who meet the categorical income and resource requirements of the former Aid to Families with Dependent Children (AFDC) 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 certain low-income Medicare beneficiaries. 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, they 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, comprehensive health screening, diagnostic and treatment services to children, 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 persons with intellectual disabilities. States may offer an array of home and community-based services to older individuals, individuals with disabilities or other individuals with chronic conditions through a variety of waiver, State plan, 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 generally 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 American Recovery and Reinvestment Act (ARRA), (P.L. 111-5) was signed into law on February 17, 2009. It contains Medicaid provisions to provide protections for Indians under Medicaid and CHIP, and monies for administration and incentive payments that promote the adoption and meaningful use of electronic health records (EHR).

The signing of the *Affordable Care Act* in March 2010 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 guaranteed to the lowest income Americans. To accomplish this, Medicaid eligibility is expanded and simplified, with the Federal government assuming most of the new coverage costs. Beyond these eligibility and financing changes, the new law expands access to home and community-based services, enhances the Federal commitment to assuring program integrity, and makes other program improvements.

Additionally, the Affordable Care Act mandates Medicaid coverage for tobacco cessation services for pregnant women. As part of CMS' broader tobacco cessation policy, CMS issued guidance in FY 2011 allowing States to claim the 50 percent Federal administrative matching rate on costs of tobacco quitlines that follow evidence-based protocols and reminding States that they have the option to provide tobacco cessation services to more populations than just the mandatory coverage of pregnant women.

Medicaid Integrity Program

The Medicaid Integrity Program (MIP), though not funded from the Medicaid appropriation, supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. MIP represents the most significant single, dedicated investment the Federal government has made in ensuring the integrity of the Medicaid program. MIP offers an opportunity to ensure the efficient administration of the program and to promote sound stewardship of State and Federal resources. 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

The Vaccines for Children (VFC) program is 100 percent Federally-funded by Medicaid and operated by the Centers for Disease Control and Prevention (CDC). 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 lacks 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 the VFC program, CDC 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 the intellectually disabled 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 the State Attorney General's office or coordinate with another office with statewide prosecutorial authority.

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, 2010 nearly 72 percent of all Medicaid beneficiaries (just over 39 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, contain costs, improve access to services, and achieve greater continuity of care. Increasingly, States are using managed care to provide acute, primary, mental health and substance use services, and 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) (or "freedom of choice" waivers) and 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 Indians) into managed care through a State plan amendment. The Deficit Reduction Act 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, improving information systems, providing expedited review of State proposals, and improving coordination with other HHS components providing technical assistance to States

related to managed care. In particular, CMS works directly with States to evaluate effectiveness of State managed care quality improvement strategies and external quality review organization technical reporting processes.

Section 1115 Health Care Reform Demonstrations

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 approved 40 statewide health care reform demonstrations in 30 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin) and the District of Columbia. CMS has also approved three non-Statewide health reform demonstrations (Kentucky, Louisiana and Missouri) and 17 demonstrations specifically related to family planning (Alabama, Arkansas, Florida, Georgia, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, North Carolina, Oregon, Pennsylvania, Texas, Washington, and Wyoming).

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

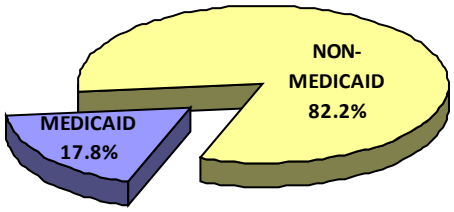
	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	FY 2013 +/- FY 2012
Aged	4.8	5.0	5.1	0.1
Disabled	9.7	9.8	9.9	0.1
Adults	12.6	12.9	13.1	0.2
Children	27.4	27.9	27.8	-0.1
Territories	1.0	1.0	1.0	0
Total	55.6	56.6	56.9	0.3

1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2013, as shown in the pie chart, 17.8 percent, or 56.9 million, of the projected 319.3 million in the total U.S. population, will be enrolled in Medicaid for the equivalent of a full year during FY 2013. In FY 2013, Medicaid will provide coverage to more than one out of every five children in the Nation.

CMS projects that in FY 2013, children and non-disabled adults under age 65 will represent 72 percent of the Medicaid population, but account for approximately 37 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, older individuals and individuals with disabilities are estimated to make up about 26 percent of the Medicaid population, yet account for approximately 63 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

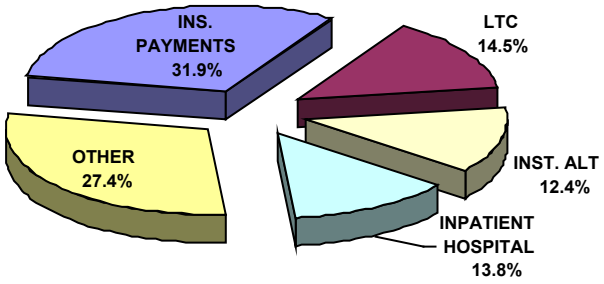
FY 2013 MEDICAID FULL YEAR ENROLLEES AND THE U.S. POPULATION



Benefit Services

As displayed in the table on the following page, the State estimates for medical assistance payments increased from $248.1 billion for FY 2012 to $256.8 billion for FY 2013.

FY 2013 STATE ESTIMATES OF BENEFITS



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 $81.9 billion in funding for FY 2013 representing 31.9 percent of the State-submitted benefit estimates for FY 2013. The second largest FY 2013 Medicaid category of service is institutional long-term care services. It is composed of nursing facilities and intermediate care facilities for the intellectually disabled. The States have submitted FY 2013 estimates totaling $37.3 billion or about 14.5 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2013 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($35.4 billion or 13.8 percent), followed by institutional alternative services such as home health, personal care, and other home and community-based services ($31.9 billion or 12.4 percent). Together these four benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for 72.6 percent of the State-estimated cost of the Medicaid program for FY 2013.

Estimated Benefit Service Growth, FY 2012 to FY 2013
November 2011 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2012	Est. FY 2013	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)	$75,543,920	$81,883,746	$6,339,826	8.4%	72.6%
Institutional Alternatives (Personal care, home health, and other home and community-based services)	$31,220,714	$31,930,444	$709,730	2.3%	8.1%
Other (Targeted case management, hospice, all other services, and collections)	$21,074,811	$20,693,800	-$381,011	-1.8%	-4.4%
Long-Term Care (Nursing facilities, intermediate care facilities for the intellectually disabled)	$36,791,689	$37,250,576	$458,887	1.2%	5.3%
Outpatient Hospital	$9,622,430	$9,755,667	$133,237	1.4%	1.5%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$7,492,332	$7,296,012	-$196,320	-2.6%	-2.2%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$34,379,261	$35,367,842	$988,581	2.9%	11.3%
Physician/Practitioner/Dental	$14,301,340	$14,887,992	$586,652	4.1%	6.7%
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)	$8,963,298	$9,165,091	$201,793	2.3%	2.3%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$248,090,010	$256,825,676	$8,735,666	3.5%	100.0%

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

FY 2012 Authorization - Public Law 111-117, Public Law 111-148, Public Law 111-152, Public Law 112-10 and P.L. 112-74

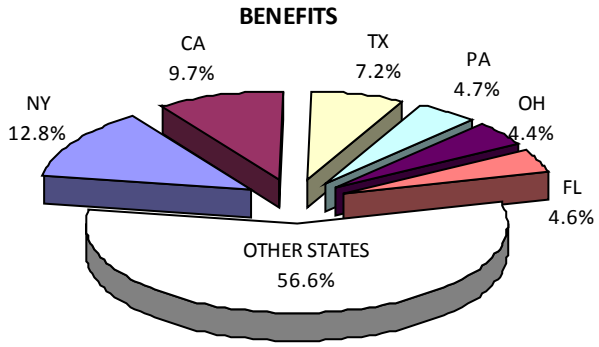
Allocation Method - Formula Grants

Distribution of Medicaid Monies

The total FY 2013 State-submitted estimates for Medicaid are $268.0 billion, composed of $256.8 billion for Medicaid medical assistance payments and $11.2 billion for State and local administration. Nine States represent over 52 percent of the total FY 2013 State estimates.

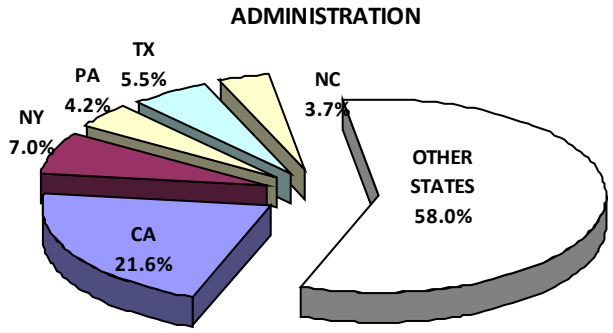
Distribution of Benefit Monies

As displayed, New York, California, Texas, Pennsylvania, Ohio, and Florida account for $111.3 billion, or over 43.3 percent, of the State-submitted estimates for benefits for FY 2013.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2013 State and local administration represents about 4.2 percent of the total State-submitted estimates for Medicaid costs for FY 2013. As displayed, California, New York, Pennsylvania, Texas, and Florida account for $4.7 billion or 41.8 percent of expenditures for State and local administration.



Funding History (Appropriation)

FY 2008	$206,885,673,000
FY 2009	$216,627,700,000
FY 2010	$292,662,511,000
FY 2011	$259,933,181,000
FY 2012	$270,724,399,000

Budget Request

CMS estimates its FY 2013 appropriation request for Grants to States for Medicaid is $269.4 billion, a decrease of $1.3 billion relative to the FY 2012 level of $270.7 billion. This appropriation is composed of $178.8 billion in monies for FY 2013 and $90.6 billion in advance appropriation monies from the FY 2012 appropriation.

These monies, together with an estimated end of year FY 2012 unobligated balance carried forward to FY 2013 of $14.7 billion will fund $284.1 billion in anticipated FY 2013 Medicaid obligations. These obligations are composed of:

- $263.7 billion in Medicaid medical assistance benefits;
- $1.4 billion for benefit obligations incurred but not yet reported;
- $14.7 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 through the first three quarters of FY 2011. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2013 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $282.7 billion in FY 2013. This represents an increase of 10.8 percent relative to the estimated net outlay level of $255.1 billion for FY 2012. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately .5 percent during this time period.

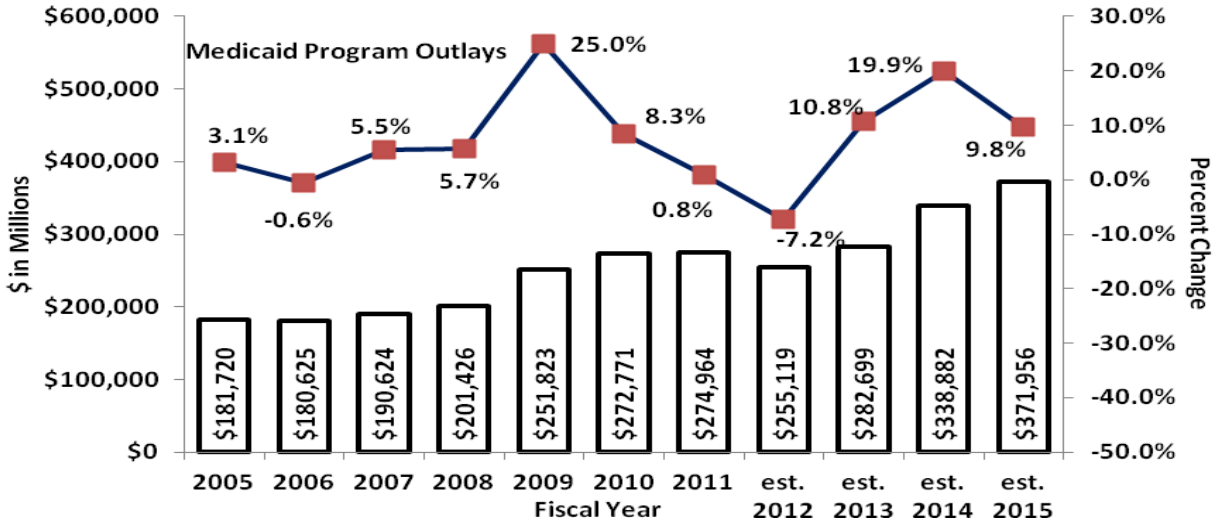
Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2011 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2011 State estimates for MAP in FY 2012 are the first State-submitted estimates for FY 2013. 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.

OACT developed the MAP estimate for FY 2013. Using the first three quarters of FY 2011 State-reported expenditures as a base, expenditures for FY 2012 and FY 2013 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. OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the November 2011 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 second half of the decade 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 for FY 2012. In addition, enrollment growth is expected to slow as the economy expands and employment levels increase.

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 with the expansion of Medicaid eligibility to persons under age 65 with incomes under 133 percent of the Federal Poverty Level (with a 5 percent income disregard). Expenditures for those eligible for Medicaid only under these new rules are paid

for entirely by the Federal government through 2016. The matching rate for those individuals phases down to 90 percent in 2020 and beyond.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation
(Estimated FY 2013 costs are $5.2 billion)

Affordable Care Act
(P.L. 111-148, P.L. 111-152)

- Expanded and Simplified Eligibility Standards and Enrollment

  Beginning in January 2014, Medicaid will be extended to all adults under 65 years of age with income under 133 percent of the Federal poverty level (with a 5 percent income disregard). This means that outdated "categories" that have limited Medicaid eligibility will be eliminated, and adults will qualify for Medicaid based on income, regardless of disability or parental status. (Current citizenship and immigration rules will continue to apply.) States could begin this coverage prior to 2014 under a new option that became effective in April 2010.

  Beginning in January 2014, the Affordable Care Act requires States to cover all children up to 133 percent of the poverty level in Medicaid (some States currently cover children over age six who are between 110 to 133 percent of the Federal poverty level in their CHIP programs.

  In addition to eliminating complex eligibility "categories" and dropping the Medicaid asset test for most individuals, the Affordable Care Act applies simplified income eligibility standards in Medicaid and CHIP, coordinated with standards in the newly-created Affordable Insurance Exchanges (Exchanges) to facilitate seamless enrollment across health programs.

- Enhanced Federal Funding

  Coverage for newly eligible beneficiary groups will be fully financed by the Federal government for three years beginning in 2014. Beginning in 2017 Federal funding for these newly eligible adults will scale down to 90 percent by 2020. Most States that had previously expanded coverage for low-income adults will also receive an increased Federal matching rate (which will phase up to 90 percent by 2020) for spending on childless adults.

  Additional Federal funding for State Medicaid programs is also available for primary care, preventive care, home and community-based services and new grants and authorities to improve quality and reform systems for delivering care.

- Improved Access to Home and Community-Based Services and Supports for Medicaid Enrollees

  The Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in the

community, including a new State plan option for States to provide community-based attendant services and supports; improvements to an existing State plan option to provide home and community-based services; additional financial incentives for States to rebalance the provision of long-term care to include more home and community-based services; and an extension of the "spousal impoverishment" protections to people who receive home and community-based services and supports.

- Enhancing Prevention and Primary Care

  Prevention and primary care will be enhanced through a variety of initiatives. States will receive 100% federal funding to increase Medicaid payment rates for primary care to Medicare levels in 2013 and 2014. Beginning in 2010, Medicaid will cover tobacco cessation services for pregnant women. States will receive a 1 percentage point increase in the Federal matching rate beginning in 2013 for recommended adult preventive services and tobacco cessation services for pregnant women, if they provide the preventive services without cost-sharing.

  Medicaid no longer pays for specified hospital acquired conditions as of July 2011. Medicare policies will establish a minimum set of standards, but States have flexibility to extend this policy beyond these minimums and deny payments for additional conditions.

- Commitment to Transparency and Information Sharing

  The law includes new provisions to explicitly promote transparency about Medicaid programs and policies. CMS has already issued proposed regulations establishing meaningful opportunities for public involvement in the development of State and Federal Medicaid demonstrations and waivers.

Temporary Payroll Tax Cut Continuation Act of 2011
(P.L. 112-78)

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 extends the TMA program from January 1, 2012 through February 29, 2012.

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 extends the QI program from January 1, 2012 through February 29, 2012.

Three Percent Withholding Repeal and Job Creation Act (P.L. 112-56)

This legislation amended the Internal Revenue Code to include Social Security benefits in the calculation of modified adjusted gross income to determine eligibility for Medicaid and for the premium tax credits in the Exchanges in 2014 and onwards.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

- Tobacco Cessation Telephone Quitlines
  (Estimated FY 2013 costs are $9 million)

  Adult Medicaid recipients smoke at a substantially higher rate compared to adults in general in the United States. A core mission of CMS, encouraged by Affordable Care Act and an important focus of HHS, is to prevent rather than just treat diseases. There is no preventive service for adults that has greater potential to reduce illness and save costs than tobacco cessation. CMS will regard tobacco quitlines as an allowable administrative activity to the extent that the quitline provides support to Medicaid beneficiaries. Allowable quitline expenditures are claimable at the 50 percent Federal matching rate, with the State funding the remaining 50 percent. Federal Medicaid administrative reimbursement for quitlines will help ensure that Medicaid recipients are provided with services that can substantially increase their likelihood of quitting smoking, thereby improving health and saving costs.

- Medicaid Financial Management Reviews
  (Estimated FY 2013 savings are $297 million)

  Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $297 million in FY 2013. 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, or IBNR)

The FY 2013 estimate of $1.4 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2012 to September 30, 2013. 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 every vaccine and for all vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. In addition to the

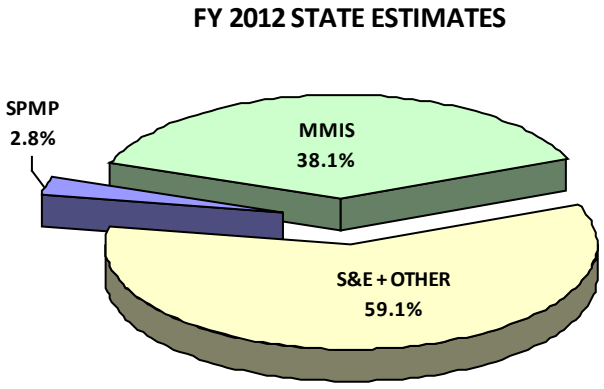
health benefits of vaccines, they also provide significant economic value. A 2011 economic evaluation found that for each birth cohort vaccinated against 13 childhood diseases (diphtheria, *haemophilus influenzae* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, 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 and over $68 billion in indirect societal costs. For each dollar invested, $10.20 is saved.

The current FY 2013 estimate for the VFC program is $4.3 billion, which is $262.0 million above the FY 2012 estimate. This 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 95 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 vaccine-preventable diseases and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, 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), Survey and Certification and Fraud Control Units

For FY 2013, based on recent actual data and the November 2011 State estimates, CMS estimated the Federal share of State and local administration costs to be $14.7 billion. This estimate is composed of $13.1 billion for Medicaid State and local administration, $1.2 billion for the costs of the health information technology provisions contained in section 4201 of ARRA, and additional funds for Medicaid State survey and certification and State Medicaid fraud control units ($0.4 billion).
State and Local Administration

In November 2011 the States estimated the Federal share of State and local administration outlays to be $11.2 billion for FY 2013. 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); and 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 2013 State-submitted estimates of $11.2 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 also adjusted to reflect the estimated costs of the electronic health records EHR provisions of ARRA, Medicaid eligibility determination and enrollment activities and Tobacco Cessation Telephone Quitlines . After these adjustments the FY 2013 estimate for State and local administration is $14.3 billion.

- ARRA Electronic Health Records, (EHR) (Section 4201) Administration
  (FY 2013 estimate is $1,061 million for provider incentives payments and $132.9 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.

- Federal Funding for Medicaid Eligibility Determination and Enrollment Activities
  (FY 2013 estimated cost is $800 million)

  The Affordable Care Act envisions a system of seamless eligibility determination and enrollment among Medicaid, CHIP, and the newly created Exchanges. To help States prepare for these new requirements in 2014, HHS proposed making Medicaid eligibility determination systems eligible for an enhanced Federal matching rate of 90 percent for development through December 2015, and 75 percent for maintenance and operations. States will need to meet performance standards and conditions for their Medicaid technology investments (including traditional claims processing systems and eligibility systems) to receive the enhanced matching rate.

- Tobacco Cessation Telephone Quitlines
  (FY 2013 estimated cost is $30 million)

  Adult Medicaid recipients smoke at a substantially higher rate compared to adults in general in the United States. A core mission of CMS, encouraged by ACA and an important focus of HHS, is to prevent rather than just treat diseases. There is no preventive service for adults that has greater potential to reduce illness and save costs than tobacco cessation. CMS will regard tobacco quitlines as an allowable administrative activity to the extent that the quitline provides support to Medicaid beneficiaries. Allowable quitline expenditures are claimable at the 50 percent matching rate, with the State funding the other 50 percent. Federal Medicaid administrative reimbursement for quitlines will help ensure that Medicaid recipients are provided with services that can substantially increase their likelihood of quitting smoking, thereby improving health and saving costs.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for the intellectually disabled in FY 2013 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2013 estimate for Medicaid State survey and certification is $230.3 million. This represents an increase of $2.3 million above the current FY 2012 estimate of $228.0 million. This increased funding level includes monies to support increasing workload requirements; 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 2013, State Medicaid fraud control unit operations are currently estimated to require $237.2 million in Federal matching funds. This represents an increase of $21.2 million over the FY 2012 funding level of $216.0 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.

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. The MFCUs achieve significant criminal case results and assist in the resolution of civil fraud cases that involve substantial recoveries to the Medicaid program.

Impact of Proposed Legislation

1. Phase Down Medicaid Provider Tax Threshold Beginning in FY 2015

   Some States finance portions of their Medicaid programs by requiring health care providers to satisfy the State share of Medicaid payments through taxation. Under this proposal, CMS would limit States' ability to use provider taxes to pay the State share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond.

   Five-year budget savings: $6,200 million

2. Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017

   Under current law, States face a patchwork of different Federal payment contributions for individuals eligible for Medicaid and CHIP. Beginning in 2017, this proposal would replace these complicated Federal matching formulas with a single matching rate specific to each State that automatically increases if a recession forces enrollment and State costs to rise.

   Five-year budget savings: $3,400 million

3. Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY 2021

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. The Affordable Care Act includes annual aggregate DSH reductions for FY 2014 through FY 2020, but in FY 2021, allotments revert to levels prior to the Affordable Care Act that had been in effect. This proposal would rebase the FY 2021 allotments off the reduced FY 2020 amount in the Affordable Care Act, and determine future allotments from the rebased level using current law methodology.

Five-year budget impact: $0

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

Medicare program is in the process of implementing innovative ways to increase efficiency for payment of DME through the DME Competitive Bidding Program, which is expected to save the Medicare program more than $25.7 billion, and Medicare beneficiaries approximately $17.1 billion over ten years. This proposal, which takes effect in FY 2013, 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: $1,190 million

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. Effective in FY 2013, this proposal provides States the flexibility to require benchmark benefit plan coverage for non-elderly, non-disabled adults with incomes above 133 percent of the FPL.

Five-year budget impact: $0

6. Extend Transitional Medical Assistance (TMA) Through CY 2013

This proposal, effective on March 1, 2012, extends authorization and funding of the TMA program through December 31, 2013. 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. Current law extends this program through February 29, 2012.

Five-year budget costs: $815 million

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

Effective on March 1, 2012, this proposal extends authorization and funding of the QI program through December 31, 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 Federal poverty level (FPL). Current law extends this program through February 29, 2012.

Five-year budget costs: $1,690 million

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

This proposal, effective in FY 2013, would require States 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: $620 million

9. 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 avoid costs for prenatal and preventive pediatric claims when third parties are responsible, 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. This proposal is effective in FY 2013.

Five-year budget savings: $630 million

10. 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. However, some manufacturers improperly report items that do not belong. Effective in FY 2013, 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: $6 million

11. Enforce Manufacturer Compliance with Drug Rebate Requirements

This proposal would allow CMS to conduct regular audits and surveys of drug manufacturer to ensure compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective. This proposal is effective in FY 2013.

Five-year budget impact: $0

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

This proposal would require electronic listing of drugs with the FDA in order to receive Medicaid coverage. Effective in FY 2013, this proposal would align Medicaid drug coverage requirements with Medicare drug coverage requirements.

Five-year budget impact: $0

13. Increase Penalties for Fraudulent Noncompliance on Rebate Agreements

Effective in FY 2013, 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

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

Effective in FY 2013, this proposal would prevent States from using Federal funds to pay the State share of Medicaid or CHIP, unless specifically authorized under law to specifically match Medicaid or CHIP funds.

Five-year budget impact: $0

15. Consolidate Redundant Error Rate Measurement Programs

Effective in FY 2013, this proposal would alleviate State program integrity reporting requirements and create a streamlined audit program by consolidating the Medicaid Eligibility Quality Control (MEQC) and Medicaid Payment Error Rate Measurement (PERM) programs.

Five-year budget impact: $0

16. Retain a Portion of Recovery Audit Contractor (RAC) Recoveries to Implement Actions That Prevent Fraud and Abuse (Medicaid impact)

Under current law, CMS can use RAC program recovery funds to administer the RAC program, but cannot use these funds for corrective actions such as new processing edits and provider education and training to prevent future improper payments. Effective in FY 2013, this proposal addresses this funding problem.

Five-year budget savings: $30 million

17. Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities (Medicaid impact)

CMS is committed to protecting Medicare, Medicaid, and all other Federal health care programs from potentially fraudulent providers. This proposal that takes effect in FY 2013 would expand the current authority to exclude individuals and entities from federal health programs if affiliated with a sanctioned entity by (1) 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 (2) extending the exclusion authority to entities affiliated with a sanctioned entity.

Five-year budget impact: $0

18. Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers (Medicaid impact)

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 impact: $0

19. Establish Hold-Harmless for Federal Poverty Guidelines (Medicaid impact)

This proposal would establish a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the Consumer Price Index for all Urban Consumers (CPI-U). To protect access to programs, including Medicaid, for low-income families and individuals, this proposal would treat the CPI-U adjustment for the poverty guidelines similarly to the treatment of the annual cost-of-living adjustments for Social Security Benefits.

Five-year budget impact: $0

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

Beginning in FY 2013, this proposal would extend the SSI for qualified refugees under the Elderly and Disabled Refugees Act for two years.

Five-year Medicaid budget cost: $22 million

21. Eliminate Medicaid Recoupment of Birthing Costs from 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 Medicaid cost: $30 million

22. 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 2013, 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: $40 million

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

Beginning in FY 2013, 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: $960 million

MEDICAID PROGRAM
Proposed Law
Dollars in Thousands

Legislative Proposal	**FY 2013**
Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017	0
Phase Down Medicaid Provider Tax Threshold Beginning in 2015	0
Rebase Medicaid Disproportionate Share Hospital (DSH) Allotments in FY 2021	0
Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates	-$180,000
Expand State Flexibility to Provide Benchmark Benefit Packages	0
Extend Transitional Medical Assistance (TMA) Through CY 2013	$640,000
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-$40,000
Strengthen Medicaid Third-Party Liability	-$110,000
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 RAC 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
Establish Hold-Harmless for Federal Poverty Guidelines (Medicaid impact)	0
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees (Medicaid impact)	$11,000
Eliminate Medicaid Recoupment of Birthing Costs from Child Support (Medicaid impact)	0
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics (Medicaid impact)	0
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics (Medicaid impact)	-$130,000
SUBTOTAL	$190,000
Extend the Qualified Individuals (QI) Program through CY 2014 (Medicaid Part B Transfer)	$695,000
TOTAL	$885,000

FY 2012 MANDATORY STATE/FORMULA GRANTS[1]

(Dollars in thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2013
Alabama	$3,671,965	$3,930,310	$3,925,353	-$4,957
Alaska	8964368	886,755	945,031	58,276
Arizona	6,631,504	5,884,698	5,883,565	-1,133
Arkansas	3,154,151	3,137,293	3,314,329	177,036
California	33,934,951	27,419,744	27,339,410	-80,334
Colorado	2,556,574	2,455,882	2,457,346	1,464
Connecticut	3,353,879	3,023,007	3,130,456	107,449
Delaware	879,541	820,959	856,521	35,562
District of Columbia	1,636,792	1,490,306	1,497,898	7,592
Florida	11,701,750	10,982,906	12,070,614	1,087,708
Georgia	5,909,192	5,672,255	5,737,216	64,961
Hawaii	982,424	843,860	904,755	60,895
Idaho	1,179,865	1,247,826	1,346,363	98,537
Illinois	7,750,839	7,383,527	7,380,699	-2,828
Indiana	4,912,614	5,116,332	5,198,839	82,507
Iowa	2,342,713	2,237,321	2,336,633	99,312

FY 2012 MANDATORY STATE/FORMULA GRANTS[1]

(Dollars in thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2013
Kansas	1,817,792	1,658,743	1,674,268	15,525
Kentucky	4,463,867	4,318,509	4,266,825	-51,684
Louisiana	4,915,949	4,959,701	4,835,716	-123,985
Maine	1,718,098	1,412,106	1,461,383	49,277
Maryland	4,294,284	3,649,004	3,880,423	231,419
Massachusetts	7,720,873	6,822,025	6,721,584	-100,441
Michigan	8,901,289	8,530,647	8,933,215	402,568
Minnesota	4,842,285	5,062,574	4,985,748	-76,826
Mississippi	3,629,993	3,996,839	4,284,295	287,456
Missouri	5,707,097	5,953,069	5,939,561	-13,508
Montana	739,807	802,755	735,972	-66,783
Nebraska	1,111,627	1,073,333	1,101,109	27,776
Nevada	977,650	1,007,264	1,062,970	55,706
New Hampshire	803,103	689,098	711,272	22,174
New Jersey	6,177,327	5,857,980	6,047,156	189,176
New Mexico	2,616,293	2,793,499	3,290,363	496,864
New York	30,158,212	31,560,163	33,560,898	2,000,735
North Carolina	7,633,582	7,753,928	7,778,960	25,032
North Dakota	490,082	473,751	453,344	-20,407
Ohio	11,058,492	11,592,756	11,675,254	82,498
Oklahoma	3,094,986	3,097,182	3,210,651	113,469
Oregon	3,175,351	3,127,377	3,233,606	106,229
Pennsylvania	13,227,690	12,164,818	12,469,159	304,341
Rhode Island	1,293,341	1,143,570	1,168,701	25,131
South Carolina	3,789,291	3,644,106	3,580,296	-63,810
South Dakota	541,561	533,994	536,813	2,819
Tennessee	5,923,638	6,269,329	6,861,115	591,786
Texas	19,264,257	18,091,472	19,068,176	976,704
Utah	1,394,824	1,414,263	1,461,234	46,971
Vermont	844,559	857,581	847,755	-9,826
Virginia	4,052,544	3,725,460	4,079,758	354,298
Washington	3,677,209	4,719,916	5,639,378	919,462
West Virginia	2,231,730	2,231,035	2,289,905	58,870
Wisconsin	4,736,191	4,251,605	4,441,083	189,478
Wyoming	325,558	305,074	305,185	111

FY 2012 MANDATORY STATE/FORMULA GRANTS[1]

(Dollars in thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2013
Subtotal	**268,845,554**	**258,077,507**	**266,918,159**	**8,840,652**
American Samoa	13,408	13,578	14,039	166
Guam	17,404	21,656	21,411	-245
Northern Mariana Islands	14,438	17,550	17,550	0
Puerto Rico	871,841	1,008,676	1,008,676	0
Virgin Islands	19,621	33,265	33,265	0
Subtotal	**936,712**	**1,095,020**	**1,094,941**	**-79**
Total States/Territories	**269,782,266**	**259,172,527**	**268,013,100**	**8,840,573**
Survey & Certification	215,826	228,000	230,280	2,280
Fraud Control Units	215,319	215,973	237,200	21,227
Vaccines For Children	3,952,677	4,009,060	4,271,015	261,955
Medicare Part B Transfer	703,327	320,000	0	-320,000
Incurred But Not Reported	117,310	1,359,500	1,359,500	0
Undistributed	20,849,319	957,666	9,947,766	8,990,100
TOTAL RESOURCES	**$295,836,044**	**$266,262,726**	**$284,058,861**	**$17,796,135**

[1] Represents current law baseline projections of obligations.

Medicaid Program
Budget Authority by Object

	FY 2012 Current Law	FY 2013 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$266,715,339,000	$265,134,264,000	-$1,581,075,000
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$4,009,060,000	$4,271,015,000	$261,955,000
Total Budget Authority	$270,724,399,000	$269,405,279,000	-$1,319,120,000

Medicaid Program
Medicaid Requirements
(dollars in thousands)

	FY 2012 Estimate	FY 2013 Estimate
November 2010 Estimates		
Medical Assistance Payments and State and Local Administration	$259,172,527	$268,013,100
State Certification	228,000	230,280
Fraud Control Units	215,973	237,200
Total Unadjusted Estimates	$259,616,500	$268,480,580
Legislation	-$335,000	$5,175,000
Policy Actions	729,000	839,000
State and Local Administration Financial Adj.	921,483	1,056,576
Obligations Incurred But Not Reported	1,359,500	1,359,500
Financial Management Reviews	-277,000	-297,000
Actuarial Adjustments	239,183	3,174,190
Total Adjustments	$2,637,166	$11,307,266
Vaccines For Children Program	$4,009,060	$4,271,015
Current Law Requirement	$266,262,726	$284,058,861
Unobligated Balances		
Start of Year	-407,762	-14,653,582
End of Year	14,653,582	0
Recoveries	-9,464,147	0
Gross Budget Authority	$271,044,399	$269,405,279
Offsetting Collections	-320,000	0
Appropriation/Net Budget Authority	$270,724,399	$269,405,279

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.

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. CMS has a measure to "Improve Children's Health Care Quality across Medicaid and CHIP through the implementation of CHIPRA Quality Initiatives". 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 in February 2011. While the use of the core set is voluntary for States, CMS is encouraging 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. The FY 2013 target is to work with States to ensure that 90 percent of States report on at least seven measures in the CHIPRA core set of quality measures. CMS will continually assess options for revising and improving targets so that information collected from States can be used in the most efficient and effective manner to improve health outcomes.

CMS has also developed a measure to improve access to and utilization of oral health care services for children enrolled in Medicaid or 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; increased reimbursement and simplified administrative processes. CMS is committed to providing technical assistance to States as they work to reach this goal. The FY 2013 target is to increase the national rates of preventive dental service by 4 percentage points over the FY 2011 baseline.

To track children's enrollment in Medicaid, CMS has a measure to "Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid". The Affordable Care Act will make significant changes to enrollment as States expand their Medicaid programs and will require the maintenance of eligibility standards for children in Medicaid through 2019. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with our State and Federal partners, continuing to implement legislative provisions that encourage program simplification, supporting outreach grantees, and bolstering data collection

activities. The FY 2013 target is to increase enrollment of children in Medicaid by 18 percent over the FY 2008 baseline (from 29,943,162 children to 35,332,931 children).

The Affordable Care Act called for the establishment of an adult quality measures program in Medicaid. 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 measure. Our FY 2013 target is to work with States to ensure that 60 percent of States report on at least three quality measures in the core set of quality measures for adults in Medicaid.

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 supports 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. Although enrollment increased by 19 percent between FY 2008 and FY 2009, we expect little growth in the next few years. Our FY 2013 target is to maintain enrollment between FY 2012 and FY 2013.

Finally, 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. Any State demonstration should be budget neutral, 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 2010, CMS completed 100 percent of the sixteen scheduled allotment and budget neutrality reviews and all were found to be budget/allotment neutral. The FY 2013 target is to complete 98 percent of the targeted budget neutrality reviews to help ensure the demonstrations are operating within the agreed upon budget neutrality limits. The target is lower than previous years' results due to the large number of scheduled reviews.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCD4 Percentage of Beneficiaries who Receive Home and Community-Based Services (Outcome)	FY 2009: 19% over prior FY (1.3 million beneficiaries) Target: 3% over prior FY (Target Exceeded)	1% over prior FY	Maintain over prior FY	Maintain
MCD5 Percentage of Section 1115 demonstration budget neutrality reviews completed (Outcome)	FY 2010: 100% Target: 96% (Target Exceeded)	98%	98%	Maintain
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (Outcome)	FY 2011: Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures (Available March 2012)	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.	N/A
MCD 7 Increase the national rate of low income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), who receive any preventive dental service. (Outcome)	FY 2011: Set baseline (Available October 2012)	Prior Result +2 percentage points	Prior Result +4 percentage points	N/A
MCD8 Improve Adult Health Care Quality Across Medicaid	FY 2011: Publish recommended core set of adult	Publish initial core set of adult quality	Work with States to ensure that 60 percent of States	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
(Outcome)	quality measures in the Federal Register. (Target Met)	measures in the Federal Register. (Target Met)	report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	
CHIP 3.2 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid (Outcome)	FY 2010: +15% over FY 2008 34,441,217 children (Historical Actual)	+17% over FY 2008 35,033,500 children	+18% over FY 2008 35,332,931 children	+299,431

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, ***[****$230,741,378,000****]*** *$251,359,000,000.*

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.

(Department of Health and Human Services Appropriations Act, 2012.)

Payments to the Health Care Trust Funds

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, 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.	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

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
Appropriation: Annual	$229,464,000	$230,741,378	$251,359,000
Lapse in Supplemental Medical Insurance	-488,844	-10,857,000	--
Lapse in General Revenue Part D: Benefits	-1,818,767	-4,149,000	--
Lapse in General Revenue Part D: Federal Administration	-73,723	-70,000	--
Lapse in Program Management	-15,468	-7,000	---
Lapse in Transfer for HCFAC Reimbursement	-310,378	-184,378	---
Lapse in Quinquennial Adjustment	---	---	---
Additional Appropriation Remaining to Cover Potential PTF Shortfalls	-1,089,622	---	---
Adjustment From Expired Accounts	18,531		
Outlays From Prior Year Mandatory Balances	-46,099		
Total Obligations	**$225,639,630**	**$215,474,000**	**$251,359,000**

Payments to the Health Care Trust Funds

Summary of Changes

2012 Appropriation

Total Budget Authority (Appropriated) - $230,741,378,000

2013 Estimate

Total Budget Authority - $251,359,000,000

Net Change, Total Appropriation - + $20,617,622,000

(Dollars in Thousands)

Changes	FY 2012 Current Law	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance (SMI)	$178,041,000	+$11,479,000
Indefinite Annual Appropriation, SMI	---	---
Hospital Insurance for the Uninsured	---	---
Hospital Insurance for Uninsured Federal Annuitants	262,000	(34,000)
Program Management Administrative Expenses	222,000	(30,000)
General Revenue for Part D (Drug) Benefit	51,431,000	+9,313,000
Indefinite Annual Appropriation, Part D Benefits	---	---
General Revenue for Part D Federal Administration	475,000	(51,000)
Part D: State Low-Income Determination	---	---
Reimbursement for HCFAC	310,378	(59,378)
Net Change	**$230,741,378**	**+ $20,617,622**

Payments to the Health Care Trust Funds
Budget Authority by Activity

(Dollars in Thousands)

	FY 2011	FY 2012	FY 2013
Supplementary Medical Insurance (SMI)	$165,338,000	$178,041,000	$189,520,000
Indefinite Annual Appropriation, SMI	---	---	---
Hospital Insurance for Uninsured	---	---	---
Hospital Insurance for Uninsured Federal Annuitants	275,000	262,000	228,000
Program Management Administrative Expenses	229,000	222,000	192,000
General Revenue for Part D Benefit	55,548,000	51,431,000	60,744,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
General Revenue for Part D Federal Administration	404,000	475,000	424,000
Part D: State Low-Income Determination	---	---	---
Reimbursement for HCFAC*	310,378	310,378	251,000
Budgetary Resources To Cover Shortfalls	7,359,622	---	---
Total Budget Authority	**$229,464,000**	**$230,741,378**	**$251,359,000**

* The amount requested in FY 2013 for Reimbursement for HCFAC is an estimate of the portion of the FY 2013 HCFAC discretionary allocation adjustment that is properly chargeable to the general funds. This reflects a change from previous years, when the full amount of the HCFAC discretionary allocation adjustment was included in the Payments to Health Care Trust Funds appropriation request.

Payments to the Health Care Trust Funds

Authorizing Legislation

(Dollars in Thousands)

	2012 Amount Authorized	2012 Budget Estimate	2013 Amount Authorized	2013 Budget Estimate
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d)(3) of Public Law 97-248)	$230,741,378	$230,741,378	N/A	$251,359,000
Total Budget Authority	**$230,741,378**	**$230,741,378**	**N/A**	**$251,359,000**

Annual Budget Authority by Activity

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
BA	$229,464,000	$230,741,378	$251,359,000	+$20,617,622

Authorizing Legislation - Sections 217(g), 201(g), 1841, 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 Public Law 108-173.

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. 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, and also provide 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 the Uninsured: This included Medicare benefits, administrative costs, and related interest for payments made on behalf of beneficiaries who were not insured for Medicare at the beginning of the program, but were deemed to be so under transitional provisions of the law (this activity received its final funding adjustment in FY 2010); and

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

Health Care Fraud and Abuse Control (HCFAC) account: The HCFAC program pays for program integrity activities in Medicare Fee-For-Service, Medicare Advantage, Medicare Part D, and Medicaid. 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 now includes two new activities: General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. They are funded by payments from the general fund to the new Medicare Prescription Drug Account. 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 2008	$188,445,000,000
FY 2009	$195,383,000,000
FY 2010	$207,286,070,000
FY 2011	$229,464,000,000
FY 2012	$230,741,378,000

Budget Request

Hospital Insurance for the Uninsured

The FY 2013 estimate is $0 for Hospital for the Uninsured. The FY 2010 appropriated request of -$414 million was the final funding activity for this group. No further adjustments in funding for this group of beneficiaries is needed.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2013 estimate of $228 million for Hospital Insurance for Uninsured Federal Annuitants is $34 million less than the FY 2012 estimate of $262 million.

Program Management Administrative Expenses

The FY 2013 estimate of $192 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to the Medicare Trust Funds is $30 million less than the FY 2012 estimate of $222 million.

Federal Contribution for SMI

The estimate of $189.5 billion for the FY 2013 Federal Contribution for SMI is a net increase of $11.5 billion over the FY 2012 estimate of $178.0 billion. The cost of the Federal match continues to rise from year to year because of beneficiary and program cost growth.

General Revenue for Part D (Benefits)

The FY 2013 estimate of $60.7 billion for General Revenue for Part D (Benefits) is $9.3 billion more than the FY 2012 estimate of $51.4 billion.

General Revenue for Part D Federal Administration

The FY 2013 estimate of $424 million for General Revenue for Part D Federal Administration is $51 million less than the FY 2012 estimate of $475 million.

General Revenue for Part D State Eligibility Determinations

The FY 2013 estimate for General Revenue Part D State Eligibility Determinations is $0.

Reimbursement for HCFAC

The FY 2013 estimate of $251.0 million for Reimbursement for HCFAC is $59.4 million less than the FY 2012 estimate of $310.4 million. This amount reflects an estimate of 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.

Permanent Budget Authority

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Tax on OASDI Benefits	$15,143,000	$18,443,000	$20,811,000	+ $2,368,000
SECA Tax Credits	25	---	---	---
HCFAC, FBI	128,405	131,872	135,300	3,428
HCFAC, Asset Forfeitures	22,402	---	---	---
HCFAC, Criminal Fines	1,195,736	1,045,000	1,126,215	81,215
HCFAC, Civil Penalties and Damages: Administration	17,514	19,500	20,200	700
Total BA	**$16,507,082**	**$19,639,372**	**$22,092,715**	**+ $2,453,343**

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 appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account will pass through the Payments to the Health Care Trust Funds account: FBI, criminal fines, and civil monetary penalties. FBI activities include prosecuting health care matters, investigations, financial and performance audits, inspections, and other evaluations. Criminal fines and civil monetary penalties are fines collected from health care fraud cases and reported as appropriations from the trust fund for HCFAC activities.

Payments to the Health Care Trust Funds
Budget Authority by Object

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
Grants, subsidies and contributions: Non-Drug	$165,338,000	$178,041,000	$189,520,000
Indefinite Annual Appropriation	---	---	---
Grants, subsidies and contributions: Drug	55,548,000	51,431,000	60,744,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
Insurance claims and indemnities	275,000	262,000	228,000
Administrative costs-General Fund Share	943,378	1,007,378	867,000
General Revenue Part D: State Eligibility Determinations	---	---	---
Budgetary Resources To Cover Shortfalls	7,359,622	---	---
Total Budget Authority	**$229,464,000**	**$230,741,378**	**$251,359,000**

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

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Medicare Benefits
(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Outlays	$557,732,000	$548,328,000	$589,564,000	+$41,236,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process. Estimates are based on PB 2013.

Authorizing Legislation - Title XVIII of the Social Security Act

FY 2013 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 51.9 million beneficiaries in FY 2013.

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 such as vision, and dental benefits to beneficiaries, 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 13 million enrollees in FY 2013.

The Prescription Drug Benefit Program, also created by the MMA, constitutes the most significant change to the Medicare program since its inception in 1965. The prescription drug benefit is funded through the SMI account 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 38 million in FY 2013 including 35 million enrolled in Part D plans and 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 2008	$454,300,596,000
FY 2009	$497,635,667,000
FY 2010	$518,948,805,000
FY 2011	$557,732,000,000
*FY 2012	$548,328,000,000
*Estimate Under Current law	

Budget Estimates

The budget estimates for Medicare benefits for FY 2013, by trust fund account, are shown in the following table.

	FY 2013	+/- from FY 2012
HI	$279,982,000,000	+$17,648,000,000
SMI – Part B	$236,075,000,000	+$7,875,000,000
SMI – Part D	$73,507,000,000	+$15,713,000,000
Total	$589,564,000,000	+$41,236,000,000

Note that Part C, Medicare Advantage, is funded by the HI and SMI trust funds.

The estimate for FY 2013 is an increase of $41,236,000,000 from FY 2012. This increase is due to higher enrollment, and increasing medical service and utilization costs.

Performance Measurement

CMS has monitored Medicare Fee-for-Service (MFFS) and Medicare Advantage (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, we are retiring our prescription drug access measures. As the Affordable Care Act is implemented, we will continue to include measures to monitor MFFS and MA access to care in order to maintain the same high rates for our beneficiaries. We exceeded our FY 2011 targets reflecting beneficiary experience in 2010.

CMS has a performance measure to reduce the out-of-pocket share of prescription drug costs for non-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap. We will measure the success of the new Affordable Care Act Coverage Gap Discount Program, which will reduce the cost Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap. This will be accomplished 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, we adjusted our FY 2012 target from 55 percent to 58 percent, and set our FY 2013 target at 55 percent.

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 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.
3) Creating a screening schedule for the next 5 to 10 years, developing a list of risk factors and conditions, and providing ongoing and/or recommended interventions.

Beneficiaries will pay nothing for the yearly AWV if the doctor or other health care provider accepts assignment. The Affordable Care Act added this benefit with no copayments or other cost-sharing on the part of the beneficiary. CMS will set targets for this measure once the 2011 rate has been calculated in June of 2012.

Outcomes and Outputs

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	***FY 2012 Target***	***FY 2013 Target***	***FY 2013 +/- FY 2012***
MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care	FY 2011: 92% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care	FY 2011: 92% 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-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap.	New in FY 2012 FY 2010: 100.0% (Historical Actual)	58.0%	55.0%	-3
MCR25: Increase the number of Medicare beneficiaries who receive an annual wellness visit	New in FY 2012	Set baseline and future target	TBD	N/A

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Children's Health Insurance Program

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
State allotments (CHIPRA of 2009, P.L. 111-3)	$13,459,000,000	$14,982,000,000	$17,406,000,000
Total Budget Authority for State Allotments	**$13,459,000,000**	**$14,982,000,000**	**$17,406,000,000**
CHIP Performance Bonus Payments [1] (P.L. 111-3)	$4,249,054,000	$7,428,706,000	$6,832,181,000
Child Health Quality Improvement (P.L. 111-3)	$45,000,000	$45,000,000	$45,000,000
Total Budgetary Resources	**$17,753,054,000**	**$22,455,706,000**	**$24,283,181,000**
Total Outlays	**$8,629,472,000**	**$9,778,928,000**	**$10,026,750,000**

[1] Funding levels reflect carry-forward balances from previous year and do not represent new appropriations.

FY 2013 Authorization – Public Law 111-3
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 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
Child Enrollment Contingency Fund	$2,114,767,000	$2,093,546,728	$2,000,085,728
Interest Estimate	$7,667,515	$6,539,000	$13,111,000
Total Budgetary Resources	**$2,122,434,515**	**$2,100,085,728**	**$2,013,196,728**
Total Outlays[1]	**$4,205,555**	**$124,682,232**	**$200,000,000**

FY 2011 - FY 2013 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).

[1] Iowa received the first contingency fund payment in FY 2011 in the amount of $28,887,787. A total of $4,205,555 has been outlaid to date.

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 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, 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 of CHIP to make innovative changes. As of September 2011, CMS has approved a total of 425 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 provision 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:

- CMS published an initial core set of quality measures for children in the Federal Register on December 29, 2009.
- CMS disseminated voluntary reporting guidance and procedures to States via a State Health Official Letter and follow-up Informational Bulletin in February 2011. CMS also held an All-State Technical Assistance Call for Medicaid and CHIP programs in March 2011.
- On March 1, 2011, CMS in collaboration with the Agency for Healthcare Research and Quality awarded $55 million dollars in cooperative agreement grants to seven Centers of Excellence with diverse talents and expertise that will advance and improve measures of healthcare quality for children. Additionally, a contract was awarded April 15, 2011 to establish a National Coordinating and Technical Assistance Center that will coordinate and disseminate information on the work of the National Centers of Excellence to support State Medicaid and CHIP quality measurement initiatives. The first national planning meeting for the Centers of Excellence, the National Coordinating and Technical Assistance Center, and several State Medicaid programs was held April 25th and 26th, 2011.

CHIPRA Electronic Health Records Program:

- A $5 million contract was awarded (in collaboration with AHRQ) to develop a pediatric electronic health record format.
- Two States awarded a CHIPRA Quality Demonstration Grant will test the pediatric electronic health record format upon completed testing of the format.
- Additional electronic health record program components are currently under development.

CHIPRA Quality Demonstration Grants:

- CMS awarded the first $20,000,000 in demonstration grants to ten States on February 22, 2010. Second Year demonstration awards were awarded in February 2011.
- All State grantees successfully submitted a final operational plan and first progress report to CMS by November 22, 2010.
- All grantees submitted their first web-based semi-annual progress reports by the August 1, 2011 deadline.

- 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 $7,667,515 in interest in FY 2011 and is estimated to accrue $6,539,000 in FY 2012.

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. CMS has a performance measure to, "Improve Children's Health Care Quality across Medicaid and CHIP through Implementation of 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' FY 2013 target is to work with States to ensure that 90 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.

CMS has also developed a measure to improve access to and utilization of oral health care services for children enrolled in Medicaid or 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 as they work to reach this goal. CMS has established an FY 2013 target to increase the national rates of preventive dental service by 4 percentage points over the FY 2011 baseline.

To track children's enrollment in CHIP, CMS has a measure to "Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP". The additional resources provided through CHIPRA and the Affordable Care Act are vital to the Administration's strategy to achieve this goal. CHIPRA provides funding for CHIP through FY 2013 and provides options for States to expand their title XXI program. The Affordable Care Act extends Federal CHIP funding through September 30, 2015 and requires the maintenance of eligibility standards for children in CHIP through FY 2019. To meet our enrollment targets, CMS will collaborate with our State and Federal partners, continue to implement CHIPRA provisions that encourage program simplifications, support CHIP outreach grantees and bolster our data collection activities. In FY 2010, CHIP enrollment increased over the 2008 baseline by 4.6 percent. CMS fell short of the FY 2010 target to increase enrollment by 5 percent, likely influenced by the economic downturn, which made more children eligible for Medicaid. This long-term measure proposes to steadily increase enrollment, although enrollment figures can be affected by States' economic situations, programmatic changes, and the reporting accuracy and timeliness of States' reporting. The FY 2013 target is to increase CHIP enrollment by 13 percent over the FY 2008 baseline.

State Allotment Funding History

FY 2004	$3,175,200,000
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 $14,982,000,000 in FY 2012 and $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 $19.1 billion in FY 2014 and $21.1 billion in FY 2015.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
CHIP 3.1 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP (Outcome)	FY 2010: +4.6% 7,705,723 children Target:+5% 7,736,903 children (Target Not Met)	+11% over FY 2008 8,179,012 children	+13% over FY 2008 8,333,750 children	+154,738
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (Outcome)	FY 2011: Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures Results available March 2012	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.	N/A
MCD 7 Increase the national rate of low income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), who receive any preventive dental service (Outcome)	FY 2011: Set Baseline Results available October 2012	+2 percentage points above baseline	+4 percentage points above baseline	N/A

FY 2012 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2012
Alabama	135,448	141,358	179,349	37,991
Alaska	19,830	21,005	23,415	2,410
Arizona	61,462	64,635	27,544	-37,091
Arkansas	90,853	95,364	105,785	10,421
California	1,254,895	1,314,260	1,564,899	250,639
Colorado	123,499	130,420	136,071	5,651
Connecticut	31,320	32,686	46,374	13,687
Delaware	13,570	14,162	15,457	1,295
District of Columbia	11,989	12,611	11,679	-932
Florida	324,871	339,812	368,755	28,942
Georgia	239,369	250,874	368,964	118,090
Hawaii	33,257	34,803	31,073	-3,730
Idaho	36,206	37,945	43,198	5,253
Illinois	273,211	285,132	295,219	10,087
Indiana	94,539	98,664	132,501	33,836
Iowa	75,497	108,994	99,900	-9,094
Kansas	55,864	58,771	59,230	458
Kentucky	129,601	135,474	153,662	18,188
Louisiana	186,019	195,190	154,928	-40,262
Maine	35,490	37,038	31,984	-5,054
Maryland	168,778	176,289	179,639	3,350
Massachusetts	316,955	330,784	340,147	9,363
Michigan	120,970	126,248	83,245	-43,003
Minnesota	20,498	21,392	32,308	10,915
Mississippi	160,649	167,658	182,126	14,468
Missouri	112,711	117,629	124,000	6,371
Montana	38,466	40,144	60,762	20,618
Nebraska	38,943	40,961	43,392	2,431
Nevada	24,078	25,129	30,487	5,358
New Hampshire	12,821	13,380	20,379	6,999
New Jersey	592,188	618,026	684,928	66,902
New Mexico	245,492	258,655	160,931	-97,724
New York	525,836	548,779	555,731	6,952
North Carolina	382,336	401,229	390,609	-10,620
North Dakota	15,258	16,064	18,316	2,252

FY 2012 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	**FY 2011 Actual**	**FY 2012 Estimate**	**FY 2013 Estimate**	**Difference +/- 2012**
Ohio	277,965	290,093	314,480	24,387
Oklahoma	120,389	126,870	196,493	69,623
Oregon	91,102	95,355	153,783	58,428
Pennsylvania	321,847	335,890	318,371	-17,518
Rhode Island	30,345	31,669	29,929	-1,739
South Carolina	98,027	102,467	101,820	-647
South Dakota	20,067	21,119	22,099	979
Tennessee	134,225	140,134	217,430	77,296
Texas	832,714	882,578	967,796	85,218
Utah	63,916	67,820	66,846	-974
Vermont	5,794	6,047	19,215	13,169
Virginia	175,234	184,004	185,589	1,585
Washington	45,366	47,620	80,704	33,085
West Virginia	41,268	43,069	48,630	5,561
Wisconsin	102,733	107,215	93,949	-13,267
Wyoming	9,989	10,443	10,880	438
Subtotal	**8,373,749**	**8,803,961**	**9,585,002**	**781,042**
American Samoa	939	980	1,023	42
Guam	4,178	4,360	4,550	190
Northern Mariana Islands	861	899	938	40
Puerto Rico	99,567	103,911	108,445	4,534
Virgin Islands	0	0	0	0
Subtotal	**105,545**	**110,150**	**114,956**	**4,806**
Total States/Territories	**8,479,294**	**8,914,110**	**9,699,958**	**785,848**
Technical Assistance	0	0	0	0
State Penalties	0	0	0	0
Other Adjustments	0	0	0	0
Subtotal Adjustments	**0**	**0**	**0**	**0**
TOTAL RESOURCES	**$8,479,294**	**$8,914,110**	**$9,699,958**	**$785,848**

Note: Obligations remain available for Federal payments for two years.

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, [$310,377,000] $610,000,000, to remain available through September 30, [2013] 2014, 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 [$219,879,000] $409,697,693 shall be for [the Medicare Integrity Program at] 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 [under Part C] and the Medicare Prescription Drug Program [under Part D of the] authorized in title XVIII of the Social Security Act and for activities described in section 1893[(b)] of such Act and for Medicaid and Children's Health Insurance Program (''CHIP'') program integrity activities, of which [$29,730,000] $102,499,971 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, [of which $31,038,000 shall be for the Medicaid and Children's Health Insurance Program (``CHIP'') program integrity activities,] and of which [$29,730,000] $97,802,336 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 of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and $299,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act: Provided further, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year [2012] 2013 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. (Department of Health and Human Services Appropriations Act, 2012.)

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$310,377,000] $610,000,000, to remain available through September 30, [2013] 2014, 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 [$219,879,000] $409,697,693 shall be for [the Medicare Integrity Program at] 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 [under Part C] and the Medicare Prescription Drug Program [under Part D of the] authorized in title XVIII of the Social Security Act and for activities described in section 1893[(b)] 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 [$29,730,000] $102,499,971 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.
[of which $31,038,000 shall be for the Medicaid and Children's Health Insurance Program (“CHIP") program integrity activities,] and	Provides a specific funding amount for the Medicaid and “CHIP” program integrity activities.
and of which [$29,730,000] $97,802,336 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.
Provided, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and $299,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act:	Provides an additional $299 million in funding allowed by the cap adjustment, provided that the $311 million in base funding is met.

Increased Funding for BBEDCA Program Integrity Adjustments

For an additional amount for "Health Care Fraud and Abuse Control Account" and in addition to amounts otherwise available for program integrity and program management, $271,722,199, to remain available through September 30, 2013, 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 $140,041,412 shall be for 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 $68,081,621 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 $63,599,166 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, of the amount provided under this heading, $1,211,899 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985: Provided further, That, of the amount provided under this heading, $270,510,300 is additional new budget authority specified for purposes of subsection 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended: Provided further, That the amount provided under this heading shall be treated for purposes of section 251(b)(2)(C) as being included under this heading in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2012.

Language Analysis

Since the Consolidated Appropriations Act of 2012 (P.L. 112-74) did not fully fund the base or the cap adjustment for 2012, the President's Budget proposes to increase the 2012 HCFAC discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

Health Care Fraud and Abuse Control
(dollars in thousands)

	FY 2011 Enacted	FY 2012 /1	FY 2013 Request	FY 2013 +/- FY2012
Discretionary				
CMS Program Integrity	$250,917	$390,220	$409,698	$19,478
Medicare Integrity(non-add)	*$219,879*	*$345,544*	*$362,792*	$17,248
Medicaid Integrity(non-add)	*$31,038*	*$44,676*	*$46,906*	$2,230
OIG	$29,730	$97,627	$102,500	$4,873
DOJ	$29,730	$93,153	$97,802	$4,649
Subtotal, Discretionary	$310,377	$581,000	$610,000	$29,000
Mandatory				
Medicare Integrity Program (MIP) **/2**	$871,526	$863,129	$865,676	$2,547
Predictive Modeling **/3**	$100,000	$0	$0	$0
FBI **/2**	$128,405	$131,872	$135,300	$3,428
OIG **/2**	$197,998	$196,090	$196,669	$579
DOJ Wedge **/2**	$61,820	$61,225	$61,405	$180
HHS Wedge **/2**	$37,869	$37,505	$37,615	$110
Subtotal, Mandatory	$1,397,618	$1,289,821	$1,296,665	$6,844
Total Funding	**$1,707,995**	**$1,870,821**	**$1,906,665**	**$35,844**

This table reflects all funding provided from The Affordable Care Act (P.L. 111-148 & P.L. 111-152) and The Small Business Jobs Act of 2010 (P.L. 111-240), as well as OMB's Fiscal year CPI-U Annual Averages and Percent Change inflationary adjustment.

/1 The President's Budget proposes to increase the 2012 discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.
/2 Inflationary adjustment is included based on OMB Economic Assumptions.
/3 Funding provided in Small Business Jobs Act of 2010 (P.L. 111-240)

Authorizing Legislation - Social Security Act, Title XVIII, Section 1817K
FY 2013 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.

HCFAC has traditionally focused on Medicare fraud, waste and abuse through activities such as Medical Review, Benefit Integrity and Provider Audits. Mandatory spending provided for in the HCFAC account has traditionally supported many high return-on-investment (ROI) activities that help to protect the Trust Fund, such as medically reviewing claims to assure correct payment.

With the receipt of discretionary funds, HCFAC has been able to expand its activities to include strengthening program integrity activities in Medicare Advantage and Medicare Part D; program integrity staffing and support; increasing funding for program integrity demonstrations/special initiatives; preventing excessive payments; program integrity oversight efforts; and error rate measurement.

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 while enhancing Federal oversight of and support and assistance to state Medicaid programs. The Medicaid Integrity Program provides States with technical assistance and support that enhances the Federal-State partnership.

HCFAC has been steadily growing since it began in 1997 and this investment in fraud fighting resources is paying dividends. From the inception of the HCFAC program through FY 2011, HCFAC has resulted in the return of $20.6 billion to Treasury and the Medicare trust funds. The ROI from various HCFAC activities ranges from 5 to 1 expended for audit, investigative, and prosecutorial work performed by OIG and DOJ to 14 to 1 for the Medicare Integrity Program's activities. The ROI for the HCFAC account from 1997 to 2011 is $5.1 returned for every $1.0 expended. The 3-year average (2009-2011) ROI is $7.2 to $1.0, which is $2.1 higher than the historical 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 Department of Justice's (DOJ's) Civil Division and U.S. Attorneys' Offices, the HHS/ Office of Inspector General (OIG), the Food and Drug Administration, and CMS.

In April, 2010, CMS consolidated and integrated the Medicare and Medicaid program integrity (PI) functions into the Center for Program Integrity (CPI). This organization was designed to consolidate, coordinate and strengthen existing PI activities, carry out the new responsibilities under new legislative authorities, and position the agency strategically to address future PI issues. In addition, CPI was charged with oversight of program administration to ensure that HCFAC dollars are spent appropriately, directed towards emerging needs, and focused on activities that create the greatest returns.

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, it 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/or find fraud such as the following:

- Provider Enrollment Screening – New screening of high-risk providers for Parts A and B before enrolling in Medicare.

- Law Enforcement Access to Data – Expands access to various databases.

- Home Health "Feet on the Street" Expansion – Expanding Home Health on-site visits.

- Enhanced Screening of Providers/Suppliers – Established enhanced screening of providers/suppliers based upon enrollment risk levels.

- National Site Visit Contractor Procurement – Published RFI for contract procurement of contractor to conduct all site visits required by Section 6028.

CMS has been actively implementing the antifraud provisions of ACA since its enactment. Four major final rules have been published dealing with provider screenings, National Provider Identifier (NPI) requirements on enrollment applications, payment suspensions, and recovery audit contractor programs for Medicaid and face-to-face encounters:

- November 17, 2010: Final rule to implement section 6407(a), requiring face-to-face encounters for Medicare beneficiaries receiving home health and hospice services.
- November 1, 2011: Final rule to implement section 6001, which imposes limitations on hospital referral safe harbors.
- February 2, 2011: Final rule, effective March 25, 2011, to enhance provider and supplier screening and payment suspensions and provide for enrollment moratoria under sections 6401, 6402, 6501,10603, and 1304:

    - Establishes requirements to suspend payments to providers and suppliers based on credible allegations of fraud in Medicare and Medicaid;
    - Implements the authority for imposing a temporary moratorium on Medicare, Medicaid, and CHIP enrollment by providers and suppliers when necessary to help prevent or fight fraud, waste, and abuse;
    - Strengthens and builds on current provider and supplier enrollment and screening procedures to establish rigorous pre-enrollment screening based on their level of risk of fraud;

- Outlines requirements for States to terminate providers from Medicaid and CHIP when terminated by Medicare or another State Medicaid program or CHIP; and,
- Authorizes CMS to terminate providers from Medicare when terminated by a state Medicaid program.

- September 16, 2011: CMS finalized new rules to help States reduce improper payments under section 6411. Medicaid health care claims will be audited through the use of Medicaid Recovery Audit Contractors (RACs) that will be working for States to identify Medicaid payments that may have been underpaid or overpaid, and recover overpayments or correct underpayments, similar to the RAC program in Medicare.

  CMS has published two proposed rules implementing additional face-to-face requirements and transparency provisions:

- July 12, 2011: CMS proposed rules to implement section 6407(d), requiring face-to-face encounters by physicians with patients for whom they order DME or home health services for Medicaid.

- December 19, 2011: CMS issued proposed rules to implement section 6002, requirements for drug and device makers to report payments to physicians.

In addition, CMS has been reaching out to 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. These summits are part of the multi-faceted HEAT effort to crack down on health care fraud and abuse and are comprehensive meetings to discuss and identify the scope of fraud, including weaknesses in the current health care systems and opportunities to move towards new collaborative solutions.

In FY 2013, CMS will continue to implement successful pilots and projects on a larger scale. One such project is the development of a compromised Medicare numbers database. This was implemented on a small scale in FY 2011, identifying 326 false front providers and realizing Part B savings of $133 million. As a result, CMS has launched plans to build a National Compromised Numbers Checklist. CMS continues to focus efforts on testing and developing more innovative approaches and technologies to attain the overarching mission of protecting the Trust Funds and other public resources against losses from fraud and other improper payments and to improve the integrity of the health care system.

CPI 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 -- To increase CMS' capability to identify and stop fraudulent claims before they are paid by enhancing existing processes and increasing predictive analytical capabilities. CMS identifies problems before a claim is paid, through our payment systems, prepayment medical review activities, and education of providers and beneficiaries. CMS is expanding its prevention efforts through the following areas:

- *Engaging Medicare Beneficiaries and Other Stakeholders in Combating Fraud*
- *Strengthening Provider and Supplier Safeguards*

- *Improving Payment Accuracy*
- *Coordinating with Law Enforcement*

Detection -- To foster collaboration with HEAT, components of HHS, DOJ, States and other stakeholders with a shared interest in protecting health insurance program integrity. CPI will promote the best use of tools, techniques and technology to detect improper payments. CMS is implementing several analytics pilots designed to identify and detect trends of improper payment activity, such as: predictive modeling for risk-based provider and supplier enrollment, geographic heat mapping based on fraud reported to 1-800-MEDICARE, and fraud detection techniques used as part of Recovery Act monitoring but applied to Medicare. In FY 2011, Congress provided an additional $100 million through the Small Business Jobs Act of 2010 to advance CMS' work in the area of predictive modeling. This funding has allowed CMS to expand models used in predictive modeling to help identify fraud.

Recovery -- Identify and recover overpayments with a strong emphasis towards projects that support the President's goal to reduce improper payments. CMS ensures that action is taken when fraud and abuse is found. 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. CMS is working to increase its recovery of overpayments to providers through expansion of the Recovery Audit Program, additional field investigations, implementation of mandatory Medicare Secondary Payment information, and better coordination with the Office of Medicare Hearings and Appeals (OMHA).

Transparency & Accountability -- Develop and deploy a comprehensive program integrity communication plan to share key messages and information with internal and external stakeholders. To ensure program integrity efforts are transparent, CPI and other CMS components track and report improper payments, taking measures to reduce the improper payment rate, such as: increasing pre-payment review, implementing competitive bidding, and implementing face-to-face requirements for high-risk areas. Performance measures are also being developed to evaluate operations and outcomes against other CMS reporting activities.

Funding History

FY 2008	$	1,132,134,000
FY 2009	$	1,358,683,000
FY 2010	$	1,483,683,000
FY 2011	$	1,707,995,000
FY 2012	$	1,870,821,000

Budget Request

The FY 2013 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2013 budget request is $1.9 billion, $35.8 million more than the full amount allowed for FY 2012 under section 1817K of Title VXIII of the Social Security Act and section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act (BBEDCA) of 1985, as amended. To fully fund the FY 2012 discretionary base and provide the cap adjustment authorized in BBEDCA, this budget includes a request of $1.2 million for FY 2012, fully offset from FY 2011 unobligated balances from the Program Management account.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include both traditional methods such as Medical Review, Benefit Integrity, Medicare Secondary Payer, Audits, and Provider Education, as well as some newer innovative approaches to fighting fraud, such as HEAT. Past experience has proven that better results are gained when a hybrid approach to combating fraud is adopted, with some limited level of redundancy. This includes using a variety of in-house, 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 and Part D Prescription Drug Plans, and using existing demonstration authority to test new methods to detect and deter potential fraudulent behavior at both the pre-enrollment stage as well as after suppliers are enrolled in the Medicare program. Some activities CMS has conducted to prevent fraud and abuse in the Medicare program include:

- Increased random site visits to providers, particularly for high-risk areas like durable medical equipment suppliers and home health agencies;
- Deactivated inactive provider identification numbers aggressively and successfully;
- Implemented a reform to the home health outlier payment policy to address concerns with disproportionate outlier payments in certain high-fraud areas;
- Developed a more robust system to conduct data analysis for more proactive fraud and abuse identification and program oversight;
- Initiated several geographic and service specific projects to target program vulnerabilities in South Florida, Texas and California;
- Set up a beneficiary hotline for reporting suspected fraud in high-risk areas and services; and,
- Issued guidance to help beneficiaries guard against identity theft.

In FY 2013, the major initiatives CMS will be funding under the MIP account include, but are not limited to, Provider Audit, Medicare Secondary Payer (MSP), Medical Review (MR), Medicare/Medicaid Data Match (Medi-Medi), Provider Education & Outreach, and Comprehensive Error Rate Testing (CERT). These activities will be discussed in more detail throughout this section.

CMS Program Integrity Budget Request

The FY 2013 CMS discretionary request level of $409.7 million will fund the expanded and new 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. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D:

Discretionary Request ($178.4 million)

Medicare Drug Integrity Contractors (MEDICs): CMS has a fiduciary responsibility to safeguard the Medicare trust funds from fraud, waste and abuse in the Part C and Part D programs. The MEDICs help accomplish these tasks by investigating complaints, referring cases to law enforcement, auditing sponsors for benefit integrity and compliance, conducting outreach to the various plans, law enforcement, and CMS partners, and issuing fraud alerts. Approximately 13 million beneficiaries are enrolled in the Medicare Advantage program and over 30 million beneficiaries are covered by a Part D drug plan. Currently, there are approximately 750 contracts that deliver Medicare benefits through the Medicare Advantage and Part D programs.

In FY 2013, additional funding for the MEDIC program will be used to support a projected increase in oversight and program integrity workload associated with anticipated Part C and Part D enrollment increases.

Part C and D Contract/Plan Oversight: This category emphasizes the assessment of whether an entity is qualified, initially and on an ongoing basis, to contract with Medicare and includes funding for Health Plan Management System (HPMS) Audit Support, Part C and D Performance Report Cards, Private Fee-For-Service (PFFS) Payment Adjudication, Actuarial Reviews and Estimates for Prescription Drug and Medicare Advantage Plans, Cost Plan Audits, and Review of Part C MA Bids.

- *Health Plan Management System (HPMS) Audit Support* - 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, complaints tracking, 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 www.medicare.gov website. Although a substantial amount of effort in this project relates to the Part C and D Contract/Plan Oversight category, it also relates to the Monitoring, Performance Assessment, and Surveillance, Program Audit, and Compliance/Enforcement categories.

- *Part C and D Performance Reporting* - This project is data driven, proactive, and includes monitoring activities such as beneficiary de-enrollments, complaints resolution, website monitoring, and formulary and benefit assessments. The Disenrollment Survey activity is a direct beneficiary contact activity that determines the reason that a beneficiary changes plans and the Complaints Resolution activity is a direct beneficiary contact activity that verifies that a beneficiary's or other stakeholder's complaint is resolved by their plan. The Website Monitoring activity checks a plan's websites to verify that required formulary and benefit content is accurate and approved by CMS. The Formulary and Benefit Assessments activity reviews and compares a prior year's formulary and benefit offerings to determine value, efficiency, etc. These analyses will focus on changes in benefit/formulary offerings for plans between contract years and analyzing benefit/formulary offerings as they pertain to certain disease states or categories and/or classes of drugs.

- *Private Fee-For-Service (PFFS) Payment Adjudication* - PFFS plans are MA plans that were first authorized under the Balance Budget Act of 1997. PFFS plans are required to provide prompt payment or denials of claims to non-contracted providers within 60 calendar days from the date of the request. PFFS plans are further required to have accessible and understandable provider payment terms and conditions and a dispute resolution process. PFFS providers have the right to appeal organizational determinations where the MA organization refuses to pay for services "in whole or in part". This project enables CMS, through a contractor, to adjudicate PFFS Plan payment disputes and to test PFFS plan payment systems to assure that they are consistent with original Medicare reimbursement policies and practices.

- *Actuarial Review for Prescription Drug and Medicare Advantage Plans* - This project assists CMS in auditing prescription drug and MA bids submitted by plans. By law, a primary tenant of the Part C and D programs are the competitive bids to be submitted and approved by CMS. Per the statutory language, the competitive bids must reflect the plans "revenue requirements" and must include information used in preparing the bids. The audits will determine the reasonableness of the bids in consideration of CMS' bid submission instructions, bid audit procedures, and professional actuarial standards. These audits are expected to partly satisfy the statutorily mandated one-third periodic audit of financial records of private health plans.

- *Cost Plan Audit* - Each year CMS audits the cost report statements submitted by Health Care Prepayment Plans (HCPP), Health Maintenance Organizations (HMO), and Competitive Medical Plans (CMP) under the cost-based Medicare Managed Care reimbursement program. These plans estimate their yearly cost needs through a budget; however, the budget cost estimates are prospective and must be audited to ensure that the funds expended under the cost reports are allowable. This ensures that the funds were expended in accordance with the contract and CMS policies.

- *Review Part C MA Bids* - This funding will support core contracts to aid in MA oversight. Part of the funding will target the annual review of plan benefit packages submitted by MA organizations to ensure benefits are non-discriminatory with an emphasis on establishing stricter lines for discrimination. In addition, funding will target annual collection and analysis of information for the Marketplace Competition Provision.

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. This category includes funding for the Targeted Contractor for programmatic wide audits and compliance assessments, Encounter Data, Managed Care Payment Validation, Part D Reconciliation Support Contractor, Validation and Analysis of Part C and D Payments, Part C and D Error Rate, and Plan Finder Quality Assurance.

- *Targeted Contractor for programmatic wide audits and compliance assessments* – Provides technical, clinical, compliance and enforcement audit support to assist CMS in conducting Part C and Part D audits. More specifically, this project will fund clinical experts to 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.

- *Encounter Data* – This data collection effort will give CMS the capacity to measure and price utilization of all enrollees in Medicare Advantage to accurately pay MA plans through risk adjustment, evaluate coverage, and compare service utilization and quality across the original FFS and MA sectors. While establishing a risk adjustment model more appropriate for MA plans is the paramount reason for collecting MA encounter data, there are other important uses of the data that will improve other key functions undertaken by CMS, including:

    - Calculation of Medicare Disproportionate Share Hospital (DSH) payments
    - Quality review and improvement activities
    - Medicare coverage purposes

  Thus, there is a need to properly collect, edit, and store the MA health care encounter data necessary to describe and price a health care encounter; this is in addition to the currently collected, edited, and stored diagnosis data. This project will also develop the capability to price the MA health care encounter data to be able to estimate the cost of a Medicare beneficiary enrolled in an MA plan.

- *Managed Care Payment Validation* - This project focuses on processing retroactive requests for changes to enrollments, disenrollments, and data on beneficiary statuses, which may affect payments to plans. This project supports CMS' program integrity effort by processing all such retroactive adjustment requests submitted by MAOs and PDPs, receiving and processing monthly certification forms (Attestations) from MAOs and PDPs, and completing monthly analysis of plan discrepancies.

- *Part D Reconciliation Support Contractor* - This project consists of analyzing the results of the Part D reconciliation calculations to understand plan impacts and to support decision-making about potential major adjustments to Part D payments. In addition, this project involves receiving, tracking, and analyzing any issues raised by plans with respect to reconciliation after completion, including appeals. Analyzing the Prescription Drug Event (PDE) data and other relevant payment information to support correct Part D payments is also included.

- *Validation and Analysis of Part C and D Payments* - This project consists of validating and analyzing monthly Part C and D payments to ensure that the proposed payment amounts are accurate prior to authorization. This process involves in-depth analyses of payment data and the recalculation of payments for approximately 30 million beneficiaries outside of the MARx and APPS payment systems. The accuracy of beneficiary and plan-level data is also evaluated. This involves running complex mainframe programs to generate beneficiary level payment calculations in short timeframes and troubleshooting when potential discrepancies/errors are identified.

- *Part C and D Error Rate* – In response to the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), CMS has enhanced its efforts to address improper payments. This project estimates payment error for Part C and Part D at the national level. Payment error is first estimated for the component parts of each program. Then, the component error estimates are aggregated to create a composite payment error rate for each program.

- *Plan Finder Quality Assurance (QA)* - The Medicare Plan Finder (MPF) is a web tool that is available to the public, which allows beneficiaries to make informed choices about Part D plans by comparing the plans' benefit package (PBP), formulary, pharmacy, and pricing data. Part D sponsors submit these data to CMS and its contractors. In addition, the web tool also provides Plan Ratings which can be used by beneficiaries to evaluate operational and quality performance of available plans. The project assists CMS in analyzing and assessing PBP, formulary, pharmacy, and pricing data files as part of the overall monitoring strategy of Part D to ensure that accurate data are posted on to the MPF tool. In addition, this contract will be responsible for performing drug basket, negotiated retail price, and longitudinal analyses as well as the comparison of MPF pricing and any additional ad hoc request related to these data. All of these tasks are essential in the monitoring and oversight of these data that are displayed to the public.

Program Audit: This category's function is to review and assess previously supplied documentation to ensure compliance with program requirements. This category includes funding for Retiree Drug System (RDS) Compliance, Audit, and Payment Error Reduction Activities; Performance Measurement and Technical Assistance for MA and SNPs; Parts C & D Audits (one-third); and Risk Adjustment Data Validation.

- *Retiree Drug Subsidy (RDS) Compliance, Audit and Payment Error Reduction Activities* - The regulations require that RDS plans must maintain and furnish to CMS, upon request, all documentation of costs incurred and other relevant information used to calculate the amounts of subsidy payments CMS made. CMS will audit enrollment files, claims, and other payment-related data to ensure appropriate payment of RDS subsidy amounts.

- *Performance Measurement and Technical Assistance for MA and SNPs*- This project funds a variety of oversight/surveillance activities and analysis of MA contracting organizations. Activities include enhancing the review of MA plan benefit packages to ensure the offerings represent high-value health care and do not discriminate against sick or high-cost beneficiaries, validating accrediting organization oversight of MA plan performance, developing a quality improvement strategy that focuses on clinical as well as operational outcomes, and developing prescriptive policies that assist the industry with implementing internal quality controls. In addition, quality of care and process improvement deficiencies has surfaced in PACE plans. PACE plans are required to be audited frequently, which is causing a significant expansion in regional office and central office resources to assure appropriate quality controls in PACE. Another activity is the analysis of Employer Group plan offerings to assure that beneficiaries are receiving benefits equal to or greater than individual market beneficiaries and to assure that beneficiary health care services are in parity with what is available in the general MA market. Furthermore, providing expert statistical and consultative services to improve the rigor of the past performance analysis, assuring the final methodology does not advantage or penalize certain applicants, and assisting CMS staff in assembling necessary performance data and briefing/supporting materials are also functions of this activity.

- *Part C and D Audits (one-third)* - This activity involves the review of costs associated with the Medicare Advantage and Prescription Drug programs and documentation used by MA organizations and Prescription Drug Plans (PDPs) sponsors to prepare their bids. Prompt audits of the financial data permits CMS to evaluate and refine CMS' bid review, thereby assuring accurate bidding and enhancing CMS' payment accuracy.

Section 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act requires 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 MA organizations and PDPs offering plans. Over the past several years, the number of MA organizations and PDPs participating in the Medicare program has substantially increased. As a result, a larger number of audits have to be performed.

- *Risk Adjustment Data Validation* – In response to the Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010, CMS has enhanced its efforts to address improper payments. This activity is focused on ensuring the accuracy of annual Part C risk adjusted payments. Diagnosis data submitted by plans is validated to check for incorrect reporting of diagnoses which can lead to overpayments and underpayments. This payment validation process involves conducting medical record reviews, estimating contract level payment errors with the intent of conducting payment recovery, and implementing an appeals process.

Compliance and Enforcement: This category's purpose is to aid in the determination of contractor compliance with CMS requirements and includes funding for Compliance Training, Education, and Outreach.

- *Compliance Training, Education, and Outreach* - CMS provides audit compliance training, technical assistance, education, and outreach to the managed care industry, MA plans, PDPs, and audit assistance contractors. Emphasis is on the compliance challenges associated with new managed care plan types (Special Needs Plans, Regional PPOs, and MSAs) and on enhanced compliance training for the Private Fee-for-Service marketplace. These training, education, and outreach models extend to internal and external stakeholders via webinars, compliance conferences, and on-line training sessions.

II. Program Integrity Staffing & Support:

Discretionary Request ($32.8 million)

Field Offices/Rapid Response/and Oversight Staffing: Staffing, which includes three field offices in high vulnerability areas of the country (New York City, Los Angeles, and Miami), and administrative needs are reflected on this line. While we have maintained seasoned FTEs, CPI is continuing to ramp up staff to include FTEs with skill sets required to perform detailed analytic work, provide contractor oversight, and develop policy. Without these FTEs, CPI would have to slow efforts of fraud prevention program implementation, such as the Fraud Prevention System, Automated Provider Screening, the collaborative approach between law enforcement and other agencies, the compromised numbers checklist, the case management system as well as strengthening other activities. This funding will also provide support services for IT infrastructure, data communications, security and administrative services.

Funding for FTEs and associated administrative costs will also be allocated from the mandatory side of the account for those that are associated with mandatory-funded projects, for example, Medical Review or Medicare Secondary Payer. These projects will be described in further detail later in this section.

Command Center: In FY 2012, CMS established a state of the art command center to facilitate timely responses to fraudulent claims and to streamline collaboration between CMS data analysts, clinical experts, Zone Program Integrity Contractors (ZPICs), and law enforcement officials. The command center will include full-time and rotating staff whose expertise and professional authority will enable CMS to take quick administrative action against egregious cases of fraud. Establishing a collaborative environment is essential to the success of the National Fraud Prevention Program. The Fraud Prevention System (FPS) requires cooperation between all entities with the authority and resources to levy administrative actions against providers and investigate and prosecute criminal conduct. During the research phase, CPI managers visited existing government and private sector command centers to discuss architectural strategies and lessons learned.

CMS expects the command center to be fully operational in FY 2013 and ongoing funding will be necessary to support the operational needs of this project.

III. Increasing Funding for Program Integrity Demonstrations/Special Initiatives:

Discretionary Request ($36.0 million)

Durable Medical Equipment (DME) Stop Gap: In FY 2009, CMS initiated its Medicare DME Stop Gap Plan in the seven States with the highest volume of DME billing and expenditures plus growth rates (FL, CA, TX, NY, MI, IL and NC). The Stop Gap Plan focused on high risk DMEPOS suppliers and ordering physicians, as well as the beneficiaries receiving equipment supplied by or ordered by them and the items of equipment which appeared vulnerable to "gaming." This project has demonstrated that by increasing site visits to and interviews of suppliers, doctors and patients, the PSC/ZPIC investigators could verify appropriate claims payments and initiate immediate action for identified problems (suspension of payment, enrollment revocations or deactivation, prepay edits, overpayment recoupment and referral to law enforcement, if appropriate). In FY 2012, CMS incorporated this work into the normal DME workload for the ZPICs.

In FY 2013, CMS will fund expansion coverage of the Stop Gap project and build this into the statement of work in areas with high volumes of fraud.

Automated Provider Screening: In FY 2011, CMS initiated pilot projects using advanced statistical methodologies and multiple data sources to develop models to identify high-risk providers. These pilots are used to develop and enhance the Automated Provider Screening (APS) tool that was launched on December 31, 2011. CMS' ensuing FY 2012 efforts focus on operationalizing and enhancing the APS by increasing the system's data accesses and end-user functionalities. With the system in full operation by FY 2013, CMS will begin integrating the APS and FPS — the two hallmark systems of the National Fraud Prevention Program. CMS will also continue its pilot projects to develop sophisticated neural network models by leveraging the improved knowledge of entity relationships identified by APS.

1-800 Next Generation Desktop: CMS is working to coordinate the use of its existing data analysis tools to improve access to near real-time data and comprehensive beneficiary Medicare records for both CMS staff and law enforcement, such as providing access to the Next Generation Desktop (NGD). Analysis suggests that more frequent data would allow CMS to detect fraud early and prevent improper payments from being made. In FY 2013, CMS will explore opportunities for using NGD as an investigative and identification tool. CMS will utilize

findings and issues from 1-800-MEDICARE calls and incorporate them into our workloads as potential leads.

OIG Hotline/Incentive Reward Payment (IRP) Database: As of FY 2012, the complaints from the OIG Hotline and 1-800 Medicare are in two separate databases. The consolidation of complaints into one system will permit the identification of problematic trends more efficiently by broadening CMS' view of potential problematic billers.

In FY 2013, CMS will continue maintenance on the current database while performing an upgrade that is compliant with both current security and software operational requirements. In turn, this will afford users a more efficient means by which to track complaints entered into the Hotline. In addition, this project will perform a technology upgrade to the IRP database in order to make it easier for users to track the lifecycle of the reward payment requests and considerations.

Case Management System: In FY 2013, CMS will continue to test ways to case manage the leads that are sent to the ZPICs, as well as those received from multiple sources, including complaints, tips, and data analysis. CMS intends to enable ZPICs to prioritize the high-risk leads while providing national outcome tracking and measuring. The projects will test ways to 1) provide a feedback loop to refine predictive models based on results, 2) measure outcomes, 3) provide CMS a method for quickly refining priorities, 4) provide systematic national tracking, and 5) increase efficiency.

Heat Maps: In FY 2013, CMS will create visual representations of fraud 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.

Medicare Summary Notice (MSN) Improvements: In FY 2010, CMS redesigned the MSN to make it easier for the beneficiaries to read. This enabled the beneficiary to focus attention on checking the MSN and contacting Medicare with concerns. This effort supports the strategic objective of detecting fraud by engaging beneficiaries to review the MSNs and communicate concerns early to CMS. In FY 2013, CMS will continue to strategize ways in which further improvements can be made to the MSN.

Technology and Strategic Decision Support: In FY 2013, funding is being requested for this project to maximize CMS' investment in multiple technologies and pilot programs. CMS is engaging and planning multiple pilots to test innovative strategies to prevent and detect fraud, waste, and abuse. This project will create the infrastructure to support key strategic support of each pilot project, while providing a high-level overview of the PI pilots. This effort will identify PI 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 will perform comparisons and evaluations of the potential technology solutions. This tool would also be used to conduct analysis of Provider Enrollment and Chain Ownership System (PECOS) improvements and will target CMS' innovative strategies.

Beneficiary Fraud Outreach: This project consists of a number of activities, initiated in FY 2012 and continuing in FY 2013, to help engage beneficiaries in fighting fraud. Activities include:

- Providing specialized training to selected volunteers in the Senior Medicare Patrol (SMP) for additional fraud control activities, including in-depth casework, research, investigation of complaints, provider education and relations;
- Improving coordination of program activities with HEAT partner agencies in the high fraud areas;
- Expanding consumer outreach efforts targeting limited English-speaking populations to include increased media outreach, Public Service Announcements, and development of multi-cultural materials; and
- Conducting outreach to "mymedicare" registered users who are able to see their claims within 24 hours of the claim being processed, since they are the most able to quickly identify and report potential fraud.

This funding will allow CMS to acquire the services of a contractor to assist in developing and implementing a beneficiary-focused strategy. Educating and empowering health care consumers to prevent health care fraud is a basic and essential strategy in the arsenal of fraud-fighting efforts. The activities proposed by this project achieve this goal in a cost effective manner by leveraging existing programs and partnerships.

Mandatory Budget

Contractor Medical Director (CMD) Support at Administrative Law Judge (ALJ) Hearings: In FY 2013, CMS proposes to hire additional Contractor Medical Directors to support anti-fraud and error rate reduction efforts. A key way to accomplish this task is participating or being a party to as many ALJ hearings as possible, given the funding provided. Currently there are a limited number of Medical Directors who have many responsibilities, which include:

- Developing local coverage decisions which are the rules for whether a claim should be paid or denied;
- Educating providers on proper coverage and documentation on claims to be submitted to Medicare;
- Serving as expert witnesses in Federal criminal or civil hearings;
- Serving as a representative of the contractors position at the ALJ hearing when a contractor takes party or participant status; and
- Representing the Medicare program to the provider community.

These are significant tasks and the current limited pool of CMDs is being stretched too thin to participate or be a party to many hearings. In FY 2012, CMS intends to have the Medicare Administrative Contractors (MACs) hire additional CMDs which can reduce the burden on the current CMDs. Funding continues to support these additional CMDs in FY 2013. This project supports the HEAT initiatives by ensuring the CMDs can serve as expert witnesses at fraud hearings without compromising their other duties.

IV. Prevent Excessive Payments:

Discretionary Request ($45.1 million)

Fraud System Enhancements: This project will develop new, as well as enhance, benefit integrity automated controls based on data analysis and changing IT infrastructure requirements during FY 2013. In addition, this project assists in funding the additional System Maintainer hours required to implement the numerous change requests generated by the Medicare Integrity Program.

Zone Program Integrity Contractors (ZPICs): ZPICs currently have multiple task orders with deliverables and metrics. Rapid response to a field office probe/initiative slows down delivery on base contract tasks. This project provides additional funding that enables ZPICs to address their base requirements while concurrently supporting CPI special projects and conducting immediate and real-time data runs to locate and assess "hot issues" identified by the field offices.

Medicare Secondary Payer (MSP): A national MSP recovery contract (MSPRC) was awarded in August 2006. The purpose of the contract is to consolidate all the functions and activities (formerly within the scope of FI, CARRIER and DMERC contracts) related to the determination and recovery of MSP debts owed by third party payers (employers, insurers, third party administrators, and plan sponsors), attorneys, and beneficiaries.

The MSPRC function provides checks and balances for preventing fraud and abuse of the Medicare program. Determining and recovering MSP debts owed to the Government is necessary to fulfill the agency's fiduciary responsibility to safeguard the integrity of the Medicare trust funds. The consolidation of MSP recovery activities in a single contract has reduced the associated administrative expenditures by approximately $30 million per year. The implementation of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) Section 111 Mandatory Reporting has resulted in a substantial increase in the MSPRC's workload. As a result of the case load volumes increasing, there is a large backlog of cases.

The MSPRC's workload has exceeded CMS' projections, requiring increased funding to support this workload. Additionally, information received through the new MMSEA Section 111 Mandatory Reporting procedures is expected to potentially quadruple the MSPRC's current workload (even with the use of a workload threshold for the MSPRC's recovery processes). In the last two years actual workloads have increased over 200% and are expected to increase an additional 300% after full implementation of MMSEA Section 111 Mandatory Reporting. Without increased funding, the MSPRC will forgo hundreds of millions and perhaps billions of recovery dollars associated with the increasing workload and potentially experience a decrease in recoveries. This funding will be used to augment base activities and allocate appropriate resources to keep workloads current while maintaining an established level of customer service with the MSP debtor community.

With many new initiatives being implemented by COBC and MSPRC to identify new MSP debt, CMS expects MSPRC recovery workload to continue to increase significantly. As a result of Section 111 Mandatory Reporting's staged implementation, the MSPRC has seen a doubling of existing workloads before Section 111 Mandatory Reporting has been fully implemented. For example, from 2009 to 2011, caseloads have increased from 200,000 to 560,000 cases and there is an extra 1,000,000 cases being held in reserve.

Raising the Level of Prepayment Medical Review: CMS conducts complex medical review on approximately 0.0025 percent of claims. The proposed funding would be dedicated to increasing the level of prepayment review on those claims that local or national data show are driving the Medicare error rate. The funding would be used to hire clinicians who would conduct complex medical review on medical records to confirm that services and items rendered are reasonable, necessary, and comply with CMS coding and documentation requests. Using the data from the Comprehensive Error Rate Testing program, CMS will allocate resources to target those Medicare Administrative Contractors who need to significantly reduce their error rates.

Mandatory Budget

Benefits Integrity (BI) (ZPIC and PSC activity): BI activities deter and detect Medicare fraud through concerted efforts with the OIG, the Government Accountability Office (GAO), DOJ, and other CMS partners. In support of BI, as it continues into FY 2013, CMS conducts proactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement. CMS follows up on beneficiary complaints that indicate fraud, and supports law enforcement as cases are negotiated. Nearly all of the BI funding is directed to Program Safeguard Contractors (PSCs) and ZPICs situated in various geographical zones throughout the United States.

CMS created PSCs to perform certain program safeguard functions including benefit integrity work and to a lesser extent, medical review, local provider education, and cost report audits.

As part of contracting reform (specified in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003), seven zones were created based on the MAC jurisdictions. The contracting strategy implemented in FY 2008-FY 2009 created ZPICs to operate within the seven zones to perform the BI work previously performed by the PSCs. With the creation of the ZPICs, there is an emphasis on designated high-risk fraud areas. Single contracts will be issued for each zone with separate task orders for: 1) Medicare Parts A, B, durable medical equipment (DME) and home health and hospice, and 2) Medicare-Medicaid data match program. This strategy increases the ability to look at providers across all benefit categories; achieve economies of scale through the consolidation of contractor management; analyze data/IT requirements; consolidate facility costs, etc.; streamline CMS costs in acquisition, management and oversight; and, provide for better coordination and fewer resources required for the States.

The continuum from detection to prosecution of fraudulent activity requires complete coordination with CMS, its contractors, and law enforcement partners. The PSCs/ZPICs meet on a regular basis with the OIG and DOJ staff to allow for information sharing. These activities include participation in fraud task forces, educational sessions and formal meetings to review the status of cases, discuss identified fraud schemes, and ensure that each others' needs are met. In addition, the PSCs/ZPICs are frequently called upon to perform medical review or data analysis for cases initiated by OIG or the FBI.

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. The audit process includes the timely receipt and acceptance of provider cost reports, desk review and audit of those cost reports, and the final settlement of the provider cost reports. In addition, the audit/settlement process determines that providers are paid properly in accordance with CMS regulation and instructions for areas such as Graduate Medical Education, disproportionate share hospital payments, bad debts and other cost reimbursable items. The audit process includes such

administrative functions as intermediary hearings and appeals to the Provider Reimbursement Review Board. The audit effort also reviews data reported in the Medicare cost reports for a specific provider type such as end-stage renal dialysis facilities. CMS contracts with fiscal intermediaries (FIs) and Medicare Administrative Contractors (MACs) to provide these audit services. To ensure accurate reimbursement, CMS conducts reviews on FI/MAC audit work, as well as other contract monitoring. CMS' performance goal is to increase the ratio of recoveries to audit dollars spent.

Medicare Secondary Payer (MSP): The 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.

Medical Review (MR): MR 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 following conditions:

1. Coverage Conditions
    - The service fits one of the benefit categories described in title XVIII of the Social Security Act and is covered under the Medicare program;
    - The service is not excluded by the Act; and
    - The service is reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Act for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.
2. Coding Conditions, or
3. Other (e.g., payment) Conditions

Medicare/Medicaid Data Match Project (Medi-Medi): The Medicare-Medicaid Data Match Program, authorized by the Deficit Reduction Act (DRA), is a partnership between CMS and participating States that enhances collaboration by identifying aberrant practices and by collecting and analyzing data from both programs with the intent of detecting fraud, waste, and abuse that may otherwise go undetected in each program. The One PI system will be integral in this process. The Medi-Medi program examines the health care claims data from two programs that share many common beneficiaries and providers to look for 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. CMS will continue to expand this program in FY 2013.

Executive Order – Do Not Pay List: On June 18, 2010, the President issued a memorandum directing that a Do Not Pay List be established, a single source through which all agencies can check the status of a potential contractor or individual. The Do Not Pay List will allow CMS to access essential information they need to determine, for example, if an individual is alive or deceased; or if a contractor had been debarred, in a more timely and cost effective manner. This will assist in reducing improper payments, which in turn, will save taxpayer dollars.

CMS started sharing information in 2010 about providers who have been terminated from the Medicare program to state Medicaid agencies within 30 days of provider termination.

In response to the “Do Not Pay” Presidential Directive, CMS has also collected information from all of its components regarding their current pre-payment and pre-award procedures in determining a recipient’s eligibility to receive Federal benefit payments, awards, grants, or contracts. CMS is also in the process of summarizing database checks currently performed and identifying any weaknesses in each program area. Additionally, CMS is requiring the program areas to update its procedures to incorporate required checks in its operations.

Additionally, as previously noted, CPI commissioned the Automated Provider Screening application on December 31, 2011. This system will be used to screen all newly enrolling and existing Medicare providers using a variety of public and private sector referential data. Exclusion lists associated with the Do Not Pay List are one component of these checks. Once all of the existing providers have been screened, CMS will use this system to pro-actively monitor all enrolled providers.

V. Program Integrity Oversight Efforts:

Discretionary Request ($88.7 million)

Enhanced Provider Oversight: In addition to the on-going revalidation efforts, CMS will continue to implement, proactive data analysis to ensure provider enrollment records are accurate. This project encompasses on-going systematic analysis of provider enrollment records by various contractors. The initial phases of this project have revealed that vulnerabilities may exist with inconsistent data between PECOS, NPPES, and the claims processing systems. The data analysis, done in conjunction with the revalidation, will allow CMS to identify discrepant data and allow the Medicare Administrative Contractor (MAC) to initiate appropriate actions to reconcile the various systems. The initial phase of this project, implemented in 2011, has produced significant results including an increased number of revocations and the deactivation of over 10,000 billing numbers in CY 2011.

Thus far, the project has been confined to only a small number of geographic regions. However, it will expand to several other areas of the country that have historically been considered high fraud areas. Based upon the continued success of this project, it is expected that it will be implemented nationwide in FY 2013. The systematic analysis and subsequent actions taken by the MAC is an integral segment of our anti-fraud programs within provider enrollment. The project has provided valuable information which CMS has used to identify and implement programmatic changes that have proven successful to deter and prevent Medicare fraud.

Overpayment/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 a physician or non-physician practitioner who has an existing overpayment or is currently under payment suspension.

To implement the aforementioned provision, CMS is developing Change Request (CR) 7166, Addition of Provider Enrollment Denial Reasons; Existing Overpayments, which will instruct Medicare contractors to deny additional Medicare billing privileges to physicians and non-physician practitioners where an overpayment exists.

Once this CR is funded and implemented, CMS will develop a similar CR in FY 2013 that will prevent physicians and non-physician practitioners from obtaining additional Medicare billing privileges when a payment suspense is in effect.

DMEPOS Validation Contractor: An accreditation is required for DMEPOS suppliers in order to obtain or maintain an enrollment number to provide services to the Medicare beneficiaries. CMS approved ten national accreditation organizations that accredit suppliers of DMEPOS suppliers in order to determine if the DMEPOS supplier meets the quality standards under Medicare Part B. CMS is responsible for performing validation surveys to examine the results of a CMS approved accreditation organization's survey of a supplier or observe a CMS approved organization's onsite survey of a DMEPOS supplier in order to validate the CMS approved organization's process. CMS does not have the clinicians with this expertise to perform this work. In order to provide validation surveys which promote the highest level of safeguard for the beneficiaries, CMS will secure the desired survey expertise through a contractor in FY 2013.

Compromised Numbers Checklist: In FY 2012, CMS will complete its centralized database for Medicare provider and beneficiary identification numbers suspected or known to have been used for fraudulent purposes. The Compromised Number Checklist (CNC) is accessible by designated Medicare contractors, enabling these entities to implement claims processing edits and share corrective actions taken against individuals. This data set has helped CMS significantly to identify false front providers which provide large savings to the Medicare Trust Fund.

During FY 2013, CMS will focus on a more robust system in order to provide comprehensive data quality validation and an initiative to include more useful information on the providers and beneficiaries who are included in this database.

One PI Data Analysis: One PI uses a single sign-on to multiple analytical tools that provide centralized and streamlined access to multiple data sources. The One PI data analysis project will continue to develop and support the web-based portal that provides CMS staff and contractors with a single access point to data contained in the Integrated Data Repository (IDR) as well as tools for analyzing those data to support program integrity. CMS will continue to train and support ZPIC and law enforcement users of One PI through this investment. CMS is beginning to test matching of Medicaid data from 10 pilot States with the historical Medicare Parts A, B, and D and provider enrollment data in the IDR.

In FY 2013, CMS will continue this support and will also serve as the platform for developing training, and refining predictive analytic models using historical data that will subsequently be promoted into a scoring engine that reviews pre-pay claims and builds risk profiles based on provider and beneficiary behavior. The investment will promote the efficient expansion of the agency's Medi-Medi data match project as required in the Deficit Reduction Act of 2005 and Section 6402a of the Affordable Care Act.

Fraud & Abuse Customer Service Initiative: In FY 2013, this project will fund a regional fraud hotline and associated investigative team in the State of Florida. Well-trained, bilingual staff field and route calls, as well as acknowledge receipt of complaints in writing. A dedicated investigative team 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). This project also allows CMS to work with the Administration on Aging 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 Medicare Summary Notices to better detect potentially fraudulent billings.

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, DOJ and HHS expanded the Strike Force model to include teams of investigators and prosecutors in a total of nine cities – Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Dallas, Texas; and Chicago, Illinois.

Each Medicare Strike Force combines data analysis capabilities of CMS and the investigative resources of the FBI and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the US Attorney's Offices (USAOs). Strike Force accomplishments from cases prosecuted in all nine cities during FY 2011 include[1]:

- 132 indictments, informations and complaints involving charges filed against 323 defendants who allegedly collectively billed the Medicare program more than $1 billion;

- 172 guilty pleas negotiated and 17 jury trials litigated, winning guilty verdicts against 26 defendants; and

- Imprisonment for 175 defendants sentenced during the fiscal year, averaging more than 47 months of incarceration.

Since the inception of the Medicare Fraud Strike Force, Strike Force prosecutors have filed more than 600 cases charging more than 1,150 defendants who collectively billed the Medicare program more than $2.9 billion; 663 defendants plead guilty and 74 others were convicted in jury trials; and 543 defendants were sentenced to imprisonment for an average term of nearly 42 months.[2]

Appeals Initiative: CMS currently experiences a high overturn rate on appeals, especially at the Administrative Law Judge (ALJ) level. CMS is currently exploring ways in which to mitigate the overturn rate and will be implementing the associated actions in FY 2013.

Qualified Independent Contractors (QIC) Participation in ALJ Hearings - The QICs are responsible for performing second level appeals (reconsiderations) activities for Medicare fee-for-service (FFS) Part A and 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. The QICs are required as "participants" in approximately 10 percent of Administrative Law Judge (ALJ) hearings, but they are not currently funded to invoke party status in ALJ hearings. Attending the hearing as a participant only affords the QIC the opportunity to submit a position paper and to appear at the hearing to answer questions. Party

[1] The accomplishments figures presented in the bullets include all reported Strike Force cases handled by DOJ Criminal Division attorneys and AUSAs in the respective USAOs during FY 2011.
[2] These statistics are for the period of May 7, 2007 through September 30, 2011.

status provides additional rights (e.g., calling witnesses, providing testimony and evidence, etc.) that are crucial to a QICs ability to successfully defend a claim denial.

The current reversal rate for cases appealed to ALJs is approximately 65 percent. While QIC participation is a valuable tool that helps to reduce the ALJ reversal rate, results from a recent pilot prove that invoking party status has a much greater impact on reducing the reversal rate. The additional rights afforded to parties (e.g., calling witnesses, providing testimony and evidence, etc.) are extremely beneficial to the ALJ hearing. By invoking party status, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Funds expenditures.

During FY 2012, each QIC will invoke party status in ALJ hearings for cases of interest to CMS, in accordance with the regulatory provisions in 42 CFR § 405.1012. The QICs will also conduct training sessions for the Medicare Administrative Contractors, Recovery Audit Contractors, and Zone Program Integrity Contractors to share lessons learned from invoking party status.

Public/Private Partnerships: One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing public-private partnership to foster cooperation and enhance program integrity in the health care system. As part of this initiative, CMS is designing and launching a nationwide, permanent Public Private Partnership (PPP), to be led by HHS/CMS in conjunction with OIG and DOJ. In order to ensure a coordinated nationwide health care anti-fraud and abuse strategy, CMS will create and implement a partnership structure that will achieve the following: (1) promote to the public the sharing of best practices and strategies surrounding health care fraud and abuse data, (2) discuss and collaborate between the public and private sectors on innovative measures to detect and prevent health care fraud and abuse, and (3) educate the public on health care fraud and provide prevention measures. The project activity will be centered within HHS/CMS, but maintain strong public and private partnership ties.

In FY 2013, 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.

Probable Fraud Measurement Pilot: CMS is estimating the rate of probable fraud in Medicare fee-for-service payments for home health and durable medical equipment services. CMS chose to estimate the rate of probable fraud in DME and home health because providers and suppliers in these service areas were defined as "high" categorical risk in the final rule on the implementation of ACA screening provisions [CMS-6028-FC amending 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. With the contracts in place, CMS anticipates that it will begin Phase I of data collection and analysis in FY 2012. Phase II of the pilot, which CMS anticipates will expand the scope of the project to a new service type, will take place during FY 2013.

Medicaid & CHIP Oversight: Transforming the Medicaid and CHIP enterprise data is necessary to complete the requirements in the Affordable Care Act, to significantly boost program integrity efforts, and improve performance and accountability across the enterprise. One way we will accomplish this is by collecting provider information and state provided reference files through the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. Combining the provider information with claims and encounter data will allow for new methods to fight fraud. These efforts will also support the data needs of the Medi-Medi Program, the Medicare Program Integrity (PI) Group and Medicaid Integrity Group (MIG). More complete, standard, and timely Medicaid and CHIP data will present tremendous new capabilities for the Fraud, Waste, and Abuse program. When Medicaid and Medicare data sets are linked and analyzed together the data can be used to identify improper billing and utilization patterns that would not be evident if each program was examined in isolation.

The FY 2013 request includes funding for projects under the MACBIS program to increase the number of States submitting an expanded data set and building out the various views of the data using business intelligence. The 2013 funding will help build the functionality to allow for the following Program Integrity outcomes:

- Streamlining current operations data projects such as the Medi-Medi Project, MIG projects, and Medicaid Analytic eXtract (MAX);
- Collecting sufficient data on providers linked accurately to payment that will lead to better practice patterns, as well as assist in fraud prevention efforts; and
- The Payment Error Rate Measurement (PERM) program will rely on the data provided from the new data environment created by MACBIS.

Mandatory Budget

National Supplier Clearinghouse (NSC): The NSC reviews and processes applications received from organizations and individuals seeking to become suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) in the Medicare program. This process includes: a) on-site visits to the prospective supplier to determine that they meet required supplier standards, b) checking that the supplier has all applicable licenses, c) checking that the supplier and its principals are not ineligible by virtue of being on the General Service Administration (GSA) and/or OIG listings; and d) checking that the supplier meets the accreditation and surety bond requirements.

Stopping fraud and abuse includes monitoring the DMEPOS suppliers. The NSC assigns fraud level indicators to assist in expanded review procedures of suppliers. These procedures include: a) increased unannounced on-site reviews, b) license expiration checks; and, c) phone calls to suppliers. The NSC assures that existing suppliers are accredited and have surety bonds in accordance with the announced CMS schedule. The NSC coordinates fraud and abuse efforts with CMS satellite offices and ZPICs. The NSC assists fraud and abuse efforts conducted by the OIG, DOJ, and the US attorney and State law enforcement officials.

Due to newly established screening levels within CMS 6028 Section 42 CFR 424.518, the number of site visits performed by the NSC will significantly increase and continue into FY 2013. Site visits will now be required on all new and revalidating DMEPOS suppliers as they are assigned a categorical risk of High (new enrollees) and Moderate (revalidating suppliers).

Provider Outreach and Education (POE): 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 Comprehensive Error Rate Testing (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 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.

Provider Enrollment and Chain Ownership System (PECOS): The 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 via paper CMS-855 A, B, I, R, and/or S. PECOS centralizes the enrollment data collected from the forms into one system and is used by Medicare contractors to enter, update, and review data. Medicare providers and suppliers may also use PECOS to submit their enrollment data electronically, as well as view and update their existing information. 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 855 enrollment forms and PECOS enhancements will streamline the process; reduce the amount of paperwork processed, and provider clearer guidance to providers on what they need to submit.

Major enhancements undertaken in FY 2012 and continuing through FY 2013 include the implementation of the following:

- Incorporation of e-signature functionality;
- Improvements of functionality MAC administrative interface;
- Complete redesign of the provider interface of PECOS;
- Automated pre-screening module interface;
- Web service feature for batch uploads of applications from large organizations & institutions; and
- Streamlined revalidation workflow.

VI. Error Rate Measurement:

Discretionary Request ($20.0 million)

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. HHS began CHIP error rate measurement in 2011 with the results being published in November 2012.

The FY 2013 request includes an increase from FY 2012 due to contractors costs, supplemental measure work (reviewing more claims and more analysis), and Mini PERMs (voluntary smaller scale measurements of state improper payments during years when a State is not being measured under PERM) potential costs. Some PERM activities in 2013 include:

- 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;
- Partner with the OIG to insure the integrity of the PERM program;
- Providing support to States, as needed, to conduct targeted reviews on areas at risk for improper payments;
- 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 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; 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 will help CMS achieve a more accurate error rate for the Medicaid and CHIP programs.

Mandatory Budget

Comprehensive Error Rate Testing (CERT): The Medicare Fee-for-Service (FFS) program is also identified as at risk for significant erroneous payments.

As part of the original IPIA compliance efforts, and to help all Medicare FFS contractors 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 paid claim error 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 medically review claims that contractors paid or denied to ensure that the payment decision was appropriate. The decisions of the independent reviewers are entered into a tracking database. Annual reports are produced that provide the basis for program planning, evaluation, and corrective actions.

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.

On November 20, 2009, Executive Order 13520 – Reducing Improper Payments, was issued by the President. The Executive Order includes additional requirements for the Medicare FFS program including supplemental error rate measurements and reporting on the Department of Treasury payment accuracy website (Paymentaccuracy.gov).

During FY 2013, 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.

These activities do not encompass the entire scope of work that CMS is conducting now to reduce improper payments. In fact, several other areas of funding have some level of a medium to high impact in reducing improper payments. Some specific examples include the activities funded out of CMS' core mandatory MIP activities, One PI data analysis, compromised numbers database, and the DMEPOS validation contractor.
CMS' core activities will continue and newer initiatives will be started based on lessons learned in future years.

VII. Affordable Care Act:

Discretionary Request ($8.8 million)

Section 6401 - Section 6401 requires States to screen all Medicaid and CHIP providers according to the risk of fraud, waste or abuse, consistent with the provider screening procedures established by the Secretary for Medicare. In the Federal regulations implementing this provision, CMS stated that for dually-participating providers, a state Medicaid agency may rely

on the screening performed by Medicare or by another State. For state Medicaid and CHIP agencies to be able to carry out their provider screening obligations without duplicating provider screening efforts previously performed by Medicare or other States, they must have access to information on provider screening activities conducted by Medicare and by other States. CMS is currently working to develop an information sharing solution in which information critical to Medicaid and CHIP provider screening and enrollment can be shared across programs in a systematic, user-friendly manner.

Section 6411- This Section requires each State and Territory to establish a Medicaid RAC program. In addition to providing regulatory and sub-regulatory guidance, CMS is hosting a number of activities to assist States in the implementation of their RAC programs. The Medicaid RACs At-A-Glance webpage was launched in February 2011. This first phase shows a U.S. map providing basic information gleaned from each State's RAC State Plan Amendment (SPA) submission and the status of the SPA and offers a link to submit feedback. The second phase of the webpage will offer substantive enhancements to support States, including information of RAC program performance metrics. Another activity is a series of broad outreach efforts to States including stakeholder conference calls and real-time webinars. Likely topics will include Medicare RAC Best Practices: Technical Assistance for States; Quarterly Expense Reports (CMS -64: RAC Reporting); State Reporting: Program Performance Metrics; and RAC Fraud Referrals to the State Medicaid Agency.

Mandatory Budget

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 Health Care Fraud and Abuse Control (HCFAC) funding.

During FY 2013, CMS will continue to develop the data and business context for this Section. Through this work, CMS will frame what source data is to be collected from each Federal healthcare data partner for Phase 1 of this effort, 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. This work includes project management and joint application development work with implementing this requirement are related to CMS expanding the data elements included in the Integrated Data Repository (IDR), as well as implementing innovative technologies that were tested through pilots during FY 2010. 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. CMS will also have to make improvements to its systems to ensure that all enrollment applications and all claims for payment submitted to the Medicare program have a National Provider Identifier. There is also cost associated with having our enrollment contractor verify that all home health agencies have a $50,000 surety bond before the application to the Medicare program is approved.

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 (system modifications for tracking RAC activities and

to interface with the Medicare Advantage Prescription Drug Payment System (MARx) and a system to pay the RAC and Interface with APPs); and outreach planning and implementation (RAC website development).

- *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 will be responsible for the examination of the Sponsoring Organizations to determine improper payments related to various audit issues.

- *Data Validation Contractor (DVC):* The data validation contractor will be necessary for verification and validation of the release of demand letters to Part D Sponsors as a result of RAC-identified improper payments. The data validation contractor will also send reports directly to CMS for validation of RAC invoice amounts.

- *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*: In order to provide seamless open communication between CMS and the Sponsoring Organizations, a RAC website has been developed. The website will be a means for issuing guidance to the organizations as well as provide further information to CMS' contractors.

NATIONAL FRAUD PREVENTION PROGRAM - PREDICTIVE MODELING

Program Description and Accomplishments

CMS implemented the predictive modeling system one day prior to the July 1, 2011 deadline established by Public Law 111-240. The Fraud Prevention System (FPS) analyzes all prepayment Medicare fee-for-service claims, surpassing the law's mandate to implement a predictive modeling system in only the ten highest-fraud states.

As of December 2011, CMS is using fifteen algorithms to detect billing and claims anomalies. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. Using these profiles, CMS creates risk scores to estimate a claim's likelihood of fraud; risk scores enable CMS to prioritize the highest-risk claims for more thorough review prior to releasing payment. Like the fraud the system seeks to find, the current and forthcoming models exhibit varying levels of

sophistication—from relatively simple tracking of timed services over a given time interval to models that predict the likelihood of fraud given certain reliable indicators. CMS anticipates increasing the number and type of its analytical models with each scheduled quarterly software update. CMS analysts are partnering with the predictive modeling teams led by IBM and Northrop Grumman to identify new program integrity vulnerabilities and build predictive models to respond to these threats.

CMS previously outlined four activities critical to the success of the predictive modeling project and has dedicated significant attention to addressing these issues:

- *Data formatting:* Ensuring that data elements are commonly defined across systems. CMS has established strong intra-agency relationships to ensure that the individuals using the data elements in the various source systems fully understand the information and are able to translate between all the systems. Predictive modeling analysts have participated in extensive training sessions on the Integrated Data Repository and how use the SAS predictive modeling and business intelligence tools to analyze the data. FPS development contractor Northrop Grumman and subcontracted partners National Government Services and Verizon have been instrumental in ensuring that the algorithms accurately and effectively leverage the claims information.

- *Data integrity*: Validating that the data is correct and up-to-date.
  In conjunction with the National Analytics Contractor, CMS has undergone extensive projects to improve the integrity of its provider enrollment data. CMS has been crosschecking Medicare Administrative Contractor local files, Social Security records, and state licensing board data with the national provider enrollment database, known as the Provider Enrollment Chain Ownership System (PECOS). These crosschecks ensure that PECOS contains the most current data information on providers and that enrolled providers have met all the administrative and licensure requirements prior requesting Medicare claims payment. The lessons learned in these data integrity checks will prove useful upon implementation of the automated provider screening in early 2012.

- *Training*: Ensuring that staff members are trained on the predictive modeling tools. Although CMS administers and manages the FPS, the system would not be successful without the coordinated efforts of the ZPIC investigators and analysts who are using the system to build and manage their caseloads. Several weeks prior to implementing the FPS, CMS hosted a day-long workshop to acquaint ZPIC users with CMS's National Fraud Prevention Program, provide an introductory training on the Fraud Prevention System, and address ZPIC concerns and suggestions with the changes presented by the new system.

  Each ZPIC is also participating in an intensive three-day rotation in CMS's interim Command Center. CPI leadership, ZPIC representatives, CMS COTRs, predictive modeling experts, and clinicians discuss the FPS algorithms and ASRs in great detail. The sessions are designed to be mutually beneficial: ZPICs get the opportunity to work side-by-side with CMS leadership and FPS experts to learn the details of the new system and the models generating their investigative leads while CMS is able to solicit candid feedback and suggestions for process improvements, system enhancements, and model updates.

  CMS also holds regular conference calls with ZPICs to discuss performance metrics, systems issues, and predictive models. After the initial system launch, ZPICs met with

CMS twice each week to triage implementation issues; in response to a decrease in the number of time-sensitive issues raised by ZPICs, CMS now holds these meetings biweekly. ZPICs also participate in a monthly Vulnerabilities and Models Workgroup to collaborate on developing and refining FPS algorithms. ZPICs may also participate in real-time online trainings, of which over 50 have been offered between July and November 2011.

- *Resources:* Providing adequate resources to fully monitor and investigate potential abuses identified by the tools.

  CMS has been developing a comprehensive strategy to ensure that all stakeholders are able to leverage the FPS effectively. CMS has been working closely with the ZPICs as they transition to using the system to manage their investigation workloads. Recognizing the opportunity for more streamlined coordination with its law enforcement partners, CMS is working closely with FBI and OIG leadership to streamline the referral and investigation process to ensure swift and decisive action against providers found to be committing fraud. To date, CMS has held several separate multi-day training and collaboration sessions with both the FBI and the OIG. CPI is also hosting an OIG leadership detail dedicated to coordinating investigative efforts and administrative actions between CMS and the OIG.

In addition to CMS's ongoing predictive modeling and FPS enhancements, FY 2012 National Fraud Prevention Program efforts have been focused on implementing CMS's new APS tool. CMS will use the system's initial implementation period to develop the necessary system protocols and perform any necessary adjustments to ensure that the tool screens applications effectively and efficiently.

In 2013, CMS will integrate the now-distinct FPS and APS projects. Even though the projects were developed and incubated separately, they were designed as complementary systems that would be integrated into one program. Automated provider screening rules will rely heavily on the data analysis of the FPS predictive modeling teams; in turn, the predictive modeling teams will be able to leverage the rich data gathered and produced by the APS tool.

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. The FBI leverages its resources in both the private and public arenas through investigative partnerships with various Federal, State and local agencies. The FBI field offices throughout the U.S. have pro-actively addressed significant health care fraud threats through coordinated initiatives, task forces, working groups, and undercover operations. The result has been the identification and investigation of many of the most egregious offenders.

In FY 2011, the FBI initiated over 900 new health care fraud investigations and had approximately 2,700 pending investigations. FBI-led investigations resulted in over 700 criminal health care fraud convictions and over 1,600 indictments and informations being filed in FY 2011. In FY 2011, FBI health care fraud investigations resulted in the operational disruption

of over 230 criminal fraud organizations, and the dismantlement of the criminal hierarchy of more than 65 health care fraud criminal enterprises.

FBI Budget Request

The FY 2013 FBI budget includes mandatory funding in the amount of $135.3 million, an increase of $3.4 million above the FY 2012 President's Budget. 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 2011, OIG's CMS oversight efforts, which are supported by HCFAC funding, resulted in 614 criminal actions and 375 civil actions against individuals or entities that engaged in health-care-related offenses. Further, OIG's CMS oversight efforts resulted in approximately $4.2 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 2013 OIG budget includes $196.7 million in mandatory funding. In addition, the FY 2013 OIG discretionary request is $102.5 million, $4.9 million above the FY 2012 President's Budget discretionary 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) and the Federal Bureau of Investigation 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 2013 DOJ budget estimate includes $61.4 million in mandatory funding. In addition, the FY 2013 DOJ discretionary request is $97.8 million, $4.6 million above the FY 2012 President's Budget discretionary level.

HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING PROJECTS

Program Description and Accomplishments

In addition to MIP, CMS also will use 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 2012, negotiated amounts were $37.5 million for distribution among HHS components and $61.2 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 in FY 2012:

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 $204 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with States to promote proper state Medicaid financing.

CMS Community Mental Health Center (CMHC) Pilot ($2.0M): This funding will assist in preventing CMHC Medicare fraud and abuse, reducing inappropriate payments by strengthening provider enrollment actions, and increasing prepay and postpay claim reviews. CMS will add models in FPS that look at anomaly analysis and rules that identify known fraud patterns which will identify those CMHCs at highest risk for improper payments.

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. OGC also 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.

Administration on Aging (AoA) SMP Support ($3.3M): 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 on Aging (AoA) SMP Grants ($7.3M): For FY 2012, 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 pilot program began in the second half of FY 2010 and is designed to detect, prosecute, and prevent pharmaceutical fraud. Pharmaceutical fraud settlements typically begin as lawsuits through the help of whistle-blowers; this funding continues the PFPP, which takes a more proactive approach. Through the PFPP, FDA will continue criminal investigations, including off-label promotion, manufacturing fraud, clinical trial and/or application fraud and other falsified data matters.

HHS Wedge Budget Request

The FY 2013 HHS Wedge request includes mandatory funding of $37.6 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

In the FY 2011 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the cut-off date for the publication of the Agency Financial Report (AFR). Based on the new estimation methodology, the error rate results and targets for FY 2012 and FY 2013 have been adjusted from 6.2 percent and 5.8 percent respectively, as reported in the FY 2011 AFR, to 5.4 percent and 5.0 percent, respectively. While our FY 2011 improper payment rate was near the target of 8.5 percent at 8.6 percent, we continue to make progress to reduce the percentage of improper payments made under the Medicare Fee-for-Service program by half, pursuant to Executive Order 13520: *Reducing Improper Payments and Eliminating Waste in Federal Programs*.

In addition to reducing the FFS error rate, CMS is also working to reduce the percentage of improper payments made under the Part C Medicare Advantage and Part D Prescription Drug programs. In FY 2011, CMS exceeded its target of 13.7 percent with an actual Part C error rate of 11.0 percent. The FY 2013 target is to reduce the Part C error rate to 9.8 percent. In FY 2011, we reported an FY 2011 baseline composite error rate for Part D of 3.2 percent. The FY 2013 target for the Part D error rate is 3.1 percent.

CMS has a performance measure for FY 2013 to strengthen CMS' Provider Enrollment actions to prevent ("High Risk") fraudulent providers and suppliers from enrolling in the Medicare program and to assure that existing providers continue to meet enrollment requirements. Since there is a linkage between billing fraud and enrollment fraud, CMS will perform enhanced provider enrollment reviews to prevent and detect Medicare fraud and to reduce waste, abuse and other improper payments. Although we expect to reduce the number of fraudulent providers that enroll in Medicare, we will also identify high risk providers and suppliers through comprehensive claims-based predictive analytics that are focused on fraud indicators and continuously strengthened. This measure is also featured in the HHS Strategic Plan, 2010-2015.

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 in order 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 systems and applications, and CMS met its FY 2011 target of training 100 percent of LE referred for training and access.

The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid and the Children's Health Insurance Program (CHIP). We are measuring improper payments in a subset of 17 States each year as a means to contain cost, reduce the burden on States, and make measurement manageable. In this way, States can plan for the reviews, and CMS has a reasonable chance to complete the measurement on time for the Department of Health and

Human Services Agency Financial Report (AFR) reporting. CMS met its Medicaid FY 2010 rolling average error rate target reported in 2009-2011 of 8.4 percent at a rate of 8.1 percent. CMS met its FY 2010 target to publish the Final Regulation in accordance with Section 601 of the Children's Health Insurance Program Reauthorization Act. We will next report the next two years on the CHIP error rates, and in FY 2013, develop baselines and future CHIP targets.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	FY 2011: 8.6%[3] Target: 8.5% (Target Not Met but Improved)	5.4%	5%	-0.4
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program	FY 2011: 11% Target: 13.7% (Target Exceeded)	10.4%	9.8%	-0.6
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program	FY 2011: Baseline 3.2% Target: Report Baseline (Target Met)	3.2%	3.1%	-.1%

[3] Beginning with the FY 2011 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeals decisions that routinely occur after the cut-off date for the published AFR. The error rates and targets for FY 2011 and future years have been adjusted to reflect this revised methodology. Without this adjustment, the FY 2011 error rate would have been 9.9 percent. The targets for FY 2012 and FY 2013 have been adjusted from 6.2 percent and 5.8 percent respectively, as reported in the FY 2011 AFR, to 5.4 percent and 5.0 percent, respectively.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
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 2011: 100%[4] Target: 100% (Target Met)	100%	100%	Maintain
MIP8: Increase the percentage of administrative actions taken for Medicare providers and suppliers identified as high risk.	N/A (New in FY 2012) FY 2011 baseline TBD March 2012	15%	TBD[5]	N/A
MCD1.1: Estimate the Payment Error Rate in the Medicaid Program	FY 2010: 8.1% Target: Report rolling average error rate in the 2011 AFR based on States reported in 2009-2011. Meet or exceed the target error rate of 8.4%. (Target Met)	Report rolling average error rate in the 2013 AFR based on States reported in 2011-2013. Meet or exceed the target error rate of 6.4%.	Report rolling average error rate in the 2014 AFR based on States reported in 2012-2014. Meet or exceed the target error rate of 6.0%.	N/A

[4] CMS trained 226 new LE personnel.

[5] No target has yet been established for 2013. In 2011, we are developing the baseline for this Goal to determine whether the 2012 goal is appropriate and how to set the target for 2013.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
MCD1.2: Estimate the Payment Error Rate in CHIP (Outcome)	FY 2010: Final Regulation published 8/11/2010. Target: Publish Final Regulation in accordance with Section 601 of CHIPRA (Target Met)	Report rolling average error rate in the 2013 AFR based on States reported in 2012-2013.	Report rolling average error rate in the 2014 AFR based on States reported in 2012-2014. Develop baseline and future targets.	N/A

Project or Activity	FY 2013 Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D	
Medicare Drug Integrity Contractors (MEDICs)	$24,000
Part C & D Contract/Plan Oversight	$31,295
Monitoring, Performance Assessment, and Surveillance	$54,289
Program Audit	$43,300
Compliance and Enforcement	$25,486
Total	**$178,370**
II. Program Integrity Staffing & Support	
Field Offices/Rapid Response/and Oversight Staffing	$30,800
Command Center	$2,000
Total	**$32,800**
III. Increasing Funding for Program Integrity Demonstrations/Special Initiatives	
DME Stop Gap	$10,300
Automated Provider Screening	$14,500
1-800 Next Generation	$2,450
OIG Hotline/Incentive Reward Payment Database	$1,500
Case Management System	$1,000
Heat Maps	$650
Medicare Summary Notice (MSN) Improvements	$1,100
Technology and Strategic Decision Support	$2,500
Beneficiary Fraud Outreach	$2,000
Total	**$36,000**
IV. Prevent Excessive Payments	
Fraud System Enhancements	$4,500
ZPIC	$1,600
Medicare Secondary Payer	$15,500
Raising the Level of Prepayment Medical Review	$23,457
Total	**$45,057**
V. Program Integrity Oversight Efforts	
Enhanced Provider Oversight	$12,300
Overpayment/Payment Suspension	$5,000
DMEPOS Validation Contractor	$1,500
Compromised Numbers Checklist	$5,000
One PI Data Analysis	$20,000
Fraud & Abuse Customer Service Initiative	$7,300
HEAT Support / Strike Force	$4,000
Appeals Initiative	$7,000

Project or Activity	FY 2013 Request
Qualified Independent Contractor (QIC) Participation in ALJ Hearings	$1,900
Public/Private Partnerships	$1,000
Probable Fraud Study Database & Analysis	$5,565
Medicaid and CHIP Oversight	$18,130
Total	**$88,695**
VI. Error Rate Measurement	
Payment Error Rate Measurement (PERM) Medicaid	$20,000
Total	**$20,000**
VII. Affordable Care Act	
Section 6401 Provider Screening/Other Enrollment	$8,276
Section 6411 Expansion of RAC for Parts C & D and Medicaid	$500
Total	**$8,776**
VIII. HCFAC Summary	
Total CMS Medicare Integrity	**$362,792**
Total CMS Medicaid Integrity	**$46,906**
Total CMS Discretionary	**$409,698**

State Grants and Demonstrations

(Budget Authority Dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$46,541	$0	$0	$0
Subtotal – TWWIIA	**$46,541**	**$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)				
National Clearinghouse for Long-Term Care (LTC) Information[1]	$0	$0	$0	$0
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Alternatives to Psychiatric Residential Treatment Facilities for Children	$57,000	$0	$0	$0
Money Follows the Person (MFP) Demonstration	$448,900	$448,900[2]	$448,900	$0
MFP Research & Evaluations	$1,100	$1,100[3]	$1,100	$0
Medicaid Transformation Grants	$0	$0	$0	$0
Medicaid Integrity Program[4]	$76,275	$78,334	$80,371	$2,037
Subtotal – DRA	**$583,275**	**$528,334**	**$530,371**	**$2,037**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment	$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	$75,000	$0	$0	$0
Incentives for Prevention of Chronic Diseases in Medicaid	$100,000	$0	$0	$0
Subtotal – Affordable Care Act	**$175,000**	**$0**	**$0**	**$0**
Appropriations/BA	**$804,816**	**$528,334**	**$530,371**	**$2,037**

[1] P.L. 111-148 extended this funding through FY 2015 and added five years of new appropriations beginning FY 2011. Budget authority has been comparably adjusted each year for the transfer of this program to the Administration on Aging (AoA) beginning in 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. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012.
[4] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U.

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, as well as extended existing programs.

Funding History

FY 2008	$763,834,000
FY 2009	$632,763,000
FY 2010	$621,763,000
FY 2011	$804,816,000
FY 2012	$528,334,000

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 & 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. By 2010, 37 States, who also received MIG funding, 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) is 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	NCE	$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 November 2011, Section 1011 provided funding to a total of 2,259 hospitals, 49,458 physicians, and 535 ambulance providers. Since inception of the program in May 2005 through November 2011, Section 1011 has disbursed $911 million in provider payments, in response to 1,347,811 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.

NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION

Program Description and Accomplishments

Section 6021(d) of the Deficit Reduction Act provided funding for the establishment of a National Clearinghouse for Long-Term Care (LTC) Information. The DRA authorized and appropriated $3 million for each of fiscal years 2006 through 2010 for this activity.

At least 70 percent of people over age 65 will require some LTC services at some point in their lives. Contrary to what many people believe, Medicare and private health insurance programs do not pay for the majority of LTC services that most people need; planning for LTC is essential. The LTC Clearinghouse serves the following functions:

- Educates consumers with respect to the availability and limitations of coverage for LTC under the Medicaid program;
- Provides contact information for obtaining State-specific information on LTC coverage, including eligibility and estate recovery requirements under State Medicaid programs;
- Provides objective information to assist consumers with the decision-making process for determining whether to purchase LTC insurance or to pursue other private market alternatives for purchasing long-term care;
- Provides contact information for additional objective resources on planning for LTC needs; and
- Maintains a list of States with State LTC insurance partnerships under the Medicaid program that provide reciprocal recognition of LTC insurance policies issued under such partnerships.

The LTC Clearinghouse is managed by a collaborative workgroup from CMS, the Assistant Secretary for Planning and Evaluation (ASPE) within HHS, and the Administration on Aging (AoA). These federal entities are working with individual States to offer a consistent message about planning ahead for long-term care. The LTC Clearinghouse was established as provided in the legislation, and its target audience is consumers from age 45-65 within the existing participating States. The two major components of the National Clearinghouse for LTC Information are the “Own Your Future” LTC Awareness Campaign and a national website.

“Own Your Future” campaign update: Starting as a demonstration project in January 2005 in five States, the “Own Your Future” campaign is an aggressive education and outreach effort designed to promote LTC planning. As of May 2010, it has expanded to 21 States and the District of Columbia. The participants include: Arkansas, Colorado, Georgia, Idaho, Iowa, Kansas, Kentucky, Maryland, Michigan, Missouri, Nebraska, Nevada, New Jersey, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Virginia, Washington and the District of Columbia. The campaign consists of three core components:

1. Direct mail supported by the State Governor in which a letter discussing the importance of LTC planning, signed by the Governor, is sent to every household with members between 45-65 years of age. The letter includes a tri-fold brochure which provides additional information about long-term care planning, and encourages each target household to order an “Own Your Future” Planning Kit for LTC. The Planning Kit is available at no cost to the consumer.

2. State-specific information about local planning resources and information on LTC services. This is incorporated into the Planning Kit for LTC. HHS covers the cost of producing and collating these materials.

3. A Governor's press conference to launch the campaign. The press conference is held concurrently with the mailing of the Governor's letter. The purpose of the press conference is to generate local media interest in the Campaign and reinforce the message being sent to targeted households through the direct mail effort.

Additionally, States conduct complementary outreach activities, including placement of a television and radio public service announcement that HHS produced.

Website: The National Clearinghouse for LTC Information website (located at http://www.longtermcare.gov) was launched in the fall of 2006. The website supports the "Own Your Future" campaign and contains educational information regarding LTC and provides a number of resources to assist in the planning process including interactive tools such as a savings calculator and contact information for a range of programs and services. The website also provides information about Medicare's limited coverage of, and payment for, LTC services and supports.

Budget Overview

The DRA authorized and appropriated $3 million for each of fiscal years 2006 through 2010 for the establishment of a national clearinghouse for LTC information. Section 8002(d) of the Affordable Care Act amends section 6021(d) of the DRA by extending the funding for the National Clearinghouse. Through the Affordable Care Act there is authorized and appropriated $3 million for each of fiscal years 2011 through 2015. Beginning in FY 2012, the funds associated with the program are being apportioned by the Administration on Aging to continue the work on this program. There is no new appropriation for this activity in the State Grants and Demonstrations account.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Program Description and Accomplishments

Section 6043 of the DRA enacted the 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. As of May 2011, all but two Emergency Room Grants ended on April 14, 2011 with their final report due by July 14, 2011. CMS is currently working with several States who have needed extra time to submit their final reports. The two States receiving additional extensions are North Carolina and Pennsylvania. During April 2011, the States of North Carolina and Pennsylvania requested and were granted a third, no-cost extension for a period of 9 months. For both States, the grant ended on January 14, 2012, with the final report due by April 14, 2012.

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. The table below details the two States who received a no-cost-extension.

State	Fund Amount Extended	End-Date
North Carolina	$306,150.00	January 14, 2012
Pennsylvania	$726,450.00	January 14, 2012
Total Funds Extended	**$1,032,600.00**	

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 the mentally retarded, 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 is evaluating the cost effectiveness of the provision of home and community-based waiver services verses institutional services in a PRTF, and also is evaluating whether children and youth in this demonstration will maintain and/or improve their functional level in home and community-based services.

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 on the following page 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 the amended their 1915c 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 2011. 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 the 20 non-participating States was released July 26, 2010. Thirteen States and one Territory (American Samoa) submitted applications on January 7, 2011, and CMS awarded thirteen new grants on February 28, 2011. The 2011 grantees are: Rhode Island, Maine, Massachusetts, Vermont, Tennessee, Mississippi, Florida, New Mexico, Colorado, Nevada, Idaho, Minnesota, and West Virginia.

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 May 2011, CMS committed $802,951,461 in grants to 43 States and the District of Columbia, including $45,497,134 to 13 new grantees. The first 30 grantees have transitioned over 17,000 individuals as of June 2011. The 43 participating States and DC have proposed to transition an additional 47,000 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 Grants					
State	*Award/ Commitment* (from initial award letter)	*Grant Funded Increased FMAP projections based on the Recovery Act increase*	*Total Award Commitment with increased FMAP for nine quarters*	*FY 2007-2011 Supplemental Award Amount*	*Balance of Award/ Commitment* (Award/Commitment minus Cumulative Award Total)
AR	$20,923,775	$633,000	$21,556,775	$12,778,106	$8,778,669
CA	$130,387,500	$3,944,569	$134,332,069	$41,595,564	$92,736,505
CO	$22,189,486	$0	$22,189,486	$2,000,000	$20,189,486
CT	$24,207,383	$732,338	$24,939,721	$22,651,979	$2,287,742
DC	$21,593,213	$162,518	$21,755,731	$21,593,213	$162,518
DE	$26,377,620	$797,993	$27,175,613	$2,384,727	$24,790,886
FL	$35,748,853	$0	$35,748,853	$4,203,999	$31,544,854
GA	$34,091,671	$1,031,364	$35,123,035	$30,294,298	$4,828,737
HI	$10,263,736	$310,505	$10,574,241	$3,727,968	$6,846,273
ID	$6,456,560	$0	$6,456,560	$695,206	$5,761,354
IL	$55,703,078	$1,685,166	$57,388,244	$14,902,910	$42,485,334
IN	$21,047,402	$636,740	$21,684,142	$19,135,222	$2,548,920
IA	$50,965,815	$1,541,851	$52,507,666	$15,275,858	$37,231,808
KS	$36,787,453	$1,112,918	$37,900,371	$17,686,555	$20,213,816
KY	$49,831,580	$1,507,538	$51,339,118	$25,708,586	$25,630,532
LA	$30,963,664	$936,733	$31,900,397	$12,842,198	$19,058,199
ME	$7,151,735	$0	$7,151,735	$699,970	$6,451,765
MD	$67,155,856	$2,031,643	$69,187,499	$59,212,377	$9,975,122
MA	$110,000,000	$0	$110,000,000	$13,486,888	$96,513,112
MI	$67,834,348	$2,052,169	$69,886,517	$27,931,016	$41,955,501
MN	$187,412,620	$0	$187,412,620	$13,421,736	$173,990,884
MS	$37,076,814	$0	$37,076,814	$1,341,394	$35,735,420
MO	$23,534,949	$535,230	$24,070,179	$23,534,949	$535,230
NE	$27,538,984	$833,128	$28,372,112	$8,979,536	$19,392,576
NV	$7,276,402	$0	$7,276,402	$800,000	$6,476,402
NH	$11,406,499	$345,077	$11,751,576	$4,816,565	$6,935,011
NJ	$30,300,000	$916,656	$31,216,656	$13,923,088	$17,293,568
NM	$23,724,360	$0	$23,724,360	$595,839	$23,128,521
NY	$82,636,864	$2,499,985	$85,136,849	$25,405,339	$59,731,510
NC	$16,897,391	$511,191	$17,408,582	$11,052,448	$6,356,134
ND	$8,945,209	$270,616	$9,215,825	$6,592,941	$2,622,884

Money Follows the Person Rebalancing Demonstration Grants					
State	*Award/ Commitment* (from initial award letter)	*Grant Funded Increased FMAP projections based on the Recovery Act increase*	*Total Award Commitment with increased FMAP for nine quarters*	*FY 2007-2011 Supplemental Award Amount*	*Balance of Award/ Commitment* (Award/Commitment minus Cumulative Award Total)
OH	$100,645,125	$3,044,783	$103,689,908	$71,380,946	$32,308,962
OK	$41,805,358	$1,264,723	$43,070,081	$17,637,095	$25,432,986
OR	$114,727,864	$3,470,823	$118,198,687	$40,269,191	$77,929,496
PA	$98,196,439	$2,970,704	$101,167,143	$21,339,337	$79,827,806
RI	$24,570,450	$0	$24,570,450	$2,503,021	$22,067,429
SC	$5,768,496	$174,512	$5,943,008	$976,997	$4,966,011
TN	$119,624,597	$0	$119,624,597	$2,357,733	$117,266,864
TX	$142,700,353	$4,317,065	$147,017,418	$123,393,873	$23,623,545
VT	$17,963,059	$0	$17,963,059	$2,123,975	$15,839,084
VA	$28,626,136	$866,017	$29,492,153	$14,180,463	$15,311,690
WA	$35,610,164	$593,765	$36,203,929	$35,610,164	$593,765
WV	$22,220,423	$0	$22,220,423	$1,267,373	$20,953,050
WI	$56,282,998	$1,702,710	$57,985,708	$17,314,847	$40,670,861
Totals	$2,095,172,282	$43,434,030	$2,138,606,312	$809,625,490	$1,328,980,822

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. The final reports for these projects were due on or before June 30, 2011. CMS is currently working with a few States that needed additional time to submit their final reports.

The following States requested and received a third no-cost-extension: Mississippi, Missouri, North Carolina and Rhode Island. The goal for the extension period for all four States is to provide the grantees the opportunity to fully implement the innovative methods, multiple electronic systems that had been under development and allow sufficient time to complete a comprehensive final report. Additionally, extension of this grant will maximize the investment of State and Federal dollars by increasing the effectiveness of assessment and follow-up needed to improve the quality of life for these medically needy individuals.

The table below summarizes the States receiving a third no-cost extension.

State	Funding Amount Extended	End-date of the NCE
Mississippi #3	$810,000.00	03/31/2012
Missouri	$609,308.22	01/31/2012
North Carolina	$1,019,550	03/31/2012
Rhode Island	$995,387.00	03/31/2012
Total Funding	**$3,434,245.20**	

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 (MIP) in Section 1936 of the Social Security Act (SSA). With the passage of this legislation, Congress provided CMS with the much needed opportunity to raise awareness of Medicaid program integrity by increasing resources to help CMS in its efforts to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program. Specifically, the legislation provided CMS with resources to establish the MIP, CMS' first national strategy to detect and prevent Medicaid fraud and abuse. The statute 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 review provider claims to determine if fraud and abuse had occurred or has the potential to occur; audit claims; identify overpayments; and conduct provider education. These contractors 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.

Building upon the accomplishments of the first several years, CMS continues to make significant progress in developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. FY 2011 marked the third full year of the national Medicaid provider audit program. Through FY 2011, 1,663 audits were underway in 44 of the States and the Medicaid Integrity Group (MIG) efforts identified an estimated $15.2 million in overpayments through both direct provider audits and automated review of State claims. To fulfill the requirement in Section 1936 of the SSA to provide support and assistance to State Medicaid program integrity efforts, the MIG has been conducting triennial comprehensive reviews of State program integrity operations, identifying problems that warranted improvement or correction in State operations. In the reviews the MIG also highlighted commendable State practices. Through FY 2011, the MIG has reviewed every State (including Puerto Rico, the District of Columbia, and Guam) at least once, with 26 States having been reviewed twice. Eighteen (18) have been scheduled for review in FY

2012 and an additional 17 reviews are being planned for FY 2013. The MIG hosted conference calls to discuss program integrity issues and best practices, and issued guidance on policy/regulatory issues. The MIG continues to build on the data strategy and information technology infrastructure of the MIP in conjuction with the Center for Medicaid and CHIP Services. The MIG continues to work with a number of States to conduct projects on cross-border, regional, and national issues. The continuing education of State program integrity employees through the Medicaid Integrity Institute (MII) remains one of the MIG's most significant achievements. In its four years of existence, the MII has offered numerous courses and provided training to over 2,400 State employees at no cost to the States. As of FY 2011, all States (including Puerto Rico and the District of Columbia) have participated in classes at the MII. States continue to report immediate value and benefit from the training offered at the MII. In addition, FY 2011 marked the second full year contractors have been in place to develop materials to conduct provider education and training on payment integrity, utilization, and quality of care issues, and to highlight the prevention of fraud, waste, and abuse in the Medicaid program.

CMS continues to evaluate the effectiveness of the MIP in the context of significant changes that have occurred since it was created and is developing an enhanced approach to partnering with State programs based on what we have learned during the program's initial five years. The next Comprehensive Medicaid Integrity Plan (CMIP), covering FY 2013-2017 will describe that approach.

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 $77.2 million, and the appropriation for FY 2012 is $78.3 million. Funds appropriated remain available until expended.

Performance Measurement

To assure the implementation and success of the Medicaid Integrity Program, CMS has been measuring the percentage return on investment (ROI) of the Medicaid Integrity Program. As the Medicaid Integrity Program has evolved over the past three years, it has become apparent that our ability to identify overpayments is not, and should not be, limited to the activities of our Medicaid Integrity Contractors. Although we will discontinue this measure after FY 2012, we are considering new measures that better reflect the resources invested through the Medicaid Integrity Program. In addition, we continue to monitor the Payment Error Rate Measurement (PERM) for Medicaid and CHIP. See the HCFAC chapter for further discussion of these measures.

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. 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.

Outreach and Enrollment Grants

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.

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.

Outreach to Indian Children

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. A total of 41 Grants were awarded on April 15, 2010.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Below is a chart of the grant awards by program and State.

Indian Outreach Grant Awards by State

Program	State	Funding
Eastern Aleutian Tribes, Inc.	Alaska	$109,675
Kodiak Area Native Association	Alaska	$192,255
Southcentral Foundation	Alaska	$94,667
Tucson Area Office Indian Health Service	Arizona	$300,000

Program	State	Funding
Native American Community Health Center, Inc.	Arizona	$149,441
Lake County Tribal Health Consortium	California	$132,139
Indian Health Council, Inc.	California	$300,000
Native American Health Center, Inc.	California	$300,000
Shingle Springs Band of Miwok Indians	California	$140,624
United American Indian Involvement	California	$300,000
Hunter Health Clinic, Inc.	Kansas	$300,000
Wampanoag Tribe of Gay Head (Aquinnah)	Massachusetts	$261,026
American Indian Health and Family Services of SE Michigan	Michigan	$300,000
Leech Lake Band of Ojibwe	Minnesota	$300,000
Blackfeet Tribe, Po'Ka Project	Montana	$300,000
Indian Health Board of Billings, Inc.	Montana	$300,000
Cherokee Indian Hospital Foundation	North Carolina	$300,000
Northern Ponca Tribe of Nebraska	Nebraska	$288,404
Pueblo of San Felipe	New Mexico	$129,263
Reno-Sparks Indian Colony	Nevada	$233,293

Program	State	Funding
Washoe Tribe of Nevada and California	Nevada	$201,219
Seneca Nation of Indians	New York	$280,994
Cherokee Nation	Oklahoma	$300,000
Indian Health Care Resource Center of Tulsa, Inc.	Oklahoma	$300,000
Northeastern Tribal Health System	Oklahoma	$290,790
Choctaw Nation of Oklahoma	Oklahoma	$300,000
Absentee Shawnee Tribe of Oklahoma	Oklahoma	$149,163
Native American Rehabilitation Association of the Northwest	Oregon	$278,579
Warm Springs Health and Wellness Center	Oregon	$262,855
Oglala Sioux Tribe	South Dakota	$300,000
Flandreau Santee Sioux Tribe	South Dakota	$300,000
Rosebud Sioux Tribe	South Dakota	$300,000
Utah Navajo Health System, Inc.	Utah	$300,000
Indian Walk In Center, Inc.	Utah	$299,684
Indian Health Service, Uintah & Ouray Clinic	Utah	$255,527
Lummi Nation	Washington	$200,565

Program	State	Funding
Makah Indian Tribe	Washington	$169,174
Seattle Indian Health Board	Washington	$299,954
Colville Confederated Tribe	Washington	$120,000
Yakama Indian Health Center	Washington	$172,258
Bad River Band of Lake Superior Tribe of Chippewa Indians	Wisconsin	$90,556

National Enrollment Campaign

The statute set-aside ten 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 technical assistance to States, grantees, and other groups to help enroll more children in Medicaid and CHIP. The campaign was highlighted this past year through the second National Children's Health Insurance Summit held November 1st-3rd in Chicago. More than 425 summit participants attended and benefited from hands-on training, breakout sessions with subject matter experts, and Learned about using new technology to help enroll children in CHIP and Medicaid.

CMS continues to provide additional technical assistance to the grantees and States through a variety of strategies including on-going webinars, supplemental toolkit materials, and the use of social media. Currently Tweets are sent out on an ongoing basis along with updates distributed through a new Facebook page highlighting CHIP happenings all over the country; social media gives the grantees a medium to connect to others looking to help enroll kids. One of CMS's most exciting developments is the launch of the first CMS managed mobile optimized website for insurekidsnow.gov. This site includes a geo-tracking feature which provides information though GPS technology. Usability and analytics are set up on the mobile site to track usage and provide data around number of page views for the site.

An additional element for the national campaign was around AI/AN outreach efforts. CMS launched a CHIP/Medicaid promotional television and radio spot featuring Olympian Billy Mills. These spots were used throughout the AI/AN target markets during various tribal events or conferences as a way to promote CHIP and Medicaid. CMS also coordinated CHIP and Medicaid enrollment events in target cities with large AI/AN populations; enrollments were completed on location through Wi-Fi internet connections.

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 an $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 frunds on August 18, 2011 and work on the National Enrollment Campaign is ongoing.

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).

The CHIPRA transition grants will provide funding to States that operate a separate or combination CHIP 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. Currently, the four grantees are: California, Michigan, Colorado, and Pennsylvania, representing $1,934,345 of the appropriated funds. The remaining $3,065,655 in grant funding is available until expended. CMS released a second solicitation on January 11, 2012 for another round of these transition grants, with a submission date of March 12, 2012. CMS expects to announce the second round of grantees in April 2012.

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 condition, defined as expressions of suicidal or homicidal thoughts or gestures and 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 expects to finalize the selection of States for the demonstration by January 27, 2012 with an announcement of States to be invited for participation in the Medicaid Emergency Psychiatric Demonstration by February 4, 2012.

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.

INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID

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 applications were accepted through May 2, 2011. Application panels were held during early June 2011 and the grants were awarded to New York, Texas, Hawaii, Minnesota, New Hampshire, California, Montana, Nevada, Wisconsin, and Connecticut on September 13, 2011. 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 will be awarded in March or April 2012.

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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Clinical Laboratory Improvement Amendments of 1988

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
BA	$43,000,000	$43,000,000	$43,000,000
FTEs	69	84	84

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

FY 2011 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 19,033 laboratories during the FY 2011-2012 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, 224,083 laboratories are registered with the CLIA program. Approximately 186,820 or 83.4 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 114,127, or 50.9 percent, of the laboratories registered under the CLIA program. Approximately 95,373 or 81.8 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of 3.5 percent for the FY 2011-2012 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 2013 CLIA budget request for CMS is $43.0 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 2011-2012 cycle include surveys of 19,033 non-accredited laboratories, State validation surveys of 795 accredited laboratories, and approximately 1,387 follow-up surveys and complaint investigations.

Performance Measurement

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. The FY 2013 target is to increase the number of States that that are in full compliance with CLIA by 2 percent over the FY 2012 actual.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
CLIA2: Increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA provisions.	FY 2011 32% Historical actual	+2% over FY 2011	+2% over FY 2012	+2%

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Quality Improvement Organizations

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
BA	$1,019,000,000	$827,000,000	$528,000,000

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 focus on Clinical Quality Improvement and Value Based Purchasing.

The 10th SOW major themes are: and Beneficiary-centered Care, Improve Individual Patient Care, Integrated Care for Populations, and Improving Health for Populations and Communities.

Beneficiary-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-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. The 10th SOW estimates that QIOs will review substantially more cases. This includes 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 for which there is evidence of how to improve and a record of QIO success in improving safety. This work will be predicated on the reduction or elimination of patient harm that is more likely a result of the patient's interaction with the health care system than an attendant disease process. This theme will increase the value of health care services as it produces higher quality care for Medicare beneficiaries. QIO activities for this theme will focus on five topics: Improving inpatient surgical safety, reducing rates of nosocomial methicillin-resistant Staphylococcus aureus (MRSA) infections, reducing health care acquired conditions by 40 percent, improving drug safety, reducing rates of pressure ulcers, and reducing rates of use of physical restraints. QIOs will work with providers to achieve the following: fewer restraints, fewer patients with pressure ulcers in nursing homes and hospitals, fewer MRSA infections, and fewer postoperative deaths due to surgical site infection, venous thromboembolic events, or perioperative myocardial infarction.

Work in the Integrated Care for Populations and Communities theme will improve care transitions by striving, among other goals, to reduce 30-day hospital readmissions by 20 percent over three years. Collaborations among QIOs, community coalitions, and professional groups, utilizing chartered value exchanges, publication of performance, and value-based purchasing will achieve what none of the parties alone could accomplish.

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. Integrated Care for Populations work will impact health care programs, products, polices, practices, community norms, and linkages and will produce higher quality of care for Medicare beneficiaries and significant 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 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

Under the QIO program, CMS maintains contracts with independent community-based organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. In addition, through the QIOs and other State and local partners, CMS collaborates with health care providers and suppliers to promote improved health status, including quality improvement in nursing homes.

We believe the improved oversight of the program and increased competition for sub national projects are providing improved outcomes and value. CMS will continue to build on the success from the new management approach.

Budget Overview

FY 2012 is the first full fiscal year the QIO 10th SOW will be fully operational. $827.0 million has been authorized to support the QIO 10th SOW during FY 2012. $528.0 million is the estimated amount determined to successfully fund QIO 10th SOW activities during FY 2013.

Starting in FY 2012 and continuing, CMS will utilize existing authority to pay for staff working on QIO activities out of the QIO account in place of the Program Management account. This is consistent with CMS efforts to ensure FTEs are funded out of appropriate and associated program accounts for all programs. This change in the way CMS pays for QIO FTEs aligns the QIO program with other recently implemented programs that pay for administrative costs out of their direct appropriations. This allows CMS to charge all costs incurred by a program to the funding source that is designated for that purpose.

Performance Measurement

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend annual vaccination against influenza. The FY 2010 influenza result of 76.5 percent, for beneficiaries residing in a long term care facility, did not exceed the FY 2010 target of 81.8 percent, and is a 6.36 percent decline from the FY 2009 result of 84.2 percent. There is a national decline of influenza immunization rates seen from 2008 to 2010 among the Medicare Current Beneficiary Survey (MCBS) Facility, MCBS Community, and the CDC's Behavior Risk Factor Surveillance System data. As a result of the QIO 10th Statement of Work (SOW) Improving Health for Populations and Communities Aim, QIOs will provide technical assistance for eligible professionals to increase Medicare

beneficiaries' understanding and utilization of the influenza immunization. Because we did not achieve our FY 2010 target, FY 2012 and FY 2013 targets are set at 84 percent and 84.8 percent, respectively.

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. The CY 2010 target of 87 percent for HbA1c was exceeded at a rate of 87.68 percent. The CY 2010 target of 82 percent for cholesterol (LDL) testing was met at a rate of 82 percent. We set the FY 2013 targets for HbA1c and cholesterol at 90 percent and 85 percent, respectively, and we expect to continue to see an increase in these rates. The 10th SOW includes efforts to improve LDL testing as a part of the Cardiac Prevention theme, and CMS plans to develop a Special Project to address Hemoglobin A1c within the next six months.

According to the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs), 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 surgical site infection 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 rehospitalization for treatment of infections. We surpassed our FY 2010 target of 92 percent at a rate of 97 percent, and as a result, we increased our FY 2012 target to 98 percent, and set our FY 2013 target at 98.5 percent. To achieve our targets, we have continued to emphasize the performance measures of Surgical Care Improvement Program Infection in the Improve Individual Patient Care Aim of the QIO 10th SOW. CMS uses the performance measures for continued accountability through public reporting (Hospital IQR), and these measures will be integrated into the hospital value-based purchasing program established by section 3001 of the Affordable Care Act beginning in 2013.

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. Of the vascular access options, an AVF is generally the best access. An increased rate of AVF access would improve quality of life for patients by improving adequacy of dialysis and decreasing emergent treatment of and hospitalizations related to complications and failures of grafts and catheters. Additionally, it is anticipated that the ESRD survival rate would improve because the complications of grafts and catheters can be fatal. The prevalent AVF FY 2011 rate was 59.8 percent, which exceeds the target by 1.8 percent and is a 3 percent increase in one year. Based on these results, the targets for FY 2012 and FY 2013 are set at to 60.5 percent and 61 percent, respectively.

The 9th SOW ended July 31, 2011. It represented a change from previous QIO contracts since it held all QIOs accountable for meeting specific, predefined performance targets under four major themes: Care Transitions, Patient Safety, Prevention and Beneficiary Protection. CMS was successful in improving oversight by conducting routine quarterly monitoring of the metrics, and requesting immediate correction of identified problems. CMS conducted formal evaluations were conducted at the 18th and 28th months of the contract, and the QIOs met or exceeded targets for both evaluations. The 10th SOW began on August 1, 2011. Performance targets are

determined under the following four categories: Improve Health for Populations and Communities (formerly Prevention), Improve Individual Patient Care (formerly Patient Safety), Integrate Care for Populations and Communities (formerly Care Transitions), and Beneficiary and Family Centered Care (formerly Beneficiary Protection).

Outcomes and Outputs Table

Measure	1 Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
QIO1: Increase influenza immunization (nursing home subpopulation)	FY 2010: 76.5% Target: 81.8% (Target Not Met)	84%	84.8%	+0.8
QIO3.1: Increase hemoglobin A1c (HbA1c) testing rate	FY 2010: 87.68% Target: 87% (Target Exceeded)	89.5%	90%	+0.5
QIO3.2: Increase cholesterol (LDL) testing rate	FY 2010: 82% Target: 82% (Target Met)	84.1%	85%	+0.9
QIO4: Increase percentage of timely antibiotic administration	FY 2010: 97% Target: 92% (Target Exceeded)	98%	98.5%	+0.5
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
QIO6.3: Prevention Patient Safety	Prevention FY 2011: 92% of the QIOs met all performance targets at the 28th month evaluation (Target Exceeded)	See QIO6.5 (Improve Health for Populations and Communities)	See QIO6.5 (Improve Health for Populations and Communities)	N/A

Measure	1 Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
Care Transitions	Patient Safety FY 2011: 93% of the QIOs met all performance targets at the 28th month evaluation (Target Exceeded)	See QIO6.5 (Improve Individual Patient Care)	See QIO6.5 (Improve Individual Patient Care)	N/A
	Care Transitions FY 2011: 86% of the QIOs met all performance targets at the 28th month evaluation (Target Exceeded)	See QIO6.5 (Integrate Care for Populations and Communities)	See QIO6.5 (Integrate Care for Populations and Communities)	N/A
QIO6.4: Beneficiary Protection	FY 2011: 94% of the QIOs met the minimum performance criteria at the 28th month evaluation (Target Exceeded)	See QIO6.6 (Beneficiary and Family Centered Care)	See QIO6.6 (Beneficiary and Family Centered Care)	N/A
QIO6.5: Improve Health for Populations and Communities Improve Individual Patient Care	New for the 10th SOW	Improve Health for Populations and Communities - 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	Improve Health for Populations and Communities - 100% of the QIOs will populate the DDST Quality Data reporting system with data that demonstrates provider assistance on EHR implementation	N/A

Measure	1 Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
Integrate Care for Populations and Communities	New for the 10th SOW	Improve Individual Patient Care - 100% of the recruitment goals by the 12th month (quarter 4)	Improve Individual Patient Care - 80% of the QIOs will meet expectations toward the 18th month targets for Urinary Catheter Utilization Rates, central line associated bloodstream infections, catheter associated urinary tract infections, clostridium difficile, pressure ulcer prevention treatment practices, and reduction of adverse drug events	N/A
	New for the 10th SOW	Integrate Care for Populations and Communities - 80% of the QIOs will meet the 12th month (quarter 4) 1-4 (interim measure) performance expectations	Integrate Care for Populations and Communities - The QIOs will show that 25% of communities are demonstrating improvement based on 4 time series graphs showing improvement towards all targets	N/A
QIO6.6: Beneficiary and Family Centered Care	New for the 10th SOW	80% of the QIOs will meet the 12th month (quarter 4) performance expectations	80% of the QIOs will meet the 18th month (quarter 6) performance expectations	N/A

Pre-Existing Condition Insurance Plan Program

(dollars in thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Budget Authority	-	-	-	-
Gross Outlays	429,000	1,637,000	2,146,000	509,000
Offsetting Collections	(27,000)	(72,000)	(91,000)	(19,000)
Total Net Outlays	402,000	1,565,000	2,055,000	490,000

Authorizing Legislation- Patient Protection and Affordable Care Act, Public Law 111-148, Section 1101

Allocation Method – Contract Application

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 remain in place until the Affordable Insurance Exchanges become operational on January 1, 2014 and provide more options for individuals with pre-existing conditions and when insurance companies can no longer deny coverage or charge higher premiums for individuals with 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. CMS established allocation ceilings for the PCIP program in each State for the life of the program. CMS is also required to establish oversight procedures, including appeals procedures and protections against fraud, waste, and abuse.

PCIP enrollment more than doubled since spring 2011 with close to 45,000 enrollees as of November 30, 2011. Initial data shows that the enrollees in the PCIP program have higher medical claims costs and utilization, on average, compared to enrollees in the State High-Risk Pools.

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 $6,050).

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).

State-administered PCIP Programs

CMS 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.

Federally-administered PCIP Program

For those States choosing not to operate their own PCIP program, CMS 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.

CMS 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 2013, CMS will continue paying claims and administrative costs that are in excess of the premiums collected from enrollees in the program. CMS will also begin to prepare to transition enrollees to the Affordable Insurance Exchanges during the first open enrollment period, beginning October 1, 2013, for coverage beginning January 1, 2014, when insurers can no longer deny coverage or charge higher premiums for individuals with pre-existing conditions. CMS will continue to monitor and audit PCIP contractors and work with PCIP contractors to use anti-fraud detection methods related to providers and enrollees, similar to those employed in their commercial products.

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Consumer Operated and Oriented Plan Program
(dollars in Thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Appropriation (rescission)	(2,200,000)	(400,000)	-	400,000
Total Loans	-	5,625,000	1,625,000	(4,000,000)
Related Payment to the Financing Account	-	2,430,698	699,491	(1,731,207)
Total Obligations	2,821	2,446,098	714,191	(1,731,907)

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, and the Consolidated Appropriations Act, 2012, Public Law 112-74, Division F, Title V, section 524.

Program Description and Accomplishments

The Affordable Care Act requires 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 markets. The program provides 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 is 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 Federal Advisory Committee was established as required by statute for the purpose of making recommendations to the Secretary on the award of loans. The Committee convened four times between January and April 2011 and issued a final report to the Secretary with recommendations for establishing the program on April 15, 2011. A Request for Comments on questions derived from the statute was issued on February 2, 2011, and comments were received on March 4, 2011. The CO-OP Program issued a proposed rule on governing the award of loans and the operation of the CO-OP program on July 20, 2011, and issued the Final Rule on December 13, 2011.

Funding Opportunity Announcement and Application Process

The CO-OP Program published a Funding Opportunity Announcement on July 28, 2011, amended on September 16th and December 9, 2011, to solicit applications from organizations seeking to become CO-OP's. Applications are accepted on a quarterly basis, with the first round received on October 17, 2011, and the second round received January 3, 2012. Quarterly applications may be accepted through December 31, 2012, as long as funding is available.

Funding History

FY 2010	$6,000,000,000
FY 2011	$-2,200,000,000
FY 2012	$-400,000,000

Budget Overview

Award of CO-OP Loans FY 2012-2013

CMS Start-up and Solvency loans are made to organizations to encourage the establishment of member operated, qualified non-profit health insurance issuers within each State. The program contracted externally for expert objective reviewers of loan applications who provide the CMS Selection Committee with recommendations on awarding loans to applicants, and provide technical assistance to both applicants and program staff. Loan agreements will establish the terms and conditions of the loans and their repayment. CMS will make awards to qualifying entities beginning in the second quarter of FY 2012 and continue to accept applications and award loans throughout FY 2012 and early FY 2013.

Loan Servicing and CO-OP Monitoring FY 2012-2013

During FY 2011 and early 2012, CMS established an infrastructure to support the awarding and monitoring of CO-OP funding. Beginning in FY 2012, loan disbursements will be scheduled based on the specific business plan of the CO-OP, and will be based upon results from monitoring and documentation of the CO-OP's completion of key milestones. CO-OP monitoring will include regular reporting and site visits, as well as technical assistance and increased oversight as required. During FY 2013, CMS will continue to actively monitor the loan portfolio and the development of the CO-OPs towards the goal of participating in the initial open enrollment of the Affordable Insurance Exchanges.

FY 2013 Loan Subsidy ($699.5 million)

CMS will continue to award loans to organizations to encourage the establishment of member operated, qualified non-profit health insurance issuers within each State.

FY 2013 Administrative Funding for CO-OP Program

The program will continue to contract for external review of applications and technical assistance to program contractors and will contract internally for IT systems to enable

application processing, establish loan servicing systems, and monitor performance. The program also will continue to provide technical assistance to the CO-OPs in preparation for health plan enrollment. The program will hire staff to provide program management, oversight of contractors, and ensure program integrity. CMS will continue to support program integrity by monitoring activities of recipient organizations, collecting documentation, conducting site visits, and engaging vendors for audits.

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Early Retiree Reinsurance Program

(dollars in thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Budget Authority	-	-	-	-
Outlays	$2,975,000	$1,973,000	$28,000	($1,945,000)

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.

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. ERRP has paid out nearly all of the appropriated funds to sponsors.

Funding History

FY 2010	$5,000,000,000

Budget Overview ($28 million)

In FY 2013, CMS will continue its program compliance, integrity, and audit work. This work will include ongoing audits of the validity of claims submitted and the use of program funds. Additionally, in FY 2013, if sponsors identify health care claims or price concession data that have been adjusted since submission to ERRP, they are required to submit corrected data to the program. These adjustments and corrections to claims and other data may result in sponsors being required to return funds to ERRP. If ERRP recoups any funds from program integrity related work, or through the submission of corrected data, ERRP will redistribute such funds as new reimbursement to additional sponsors with pending reimbursement requests, in the order approved requests were submitted.

Other program operations will include processing appeals, system maintenance, and technical support.

Affordable Insurance Exchange Grants

(dollars in thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Total Obligations	$478,373	$1,140,206	$867,785	-$272,421
Outlays	$24,113	$ 905,764	$ 1,086,705	+$180,941

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 Insurance Exchange Grants program provides Federal funding for implementation of Affordable Insurance Exchanges whether State-based, or for the work a State does as part of a Federally-facilitated Exchange. Exchanges will give 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 easier and more understandable and will provide individuals and small businesses with more options and greater control over their health insurance purchases.

The Affordable Care Act provides each State with the option to set up an Exchange, or to have the Federal government set-up an Exchange in that State. In general, Exchanges must facilitate the purchase of qualified health plans (QHPs), help small businesses enroll their employees in health insurance through a Small Business Health Options Plan (SHOP Exchange), and meet other requirements such as providing information to consumers and certifying QHPs.

Section 1311 of the ACA provides amounts necessary to enable the Secretary to award grants to States to support the State's role in establishing an Exchange (under any model) and allows for renewal of grants through January 1, 2015. States may continue to spend grants in 2015 and after for any additional costs related to establishing an Exchange, but Exchanges will be self-funded for ongoing maintenance, operation, and expansion costs. Territories that commit to establishing an Exchange may also receive grant funding.

CMS has used a phased approach to provide States with resources 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 of 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 have indicated an intent to establish an Exchange. In February of 2011, CMS awarded Early Innovator funding to six States and one consortium of States to develop Exchange IT systems that will serve as models for other States. This approach aims to reduce the need for each State to "reinvent the wheel" and aids States in Exchange establishment by accelerating the development of Exchange IT systems. Finally, in 2011, CMS made awards to 28 States and the District of Columbia for Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges. This funding opportunity provides States with financial support for activities related to the establishment of an Exchange, including the development of major business processes such as plan management, eligibility and enrollment, consumer outreach and education, and financial management. As of December 2011, examples of State progress include, but are not limited to:

- 46 States have begun background research; 43 have completed background research for their planning grant.
- 46 States have consulted with stakeholders; 42 have regular meetings or meetings underway;
- 17 States have authority to establish an Exchange.
- 21 States have developed a governance model; 14 have appointed a governing body; 10 have developed charters and bylaws.
- 43 States have begun their initial IT gap analysis; and of these 37 have completed that initial IT gap analysis; 17 have drafted business requirements.

Funding History (obligations)

FY 2010	$49,321,679
FY 2011	$478,373,712
FY 2012	TBD

* Section 1311(a) of the Affordable Care Act appropriated such sums as are necessary for the Secretary to award grants under this account, therefore, the amount obligated each fiscal year equals the total amount of resources available in that year.

Budget Overview ($1,087 million)

CMS expects to award additional establishment grants in FY 2012 to States that have not yet received funding through the establishment cooperative agreements, and those that currently have establishment funding. Overall estimates of spending in the Exchange grant program have increased since the FY 2012 President's Budget due to better estimates of the resources necessary to establish Exchanges at the State-level, as well as programmatic decisions that will allow more States to participate in Exchange development such as the Partnership Model proposed in the Exchange regulation titled, *Establishment of Exchanges and Qualified Health Plans [CMS-9989-P]*, published in July of 2011.

In accordance with the Exchange proposed rule, all Exchanges must begin open enrollment of consumers into plans by October 1, 2013 for coverage beginning January 1, 2014. States will continue intensive development, building, and testing of systems and business processes needed to establish Exchanges.

Funding from the Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges will enable States to undertake critical activities such as procuring contracts for information systems development and consultancy services, and perform the analysis necessary to ensure development of the Exchanges is on-track to begin full operations by January, 2014. Sample activities include:

- Further development, implementation, 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, and
    - Interfaces with other partners such as State Medicaid agencies;
- Developing advertising, marketing, and outreach campaigns;
- Analyzing and implementing key policy and operational processes;
- Ensuring capacities are in place to provide assistance to individuals and small businesses;
- Procuring vendor assistance to enroll 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.

Additionally, States will be encouraged to use grant funding to develop capacities to provide assistance to individuals and small businesses, as appropriate.

CMS will also use funding from the Affordable Insurance Exchange Grants account to fund administrative activities necessary to enable renewal of grants made to the States and Territories. 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. Additionally, funding will be used for contracts to provide technical assistance to States on Exchange business functions (e.g., eligibility, plan management) to help States use their grant funding to implement these programmatic components in line with Federal policy.

Performance Measurement

CMS has a measure to track its' progress towards setting up the Exchanges. 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 insurance through Exchanges will have the ability to enroll for coverage beginning in 2014.

The FY 2011 process measure tracked the completion of important implementation milestones in each of the 50 States and the District of Columbia. In FY 2011, there was stakeholder consultation performed in 45 States and the District of Columbia. Only five States have not yet engaged with the federal government around Exchanges. In cases in which States opt not, or are unable, to implement their own Exchanges, CMS will complete these milestones as part of establishing a Federally-facilitated Exchange in that State. CMS revised our measure and future targets to focus on the Federal role in supporting Exchange development. Please see Output and Outcomes table in Program Operations narrative for additional information.

Grants Table

	Planning Grants		Early Innovator Grants		Territory Prelim Est.		Establishment Level I		Establishment Level II		**Total**
AL	$1,000,000						$8,592,139				**$9,592,139**
AK											**$0**
AZ	$999,670						$29,877,427				**$30,877,097**
AR	$1,000,000										**$1,000,000**
CA	$1,000,000						$39,421,383				**$40,421,383**
CO	$999,987										**$999,987**
CT	$996,850						$6,687,933				**$7,684,783**
DE	$1,000,000						$3,400,096				**$4,400,096**
DC	$1,000,000						$8,200,716				**$9,200,716**
FL	$1,000,000	*									**$1,000,000**
GA	$1,000,000										**$1,000,000**
HI	$1,000,000						$14,440,144				**$15,440,144**
ID	$1,000,000						$20,376,556				**$21,376,556**
IL	$1,000,000						$5,128,454				**$6,128,454**
IN	$1,000,000						$6,895,126				**$7,895,126**
IA	$1,000,000						$7,753,662				**$8,753,662**
KS	$1,000,000		$31,537,465	*							**$32,537,465**
KY	$1,000,000						$7,670,803				**$8,670,803**
LA	$998,416	*									**$998,416**
ME	$1,000,000						$5,877,676				**$6,877,676**
MD	$999,227		$6,227,454				$27,186,749				**$34,413,430**
MA	$1,000,000		$35,591,333	†							**$36,591,333**
MI	$999,772						$9,849,305				**$10,849,077**
MN	$1,000,000						$4,168,071				**$5,168,071**
MS	$1,000,000						$20,143,618				**$21,143,618**
MO	$1,000,000						$20,865,716				**$21,865,716**
MT	$1,000,000										**$1,000,000**
NE	$1,000,000						$5,481,838				**$6,481,838**
NV	$1,000,000						$4,045,076				**$5,045,076**
NH	$1,000,000										**$1,000,000**
NJ	$1,000,000										**$1,000,000**
NM	$1,000,000						$34,279,483				**$35,279,483**
NY	$1,000,000		$27,431,432				$10,774,898				**$39,206,330**
NC	$1,000,000						$12,396,019				**$13,396,019**
ND	$1,000,000										**$1,000,000**
OH	$1,000,000										**$1,000,000**
OK	$1,000,000		$54,608,456	*							**$55,608,456**
OR	$1,000,000		$48,096,307				$8,969,600				**$58,065,907**
PA	$1,000,000										**$1,000,000**
RI	$1,000,000						$5,240,668		$58,515,871	¥	**$64,756,539**
SC	$1,000,000										**$1,000,000**
SD	$1,000,000										**$1,000,000**
TN	$1,000,000						$1,560,220				**$2,560,220**
TX	$1,000,000										**$1,000,000**
UT	$1,000,000										**$1,000,000**
VT	$1,000,000						$18,090,369				**$19,090,369**
VA	$1,000,000										**$1,000,000**
WA	$996,285						$22,942,671				**$23,938,956**
WV	$1,000,000						$9,667,694				**$10,667,694**
WI	$999,873		$38,058,074	*							**$39,057,947**
WY	$800,000										**$800,000**
Puerto Rico					$917,205						**$917,205**
Amer Sam					$1,000,000						**$1,000,000**
Guam					$1,000,000						**$1,000,000**
US Vir Isld					$1,000,000						**$1,000,000**
Total	$49,790,080		$241,550,521		$3,917,205		$379,984,110		$58,515,871		**$733,757,787**

* Governor subsequently stated that the grant would not be used.

† Massachusetts received a grant on behalf of a consortium of New England States.

¥ Level II Establishment

Health Insurance Rate Review Grants

(dollars in thousands)

	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013 +/- FY 2012
Budget Authority	-	-	-	-
Outlays	$12,000	$80,000	$80,000	$0

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 program of grants to States, the District of Columbia, and the U.S. territories to enhance the health insurance rate review process. The five-year grants program of $250 million began in fiscal year 2010. 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 justifications for such unreasonable rates that grantees must employ in their annual rate review processes under the grants.

FY 2010

Cycle I grants for FY 2010 were released on June 7, 2010. Applications were due on July 7, 2010. Following receipt of the applications, an objective review committee analyzed the submitted applications and awards were made 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. Five million of that was carried over to FY 2011. At the beginning of FY 2011, the total amount remaining from the original allocation was $204,000,000.

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. Similar to Cycle I, Cycle II grants will be used to further enhance a recipient's rate review process, building upon what they have already done with the Cycle I grants and working towards the continued improvement of an "effective rate review program" as outlined in Federal regulation. The Cycle II grant funding opportunity is designed to provide States with multiple opportunities to apply for funding (during Phase I or Phase II), depending on the status of their progress toward meeting the criteria for an effective rate review process.

In order to be eligible for and receive Cycle II, Phase I funding, a State must demonstrate that, as of the Cycle II, Phase I application due date, it either: (i) already meets the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle II, Phase I 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 meeting the milestones in its application that support the development or enhancement of an effective rate review program.

In addition to the Baseline Grant Award, two additional segments of funds are also available under the Cycle II, Phase I and Phase II grants. "*Workload"* funds are available to States based on population and the number of health insurance issuers in the State. While the proposed rate review regulation would 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.

Certain States will be eligible, and awarded both the "*Workload*" and the "*Performance*" funds. The "*Workload*" and "*Performance*" funds can be for a period of one, two, or three years, as stipulated in the Notice of Grant Award. States receiving the "*Workload*" or "*Performance*" funds will be required to use these funds in support of enhancing or developing an effective rate review program.

Funding History

FY 2010	$250,000,000

Budget Overview ($80 million)

CMS projects that $80 million will be drawn down in FY 2012 and an additional $80 million will be drawn down in FY 2013. The funding authorized in FY 2012 will continue to support the distribution of grants to States so that States, in collaboration with HHS, will continue to expand upon the rate review activities initiated in the first cycles of the grant program and develop robust processes for the review of "unreasonable" health insurance rates. Funding will be used by States, territories, and the District of Columbia to increase their capacity to conduct review and rate filings, publish rate filings, audit filers, educate consumers, and build infrastructure to advance CMS' goal of monitoring and reviewing health plan rate filings. The grant funding for improving States' process of reviewing proposed rate increases will improve 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 2011 Actual	FY 2012 Current Law	FY 2013 Estimate
BA	$10,000,000	$0	$0
Obligations	$95,000	$1,693,000	$1,362,000

Note: Figures in this chart represent Sec. 3021 funding.

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), works to transform the Medicare, Medicaid and CHIP programs to deliver better care, better health and reduced costs through improvements for CMS beneficiaries. The Center was created to test innovative payment and service delivery models that reduce Medicare and Medicaid costs while preserving or enhancing quality of care for beneficiaries. Further, The Innovation Center has statutory authority to expand successful models through rulemaking.

The Innovation Center is an integral part of CMS' efforts to transform itself from a claims payer in a fragmented care system into a health care partner, that is a major force for the continual improvement of health care for Medicare, Medicaid, and CHIP beneficiaries, and better value for our health care dollars. The CMS vision 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 will be spent efficiently, significantly reducing the rate of spending growth; and where clinical and delivery system best practices will be diffused rapidly. CMMI's strategic principles reflect a responsibility to create a business context to support the CMS vision, working with all parties to develop and spread knowledge in pursuit of better health, better care and lower costs for Medicare, Medicaid and CHIP beneficiaries.

Officially launched in November 2010, the Innovation Center communicates and consults with a wide array of partners and stakeholders. A continuous process of garnering ideas, developing support for Innovation Center initiatives, and disseminating information about new and upcoming programs is crucial to the success of the Center's work.

The Innovation Center's strategy for communicating with and engaging stakeholders has included extensive outreach to gather input, both through sessions with broader-audiences – including Open Door Forums and participation in conferences – and through listening sessions with targeted groups such as insurers, academic medical systems, Beacon Communities, and State Medicaid Directors. These sessions have covered a range of issues including bundled payments, improving perinatal outcomes, accountable care organizations, and care transitions. The Innovation Center has sought to proactively partner with professional societies, news media, and other organizations to spread knowledge about and enlist support for the three- part aim—better health care and better health at reduced cost through improvement. The Innovation Center has also sponsored

numerous events, including over 50 designed to raise awareness about the Partnership for Patients, and hosted the first-ever Care Innovations Summit in collaboration with The West Wireless Health Institute and Health Affairs that drew leaders in health care innovation from across the country. In addition, the Innovation Center has developed and expanded its online presence (http://innovations.cms.gov/).

The Innovation Center has established a process for open and collaborative model development, allowing it to capture new ideas for care and payment models though its website as well as through meetings and calls with stakeholders. As it synthesizes input from all of these sources, the Innovation Center has launched an initial portfolio of health care delivery and payment models for field tests and continues soliciting new suggestions and proposals. The Innovation Center's portfolio will continue to grow as compelling ideas surface and are developed.

CMMI has launched a number of projects in its first year of operation including:

Partnership for Patients: CMS has dedicated up to $1 billion in ACA funding to test models to reduce hospital-acquired conditions and improve transitions in care, including up to $500 million in Innovation Center funding. This public-private partnership supports the efforts of physicians, nurses and other community-based organizations to make care safer and better coordinate patients' transitions from hospitals to other settings. Through Hospital Engagement Contractors, the Innovation Center will support the dissemination of proven methods for dramatically reducing both harm caused in hospitals and preventable hospital readmissions. To date, just over 7,000 organizations—including more than 3,200 hospitals—have joined the Partnership for Patients and pledged to support its goals. If its goals are achieved, the partnership has the potential to save 60,000 lives and reduce millions of preventable injuries and complications in patient care over the next three years. In collaboration with Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and the Office of Assistant Secretary for Health, the Partnership for Patients has set two ambitious goals for all U.S. hospitals by 2013: 1) reduce preventable all-cause harm by 40 percent, and 2) reduce hospital readmissions by 20 percent. In December 2011, $218 million was awarded to 26 State, regional, national, or hospital system organizations to be Hospital Engagement Networks. As Hospital Engagement Networks, these organizations will help identify solutions already working to reduce healthcare acquired conditions, and work to spread them to other hospitals and health care providers.

Health Care Innovation Challenge: The Health Care Innovation Challenge will award up $1 billion in grants to applicants that can implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs. The objectives of this initiative are to engage a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field and that produce better care, better health, and reduced costs. Grants will go to innovators who can rapidly deploy care improvement models (within six months of award) and will particularly focus on workforce and infrastructure issues.

Pioneer Accountable Care Organizations (ACO): This is an alternative, but complementary model to the Medicare Shared Savings Program for 32 health care provider organizations agreeing to test a rapid transition to a population-based model of care, with a more aggressive transition than in the Shared Savings Program. Pioneer ACOs will be positioned

to rapidly demonstrate what can be achieved when Medicare fee-for-service beneficiaries receive highly coordinated care in a new payment model. The first performance year for the 32 Pioneer ACO began in January 2012. The Center also sponsored ACO Accelerated Development Learning Sessions for leaders of the emerging ACOs to share ideas and learn more about how to evolve into an effective ACO.

Advance Payment ACO Model: The Advance Payment Model is designed to provide support to certain ACOs, such as physician-based and rural ACOs whose ability to achieve the three-part aim would be improved with additional access to capital. Designed for organizations participating in the Medicare Shared Savings Program, the Advance Payment Model provides up-front payments to providers which they will repay through the shared savings they earn.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: This demonstration will evaluate the impact of advanced primary care practice on improving health, improving care, and reducing healthcare costs among Medicare beneficiaries served by FQHCs and assess the impact that additional support has on FQHCs' ability to transform their practices and be formally recognized as patient-centered medical homes. The Innovation Center selected 500 FQHCs for this demonstration in fall 2011.

State Demonstrations to Integrate Care for Dual Eligible Individuals: Fifteen States have been awarded design contracts to develop new ways to meet the needs of some of the nearly nine million Americans enrolled in both the Medicare and Medicaid programs – sometimes described as "dual eligibles." If successful, the State demonstrations will establish new methods of payment and care integration for some of Medicare and Medicaid's most vulnerable and most costly patients.

Financial Alignment Model Demonstrations: The Innovation Center and the Medicare-Medicaid Coordination Office are providing new opportunities for States to implement new care and payment systems to better coordinate care for Medicare-Medicaid enrollees. Thirty-eight States and the District of Columbia have expressed interest in pursuing either the capitated or managed fee-for-service financial alignment model proposed by CMS.

Reducing Preventable Hospitalizations among Nursing Facility Residents: The Innovation Center, in collaboration with the Medicare-Medicaid Coordination Office, is launching a new demonstration focused on reducing preventable inpatient hospitalizations among residents of nursing facilities.

Bundled Payments for Care Improvement: The Innovation Center will test multiple models for making episode-based (bundled) Medicare payments. Under the current FFS system, separate FFS payment 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.

Comprehensive Primary Care (CPC) initiative: A new CMS-led, multi-payer initiative fosters collaboration between public and private payers to strengthen primary care for all Americans. Primary care is critical to promoting health, improving care, and reducing overall system costs, but it has been historically under-funded and under-valued in the United

States health care system. Without a significant investment across multiple payers, independent health plans-- covering only their own members and offering support only for their segment of the total practice population-- cannot provide enough resources to transform entire primary care practices and make expanded services available to all patients served by those practices. The CPC initiative offers a way to break through this historical impasse by inviting payers to join with Medicare in investing in primary care in 5-7 selected localities across the country.

Innovation Advisors Program: Crucial to the efforts of transforming the healthcare system is supporting individuals who can test, implement and refine new models to drive delivery system reform. The Innovation Center seeks to deepen the capacity for transformation by creating a network of experts in improving the delivery system for Medicare, Medicaid and CHIP beneficiaries. These individuals will support the Innovation Center in testing new models of care delivery; utilize their knowledge and skills in their home organization or area in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement; work with other local organizations or groups in driving delivery system reform; develop new ideas or innovations for possible testing of diffusion by the Innovation Center; and build durable skills in system improvement throughout their area or region.

CMS has estimated that the models below, a cross-section of CMMI activity, could save over $3 billion in Medicare and Medicaid costs over five years (FY 2012-2016). Additional savings to be achieved from other initiatives have not yet been fully quantified.

- Pioneer ACO
- Advanced Payment ACO Model
- Reducing Preventable Hospitalizations among Nursing Facility Residents
- Bundled Payments for Care Improvement
- Comprehensive Primary Care Initiative

Funding History (Budget Authority)

FY 2010	$5,000,000
FY 2011* Available:	$10,000,000,000

* Available for activities initiated through FY 2019

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 Innovation Center expects to launch additional new projects each year.

Testing models generally requires the following operational activities:

- Data Sharing;
- Implementation Assistance;

- Learning & Diffusion;
- Payment Administration and/or Reconciliation; and
- 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 to facilitate the testing of models and the rapid and widespread diffusion of best practices as well as validated service delivery and payment models;
- Setting up a process for harvesting best practice models and identifying need gaps for designing new innovations in care delivery improvement and sustainability;
- Planning, design, and business process requirements assessment for an information systems environment;
- Project management support; and
- Production of the Report to Congress required by law.

Finally, appropriated funding is used for Innovation Center administrative costs, including personnel and benefits, overhead, inter-agency agreements, and other routine operating costs.

Performance Metrics

Innovation Center performance metrics, including actual data for FY2011 and targets for future years, will be included in FY 2014 budget documents.

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Information Technology
(Dollars)

Funds Source	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
Program Operations 1/	$ 832,554,000	$ 1,002,966,000	$ 1,064,452,000
Federal Administration	25,523,000	46,616,000	34,533,000
Survey & Certification	4,618,000	2,795,000	2,775,000
Research 3/	5,700,000	5,850,000	
Subtotal, Program Management Appropriation	**$ 868,395,000**	**$ 1,058,227,000**	**$ 1,101,760,000**
Coordination of Benefits (COB) User Fee	$ 10,034,018	$ 8,015,000	$ 7,074,790
CLIA User Fees	4,214,607	4,500,000	4,750,000
ESRD Network	4,000,000	1,200,000	1,200,000
Program Integrity (MIP/HCFAC)	134,910,325	152,066,187	118,430,207
ARRA/Hitech	87,794,849	85,883,179	95,552,452
Quality Improvement Organizations 2/	TBD	TBD	TBD
Subtotal, Additional Funding Sources	**$ 240,953,799**	**$ 251,664,366**	**$ 227,007,449**
Total, CMS IT Portfolio	**$ 1,109,348,799**	**$ 1,309,891,366**	**$ 1,328,767,449**

1/ Starting in FY 2012, new program areas are incorporated into Program Operations (including MIPPA IT)
2/ QIO estimates are currently being developed for the 10th scope of work in FY 2011 and FY 2012
3/ Starting in FY 2013 the Research projects will be absorbed into Program Operations

Program Description and Accomplishments

As shown in the table above, CMS' 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, the Center for Consumer Information and Insurance Oversight 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' 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 Medicare 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 2013 request also includes funds for HIPPA Version 3, which is the next iteration of the EDI 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' 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 2013 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.

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 End Stage Renal Disease 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.

QIO

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 2013 budget level request for Program Management Information Technology is over $1.1 billion. This request is a $43.5 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 establishment of the Center for Consumer Information and Insurance Oversight. The increases in 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, websites redesigns, system and security documentation and additional capacity for storage.

In addition, the increase in funds for Program Operations will also provide for insurance market oversight and Health Care 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.

Also starting in FY 2013 the Research portion of the Program Management budget will be absorbed by the Program Operations line. This funding will cover data management and processing of the Medicare Current Beneficiary Survey and the chronically ill Medicare beneficiary research, data, and demonstration project.

The Program Management IT also supports funding in Federal Administration to accommodate workloads triggered by the Affordable Care Act, including support for the Center for Consumer Information and Insurance Oversight.

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' discretionary Program Management appropriation. The FY 2013 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.

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FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **CMS** will use **$1,100,690.00** of its **FY 2013** budget to support 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.

Of the amount specified above, **$608,259.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$9,232.00
Line of Business - Grants Management	$579.00
Line of Business - Financial	$18,064.00
Line of Business - Budget Formulation and Execution	$13,263.00
Disaster Assistance Improvement Plan	$6,782.00
Federal Health Architecture	$535,100.00
Integrated Acquisition Environment-Grants and Loans	$25,239.00
Line of Business - Geospatial	$0.00
FY 2013 Developmental E-Gov Initiatives Total	**$608,259.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and

standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

In addition, **$492,431.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$348,433.00
GovBenefits	$20,743.00
Integrated Acquisition Environment	$80,041.00
Grants.gov	$43,214.00
FY 2013 Ongoing E-Gov Initiatives Total	**$492,431.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

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

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Centers for Medicare & Medicaid Services

Office of National Drug Control Policy (ONDCP) Budget

Resource Summary

	Budget Authority ($ in Millions)			
	FY 2011 Actual	FY 2012 Current Law	FY 2013 Estimate	FY 2013+/- FY 2012
Drug Resources by Function:				
Treatment	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources by Decision Unit:				
Centers for Medicare & Medicaid Services	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources Personnel Summary				
Total FTEs (direct only)	0	0	0	0

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.

Beginning with the FY 2012 Congressional budget request, ONDCP significantly expanded the scope of CMS's drug control agency designation, to include more Medicaid services as well as Medicare. Long-term, ONDCP and the HHS Office of the Assistant Secretary for Planning and Evaluation are co-sponsoring research to determine what the total Federal drug treatment outlays under Medicare and Medicaid have been historically. It is anticipated that the historical information from this study will improve the accuracy of future estimates. In the meantime, ONDCP developed its own placeholder estimates of future Federal spending in these programs.

The FY 2012 CMS Congressional Budget Justification included placeholder outlay estimates developed by ONDCP for substance abuse treatment spending in Medicare and Medicaid, based on data in the 2008 report '*SAMHSA Spending Estimates: MHSA Spending Projections for 2004–2014'*.[1] ONDCP has again estimated Medicaid spending based on the 2008 report. ONDCP estimated that Medicaid spent $3.75 billion in FY 2011 on substance abuse treatment. ONDCP also projected that Medicaid will spend $3.56 billion in FY 2012 and $3.79 billion in FY 2013 on substance abuse treatment. The CMS' Office of the Actuary

[1] OACT did not develop nor approve the Medicaid estimates. Medicaid estimates are not consistent with the FY 2013 President's Budget Medicaid baseline projections, and do not incorporate the impact of recent legislation (including the Recovery Act and Affordable Care Act), or recent economic and policy changes to the programs. These estimates are for use while HHS develops a more accurate estimate consistent with current program spending.

estimated that Medicare's spending on substance abuse totaled $890 million in FY 2011, and will sum to $910 million in FY 2012 and $960 million in FY 2013. Together, the estimates for the two programs totaled $4.64 billion in FY 2011, $4.47 billion in FY 2012, and $4.75 billion in FY 2013.

Background

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. 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.

Budget Summary

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2013 CMS budget submission to the Congressional Appropriations Committees will include 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 that no funding is requested for drug control benefit payments

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

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CMS Program Management
Budget Authority by Object

	2012 Enacted	2013 Budget Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$453,106,000	$472,428,000	$19,322,000
Other than full-time permanent (11.3)	$11,162,000	$11,407,000	$245,000
Other personnel compensation (11.5)	$7,627,000	$7,947,000	$320,000
Military personnel (11.7)	$9,668,000	$9,781,000	$113,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$481,563,000**	**$501,563,000**	**$20,000,000**
Civilian benefits (12.1)	$116,522,000	$125,011,000	$8,489,000
Military benefits (12.2)	$4,981,000	$5,038,000	$57,000
Benefits to former personnel (13.0)	$0		$0
Total Pay Costs	**$603,066,000**	**$631,612,000**	**$28,546,000**
Travel and transportation of persons (21.0)	$12,363,000	$9,219,000	($3,144,000)
Transportation of things (22.0)	$0	$0	$0
Rental payments to GSA (23.1)	$24,000,000	$24,949,000	$949,000
Communication, utilities, and misc. charges (23.3)	$300,000	$300,000	$0
Printing and reproduction (24.0)	$4,161,000	$3,329,000	($832,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$1,782,233,000	$2,669,259,000	$887,026,000
Purchase of goods and services from government accounts (25.3)	$3,523,000	$3,523,000	$0
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$21,160,000	$24,567,000	$3,407,000
Medical care (25.6)	$1,283,223,000	$1,389,922,000	$106,699,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$3,090,139,000**	**$4,087,271,000**	**$997,132,000**
Supplies and materials (26.0)	$1,083,000	$1,124,000	$41,000
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	$52,004,000	($21,996,000)
Interest and dividends (43.0)	$0	$0	$0
Refunds (44.0)	$0	$0	$0
Total Non-Pay Costs	**$3,217,046,000**	**$4,189,196,000**	**$972,150,000**
Total Budget Authority by Object Class	**$3,820,112,000**	**$4,820,808,000**	**$1,000,696,000**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$16,753,000	$17,010,000	$257,000
Other personnel compensation (11.5)	$269,000	$274,000	$5,000
Civilian benefits (12.1)	$4,285,000	$4,482,000	$197,000
Other Contractual Services:			
Other services (25.2)	$118,693,000	$118,234,000	($459,000)
Total Budget Authority by Object Class	**$140,000,000**	**$140,000,000**	**$0**

CMS Program Management
Salaries and Expenses

	2012 Enacted	2013 Budget Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$453,106,000	$472,428,000	$19,322,000
Other than full-time permanent (11.3)	$11,162,000	$11,407,000	$245,000
Other personnel compensation (11.5)	$7,627,000	$7,947,000	$320,000
Military personnel (11.7)	$9,668,000	$9,781,000	$113,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$481,563,000**	**$501,563,000**	**$20,000,000**
Civilian benefits (12.1)	$116,522,000	$125,011,000	$8,489,000
Military benefits (12.2)	$4,981,000	$5,038,000	$57,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$603,066,000**	**$631,612,000**	**$28,546,000**
Travel and transportation of persons (21.0)	$12,363,000	$9,219,000	($3,144,000)
Transportation of things (22.0)	$0	$0	$0
Rental payments to Others GSA (23.2)	$0	$0	$0
Communication, utilities, and misc. charges (23.3)	$300,000	$300,000	$0
Printing and reproduction (24.0)	$4,161,000	$3,329,000	($832,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$1,782,233,000	$2,669,259,000	$887,026,000
Purchase of goods and services from government accounts (25.3)	$3,523,000	$3,523,000	$0
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$21,160,000	$24,567,000	$3,407,000
Medical care (25.6)	$1,283,223,000	$1,389,922,000	$106,699,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$3,090,139,000**	**$4,087,271,000**	**$997,132,000**
Supplies and materials (26.0)	$1,083,000	$1,124,000	$41,000
Total Non-Pay Costs	**$3,108,046,000**	**$4,101,243,000**	**$993,197,000**
Total Salary and Expense	**$3,711,112,000**	**$4,732,855,000**	**$1,021,743,000**
Direct FTE	**4,536**	**4,672**	**136**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$16,753,000	$17,010,000	$257,000
Other personnel compensation (11.5)	$269,000	$274,000	$5,000
Civilian benefits (12.1)	$4,285,000	$4,482,000	$197,000
Other Contractual Services:			
Other services (25.2)	$118,693,000	$118,234,000	($459,000)
Total Salary and Expense	**$140,000,000**	**$140,000,000**	**$0**
Direct FTE	**160**	**161**	**1**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2011 Actual	2012 Estimate	2013 Estimate
Office of the Administrator			
Direct FTEs	32	35	33
Reimbursable FTEs	0	0	0
Subtotal	32	35	33
Office of Minority Health			
Direct FTEs	5	4	3
Reimbursable FTEs	0	0	0
Subtotal	5	4	3
Center for Medicare			
Direct FTEs	675	723	686
Reimbursable FTEs	5	5	5
Subtotal	680	728	691
Center for Medicaid and CHIP Services			
Direct FTEs	331	301	286
Reimbursable FTEs	34	0	0
Subtotal	365	301	286
Center for Program Integrity			
Direct FTEs	40	5	5
Reimbursable FTEs	0	0	0
Subtotal	40	5	5
Center for Strategic Planning			
Direct FTEs	69	80	76
Reimbursable FTEs	0	0	0
Subtotal	69	80	76
Center for Medicare and Medicaid Innovation			
Direct FTEs	33	53	50
Reimbursable FTEs	0	0	0
Subtotal	33	53	50
Center for Consumer Information and Insurance Oversight			
Direct FTEs	0	246	602
Reimbursable FTEs	0	0	0
Subtotal	0	246	602
Office of Federal Coordinated Health Care			
Direct FTEs	0	22	21
Reimbursable FTEs	0	0	0
Subtotal	0	22	21
Office of Public Engagement			
Direct FTEs	105	106	101
Reimbursable FTEs	0	0	0
Subtotal	105	106	101
Office of Communications			
Direct FTEs	149	158	150
Reimbursable FTEs	0	0	0
Subtotal	149	158	150
Office of the Actuary			
Direct FTEs	85	88	84
Reimbursable FTEs	0	0	0
Subtotal	85	88	84
Office of Clinical Standards and Quality			
Direct FTEs	184	194	184
Reimbursable FTEs	0	42	42
Subtotal	184	236	226

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2011 Actual	2012 Estimate	2013 Estimate
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	134	147	139
Reimbursable FTEs	0	0	0
Subtotal	134	147	139
Office of Equal Opportunity and Civil Rights			
Direct FTEs	28	31	29
Reimbursable FTEs	0	0	0
Subtotal	28	31	29
Office of Legislation			
Direct FTEs	40	49	46
Reimbursable FTEs	0	0	0
Subtotal	40	49	46
Office of Acquisition & Grants Management			
Direct FTEs	101	150	142
Reimbursable FTEs	2	2	2
Subtotal	103	152	144
Office of E-Health Standards and Services			
Direct FTEs	14	18	17
Reimbursable FTEs	0	0	0
Subtotal	14	18	17
Office of Financial Management			
Direct FTEs	289	249	237
Reimbursable FTEs	26	29	30
Subtotal	315	278	267
Office of Information Services			
Direct FTEs	356	426	404
Reimbursable FTEs	3	3	3
Subtotal	359	429	407
Office of Operations Management			
Direct FTEs	183	206	196
Reimbursable FTEs	0	0	0
Subtotal	183	206	196
Consortia			
Direct FTEs	1,237	1,245	1,181
Reimbursable FTEs	35	42	42
Subtotal	1,272	1,287	1,223
Total, CMS Program Management FTE 1/	**4,194**	**4,659**	**4,796**
Total, CMS Military Staffing (Non-Add) 1/	*107*	*107*	*107*
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE 1/	**102**	**160**	**161**

1/ FY 2011 reflects actual FTE consumption. Reflects discretionary Program Management staffing, only.

Average GS Grade

FY 2009	**13.4**
FY 2010	**13.4**
FY 2011	**13.4**
FY 2012	**13.4**
FY 2013	**13.4**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2011 Actual	2012 Estimate	2013 Estimate
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$165	$165	$166
Subtotal	74	74	74
Total - ES Salaries	$12,380	$12,380	$12,426
GS-15	499	548	576
GS-14	586	643	661
GS-13	1,899	2,084	2,074
GS-12	723	793	810
GS-11	221	242	273
GS-10	1	1	1
GS-9	194	213	270
GS-8	7	7	7
GS-7	96	106	107
GS-6	11	12	11
GS-5	14	15	17
GS-4	3	4	5
GS-3	2	2	2
GS-2	1	1	1
GS-1	0	0	0
Subtotal 1/	4,257	4,671	4,814
Total - GS Salary 1/	$423,308	$465,601	$484,345
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$99.438	$99.679	$100.612

1/ Reflects direct discretionary and user fee financed staffing within the Program Management account.

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 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		40	45	47
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		40	45	47
4) Average Annual PCA Physician Pay (without PCA payment)		148,100	148,100	148,100
5) Average Annual PCA Payment		24,425	24,425	24,425
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.	40	45	47

*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 enactment of the Affordable Care Act, CMS had to set up several new program offices to implement new programs. These program offices required establishing additional new Medical Officer positions to fill 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.

Significant Items in Appropriations Committee Reports 305

Significant Items of Interest to Congress
FY 2012 Senate Appropriations Committee Report Language
(Senate Report 112-84)

Item

Research, Demonstrations and Evaluations- The Committee encourages the Center for Medicare and Medicaid Innovation to collaborate with AHRQ to expand and implement research that has resulted in successful strategies to reduce waste and duplication in hospitals while improving the quality of health care. The Committee believes that AHRQ's research translation activities, such as its ACTION network, could be used to promote these strategies to hospitals and help with their implementation.

Action Taken or To Be Taken

In conjunction with AHRQ, CDC and OASH/OHQ, the Center for Medicare and Medicaid Innovation (CMMI) undertook the Evaluation of the Hospital Acquired Condition (HAC) Program beginning in FY 2010. The evaluation, led by CMMI, receives technical assistance and funding from the three other agencies. The evaluation consists of nine major tasks. CMS and AHRQ are cooperating closely on the task to validate the present on admission indicators on hospital claims using medical records. CMMI will continue to collaborate with AHRQ on the Partnership for Patients imitative, which aims to reduce preventable hospital, acquired conditions by 40 percent and 30-day readmissions by 20 percent. AHRQ national quality measurement capabilities and numerous other AHQR tools and programs are being aligned to support progress on these two ambitious aims.

Item

Atrial Fibrillation [AFib] - The Committee is aware that AFib is the most common chronic cardiac arrhythmia, affecting an estimated 2.3 million Americans. The number of patients with AFib is likely to increase significantly, underscoring a substantial public health risk. Already, the disease accounts for approximately one third of hospitalizations for cardiac rhythm disturbances; costing $4,700 per patient annually. AFib also has significant morbidity and mortality consequences, increasing the risk of stroke approximately five-fold and causing an estimated 15 percent of all strokes in the United States. The Committee encourages CMS to consider targeting AFib patients in current and planned Medicare payment and quality improvement programs for the purpose of improving patient outcomes and reducing avoidable health care costs, including those associated with hospital admissions and readmissions for these patients. Such programs could include those pertaining to quality reporting, performance measurement, medication therapy management, wellness assessments, transitions of care, support services, and post-acute care.

Action Taken or To Be Taken

CMS, through its Quality Improvement Organization (QIO) Program at CMS are supporting the Million Hearts national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Because Atrial Fibrillation (AFib) can lead to strokes, the QIOs will be reminded to encourage health care providers caring for patients with an Atrial Fibrillations diagnosis to participate in its Cardiac Population Health Learning and Action Network.

Effective with discharges in CY 2014, CMS will add a clinical process of care measure to the Hospital Inpatient Quality Reporting Program, Anticoagulation Therapy for Atrial Fibrillation/Flutter for stroke patients. CMS will consider adding this measure and other added Atrial Fibrillation measures to the Hospital Value-Based Purchasing Program as soon as the

statute allows measure addition. CMS will also consider adding Quality Improvement Organization improvement assistance upon adoption in the Hospital Value Based Purchasing Program. These efforts are designed to reduce admissions and improve quality of care for stroke patients with Atrial Fibrillation.

In addition, CMS' Physician Quality Reporting System (PQRS), and the CMS Electronic Health Record Incentive Program, currently include clinical quality performance measures related to the management of AFib. PQRS has two specific measures that address the management of AFib that are includes in the 2012 PQRS program. These clinical quality measures are: "Warfarin Therapy for Patients with AFib" that measures the percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic Atrial Fibrillation who were prescribed Warfarin therapy; and "Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Afib at Discharge". This measure assesses the percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent persistent or paroxysmal Atrial Fibrillation who were prescribed an anticoagulant at discharge. The measure "Warfarin Therapy for Patients with AFib" is also included in stage I of the CMS EHR Incentive Program. In addition, the EHR Incentive Program requires hospitals and Critical Access Hospitals (CAH) to report in Stage I the clinical quality measure "Stroke-3 Ischemic Stroke-Anticoagulation for Atrial Fibrillation/Flutter". This measure addresses the population of ischemic stroke patients with Atrial Fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.

Item

Chronic Kidney Disease- The Committee is aware that approximately 23 million Americans have evidence of kidney disease and another 20 million are at risk of developing it. Therefore the Committee strongly supports efforts to prevent kidney disease and detect symptoms early to improve treatment outcomes. The Kidney Disease Education and Awareness program authorized in section 152 of the Medicare Improvements for Patients and Provides Act of 2008 is one such program. The intent of this program is to increase awareness and screening of chronic kidney disease and enhance surveillance systems to better access the incidence and prevalence of the disease. The program would be carried out through a 5-year pilot in three States, with a GAO evaluation. The Committee encourages CMS to consider implementing this demonstration to determine if greater outreach can improve health outcomes and generate cost savings for the Federal Government.

Action Taken or To Be Taken

CMS understands the concern of the Committee that the prevention of chronic kidney disease is a health priority. A Chronic Kidney Disease (CKD) task was a new component of the QIO 9th scope of work in August 2008. Eleven QIOs were awarded this three year sub-national task aimed at improving detection of CKD in diabetic beneficiaries, improving treatment of CKD to prevent the progression of kidney disease, and improving arterio venous (AV) fistula placement in new hemodialysis patients. Three new measures were used to track CKD improvements: urine microalbumin testing to detect CKD, use of medication therapy to slow the progression of kidney disease, and AV fistula placement in incident hemodialysis patients. In the future, CMS will consider implementing a demonstration on improving health outcomes through the prevention of Chronic Kidney Disease.

Item

Collaboration With the Food and Drug Administration (FDA) - The Committee encourages CMS to review information from FDA that describes if a newly approved drug indication was approved by FDA through either a non- inferiority or a superiority trial. A manufacturer can choose to submit a new drug application using either a non-inferiority or a superiority clinical trial or both.

Action Taken or To Be Taken

CMS' ability to review information on non-inferiority or superiority clinical trials is contingent on FDA's ability and willingness to provide this information. CMS notes that Section [1927] of the Social Security Act provides a definition of Covered Outpatient Drug (COD), which only discusses medical indications in the context of "medically accepted indications", and CMS does not believe that coverage decisions could be based on this additional information provided by the FDA.

Item

Medicare Secondary Payer- The Committee is concerned by the delays experienced in the Medicare Secondary reimbursement system, in part caused by a lack of clear information about the amount owed to Medicare. The Committee expects CMS to submit a plan to the Committee within 180 days of enactment of this act that allows Medicare beneficiaries to obtain a final and reliable demand letter regarding how much they must reimburse Medicare under the Medicare Secondary Payer Act prior to reaching a settlement in the associated litigation. That plan must identify any statutory or other barriers to implementing such a process, make recommendations related to any barriers identified and propose a timeline for implementation.

Action Taken or To Be Taken

CMS will develop a plan that allows the Medicare beneficiary/representative to obtain Medicare's final conditional payment prior to settlement. This plan will identify any statutory barriers to providing this information. CMS has already implemented efficiencies in the MSP recovery process including options that under certain conditions will allow the beneficiary/representative to obtain Medicare final conditional payment amounts prior to settlement. Some of CMS' recent efforts are as follows:

- On June 30, 2011, CMS established a minimum threshold of $25 of all recovery demands. (We note that this is consistent with the threshold used by the Department of Treasury for collecting delinquent debt pursuant to the Debt Collection Improvement Act of 1996.)
- On September 6, 2011, CMS implemented a $300 threshold for certain liability settlements. When establish criteria are met, reporting and repayment is not required if the settlement is for $300 or less.
- On September 30, 2011, the Medicare Secondary Payer Recovery Contractor implemented a self-service information feature to its customer service line. This feature gives callers access to the most up-to-date Demand/Conditional Payment amounts, and the dates that those letters were issued, without having to speak to a customer service representative. The self-service feature is available for extended hours, and callers have the option of requesting information on multiple cases during one phone call.
- Effective November 7, 2011, CMS implemented a simple fixed percentage option for certain types of settlements of $5,000 or less. Under this option the beneficiary/representative can elect to pay Medicare 25% of the settlement to resolve Medicare's recovery claim.

- In February 2012, CMS will implement a process for certain settlements where the beneficiary/representative can self-identify its conditional payment amount to Medicare prior to finalizing a settlement. If all criteria are met, Medicare will respond to the beneficiary within 60 days providing Medicare's final conditional payment amount prior to settlement.
- CMS plans to implement an Medicare Secondary Payer Recovery Contractor portal, where the beneficiary/representative can obtain information about Medicare's claim payments, conditional payment amounts, demand letters, etc., and input information related to a settlement, disputed claims, etc. We expect the portal to be operational in July 2012.

The above-referenced options are designed to give the beneficiary finality with regard to certain settlements without eliminating Medicare's control over its own process.

Item

Mobile Oxygen Therapy- The Committee is aware of ongoing research into mobile applications of oxygen therapy in wound care, which might allow for less onerous and less expensive forms of delivery. Some of these devices provide episodic oxygen delivery while others provide continuous streams of oxygen. The Committee encourages CMS to review clinical data on all forms of mobile oxygen delivery, with an eye towards improved wound healing.

Action Taken or To Be Taken

CMS appreciates the Committee's suggestion to review clinical data on all forms of mobile oxygen delivery in wound care. CMS is committed to facilitating continued improvements on this important care issue. CMS would be open to commissioning a Technology Assessment through AHRQ to review the relevant evidence; however, doing so will require additional resources and could interfere with other pressing program needs.

Item

Remote Access to Care- The Committee is concerned by a recent letter from CMS to a grantee of the Federal Native Hawaiian Health Care program that effectively blocks the implementation of a Hawaii State law allowing advanced practice registered nurses to practice without the physical supervision of a physician. Given the barrier imposed by island geography, blocking the State law may have unintended consequences of reducing access to care. The Committee urges CMS to work with the Health Resources Services Administration to find a suitable resolution that maximizes access to care in remote locations.

Action Taken or To Be Taken

CMS appreciates the Committee's concerns regarding access to care. The referenced letter to the Federal Native Hawaiian Health Center accurately stated the regulations for Federally Qualified Health Centers (FQHCs) at 42 Code of Federal Regulations 491.8(b)(2), which requires a physician's visit every two weeks (except in extraordinary circumstances) to provide medical direct and medical care. The physician supervision requirement is based upon Section 1861(aa)(3)(B) of the Social Security Act. CMS is committed to revising regulations to ensure both access to care and patient health and safety within the bounds laid out by statute. CMS will continue to work with the Health Resources Services Administration to explore avenues to maximize access to care in remote locations.

Item

Uniformed Services Plan- The Committee understands that CMS may assume responsibility for future enrollees of the Uniformed Services Family Health Plans [USFHP] past age 65

pending the final disposition of a Department of Defense [DOD] proposal included in the fiscal year 2012 National Defense Authorization Act. The Committee is aware of the high patient satisfaction rates that this plan enjoys. The Committee directs CMS to work with DOD to ensure that beneficiaries experience the smoothest possible transition. In addition, the Committee urges CMS to explore the quality of care, cost-effectiveness and medical outcomes of this model to determine if a demonstration is warranted on capitation-based payment systems. If this proposal is enacted, the Committee requests a report in the fiscal 2013 justification on the steps CMS has taken to ensure the continuity of care for beneficiaries and to review the USFHP model for any strategies CMS might adopt around delivering high-quality integrated care.

Action Taken or To Be Taken

CMS stands ready to assume responsibility for future Medicare eligible enrollees of the Uniformed Services Family Health Plans. CMS has already taken steps to begin the planning process for this transition. For example, CMS staff met with representatives from the Pacific Medical Center (PMC), which is one of the USFHPs and discussed opportunities for the PMC to become a Medicare Advantage plan and offered to seamlessly transfer beneficiaries to such a plan. CMS will continue to reach out to PMC and other USFHPs to ensure a seamless transition and will explore the quality of care, cost effectiveness, and outcomes of this model to determine if a demonstration is warranted. An initial review of the data suggests that this new model approach could result in increased costs to Medicare and may have limited opportunity for scalability. CMS will continue to work closely with USFHP to ensure a seamless transition and integrate high-quality care for beneficiaries.

Item

Vaccination- It is estimated that the cost of the health burden to society from vaccine preventable diseases, including influenza, is approximately $10,000,000 annually. In particular, the Committee is concerned that the majority of healthcare workers do not regularly recommend vaccinations and that adult vaccination rates are particularly low for minority groups. The Committee commends CMS for including healthcare workers in seasonal influenza vaccination reporting rates and performance metric. The Committee looks forward to reviewing the data that will be collected beginning in 2012.

Action Taken or To Be Taken

CMS understands the importance of encouraging recommended vaccinations and is seeking to encourage and measure utilization on several fronts. CMS finalized the inclusion of a Healthcare Worker Seasonal Influenza Vaccination measure in the Hospital Inpatient Quality Reporting Program (IQR). Hospitals will begin submitting data on this measure in January 2013. CMS is also targeting early 2014 to add this measure to Hospital Compare. In addition, a Healthcare Worker Seasonal Influenza Vaccination Measure has been finalized for inclusion in the Ambulatory Surgical Center (ASC) Quality Reporting Program and data collection by ASCs for this measure will begin in 2014.

Item

Dental Disease- The Committee notes that, although virtually all dental disease is fully preventable, tooth decay remains the most chronic illness among children. With more children expected to receive coverage for dental services, there will be even greater pressure on an already challenged dental delivery system. Increasing entry points into the oral health care delivery system is increasingly being recognized as essential to improving access to oral health care. Currently, 34 States allow dental hygienists to provide dental care outside of a dental office without prior exam or pre-authorization by a dentist. The Committee urges CMS and

HRSA to take steps to facilitate expanded access to dental services in community health centers and other public health settings. Further, dental Medicaid regulations should be updated to reflect how practice has evolved and dental services are currently delivered.

Action Taken or To Be Taken
In March 2011, CMS issued a reminder to States, in an informational bulletin, that the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended the Social Security Act to prohibit States from preventing federally-qualified health centers from entering into contractual relationships with private practice dental providers. Through this mechanism, community health centers may increase the dental resources available to their patients. In its Dental Strategy (released April 2011), CMS recommends that States consider increasing entry points to the dental care for children by reimbursing new practitioners, for example mid-level dental providers, dental hygienists providing direct care and physicians. In December 2011, CMS wrote a letter to the National Uniform Claims Commission supporting a request from Minnesota's Medicaid's program for two new provider taxonomy codes, which would permit Minnesota to reimburse for dental services by newly-graduated dental therapists and advance practice dental therapists.

CMS also established a developmental Government Performance Results Act goals to increase the national rate of low-income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP) who receive any preventative dental service-collecting baseline data in 2011 and reporting that baseline starting point later in 2012. CMS continues to look for opportunities to update State guidance and regulations in alignment with prevention and access provisions of CHIPRA and the Affordable Care Act.

Item
Tuberculosis [TB] - The Committee is concerned about the growth in cases of drug-resistant forms of TB, including 114 cases of multi-drug-resistant TB in the United States in 2009. The Committee notes that timely and effective treatment regimens are necessary to reduce transmission of drug-resistant TB. Therefore, the Committee strongly supports the ongoing collaboration between CMS and CDC that has thus far resulted in multi-level communication to States about options in Medicaid. The Committee encourages CMS to continue this collaboration.

Action Taken or To Be Taken
CMS will continue to collaborate with CDC upon identification of needed policy clarifications. CMS will also continue to provide technical assistance to State Medicaid Agencies on available Medicaid coverage authorities that facilitate the service provision to individuals diagnosed with Tuberculosis.

Item
Ambulatory Surgical Centers (ASC) - The conferees understand that in 2008, ASCs provided 3.3 million Medicare recipients with outpatient surgical services, including screening services. The conferees have heard concerns related to the use of the consumer price index for urban consumers (CPI-U) to update the payment rates of ASCs, a different method than is used for other comparable service providers. The conferees request that CMS develop a report that compares other potential options for updating the payment rates of ASCs and report back the findings in the fiscal year 2013 budget request.

Action Taken or To Be Taken
During the 2013 rulemaking cycle, CMS intends to analyze and compare potential options for updating the payment rates of Ambulatory Surgical Centers (ASC) (through an alternative input price index or an ASC-specific market basket), and determine which update method best approximates annual changes to ASC costs.

Item
CMS Test Environment for Testing Industry Solutions in Secure Setting- The conferees direct and provide $5,000,000 for CMS to provide a test environment "sandbox" where vendors can work independently and with CMS to seek solutions and execute "proof of concept" tests to Medicare issues in a secure environment, using Medicare data, on CMS technical architecture. The Conferees recommends support within the Enterprise IT Activities function to establish an isolated, stand-alone environment for independent and vendor testing of industry solutions that could provide significant benefit to CMS operations. The test environment will provide controlled access to Medicare data to run "proof of concept" tests that determine solution effectiveness in addressing Medicare issues such as improper payment and quality measures. The test environment must ensure data privacy and security, comply with CMS technical architecture standards, provide temporary access and secure connectivity for vendor testing, and make relevant data sets available for product testing. The conferees request a report and timeline in the fiscal year 2013 budget request.

Action Taken or To Be Taken
CMS agrees with the conferees' suggestion to explore solutions to enable efficient management and greater dissemination of Medicare data. Such solutions might include a data "enclave" that would permit various types of CMS data users secure access to Medicare data in a controlled environment in order to conduct a variety of analyses including research, program integrity, and analysis for quality measurement purposes. CMS is currently engaged in a pilot project to explore the feasibility of such an approach. The CMS Data Enclave Pilot will help CMS explore and develop recommendations for potential challenges related to the application process, secure access methods, training needs for enclave participants, data output review, security within the environment, data retention, participant workspace requirements, and operating/maintenance costs. The first step in CMS's enclave pilot was the creation of an options paper that compared existing Research Data Centers (RDCs) maintained by the U.S. Census Bureau and the National Center for Health Statistics to develop a recommended initial enclave design based on the differences between these two RDC's and the quantity of CMS data, privacy of CMS data, and needs of CMS stakeholders.

Following the completion of the initial enclave options paper in November 2011, CMS is currently leveraging its existing infrastructure to construct a small enclave environment to test the recommended approach. CMS expects to use data partners from other HHS entities to test our enclave environment beginning in April 2012. CMS intends to use the lessons learned from the Data Enclave Pilot to review current data policies and inform the creation of a series of contracts for the development of infrastructure and other activities that will more permanently incorporate new secure data access environments that fully comply with CMS's technical architecture standards. We envision that these multi-year contracts will be awarded by the end of FY 2012 and would require a series of staged deliverables occurring throughout 2013 and 2014

Item
Comparison of Residency Position- The conferees request CMS conduct an analysis evaluating the implementation of Section 5503 of Public Law 111-148 on the allocation of

Medicare Graduate Medical Education (GME) resident slots to hospitals. This analysis shall compare how residency slots are allocated according to two assignment strategies. Strategy one is the allocation of GME slots according to the current final CMS Federal Rule as published in the *Federal Register* on November 24, 2010. The current final rule states that fiscal year 2009 report data not be included if it was reported after March 23, 2010. Strategy two involves an assessment of GME slot allocation which includes all fiscal year 2009 cost reports, including data for hospitals whose fiscal year ended on December 31, 2009, and as such have cost data reported after March 23, 2010. The report of this analysis shall include the number of Medicare GME slots allocated to each hospital under the two different allocation strategies. The conferees request CMS provide the final report with the detailed hospital level information under each option to the House and Senate Appropriations Committees not later than 6 months after enactment.

Action Taken or To Be Taken

For purposes of implementing section 5503 of the Affordable Care Act, the Social Security Act defines the reference cost report, which is the cost report used to determine how many full-time equivalent (FTE) slots were not being used by a hospital and the amount by which a hospital's resident cap would be reduced to reflect those unused slots. To determine if a hospital's resident cap should be reduced under the provision, CMS reviewed the 3 most recent cost reporting periods ending on or before March 23, 2010 and used the cost reporting period with the lowest difference between the number of filled FTE's trained by the hospital and the hospital's historical FTE cap, as the reference cost report. A hospital's resident cap would then be reduced by 65 percent of the difference between the number of filled resident slots on the reference cost report and the hospital's historical cap. During the rulemaking to implement section 5503 of the Affordable Care Act, one hospital raised a concern about the requirement to use a cost report that was submitted by March 23, 2010, rather than a cost report that had ended by March 23, 2010 and that was submitted even after March 23, 2010, as the reference cost report. If CMS had used the alternative policy suggested by the Conferees, we believe at least one hospital would have had its resident cap reduced by fewer residents, resulting in fewer resident positions being available for redistribution. To conduct the analysis requested by the Conferees in an efficient and expeditious manner, CMS will contact the fiscal intermediaries and Medicare Administrative Contractors to identify those hospital applicants that requested that CMS use a fiscal year ending (FYE) December 31, 2009 cost report as the reference cost report and obtain the appropriate cost report data to conduct the requested comparison within the time period identified.

Item

Dialysis Facilities- The conferees are concerned by reports of delays in the processing for surveys and certifications for dialysis facilities and encourage CMS to reduce the wait times. Further, the conferees request CMS report back to the Congress within 6 months on major impediments related to processing applications timely and provide its plan to address these impediments.

Action Taken or To Be Taken

CMS appreciates and shares Congress' interest in timely survey and certification of facilities. With regard to initial surveys of ESRD providers that newly seek to participate in Medicare, the number of Medicare-participating ESRD facilities has increased by 37.3% from 2001 to 2010, and continues to increase at the rate of approximately 2-3% per year, presenting a significant workload challenge for State surveyors. Many other provider types also continue to increase in number, including home health agencies (HHAs) and ambulatory surgical centers (which

increased in number by 69.3% and 60.8% between 2001 and 2010, respectively), generating an increased overall survey workload. The frequency of recertification surveys for HHAs is set by statute, so an increase in the number of HHAs will translate directly into mandated survey workload. To help promote access to care in response to these challenges, CMS plans to give higher priority to areas where patients have the lowest access to dialysis facilities. Further, CMS has been undertaking a focused review of ESRD and other survey processes to determine where there may be opportunities for increased survey efficiency. CMS hopes that such augmented efficiency will counteract some effects of the increased survey workload and help us manage survey responsibilities within the available resources. For example, we are working on regulations that will reduce regulatory burden on ESRD facilities relative to life-safety code requirements and help contain some of the growing CMS onsite survey costs.

Item

Strategic Plan- The conferees urge CMS to develop an overall strategic plan that links its vision for operations, program integrity, information technology, and other areas into a comprehensive approach with measurable objectives and resources. The conferees request a copy of this plan no later than 180 days after enactment.

Action Taken or To Be Taken

CMS is in the process of developing a long-range strategic plan that builds on our current charge under the Affordable Care Act and reflects a consensus on CMS's corporate identity. CMS will develop a succinct document that communicates our vision, mission, goals and objectives and engages both internal and external partners and stakeholders to achieve alignment of clearly articulated common goals. The CMS strategic plan, including measureable objectives and related resources, will be linked to the HHS strategic Plan and other plans related to program integrity, information technology, and related areas.