DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2015

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 Administrator

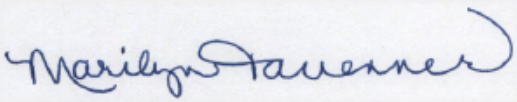
I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2015 performance budget. Our programs will touch the lives of almost 123 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2015. We take our role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow dramatically. We now have an opportunity to help millions of additional Americans access affordable, quality health care through new provisions enacted in the Affordable Care Act. These provisions include important consumer protections including preventing insurers from denying anyone coverage for pre-existing conditions, or charging them more for coverage, based on their health condition. This performance budget proposes improvements in our 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 continued implementation of the Health Insurance Marketplace and consumer protection programs. The implementation of the Marketplace and making affordable health insurance available to millions of Americans continues to be our priority in FY 2015.

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 2015 Program Management request reflects a level of funding 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 2015 performance budget.



Marilyn Tavenner

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Central Office Org Chart Text Version

Consortia Org Chart Text Version

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

APPROVED LEADERSHIP
As of March 3, 2014
*** Acting**
****Reports to Offices of Enterprise Management**
*****Reports to Deputy Admin. for Innovation and Quality**

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
Anita Pinder, Director
Vacant, Dep. Dir.

OFFICE OF COMMUNICATIONS
Julie Bataille, Director
Michele Patrick, Dep. Dir.
Mary Wallace, Dep. Dir.

OFFICE OF LEGISLATION
Lauren Aronson, Director
Jennifer Boulanger, Dep. Dir.

FEDERAL COORDINATED HEALTH CARE OFFICE
Melanie Bella, Director
Cheryl Powell, Dep. Dir.

OFFICE OF MINORITY HEALTH
Cara V. James, Director
Vacant, Dep. Dir.

OFFICE OF THE ACTUARY
Paul Spitalnic, Chief Actuary

OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS
Kathleen Cantwell, Director
Olen Clybourn, Dep. Dir.

Marilyn Tavenner
ADMINISTRATOR

Jonathan Blum
PRINCIPAL DEPUTY ADMINISTRATOR

Tim Love
CHIEF OPERATING OFFICER

Aryana Khalid
CHIEF OF STAFF

David Nelson
DEPUTY CHIEF OPERATING OFFICER

Patrick Conway, M.D.
DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY AND CMS CHIEF MEDICAL OFFICER

CENTER FOR STRATEGIC PLANNING

Tim Love *
Deputy Administrator and Director

Vacant
Deputy Center Director

***CENTER FOR CLINICAL STANDARDS AND QUALITY
Wesley Perich, Dep. Dir.
Shari Ling, M.D., Dep. Chief Medical Officer

OPERATIONS

Tim Love, Chief Operating Officer
David Nelson, Deputy Chief Operating Officer & CMS Chief Information Officer

OAGM—Daniel Kane, Director

OFM--Deborah Taylor, Director & Chief Financial Officer

OIS—Janet Vogel, Director

OOM—James Weber, Director

CFMFFSO--Nanette Foster Reilly, Consortium Administrator

CMCHO--Jackie Garner, Consortium Administrator

CMHPO--James T. Kerr, Consortium Administrator

CQISCO—James Randolph Farris, M.D., Consortium Admin.

OHI—Angela Brice-Smith, Director *

OEM—Niall Brennan, Director *

***OEP-Sandra Kraft, Director*

***OESS-Robert Tagalicod, Director*

***OEB-Todd Lawson, Director **

***OIPDA-Christine Cox, Director **

CENTER FOR MEDICARE

Liz Richter *
Deputy Administrator and Director

Liz Richter
Deputy Center Director

Cynthia Tudor *
Deputy Center Director

CENTER FOR MEDICAID AND CHIP SERVICES

Cindy Mann
Deputy Administrator and Director

Julie Boughn
Deputy Center Director

Penny Thompson
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Deputy Administrator and Director

Ted Doolittle
Deputy Policy Director

Elisabeth Handley
Deputy Operations Director

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

Gary Cohen
Deputy Administrator and Director

Chiquita Brooks-Lasure
Deputy Center & Policy Director

Cynthia MacDonald
Deputy Center & Operations Director

***CENTER FOR MEDICARE AND MEDICAID INNOVATION

Sean Cavanaugh
Deputy Director for Programs & Policy

Karen Jackson *
Deputy Director for Operations

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

Executive Summary **Page**

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. 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 investment funding for technological advances including health information technology and the use of electronic health records, along with prevention and wellness activities. In March 2010, the President signed into law the Affordable Care Act. 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 market regulations. These provisions include: 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. CMS has worked with States to create new competitive health insurance markets that operate through Health Insurance Marketplaces and provide millions of Americans with access to affordable coverage.

CMS remains the largest purchaser of health care in the United States. Our programs combined currently pay almost one-third of the Nation's health expenditures. For 45 years, these programs have helped pay the medical bills of millions of older and low-income Americans. In FY 2015, we expect to serve almost 123 million Medicare, Medicaid and CHIP beneficiaries, more than one-in-three Americans. With the implementation of the Affordable Care Act provisions, CMS is helping to provide affordable health care coverage 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 2015, benefit outlays for our traditional programs are expected to total $953.9 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 $51.8 billion. 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 less than one-half of one percent of these benefits.

Mission

As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.

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 on the next page displays our FY 2014 and FY 2015 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 activities related to the Federally-facilitated Marketplace, insurance market reform and oversight, and consumer information. This request will allow CMS to maintain statutory and policy-level survey frequencies in the Nation's health care facilities. Major initiatives and activities within each of these accounts are discussed in more detail on the following pages.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Management	$3,973.2	$4,199.7	$226.6
HCFAC – Discretionary	$293.6	$318.6	$25.0
Grants to States for Medicaid	$284,208.6	$338,081.2	$53,872.6
Payments to Health Care Trust Funds	$255,185.0	$259,212.0	$4,027.0
Grand Total	**$543,660.4**	**$601,811.5**	**$58,151.1**

Totals may not add, due to rounding.

Key Initiatives

- **Federally-Facilitated Marketplace**

  CMS is responsible for operating the Federally-facilitated Marketplace in states that elect not to set up their own Marketplace. The Marketplace will give tens of millions of Americans and small businesses access to affordable coverage. Implementation of the Federally-facilitated Marketplace is an unprecedented effort for CMS. CMS' FY 2015 Program Management request includes $629.2 million in appropriated funding for the Marketplaces, along with $1.2 billion in projected user fee collections to fund the Marketplaces at a Program Management program level totaling $1.8 billion.

- **Program Integrity**

  CMS' FY 2015 request includes a proposal to increase the HCFAC discretionary funding by $25.0 million in FY 2015. This funding will be used to support program integrity activities in private insurance, including the Health Insurance Marketplaces and help ensure the prudent use of Federal funds.

- **Proposed Law**

  Implementation Funding for Administration Proposals

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

improve efficiencies and enhance program integrity in a timely manner. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our traditional Program Management request.

Extend Funding for CMS' Consensus-Based Entity

CMS' request includes a proposal to extend the funding for MIPPA section 183, Consensus-Based Entity, at $10.0 million per year from FY 2015 through FY 2017 in order to focus on performance measurement. In addition, CMS also proposes to extend the funding for ACA section 3014, Quality Measurement, at $20.0 million per year from FY 2015 through FY 2017. These extensions will allow CMS to continue support for a consensus-based entity who will develop multi-stakeholder groups and facilitate the stakeholder groups' input on the endorsement and use of endorsed and non-endorsed quality measures for reporting performance information.

Federal Payment Levy Program Fees

The Federal Payment Levy Program authorizes CMS to impose a levy on Medicare providers for debt owed to the Federal Government. The FY 2015 request includes a proposal that authorizes CMS to assess a fee that would offset the administrative costs incurred in carrying out this program. Under this proposal, the Department of the Treasury would continue to receive the full amount of the levy and the Medicare provider would pay fees directly to CMS to cover administrative costs. Collections are estimated at $2.0 million in FY 2015.

Reinvesting Home Health Civil Monetary Penalties (CMPs)

Under current law, States conduct initial, recertification, and complaint surveys of Home Health Agencies (HHAs) under their purview; should the surveyors find an HHA to be deficient in meeting required quality and safety standards, they can levy a variety of penalties, including CMPs, which are then returned in full to the Treasury. Under this proposal, CMS would be authorized to retain and invest a portion of the CMPs recovered from HHAs to help improve beneficiary quality of care and to assist HHAs in meeting Medicare's Conditions of Participation. Collections are estimated at $1.0 million in FY 2015.

Survey and Certification Revisit Fees

CMS' FY 2015 request includes a proposal to collect Survey and Certification Revisit Fees. The Revisit Fee will provide CMS a greater ability to revisit poor performers while creating an incentive for facilities to ensure continuing quality of care. This fee will be phased in over a number of years to avoid disruption to ongoing facility activities.

FY 2015 Request

Program Management

In FY 2015, CMS requests $4,199.7 million in appropriated funding. CMS' request reflects funding needed to support Marketplace operations in FY 2015, and to maintain unprecedented growth in our traditional programs, particularly Medicaid. While the FY 2015

budget environment will be constrained, effective implementation of the Affordable Care Act (ACA) remains a top Administration priority. The request includes $184 million in funding for 23 provisions of the ACA that impact Medicare, Medicaid, and CHIP and for associated support costs. Some of this request is discussed in detail in this document. CMS' requested investment in FY 2015 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 2015 budget request for Program Operations totals $2,987.9 million, a $163.1 million increase over the FY 2014 enacted level. Most of the funding within the Program Operations line supports CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), maintain our 1-800 call centers, oversee Part C and D plans, and to provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2015 request includes funding for Medicaid and CHIP operations and for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

  Program Operations also includes funds for many provisions enacted in the Affordable Care Act. These provisions enhance all three existing health care programs—Medicare, Medicaid, and CHIP—and include the establishment of new consumer protections and private insurance market reforms. Our discretionary request includes $544.2 million to partially fund operations at the Marketplaces in 2015, including enrollment, outreach and education for a new and diverse cohort of consumers; we believe we will need an additional $1.2 billion in user fee financing along with $85.0 million in the Federal Administration line to fund Marketplace operations in FY 2015.

- Federal Administration:

  CMS requests $787.5 million in FY 2015, a $55.0 million increase over the FY 2014 enacted level. The FY 2015 request includes $674.1 million to support 4,738 direct FTEs, an increase of 196 FTEs over the FY 2014 level. Our payroll estimate assumes a 1.0 percent civilian and military cost of living allowance (COLA) in 2015.

  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 FY 2015 request includes $424.4 million for State survey and certification activities, a $49.0 million increase over the FY 2014 enacted level. Of this amount, $367.9 million will support direct survey costs, $18.8 million will support additional costs related to direct surveys, and $37.7 million will be used for surveyor training, Federally-directed surveys and information technology. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and supports policy level survey frequencies at other facility types.

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 request supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers and ambulatory surgery centers. The budget also supports contracts to strengthen quality improvement and national program consistency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

- State High-Risk Pool Grants:

  CMS no longer requests funds for State High-Risk Pool grants beginning in FY 2015.

Health Care Fraud and Abuse Control

CMS requests $318.6 million in discretionary HCFAC funding in FY 2015, a $25.0 million increase over the FY 2014 enacted level. This 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 the oversight of Medicare Parts C and D; state-of-the-art analytic technology to detect and prevent improper payments; staffing to implement corrective actions; support for Medicare Strike Forces, used to identify and prosecute fraudulent providers; and pre-enrollment provider screening. To help ensure the prudent use of Federal funds, $25 million is for program integrity activities in private insurance, including the Health Insurance Marketplaces.

Grants to States for Medicaid

The FY 2015 Medicaid request is $338.1 billion, an increase of $53.9 billion above the FY 2014 enacted level. The majority of this increase is attributed to increased enrollment resulting from the ACA Medicaid expansion. This appropriation consists of $234.6 billion for FY 2015 and $103.5 billion in an advance appropriation from FY 2014. These funds will finance $338.1 billion in estimated obligations in FY 2015. These obligations consist of:

- $308.6 billion in Medicaid medical assistance benefits;
- $6.6 billion for benefit obligations incurred but not yet reported;
- $18.8 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.1 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2015 request for Payments to the Health Care Trust Funds account totals $259.2 billion, an increase of $4.0 billion above the FY 2014 enacted level. Our FY 2015 request is driven by increases for the prescription drug benefit. 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 2015 request for its four annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $601.8 billion in FY 2015, an increase of $58.2 billion above the FY 2014 enacted level.

CMS' FY 2015 program level request for Program Management totals $4.2 billion, a $226.6 million increase over the FY 2014 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 the Federal Marketplace.

CMS requests $318.6 million in discretionary HCFAC funds, a $25.0 million increase over the FY 2014 enacted level. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

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

OVERVIEW OF CMS PERFORMANCE

The CMS FY 2015 performance budget includes a proposal of 44 goals (71 performance measures). We continue to track many of the measures included in the FY 2014 plan, with new FY 2015 targets consistent with the President's goals and priorities. Some performance measures were retired due to consistent annual success or to focus on new CMS responsibilities, challenges and strategic priorities. Our plan is structured to reflect our mission: *As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.* 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.

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 2015 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 (GPRA-MA), which amplify some aspects of the original 1993 law.

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

CMS continues to be an active participant in the HHS Agency Priority Goals for FY 2014 – 2015. CMS leads a collaborative effort with its HHS partners in the Office of the Assistant Secretary for Health (ASH), the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare Research and Quality (AHRQ), "To improve patient safety: To reduce the national rate of healthcare-associated infections (HAIs) by September 30, 2015 by demonstrating a 10 percent reduction in national hospital-acquired catheter associated urinary tract infections (CAUTI)" 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 ASH.

CMS is also undertaking a major initiative to implement the Affordable Care Act (ACA). With this responsibility comes the opportunity to collect data and measure our progress toward meeting the challenges offered by health care reform. We have a number of performance measures to track this important work.

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

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

Program	FY 2013 Final 1/	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Operations	$2,633,412	$2,824,823	$2,987,891	$163,068
Federal Administration	$732,533	$732,533	$787,500	$54,967
State Survey & Certification	$355,578	$375,330	$424,353	$49,023
Research 2/	$20,053	$20,054	$0	($20,054)
High-Risk Pool Grants	$0	$0	$0	$0
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$3,741,576**	**$3,952,740**	**$4,199,744**	**$247,004**
High-Risk Pool Grants 3/	$41,756	$20,420	$0	($20,420)
Subtotal, Appropriation/BA Current Law (Mandatory; 0511)	**$41,756**	**$20,420**	**$0**	**($20,420)**
Comparability Adjustment (SHIP Transfer to ACL) 4/	($46,040)	$0	$0	$0
Subtotal, Appropriation/BA Current Law (Disc. + Mand.; 0511)	**$3,737,292**	**$3,973,160**	**$4,199,744**	**$226,584**
MIPPA (Mandatory; P.L. 110-275)	$2,847	$2,784	$3,000	$216
Affordable Care Act (ACA; Mandatory; P.L. 111-148/111-152)	$71,175	$69,600	$55,000	($14,600)
ATRA (Mandatory; P.L. 112-240)/Bipartisan Budget Bill	$16,608	$3,750	$0	($3,750)
Total, Appropriation/BA Current Law (0511)	**$3,827,921**	**$4,049,294**	**$4,257,744**	**$208,450**
Proposed Law Appropriation (Mandatory) 5/	$0	$0	$430,000	$430,000
Total, Appropriation/BA Proposed Law (0511)	**$3,827,921**	**$4,049,294**	**$4,687,744**	**$638,450**
Est. Offsetting Collections from Non-Federal Sources:				
User Fees, C.L.	$204,856	$145,359	$186,213	$40,854
Marketplace User Fees, C.L.	$0	$200,000	$1,179,700	$979,700
Risk Corridors, C.L.	$0	$0	$5,450,000	$5,450,000
Recovery Audit Contracts, C.L.	$477,237	$762,811	$750,000	($12,811)
Subtotal, New BA, Current Law 6/	**$4,510,014**	**$5,157,464**	**$11,823,657**	**$6,666,193**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2013) 7/	$167,159	$180,303	$0	($180,303)
Program Level, Current Law (0511)	**$4,677,173**	**$5,337,767**	**$11,823,657**	**$6,485,890**
Proposed Law Offsetting Collections 8/	$0	$0	$3,000	$3,000
Program Level, Proposed Law (0511)	**$4,677,173**	**$5,337,767**	**$12,256,657**	**$6,918,890**
Affordable Care Act (ACA; P.L. 111-148/111-152):				
Section 2701 Adult Health Quality Measures	$56,940	$55,680	$0	($55,680)
Section 10323 Medicare Coverage/Environmental Health Hazards	$418	$928	$1,000	$72
Prevention and Public Health Fund	$453,803	$0	$0	$0
Total, ACA Appropriation/BA C.L. (Mandatory; 0509) 9/	**$511,161**	**$56,608**	**$1,000**	**($55,608)**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):				
Section 4103 Medicare Incentives	$94,900	$92,800	$100,000	$7,200
Section 4201 Medicaid Incentives	$37,960	$37,120	$40,000	$2,880
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 9/	**$132,860**	**$129,920**	**$140,000**	**$10,080**
Total, Program Management Appropriation/BA, P.L. (All Sources)	**$4,471,942**	**$4,235,822**	**$4,828,744**	**$592,922**
Total Prog. Mgt. Program Level, Proposed Law (All Sources)	**$5,321,194**	**$5,524,295**	**$12,397,657**	**$6,873,362**
HCFAC Discretionary	**$293,587**	**$293,588**	**$318,588**	**$25,000**
Non-CMS Administration 10/	**$2,060,046**	**$1,901,000**	**$1,950,000**	**$49,000**
CMS FTEs:				
Direct (Federal Administration)	4,689	4,542	4,738	196
Reimbursable (CLIA, CoB, RAC)	105	112	125	13
Subtotal, Program Management FTEs	**4,794**	**4,654**	**4,863**	**209**
Affordable Care Act (Mandatory)	26	29	29	0
ARRA Implementation (Mandatory)	124	130	161	31
Total, Program Management FTEs, Current Law	**4,944**	**4,813**	**5,053**	**240**
Program Management, Proposed Law	0	0	20	20
Total, Program Management FTEs	**4,944**	**4,813**	**5,073**	**260**
Affordable Care Act (Mandatory)	379	562	580	18
HCFAC Mandatory	192	237	241	4
HCFAC Discretionary	143	162	181	19
Medicaid Integrity (State Grants; Mandatory)	78	88	100	12
QIO	153	182	205	23
Total, CMS FTEs	**5,889**	**6,044**	**6,380**	**336**

1/ The FY 2013 Final column is shown as enacted, net of rescissions, transfers, reprogrammings and the sequester. FY 2013 staffing, as presented below, reflects actual FTE consumption.
2/ In FY 2015, CMS proposes to fund activities previously funded through the Research line in the Program Operations line.
3/ In Fiscal Years 2013 and 2014, the High-Risk Pool grants are considered a CHIMP and rebased mandatory once an appropriations bill is enacted.
4/ Reflects the transfer of the SHIP program to the Administration for Community Living (ACL) in FY 2014.
5/ CMS' FY 2015 request includes proposals for $400.0 million in administrative funding to implement the health care proposals in the President's budget, along with $30.0 million to extend funding for MIPPA section 183, Consensus-Based Entity, and ACA section 3014, Quality Measurement.
6/ The FY 2014 column excludes $5.1 million in 'pop-up' authority related to the FY 2013 sequester.
7/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.
8/ CMS' FY 2015 request includes proposals for three new offsetting collections: a Survey and Certification Revisit Fee, administrative fees to offset costs incurred for the Federal Payment Levy Program, and the retention of a portion HHA Civil Monetary Penalties for quality improvements.
9/ Includes ACA and ARRA mandatory funds included within the CMS Program Management account.
10/ Includes funds for the SSA, DHHS/OS, and the Medicare Payment Advisory Commission (MedPAC).

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

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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 **[**$3,669,744,000**]***$4,199,744,000*, 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, 2019**]***expended*: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further,* That the Secretary is directed to collect fees in fiscal year **[**2014**]***2015* 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 $22,004,000 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 **[**$3,669,744,000**]***$4,199,744,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;*	Provides an appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until **[**September 30, 2019**]***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.

Program Management

Language Analysis

Language Provision	Explanation
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2014**]***2015* 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 $22,004,000 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 2015. Funding for the State High-Risk Pool program, included in the reference to Title XXVII of the Public Health Service Act above, is no longer being requested in FY 2015.

CMS Program Management
Amounts Available for Obligation

	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,828,227,000	$3,952,740,000	$4,199,744,000
Across-the-board reductions (L/HHS)	-$7,656,000	$0	$0
Secretary's 1-Percent Transfer	$113,588,000	$0	$0
Sequester	-$192,583,000	$0	$0
Subtotal, Appropriation (L/HHS)	$3,741,576,000	$3,952,740,000	$4,199,744,000
Comparable transfer to (ACL):	-$46,040,000	$0	$0
Subtotal, adjusted trust fund discr. appropriation	$3,695,536,000	$3,952,740,000	$4,199,744,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$44,000,000	$22,004,000	$0
Sequester	-$2,244,000	-$1,584,000	$0
Subtotal, Appropriation (L/HHS)	$41,756,000	$20,420,000	$0
Bipartisan Balanced Budget	$0	$3,750,000	$0
ACA (PL 111-148/152) 1/	$25,440,000	$26,000,000	$6,000,000
ATRA (PL 112-240)	$17,500,000	$0	$0
Sequester	-$2,190,000	-$1,872,000	$0
Subtotal, trust fund mand. appropriation	$40,750,000	$27,878,000	$6,000,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund mand. appropriation	$40,750,000	$27,878,000	$6,000,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$110,000,000	$110,000,000	$50,000,000
PPHF	$453,803,000	$0	$0
Sequester	-$5,763,000	-$8,136,000	$0
Subtotal, trust fund mand. appropriation	$561,040,000	$104,864,000	$53,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$53,543,000	$50,000,000	$50,000,000
Coordination of benefits user fees	$41,307,000	$0	$30,000,000
MA/PDP user fees	$72,245,000	$71,100,000	$71,100,000
Sale of data user fees	$12,911,000	$7,240,000	$7,378,000
Provider enrollment user fees	$24,896,000	$27,735,000	$27,735,000
Marketplace user fees	$0	$215,517,000	$1,179,700,000
Recovery audit contracts	$502,355,000	$821,995,000	$750,000,000
Risk Corridors	$0	$0	$5,450,000,000
Sequester 2/	-$35,386,000	-$85,417,000	$0
Subtotal, offsetting collections 2/, 3/	$671,871,000	$1,108,170,000	$7,565,913,000
Unobligated balance, start of year	$1,130,727,000	$857,828,000	$716,613,000
Unobligated balance, end of year 1/, 2/, 3/	-$857,828,000	-$716,613,000	-$604,805,000
Prior year recoveries	$16,076,000	$0	$0
Unobligated balance, lapsing	-$43,950,000	$0	$0
Total obligations 3/, 4/	**$5,255,978,000**	**$5,355,287,000**	**$11,936,465,000**
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
Sequester	-$7,140,000	-$10,080,000	$0
Unobligated balance, start of year	$165,924,000	$168,277,000	$168,197,000
Unobligated balance, end of year	-$168,277,000	-$168,197,000	-$170,673,000
Prior year recoveries	$1,213,000	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$131,720,000**	**$130,000,000**	**$137,524,000**

1/ Excludes a $200.0 million rescission from ACA section 3026 in FY 2013.
2/ The FY 2013 user fee line includes $10.3 million in sequestration reductions.
3/ Current law display. Excludes the following amounts for reimbursable activities carried out by this account: FY 2013: $37,379,000. Reflects actual budget authority in FY 2013, comparably adjusted, as opposed to enacted values. In FY 2014, this table excludes $5.1 million in 'pop-up authority' related to the FY 2013 sequester.
4/ Excludes funding provided by the American Recovery and Reinvestment Act (ARRA; PL 111-5).

Summary of Changes

2014	
Total estimated budget authority 1/	$3,973,160,000
(Obligations) 1/	($3,994,171,000)
2015	
Total estimated budget authority 1/	$4,199,744,000
(Obligations) 1/	($4,199,744,000)
Net Change	**$226,584,000**

	2014 Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Pay Raise				$4,650,000
2. Annualization of Pay Raise				$1,550,000
3. Rent				$100,000
Subtotal, Built-in Increases 1/				**$6,300,000**
B. Program:				
1. Program Operations		$2,824,823,000		$698,381,000
2. Federal Administration	4,542	$732,533,000	196	$48,711,000
3. State Survey & Certification		$375,330,000		$49,827,000
Subtotal, Program Increases 1/				**$796,919,000**
Total Increases 1/				**$803,219,000**
Decreases:				
A. Program:				
1. Program Operations		$2,824,823,000		($535,313,000)
2. Federal Administration		$732,533,000		($44,000)
3. State Survey & Certification		$375,330,000		($804,000)
4. Research 2/		$20,054,000		($20,054,000)
5. State High-Risk Pools 3/		$20,420,000		($20,420,000)
Subtotal, Program Decreases 1/				**($576,635,000)**
Total Decreases 1/				**($576,635,000)**
Net Change 1/				**$226,584,000**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and obligations from mandatory funds, except State High-Risk Pools.
2/ In FY 2015, ongoing research activities will be funded from the Program Operations line.
3/ Displayed net of sequester in FY 2014.

American Recovery and Reinvestment Act (ARRA):

2014				
Total estimated budget authority 1/				$129,920,000
(Obligations)				($131,720,000)
2015				
Total estimated budget authority				$140,000,000
(Obligations)				($130,000,000)
Net Change				**$10,080,000**
Increases:				
A. Built-in:				
1. Pay Raise				$177,000
B. Program:				
1. Medicare and Medicaid HIT	130	$129,920,000	31	$14,837,000
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT		$129,920,000		($4,934,000)
Net Change				**$10,080,000**

1/ Displayed net of sequester in FY 2014.

CMS Program Management

Budget Authority by Activity

(Dollars in Thousands)

	FY 2013 Actual	FY 2014 Base	FY 2015 President's Budget
1. Program Operations	$2,658,900	$2,519,823	$2,987,891
Additional Medicare Operations Funding	$0	$305,000	$0
Secretary's 1-Percent Transfer	$113,588	$0	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
ACA (PL 111-148/152)	$20,000	$20,000	$0
ATRA (PL 112-240)	$17,500	$0	$0
Bipartisan Balanced Budget	$0	$3,750	$0
PPHF	$453,803	$0	$0
Enacted Rescission	-$5,318	$0	$0
Sequester	-$135,823	-$1,656	$0
Comparability Adjustment	-$45,115	$0	$0
Subtotal, Program Operations	**$3,080,535**	**$2,849,917**	**$2,990,891**
(Obligations)	($3,081,490)	($2,887,812)	($3,003,065)
2. Federal Administration	$772,963	$732,533	$787,500
ACA (PL 111-148/152)	$60,000	$60,000	$0
Enacted Rescission	-$1,546	$0	$0
Sequester	-$41,945	-$4,320	$0
Comparability Adjustment	-$925	$0	$0
Subtotal, Federal Administration	**$788,547**	**$788,213**	**$787,500**
(Obligations)	($787,383)	($839,722)	($859,710)
3. State Survey & Certification	$375,203	$375,330	$424,353
Enacted Rescission	-$750	$0	$0
Sequester	-$18,875	$0	$0
Subtotal, State Survey & Certification	**$355,578**	**$375,330**	**$424,353**
(Obligations)	($371,457)	($398,700)	($447,723)
4. Research, Demonstration & Evaluation	$21,160	$20,054	$0
ACA (PL 111-148/152)	$55,440	$56,000	$56,000
Enacted Rescission 1/	-$42	$0	$0
Sequester	-$3,892	-$4,032	$0
Subtotal, Research, Demonstration & Evaluation 1/	**$72,666**	**$72,022**	**$56,000**
(Obligations)	($331,324)	($99,633)	($60,054)
5. High-Risk Pool Grants	$44,000	$22,004	$0
Sequester	-$2,244	-$1,584	$0
Subtotal, High-Risk Pool Grants	**$41,756**	**$20,420**	**$0**
(Obligations)	($41,756)	($20,420)	$0
6. User Fees 2/	**$204,902**	**$371,592**	**$1,365,913**
Sequester 2/	-$10,268	-$26,233	$0
Subtotal, User Fees	**$194,634**	**$345,359**	**$1,365,913**
(Obligations)	($187,813)	($346,189)	($1,365,913)
7. Recovery Audit Contracts 2/	**$502,355**	**$821,995**	**$750,000**
Sequester	-$25,118	-$59,184	$0
Subtotal, Recovery Audit Contracts	**$477,237**	**$762,811**	**$750,000**
(Obligations)	($454,755)	($762,811)	($750,000)
8. Risk Corridors	**$0**	**$0**	**$5,450,000**
Sequester	$0	$0	$0
Subtotal, Risk Corridors	**$0**	**$0**	**$5,450,000**
(Obligations)			($5,450,000)
Total, Budget Authority 1/, 2/, 3/	**$5,010,953**	**$5,214,072**	**$11,824,657**
(Obligations) 2/, 3/	**($5,255,978)**	**($5,355,287)**	**($11,936,465)**
FTE 3/	**4,820**	**4,683**	**4,892**

1/ Excludes a $200.0 million rescission from ACA section 3026 in FY 2013.

2/ Reflects actual budget authority (BA) and staffing in FY 2013, comparably adjusted, as opposed to enacted values. The FY 2013 user fee line reflects $10.3 million in sequestration reductions. Excludes $37,379,000 for other reimbursable activities carried out by the Program Management account. In FY 2014, this table excludes $5.1 million in 'pop-up authority' related to the FY 2013 sequester.

3/ Reflects CMS' current law request.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$140,000**	**$140,000**	**$140,000**
Sequester	-$7,140	-$10,080	$0
Subtotal, ARRA	**$132,860**	**$129,920**	**$140,000**
(Obligations)	**($131,720)**	**($130,000)**	**($137,524)**
FTE	**124**	**130**	**161**

CMS Program Management
Authorizing Legislation

	FY 2014 Amount Authorized	FY 2014 Enacted	FY 2015 Amount Authorized	FY 2015 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite		
- Section 1115 1/	$2,000,000	$2,000,000		
b) P.L. 92-603, Section 222	Indefinite	Indefinite		
c) P.L. 90-248, Section 402	Indefinite	Indefinite		
d) Social Security Act, Title XVIII	Indefinite	Indefinite		
2. Program Operations:				
Social Security Act, Titles XI, XVIII, XIX and XXI	Indefinite	Indefinite	Indefinite	Indefinite
a) Social Security Act, Title XI				
- Section 1110			Indefinite	Indefinite
- Section 1115 1/			$2,000,000	$2,000,000
b) P.L. 92-603, Section 222			Indefinite	Indefinite
c) P.L. 90-248, Section 402			Indefinite	Indefinite
d) Social Security Act, Title XVIII			Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. High-Risk Pool Grants:				
Trade Act of 2002; High-Risk Pool Funding Extension Act of 2006	Indefinite	Indefinite	Indefinite	Indefinite
6. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
7. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003	2/	2/	2/	2/
8. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
9. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
10. Marketplace:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
11. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2015.
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
2006				
General Fund Appropriation:				
DRA (PL 109-171)	$0	$0	$0	$38,000,000
Trust Fund Appropriation:				
Base	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,170,927,000
Rescissions (P.L. 109-148/149)	$0	$0	$0	($91,109,000)
Transfers (P.L. 109-149)	$0	$0	$0	$40,000,000
DRA (PL 109-171)	$0	$0	$0	$36,000,000
Subtotal	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,155,818,000
2007				
Trust Fund Appropriation:				
Base	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,141,108,000
TRHCA (PL 109-432)	$0	$0	$0	$105,000,000
Subtotal	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,246,108,000
2008				
General Fund Appropriation:				
MMSEA (PL 110-173)	$0	$0	$0	$60,000,000
Supplemental (PL 110-252)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,207,690,000
Rescissions (P.L. 110-161)	$0	$0	$0	($56,038,000)
MMSEA (PL 110-173)	$0	$0	$0	$55,000,000
MIPPA (PL 110-275)	$0	$0	$0	$20,000,000
Subtotal	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,226,652,000
2009				
General Fund Appropriation:				
CHIPRA (PL 111-3)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,305,386,000
MIPPA (PL 110-275)	$0	$0	$0	$182,500,000
Subtotal	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,487,886,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Trust Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$2,000,000
2010				
General Fund Appropriation:				
ACA (PL 111-148/152)	$0	$0	$0	$251,600,000
Trust Fund Appropriation:				
Base **1/**	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,470,242,000
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$95,300,000
Subtotal	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,600,542,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2011				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$60,000,000
MMEA (PL 111-309)	$0	$0	$0	$200,000,000
Trust Fund Appropriation:				
Base **1/**	$3,646,147,000	$3,470,242,000	$3,470,242,000	$3,470,242,000
Rescissions (P.L. 112-10)	$0	$0	$0	($6,940,000)
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$527,750,000
Subtotal	$3,646,147,000	$3,470,242,000	$3,470,242,000	$4,026,052,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2012				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Trust Fund Appropriation:				
Base **1/**	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,879,476,000
Rescissions (P.L. 112-74)	$0	$0	$0	($7,249,000)
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$25,302,000
Subtotal	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,932,529,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2013				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Transfers	$0	$0	$0	$453,803,000
Sequestration	$0	$0	$0	($5,763,000)
Trust Fund Appropriation:				
Base **1/**	$4,820,808,000	$0	$4,370,112,000	$3,872,227,000
Transfers (P.L. 113-6)	$0	$0	$0	$113,588,000
Rescissions (P.L. 113-6)	$0	$0	$0	($7,656,000)
Sequestration	$0	$0	$0	($194,827,000)
ATRA (PL 112-240)	$0	$0	$0	$17,500,000
ACA (PL 111-148/152)	$0	$0	$0	$25,440,000
Sequestration	$0	$0	$0	($2,190,000)
Subtotal	$4,820,808,000	$0	$4,370,112,000	$3,824,082,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($7,140,000)
2014				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Sequestration	$0	$0	$0	($8,136,000)
Trust Fund Appropriation:				
Base **1/**	$5,217,357,000	$0	$5,217,357,000	$3,669,744,000
Additional Medicare Ops. (PL 113-76)	$0	$0	$0	$305,000,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$26,000,000
Bipartisan Balanced Budget				$3,750,000
Sequestration	$0	$0	$0	($1,872,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,001,038,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)
2015 2/				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Trust Fund Appropriation:				
Base	$4,199,744,000	$0	$0	$0
ACA (PL 111-148/152)	$0	$0	$0	$6,000,000
Subtotal	$4,199,744,000	$0	$0	$6,000,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

1/ High-Risk Pools are considered a CHIMP and rebased as mandatory once an appropriations bill is enacted.

2/ Reflects the FY 2015 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 2015

CMS Program Management has no appropriations not authorized by law.

Program Management
Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' traditional programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), as well as the insurance Marketplace, new private health insurance provisions and consumer protections enacted by the Affordable Care Act. The FY 2015 request includes funding for three of CMS' traditional Program Management line items: Program Operations, Federal Administration, and Medicare State Survey and Certification.

The table below and the subsequent narrative on the following language provide additional summary-level information on each of the line items in the FY 2015 request.

Program Management Summary Table
($ in millions)

Line Item	FY 2014 Enacted	FY 2015 Request	FY 2015 +/- FY 2014
Program Operations	$2,824.8	$2,987.9	+$163.1
Federal Administration	$732.5	$787.5	+$55.0
Survey & Certification	$375.3	$424.4	+$49.0
Research	$20.1	$0.0	-$20.1
State High Risk Pools	$20.4	$0.0	-$20.4
Program Management 1/	**$3,973.2**	**$4,199.7**	**+$226.6**
FTEs – Federal Administration	4,542	4,738	+196

1/ Numbers may not add, due to rounding. Numbers are adjusted to include High-Risk Pools.

FY 2015 Request

Program Management: CMS' FY 2015 Program Management request totals $4,199.7 million, a $226.6 million increase over the FY 2014 enacted level.

- Program Operations:

  CMS' budget request for Program Operations totals $2,987.9 million in FY 2015, a $163.1 million increase over the FY 2014 enacted level. This request includes $544.2 million for the Marketplace, excluding user fees. This request will allow CMS to continue to effectively administer Medicare, Medicaid, CHIP, and to implement and oversee private health insurance reforms such as the Marketplace.

  The majority of the Program Operations line funds CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System

(HIGLAS), maintain our 1-800 call centers, oversee Part C and D plans, and to provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2015 request includes funding for Medicaid and CHIP operations and ongoing research projects including a share of the Medicare Current Beneficiary Survey (MCBS).

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

- Federal Administration:

  CMS requests $787.5 million in FY 2015, a $55.0 million increase over the FY 2014 enacted level. The FY 2015 request includes $674.1 million to support 4,738 direct FTEs, an increase of 196 FTEs over the FY 2014 level. Our FY 2015 request also funds other objects of expense for ongoing activities and ACA implementation efforts. CMS' FY 2015 request includes $85.0 million to support the Marketplace.

- Survey and Certification:

  CMS requests $424.4 million in FY 2015, a $49.0 million increase over the FY 2014 enacted level. Of this amount, $367.9 million will support direct survey costs, $18.8 million will support additional costs related to direct surveys, and $37.7 million will be used for surveyor training, Federally-directed surveys and information technology. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and allows for policy level survey frequencies at other types of facilities.

- State High Risk Pools:

  Funding for State High Risk Pools is no longer requested as part of CMS' FY 2015 request. Enrollees in State high-risk pools can access affordable coverage through the Marketplace.

Program Management Proposed Law Summary

The CMS budget request includes proposed appropriations totaling $430.0 million in FY 2015. Of this amount, $400.0 million would be requested through a General Fund appropriation to implement the Administration's health care proposals. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our discretionary request. The remaining $30.0 million for the extension of CMS' consensus-based entity would be funded through mandatory offsetting collections from the HI and SMI Trust Funds.

CMS' FY 2015 request also includes proposals for offsetting collections, with collections expected to begin in Fiscal Years 2014 and 2015. The authority to implement the new user fees will be requested through authorizing language proposals, not appropriations language. These proposals are described in more detail below:

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

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

Extend Funding for CMS' Consensus-Based Entity ($30,000,000)

CMS' request includes a proposal to extend the funding for MIPPA section 183, Consensus-Based Entity, at $10.0 million per year from FY 2015 through FY 2017 in order to focus on performance measurement. In addition, CMS also proposes to extend the funding for ACA section 3014, Quality Measurement, at $20.0 million per year from FY 2015 through FY 2017. These extensions will allow CMS to continue support for a consensus-based entity who will develop multi-stakeholder groups and facilitate the stakeholder groups' input on the endorsement and use of endorsed and non-endorsed quality measures for reporting performance information.

Federal Payment Levy Program Fees

The Federal Payment Levy Program authorizes CMS to impose a levy on Medicare providers for debt owed to the Federal Government. The FY 2015 request includes a proposal that authorizes CMS to assess a fee that would offset the administrative costs incurred in carrying out this program. Under this proposal, the Department of the Treasury would continue to receive the full amount of the levy and the Medicare provider would pay fees directly to CMS to cover administrative costs. Collections are estimated at $2.0 million in FY 2015 for administrative costs (no budget impact).

Reinvesting Home Health Civil Monetary Penalties

Under current law, States conduct initial, recertification, and complaint surveys of Home Health Agencies (HHAs) under their purview; should the surveyors find an HHA

to be deficient in meeting required quality and safety standards, they can levy a variety of penalties, including CMPs, which are then returned in full to the Treasury. Under this proposal, CMS would be authorized to retain and invest a portion of the CMPs recovered from HHAs to help improve beneficiary quality of care and to assist HHAs in meeting Medicare's Conditions of Participation. Collections are estimated at $1.0 million in FY 2015 ($10 million cost over 10-years).

Survey and Certification Revisit Fees

CMS' FY 2015 request includes a proposal to collect and expend Survey and Certification Revisit Fees. This proposal will provide CMS the authority to charge providers fees to recover the full-cost of Medicare revisit surveys. Revisit surveys are conducted to verify that deficiencies cited during initial certification, recertification or substantiated complaint surveys have been corrected. Revisit Fees will allow CMS a greater ability to revisit poor performers while creating an incentive for facilities to ensure continuing quality of care. This fee would be phased in over a number of years to avoid undue disruption to health care facilities (no budget impact).

Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Program Operations	$2,772,488	$2,824,823	$2,987,891
Rescission	($5,318)	$0	$0
Sequester	($133,758)	$0	$0
Comparability Adjustment 1/	($45,115)	$0	$0
Mandatory Appropriation, Proposed Law 2/	$0	$0	$430,000
Appropriation, Net, Proposed Law	$2,588,297	$2,824,823	$3,417,891
Federal Administration	$772,963	$732,533	$787,500
Rescission	($1,546)	$0	$0
Sequester	($38,884)	$0	$0
Comparability Adjustment 1/	($925)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$731,608	$732,533	$787,500
State Survey & Certification	$375,203	$375,330	$424,353
Rescission	($750)	$0	$0
Sequester	($18,875)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$355,578	$375,330	$424,353
Research, Demonstration & Evaluation	$21,160	$20,054	$0
Rescission	($42)	$0	$0
Sequester	($1,065)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,053	$20,054	$0
State High-Risk Pool Grants 3/	$44,000	$22,004	$0
Rescission	$0	$0	$0
Sequester	($2,244)	($1,584)	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$41,756	$20,420	$0
Discretionary Appropriation, Net	**$3,695,536**	**$3,952,740**	**$4,199,744**
Mandatory Appropriation, Net 3/	**$41,756**	**$20,420**	**$0**
Mandatory Appropriation, Proposed Law	**$0**	**$0**	**$430,000**
Total Appropriation, Proposed Law 4/	**$3,737,292**	**$3,973,160**	**$4,629,744**

1/ Reflects the transfer of the SHIP's to the ACL in Fiscal Year 2014.
2/ Reflects the separate $400.0 million general fund appropriation needed to implement the proposals contaned in the President's Budget, along with $30.0 million in funding for CMS quality measure initiatives.
3/ In FY 2013 and FY 2014, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill is enacted.
4/ In addition, CMS is proposing offsetting collections for facility revisit surveys, the Federal Payment Levy Program recoupment of administrative fees, and reinvesting home health civil monetary penalties.

Program Operations

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$2,633,412,000	$2,824,823,000	$2,987,891,000	+163,068,000
Comparability Adjustment 1/	$(45,115,000)	$0	$0	+0
Adjusted BA 2/	$2,588,297,000	$2,824,823,000	$2,987,891,000	+163,068,000

1/ The FY 2013 Final level includes a comparability adjustment to reflect the FY 2014 transfer of funding for the State Health Insurance Assistance Program (SHIP) from CMS to the Administration for Community Living (ACL).

2/ The FY 2013 Final and FY 2014 Enacted Program Operations funding level does not include $20.053 and $20.054 million for Research, Demonstrations, and Evaluation funded from the Program Operations account in the FY 2015 budget requests.

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 2015 Authorization – One Year/Multi-Year
Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

CMS is responsible for administering and overseeing three of the Nation's largest ongoing health care programs. These programs include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with end-stage renal disease (ESRD); the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; and the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels.

In addition, CMS is responsible for operating the new Federal Marketplace (Marketplace), also known as the Exchange, for each State that elects not to establish a State-based Marketplace (SBM) program. The Marketplace allows individuals and small businesses to pool their purchasing power and compare health plan options on price and quality. Both the Federally-facilitated and State-based Marketplaces began enrollment on October 1, 2013.

CMS is also responsible for administering and overseeing private insurance oversight included in the Affordable Care Act (ACA). Some market reforms newly effective in 2014 include:

- Most health insurance issuers will be prohibited from denying coverage to people because of a pre-existing condition or any other health factor.
- Most health insurance issuers in the individual and small group markets will no longer be able to use factors -- such as pre-existing conditions, health status, claims history, duration of coverage, gender, occupation, and small employer size and industry - to charge consumers greater premiums.
- Expanded renewability requirements will prohibit most issuers from refusing to renew coverage because an individual or employee becomes sick or has a pre-existing condition.

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

Program Description and Accomplishments

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, 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 55.2 million beneficiaries expected in FY 2015. 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 2015, CMS estimates over 15 million beneficiaries will enroll in MA plans.

Medicare Part D provides voluntary prescription drug coverage. Most Medicare beneficiaries, including nearly 12 million low-income beneficiaries in 2015, 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 2015, approximately 41 million beneficiaries will receive Part D benefits, including approximately 39 million enrolled in a Part D private plan and 2 million who receive benefits through the Retiree Drug Subsidy.

Medicaid and CHIP

Authorized in 1965 under title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed jointly by States and the Federal Government that has provided health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. The ACA provided States the option of expanding eligibility for Medicaid to adults with incomes below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. In addition, Medicaid also provides community based long-term care services and supports to seniors and individuals with disabilities, as well as institutional care and long-term care services. As a result, Medicaid programs vary widely from State to State. The grants made to States for the Federal share of Medicaid services and State administration of this program is appropriated annually. They are explained in further detail in the Medicaid chapter, located within the “Mandatory Appropriations” section of this book. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid systems support, managed care review and oversight, Section 1115 waiver demonstration management, and other program-related initiatives.

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

Health Insurance Market Reform

CMS is responsible for operating the Federally-facilitated Marketplace in States that elect not to set up their own Marketplaces. Starting this year, the Marketplace gives millions of Americans and small businesses access to affordable coverage. Implementation of the Federally-facilitated Marketplace is an unprecedented effort for CMS. CMS' FY 2015 Program Management request includes $629 million in appropriated funding for the Marketplaces including $85 million in Federal Administration, which combined with $1.2 billion in projected user fee collections would fully fund the Marketplaces at a program level totaling $1.8 billion.

CMS, in close collaboration with the Departments of Labor and Treasury, is also responsible for ensuring compliance with the new insurance market rules enacted in the ACA. CMS oversees the new medical loss ratio rules, reviews large health insurance rate increases in States without an effective rate review program, and provides guidance and oversight for the new Marketplaces.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 123 million beneficiaries in FY 2015. The funding request for Research includes projects that cannot legally be funded with other CMS mandatory authorities.

Funding History (Non-Comparable)

FY 2009	$2,265,715,000
FY 2010	$2,335,862,000
FY 2011	$2,325,801,000
FY 2012	$2,658,900,000
FY 2013	$2,633,412,000
FY 2014	$2,824,823,000

Budget Request: $2,987.9 Million

CMS' FY 2015 budget request for Program Operations is $2,987.9 million, an increase of $163.1 million above the FY 2014 Enacted level. This request will allow CMS to continue operating Medicare, Medicaid, and CHIP, and to administer health insurance reforms, such as the Federally-facilitated Marketplace.

Program Operations
(Dollars in Millions)

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Operations[1]				
I. Medicare Parts A&B				
Ongoing Operations	$891.824	$781.599	$979.012	+197.413
FFS Operations Support	$49.261	$40.410	$48.307	+7.896
Claims Processing Investments	$61.289	$71.237	$82.311	+11.074
DME/Part B Competitive Bidding	$27.215	$60.000	$33.600	-26.400
Contracting Reform	$29.269	$16.194	$22.298	+6.104
II. Other Medicare Operational Costs				
Accounting & Audits	$160.438	$104.059	$129.659	+25.600
QIC Appeals (BIPA 521/522)	$68.669	$88.800	$121.436	+32.636
HIPAA Administrative Simplification	$23.542	$28.492	$53.571	+25.079
ICD-10/5010	$25.619	$27.998	$30.327	+2.329
Research, Demonstration, & Evaluation[2]	$20.053	$20.054	$15.967	+15.967
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	$19.029	$15.248	$31.464	+16.215
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$66.579	$60.154	$65.914	+5.760
Oversight & Management	$216.736	$196.863	$390.470	+193.607
V. Health Care Quality				
Health Care Improvement Initiatives	$80.923	$43.183	$69.127	+25.944
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$242.607[3]	$258.184	$335.362	+77.178
Provider Outreach	$28.688	$23.904	$24.534	+0.630
Consumer Outreach	$359.732	$90.244	$76.850	-13.394
VII. Information Technology				
IT Investments	$236.876	$613.253	$477.682	-135.571
VIII. Other				
Additional Funding for Medicare Operations	-	$305.000[4]	-	-305.000
TOTAL	**$2,588.297**	**$2,824.823**	**$2,987,891**	**+163.068**

[1] The levels below only reflect funding from discretionary Program Operations. Some activities are funded from multiple sources in FY 2013 and FY 2014.
[2] The FY 2013 final level and FY 2014 Enacted level for Research, Demonstration, and Evaluation are only shown for comparable purposes – FY 2013 and FY 2014 funding is provided under a separate PPA. The President's Budget includes the Research line in Program Operations.
[3] The FY 2013 final level includes a comparability adjustment (-$45.115 million) for the National Medicare Education Program (NMEP) to reflect the FY 2014 transfer of funding for the SHIP from CMS to the ACL.
[4] This funding was appropriated under Section 222 of the Consolidated Appropriations Act, 2014 to support program management activity related to the Medicare Program.

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

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

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

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

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

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

Medicare Appeals – The statutorily mandated Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse contractor determination, including coverage and payment decisions. There are five levels in the Medicare Part A and

Part B appeals process starting with the Medicare Administrative Contractor (MAC) and ending with judicial review in Federal District Court.

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

In FY 2013, the MACs processed approximately 3.5 million redeterminations. In FY 2014, CMS anticipates the MACs will process 3.8 million redeterminations. In FY 2015 CMS estimates the MACs will process over 4.0 million redeterminations reflecting higher than normal but steady growth in the number of redeterminations as seen in prior fiscal years.

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

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

In FY 2013, contractors responded to almost 36 million telephone inquiries and 600,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. The contractors utilized Interactive Voice Response (IVR) systems to automate approximately 64 percent of their telephone inquiries. CMS estimates receiving 34 million telephone inquiries in FY 2015 and a slight increase in the IVR utilization rate. Utilization of the IVR frees up customer service representatives to handle the more complex questions. CMS has made a number of efforts that contribute to decreased volume in FFS provider calls to MAC contractors' toll free lines. These efforts include:

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

The following table displays provider toll-free line call volumes from FY 2009 through FY 2015 (estimated):

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

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Final	FY 2014 Estimate	FY 2015 Estimate
Completed Calls	50.1	44.4	41.1	38.8	35.6	34.4	34.4

CMS believes the FFS related call volume will slightly decline in FY 2014 and remain stable in FY 2015, allowing CMS to absorb inquiries related to the implementation of Medicare related ACA provisions and other initiatives, such as ICD-10 and allowing CMS to provide better service for more complex calls.

Participating Physician/Supplier Program (PARDOC) – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who "participate" in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows. Every year, the MACs are instructed to furnish participation enrollment materials to providers. The open enrollment period runs from November 15 through December 31 of each year. CMS has made more information available at http://www.medicare.gov about physicians participating in Medicare. The National Participating Physician Directory includes the providers' medical school and year of graduation, any board certification in a specialty, gender, hospitals at which they have admitting privileges, and any foreign language capabilities. In 2013, 716,676 physicians "participated" out of 735,041 enrolled physicians (97.5%), and out of a total of 1,232,819 physicians, LLPs, and NPPs, 1,190,353 participated (96.6%).

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.

Virtual Data Centers - The Virtual Data Centers (VDC) are the foundation that supports all CMS production data center operations. CMS requires continual updating of its infrastructure to meet the growing legislation, administrative, and technical demands of an evolving health care landscape. The establishment of the new VDC Infrastructure has built upon the solid foundation of the Enterprise Data Centers and currently supports traditional CMS data center workloads like Medicare fee for Service Claims processing, the Medicare.gov website, and the Medicare

Provider systems while expanding to provide hosting services for new ACA workloads like the Healthcare.gov, Medicaid and CHIP Business Information Solutions (MACBIS), and the Open Payments systems. A standardized architecture across 8 VDCs allows for consistent and stable operations that are flexible enough to support the business needs of CMS.

Budget Request: $979.0 Million

The FY 2015 budget request for Ongoing Operations is $979.0 million, an increase of $197.4 million above the FY 2014 Enacted level. CMS' request supports a projected 1.5 percent increase in claims volume from the current FY 2014 projections.

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

In FY 2015, CMS' contractors expect to:

- Process nearly 1.3 billion claims
- Handle 4.0 million redeterminations
- Answer 34.4 million toll-free inquiries

The following table displays claims volumes and unit costs for the period FY 2009 to FY 2015. The unit costs reflect the total funds provided to our contractors in the Ongoing Operations line for claims processing, data centers, appeals, inquiries, enrollment, outreach and education, provider reimbursement, and PARDOC workloads. CMS has maintained its unit cost over the last several years. We remain committed to achieving efficiencies in our fee-for-service operations.

Claims Volume and Unit Costs
(FYs 2009 – 2015)

Volume (in millions)	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**	**FY 2014 Estimate**	**FY 2015 Estimate**
Part A	191.4	195.2	199.1	207.3	207.6	210.7	213.9
Part B	992.2	979.5	989.8	1,011.9	1,006.3	1,021.4	1,036.7
Total	**1,183.6**	**1,174.7**	**1,188.9**	**1,219.2**	**1,213.9**	**1,232.1**	**1,250.6**
Unit Cost (in dollars)							
Total	**$0.85**	**$0.89**	**$0.87**	**$0.83**	**$0.78**	**$0.76***	**$0.78**

* Represents estimated costs per claim. When all Program Operations funding is distributed, FY 2014 unit cost calculations could change.

Fee-for-Service Operations and Systems Support

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

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

Office of Minority Health - The Centers for Medicare and Medicaid Services Office of Minority Health (OMH) is responsible for providing leadership, vision and direction to address HHS and CMS Strategic Plan goals and objectives related to improving minority health and eliminating health disparities. CMS is developing programs in and consulting with HHS Federal agencies and other public and private sector agencies and organizations to collaborate in addressing health equity.

Provider Internet Transaction Pilots - Medicare Administrative Contractors (MACs) have been in the process of establishing internet based services for providers. There are ongoing changes to meet new CMS requirements to insure continued compliance with CMS architecture, security, privacy, and data exchange requirements. CMS must support the existing portals, and ensure continued contractor compliance with Agency standards.

Prototypic Shared Services - The purpose of the Shared Services investment is to implement shared services across the agency to more effectively conduct our business, to create efficiencies by leveraging resources and to realize cost savings. CMS is looking to leverage existing projects/systems/programs and refine systems to meet crosscutting business needs. There are multiple projects that fall under prototypic shared services including but not limited to Conference Planning, Sharepoint, EPPE, etc.

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.

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.

Claims Surveillance DME Competitive Bidding & Bundled ESRD PPS - CMS has developed the capacity to monitor claims and assessment data to examine key aspects of our payment programs. This payment monitoring capacity allows for program officials to analyze the effects of changes to the payment system on beneficiary utilization, health outcomes and care delivery. CMS will continue with our work to expand and update these claims surveillance programs as well as develop a broader monitoring framework to address spending variation across the Medicare program.

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. CMS performs provider enrollment, claims processing, payment, program integrity, and customer service.

Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures - It is critical to CMS' mission to continue disseminating information that will help Medicare Advantage (MA) beneficiaries choose among health plan information that contributes to better health care through the identification of quality improvement opportunities and provides for the proper oversight and management of the MA programs. CMS provides for the proper oversight and management of MA organizations (MAOs) and SNPs quality performance by developing and improving specific HEDIS measures for MAOs and SNPs, reviewing and approving SNP Models of Care as well as reviewing and approving SNP Structure and Process (S&P) measures.

Home Health Prospective Payment System (PPS) Refinement - CMS must continue to monitor the effects of payment system revisions; case-mix growth in the home health industry; and potential suspect billing patterns which may require immediate HH PPS changes. Analytical support is critical for assessing the effects of the home health PPS refinements and revisions. This valuable research and analysis will continue to further strengthen the HH PPS.

Budget Request: $48.3 Million

The FY 2015 budget request for fee-for-service operations support is $48.3 million, an increase of $7.9 million above the FY 2014 Enacted level. The increase supports the FY 2015 funding request for Minority Health initiatives. The activities that make up this request are as follows:

Printing and Postage: $7.2 million, a decrease of $0.6 million below the FY 2014 Enacted level. This funds CMS' ongoing FFS printing and postage needs.

Minority Health: $6.0 million, an increase of $6.0 million above the FY 2014 Enacted level. Funding is necessary for contract costs to aid in the analysis and support to provide more culturally and linguistically appropriate services for CMS beneficiaries, addressing diabetes health and health care disparities, improving access to care for the newly insured and improving CMS' understanding of disparities in access to care and health care quality.

MAC Provider Internet Transaction Portals: $4.8 million, an increase of $4.1 million above the FY 2014 Enacted level. This request supports maintenance and expansion of existing MAC provider portals for claims-related transactions and continued compliance with associated security documents and processes. In FY2015, CMS plans to begin the migration of the MAC internet portals to the enterprise portal and to using Enterprise Identify Management (EIDM), two of the Agency's shared services. The anticipated costs to migrate are $600,000 per contractor portal. Because there are 8 unique portals, the total costs are anticipated to be $4.8 million in fiscal year 2015. Integration of the MAC portals as portlets within the enterprise portal will happen concurrently with the migration to EIDM.

Actuarial Services & Contract Audits: $3.4 million, a decrease of $0.4 million below the FY 2014 Enacted level. This request supports contracts assisting the Actuary in providing cost estimates for various demonstrations and other issues required by provisions of law. In addition, this

funding will be used to enter into agreements with the Defense Contract Audit Agency, as well as contracts with support contractors to aggressively address any backlogged audit efforts.

Ongoing ACA Reform and Support Cost: $2.7 million, an increase of $0.4 million above the FY 2014 Enacted level. This request supports contract costs for Hospice Payment Reform, Mis-valued Physician Fee Schedule Codes, Consumer Research/Social Marketing to Support ACA, and Improvements to Medicare DSH Implementation.

Prototypic Shared Services: $2.3 million, a decrease of $1.8 million below the FY 2014 Enacted level. This will fund the next phase of development of business requirements for the Sharepoint collaboration tool. There are at least 8 collaboration tools that CMS is using and the goal of the requirements gathering is to reduce the number of disparate tools to achieve better coordination, communication, and cost savings through economies of scale and to reduce duplication.

This will also fund the refinement of the business requirements and the reengineering of Data Agreement and Data Shipping Tracking System (DADSS) for the Data Use Agreement (DUA) automation efforts. The DUAs are for both internal enterprise as well as external stakeholders who would like access to CMS data.

Medicare Beneficiary Ombudsman: $2.1 million, an increase of $0.5 million above the FY 2014 Enacted level. This request provides continued support in developing the Medicare Beneficiary Ombudsman Report to Congress and the CAO Report to Congress, support of identifying, tracking, and analyzing systemic Medicare program issues and support for Ombudsman-focused outreach mechanisms.

A-123 Assessment: $2.0 million, the same as the FY 2014 Enacted level. 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.

Claims Surveillance DME Competitive Bidding & Bundled ESRD PPS: $1.7 million, a decrease of $0.8 million below the FY 2014 Enacted level. Funding will allow for the continuation of a research and analysis contract with the University of Michigan and will include updating analytic files, conducting complex case mix adjustment research including comorbid conditions, developing and modeling options for refinements to the ESRD, and providing critical regulatory support. Funding for 2015 incorporates a 3% increase in costs as specified in the contract.

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens: $1.4 million, a decrease of $0.8 million below the FY 2014 Enacted level. Contracting support is necessary to operate the program and process payments quarterly. The funding needs have decreased due to providers in a number of States exhausting their allotments resulting in a reduction in the number of payment requests. Additional program efficiencies also have been implemented by the administrative contractor, which results in savings.

Medicare HEDIS Quality of Care Performance Measures: $1.2 million, a decrease of $0.3 million below the FY 2014 Enacted level. Funding supports a contractor that coordinates and provides research support to the Geriatric Advisory Panel (GMAP) to assist in the development,

evaluation, and refinement of quality of care performance measures relevant to MA organizations.

Home Health PPS Refinement: $1.0 million, the same as the FY 2014 Enacted level. Funding supports reassessing the current HH PPS and developing recommendations for changes in payment methodology to better align payment with patients' needs and address payment incentives and vulnerabilities.

Other Operational Costs: $12.5 million, an increase of $1.6 million above the FY 2014 Enacted level. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

Claims Processing Investments

CMS' claims processing systems currently process nearly 1.3 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: $82.3 Million

The FY 2015 budget request for claims processing investments is $82.3 million, an increase of $11.1 million above the FY 2014 Enacted level. This request reflects the ongoing costs associated with maintaining claims processing systems. Maintaining these systems will provide integration and regression testing for claims adjudication, payments, and remittance advices that support various system interfaces, which is essential in ensuring accurate payments. Software changes to the claims processing systems has four quarterly releases that control, implement, and update software changes due to legislative mandates that dictate the amount of payment for services or coverage levels. Additionally these systems must implement changes needed to support the Medicare Administrative Contractor (MAC) authority for the Medicare Fee for Service Program.

Competitive Bidding

DME Competitive Bidding – Section 302(b)(1) of the MMA authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007. MIPPA and the ACA subsequently amended and expanded the program to cover 100 MSAs after implementation of Round 2, and the ACA mandates that all areas of the country must be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Budget Request: $33.6 Million

The FY 2015 budget request for competitive bidding is $33.6 million, a decrease of $26.4 million below the FY 2014 Enacted level. CMS is requesting a reduced amount in FY 2015 (as compared to FY 2014) due to the non-severable nature of the work attributed with re-competing Round 2 and the National Mail Order (NMO) contract. Due to the timing of the bidding cycle, the entire funding for this workload is required in the last quarter of FY 2014. The funding required for 2015 reflects the work remaining to be completed for the competitive bidding process for those bidding rounds.

Funding is needed for the Competitive Bidding Implementation Contractor (CBIC) to expand operations in order to successfully re-compete the Round 2, NMO, and Round 1 Re-compete competitions. In addition to conducting these competitions, CMS must continue to conduct the oversight and maintenance periods for the Round 2, NMO, and Round 1 Re-compete competitions. Additionally, the Competitive Bidding Program requires CMS to update and maintain the bidding system along with the bid evaluation system.

The DMEPOS competitive bidding program saved the Medicare fee-for-service program approximately $400 million over the first two years of operation, and according to current actuarial estimates, the program is projected to save the Medicare program approximately $27 billion between 2015 and 2024, with an additional $18 billion in savings for beneficiaries during that same period.

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. Following are the major funding requirements for this effort:

IT Systems - Contractor Management Information System (CMIS), maintenance and enhancements for the electronic change management portal (eChimp) system, and the Common Electronic Data Interchange (CEDI) system. The CMIS is an application that allows CMS to effectively manage, monitor, and report on the performance of its Medicare fee-for-service contractors. CMIS is a web-based analytical application that has been deployed on the

CMS net. The eChimp system is used by CMS, Medicare FFS Contractors, and MACs to support the Fee for Service Change Management Process. This support includes online forms for the MACs to report the functions involved in reviewing and implementing the requirements in the change requests and an electronic approval process. The CEDI front-end system provides a single front-end solution for the submission of electronic claims-related transactions for Medicare durable medical equipment suppliers. This standardization allows greater efficiencies in inbound and outbound EDI exchange. The need for standardization, modernization, and consolidation in both front-end and post-claims adjudication functions and processes is imperative for efficiencies. The Standard Front End (SFE) is a system that is cost effective, extensible, and sufficiently flexible to meet current needs and support future enterprise EDI and electronic commerce requirements.

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

CMS began to develop detailed acquisition plans and solicitation documents for the "second generation" contracts in FY 2009. As of the end of FY 2013, CMS has completed and implemented all four "second generation" DME MAC contract awards. In addition, CMS is now in the process of procuring "second generation" A/B MAC contracts.

On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of procurements. Through a series of incremental actions, CMS plans to reduce the number of A/B MACs from fifteen to ten by 2017. As of the end of FY 2013, CMS has competed and implemented five of these "second generation" (or Round II) A/B MAC contracts (A/B MAC Jurisdictions E, F, H, L and K). During FY 2014 and 2015, in addition to settling out a number of legacy (FI/carrier) contract termination claims, including the last FI and carrier contracts (which related to Jurisdiction 6), CMS also anticipates awarding and implementing the Round II contracts for Jurisdictions N, J and M (formerly Jurisdictions 9, 10 and 11).

Below is the general status of MAC procurements as provided on the following link: http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACContractStatus.html

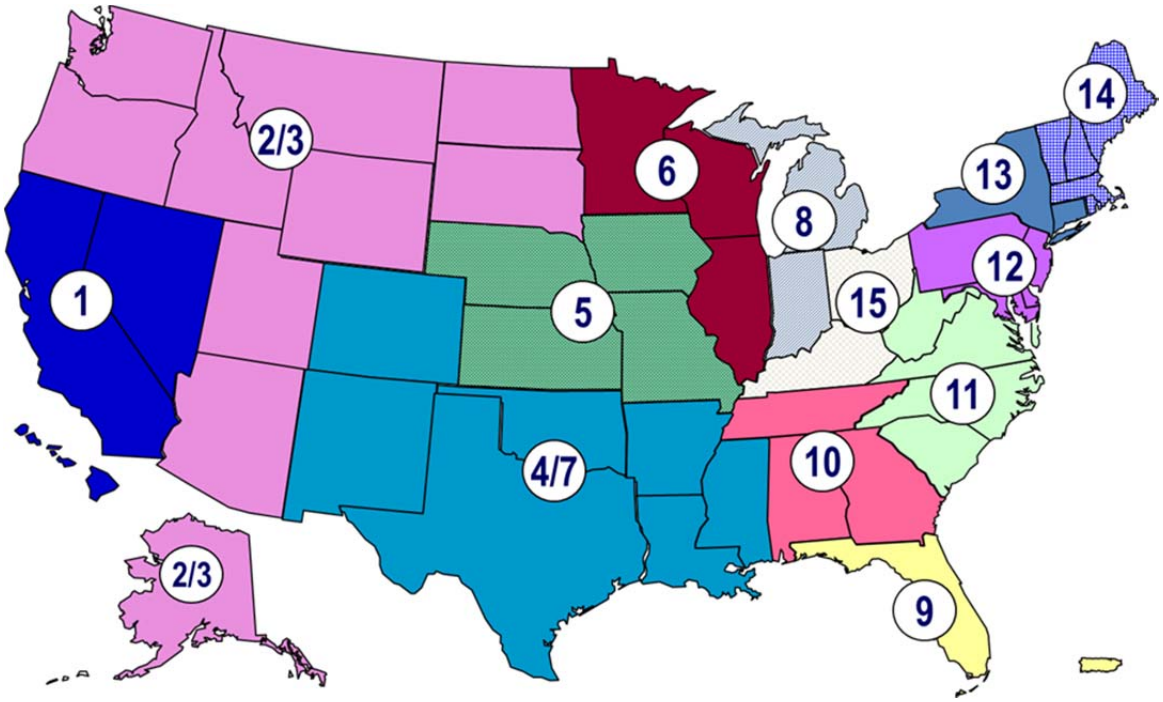
Former Jurisdiction Designation	New Jurisdiction Designation	Current Contractor	Status
A (DME)	[no change]	NHIC, Corp.	Fully Implemented NHIC Awarded Rebid 3/2011
B (DME)	[no change]	National Government Services, Inc. (NGS)	Fully Implemented NGS Awarded Rebid, 9/2010

Former Jurisdiction Designation	New Jurisdiction Designation	Current Contractor	Status
C (DME)	[no change]	CGS Administrators, LLC	Recompete Contract Awarded to CGS Administrators, LLC on August 31, 2012. Award protest received; protest denied 12/21/2012. Contract was Fully Implemented as of April 2013.
D (DME)	[no change]	Noridian Healthcare Solutions,LLC (Noridian) (formerly Noridian Administrative Services)	Fully Implemented Noridian Awarded Rebid, 2/2011
1	E	Palmetto Government Benefits Administrators	Recompete contract awarded to Noridian on September 20, 2012. Award protest received; COFC denied protest on 4/17/2013. Jurisdiction E was fully implemented September 13, 2013
2	F	Noridian Healthcare Solutions,LLC (Noridian) (formerly Noridian Administrative Services)	Consolidated with Jurisdiction 3 forming Jurisdiction F. Contract awarded to NAS 8/2011; contract fully implemented February 28, 2012
3	F	Noridian Healthcare Solutions,LLC (Noridian) (formerly Noridian Administrative Services)	Contract awarded to NAS 8/2011. Consolidated with Jurisdiction 2 forming Jurisdiction F; contract fully implemented February 28, 2012
4	H	Novitas Solutions, Inc. (formerly Highmark Medicare Services)	Consolidated with Jurisdiction 7 forming Jurisdiction H. Contract awarded to Highmark Medicare Services (now called Novitas Solutions Inc.) on 11/9/11; Award protest received; GAO denied the protest on 3/1/2012. Fully Implemented November 2012
5	G	Wisconsin Physicians Service Insurance Corporation (WPS)	Re-compete contract awarded to WPS on July 31, 2012. Implementation complete To be consolidated with Jurisdiction 6 in several years (and renamed Jurisdiction G)

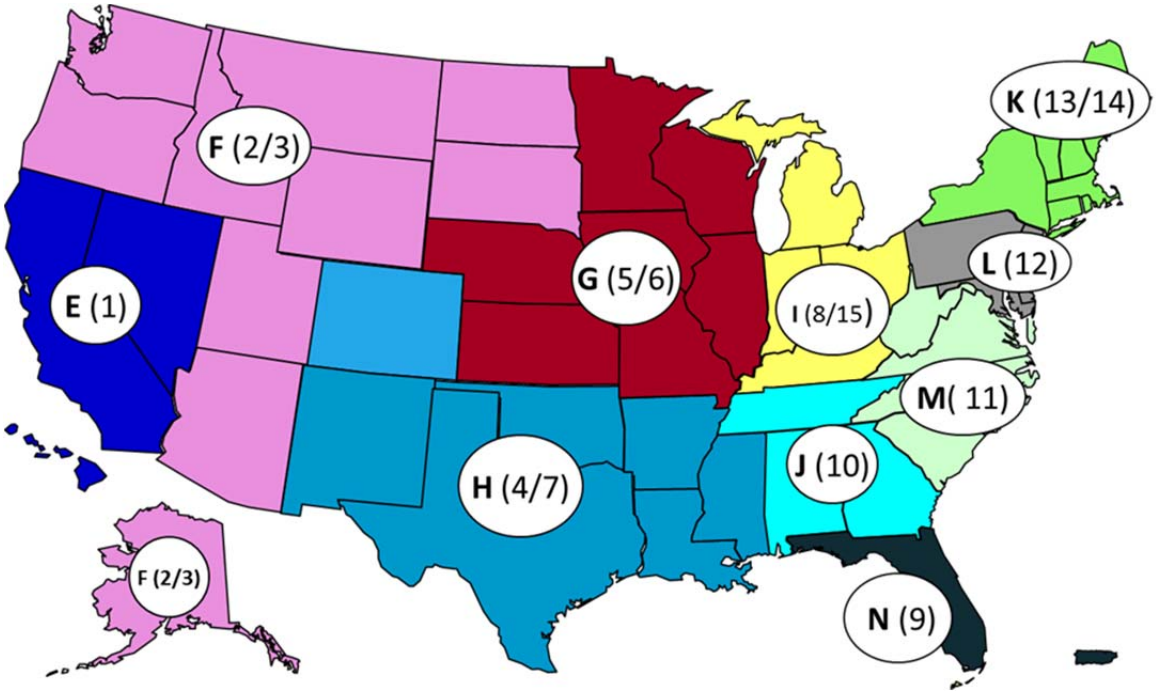
Former Jurisdiction Designation	New Jurisdiction Designation	Current Contractor	Status
6	G	National Government Services, Inc.	Contract awarded to NGS 9/27/2012. Award protests received; GAO denied both protests 1/16/2012. Jurisdiction 6 was fully implemented September 7, 2013.
7	H	Novitas Solutions, Inc. (formerly Highmark Medicare Services)	Consolidated with Jurisdiction 4 forming Jurisdiction H. Contract awarded to Highmark Medicare Services (now called Novitas) on 11/09/11; Award protest received; GAO denied the protest on 3/01/2012. Fully implemented November 12, 2012
8	I	Wisconsin Physicians Service Insurance Corporation	Contract awarded to WPS 09/30/2011; Award protest received; GAO denied protest 1/30/2012; Implementation completed on 8/20/2012. To be consolidated with J15 in several years
9	N	First Coast Service Options, Inc.	Recompete in progress as of 2/22/2013
10	J	Cahaba Government Benefit Administrators	Recompete in progress as of 2/22/2013
11	M	Palmetto Government Benefits Administrators	Fully implemented June 2011
12	L	Novitas Solutions, Inc.	Recompete contract awarded to Novitas Solutions, Inc. on September 17, 2012. GAO resolved the protest on April 16, 2013. Jurisdiction L contract was fully implemented July 29, 2013.
13	K	National Government Services, Inc.	Recompete contract awarded to NGS on February 22, 2013. Jurisdiction K was fully implemented October 25, 2013.

Former Jurisdiction Designation	New Jurisdiction Designation	Current Contractor	Status
14	K	NHIC, Corp.	Recompete contract awarded to NGS on February 22, 2013. JK was fully implemented October 25, 2013.
15	I	CGS Administrators, LLC	Fully implemented October 17, 2011. To be consolidated with Jurisdiction 8 in several years

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



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



Budget Request: $22.3 Million

The FY 2015 budget request for contracting reform is $22.3 million, an increase of $6.1 million above the FY 2014 Enacted level. This request includes funding for MAC implementation and transition costs as a result of re-competes, implementation and audit expertise, and four IT systems.

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

IT Systems: $8.8 million, an increase of $3.1 million above the FY 2014 Enacted level. This budget request continues the efficiencies produced by the Contractor Management Information System (CMIS), eChimp system and Common Electronic Interchange System (CEDI). This funding also includes the Standard Front End system which provides opportunities to consolidate CMS's current EDI solutions efficiently into a single, logical service, reduce maintenance requirements, and save costs.

MAC Transition Costs: $13.5 million, an increase of $3.0 million above the FY 2014 Enacted level. CMS' request supports contract termination claims/settlements that will come due in FY 2015 for several large legacy contracts that ended during FY 2013 and will need to be settled out in FY 2015.

Moreover, this funding will provide for any required transition costs when CMS replaces incumbent MACs with new contractors, such as for performance reasons. This funding allows for the smooth transition of Medicare contract activities from one Medicare contractor to another and ensures continuity of Medicare claims operations.

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. This will save millions of taxpayer dollars that fund Medicare and Medicaid each year, while eliminating redundant and inefficient / ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (DHHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with DHHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of DHHS.

HIGLAS implementation has yielded significant improvements and benefits to the Nation's Medicare program which has strengthened the Federal government's fiscal management and program operations/management of the Medicare program. HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS is a critical success factor in ensuring DHHS meets FFMIA compliance requirements. Through the implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the implementation of administrative program accounting functions at CMS central office, 100% of CMS core program dollars (Medicare, Medicaid and Children's Health Insurance Program (CHIP)) are accounted for in HIGLAS. In addition, the transition of Medicare contractors to HIGLAS enables CMS to resolve material weaknesses identified in the CFO audits related to the accounting of Federal dollars. The MAC transition schedule was completed in FY12.

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

May 2005 through FY 2013, CMS estimates that more than $620 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes. In addition, new financial functionality for the Affordable Care Act related legislation has been implemented in HIGLAS. During 2nd Quarter FY14, CMS implemented the initial capability to account for the Health Insurance Marketplace payments in HIGLAS. Additional programs and financial functionality for the Affordable Care Act related legislation is planned for implementation in HIGLAS during FY15.

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

Budget Request: $129.7 Million

The FY 2015 budget request for HIGLAS and the CFO audit is $129.7 million, an increase of $25.6 million above the FY 2014 Enacted level. In FY 2015, CMS will support the production and application maintenance of HIGLAS, as well as support future system enhancements, upgrades, and/or initiatives.

HIGLAS: $119.7 million. This request supports operations and maintenance costs including payment to the entity that performs data processing and hosts the HIGLAS application (including hardware and software maintenance), payment for the disaster recovery hot site and continuity of operations support, development and implementation of quarterly software releases to update HIGLAS for changes in two Medicare claims processing and payment rules systems, shared system maintainer costs related to changes made to enable HIGLAS interfaces, HIGLAS production help desk, and HIGLAS technical and analytical services. This budget request is also attributable to future system enhancements, new initiatives, and/or new legislative mandates. During this time period, HIGLAS will complete a software upgrade, as well as implement additional Affordable Care Act activities related to the Marketplace, such as the Reinsurance Contributions and Payments, Cost-Sharing Reduction (CSR) Reconciliation, Risk Adjustment Collections and Payments, and Risk Corridors.

HIGLAS Costs - FY 2012 through FY 2015
(Dollars in Millions)

	FY 2012 Final	FY 2013 Final	FY 2014 Enacted	FY 2015 PB
Development, Modernization & Enhancement	$33.9	$32.2	$8.5	$4.0
Operations & Management	$118.2	$118.2	$85.7	$115.7
Total	$152.1	$151.4	$94.2	$119.7

CFO/Financial Statement Audits: $10.0 million. The cost of the audit is funded through an interagency agreement between CMS and the Department. The request is based upon the General Services Administration (GSA) rate schedules and federal audit requirements.

Qualified Independent Contractor Appeals (QIC)

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

Generally, QICs must process Medicare Parts A & B claim appeals within 60 calendar days of the date the QIC receives a timely filed reconsideration request.[5] In accordance with 42 CFR §405.970(c), if a QIC is unable to complete the appeal within the mandated timeframe, then it must notify the appellant that it cannot timely complete the appeal and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge (ALJ).

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

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

Budget Request: $121.4 Million

The FY 2015 budget request for QIC appeals (BIPA section 521) is $121.4 million, an increase of $32.6 million above the FY 2014 Enacted level. Of this request, the Budget includes $114.5 million for QIC operations, an increase of $31.0 million above the FY 2014 Enacted level and $6.9 million for Medicare Appeals System costs, an increase of $1.6 million above the FY 2014 Enacted level. CMS' substantial increase in funding for QIC operations is necessary to manage the increase in workloads and to complete appeals within the required 60-day timeframe.

The number of appeals has consistently increased over the last several years. In FY 2013, the largest appeals increases have involved Part A Durable Medical Equipment (DME) claims. CMS is anticipating continued increases in overall appeal receipts in FY 2014 and FY 2015. The workload chart below contains actual receipts by fiscal year and current projections of appeals for FY 2013 through FY 2015.

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

The following chart displays historical QIC appeals and anticipated appeals workload for the upcoming fiscal years:

QIC Appeals Workload

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Estimate	FY 2015 Estimate
QIC Appeals	456,849	494,077	520,221	758,921	989,944	1,187,933	1,306,726
% Increase from Previous Year	11.0%	8.1%	5.3%	45.9%	30.4%	20.0%	10.0%

The following chart details the percentage of appeals completed in the statutory timeline by type from FY 2007 through FY 2014:

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%	92.76%
2012	82.23%	88.99%
2013*	21.47%	99.75%
2014*	90.58%	99.93%

*MAS data as of Feb 12, 2014 (FY 2014 represents Oct 13 - Jan 14)

With well over 100 million claims denied each year, it is difficult to pinpoint a single cause for the increase in appeal receipts. Many factors have contributed to the increases in recent FYs and anticipated increases in the future:

- Continued growth in the beneficiary population.

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

- Increased program integrity efforts and medical review initiatives to ensure proper claims payment. The implementation of the Fraud Prevention System, along with increased efforts in traditional methods to review and edit claims to detect improper payments, increases the number of claims denials that will be appealed.

- Continued increase in Part A appeals submitted by State Medicaid Agencies for home health claims that were previously part of a CMS/SMA third party liability demonstration; and

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

HIPAA Administrative Simplification

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

- *National Provider Identifier (NPI) & National Plan and Provider Enumeration System (NPPES)* – HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. CMS was delegated the responsibility to build a system, known as the NPPES, which assigns NPIs and processes NPI applications. It also makes subsequent changes to the data of enumerated providers. Providers are required to keep their NPPES data current by submitting timely updates. CMS estimated that there are approximately 2.3 million covered health care providers who must obtain NPIs and approximately 3.7 million non-covered providers who may be eligible and apply for NPIs. Currently, over 4.0 million NPIs have been assigned and over 4.3 million changes have been applied to the NPPES records of enumerated providers.

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

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

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

    - Enforcement activities consist of investigating contractor activity to review, providing analysis and tracking complaints. The enforcement contract includes maintenance of the website for electronic submission of complaints; assistance with evaluating technical complaints; and managing the correspondence to and from complainants and the entities against which the complaint is filed. The Administrative Simplification Enforcement Tool (ASET) is a web-based application that provides online complaint

filing and management to parties who wish to file a complaint. Enforcement also includes a HIPAA Identification Tracking System (HITS) tool which compiles statistics and generates reports for use in managing the complaint process. The system currently has information on 1,200 complaints.

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

- *ACA Initiatives Sections 1104 and 10109* – Section 1104 establishes a series of new operating rules and standards for administrative transactions that will improve the utility of the existing HIPAA transactions. The law mandates substantial additional requirements for all HIPAA covered entities such as industry health plans, providers, and clearinghouses. Additionally, all CMS health care programs such as Medicare, Medicare Advantage, Medicaid, Accountable Care Organizations, and health plans participating in the Marketplaces are required to comply with the requirements or face hefty penalties.

  While past standards significantly decrease administrative burden on covered entities by creating greater uniformity in data exchange and reduce the amount of paper forms needed for transmitting data, gaps created by the flexibility in the standards permit each health benefit plan to use the transactions in very different ways. ACA amended Administrative Simplification helps to close these gaps and creates uniformity.

  - *Section 1104* requires the Secretary to adopt 2 new standards and 8 new sets of operating rules for administrative transactions by 2016. It also establishes a Review Committee to recommend amendments to standards and operating rules. The law requires that CMS and all health private and commercial health plans adopt and implement an ongoing certification of compliance process triggered with every new or modified standard or operating rule. This requires CMS to build the infrastructure and systems to certify health plans, establish a new enforcement and appeals process that ensures certification compliance, and design the internal systems and processes to assess federally mandated penalties and to comply with Treasury reporting requirements.

  - *Section 10109* requires that the Secretary seek input from the National Committee on Vital and Health Statistics (NCVHS) and industry groups on specific areas to further reduce administrative costs, including: Provider Enrollment, Property and Casualty Industry Inclusion under HIPAA, Consistency and Standardization in Audits, and Consistency of Claim Edits.

Budget Request: $53.6 Million

The FY 2015 budget request for HIPAA Administrative Simplification is $53.6 million, an increase of $25.1 million above the FY 2014 Enacted level. The increase supports CMS' HIPAA

administrative simplification efforts as mandated by the ACA. Funding is requested for the following activities:

- *NPI & NPPES*: $8.3 million, a decrease of $0.2 million below the FY 2014 Enacted level. 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)*: $10.8 million, a decrease of $2.2 million below the FY 2014 Enacted level. 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 2015 request will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA EDI standard.

- *HIPAA Outreach, Enforcement, Compliance Reviews, Pilot*: $4.5 million, a decrease of $2.5 million below the FY 2014 Enacted level. Contractor support will be needed to complete IT system requirements, develop regulations, and conduct training, outreach and education. CMS's goal is to reduce the clerical burden on patients, providers, and health plans by reducing the amount and complexity of forms and data entry required prior to or at the point of care. The industry has requested that CMS conduct more outreach to assist in understanding the new policies that are being published, and the Regional Offices require greater support from Central Office. The gap analysis pilot will help in the adoption of an updated version of the standard when the time comes and the Review Committee is established to make its recommendations to the Secretary.

- *ACA Initiatives Sections 1104 and 10109*: $30 million, an increase of $30 million above the FY 2014 Enacted level. Section 1104 establishes a series of new operating rules and standards for administrative transactions that will improve the utility of the existing HIPAA transactions. The law mandates substantial additional requirements for all HIPAA covered entities such as industry health plans, providers, and clearinghouses. Additionally, all CMS health care programs such as Medicare, Medicare Advantage, and Medicaid will be impacted as covered entities and are also required to comply with the requirements or face hefty penalties. CMS requests funding for Medicare/Medicaid implementation of Section 1104, certification compliance implementation and audit, project management, and outreach and education.

    If funding is not received, CMS programs will be delayed in implementing new standards and operating rules, while other covered entities move forward with their implementations. This will stifle the health care industry infrastructure that supports the electronic exchange of

data (provider claims and reimbursement) slowing substantial industry-wide cost savings in health care administration. Additionally, all covered entities including all CMS health care programs like Medicare, Medicare Advantage, Medicaid, ACOs, and health plans participating in the Marketplaces are susceptible to non-compliance sanctions and therefore face hefty penalties.

ICD-10 and Version 5010 Regulations

The Health Insurance Portability and Accountability Act requires CMS, along with the entire U.S. health care industry, to transition to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9) code set by October 1, 2014. CMS published a final rule on January 16, 2009.

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

The transition to ICD-10 will have a great impact on the entire health care industry and multiple downstream sectors. This large-scale implementation will impact all HIPAA covered entities including federal and state government and private sector health plans, clearinghouses, and providers. Additionally, ICD-10 will impact multiple non-HIPAA covered entities that are involved in public health surveillance and reporting, research and data analysis, and health care policy.

The ICD-10 transition impacts all CMS health care programs including Medicare, Medicare Advantage, Medicaid, Accountable Care Organizations, health plans that support the Health Insurance Marketplaces, the Medicare & Medicaid Electronic Health Record Incentive Programs and CMS' Quality Reporting programs. The transition for CMS alone requires the conversion of 76 internal systems, numerous quality measurement and quality reporting programs, program integrity programs, and payment and risk adjustment policies across CMS designed to protect the Medicare Trust Fund.

As the largest payer in the U.S., CMS must be equipped to handle increased volume of provider payment issues, including payment rejections and denials, coordination of benefit issues, appeals, and call center inquiries. While systems will be ready to accept ICD-10 on October 1, 2014, the volume of claims with later dates of service are expected to increase through January-March 2015 and only then do we expect to learn of any processing aberrations with necessary resolutions to follow. CMS also anticipates the need for increased call center support through most of FY15 for the Medicare Administrative Contractor, 1-800-Medicare, Medicare Advantage, and Medicaid programs for providers requiring additional instruction and for beneficiaries who are incorrectly billed for services due to invalid coding.

- *Current ICD-10 Status:* The ICD-10 implementation is scheduled for October 1, 2014 and is on-track. In support of CMS' implementation targets, key activities include:

    - Analysis change requests were prepared by CMS' Medicare Administrative Contractors (MACs) and analyzed by CMS. CMS facilitated information sharing meetings with the MACs and the Shared Systems maintainers to answer questions and resolve issues so that the implementation plans could be finalized.

- Policy change requests have been prepared for a consolidated contractor implementation effort.

- Conversion of groupers, pricers, code editors, and National Coverage Determinations (NCD) is on schedule for completion by October 1, 2013.

- CMS also contracted to have locally coded NCDs converted by one contractor and made available to all MACs, saving time and money by eliminating duplicative effort. This is scheduled for April 2014.

- CMS also secured a GEMs-based ICD-9/ICD-10 translation tool (CTT) and made it available to all MACs.

- All MAC and CMS manuals are being examined for potential ICD-10 references and being revised accordingly.

- The Steering Committee is also working to resolve outstanding policy issues, and identifying risk mitigation strategies to ensure that the agency's primary goal of making payments to providers will be met in response to industry-wide concerns, outreach and education efforts have been ramped up/targeted based on the survey results.

- CMS continues to reach out to the industry through participation at conferences, webinars, targeted electronic messaging through listservs, Medscape learning modules, hosting national call-in programs, and Medicare Learning Network materials. CMS has also provided guidance manuals for small providers, small hospitals, and small payers.

- State Medicaid agencies are reporting progress toward ICD-10 compliance on periodic self-assessments conducted by CMS, while others have continued to need additional assistance. CMS has been providing ICD-10 training and technical assistance to States as requested and based on progress reported on the assessments. CMS has produced materials targeted for States, conducted a first round of technical assistance site visits to 20 States, and is currently involved in a second round of technical site visits to 35 States.

- *ICD-10 and other Health Care Initiatives*: ICD-10 is essential to achieving Affordable Care Act (ACA) initiatives, specifically in the areas of fraud, waste, and abuse prevention, and to move the current volume-based system to a value-based purchasing system. ICD-10 data also may be instrumental in various provider incentive programs such as meaningful use of certified electronic health record (EHR) technology and quality measures determined by CMS. The more detailed nature of the ICD-10-CM and ICD-10-PCS codes will enhance the provider's ability to document that they have met the stringent quality measure criteria to receive incentive payments.

Budget Request: $30.3 Million

The FY 2015 budget request for ICD-10/Version 5010 is $30.3 million, an increase of $2.3 million above the FY 2014 Enacted level. The increase reflects the complex nature of post-implementation activities.

- *IT System Costs*: $17.6 million. This request supports systems conversions, including updating Medicare Fee for Service core payment processing systems, and all downstream and front-end systems which impact risk adjustment, payment models, quality measures and quality reporting, coordination of benefits, and fraud and abuse systems. System remediation is expected following post implementation to correct issues with regards to provider payment, coordination of benefits, and to minimize disruptions to patient care.

- *Code Policy*: $2.8 million. This request supports all activities associated with updating CMS processes, policy changes and code analysis for national coverage determinations, and quality measures. National coverage determinations are evaluated and updated on an annual basis. Additionally, code policy changes will be needed to analyze and evaluate ICD-10 data for purposes of developing risk adjustment models for Medicare Advantage plans. Quality measures will utilize ICD-10 policy changes to determine payment.

- *Training, Outreach & Education*: $5.9 million. This request supports the development and implementation for industry education and outreach, coding training for CMS and related personnel, State Medicaid agencies, MACS, Medicare Advantage plans, ICD-10 website maintenance, materials development, and national provider webinars.

- *Planning Requirements*: $4.0 million. This request supports risk mitigation, implementation oversight, and program management activities for 76 systems and major CMS program areas.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 123 million beneficiaries in FY 2015. This request leverages other funding sources, such as ACA section 3021, to support RDE projects wherever possible.

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

Medicare Current Beneficiary Survey – The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose, in-person survey of a representative sample of the Medicare population. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete information

on health care costs, utilization, access to and quality of care. The MCBS is a unique and valued data source, having been continuously fielded for more than 20 years (encompassing over 1 million interviews) and evolving as the agency's needs have progressed.

Originally initiated under section 1875 of the Social Security Act (SSA), the MCBS has adapted over time; continuing to provide key information for more traditional research, evaluation and monitoring to CMS but also adapting to provide unique information and insight for Innovation Center activities. For example, CMS will use survey data collected by the MCBS for a variety of purposes, including assessment of the potential number of beneficiaries eligible for proposed new care and payment models, their baseline utilization and patterns of usual care, and the decisional factors that help determine when and where beneficiaries seek care. The longitudinal and comprehensive nature of the MCBS provide the opportunity for both pre/post and observational studies (with a control and comparison group) for beneficiaries involved with CMS models or programs (e.g., Accountable Care Organizations, Medical Homes).

MCBS continues to be used by the CMS to track trends in out-of-pocket spending and monitor Medicare supplemental insurance (Medigap), and is a major basis for the annual Trustees' Report. MCBS data have also been used to track beneficiary's knowledge and sources of information about Medicare, especially following the implementation of a new program or services (e.g. Part D, "Welcome to Medicare" benefits, etc.). Self-reported MCBS' data on immunizations is currently used to track whether CMS is meeting population health objectives.

In addition to CMS use, the MCBS consistently provides value and unique data to external users, as demonstrated by more than 700 research articles published using the MCBS to date and over 300 MCBS files purchased and shipped to researchers each year. MCBS survey data are also vital in the production of highly regarded publications, including the Kaiser Family Foundation *Medicare Chart Book* and the Medicare Payment Advisory Commission's (MedPAC) annual *Data Book*. Moving forward the MCBS will continue to play a critical role in the monitoring and evaluation of key provisions of the ACA, with an emphasis on supporting efforts to test innovative payment and service delivery models ability to reduce costs and improve quality as well as monitoring changes to Part D coverage, changes to cost-sharing and premiums, and the use and knowledge of new Medicare-covered preventive services.

Given the multi-purpose nature of the MCBS and its significant use and applicability to ACA section 3021 research and evaluation, CMS will jointly fund the MCBS in FY 2015 from both the Program Management and ACA Section 3021 appropriations. CMS is estimating an equal cost allocation in FY 2015 between these two appropriations, but will reassess the allocation on an annual basis.

Other Research – Other research activities include various projects aimed at maintaining and building the necessary data and information products to support both internal and external research, and various types of evaluation research (i.e., program evaluations, prospective payment systems evaluation, refinement and monitoring).

CMS continues to develop, enhance and administer multiple initiatives aimed at providing important data products and information key to research efforts. One such tool is the chronic conditions warehouse (CCW). The CCW houses CMS data that are easily linked, at the individual patient level, for all Medicare and Medicaid claims data, eligibility data, nursing home and home health assessments, and CMS beneficiary survey data. This data warehouse transforms and summarizes this administrative health insurance information into research data files, thus providing researchers all the information they need to conduct studies focused on

improving the quality and cost of care provided to chronically ill beneficiaries. To further facilitate research and assure the security of CMS' administrative data, the CMS Virtual Research Data Center (VRDC) was constructed within the current CCW infrastructure. The VRDC provides approved researchers with access to more timely CMS data in a secure and more cost effective manner. In addition, the CCW project supports the CCW Website (www.ccwdata.org) which includes documentation on the various data sets available via the CCW and provides a number of static data tables related to the Medicare and Medicaid population as well as an interactive Chronic Conditions Dashboard. Finally, the CCW project also includes help desk and training (both classroom and virtual) to better acclimate researchers to the complexity of working with Medicare and Medicaid data.

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

Historically Black Colleges University and Hispanic Serving Institutions Research Grant Programs – Consistent with the HBCU Executive Order 13532 and HSI Executive Order 13555, CMS awards grants to HBCU and HSI investigators to research topics of relevance to CMS African American and Hispanic American Medicare, Medicaid, and CHIP beneficiaries. 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. HBCU and HSI funding for FY 2013 amounted to three research projects funded at a total of $600,000 ($200,000 per project).

Budget Request: $16.0 Million

The FY 2015 budget request for Research, Demonstration, and Evaluation is $16.0 million, a decrease of $4.1 million below the FY 2014 Enacted level. The decrease assumes CMS will split fund the MCBS as described in the narrative.

- *MCBS*: $10.0 million, a decrease of $2.1 million below the FY 2014 Enacted level. The gap between actual operating expenses and the President's Budget has been widening, and as a result the survey may need to cut areas. Increased funding is needed to maintain the survey's content and utility, and in addition support mandated content changes like revisions based on S. 4302 of the ACA.

- *Other Research*: $6.0 million, a decrease of $1.9 million above the FY 2014 Enacted level. This funding supports efforts that build and improve CMS' health service research, data and analytical capacity, as well as program evaluations. These activities include, for example, the Chronic Condition Warehouse (CCW), Research Data Assistance Center (ResDAC) and CER Public Use Data Files and Medicaid Analytic Data.

III. MEDICAID & CHIP INITIATIVES

Program Description and Accomplishments

Medicaid and CHIP Operations

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

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a larger population of medically vulnerable Americans, including low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services and supports, who all should receive coordinated, quality care. The enrollment for Medicaid and CHIP is expected to be 70.9 million in FY 2015, about 22 percent of the current U.S. population.

Congress passed several pieces of legislation in recent years that have impacted Medicaid. The ACA provided States the option of expanding Medicaid eligibility for adults with incomes below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014; States were provided the option to expand coverage earlier. The ACA makes available a 100% Federal matching rate for three years, phasing down to 90% in 2020 and beyond, to provide services to beneficiaries who are newly eligible under the ACA, and simplified Medicaid and CHIP eligibility and enrollment procedures. The ACA also provided substantial new funding for developing a Medicaid adult quality measurement program to complement the child health quality measures mandated by Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In addition, the law includes other provisions that expand the Federal-State partnership in disease prevention and quality improvement in health care.

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

CMS funds the operations of Medicaid and CHIP in the CMS Program Operations account. These funds support the following priority activities for Medicaid and CHIP:

- *Medicaid Systems Support* – This focuses on collecting, managing and housing Medicaid related data for the administration of the Medicaid and CHIP program at the Federal level to produce statistical reports, support Medicaid related research, and assists in the detection of fraud and abuse in the Medicaid programs. Moreover, Medicaid Systems support the Medicaid Drug Rebate program, the Federal Upper Limits program, procurement of compendia data, State Plan Amendments, Early and Periodic Screening Diagnostic & Treatment program, Drug Data Reporting for Medicaid (DDR) web application and the DCCA Data Center (hosting for multiple Medicaid applications), and the Medicaid & State Children Health Insurance Program Budget & Expenditure System (MBES/CBES), a legally mandated system that was created to enable the States to submit budget and expenditure data to CMS for the Medicaid and Children's Health Insurance Program, and Medicaid and grant funding. Medicaid Data Systems also include the Medicaid Statistical Information System (MSIS), which collects beneficiary level eligibility and claims data which is core to program administration, program integrity and for Medicaid research and analysis performed by the Congressional Budget Office and the Congressional Research Service. MSIS, and the accompanying data marts and stores, are key resources for other Federal agencies and research projects involving Medicaid.

- *Survey of Retail Prices* – The Survey of Retail Prices is divided into two parts. Part I consists of a nationwide retail survey for collecting information about consumer prices. Part II of the survey helps determine pharmacies' acquisition costs of drugs to serve as a source of information for States to set reasonable payment rates to pharmacies. Due to budgetary limitations, we determined that collecting the actual invoice prices from retail community pharmacies in Part II was more critical. Part I was suspended in July 2013. The FY 2015 President's Budget includes a proposal to fund Part I and Part II of this survey through mandatory funding.

- *CHIPRA Initiatives* - CMS continues to champion efforts to enroll and retain more children in Medicaid and CHIP by providing technical assistance to States, grantees, and other critical stakeholder groups. The CHIPRA grants allow CMS to successfully target and implement outreach strategies in geographical areas with high rates of eligible but un-enrolled children, including children who are racial and ethnic minorities or who reside in rural areas. This funding also allows CMS to address the Agency's focus to improve access to pediatric dental services for Medicaid and CHIP children, which has traditionally been underutilized. Additionally, continued funding will support outreach activities designed to help families understand new application procedures and health coverage opportunities, including Medicaid, CHIP and insurance affordability programs under the ACA. Significant milestones include: released Funding Opportunity Announcement on January 7, 2013; awarded 39 grantees on July 15, 2013; offered numerous presentations to grantees and other key stakeholders regarding outreach and enrollment best practices, technical assistance on Affordable Care Act implementation. We continue to provide pertinent grantee information to promote successful operation of the grants.

- *Basic Health Program Implementation* – This implementation funding is for administrative support and oversight of the implementation of the Basic Health Program (BHP) provided by sections 1331 and 10203 of the Affordable Care Act. Section 1331 directs the Secretary to establish a BHP, an option in which States may choose to enroll eligible individuals in lieu of

offering such individuals coverage through a Qualified Health Plan in the Marketplace. Significant milestones in implementing BHP to date include: the establishment of a Learning Collaborative with 7 States and the District of Columbia in May 2013 to solicit input from States; publication of the proposed rule on September 25, 2013; meet with States, advocates, Tribes and other stakeholders to discuss BHP policy and operations and to provide an overview of the proposed rule; publication of the proposed payment notice describing the BHP funding methodology for program year 2015 on December 23, 2013, followed by an all-state/advocate call to provide an overview of the proposed payment notice; and stakeholder meetings to discuss comments received on the proposed rule and proposed payment notice.

- *The National HCBS Quality Enterprise* – A priority objective for CMS continues to be initiatives that advance work towards helping States rebalance their Medicaid dollars to increase access to high quality, lower-cost non institutionally-based long-term services. In compliance with new home and community based regulations published on January 16, 2014 with an effective date of March 17, 2014, CMS supports the HCBS characteristics and settings, person-centered planning, self-direction, restrictive interventions, and transition plans as well as expansion of Medicaid managed long term services. The success of this transformation will have a significant impact on State and federal Medicaid expenditures for long term services. Over time the National HCBS Quality Enterprise has provided mandatory and voluntary technical assistance to more than 30 States and assists States to come into compliance with the required Quality Assurances in the HCBS waiver regulations. They have also assisted CMS in rolling out the New Quality Strategy by providing education and training to CMS staff (including the Regional Offices) and to States. The HCBS Settings project will continue to provide technical assistance and training to CMS staff and States on new regulations, assist in the implementation of these new requirements, and will continue to focus on quality assurances.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency* – Section 1115 of the Social Security Act authorizes CMS to waive requirements of section 1902 of the Social Security Act to allow State flexibility to test unique approaches to program design and administration that are aimed at enhancing beneficiary access to quality services. Under section 1115 authority, many States have significantly restructured their Medicaid and/or CHIP programs in the areas of eligibility, benefits, service delivery systems, and financing with the goal of expanding health insurance coverage to lower income, vulnerable populations.

- *Managed Care Review and Oversight* – Many States are now moving to enroll their highest cost populations in managed care arrangements, including persons with chronic and disabling conditions. This also includes long term and behavioral health care services in addition to primary and acute care, adding a new opportunity for enhanced integration of care and new challenges to meet the needs of the most vulnerable Medicaid beneficiaries. Most State plans to integrate services for the dually eligible are building on some form of managed care arrangement. CMS expects the growth in managed care delivery systems to reach upwards of 80% of Medicaid beneficiaries nationwide in managed care plans within 2 years.

- *Certification of Pediatric Coverage as Comparable to CHIP* – Section 10203 directs the Secretary, by no later than April 1, 2015, to review the benefits offered for children and the related cost-sharing imposed by Qualified Health Plans (QHP) offered through the

Exchange. CMS must certify that those plans are at least comparable to the benefits and cost-sharing protections provided under Children's Health Insurance Programs (CHIP). Significant milestones include meeting with advocates to discuss their concerns and recommendations for a certification process; brief DHHS on the statutory provision, analysis to date and potential approaches to certification; and consult with the National Academy for State Health Policy (NASHP) and the Center for Children and Families (CCF) (Georgetown) on their study of comparability of benefits and cost-sharing between CHIP and QHPs.

- *Learning Collaborative* – These are forums for facilitating consultation between CMS and States with the goal of designing the programs, tools and systems needed to ensure that high-performing State health insurance programs are in place and are equipped to handle the fundamental changes brought about by the ACA. The learning collaborative process enables participants to identify gaps in knowledge and technical skills, engage existing subject matter authorities to help address the challenges associated with implementing program changes and create a supportive environment that encourages the adoption of promising practices and problem-solving strategies. The Learning Collaborative approach is envisioned as a way to build States' confidence and support efforts to test, evaluate and implement ideas that will help States and federal agencies make progress toward the goals of the new health care system.

- *Medicaid Expansion* – The ACA enables States to expand their existing Medicaid programs to cover individuals with incomes up to 133% of the FPL. For States that expand their Medicaid programs, the Federal government will cover 100% of the medical assistance costs for newly eligible populations for CYs 2014 through 2016, after which the level of assistance gradually phases down to 90% in CY 2020 and beyond. CMS and States will implement methodologies that distinguish newly eligible populations from previously eligible populations. CMS also helped States implement verification procedures for beneficiaries by issuing a verification plan template for States and provided feedback on all State submitted verification plans. CMS continues to provide technical assistance to States as they implement the new Medicaid eligibility requirements.

Budget Request: $31.5 Million

The FY 2015 request for Medicaid and CHIP operations is $31.5 million, an increase of $16.2 million above the FY 2014 Enacted level. Funding in this section includes support for certain administrative activities necessary to operate Medicaid and CHIP. Information on benefit dollars for these programs can be found in the chapters titled "Medicaid" and "CHIP" later in this book.

- *Medicaid Systems Support:* $16.1 million, an increase of $8.9 million above the FY 2014 Enacted level. This request will aid in funding the operation and maintenance for the Medicaid & Child Health Budget & Expenditure System (MBES), Medicaid Drug Rebate/Federal Upper Limit System, Medicaid IT Architecture (MITA), and the Medicaid Statistical Information System (MSIS) among others. Operation and maintenance includes maintaining (upgrading hardware, operating systems, etc.) the system infrastructure to support the systems. In addition, enhancements are applied to applications as changes to statutory requirements change. All of these systems are mission critical to administering the Medicaid and CHIP program.

- *CHIPRA Initiatives*: $3.7 million, an increase of $2.8 million above the FY 2014 Enacted level. Funding is requested to continue functionality and quality oversight of the Provider

Locater Tool on the Insure Kids Now website. Also, CMS is requesting funding to perform oversight, monitoring, data collection, and analysis of all awarded outreach grants for the final Report to Congress. See discussion above detailing how these initiatives support the agency's initiative to enroll and retain children in coverage and to improve access to pediatric dental services for Medicaid and CHIP children.

- *Basic Health Program Implementation*: $2.5 million, an increase of $2.5 million above the FY 2014 Enacted level. Contractor support is necessary for monitoring State implementation of new BHPs. Responsibilities include technical assistance to States on reporting performance standards, collection of data, analysis of the first year of Marketplace data on similar populations and recommended adjustments to the BHP funding formula, and monitoring of access to services, costs to beneficiaries, complaints, appeals, quality of care, and churning. Funding also supports the first year evaluation of the implementation of BHP and comparison to coverage offered in Medicaid and through the Qualified Health Plans in the Marketplace.

- *The National HCBS Quality Enterprise*: $2.3 million, a decrease of $0.2 million below the FY 2014 Enacted level. Contract support is required to provide practical expertise to support States' efforts to improve quality and compliance with policy, regulations and system goals, to adopt a strategic approach to improving quality outcomes across home and community-based services programs as States design and implement their reform initiatives, and practical expertise in achieving goals of corrective action plans, oversight and program integrity, and assisting States to implement new HCBS regulations, effective March 17, 2014.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $2.0 million, an increase of $2.0 million above the FY 2014 Enacted level. Funding is requested to assist with program oversight and evaluation of State demonstration programs, as well as to maintain the website used to support the public commenting capability. CMS needs to build infrastructure to improve tracking of post-approval State deliverables required to ensure sufficient program performance as well as to evaluate the innovations being tested to ascertain best practices for program design and administration.

- *Managed Care Review and Oversight*: $1.6 million, an increase of $1.6 million above the FY 2014 Enacted level. This project supports CMS' attempts to correct deficiencies raised by the GAO related to the quality and extent of CMS oversight of Medicaid managed care programs. It will provide critical and essential tools that do not exist currently for our staff to more effectively exercise their oversight and financial stewardship role. This will also minimize agency vulnerability to future audits.

- *Certification of Pediatric Coverage as Comparable to CHIP:* $1.6 million, an increase of $1.6 million above the FY 2014 Enacted level. Funds are necessary for contractor services to assist in the development of the definitions, standards, and methodologies to determine the comparability of benefits and cost-sharing for children in QHPs and State CHIPs as well as to validate the data from the QHPs to determine if the benefits and cost sharing protections provided to children are comparable to the State's CHIP, so plans can be certified by no later than April 1, 2015.

- *Learning Collaborative:* $0.9 million, an increase of $0.9 million above the FY 2014 Enacted level. The LC will continue to work on issues related to monitoring performance and revising

procedures based on initial ACA experience. In addition, the LCs work related to Value-Based Purchasing and Data Analytics ensure high-performing Medicaid and CHIP programs will be continued in 2015.

- *Medicaid Expansion:* $0.8 million, an increase of $0.8 million above the FY 2014 Enacted level. Funds are requested to continue the direct assistance and oversight of States' progress with outreaching, educating, and enrolling millions of newly eligible adults. Funding is also needed for expected refinement of the tools developed for States to train on the new program rules.

IV. HEALTH CARE PLANNING AND OVERSIGHT

Program Description and Accomplishments

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

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

Part C and D Information Technology (IT) Systems Investments

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

These systems include:

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

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

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

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

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

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

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

Budget Request: $65.9 Million

The FY 2015 budget request for Parts C and D IT Systems Investments is $65.9 million, an increase of $5.8 million above the FY 2014 Enacted level. This increase supports ongoing systems maintenance and implementation. The increase in funding validates Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems. These activities include data center hosting, hardware/software maintenance, system technical support, database administration and system security testing.

Oversight and Management of Health Plans

Oversight & Management of Marketplaces – The Health Insurance Marketplace, also known as the Affordable Insurance Exchange, sets up a new competitive private health insurance market giving millions of Americans and small businesses access to affordable coverage. The Marketplace allows individuals and small businesses to pool their purchasing power and compare health plan options. If a State elects not to establish a State-based Marketplace, CMS must establish a Federally-facilitated Marketplace (FFM) in that State and oversee all Marketplace functions. These functions include:

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

CMS is operating an FFM in 33 States in 2014, and will likely continue to operate a Marketplace in the majority of States in FY 2015. In addition to operating the FFM in States that opt not to establish their own Marketplace, CMS has responsibilities on behalf of all Marketplaces, such as developing quality improvement and transparency standards, determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, performing eligibility appeals, and conducting certification and oversight of State-based Marketplaces.

CMS must also oversee Marketplace-related programs, including two transitional risk- sharing programs - reinsurance and risk corridors - as well as a permanent risk adjustment program. These programs are sometimes referred to in aggregate as premium stabilization programs, or the "3Rs." States that operate a State-based Marketplace will have the opportunity to operate a risk adjustment program using a methodology certified by CMS or using the federal

methodology. In States that do not operate a risk adjustment program, CMS will operate the program. In 2015, CMS expects to operate the risk adjustment program in 49 States and the District of Columbia.

States also have the opportunity to operate reinsurance. Beginning in FY 2015 CMS will collect reinsurance contributions in all States and distribute funding to State-operated programs in order to make reinsurance payments. In States that do not operate reinsurance, CMS will operate the program. In 2015, CMS expects to operate the program in 49 States and the District of Columbia. Risk corridors are a temporary federal program that will be operated solely by CMS.

Other financial management activities include the implementation of advance payment of the premium tax credits and payment of cost-sharing reductions for individuals enrolling in QHPs. CMS works with other Federal agencies such as Treasury and the Social Security Administration to verify eligibility for these programs. CMS is responsible for developing these insurance affordability programs and for making payments in all States. CMS will continue development of a program integrity initiative to ensure proper use of the federal dollars associated with these programs.

In 2013, CMS initiated operations of the Federally-facilitated Marketplace, including certification of qualified health plans, awarding grants to Navigators, implementing a Marketplace Call Center, and re-launching Healthcare.gov as the online component of the Health Insurance Marketplaces.

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).

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.

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

QIC Appeals Workload for Parts C/D – FY 2009 through FY 2015

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Est. Actual	FY 2014 Estimate	FY 2015 Estimate
Part C Appeals	61,625	62,420	64,843	97,869	125,800	113,204	119,000
Part D Benefit Appeals	20,733	18,958	13,872	14,879	25,500	24,000	40,000
Part D LEP appeals	40,728	35,246	31,332	36,456	42,000	44,108	72,000

Insurance Market Reform – The Affordable Care Act includes several provisions that reform the private health insurance market. Between FYs 2010 and 2013, CMS released several significant rules related to these reforms, including regulations on new market reforms that go into effect in 2014. These regulations implement provisions relating to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, essential health benefits (EHB), and catastrophic plans. CMS continues to release technical sub-regulatory guidance related to these rules as well as the market rules that went into effect in 2010. Additional details on these regulations and related guidance can be found at: http://cciio.cms.gov/resources/regulations/index.html. Moving into FY 2015, CMS will be focused on working with States to ensure that these rules are being enforced and that consumers are benefiting from the changes included in the Affordable Care Act.

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

Rate Review – Section 2794 of the Affordable Care Act requires HHS, in conjunction with the States, to review potentially unreasonable health insurance premium increases (currently those increases above 10%). Beginning in 2014, the Secretary is also required to monitor rate increases across all markets (inside and outside the Affordable Insurance Exchange). The law also provides funding for States to improve their rate review processes through the Rate Review Grant Program.

Since September 2011, issuers seeking rate increases of 10 percent or more have been required to submit their proposed rate increase for review. These rates then undergo an actuarial review by either a State, or, if a State is unable to review the proposed increases, then CMS. Information on these proposed rate increases as well as any justifications for increases found to be unreasonable are made available to the public on Healthcare.gov. Beginning with rates that going into effect in 2014, the Affordable Care Act requires that the Secretary, in conjunction with the States, "monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange." To assist in this monitoring function, CMS released final rules that adds a reporting threshold for any rate increase above zero as well as

amends the standards for health insurance issuers and States regarding reporting, utilization, and collection of data for the program. Those increases above 10 percent would continue to undergo an actuarial review for reasonableness. CMS also updated the data template used to collect information on rate increases. The new template allows States and CMS to review for the rating rules that go into effect in 2014 as well as to review rates for the reasonableness of the proposed increases. A copy of the rules and updated data template can be found at: http://cciio.cms.gov/resources/regulations/index.html.

Budget Request: $390.5 Million

The FY 2015 budget request for Oversight and Management of health plans is $390.5 million, an increase of $193.6 million above the FY 2014 Enacted level.

- *Oversight and Management of Marketplaces*: The FY 2015 Program Management budget request for the Health Insurance Marketplace is $307.3 million, an increase of $179.1 million above the FY 2014 enacted level. In addition, CMS expects to expend $442.2 million in user fees and $20.3 million in Reinsurance administrative contributions (see Transitional Reinsurance chapter) to fully fund Marketplace Oversight and Management activities at a program level of $769.7 million.

  A minimum function of the Federally-facilitated Marketplace (FFM) is to determine eligibility for enrollment in a qualified health plan and for insurance affordability programs including advance payments of the premium tax credits (APTC), cost-sharing reductions (CSR), Medicaid and CHIP, as well as exemptions from the shared responsibility requirements. In those States that do not elect to establish their own Marketplace, the FFM is required to perform these functions. In order to determine eligibility for APTC, CSRs, Medicaid, and CHIP, the Marketplace needs up-to-date data sources to verify applicant information, including information related to income. CMS will purchase access to commercial wage data to provide for more accurate verification of an individual's income and minimize the risk of repayment of the tax credit at reconciliation.

  Of the Marketplace applicants that CMS expects to support through the eligibility determination process, including those who are ultimately not eligible, CMS expects a significant number will require additional support to complete the application. To assist in this process, eligibility support staff process incoming mail, including paper applications and verification documentation. Additionally, eligibility support staff associate applications with existing accounts, populate systems with information from such documentation, conduct research, analyze issues, and support complex issue resolution.

  CMS has established an appeals process for the individual and SHOP markets. CMS also adjudicates appeals for decisions made by the Marketplace regarding exemptions from the shared responsibility payment. This work entails overall management of the eligibility appeals process, coordination of data collection with appellants, general case management, and federal hearing support.

  CMS administers the insurance affordability programs on behalf of all Marketplaces. This process involves receiving enrollment information from Marketplaces, including the level of APTC selected, to calculate and distribute monthly, aggregate payments to issuers for APTC and CSR owed. At the end of the year, CMS must collect information from issuers to reconcile the advance CSR payments to actual cost-sharing experienced by the enrollees.

CMS will first complete CSR reconciliation in FY 2015, which may entail additional technical assistance to stakeholders including webinars, user group calls, and other operational support documentation.

CMS also utilizes data from the Marketplaces to determine user fees for the FFM. User fees are deducted from the APTC/CSR payments owed to issuers on a monthly basis, calculated as a percent of premium for each policy issued in the FFM.

In addition, CMS must implement the three market stabilizing programs (reinsurance, risk corridors, and risk adjustment). Beginning in 2015, CMS will collect reinsurance contributions from all issuers, distribute reinsurance payments, calculate risk scores and make the risk adjustment transfers, and calculate risk corridors payments and charges.

In FY 2015, CMS will focus activity under the FFM on continuing to qualify new health plans to be members of a Marketplace across both the individual and small group markets. Although QHPs will already have been certified in FY 2014 for the 2015 benefit year, CMS expects that new plans will seek certification for the 2016 benefit year. Maintaining a steady state of technical assistance and issuer support is important. For QHPs that have been certified, CMS will engage in the annual process of re-certifying and potentially de-certifying plans. Since the rate and benefit analysis review was compressed in 2014, CMS requests funding for post-certification monitoring. CMS is tasked with QHP issuer oversight in the FFM. In conjunction with States, CMS will monitor the performance and compliance of FFM issuers, and work with issuers and their respective States to address any areas of concern.

The FY 2015 funding request continues FY 2014 activities around building functionality to implement quality provisions related to QHP-certification, and continue plan-related oversight including oversight of agents and brokers. The FY 2015 funding request includes further development of CMS's monitoring tools and strategies and the development of the compliance review standard operating procedures and strategies, so as to effectively coordinate CMS's oversight activities with the State Departments of Insurance. In 2015, CMS also plans to take on new activities, including the preparation and review of re-certification and subsequent applications for the plan year beginning in 2016 and updates to requirements for QHPs for future years.

In FY 2015, a critical component of SHOP activities will be a managed services contract to provide premium aggregation (i.e., billing and payment functionality) in States where a Federally-facilitated SHOP is operating. Integrated into the managed services contract will be a call center with the capacity to support small businesses and the unique issues they will face when obtaining small group coverage through SHOPs. This assistance will include technical and customer support for small employers and agents and brokers working with small employers. SHOP employers need customer service when applying for SHOP coverage and assistance with benefit administration activities, such as changing employee employment status and setting up accounts for eligible employees.

SHOP support activities in FY 2015 will continue to focus on providing SHOP-specific technical assistance to States, analyzing small group markets in each State and conducting SHOP-specific issuer and broker training.

CMS has a statutory responsibility for developing and implementing a robust quality rating system, developing an enrollee satisfaction survey for the Marketplace, providing valid,

reliable and comparable information to Marketplace enrollees, prospective enrollees and small employers/employees on quality measures, and specifying the quality-related requirements for certification. FY 2015 funding will ensure that CMS fully implements the qualified health plan specific tools in FY 2016 and displays this information in 2016.

The FY 2015 funding request will also support the development of a comprehensive, coordinated oversight and monitoring strategy of the SBMs that build on current grant oversight requirements. States must meet at least the minimum functions: ensure efficient and non-discriminatory administration, prevent fraud and abuse, streamline eligibility and enrollment, minimize acquisition expenses, promote financial integrity and public accountability, inform consumer choice, and prohibit conflicts of interest. To support this, SBMs will be required to submit reports for review to CMS and in selected cases, site visits will be conducted. CMS will be responsible for reviewing these materials and working with the SBMs as necessary to improve performance. CMS will also conduct similar, though more limited oversight, of the activities performed by Partnership States.

- *Medicare Parts C and D*: CMS requests $68.5 million, an increase of $9.2 million above the FY 2014 Enacted level. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, and the on-going Medicare Part C and Part D reconsideration contracts. CMS' increase in funding for C and D operations is necessary to manage the increasing appeal workloads and is critical to the Agency fulfilling its statutory obligation to provide Medicare Advantage enrollees with meaningful due process by contracting with an independent review entity (IRE) to review adverse decisions made by Medicare health plans.

  It also funds ongoing ACA 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*: CMS requests $5.5 million, an increase of $1.5 million above the FY 2014 Enacted level. Funding will support the review of form filings, market conduct examinations, and complaint-driven investigations in States where CMS has assumed primary enforcement authority.

- *Medical Loss Ratio (MLR):* CMS requests $5.4 million, an increase of $1.7 million above the FY 2014 Enacted level. Funding supports a contractor to conduct audits of the annual reports health insurance issuers submit to CMS on their allocation of premium dollars. This request also provides funding for analysis of the MLR data.

- *Rate Review:* CMS requests $3.8 million, an increase of $2.0 million above the FY 2014 Enacted level. Funding will support the actuarial review of proposed rate increases in the States where CMS is the primary rate review regulator and the actuarial monitoring of all rate increases.

V. HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality Improvement Initiatives

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value based purchasing (VBP) programs and other CMS health care quality initiatives. In FY 2015, CMS plans to perform activities that achieve the development of a coordinated quality improvement strategy aimed at adjusting payments to providers and suppliers based on quality performance, increasing availability of information on performance, and sharing in savings with providers who meet efficiency targets while also providing high quality care.

Examples of these initiatives include:

- *Medicare Shared Savings Program* – On October 20, 2011, CMS released a rule establishing the Shared Savings Program in which provider groups and suppliers who agree to meet quality standards can be eligible to share in the cost-savings they achieve through the Medicare program. The final rule stipulates that groups of providers from Accountable Care Organizations (ACOs) will be held accountable for the efficiency and quality of care rendered to at least 5,000 Medicare beneficiaries. ACOs qualify to share in savings generated for Medicare if they generate shareable savings and meet 33 quality benchmarks. CMS continues to ramp up the program that continues to have strong industry interest. In 2012, CMS announced 114 new ACOs. In January 2013, 106 ACOs were added to the program. Recently in January 2014, an additional 123 ACOs were added to the program. Additional application cycles will occur on an annual basis so more ACOs can join the 343 ACOs currently participating in the program. The program requires new types of technical support to measure quality and cost of care, share Medicare claims data, deliver feedback reports on quality, cost and utilization, monitor program compliance to guard against inappropriate avoidance of beneficiaries and their care, and support annual application cycles for the rapidly growing program. In FY 2013 funds were also used for data sharing, database support, help desk, testing, ACO portlet hosting, storage and licensing contracts to develop and maintain IT infrastructure to provide data required to run the program in more efficient and effective manners. We expect to maintain the operational excellence the program has achieved and that strong industry interest in the program will continue resulting in more ACOs joining the program in 2015.

- *Physician Feedback Improvements* – The ACA required CMS to provide reports to physicians and groups of physicians that compare their resource use among Medicare fee-for-service patients with that of similar physicians or groups of physicians. These feedback reports also include indicators of clinical quality and they are the primary mechanism for informing physician groups of their performance under the value based payment modifier. The reports to be produced and disseminated in 2014 build on lessons learned from the reports produced in 2012 and 2013 and include many refinements suggested by stakeholders. The 2014 reports will cover all Medicare-enrolled physicians that furnish services to fee for service beneficiaries using data from 2013.

- *Physician Value Based Payment Modifier* – The ACA established a value-based payment modifier under the Part B Physician Fee Schedule and requires the Secretary to publish the performance period and measures of cost and quality of care that will be used to adjust

physician payments under the modifier. The modifier will be phased in starting in 2015 so that, by 2017, all participating physicians will be subject to the modifier. It will apply to each payment physicians' receive under the Physician Fee Schedule. CMS established initial cost and quality measures, as well as the initial performance period in the CY 2012 Physician Fee Schedule Final Rule and finalized policies in the CY 2013 Physician Fee Schedule to begin implementation of the value-based payment modifier by applying it to certain groups of physicians in 2015. The CY 2014 Physician Fee Schedule Final Rule established policies for the second year of the phase in (2016), continuing to expand the number of physicians and physician groups subject to the value-based payment modifier so as to apply the modifier to all physicians by 2017.

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

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

- *Medicare Data for Performance Measurement (ACA Section 10332)* - The ACA added a new subsection to Section 1874 of the Social Security Act, requiring that the Secretary establish a process to allow for the use of standardized extracts of Medicare Parts A, B, and D claims data by Qualified Entities (QEs) to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. As of September 2013, 12 qualified entities have been approved to participate.

- *Program Support Activities for the Competitive Acquisition Ombudsman (CAO)* - MIPPA HR 6331 Section 154 (f) mandates the establishment of the Competitive Acquisition Ombudsman Program (CAO) in order to respond to inquiries and complaints from suppliers and individuals regarding the DMEPOS Competitive Bidding Program, calling for nationally directed Ombudsman services for suppliers and people with Medicare. The purpose of this

contract is to support the operations of this national program to facilitate assistance to suppliers of durable medical equipment, beneficiaries that use durable medical equipment, and to provide substantive issues to enable the development of the CAO's mandated Annual Report to Congress from the Secretary of the Department of Health and Human Services (HHS).

Budget Request: $69.1 Million

The FY 2015 budget request for health care quality improvements is $69.1 million, an increase of $25.9 million above the FY 2014 Enacted level.

- *Medicare Shared Savings Program*: $32.4 million, an increase of $15.0 million above the FY 2014 Enacted level. In FY 2015, we must continue to fund the existing ACO program analytics, program monitoring, quality measurement and application review and marketing support contracts as the program continues its rapid expansion. FY2015 funding is required to facilitate an enhanced system that streamlines and automates our documentation reviews for ACO submissions including applications, marketing approval, and ACO Participant List addition and deletion requests. CMS must maintain and refine infrastructure to assign beneficiaries, calculate shared savings payments, conduct claims data analysis, develop and analyze and distribute reports and data files to ACOs, and monitor for the inappropriate avoidance of at risk beneficiaries and the potential under/over utilization of care. Our funding request leverages efficiencies from our initial investment in program implementation and our work with other CMS components.

- *Physician feedback reports and value based payment adjustments:* $16.1 million, an increase of $1.9 million above the FY 2014 Enacted level. This funding is required to continue our funding support contract that develops feedback reports for all physicians and groups of physicians. The reports to be produced and disseminated in FY 2015 build on lessons learned from the reports produced in previous years and will include a wide range of quality and cost measures and utilization statistics. The FY 2015 reports also will incorporate quality, cost, and utilization information at the beneficiary level to ensure that physicians and physician groups have useful and actionable information to improve quality and coordinate care.

- *Physician Value-Based Purchasing IT:* $9.0 million, an increase of $3.7 million above the FY 2014 Enacted level. This funding is required for critical data infrastructure necessary to support the value based payment modifier and physician feedback programs. Specific information technology infrastructure support required to produce and disseminate the reports and calculate the payment modifier include Integrated Data Repository (IDR) capacity, IDR backup and tape infrastructure, IDR operations and maintenance, testing, IDR development support, IT program management, security control assessments and data storage.

- *Value Based Payment Modifier*: $5.0 million, an increase of $5.0 million above the FY 2014 Enacted level. The funding will provide research and development to support the refinement and expansion of the value based payment modifier methodology to all physicians, including incorporating episode based costs into the physician feedback reports. CMS is in the process of implementing the value-based payment modifier; first applying it to certain physician groups beginning in 2015 and eventually to all physicians under the Physician Fee Schedule by 2017. To do so, we must standardize Medicare payment data, simulate

various options to construct the value-based payment modifier for the diverse range of physician specialties, establish benchmarks for quality and cost of care and develop composite measures of quality and cost. Funding for FY 2015 is also required to continue funding the program analytics contracts that are responsible for developing and implementing the value-based payment modifier and for including episode-based costs in the value-based payment modifier.

- *Hospital Value Based Purchasing (VBP) Medicare Spending per Beneficiary (MSBP)*: $0.7 million, an increase of $0.7 million above the FY 2014 Enacted level. CMS finalized, through notice and comment rulemaking, the inclusion of the MSPB measure in the hospital VBP for FY 2015 payment adjustments. Funding is required to support and integrate Medicare data standardization into the claims processing system to support the calculation of the measure; calculate the MSPB measure, which is included in hospitals total-performance score on which hospital VBP payments must be based; and provide feedback and data sets to hospitals on their performance on the measure.

- *Hospital Readmission Reduction Program*: $0.5 million, the same as the FY 2014 Enacted level. The ACA requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning October 1, 2012. Funding is required to expand the methodologies used to identify hospitals with high rates of readmissions. CMS will make readmission rates for hospitals publicly available. Funding is also needed to expand the types of conditions considered under this policy in future years as required by the law. In FY 2015 CMS will continue to administer payment adjustments for hospitals pursuant to the ACA provision. CMS will calculate hospital specific readmission rates, calculate the hospital specific payment adjustment factor for excess readmissions and engage in rulemaking to maintain the current measures.

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

- *Medicare Data for Performance Measurement:* $5.0 million, an increase of $1.0 million above the FY 2014 Enacted level. The funds will be used to continue operations, oversight, monitoring, and evaluation of the program. CMS will procure the services of contractor staff to support three major areas: program management, data preparation and distribution and technical assistance.

- *Program Support Activities for the Competitive Acquisition Ombudsman (CAO)*: $0.4 million, an increase of $0.4 million above the FY 2014 Enacted level. In 2015, CMS needs funding for continued efforts in program monitoring and development of outreach strategies to ensure access to program benefits for all citizens that use DMEPOS products.

VI. OUTREACH AND EDUCATION

Program Description and Accomplishments

National Medicare Education Program (NMEP)

The National Medicare Education Program (NMEP) educates Medicare beneficiaries and their caregivers so they can make informed health care decisions. The program is comprised of five

major activities including: beneficiary materials, the beneficiary contact center (BCC) or 1-800-MEDICARE, internet services, community-based outreach, and program support services.

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

  The costs associated with this funding line are printing/postage for the monthly mail contract (English and Spanish handbook to new enrollees), printing/postage for the October mailing (English and Spanish handbook to all current beneficiary households), large print English and Spanish handbooks, freight (shipping the handbook to local mail facilities, thus saving on postage costs), and on-site quality monitoring by Government Printing Office personnel. In addition, Section 1502(a) of the Affordable Care Act added new section 6055 (Reporting of Health Insurance Coverage) to the Internal Revenue Code to require every health insurance issuer to provide notice of minimum essential coverage (MEC) to impacted individuals on an annual basis beginning in 2015. As such, CMS is required to send a mailing to every beneficiary informing them of the minimum essential coverage provided through the Medicare program.

The chart below displays the actual number of *Medicare & You* handbooks distributed for FYs 2010 through 2013 and the estimated distribution for FYs 2014 and 2015. 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 2010 Actuals	FY2011 Actuals	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Estimate	FY 2015 Estimate
Number of Handbooks Distributed	43.6	39.3	40.8	41.8	43.1	44.4

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

- *1-800-MEDICARE/Beneficiary Contact Center (BCC)* – The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. This line provides beneficiaries with responses to both general and claim-specific Medicare questions. CSRs respond to inquiries including, but not limited to: Authorizations, Benefit Periods, Claims (including denials, filing or status), Election Periods, Deductibles, Coverage, Eligibility and Enrollment, Complaints, Plan

Compares, Prescription Drug Benefit Enrollment and Disenrollment, Appeal Status, etc. Beneficiaries can also use 1-800 MEDICARE to report fraud allegations.

1-800 MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800 MEDICARE while seeking to preserve the efficiencies and cost-effectiveness. Additionally, CMS uses a variety of quality assurance technologies and services to ensure that the responses provided are accurate and complete and continue to maintain excellent customer service. For example, in FY 2013, CMS enhanced the 1-800-Medicare language line services to include many native Alaskan languages. CMS also implemented the Avoke quality call recording tool which captures beneficiary inquires. In FY 2014 CMS plans to enhance the Learning Management System to accurately report CSR training metrics at the1-800-Medicare call centers and identify knowledge gaps. In FY 2015, CMS plans to enhance multimedia training formats for 1-800-Medicare CSRs to include video and virtual classroom capabilities. CMS also plans to consolidate call monitoring tools into a single solution.

The following table displays call volume experienced from FYs 2010 through 2013 and the number of call we expect to receive in FYs 2014 and 2015. In FY 2015, CMS expects to receive 26 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 2010 Actuals	FY 2011 Actuals	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Estimate	FY 2015 Estimate
Number of Calls	25.6	25.3	25.6	25.4	25.6	26.0

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

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

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

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

In FY 2015, CMS estimates 300.0 million page views to http://www.medicare.gov, approximately a five-percent increase in traffic from the page views anticipated in FY 2014. 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 2010 Actuals	FY 2011 Estimate	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Estimate	FY 2015 Estimate
Number of http://www.medicare.gov Page Views	231.4	241.0	270.0	266.9	285.0	300.0

Note: CMS migrated to a new web analytics system in FY 11. As a result, the web statistics were re-baselined as the new tool measures page views differently. Some of the benefits of this new system include increased visibility into user behavior and timelier access to web statistics. By all other metrics (for example online enrollments, number of completed transactions, system measures, CPU memory and others), traffic is consistent with the 2% + growth we have noted in previous years.

- *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 is transferring administration of SHIPs, which comprises the majority of the funding for community-based outreach, to the Administration for Community Living in FY 2014. For FY 2013, the SHIPs served over 2.6 million Medicare beneficiaries through one-on-one counseling and reached approximately 5.3 million total persons through public and media outreach.

- *Program Support Services* - This activity includes the multi-media Medicare education campaign, assessment activities, and consumer research. In addition, it funds the *Medicare & You* handbook support activities such as electronic and composition support, and production of the handbook, Medicare Summary Notice, and other NMEP materials in formats such as Braille, large print 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 2013 Final	FY 2014 Enacted Level	FY 2015 Budget Request	Description of Activity in FY 2013
Beneficiary Materials	Total	$50.6	$49.2	$57.5	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. Provides annual notice to as many as 49 million beneficiaries whose minimum essential coverage is provided through Medicare.
	Program Management	$32.6	$49.2	$39.5	
	User Fees	$18.0	$0.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	Total	$214.2	$246.6	$303.1	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives for 12 months. Includes funding previously allotted to FFS Medicare contractors for claims-related inquiries.
	Program Management	$165.4	$175.5	$250.0	
	User Fees	$48.8	$71.1	$53.1	
Internet	Total	$24.1	$14.8	$22.8	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	$21.3	$14.8	$22.8	
	QIO	$2.8	(TBD)	(TBD)	
Community-Based Outreach	Total	$2.8	$2.3	$2.6	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	$2.8	$2.3	$2.6	
Program Support Services	Total	$20.5	$16.4	$20.5	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	$20.5	$16.4	$20.5	
	QIO	-	-	-	
	Total	**$312.2**	**$329.3**	**$406.5**	
	Program Management	**$242.6**	**$258.2**	**$335.4**	
	User Fees	**$66.8**	**$71.1**	**$71.1**	
	QIO	**$2.8**	(TBD)	(TBD)	

Budget Request: $335.4 Million

The FY 2015 Program Management budget request for NMEP is $335.4 million, an increase of $77.2 million above the FY 2014 Enacted level. The following bullets highlight activities funded under the Program Management request:

- *Beneficiary Materials*: The FY 2015 budget request for Beneficiary Materials is $39.5 million, a decrease of $9.7 million below the FY 2014 Enacted level. Although the Program Management request for Beneficiary Materials is decreasing, the total cost in FY 2015 is consistent with the FY2014 Enacted level. The distribution of NMEP user fees across activities is different in FY 2014 than in FY 2015 and more of the cost for the Medicare & You handbook will be supported by user fees. 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.

  In addition to the Handbook, Section 1502 of ACA requires CMS to send a mailing to every beneficiary informing them of the minimum essential coverage provided through the Medicare program. The mailing may be required by the Internal Revenue Service as proof of coverage for tax purposes for beneficiaries starting in tax year 2015, and therefore must include beneficiary-specific information. While full funding for the mailing won't be required until FY 2016, CMS requests $3.1 million in FY 2015 (included in the Beneficiary Materials request) for contractor support to help set up the file format for reporting to the IRS and the file format for the mail tape that will feed variable data, such as addresses, names, dates of coverage, etc., into the MEC notices.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The FY 2015 budget request for 1-800-MEDICARE/BCC activities is $250.0 million, an increase of $74.5 million above the FY 2014 Enacted level. Due to the fact that the BCC contract is incrementally funded, the increase for FY 2015 supports ongoing operations and a small increase in efforts due to increasing numbers of beneficiaries and call volume. This request supports a call volume estimated at 26.0 million calls in FY 2015, 0.4 million more calls than estimated for FY 2014. CMS expects to operate at no more than a 5-minute ASA in FY 2015, consistent with current policy.

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

- *Internet*: The FY 2015 budget request for Internet is $22.8 million, an increase of $8.0 million above the FY 2014 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 open enrollment period requirements. This includes expanded Agency programs, ongoing security and testing, and monitoring activities. This funding supports ongoing efforts to increase beneficiary self-service via online channels and provide beneficiaries with expanded, easy to understand Medicare information through interactive tools, including an interactive electronic tool for the *Medicare & You* handbook. This includes expanding MyMedicare.gov services to provide integrated health management capabilities. CMS believes it is especially important to provide sufficient

funding to activities that increase beneficiary self-service online. Because services accessed online are generally much less resource intensive than services accessed in person or via telephone, providing funds now to increase beneficiaries' use of online tools will reduce costs in the future.

- *Community-Based* Outreach: The FY 2015 budget request for Community-Based Outreach is $2.6 million, an increase of $0.3 million above the FY 2014 Enacted level.

- *Program Support Services:* The FY 2015 budget request for Program Support Services is $20.5 million, an increase of $4.1 million above the FY 2014 Enacted level. This project provides funding for support of the National Medicare Education Program (NMEP) and includes: producing accessible materials for low vision/blind and disabled beneficiaries (audio tape, Braille and large print and e-reader designs), electronic and composition support for the *Medicare &You* (M&Y) Handbook, mail file creation for the statutory September mailing of the M&Y Handbook, NMEP consumer research and assessment (including consumer testing of the Medicare & You handbook), a publication ordering web site for partners, support for the Advisory Panel on Outreach and Education (APOE), and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

In addition to the Program Management request, the NMEP will receive approximately $71.1 million in user fees bringing the total funding level for NMEP to $406.5 million.

Provider Outreach

Provider Toll-Free Service – Per section 1874(A) (g) (3) of the Social Security Act, CMS is required to offer a toll-free telephone service to providers. CMS maintains toll-free numbers for general provider inquiries and questions about enrollment, electronic claims, and Medicare secondary payer issues. The costs of the toll-free lines and support contracts are included in this category. The costs of answering the inquiries, including customer service representatives, are included in Ongoing Operations under Provider Inquiries. While CMS projects a reduction in call volume in FY 2013, we believe that the call volume will be stable or increase over the next few years, due to the continued implementation of the Affordable Care Act (ACA) as well as ongoing projects that will fold in calls from other business areas handled by the contractors. Although the number of calls is projected to decrease, the length of each call has increased due and the increasing complexities of the calls that go to Customer Service Representatives.

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

CMS also conducts National Provider Calls, which are educational conference calls conducted for the Medicare provider and supplier community that educate and inform participants about new policies and/or changes to the Medicare program. National Provider Calls offer participants:

- In-depth presentations by CMS subject matter experts providing the latest information on topics specific to Medicare providers and suppliers.

- Slide presentations and other related materials posted to the CMS website prior to the call that participants can download and reference during the call.
- Opportunities to ask questions of CMS subject matter experts.
- 24/7 access to all National Provider Call training materials on the CMS website in various formats, e.g., written transcripts, audio recordings, and podcasts, as well as video slideshow presentations that are accessible on the CMS YouTube Channel.
- On-line registration for all calls.
- Opportunities to provide CMS with feedback by responding to polling questions during the registration process and completing an anonymous evaluation after the call.

Additionally, in terms of managing CMS' Continuing Education (CE) Program, this request will support the MLN learning management system, which currently hosts twenty (20) web-based training courses developed by the Medicare Learning Network. Many of these courses offer continuing education credits. During the last two (2) years, the interest in Continuing Education (CE) by other CMS components has grown significantly. This demand has necessitated an expansion of the current CE program. We are currently working toward having accredited a total of 40+ educational activities from across all CMS components.

Federal Coverage and Payment Coordination - CMS has specific statutory requirements under Section 2602 of the Affordable Care Act to improve the coordination between the federal government and States for individuals eligible for benefits under Medicare and Medicaid (Medicare-Medicaid enrollees). The following activities will support CMS efforts to meet the following statutory requirements:

- Support State efforts to improve care coordination for Medicare-Medicaid enrollees (Section 2602 (d)(3));
- Provide States and providers with the information and tools necessary to develop programs that align benefits under Medicare and Medicaid programs for Medicare-Medicaid enrollees (Section 2602 (d)(1));
- Increase Medicare-Medicaid enrollees' understanding of and satisfaction with coverage under the Medicare and Medicaid programs (Section 2602(c)(4));
- Study the provision of drug coverage for new full-benefit dual eligible individuals and monitor and report on annual health outcomes and access to benefits for all Medicare-Medicaid enrollees (Section 2602(d)(5)); and
- Improve care continuity for Medicare-Medicaid enrollees (Section 2602(c)(6)) by increasing enrollment of dual eligible beneficiaries in high quality, fully integrated programs.

Budget Request: $24.5 Million

The FY 2015 budget request for Provider Outreach is $24.5 million, the same as the FY 2014 Enacted level.

- *Provider Toll-Free Service*: $8.1 million, the same as the FY 2014 Enacted level. The minutes of telephone service, which drive costs, are projected to remain consistent in FY 2014 and FY 2015. Making sure that each caller receives an appropriate level of service requires that CMS be technologically current and work with a technical support contractor for network optimization. The goal is to make the best use of our human and technological resources to provide timely, accurate, and consistent responses to providers. This funding also covers modest ongoing costs of a provider toll-free number consolidation project to

investigate approaches and technologies to simplify the provider's experience when calling Medicare.

- National *Provider Education, Outreach, and Training*: $8.3 million, the same as the FY 2014 Enacted level. 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.

  National Provider Education, Outreach, and Training is an essential activity to reduce the Medicare Error Rate. The Medicare provider community must be properly educated and informed of ongoing changes and new requirements under the Medicare program in a consistent and timely manner. Education is a key driver for proper billing. As billing instructions to providers increase, educational products increase proportionately. Additional National Provider Calls will need to be scheduled to ensure that Medicare providers have the information they need to file claims correctly for services rendered. CMS will also be piloting the use of new technology to increase the number of providers we reach and at the same time, improve the effectiveness of our outreach.

- Federal Coverage and Payment Coordination: $8.1 million, the same as the FY 2014 Enacted level. CMS requests funding to support the following contracts:

  - Technical Assistance to States Contract to continue CMS' ability to assist States in developing and implementing integrated models of care for Medicare-Medicaid enrollees which align Medicare and Medicaid incentives to provide optimal levels of high quality care.
  - Technical Assistance to Providers Contract to continue to identify, promote, and disseminate best practices of care for providers in coordinating services across Medicare and Medicaid for dually eligible individuals.
  - Analytics Contract to continue analysis of newly linked Medicare-Medicaid data files in order to promote understanding of the dually eligible population and subpopulations to inform policy development as well as development and testing of innovative, data-drive care models.
  - Communicating with Medicare-Medicaid Enrollees Contract to identify the best means and messages for communicating critical information to individuals who become dually eligible.
  - Quality contracts to enable CMS to continue engaging a multi-stakeholder group in developing a national strategic framework for quality measurement for Medicare-Medicaid enrollees in a public process as well as to work toward implementing those recommendations through development of quality measures and care tools.

Consumer Outreach

Consumer Information & Outreach for the Health Insurance Marketplace – Consumer information and outreach efforts are necessary to educate individuals on their health insurance options and responsibilities, increase awareness on access to affordable coverage, and assist consumers in making informed health care decisions. CMS is responsible for consumer outreach and education activities in the Federally-facilitated Marketplace. Beginning in the summer of 2013, CMS ramped up efforts in this area in preparation for the initial open enrollment. In June, CMS re-launched HealthCare.gov, with a focus on Marketplaces, educating consumers about their health insurance options, and directing them to the

appropriate Marketplace website for their State. CMS also opened the Marketplace consumer contact center to begin fielding calls about coverage expansion ahead of open enrollment. CMS has also launched partnerships with hundreds of organizations through the Champions for Coverage program, banding with groups throughout the country to communicate with their members about the importance of insurance coverage.

Marketplace Enrollment Assistance – In August 2013, CMS made the initial Navigator grant awards to over 105 entities in FFM and Partnership States. In addition to the Navigator program, CMS hired contractors to provide in-person assistance with filing applications. There are differences in the geographic and demographic communities that Navigators serve versus those served by the enrollment assistance program, indicating the importance of maintaining a variety of consumer assistance options.

HealthCare.gov - Consumers now can use the site to enroll in the new Health Insurance Marketplaces, also known as Exchanges. The website provides the public with ways to search and compare private plans, learn more about coverage and benefits, and serves as a resource on the ACA and how it may affect different individuals.

Federal External Review Program - On July 23, 2010, CMS issued a regulation to empower consumers to appeal decisions made by their health plans or insurance companies, ending some of the worst insurance abuses and giving consumers more control in their health care decisions. The regulation was effective on September 23, 2010, in every State, providing consumers enrolled in non-grandfathered health plans with the right to appeal decisions, including claims, denials and rescissions, made by their health plans. This includes the right to appeal initial denials of claims determinations and decisions made by a health plan at the conclusion of the plans' internal appeals process even if these decisions were made on behalf of a health plan by a contracted outside, independent entity. The regulation articulates requirements for State operated external review processes and establishes a Federal External Review Program (FERP). CMS is responsible for providing technical assistance to help States create new or improve existing independent, external review processes, and for administering FERP for residents of States that do not have a State-operated external review process that meets certain minimum consumer protections articulated in the July 23, 2010 regulation, subsequent June 22, 2011 amended regulation, and guidance issued by the Secretary. The FERP is also open to all self-insured non-Federal governmental employee health plans if they choose to participate. Additionally, the FERP will conduct consumer outreach, technical assistance for consumers and health plans, and analyses on appeals data.

Issuer Data Collection and Management – The Health Insurance Oversight System (HIOS) collect and compute the rates and benefits of coverage options on the HealthCare.gov Plan-Finder. The data submitted to HealthCare.gov informs the oversight efforts within the Center and serve as an important analytical resource for the department. Internally, this data is used to identify firms authorized to sell insurance and used to track those responsible for rate review and medical loss ratio filings as well as other oversight provisions of the Affordable Care Act (ACA).

Indian Health Care – Sec 10221 of the ACA amended and permanently reauthorized the Indian Health Care Improvement Act, the underlying authority for the Indian Health Service (IHS), a sister agency within HHS. The IHS provides health care to over 2 million American Indians and Alaska Natives (AI/ANs), by directly operating hospitals and clinics, or through contracts with Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance

Act, or through contracts with urban Indian organizations. CMS works in a collaborative manner with the Indian health programs to provide outreach and training on CMS programs.

Summary of Benefits and Coverage (SBC) – The SBC is a standardized document that summarizes health insurance coverage and the uniform glossary provides definitions of terms commonly used in health insurance coverage. The SBC includes coverage examples which are a tool to help consumers compare health insurance coverage options. Specifically, these coverage examples provide consumers with information on how cost sharing mechanisms (including coinsurance, copayments, and deductibles) and benefit limits and exclusions work. All plans and issuers providing health insurance coverage to consumers are required to provide summaries of benefits, specific information regarding coverage, and a glossary of medical insurance terms to consumers. This will allow consumers to make informed comparisons of health insurance options by providing consumers with equivalent information on all available coverage options.

Budget Request: $76.9 Million

The FY 2015 budget request for consumer outreach is $76.9 million, a decrease of $13.4 million below the FY 2014 Enacted level. Although the Program Management request for Marketplace activities in Consumer Outreach is decreasing, CMS anticipates covering a much larger portion of Marketplace outreach costs by collecting and expending more user fees in FY 2015 as compared to FY 2014, as described in more detail below.

- *Consumer Information & Outreach for Marketplaces*: CMS requests $71.4 million, a decrease of $13.6 million below the FY 2014 Enacted level. This request funds consumer outreach efforts, the implementation of the Federal Marketplace consumer contact center, and Marketplace Navigators and non-Navigator enrollment assisters.

  Consumer outreach efforts cast a wide net and target various segments of the population, including the uninsured and historically hard to reach populations. CMS anticipates new individuals will apply for Marketplace coverage in FY 2015, based on CBO projections, and these individuals may be harder to reach than the early adopters. A broad base of enrollees is necessary to maintain a balanced risk pool within the Marketplaces and avoid adverse selection.

  CMS operates a toll- free line to help consumers with questions about health insurance coverage through the Federally-facilitated Marketplace and SHOP. The call center opened in June 2013 to start answering general questions ahead of the first open enrollment period in October 2013. The Marketplace Consumer Contact Center assists individuals to determine if they are eligible for insurance affordability programs, and to enroll in a health plan that meets their needs and budget. Customer service representatives respond to enrollment inquiries and perform plan comparisons and enrollments. In addition to phone calls, consumers may contact the center through web chat, email, and letter mail. CMS anticipates additional development work on the call center will continue into FY 2015 to improve services, such as the interactive voice response (IVR).

  CMS requests FY 2015 funding to perform ongoing in person consumer assistance within the Marketplaces. CMS anticipates that there will be confusion and the need for targeted education and awareness activities, as well as significant one-on-one assistance for consumers who have not participated in an insurance market in the past and for those who may be transitioning in and out of public coverage programs. As people become more

familiar with the Marketplace, more consumers will likely want to enroll in qualified health plans through the Marketplace. Additionally, consumers will have to reevaluate their eligibility for the Marketplace and for insurance affordability programs each year, as well as reevaluate their plan selection. Many will continue to seek assistance from Navigators and enrollment assisters as part of the reevaluation process.

In addition to the Program Management request, activities in Consumer Outreach & Education for Marketplaces will receive approximately $702.5 million in user fees bringing the total funding level for Consumer Outreach & Education for Marketplaces to $773.8 million.

- *Information Maintenance of HealthCare.Gov:* $2.3 million, an increase of $0.3 million above the FY 2014 Enacted level. Includes IT functions for the site, also described in the IT section, and supports on going website maintenance involving 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:* $2.1 million, an increase of $1.6 million above the FY 2014 Enacted level request. This request supports an estimated 360 appeals. Through an inter-agency agreement (IAA) with the Office of Personnel Management (OPM), CMS established and operated an interim federal external review program in FY 2011. Through a subsequent IAA with OPM, CMS engaged a contractor, an independent review organization, to operate the permanent FERP.

  Grandfathered plans and issuers are not subject to Section 2719 of the Public Health Service (PHS) Act; however, an increasing number of these entities lose their grandfathered status annually. We anticipate that many of these non-grandfathered issuers will elect to use the FERP. Thus, an increasing number of consumers will have access to external review that complies with Section 2719 of the PHS Act through the FERP. On January 1, 2016, States must come into compliance with a stricter set of external review standards or fall into the FERP. We anticipate that more States will make changes to State processes, resulting in their compliance in preparation for the January 1, 2016 deadline, thus decreasing the number of States that fall into the FERP. However, as more consumers become insured, through coverage sold in the Marketplaces, and as they become more acquainted with using their coverage and more familiar with their rights to external review, consumers will increasingly take advantage of their right to file an independent review of their claims denials. Accordingly, we anticipate an increase in the number of consumers accessing the FERP through FY 2015.

- *Issuer Data Collection and Management*: $0.5 million, a decrease of $0.7 million below the FY 2014 Enacted level. As market rules are put in place, CMS anticipates that changes in the non-Exchange market place will need to be tracked and evaluated. This includes not only the composition of non-Exchange offerings, but also the impacts on consumer satisfaction and regulatory compliance. Funding supports the continuation of the Health Plan Identifier (HPID) program and given its importance to the Marketplaces, continued analysis is required and monitoring third parties who are affected by the data will require continued focus.

- *Summary of Benefits and Coverage (SBC)*: $0.2 million, a decrease of $0.8 million below the FY 2014 Enacted level. The funds requested for FY 2015 are lower than in past FY's because, it is anticipated that the focus will shift from development of new coverage examples and translations into different languages and onto the maintenance and updating of existing coverage examples and translations of SBC documents. Although the need for the development of new coverage examples will not be eliminated, we anticipate that there would be a need to develop fewer new coverage examples.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Enterprise IT Activities

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

- *Ongoing enterprise activities* – Supports all application needs, such as enterprise-wide identity management and standards development. Also includes application hosting and infrastructure, software testing, helpdesk, security testing, database maintenance and storage costs.

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

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

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

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

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

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

Infrastructure Investments

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

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

- *Virtual Call Center* – This critical project has greatly increased the overall efficiency and effectiveness of the 1-800-MEDICARE call center. Through this project, CMS is able to standardize the management of the Medicare beneficiary call center operations with best practice technology and process improvements, allowing for greatly improved customer service. The call center strategy provides efficient and timely service using the latest technology and support functions.

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

CMS ACA IT

This request supports the enterprise and architectural structure of the Marketplace implementation.

Health Insurance Marketplace IT – Several key information technology investments support the Marketplace, such as the data services hub, the FFM IT system, and the

Healthcare.gov webportal. In FY 2015, CMS will continue development on Marketplace IT systems for program requirements that are implemented on a longer timeline, such as quality reporting, and will also transition to general operations and maintenance of existing systems.

CMS Shared Services

This request will support CMS's continued development and operation of shared services, i.e. IT applications and infrastructure that will meet the programmatic needs of multiple business units. Specific shared services include Master Data Management, Enterprise Identity Management, Enterprise Portal, and Business Rules Enterprise Services.

Note that the request for funding for shared services represents only a portion of the total need. Costs are also allocated to other (mandatory) funding sources, such as CMMI, HCFAC QIO, etc.

Budget Request: $477.7 Million

The FY 2015 budget request for information technology investments supporting all Program Operations is $477.7 million, a decrease of $135.6 million below the FY 2014 Enacted level. This category includes four major IT investment activities, as shown in the table below.

For reference this table also shows estimates of non-BA funding sources:

FY 2015 IT Investments Request
(Millions of Dollars)

Activity	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Enterprise IT Activities	$233.0	$236.8	$3.8
Infrastructure Investments	$25.8	$32.0	$6.2
ACA IT	$326.6	$171.8	-$154.8
Shared Services	$27.9	$37.1	$9.2
Total Program Ops Request	$613.3	$477.7	-$135.6
Other Funding Sources			
Marketplace User Fees	$0.0	$35.0	$35.0
Total Estimated Program Level	**$613.3**	**$512.7**	**-$100.6**

- *Enterprise IT Activities*: $236.8 million, an increase of $3.8 million above the FY 2014 Enacted level. This funding is needed to continue IT activities which support improvements in the effectiveness and efficiency of CMS program management operations. These activities provide the operational support to manage the Agency's data environment for mission critical and enterprise-wide CMS IT strategies. One such area is the Baltimore Data Center (BDC), which supports all facets of CMS business operations. CMS has maximized the Agency-wide approach of utilizing cost effective technology to decrease this funding in FY 2015.

- *Infrastructure Investments*: $32.0 million, an increase of $6.2 million above the FY 2014 Enacted level. Funding is needed to continue to support the activities of the virtual call center 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 to continue operations of legislative mandates. CMS continues to maximize the Agency-wide approach of utilizing cost effective technology to decrease this funding in FY 2015.

- *CMS ACA IT*: CMS requests $171.8 million, a decrease of $154.8 million below the FY 2014 Enacted level. This request includes key components to implement the Marketplace IT strategy:

  CMS requests operations and maintenance funding for the data services hub contract. The Data Services Hub is a single interface to the States and federal partners to provide information exchange and business functionality in support of Marketplace operations; it interfaces with many federal entities and perform multiple tasks including verifying citizenship, immigration status, and Advance Premium Tax Credit (APTC) determinations the applicable federal agency including: the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS). This Data Services Hub will deliver information to the States for Marketplaces, Medicaid, and CHIP.

  In FY15 HIOS will continue to serve as CMS' primary data collection vehicle for information provided by regulated health insurance companies in the small group, individual/family, and large group markets in all 50 States and U.S. territories and the State Departments of Insurance that regulate them. Without the HIOS contract, the Plan Finder on HealthCare.gov would not be an interactive tool for consumers to research, find and compare their health insurance options in the private insurance market.

  In FY 2015, the IT Security project will continue to support Marketplace and other ACA related IT Security needs. This project will ensure compliance of Marketplace/ACA systems with federally mandated security regulations.

  Funding will allow for continued operations and additional development of the FFM IT system, which is a platform for organizing the Federally-facilitated 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. FFM IT supports the core business functions of a Marketplace including administration, health plan management, eligibility and enrollment, risk adjustment, premium tax credit administration, program integrity, and portal for customers.

  In addition to the Program Management request, activities in Marketplace IT will receive approximately $35.0 million in user fees bringing the total funding level for Marketplace IT to $200.5 million.

- *Shared Services*: $37.1 million, an increase of $9.2 million above the FY 2014 Enacted level. Funding is needed to cover the program management allocation for key shared services including Master Data Management, Enterprise Identity Management, Enterprise Portal, and Business Rules Enterprise Services. Shared services enable CMS programs to utilize common services, such as eligibility verification, identity proofing, authentication, and data services, reducing redundant development and leveraging efficiencies of scale.

Performance Measurement

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

MCR9 Ensure Beneficiary Telephone Customer Service: Beneficiary telephone customer service is a central part of CMS' customer service function. The Beneficiary Contact Center (BCC) is expanding to handle calls and inquiries related to the new Health Insurance Marketplace. As a result, the contact center is now being called the Contact Center Operations (CCO) to reflect the handling of both beneficiary (Medicare) and consumer (Marketplace) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate Customer Service Representatives' (CSRs') performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance in handling telephone inquiries using the quality standards of privacy act compliance, knowledge skills, and customer skills every month. The CCO has exceeded the FY 2013 target of 90 percent for each standard. Despite exceeding targets in previous reporting years, we will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching staff. The resources required to ensure a higher quality metric would be better allocated to the increased amount of contacts associated with the incoming baby-boomer population as well as the inclusion of the new Health Insurance Marketplace inquiries. The FY 2015 target is 90 percent.

MCR12 Maintain CMS' Improved Rating on Financial Statements: Our annual goal is to maintain an unqualified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, and budgetary resources of CMS. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

CMS met its FY 2013 target of maintaining an unqualified opinion on four out of the six principal financial statements. During FY 2012 the auditors could not express an opinion on the financial condition of the CMS Statement of Social Insurance (SOSI) as of January 1, 2013 or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). 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 Patient Protection and Affordable Care Act and current law. Due to these limitations, the auditors were unable to obtain sufficient evidential support for the amounts presented in the SOSI and consequently, the SCSIA. Since FY 2010, CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA). CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems,* since, as of September 2013; CMS has all core program dollars accounted for in the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS is CMS' official financial system of record, as we produce our financial statements via HIGLAS. Overall, CMS continued to improve its financial management performance in many areas as evidenced by no material weaknesses being reported as a result

of the agency's CFO audit and OMB Circular A-123 review. Our FY 2015 target is to maintain an unqualified opinion on the CMS financial statements.

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

CMS is measuring activities towards transitioning to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set, and has met its FY 2012 and FY 2013 targets, as reflected in the table at the end of this chapter. Some FY 2015 post-implementation activities will include, but are not limited to: a well-organized outreach, education, and training programs to help with payment issues (denials and rejections), coordination of benefits and appeals. There will be a need for communication and clear instruction from the regulators as well as leadership in directing industry-wide problem solving. There must be a post-implementation plan to include internal and external dependencies as well as a strategy for mitigating risks across the health care industry across the health care spectrum, Federal and State agencies, State and local health departments, etc. For example, we see the potential need for advance and/or accelerated payments to small physician practices that may be at-risk for going out of business because they have not made preparations for the ICD-10 transition and continue to submit invalid ICD-9 codes. We are also planning to institute an industry-wide ICD-10 Solutions Center which would manage critical issues arising during implementation and require immediate action and responsiveness to industry concerns.

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

FY 2015 targets will be to continue external ICD-10 outreach and communications for post-implementation, review and monitor ICD-10 industry compliance level and State Medicaid program baselines, continue post implementation monitoring and assessment and monitor and remediate claims payment, policy, and systems issues.

MCR21 Effectively Manage Information Technology (IT) Systems and Investments to Minimize Risks and Maximize Returns: CMS has four performance measures representing effective management of CMS IT systems and investments to minimize risks and maximize returns. CMS ensures that IT investments are managed effectively by adhering to the Expedited Life Cycle (XLC) framework, by conducting post-implementation reviews, and by making sure that CMS IT systems have a formal Authority to Operate (ATO) and are included in a vulnerability management program.

CMS met two of its FY 2012 targets. One hundred percent of the Federal Information System Management Act (FISMA) systems were scanned and monitored by a vulnerability management system. The FY 2015 target is set at 100 percent. In addition, 100 percent of IT projects have adapted to the XLC framework. The FY 2015 target is 95 percent.

CMS exceeded the FY 2012 Post Implementation Review (PIR) target of 12 PIRs with an actual of 16 PIRs. Going forward, the PIR targets will be reflected in percentages. It is more realistic to base projections on the percentage of candidate PIRs completed rather than to strive to reach a numerical target because the number of systems moving through the life cycle during any given year is variable, making it impossible to accurately predict the number of systems that will be good candidates for the PIR. In FY 2015, the goal is to complete PIRs for 70 percent of new IT implementation projects that have been in operations for up to 12 months.

CMS did not meet the FY 2012 target of 90 percent of CMS FISMA systems ATO based on defining the number of CMS FISMA systems for the following reasons: 1) In the FISMA system inventory list, there are systems that did not fully follow the lifecycle; some either went into production prior to getting an ATO, and others still do not have an ATO. These systems may have followed parts of the lifecycle, but they did not fully complete it properly and 2)the influx of systems from ACA created a large backlog of current and future systems that needed Security Control Assessments (SCAs) at one time. CMS does not have the resources to test them all at once. The FY 2015 target is set at 90 percent.

MCR22 Improve the Accuracy of Medicare Physician Fee Schedule Payments: The purpose of this measure is to achieve more accurate pricing under the Medicare physician fee schedule, consistent with CMS' goal of moving to a value driven health care system. The Medicare Physician Fee Schedule (PFS) is a payment system used to pay practitioners for Medicare services. In this process, each service is assigned an unique code and a relative value unit (RVU), which helps Medicare determine the payment for the services. Like other payment systems, the Medicare PFS is not perfect and is vulnerable to mispricing. In order to achieve CMS' goal of moving to a value driven health care system, it is imperative to have a payment system that provides accurate payment for the services rendered. The Affordable Care Act directed the Secretary of Health and Human Services to establish a systematic process for identifying and reviewing potentially misvalued services. This measure aims to quantify CMS' progress in determining which services under the Medicare PFS are misvalued and in setting the appropriate values for those services.

Originally, CMS set the baseline for this analysis as the number of codes previously identified through the potentially misvalued codes initiative, which began in 2008. CMS planned to have reviewed 20 percent of the identified potentially misvalued codes in 2012 and an additional 20 percent in both CY 2013 and CY 2014, achieving review and appropriate valuation of 60 percent of the baseline. However, in CY 2012, CMS exceeded target of 20 percent by reviewing 78 percent of codes identified between 2008 and 2011. The number of codes CMS identified as potentially misvalued through 2011 was approximately 1,167. From the start of the misvalued code initiative in 2008 through the end of 2013, CMS reviewed 1189 codes.

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

CMS exceeded the targets for 2013 with 47 percent of potentially misvalued codes identified in 2012, and 20 percent of unreviewed potentially misvalued codes identified from 2008 to 2011. The target for FY 2015 will be as follows:

1) 40 percent of potentially misvalued codes identified in 2014.
2) 20 percent of potentially misvalued codes identified in 2013.
3) 20 percent of potentially misvalued codes identified in 2012.

MCR26 Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent over the previous year's target rate: In order to improve quality of care and reduce Medicare expenditures, CMS is measuring preventable Medicare inpatient hospital readmissions. CMS established the Hospital Readmissions Reduction Program in FY 2013, which would reduce a portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: acute myocardial infarction, pneumonia, and congestive heart failure. We are proposing to expand to two additional readmissions measures for FY 2015: Chronic Obstructive Pulmonary Disease, and Total Hip Arthroplasty and Total Knee Arthroplasty.

In addition to the Hospital Readmissions Reduction Program, CMS leverages efforts of other programs to reduce hospital readmissions. Among these is the Partnership for Patients (PfP) to reduce preventable complications during a transition from one care setting to another which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations (ACOs), which must report on 33 quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program.

CMS targets reduction of all-cause Medicare hospital readmissions by one percent per year by 2015, beginning with a baseline of 18.7 percent on CY 2010 data set in FY 2012. Based on CY 2011 fee-for-service and Medicare Advantage inpatient claims data, the Medicare all-cause hospital readmission rate is estimated to be 18.6 percent, which falls slightly above the 2013 target of 18.5 percent. Much of this slight short fall is due to rounding (the CY 2011 rate before rounding was 18.561 percent). We note that although hospital specific readmission data was publicly available in 2011 on the Hospital Compare website, many of CMS' endeavors aimed at reducing hospital readmissions (discussed above) were not fully developed or implemented until after CY 2011, which is the period for assessing the 2013 target for this goal. Despite not successfully achieving the 2013 target, we believe we will meet or exceed the 2014 target for this goal as the data used to assess future targets will include admissions data that reflects hospitals' experiences under and in response to CMS' efforts aimed at reducing hospital readmissions. We have set the FY 2015 target at 18.1 percent. The readmission rate will be monitored annually through FY 2015.

MCR27 Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Among Eligible Professionals (EP) and Hospitals: CMS has performance measures to promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals and hospitals. CMS is measuring the number of eligible professionals, eligible hospitals and eligible Critical Access hospitals receiving Medicare and Medicaid EHR Incentive Payments for the successful demonstration of meaningful use. Additionally, CMS measured the number of eligible professionals and hospitals receiving Medicaid EHR Incentive Payments for adopting, implementing, or upgrading (AIU) their EHR. This measure supports the HHS Priority Goal to improve health care through adoption or meaningful use of health information technology, which aimed by September 30, 2013, to increase the number of eligible providers who receive an incentive payment from the Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology to 230,000.

In FY2013, the target was exceeded as there were over 325,000 eligible providers who received an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology. CMS set FY 2014 targets based on previous performance and has now updated the FY 2014 target to 375,000. The new FY 2015 target is 425,000. For more information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs.

MCR28 Reduce Healthcare-Associated Infections: Healthcare-associated infections (HAIs) are a significant cause of morbidity and mortality in the United States. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death, and catheter-associated urinary tract infections (CAUTI) are among the most common. Research has shown that a significant portion of these infections can be prevented. As such; the FY2014-15 HAI Agency Priority Goal (APG) is to reduce the national CAUTI standardized infection ratio by 10 percent by September 2015 over the current 2012 baseline of 1.02. This APG is led by CMS with the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and the Office of the Assistant Secretary for Health.

National Healthcare Safety Network FY 2012 CLABSI data was calculated at 0.566 Standardized Infection Ratio (SIR) or a 17 percent reduction in the SIR over the baseline of 0.68 SIR, and is ahead of the midway goal target of 0.60 SIR or a 12.5 percent reduction.

NHSN FY 2012 CAUTI data was calculated at 1.056 SIR or a 17 percent increase (opposite of the desired outcome) in the SIR over the baseline of 0.94 SIR, and is behind the midway goal target of 0.85 SIR or a 10 percent reduction. The reasons behind the increase in the CAUTI SIR are felt to be multifactorial:

- New Reporters: Approximately 2000 new hospitals began reporting CAUTI ICU data to NHSN in 2012 as requirement for participation in CMS' Hospital Inpatient Quality Reporting Program. These new reporters were shown to have a consistently higher SIR than facilities reporting prior to 2012.

- Better Reporting: Further review of the data with several facilities revealed that the national SIR for those facilities reporting prior to 2012 reporting requirements in the Hospital Inpatient Quality Reporting program also increased. This may have been a consequence of CDC outreach and education performed throughout 2012 to clarify reporting requirements and reduce under-reporting errors. Improved accuracy of reporting would increase the number of CAUTIs reported, raising the SIR among this group of hospitals

- Need for continued widespread implementation of prevention strategies:

    - Despite measurement-related factors that could be contributing to increasing SIRs, data from large prevention projects are showing that CAUTIs can be significantly decreased in US hospitals using the current interventions and metrics; Widespread and consistent application of CDC CAUTI prevention recommendations and proven interventions such as Comprehensive Unit-Based Safety Program (CUSP) should reduce these infections, just as they have been reduced in these prevention projects; Therefore, it is key, not only to sustain the large-scale infection prevention programs currently in place, but to also spread these protocols in acute-care facilities identified as needing them through data-driven analysis.

We plan to focus on efforts to continue and sustain successes seen in CLABSI reduction while intensifying work to reduce CAUTIs through the following tactics:

- Collaboration among multiple stakeholders in the healthcare community;

- Tracking and monitoring data that drives improvement;

- Linking higher quality, safer and more efficient care to payment;

- Research and testing to refine evolving HAI prevention guidelines, optimize implementation strategies and tools and integrate health information technology.

It's important to note that the proposed FY 2014-2015 HAI APG is only in part, a continuation of the FY 2011-13 HAI APG. There are also factors which differentiate this iteration from the previous two years. While we will continue to monitor, track and report reduction of nationwide hospital-acquired CAUTI, the HAI workgroup has decided not to recommend CLABSI for inclusion in FY2014. Although the workgroup did not recommend continuation of CLABSI as part of the FY 2014-15 HAI APG, there are and continue to be significant, evidence-based interventions that when implemented in units, can prevent infection and further drive down CLABSI incidence. The impact of on-going CLABSI prevention work will be monitored as a CDC GPRA goal for FY 2014-15.

For more specific information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs..

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

Through rulemaking, CMS established performance standards for the selected measures, including performance periods, and a methodology for assessing the total performance of each facility. In addition, as part of this program, CMS develops procedures for making performance information available to the public, as well as procedures for ensuring that facilities have an

opportunity to review information before public release. The first payment year (PY) of the QIP 2012, was outlined in two rules, which were published in the Federal Register in 2010 and 2011, and included assessment on three measures (two related to anemia management and one on dialysis adequacy). The PY 2013 and PY 2014 QIP were established by a rule published in the Federal Register in November 10, 2011, and included additional areas of evaluation (vascular access type, infection monitoring, mineral metabolism monitoring, and patients' experience of care survey administration). The PY 2015 QIP was finalized in the Federal Register on November 9, 2012. It added new measures for anemia management, and replaced the dialysis adequacy measure with one that includes adult hemodialysis patients, adult peritoneal dialysis patients and pediatric in-center hemodialysis patients. For future years of the program, CMS aims to strengthen the QIP by evaluating facilities on a wider range of measures covering more topic areas. For example, CMS is currently developing measures to assess fluid weight management, on transplantations, iron management, and transfusions, and additional measures on bone mineral metabolism. The proposed PY 2016 rule was published in the Federal Register in July 2013.

In FY2013 CMS met all of its goals including publishing the PY 2015 rule, adjusting payments for facilities not meeting performance standards (based on 2011 claims data), and developing and completing the ESRD QIP Final Monitoring Report for PY 2012. For FY2014 CMS has already met all of its goals including publishing the PY 2016 rule, adjusting payments for facilities not meeting performance standards (based on 2012 claims data), and developing and completing the ESRD QIP Final Monitoring Report for PY 2013. FY 2015 targets include publishing the PY 2017 rule, adjusting payments for facilities not meeting performance standards (based on 2013 claims data) and developing and completing the ESRD QIP Final Monitoring Report for PY 2014.

PHI2 Increase the Number of Young Adults Ages 19 to 25 Who Are Covered as a Dependent on Their Parent's Employer-sponsored Insurance Policy: To extend health insurance coverage to a segment of the American population that is disproportionately uninsured, CMS is monitoring the implementation of a regulation that allows adult children to remain on their parents' employer-sponsored health insurance plans through age 26. In FY 2012, 10.2 million young adults were covered under this regulation, exceeding our target of 8.7 million. CMS' goal is that 9.7 million adult children are covered as dependents on a parent's employer-sponsored insurance policy to by FY 2014. CMS and State regulatory authorities are performing audits to monitor compliance with the requirements that issuers offer coverage for young adults ages 19 to 25. After FY 2014, we plan to report this number as a contextual measure.

PHI3 Protect Individual and Small Businesses from Potentially Unreasonable Health Insurance premium Increases through the Effective Rate Review Program: The Affordable Care Act brings an unprecedented level of scrutiny and transparency to health insurance rate increases in the individual and small group markets through the creation of an Effective Rate Review program. This program will protect individual and small businesses from potentially unreasonable health insurance premium increases. In every State, large, proposed rate increases will be evaluated by independent experts to assess whether the increases are based on reasonable cost assumptions and solid evidence. Reasonableness determinations can lead to lower implemented rate increases. CMS has begun to measure how the Effective Rate Review program has assisted States in improving their capabilities to review requested rate increases. Our FY 2015 target is to increase the percentage of submissions where issuers reduce the implemented rate increase as a result of Effective Rate Review to 65 percent.

PHI4.1 Increase the Proportion of Legal Residents under Age 65 covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion: CMS tracks progress toward setting up Health Insurance Marketplaces (Exchanges) to ensure that millions of individuals estimated to gain insurance through Marketplaces will have the ability to enroll beginning in October 2013. We met our FY 2013 targets to Release 2014 HHS notice of benefit and payment parameters; have data sharing agreements for hub use in place with every State; and have health plans certified in all Federally-facilitated Exchange States. Our FY 2015 target is for 89 percent of Legal Residents to have Health Insurance Coverage.

PHI5 Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces (Exchanges): Health Insurance Marketplaces are designed to make buying health coverage easier and more affordable. Marketplaces will bring new transparency to the market and will allow individuals to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance, and enroll in a health plan that meets their needs. Baseline enrollment data for CY 2014 will be available in March 2015. We will set our CY 2015 target once baseline data is available.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR9.1a: Quality Standards: Minimum of 90% pass rate for Adherence to Privacy Act (Outcome)	FY 2013: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1b: Quality Standards: Minimum of 90% expectations for Customer Skills Assessment (Outcome)	FY 2013: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1c: Quality Standards: Minimum of 90% meets expectations for Knowledge Skills Assessment (Outcome)	FY 2013: 93% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.3: Minimum of 90% pass rate for the Customer Satisfaction Survey (Outcome)	FY 2013: 93% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR12: Maintain an unqualified opinion	FY 2013: Maintain an unqualified	Maintain an unqualified opinion	Maintain an unqualified	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
	opinion (Target Met)		opinion	
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2014: External ICD-10 outreach and communications continued. (Target Met) FY 2013: ICD-10 Industry Compliance Level and State Medicaid program readiness baselines updated. (Target Met) FY 2013: ICD-10 industry compliance Level and State Medicaid program readiness baselines in May 2013 was completed (Target Met)	1) Continue the external outreach and communica-tions of the International Classification of Diseases (ICD-10) 2) Update ICD-10 industry compliance Level and State Medicaid program readiness baselines 3) Complete CMS implementation of ICD-10	1)Continue external ICD-10 outreach and Communications for post-implementation 2) Update ICD-10 industry compliance Level and State Medicaid program baselines 3) Continue post implementation monitoring and assessment 4) Monitor and remediate claims payment policy, and systems issues.	N/A
MCR21.1: Percent of CMS Federal Information Security Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. (Outcome).	FY 2012: 78% Target: 90% (Target Not Met)	90%	90%	Maintain
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution (Outcome)	FY 2012: 100% Target: 100% (Target Met)	100%	100%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (EXL) framework (Outcome)	FY 2012: 100% Target: 90% (Target Exceeded)	95%	95%	Maintain
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) (Outcome)	FY 2012: 16 PIRs (or 53%) Target: 12 PIRs (Target Exceeded)	65%	70%	+5 pp
MCR22: Review potentially misvalued codes and unreviewed misvalued codes (Outcome)	FY 2013: 47% of potentially misvalued codes identified in 2012, 91% of unreviewed potentially misvalued codes identified 2008 to 2012, Target: Review 20% of unreviewed potentially misvalued codes identified 2008 to 2011 and review 40% of potentially misvalued codes identified in 2012 (Target Exceeded	Review & Value Appropriately 40% of potentially misvalued codes identified in 2013 Review & Value Appropriately 20% of potentially misvalued codes identified in 2012 Review & Value Appropriately 20% of unreviewed potentially misvalued codes identified 2008 to 2011	Review & Value Appropriately 40% of potentially misvalued codes identified in 2014 Review & Value Appropriately 20% of potentially misvalued codes identified in 2013 Review & Value Appropriately 20% of unreviewed potentially misvalued codes identified 2012	N/A
MCR26: Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent over the previous year's target rate Baseline: 18.7% (CY 2010 data)	FY 2013: 18.6%[5] Percent Target: 18.5% (Target Not Met but Improved)	18.3%	18.1%	-.2 pp

[5] Based on CY 2011 data

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR27.1: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use for Medicare	FY 2013: 123,355 Target: 138,000 (Target Not Met, But Improved)	240,000	260,000	+20,000
MCR27.2: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicaid	FY 2013: 21,138 Target : 8,000 (Target Exceeded)	28,000	50,000	+22,000
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 2013: 2,338 Target: 2,205 (Target Exceeded)	4,000	4,500	+500
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 2013: 1,519 Target : 1,000 (Target Exceeded)	2,800	3,000	+200

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR27.5: Increase number of Eligible Professionals receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program	FY 2013 : 45,990 Target: 77,295 (Target Not Met)	110,000	165,000	+55,000
MCR27.6: Increase number of Eligible Hospitals receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program	FY 2013: 897 Target : 3,500 (Target Not Met)	3,550	3,600	+50

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR28.1 Reduce by 25[6] percent hospital-acquired central-line associated blood-stream infections (CLABSI) by the end of FY 2013. FY 2013 result will be available March 31, 2014[7]	FY 2012: 17% Reduction Target: 12.5% (Target Exceeded)	Discontinued-Further movement and reduction of hospital-acquired CLABSI is felt to optimally benefit from targeted intervention in areas where NHSN hospital and unit data show rates to be highest. As such, this goal is not recommended for continuation as a broader HAI high priority goal however is being recommended for close monitoring and continued reporting as a CDC GPRA goal.	Discontinued as HAI Agency Priority Goal	N/A
MCR28.2: Reduce by 10[8] percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2015. FY 2013 result will be available March 31, 2014[9]	FY 2012: 17% Increase Target: 10% (Target Not Met)	5%[10]	10%[11]	TBD

[6] The CLABSI 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).

[7] National Healthcare Safety Network (NHSN) CLABSI data as of March 2013 (FY 2013 midpoint) was calculated at 0.55 Standardized Infection Ratio (SIR) or a 19 percent reduction in the SIR over the baseline of 0.68 SIR, and is ahead of the midway goal of 0.60 SIR or a 12.5 percent reduction.

[8] The CAUTI 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).

[9] NHSN CAUTI data through March 2013 (FY 2013 midpoint) was calculated at 1.02 SIR or a 9 percent increase (opposite of desired outcome) in the SIR over the baseline of 0.94 SIR, and is behind the midway goal of 0.85 SIR or a 10 percent reduction.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
MCR29.1: Develop drafts and final ESRD QIP rules for payment years (PY) 2014 through 2016	FY 2014: 2016 Final Rule Published December 2, 2013 (Target Met)	Publish PY 2016 final rule (Target Met)	Publish 2017 final rule	N/A
MCR29.2: Implementation of ESRD QIP payment reduction (to meet statutory requirement)	FY 2013: Payments adjusted for facilities not meeting performance standards (based on 2011 claims data) (Target Met)	Adjust payments for facilities not meeting performance standards (based on 2012 claims data) (Target Met)	Adjust payments for facilities not meeting performance standards (based on 2013 claims data)	N/A
MCR29.3: Obtain monitoring and evaluation contractor and implement monitoring strategy	FY 2012: Developed and completed ESRD QIP Final Monitoring Report for PY 2012 (Target Met)	Develop and complete ESRD QIP Final Monitoring Report for PY 2013	Develop and complete ESRD QIP Final Monitoring Report for PY 2014	N/A
PHI2 Increase the Number of Young Adults Ages 19 to 25 Who Are Covered as a Dependent on Their Parent's Employer-sponsored Insurance Policy	FY 2012: 10.2 million Target: 8.7 million (Target Exceeded)	9.7 million	N/A	N/A
PHI3: Increase the percentage of submissions where issuers reduce the implemented rate increase as a result of Effective Rate Review.	FY 2012: 50% Baseline	60%	65%	+5 pp

[10] The midway CAUTI target for FY 2014-15 is a 5 percent reduction in the CAUTI SIR from its baseline (1.02) or target SIR 0.97. The midway point is September 2014 and the midpoint data will be reported in March of 2015.

[11] The final CAUTI target for FY 2014-15 will be 10 percent reduction in the national CAUTI SIR from baseline or a target SIR 0.92. The end period for this goal is September 2015 and the final goal data will be reported in March of 2016.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
PHI4.1: Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces and Implementing Medicaid Expansion	FY 2013: 1) Release 2014 HHS notice of benefit and payment parameters 2) Established data sharing agreements for hub use in place with every State 3) Health plans certified in all Federally-facilitated Exchange States (Target met)	Establish Individual and Small Business Health Options Program Exchanges in 50 States +DC	89% of Legal Residents with Health Insurance Coverage	N/A
PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces	New for 2015 CY 2014 Baseline Available March 2014	Set Baseline	CY 2015 target will be set when CY 2014 baseline is available	N/A

Federal Administration

	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	FY 2015 PB +/- FY 2014
BA	$732,533,000	$732,533,000	$787,500,000	+$54,967,000
Comparability Adjustment[1/]	-$925,000	$0	$0	$0
FTE	4,689	4,542	4,738	+196

1/ Comparably adjusted for the SHIP transfer to ACL in FY 2013.

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2015 Authorization – One Year; No separate authorization of appropriations
Allocation Method - Various

Program Description and Accomplishments

CMS oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), the Nation's largest health insurance programs. CMS currently oversees benefits for consumers and employers through the Federal Marketplace (Marketplace), the Pre-existing Condition Insurance Program (PCIP), the Early Retirement Reinsurance Program (ERRP), and State High-Risk Pools. CMS is responsible for setting up the new Marketplace for each State, also known as Exchanges, that elects not to establish a State-based Exchange (SBE). In addition, CMS is responsible for enforcing new rights and greater accountability for consumers and providers in the private health insurance market, and CMS disseminates an unprecedented level of consumer information regarding coverage options. As the largest purchaser of health care in the United States, CMS expects to serve almost 123 million beneficiaries in the traditional programs and millions of new consumers in the private insurance market in 2015.

The Federal Administration account funds the majority of CMS' staff and operating expenses for routine activities such as planning, implementing, evaluating and ensuring accountability in a variety of health care financing programs. Remaining staff are funded through different budget accounts and are not included in the Federal Administration request. Staff funded from these other sources can only work on specific programs and activities and cannot work on general operations.

Since 1988, CMS has utilized an indirect cost allocation methodology that enables the Agency to use these other fund sources to offset some costs that would otherwise be funded out of the Federal Administration account. CMS will continue to leverage all available fund sources in accordance with CMS' cost allocation principles.

CMS currently employs approximately 5,900 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. CMS also have staff in the fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program.

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

Personnel Compensation and Benefits:

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

CMS' staffing level and related compensation and benefits expense is largely workload-driven. Over the last decade, CMS' core workloads have increased dramatically due to major legislative and Secretarial initiatives. These include the completion of activities mandated by the Health Insurance Portability and Accountability Act (HIPAA); the Balanced Budget Act (BBA); the Ticket to Work and Work Incentives Improvement Act (TWWIIA); the Balanced Budget Refinement Act (BBRA); the Benefits Improvement and Protection Act (BIPA); the Trade Act; the Medicare Modernization Act (MMA); the Deficit Reduction Act (DRA); the Tax Relief and Health Care Act (TRHCA); the Medicare, Medicaid and SCHIP Extension Act (MMSEA); the Medicare Improvements for Patients and Providers Act (MIPPA); the Childrens' Health Insurance Program

Insurance Reauthorization Act (CHIPRA); the American Recovery and Reinvestment Act (ARRA); the Medicare and Medicaid Extenders Act; and, the Affordable Care Act (ACA). In addition, CMS is responsible for the concurrent implementation of a number of Secretarial priorities, including quality improvement, value-based purchasing, price transparency, consumer choice, e-health initiatives, and enhanced beneficiary outreach.

Other Objects:

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

Most of these costs—including rent, communications, utilities; the Central Office building loan; and CMS' share of Departmental costs such as the Service and Supply Fund; Office of General Counsel support; and the Federal Protective Services contracts—are determined by the Department or another government agency and are not negotiable. Other costs—including IT infrastructure costs, building maintenance, and most of our inter- and intra-agency agreements—are essential for carrying out our mission as a government agency. It is important to note that the Federal Administration account only covers a portion of these costs, as CMS' other budget accounts also contribute their fair share towards administrative functions and activities that are used by the entire agency.

CMS' FY 2015 request has been prepared in accordance with Executive Order 13589, Promoting Efficient Spending.

- Rent, Communication & Utilities

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

- Building Loans

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

- Service and Supply Fund

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

on their core mission objectives, and to eliminate duplication of functions, thus achieving economies of scale.

- Administrative Services

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

- Information Technology (IT)

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

- Inter-Agency Agreements

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

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

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

- Supplies and Equipment

This category funds general everyday office supplies and materials for CMS employees, including new and replacement furniture, office equipment, paper 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 2014, CMS will pay about $14.6 million for these services. OGC calculates the charge and informs CMS of the amount it must pay.

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

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

- Training

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

- Travel

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

- Conducting performance reviews of Medicare Administrative Contractors (MACs) and remaining fiscal intermediaries and carriers who handle the administrative processes

needed to run the Medicare fee-for-service program. These contractors are located throughout the country and CMS staff must travel to their locations. Reviews and oversight ensure that the contractors are carrying out their responsibilities properly, in accordance with CMS policies and regulations. CMS has always conducted on-site performance reviews, but now that the new MACs can earn incentive payments, these reviews are critical to ensuring that the incentives are appropriate.

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

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

- Printing and Postage

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

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

Funding History

2010	$696,880,000
2011	$685,806,000
2012	$772,963,000
2013	$732,533,000
2014	$732,533,000

Non-comparable values.

Budget Overview and Supported Activities

FY 2015 Request ($787.5 million):

Personnel Compensation and Benefits ($674.1 million): The FY 2015 budget request for payroll totals $674.1 million in discretionary funding to support 4,738 direct FTEs, a $46.2 million (196 FTEs) increase above the FY 2014 enacted level. This increase results from actions taken to mitigate staffing losses that have resulted from a sequestration-driven hiring freeze. Staffing funded from the Federal Administration line is necessary to implement private market insurance reforms, including the Federal Marketplace, maintain and improve our traditional programs in light of significant beneficiary population growth, and to improve program integrity. CMS' payroll estimate assumes a 1.0 percent pay increase for civilians and the Commissioned Corps in 2015.

Rent, Communication & Utilities ($5.1 million): The FY 2015 budget request supports rent, communications and utilities at $5.1 million, a $100,000 inflationary increase above the FY 2014 enacted level. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Service and Supply Fund ($3.8 million): The FY 2015 estimate for the Service and Supply Fund totals $3.8 million in discretionary funds. This estimate remains the same as the FY 2014 enacted amount. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Services ($15.1 million): The FY 2015 budget request for Administrative Services is $15.1 million, a $2.2 million increase above the FY 2014 enacted level. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Information Technology ($38.8 million): The FY 2015 budget request for Administrative IT is $38.8 million, nearly a straight-line of the FY 2014 enacted amount.

Inter-Agency Agreements ($3.8 million): The FY 2015 request for Inter-Agency Agreements is $3.8 million, an $827,000 inflationary increase over the FY 2014 enacted amount.

Supplies and Equipment ($1.3 million): The FY 2015 estimate for supplies and equipment is $1.3 million, a $90,000 increase over the FY 2014 enacted level.

Administrative Contracts and Intra-Agency Agreements ($32.0 million): The FY 2015 budget request for Contracts and Intra-Agency Agreements totals $32.0 million, a $5.6 million increase over the FY 2014 enacted amount. This increase will allow us to fund the majority of our mandatory contracts within the Federal Administration line. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Training ($2.9 million): The discretionary training estimate for FY 2015 is $2.9 million. This estimate remains the same as the FY 2014 enacted level.

Travel ($6.8 million): The FY 2015 budget request for travel totals $6.8 million. This estimate remains the same as the FY 2014 enacted level.

Printing and Postage ($3.8 million): The printing and postage estimate for the FY 2015 request totals $3.8 million, about the same as the FY 2014 enacted level.

Federal Administration Discretionary Summary
(Dollars in thousands)

Objects of Expense	FY 2014 Final	FY 2015 President's Budget	FY 2015 +/- FY 2014
Personnel Compensation	$627,959	$674,132	$46,173
Rent, Communications and Utilities	$5,000	$5,100	$100
Central Office Loan	$0	$0	$0
Service and Supply Fund	$3,763	$3,763	$0
Administrative Services	$12,904	$15,079	$2,175
Administrative IT	$38,850	$38,806	-$44
Inter-Agency Agreements	$3,055	$3,882	$827
Supplies and Equipment	$1,163	$1,253	$90
Administrative Contracts and Intra-Agency Agreements	$26,337	$31,978	$5,641
Training	$2,938	$2,938	$0
Travel	$6,753	$6,753	$0
Printing and Postage	$3,811	$3,816	$5
Subtotal, Non-Pay Objects of Expense	$104,574	$113,368	$8,794
Total, Federal Administration [1/]	**$732,533**	**$787,500**	**$54,967**

1/ Only reflects CMS' discretionary Federal Administration request and excludes costs that are borne by other budget accounts.

Medicare Survey and Certification

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$355,578,000	$375,330,000	$424,353,000	+$49,023,000

Authorizing Legislation - Social Security Act, title XVIII, section 1864
FY 2015 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, and for millions of other Americans who rely on the U.S. health care system, 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. Using about 7000 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards. In FY 2013, 89.7 percent of Medicare participating nursing homes were cited for health care deficiencies (such as abuse, avoidable injury from falls or pressure ulcers, infection control lapses, deaths from medication errors). The average number of health deficiencies per standard survey was approximately six. Similarly, 71 percent of dialysis facilities surveyed were cited for failing to meet regulatory requirements in FY 2013 (such as infections or hazards to life from poor equipment cleaning or water quality); 58 percent of hospitals surveyed were cited for deficiencies such as wrong site surgery, medication errors, poor outcomes, failure to maintain an effective quality improvement system; and 47 percent of home health agencies (HHAs) surveyed received deficiency citations. In FY 2013 approximately 67 percent of ambulatory surgical centers (ASCs) surveyed were cited for deficiencies. In FY 2013 the number of surveyed ASCs cited for infection control deficiencies was 50 percent, a slight improvement over the 57-59 percent range in prior years as CMS and CDC continue efforts to address this serious issue. These examples illustrate the profound importance of regular, comprehensive inspections of health care facilities, as well as timely and effective investigation of complaints

Twenty two recent reports (2010-2013) from the Government Accountability Office (GAO) and the Office of Inspector General (OIG) highlight the need for Federal oversight to ensure quality of care. At various times, the GAO has placed areas of survey and certification oversight, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement. Recent reports from the OIG focused on adverse events in hospitals, nursing homes, and ASCs. We are therefore implementing a variety of the OIG recommendations to strengthen survey and certification oversight, such as improvements in infection control, adverse event reporting, and internal quality assessment and performance improvement systems. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to ensuring Federal dollars support only quality care.

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 all nursing homes every 12 months on average and each home health agency must be surveyed at least every 3 years. Survey frequencies for all other facility types are determined by policy and funding levels. Direct survey costs are affected primarily by the number of Medicare-participating providers and the onsite survey time required. The number of providers continues to increase, with home health agencies, ambulatory surgical centers, and dialysis facilities growing the fastest in number (increasing by 80 percent, 55 percent, and 42 percent respectively between FY 2002 and FY 2013). Between 2013 and 2015 we project these numbers to increase by at least another 4%.

In addition to the cost of conducting surveys, Direct Survey costs also include Other Direct Survey costs, which support State program operations or responsibilities. These costs include support for State responsibilities for the Minimum Data Set (MDS), which helps hold nursing homes accountable for proper assessment of resident needs and conditions, as well as providing data to monitor and improve nursing home care. Similarly, we include support for State responsibilities, such as 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 contractors that assist States to address performance issues, and assistance to States for emergency preparedness and post-disaster recovery surveys. Validation surveys to assess the adequacy of State survey performance and those of CMS-approved accrediting organizations represent another form of direct survey costs and are required by law for long term care facilities and for accrediting organization oversight.

Survey frequencies for non-statutorily mandated facilities has been decreasing due to a growing number of facilities, demands to survey more facility types, and the effects of budget sequestration in FY 2013.

Reduced survey frequencies have consequences. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various Ambulatory Surgical Centers (ASCs), potentially affecting more than 50,000 people. A CMS pilot in 2008 found that 57 percent of randomly-selected ASCs were cited for deficiencies in infection control practice. ASCs account for approximately 43 percent of all same-day (ambulatory) surgery in the United States, amounting to about 15 million procedures every year and have been among the fastest growing provider types participating in Medicare. In 2010, CMS, with assistance from the 2009 Recovery Act, expanded the pilot's initiative to all States to increase awareness of proper infection control practices among ASCs, improve the ability of surveyors to identify problems in infection practices, and ensure corrective action by ASCs to remedy problems and prevent future serious infections. To maintain appropriate oversight and address widespread problems in infection control, CMS also increased the survey frequency for ASCs to every 3 years in 2010, and standardized the average frequency at once every 4 years thereafter. Similarly, access to care is often impaired when survey capacity is impaired, as new providers that seek to participate in Medicare experience long delays to establish their qualifications through an onsite survey.

In recent years, CMS improved standards and survey processes for many types of providers, especially dialysis facilities for end stage renal disease (ESRD), ambulatory surgical centers (ASC), hospices, home health, organ transplant centers, and nursing homes. In FY 2008, CMS began onsite surveys of all organ transplant centers in the U.S., including enforcement of outcome standards if patient deaths or graft failure exceed 150 percent of the risk-adjusted expected number.

Patient survival for all types of organ transplants has improved, with the greatest improvements achieved in programs that entered into a System Improvement Agreement with CMS after being cited by CMS for subpar patient outcomes. Since 2008, dialysis facilities have also been surveyed in accordance with substantially improved ESRD regulations. CMS has increasingly used statistical information to review outcomes as well as focus more attention on facilities whose performance data indicate a higher risk of poor patient outcomes.

Nursing home survey processes have been improved through clarified surveyor guidance (such as guidance on surveying for the use of unnecessary medications), further development and deployment of the Quality Indicator Survey (QIS), and continued focus on the nursing homes judged to have the highest risk of poor quality of care (through the CMS *Special Focus Facility* (*SFF*) initiative).

A 2012 analysis of nursing homes identified for special attention from 2005-2011 through the *SFF* initiative found that such nursing homes came into compliance with CMS requirements 50 percent more quickly compared the comparison of candidate facilities that were not surveyed with the same frequency.

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

Support Contracts and Information Technology

Support Contracts

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

Federally-directed surveys constitute the second largest category of support contracts. These surveys either directly assist States, substitute for State surveys in certain specialized areas (such as organ transplant hospitals or psychiatric hospitals), or assist CMS Regional Offices in conducting comparative surveys designed to check the accuracy and adequacy of surveys done by States. They also augment national capacity to promote emergency preparedness and recovery by providing a mobile cadre of surveyors who can transit to an area of crisis.

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

efforts to ensure national program oversight and consistency.

Support contracts permit CMS to use performance data to direct survey attention to higher risk areas, prepare for surveys, and track provider progress. For example, CMS uses performance information to assure that onsite surveys are conducted – every year – for at least the 10 percent of dialysis facilities that CMS and the States consider to be at highest risk for poor quality of care or safety. Similarly, CMS now makes extensive use of risk-adjusted patient outcome data for organ transplant programs. CMS also applies an algorithm to identify providers with the highest risk of poor care, in nursing homes, organ transplant hospitals, dialysis facilities, and home health agencies. As a consumer service and market-oriented incentive for nursing homes to improve quality, CMS also maintains a *Five Star Quality Rating System*, with results updated monthly on the *Nursing Home Compare* website, one of CMS' most-visited websites. Beginning in 2012 and 2013, support contracts enabled CMS to begin publishing the reports of onsite surveys for nursing homes and for hospital complaint surveys in a searchable database accessible via the internet.

Information Technology

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

CMS is implementing an improved data-driven standard survey system to be used in the certification of nursing homes that participate in the Medicare and Medicaid programs. The QIS was developed in response to concerns identified by CMS, GAO, and OIG regarding the current survey process. The concerns focus on achieving greater consistency in how compliance with Federal requirements is assessed for the 15,800 Medicare and Medicaid nursing homes that must be surveyed each year. The new QIS process uses both off site and on site information to develop computer generated quality of care indicators, comparing delivery of care with national norms. The QIS requires surveyors to use computers on site during the survey as the survey team gathers information, generates quality of care indicators and identifies those areas that are triggered for investigation in the second stage of the survey. Approximately 5,000 State and Federal surveyors will require training on the new survey process. Training is extensive and is conducted with contractor assistance. There are 26 States that are now either in the process of, or have completely transitioned to the QIS. In the meantime, CMS continues to run two survey processes, the traditional survey process and the QIS survey process. CMS is not currently expanding the number of QIS States due to continued budget uncertainties, the added initial cost of implementing QIS in new States, and difficulties in completing nursing home surveys in many QIS States. The QIS surveys have also been found to require more survey time in the newer States compared to the traditional survey. CMS has been implementing adjustments to the QIS survey that promise to address this issue.

Evidence-Based Practices

CMS Survey and Certification functions have increasingly relied on a foundation of evidence-based practice. For example, CMS reports to Congress on the performance of CMS-approved accrediting organizations each year are based on evidence from systematically-collected data from validation surveys (pursuant to new legislation enacted by Congress in 2008). Data gathered from pilot tests of new techniques has led to many improvements survey processes that were later adopted nationwide. Examples include better inspection of infection control practices in ESRD facilities, an entirely new, more efficient and effective ESRD survey process implemented in 2013, the use of checklists (derived from CDC research) and improved survey processes for all ASC facilities that were implemented nationally in 2010. Accumulated evidence of nursing home quality led to creation of the *Five- Star Quality Rating System* that is publicly available on CMS's *Nursing Home Compare* website. Further, the new Quality Indicator Survey for nursing homes employs quality measure data and onsite information to construct computer-generated quality of care indicators that guide the onsite survey process.

In 2011-13 CMS began publishing the results of all nursing home surveys and all CMS hospital complaint surveys, making such information available online in searchable databases for public use. The FY2015 budget request expands the use of evidence-based approaches, particularly through pilot tests of potentially improved survey processes as part of the CMS Survey and Certification Efficiency and Effectiveness Initiative. For example, a targeted survey that focuses on an organ transplant center's quality assessment and performance improvement system may provide an efficient method of gaining insight into the overall center performance and reduce the need for more frequent, full surveys. Similarly, we expect to test methods that may better calibrate the intensity of home health agency surveys with the degree to which evidence suggests the need for surveyor attention.

Funding History

FY 2010	$346,900,000
FY 2011	$361,276,000
FY 2012	$375,203,000
FY 2013	$355,578,000
FY 2014	$375,330,000

Budget Request

CMS' FY 2015 budget request for Medicare Survey and Certification is $424.4 million, a $49.0 million increase over the FY 2014 enacted level. Key cost drivers include the cumulative impact of more providers, the ending of furloughs and salary freezes on the part of States (including in some States, authorizing catch-up pay increases after many years of salary freezes or reductions), improved CMS standards, inflation and new survey processes and responsibilities (such as transplant hospitals, organ procurement organizations, advanced diagnostic imaging, and community mental health center surveys). Implementation of the GAO and OIG recommendations for improvements to oversight and survey processes also contributes to the cost increase. Another factor is continued expansion in the role that survey and certification plays in addressing issues of national importance such as, reducing the use of anti-psychotics and improving dementia care in nursing homes, reducing infections, pressure ulcers and other healthcare-association conditions (HACs) in a multiplicity of provider types, reducing hospital readmissions and coordinating with the Department of Justice (DOJ) and other agencies to address fraud or poor quality of care.

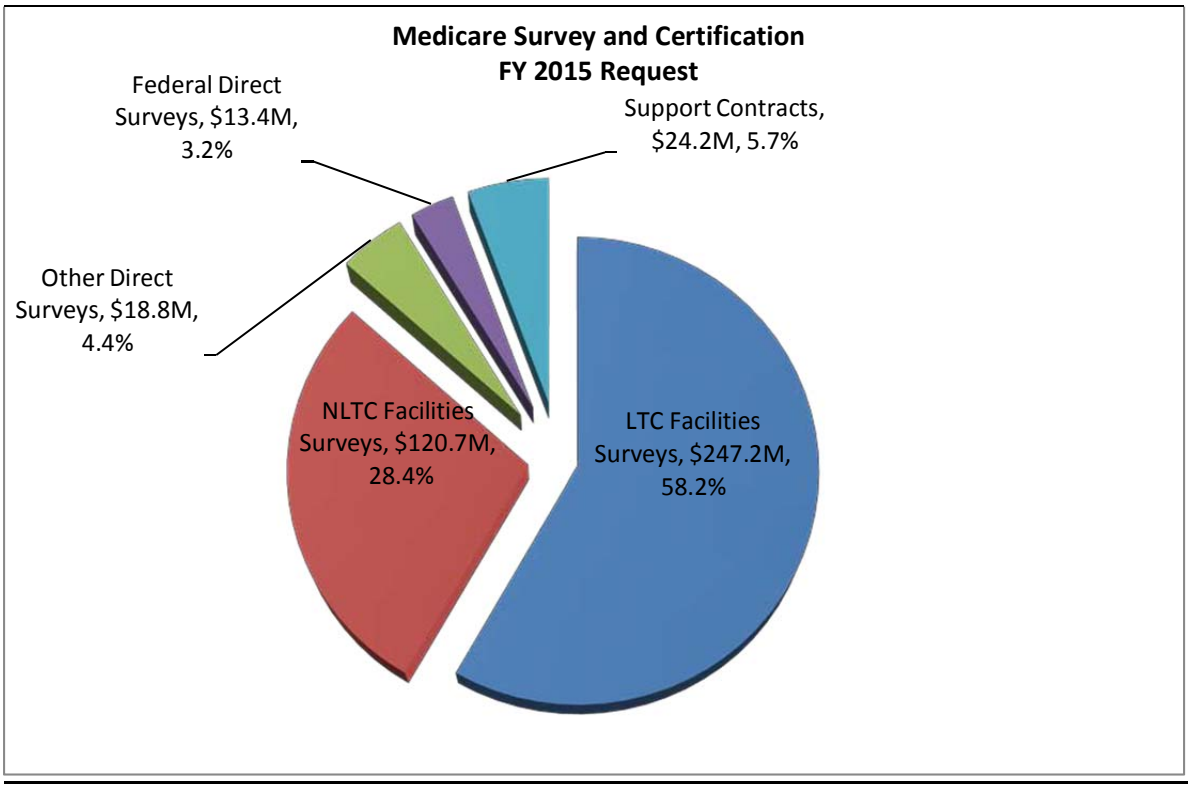
To contain costs in the face of a greater survey workload, CMS' request already assumes administrative efficiencies resulting from the Survey and Certification Efficiency and Effectiveness Initiative finalized in early 2013, with projected savings totaling over $50 million. Efficiency initiatives include redesigning the procedures for ESRD and organ transplant hospital surveys to take a more risk- based approach that can reduce average onsite survey time. Fewer full surveys of accredited hospitals will be conducted following a complaint investigation that finds Condition-level deficiencies, in favor of more focused surveys of particular areas of concern.

Nursing home sprinkler status and compliance history will be weighted more heavily in determining the amount of onsite survey time spent evaluating compliance with the life safety code, so the amount of survey attention can be calibrated more closely to the degree of predicted risk. CMS regulatory changes and increased oversight and coordination of CMS-approved accrediting organizations (AOs) should lead to closer alignment of AO surveys and CMS standards.

As described below in more detail, approximately $367.9 million of this amount will support State direct survey costs, $18.8 million will support additional costs related to State direct surveys, and $37.6 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, ESRD facilities, hospices, and others. Compared with recent FY 2014 survey rates, the request supports more frequent surveys of certain providers or suppliers, including ESRD facilities and ambulatory surgical centers. The request will therefore promote performance that more closely aligns with CMS policy and past practice. It will mitigate the delay experienced by prospective providers that newly seek Medicare participation. 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 GAO and OIG.

In FY 2015, the Administration is again proposing a revisit survey user fee that would gradually phased in over time. The proposal provides CMS with the ability to revisit providers that have been cited for deficiencies and confirm that they have restored their services to substantial compliance with CMS requirements. Thus, the fee would only apply to providers or suppliers that have had serious quality of care or safety deficiencies. The revisit fee would create additional incentive for facilities to correct the problems in a timely and effective manner. To enable providers the opportunity to plan, the revisit user fee would be phased-in over a multi-year period and no significant revenue would be anticipated from the fee until FY 2016. Prior experience with a revisit user fee in FY 2007 demonstrated its feasibility, and the multi-year phase-in approach should make a future fee even more feasible.



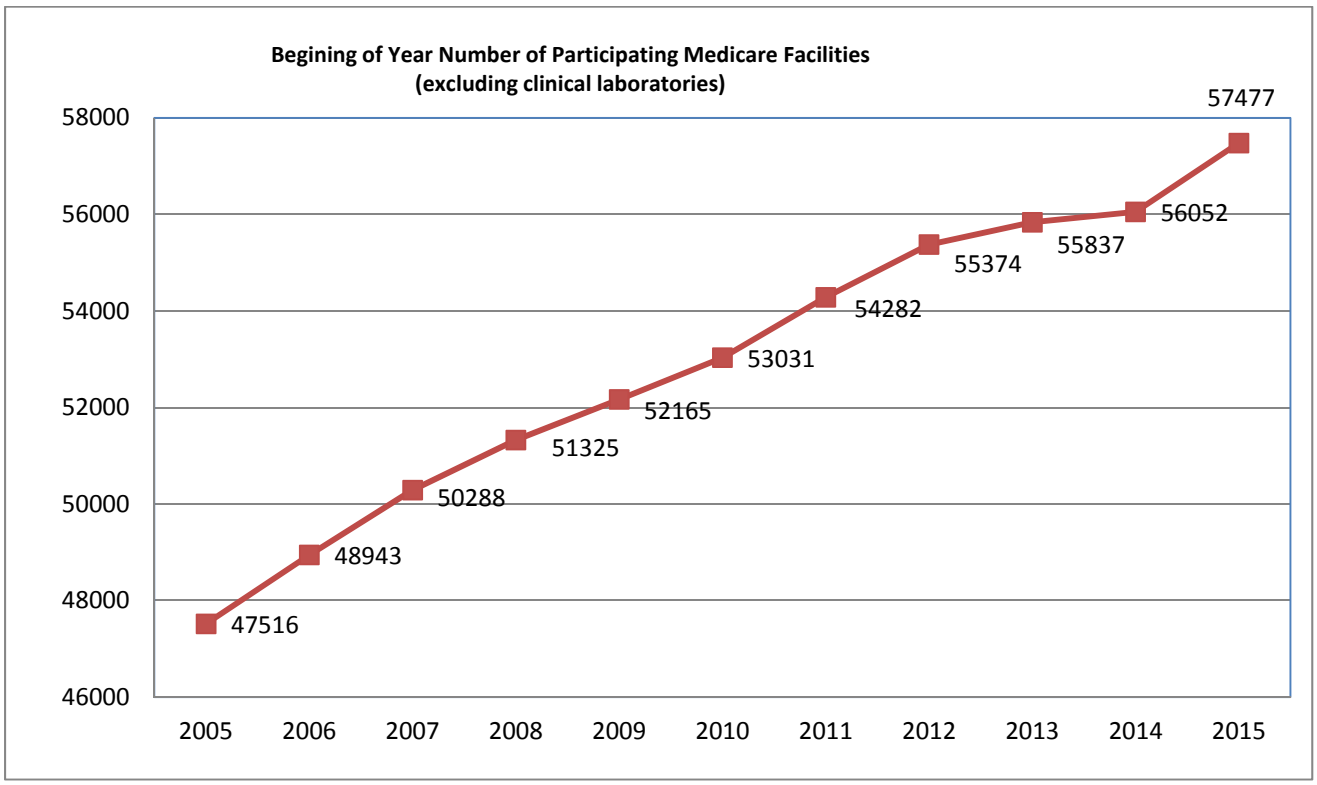
State Direct State Survey Costs - $367.9 million

The FY 2015 request includes $367.9 million for State direct survey costs. This is an increase of $32.4 million over the FY 2014 enacted level. This funding will enable CMS to continue to meet statutory survey frequencies as well as increase the survey frequencies for non- statutory facilities from the FY 2014 levels to CMS policy levels. Among other things, the budget will also improve survey frequency for dialysis facilities, non-accredited hospitals, and ambulatory surgical facilities from once every 5.0, 4.8, and 4.0 years respectively to every 3.0 years, on average, compared to the 2014 Enacted level. The LTC funding levels include funding of $3.8 million in FY 2015 for the *Special Focus Facility* initiative that is required by law to address nursing homes that are persistent poor performers, up slightly from $3.5 million in FY 2014. This budget also mitigates many of the impacts caused by sequestration, such as delays experienced by prospective providers newly seeking Medicare participation; increasing wait times for certification of providers planning to acquire other providers; less timely State revisit surveys that confirm provider compliance and end imposed sanctions such as civil monetary penalties; delayed complaint investigation response; less frequent targeted surveys that address poorly-performing home health agencies. The budget would also continue improvements in transparency and the *Nursing Home Compare* website, and improve oversight of accrediting organizations (AOs) through more effective monitoring and ensuring that all AOs have a reasonable number of validation surveys to assess the adequacy of AO surveys.

Conditions of Participation (COPs) for Community Mental Health Centers (CMHCs) were published in final form in FY 2014. The budget provides funding for State surveys of CMHCs in FY 2015. 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.

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

Between FY 2012 and the end of FY 2015, the number of Medicare-certified facilities to be surveyed is expected to have increased 4.0% percent, from 55,374 to 57,477 facilities in FY 2015, as shown in the following graph, excluding clinical laboratories.



Direct Survey Costs (Dollars in Millions)

Provider Type	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Budget Request
Skilled Nursing Facility (SNF)	$13.6	$14.1	$14.9
SNF/NF (dually-certified)	$211.5	$228.0	$232.2
Home Health Agencies	$24.8	$23.8	$24.3
Non-Accredited Hospitals	$12.6	$14.0	$17.0
Accredited Hospitals	$22.0	$18.8	$33.0
Ambulatory Surgery Centers	$11.0	$9.0	$11.8
ESRD Facilities	$15.6	$17.8	$23.3
Hospices	$6.9	$6.6	$5.4
Outpatient Physical Therapy	$0.9	$1.0	$1.3
Outpatient Rehabilitation	$0.1	$0.2	$0.2
Portable X-Rays	$0.2	$0.2	$0.3
Rural Health Clinics	$1.6	$1.7	$2.4
Transplant Centers	$0.6	$0.3	$0.7
Community Mental Health Centers	$0.0	$0.0	$1.1
Subtotal, Direct Survey Costs	**$321.4**	**$335.5**	**$367.9**
Other Direct Survey Costs	$10.1	$19.6	$18.8
Total, Direct Surveys [1]/	**$331.5**	**$355.1**	**$386.7**

[1] Total may not add due to rounding.

CMS' FY 2015 Budget request provides for inspections of long-term care facilities and home health agencies at the levels required by statute, assuming that increased efficiencies can be implemented. CMS continues to advance efforts to address healthcare associated infections (HAI) across all providers. The request continues the enhanced survey process in ASCs to target infection control deficiencies with an average survey frequency that meets policy level of every 3 - 4 years.

The following chart includes updated frequency rates for FY 2013 through FY 2015.

Type of Facility	FY 2013 Actuals Freg. + (percent/yr)	FY 2014 Enacted Budget	FY 2015 Budget Request
Long-Term Care Facilities	Every Year (100%)	Every Year (100%)	Every Year (100%)
Home Health Agencies	Every 2.4 Years (42.2%)	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Accredited Hospitals	Every 3.8 Years (26.4%)	Every 4.8 Years (20.8%)	Every 3 Years (33.3%)
Accredited Hospitals	2% Year	1.0% Year	2.5% Year
ESRD Facilities	Every 3.4 Years (29.6%)	Every 5 Years (20.0%)	Every 3 Years (33.3%)
Organ Transplant Facilities	Every 3.2 Years (30.1%)	Every 5 Years (20.0%)	Every 5 Years (20%)
Ambulatory Surgical Center	Every 4.1 Years (24.0%)	Every 4 Years (20.0%)	Every 3 Years (33.3%)
Community Mental Health Centers	Not Funded	Not Funded	Every 6 Years (16.7%)
Hospice	Every 6.4 Years (15.7%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
All Other Non-LTC Facilities 1/	Every 5.7 Years (17.6%)	Every 9 Years (11.1%)	Every 6 Years (16.7%)

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

In FY 2015, CMS expects to complete 24,434 initial and recertification inspections, as shown in the Surveys and Complaint Visits table, below. In addition, CMS estimates 51,477 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2015 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of pressure ulcers in nursing homes and to decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication. Additional information about Survey and Certification performance measures is included in the performance section of this chapter.

Survey and Complaint Visit Table

FY 2014 Enacted Budget					
Type of Facility	**Projected # Fac (Start of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	816	816	30	880	1726
SNF/NF (dually-certified)	14295	14445	120	45750	60325
Home Health Agencies	10625	2925	90	1550	4565
Accredited Hospitals	4545	30	0	4515	4545
Transplant Ctrs	264	1*	12*	12*	25*
Non-accredited Hospitals	1712	357	68	1010	1435
Hospices	4620	635	52	615	1302
Outpatient Physical Therapy	2624	292	29	10	331
Outpatient Rehabilitation	415	46	5	4	55
Portable X-Rays	565	63	30	4	97
ESRD Facilities	5685	1137	238	905	2280
Rural Health Clinics	3885	432	215	40	687
Ambulatory Surgery Centers	5470	885	56	120	1061
CMHC	660				
Total	**56,181**	**22,064**	**945**	**55,415**	**78,434**

FY 2015 Budget Request					
Type of Facility	**Projected # Fac (Start of FY)**	**Total Recert. Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	805	805	28	808	1641
SNF/NF (dually-certified)	14330	14460	114	43450	58024
Home Health Agencies	12625	2790	92	1496	4378
Accredited Hospitals	4565	114	0	3685	3799
Transplant Ctrs	245	2*	10*	11*	23*
Non-accredited Hospitals	1660	553	32	470	1055
Hospices	3835	428	45	594	1067
Outpatient Physical Therapy	2385	398	26	8	432
Outpatient Rehabilitation	305	51	5	7	63
Portable X-Rays	585	98	35	5	138
ESRD Facilities	5910	1970	235	782	2987
Rural Health Clinics	4025	671	210	37	918
Ambulatory Surgery Centers	5590	1090	45	117	1252
CMHC	612	0	127	7	134
Total	**57,477**	**23,430**	**1,004**	**51,477**	**75,911**

** To increase efficiency and effectiveness for this specialized survey, almost all recertification surveys of organ transplant centers are now being conducted by a national contractor and not shown in this chart that reflects State survey agency work.*

Other State Direct Survey Costs - $18.8 million

The FY 2015 direct survey cost estimate also includes $18.8 million in other direct survey costs for several continuing activities. This is a decrease of $0.8 million under the FY14 enacted level. Examples of such activities include:

- MDS State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects
- OASIS State program costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support
- Validation surveys that assess the adequacy of surveys conducted by States and CMS-approved accrediting organizations particularly for the non-long-term care accredited facilities such as home health agencies, ASCs, and hospices.
- Manuals, worksheets, and reference tools for surveyors, such as the life safety code.

Federal Direct Surveys and Support Contracts and Information Technology - $37.7 million

Federal Direct Surveys - $13.4 million

CMS will be engaged with a small number of national contractors (in lieu of or with States) to conduct certain surveys on behalf of CMS in areas that are highly specialized or so small in number that States have difficulty maintaining infrequently-used expertise. For example, almost all organ transplant hospitals are surveyed by a national contractor, as are the psychiatric hospital special conditions. CMS contractors also assist States or federal surveyors in emergencies, addressing State performance lapses, or in responding to special challenges. Contractors are used to provide special support to States for ESRD facility nursing home surveys. Federal direct surveys have been seriously affected by sequestration, as CMS reduced these contracts in order to protect States from the full impact of sequestration. This has reduced CMS ability to address crises, mitigate performance problems experienced by States and oversee quality. In addition, prospective improvements in survey processes are often pre-tested with national contractors before enlisting State volunteers for pilot-testing, so the reduction in national contractors has impacted the survey efficiency and improvement efforts. The FY2015 budget would aid in restoration of the federal direct survey capability.

Support Contracts and Information Technology - $24.3 million

Support contracts and information technology, managed by CMS, constitute $24.3 million of the FY 2015 request.

Support Contracts

The FY 2015 request for support contracts totals $22.3 million. This is an increase of $3.9 million over the FY 2014 enacted level. One of the largest categories in support contracts continues to be surveyor training and fulfilling the statutorily-required training mandates of sections 1819, 1919, and 1891 of the Social Security Act. Implementing more efficient and effective training of surveyors is an area that has a high return on investment.

Through web-based and case-study training, surveyors can gain the skills necessary to perform proficiently, while providing quality care for beneficiaries. CMS is developing an increasing array of web-based trainings in order to reduce State travel expenses and gain efficiencies. Although CMS efforts to develop more online or web-based trainings results in greater CMS support contract costs, there is a net benefit as the reduction in State travel costs and travel time exceeds the increase in CMS expenses.

The FY 2015 request will also continue to provide funds for maintenance and continued improvement of the CMS *Nursing Home Compare* website and *Five Star Quality Rating System* for nursing homes, and continued publication of full survey reports in a searchable database on the web for all nursing home surveys and for hospital complaint investigations.

Information Technology

The IT funding request for FY 2015 is $2.0 million, which is consistent with the FY14 enacted level. This request includes $80,000 million for an IT training system and $0.3 million for the continued implementation of the IT portion of the QIS. These funds support the ongoing system support and maintenance for current and future states implementation to the QIS process. IT expenses are incurred for systems work, regardless of the number of States.

Performance Measurement

CMS uses performance measures to support our mission and to inform the decision-making process. For example, in FY 2015 we are introducing a new measure derived from the CMS began nationwide, the *Partnership to Improve Dementia Care in Nursing Homes*, to improve dementia care and reduce the use of antipsychotic medications. CMS also evaluates the performance of State survey agencies and ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements via Federal Validation Surveys. CMS' *State Performance Standards System* tracks measures such as survey frequency, timeliness, complaint investigations, and quality of surveys.

MSC1 Decrease the Prevalence of Pressure Ulcers in Nursing Homes: CMS measures quality of care and other survey and certification activities in nursing homes to assess the effectiveness of State surveys. Measure MSC1 is clinically significant and is closely tied to the care given to beneficiaries. The CMS Regional Offices 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. A decrease in the prevalence of pressure ulcers of even 0.1 percentage points represents more than 1,000 fewer nursing home residents with a pressure ulcer. The success of the efforts can be attributed to greater collaboration between State survey agencies and Quality Improvement Organizations and the national *Advancing Excellence in America's Nursing Homes* campaign.

In October 2010, all nursing homes began submitting nursing home clinical assessment data using the Minimum Data Set (MDS), Version 3.0; therefore, CMS rescaled and rebased the measure. Beginning with the FY 2012 reporting period, we are reporting the prevalence of pressure ulcers, Stage 2 and greater, in high-risk, long-stay residents. In FY 2012, the actual reported prevalence of Stage 2 and greater pressure ulcers among high risk residents was 6.5 percent, exceeding our target of 6.9 percent. Our FY 2015 target is 6.6 percent.

MSC2 Percentage of States that Survey Nursing Homes at Least Every 15 Months and MSC3 Percentage of States that Survey Home Health Agencies at Least Every 36 Months: CMS has performance measures to assess whether CMS and our survey partners are meeting the core statutory obligations for carrying out surveys with routine frequency. Although 99.2 percent of all nursing homes were surveyed within the statutory 15-month timeframe CMS did not meet its FY 2012 target of 97 percent of States completing all surveys, as only 83 percent of States achieved 100 percent. In addition, only 83 percent of States surveyed all home health agencies at least every 36 months, missing the FY 2012 target of 96 percent. The primary factor affecting the ability to meet the FY 2012 targets was State employee furloughs and hiring freezes, which prevented surveyors from completing their required surveys. The FY 2015 targets are for 97 percent of States to survey nursing homes at least every 15 months and for States to survey at least 96 percent of home health agencies at least every 36 months. This methodology requires a State to comply with 100 percent of its surveys, and the metric is, therefore, sensitive to States achieving this absolute bar. In order to assist States, CMS must ensure that proper operational controls, such as training and regulations, are in place. CMS also issues annual instructions to States, which update the agency's policies, priorities, and the statutory survey frequency requirements to meet these targets.

MSC5 Improve Dementia Care in Nursing Homes by Decreasing the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication: Antipsychotic medications have common and dangerous side effects including the risk of death, when used to treat the behavioral and psychological symptoms of dementia. A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the partnership and have been incorporated into clinical practice guidelines and various tools and resources. Our FY 2011 baseline is 23.87 percent. In the three years immediately prior to CMS intervention in CY 2012, the prevalence rates had consistently risen each quarter. CMS' FY 2014 target is 20.3 percent (a 15 percent reduction from the 2011 baseline) and the FY2015 target is 19.0 percent (a 20 percent reduction). While it is unlikely that zero percent will ever be an achievable target, it is clear that the eventual target will be prevalence much lower than 19.0 percent.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
MSC1: Decrease the prevalence of pressure ulcers in nursing homes	FY 2012: 6.5% Target: 6.9% (Target Exceeded)	6.7%	6.6%	-.1 pp
MSC2: Percentage of States that survey 100% of nursing homes at least every 15 months	FY 2012: 83% Target: 97% (Target Not Met)	97%	97%	Maintain
MSC3: Percentage of States that survey 100% of Home Health Agencies at least every 36 months	FY 2012: 83% Target: 96% (Target Not Met)	96%	96%	Maintain
MSC5: Improve Dementia Care in Nursing Homes by Decreasing the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication	New for FY 2015 FY 2011: Baseline 23.87%	20.3%	19%	-1.3 pp

State High-Risk Health Insurance Pool Program

(Dollars in Thousands)

Program	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
State High-Risk Health Insurance Pool Program 1/	$41,756	$20,420	$0	-$20,420

1/ The State High-Risk Pool line is considered a change in mandatory program (CHIMP) and includes a 7.2 percent (-$1.6 million) mandatory sequester reduction in FY 2014.

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

Allocation Method - Grants

Program Description and Accomplishments

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

In FY 2006, section 6202 of the Deficit Reduction Act (P.L.109-171) and State High-Risk Pool Funding Extension Act of 2006 (P.L. 109-172) extended the funding of grants under section 2745 of the Public Health Service Act by authorizing and appropriating: 1) $15 million for seed grants to assist States to create and initially fund qualified high-risk pools; and 2) $75 million for grants to help fund prior year operational losses and current year bonus grants for supplemental consumer benefits to the existing qualified high-risk pools. CMS awarded grants to 36 States in FY 2006 and 5 States in FY 2007. These funds were included in the CMS mandatory State Grants and Demonstrations account. The Consolidated Appropriations Act of 2008 (P.L. 110-161) appropriated $49.1 million for high-risk pools for FY 2008 in the CMS discretionary Program Management account. In FY 2009, $75 million was appropriated for the high-risk pools grant program through the Omnibus Appropriation Act, 2009 (P.L. 111-8). On December 16, 2009, the Consolidated Appropriations Act, 2010 (P.L. 111-117) appropriated $55 million for FY 2010.

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

Appropriations Act, 2012 (P. L. 112-74) which provided $44.0 million for the grant program in FY 2012. On March 26, 2013, President Obama signed into law the Consolidated and Further Continuing Appropriations Act, 2013 (P.L.113-6) which provided $41,756,000 for the State High-Risk Health Insurance Pool Program. On January 17, 2014, President Obama signed into law the Consolidated Appropriations Act, 2014 (P.L.113-76) which provided $20,400,000 in FY 2014. The FY 2014 appropriations will continue to fund operational losses and bonus grants to States that met the eligibility criteria established by section 2745 of the Public Health Service Act for the fiscal year ending September 30, 2014.

With enrollment in excess of 180,000[1] enrollees as of December 31, 2013, high-risk pools have provided a mechanism for high-risk individuals to maintain continuous coverage prior to January 1, 2014 when the Affordable Care Act's insurance market reforms take full effect.

The table on the following two pages displays the FY 2013 grant appropriations awarded by State.

FY 2013 Operational and Bonus Grants by State

State	Operation Losses	Bonus Grant	Total Award	Bonus Grant Category
Alabama Health Insurance Plan	$691,677	$0	$691,677	N/A
Alaska Comprehensive Health Insurance Association	$425,977	$242,331	$668,308	Premium Holiday
Arkansas Comprehensive Health Insurance Plan	$645,978	$362,376	$1,008,354	Disease Management & Low-Income Premium Subsidy
CoverColorado	$1,164,565	$0	$1,164,565	N/A
Connecticut Health Reinsurance Association	$578,791	$325,852	$904,643	Premium Holiday
Idaho Individual High Risk Reinsurance Pool	$528,434	$298,393	$826,827	Supplemental Consumer Benefits
Illinois Comprehensive Health Insurance Plan	$1,674,159	$925,282	$2,599,441	Premium Relief
Indiana Comprehensive Health Insurance Association	$948,859	$528,489	$1,477,348	Disease Management & Low-Income Premium Subsidy
Iowa Comprehensive Health Association	$605,021	$0	$605,021	N/A
Kansas Health Insurance Association	$543,743	$306,523	$850,266	Disease Management
Kentucky Access	$754,882	$422,087	$1,176,969	Disease Management
Louisiana Health Plan	$730,380	$407,972	$1,138,352	Disease Management & Expanded Consumer Benefits

[1] The twenty-seventh edition, 2013/2014 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. This is based on the total population of all 35 State High-Risk Pool Programs.

State	Operation Losses	Bonus Grant	Total Award Amount	Bonus Grant Category
Maryland Health Insurance Plan	$1,439,378	$799,371	$2,238,749	Low-Income Premium Subsidy
Minnesota Comprehensive Health Association	$1,587,692	$882,192	$2,469,884	Low-Income Premium Subsidy
Mississippi Comprehensive Health Insurance Risk Pool Association	$674,865	$378,317	$1,053,182	Disease Management & Expanded Consumer Benefits
Missouri Health Insurance Pool	$837,652	$467,040	$1,304,692	Low-income Premium Subsidy
Montana Comprehensive Health Association	$529,069	$299,068	$828,137	Premium Subsidy & Disease Management
Nebraska Comprehensive Health Insurance Pool	$570,254	$321,616	$891,870	Premium Reduction
New Hampshire Health Plan	$522,891	$295,756	$818,647	Low-Income Premium Subsidy
New Mexico Medical Insurance Pool	$853,936	$477,489	$1,331,425	Low-Income Premium Subsidy
North Carolina Health Insurance Risk Pool	$1,389,539	$769,022	$2,158,561	Low-Income Premium Subsidy
Comprehensive Health Association of North Dakota	$443,206	$252,011	$695,217	Premium Reduction
Oklahoma Health Insurance High Risk Pool	$696,488	$389,853	$1,086,341	Premium Reduction
Oregon Medical Insurance Pool	$1,005,989	$560,778	$1,566,767	Expanded Consumer Benefits - Medication
South Carolina Health Insurance Pool	$731,043	$408,204	$1,139,247	Premium Reduction
South Dakota Risk Pool	$421,225	$239,772	$660,997	Extended Customer Benefits - to help offset the out-of-pocket medical expenses
Texas Health Insurance Risk Pool	$3,510,091	$1,923,811	$5,433,902	Premium Reduction
Utah Comprehensive Health Insurance Pool	$632,109	$355,175	$987,284	Premium Reduction
Washington State Health Insurance Pool	$835,225	$465,490	$1,300,715	Premium Reduction

State	Operation Losses	Bonus Grant	Total Award Amount	Bonus Grant Category
Wisconsin Health Insurance Risk-Sharing Plan	$1,440,015	$800,478	$2,240,493	Disease Management & Low-Income Premium Subsidy
Wyoming Health Insurance Pool	$438,121	$0	$438,121	N/A
Totals	**$27,851,252**	**$13,904,748**	**$41,756,000**	

Funding History

FY 2011	**$54,890,000**
FY 2012	**$44,000,000**
FY 2013	**$41,756,000**
FY 2014	**$20,420,000**

Budget Request

CMS is not requesting funding for the State High-Risk Health Insurance Pool Program in FY 2015 or in future years. Beginning on January 1, 2014, health insurance plans cannot refuse to cover a person or charge them more because they have a pre-existing condition. Current enrollees in the high risk pools now have access to new coverage options in the Health Insurance Marketplaces, which opened on October 1, 2013. A State High-Risk Pool may continue operating in future years at the State's own discretion.

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

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Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$177,872,985,000] *$234,608,916,000* to remain available until expended.

For making, after May 31, [2014] *2015*, 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 [2014] *2015* 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 [2015] *2016*, [$103,472,323,000] *$113,272,140,000* to remain available until expended.

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

Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $234,608,916,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the authorized advance appropriation of $103.5 billion for the first quarter of FY 2015. 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, 2015, payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2015 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 2015 to meet unanticipated costs including budget authority to the Vaccines for Children program for payments on behalf of States.

Medicaid

Language Analysis

Language Provision	Explanation
For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2016, $113,272,140,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of FY 2016 to ensure continuity of funding for the Medicaid program including the Vaccines for Children program in the event a regular appropriation for FY 2016 is not enacted by October 1, 2015
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Medicaid Program
Appropriation
Amounts Available for Obligation
(Dollars in Thousands)

	2013 Final	2014 Enacted	2015 President's Budget
Appropriation Annual	$90,614,082	$284,208,616	$338,081,239
Appropriation Indefinite	$158,826,786	$26,159,949	$0
Unobligated balance, start of year	$21,091,365	$2,282,850	$0
Unobligated balance, end of year	-$2,282,850	$0	$0
Recoveries of Prior Year Obligations	$18,143,492	$0	$0
Collections/Refunds	$527,621	$390,000	$6,400
Total Gross Obligations	$286,920,496	$313,041,415	$338,087,639
Offsetting Collections Medicare Part B QI Program	-$477,445	-$390,000	$0
Offsetting Collections (Other)	-$50,176	$0	-$6,400
Obligations Incurred but not Reported	$0	-$4,211,000	-$6,641,000
Total Net Obligations	$286,392,875	$308,440,415	$331,440,239

Medicaid Program
Summary of Changes
(Dollars in Thousands)

2015 Estimated Budget Authority		$338,081,239
2014 Budget Authority Request from PB 2014		$284,208,616
Net Change		$53,872,623
Explanation of Changes	FY 2014 PB Budget Authority	FY 2015 Change From Base Budget Authority
Program Increases		
Medical Assistance Payments	$251,900,000	$14,900,000
Legislation and Administrative Actions	$31,627,000	$10,255,600
Obligations Incurred But Not Reported	$2,369,000	$4,272,000
State and Local Administration	$12,880,631	$589,418
State and Local Administration Financial Adj.	$3,105,817	$1,713,779
Financial Management Reviews	-$182,000	$97,000
State Certification	$240,600	$1,800
Unobligated Balance Carry Forward	-$21,951,882	$21,951,882
Offsetting Collections from Medicare Part B premiums	-$300,000	$300,000
Fraud Control Units	$226,067	$7,910
Total Program Increases	$279,915,233	$54,089,389
Program Decreases		
Vaccines for Children Program	$4,293,383	-$216,766
Total Program Decreases	$4,293,383	-$216,766
TOTAL	$284,208,616	$53,872,623

Medicaid Program
Authorizing Legislation

	FY 2014 Amount Authorized	FY 2014 Current Law	FY 2015 Amount Authorized	FY 2015 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$306,806,095,000	Indefinite	$334,004,622,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,562,470,000		$4,076,617,000
Total Appropriations		$310,368,565,000		$338,081,239,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2005	$177,540,763,000	$177,540,763,000	$177,540,763,000	$177,540,763,000	
2006	$215,471,709,000	$215,471,709,000	$215,471,709,000	$215,471,709,000	
2007	$200,856,073,000	------	------	$168,254,782,000	1/
2008	$206,885,673,000	$206,887,673,000	$206,885,673,000	$206,885,673,000	
2009	$216,627,700,000	------	------	$254,890,065,000	2/
2010	$292,662,503,000	$292,662,511,000	$292,662,511,000	$292,662,511,000	
2011	$259,933,181,000	------	------	$258,365,747,000	3/
2012	$270,724,399,000	------	------	$270,724,399,000	
2013	$269,405,279,000	------	------	$269,405,279,000	4/
2014	$284,208,616,000	------	------	$284,208,616,000	5/
2015	$338,081,239,000				

1/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
2/ Includes $38,262.4 million under indefinite authority.
3/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
4/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
5/ Based on updated estimates, CMS also anticipates using $26.2 billion in indefinite funding authority during FY 2014.

Medicaid
(Dollars in Thousands)

	FY 2013 Actual	FY 2014 Current Law	FY 2015 Estimate	FY 2015 +/- FY 2014
Medical Assistance Payments (MAP)	$265,546,292	$286,712,200	$308,597,600	$21,885,400
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$0	$4,211,000	$6,641,000	$2,430,000
Vaccines for Children	$3,607,016	$3,562,470	$4,076,617	$514,147
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$17,767,188	$18,555,745	$18,772,422	$216,677
Obligations (gross)	$286,920,496	$313,041,415	$338,087,639	$25,046,224
Unobligated Balance, Start of Year	-$21,091,365	-$2,282,850	$0	$2,282,850
Unobligated Balance, End of Year	$2,282,850	$0	$0	$0
Recoveries of Prior Year Obligations	-$18,143,492	$0	$0	$0
Appropriation Budget Authority (gross)	$249,968,489	$310,758,565	$338,087,639	$27,329,074
Collections	-$527,621	-$390,000	-$6,400	$383,600
Total Budget Authority (net)	$249,440,868	$310,368,565	$338,081,239	$27,712,674
Indefinite Authority	$158,826,786	$26,159,949	$0	$26,159,949
Advanced Appropriation	-$90,614,082	-$106,335,631	-$103,472,323	$2,863,308
Annual Appropriation	$0	$177,872,985	$234,608,916	$56,735,931

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

FY 2014 Authorization - Public Law 111-148, Public Law 111-152, Public Law 113-46, Public Law 113-67, Public Law 113-73, Public Law 113-76

Allocation Method - Formula Grants

Program Description and Accomplishments

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

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

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

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

The Affordable Care Act ushered in major improvements in health care coverage, cost and quality for all Americans. Under the law, Medicaid is the mechanism by which affordable coverage is provided to the lowest income Americans. To accomplish this, Medicaid eligibility is expanded and simplified, with the Federal government paying most of the new coverage costs. Beyond these eligibility and financing changes, the new law improves access to home and community-based services, enhances the Federal commitment to assuring program integrity, and makes other program improvements.

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

Medicaid Integrity Program

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

Vaccines for Children Program

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

Medicaid Survey and Certification

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

Medicaid Fraud Control Units (MFCUs)

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

Managed Care

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

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

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

As Medicaid managed care programs continue to grow, CMS remains committed to ensuring that high-quality, cost-effective health care is provided to Medicaid beneficiaries. CMS’ efforts include evaluating and monitoring demonstration and waiver programs, enhancing information systems, and providing expedited review of State proposals. CMS has begun implementing a strategic plan to significantly expand its oversight and monitoring activities of Medicaid managed care programs. Key elements include expanded technical assistance to States, more extensive and routine program reviews, identification and remediation of managed care payment anomalies, and formalizing managed care policy.

Section 1115 Demonstrations

Under section 1115 authority, many States have significantly restructured their Medicaid and/or CHIP programs in the areas of eligibility, benefits, service delivery systems, and financing with the goal of expanding health insurance coverage to lower income, vulnerable populations. Most demonstrations are statewide and include the majority of the Medicaid population in the state.

Since the enactment of the Affordable Care Act, an increasing number of States have used 1115 demonstrations to promote healthcare transformation in alignment with the law. Several

states have recently used this authority to implement alternatives to Medicaid expansion, such as incentive-based reform programs or premium assistance to wrap-around qualified health plans offered in the individual market. To better monitor the program transformations that are being operationalized through these Medicaid demonstrations, CMS is implementing a strategy to build infrastructure for monitoring and evaluating state performance. The improved infrastructure will provide CMS with robust data to assess best practices for program design and administration. The most current fiscal data available indicates the Federal share of obligations for 1115 demonstrations in FY 2013 was $53.2 billion:

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

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

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

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 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	FY 2015 +/- FY 2014
Aged	5.2	5.4	5.5	0.2
Disabled	9.7	9.8	9.8	0.0
Adults	14.8	19.2	24.0	4.8
Children	28.3	29.5	30.8	1.3
Territories	1.0	1.0	1.0	0
Total/1	59.1	64.9	71.2	6.3

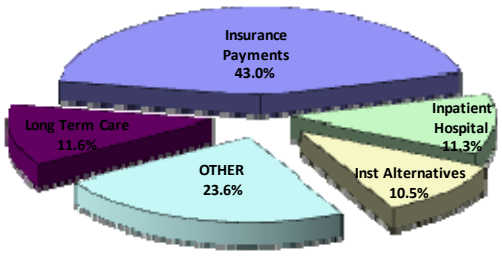
1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2015, 71.2 million of the projected 325.7 million in the total U.S. population will be enrolled in Medicaid for the equivalent of a full year during FY 2015. In FY 2015, Medicaid will provide coverage to more than one out of every five children in the nation.

CMS projects that in FY 2015, non-disabled children and adults under age 65 will represent 78 percent of the Medicaid population (compared to 74 percent in FY2012), but account for approximately 42 percent of the Medicaid benefit outlays, excluding Disproportionate Share Hospital (DSH) payments and Medicaid beneficiaries in the Territories. In contrast, older individuals and individuals with disabilities are estimated to make up about 21 percent of the Medicaid population, yet account for approximately 58 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services

As displayed in the table on the following page, the State estimates for medical assistance payments increased from $289.6 billion for FY 2014 to $305.9 billion for FY 2015.



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 $131.6 billion in funding for FY 2015 representing 43 percent of the State-submitted benefit estimates for FY 2015. The second largest FY 2015 Medicaid category of service is institutional long-term care services. It is composed of nursing facilities and intermediate care facilities for individuals with intellectual disabilities. The States have submitted FY 2015 estimates totaling $35.5 billion or almost 12 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2015 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($34.5 billion or 11 percent), followed by institutional alternative services such as home health, personal care, and other home and community-based services ($32.0 billion or 10 percent). Together these four benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for 76 percent of the State-estimated cost of the Medicaid program for FY 2015.

Estimated Benefit Service Growth, FY 2014 to FY 2015
November 2013 State-Submitted Estimates and Actuarial Adjustments
(Dollars in Thousands)

Major Service Category	Est. FY 2014	Est. FY 2015	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)	$113,080,599	$131,645,188	$18,564,589	16.4%	113.8%
Institutional Alternatives (fee-for-service (FFS) personal care, home health, and home and community-based care)	$31,244,002	$32,005,087	$761,085	2.4%	4.7%
Other (Targeted case management, hospice, all other services, and collections)	$27,286,949	$25,543,914	-$1,743,035	-6.4%	-10.7%
Long-Term Care (FFS nursing facilities, intermediate care facilities for the mentally retarded)	$36,470,365	$35,505,073	-$965,292	-2.6%	-5.9%
Outpatient Hospital	$9,436,262	$9,142,223	-$294,039	-3.1%	-1.8%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$4,857,359	$4,893,536	$36,177	0.7%	0.2%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$33,386,302	$34,532,156	$1,145,854	3.4%	7.0%
Physician/Practitioner/Dental	$15,079,832	$14,944,343	-$135,489	-0.9%	-0.8%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$8,992,042	$9,104,860	$112,818	1.3%	0.7%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$9,765,553	$8,602,594	-$1,162,959	-11.9%	-7.1%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$289,599,265	$305,918,974	$16,319,709	5.6%	100.0%

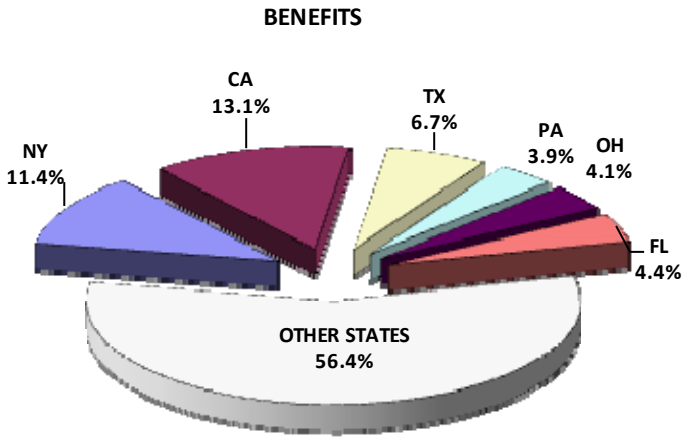
Note: This table reflects current law estimates.

Distribution of Medicaid Monies

The total FY 2015 State-submitted estimates for Medicaid are $319.4 billion, composed of $305.9 billion for Medicaid medical assistance payments and $13.5 billion for State and local administration.

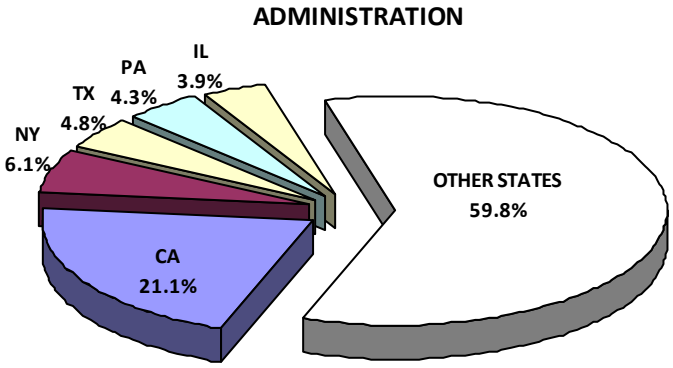
Distribution of Benefit Monies

As displayed, California, New York, Texas, Florida, Ohio and Pennsylvania account for $133.2 billion, or over 43 percent, of the State-submitted estimates for benefits for FY 2015. Ten States represent over 55 percent of these estimates.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2015 State and local administration represents about 4.2 percent of the total State-submitted estimates for Medicaid costs for FY 2015. As displayed, California, New York, Texas, Pennsylvania, and Illinois account for $5.4 billion or more than 40 percent of the FY 2015 estimates for State and local administration. Ten States represent over 56 percent of these estimates.



Funding History (Appropriation)

FY 2010	$292,662,511,000
FY 2011	$259,933,181,000 [1/]
FY 2012	$270,724,399,000
FY 2013	$269,405,279,000
FY 2014	$284,208,616,000 [2/]

[1/] Full year continuing resolution appropriation provided indefinite funding authority.
[2/] Based on updated estimates, CMS also anticipates using $26.2 billion in indefinite authority during FY 2014.

Budget Request

CMS estimates its FY 2015 appropriation request for Grants to States for Medicaid is $338.1 billion, an increase of $27.7 billion relative to the FY 2014 level of $310.4 billion. This appropriation is composed of $103.5 billion in authorized advance appropriation for FY 2015 and a remaining appropriation of $234.6 billion for FY 2015.

Resources will fund $338.1 billion in anticipated FY 2015 Medicaid gross obligations. These obligations are composed of:

- $308.6 billion in Medicaid medical assistance benefits;
- $6.6 billion for benefit obligations incurred but not yet reported;
- $18.8 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $4.1 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

This submission is based on projections from State-submitted estimates and the CMS' Office of the Actuary (OACT) using Medicaid expenditure data as recent as the first quarter of FY 2014. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2015 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $331.4 billion in FY 2015. This represents an increase of 7.5 percent relative to the estimated net outlay level of $308.4 billion for FY 2014. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 9.7 percent during this time period.

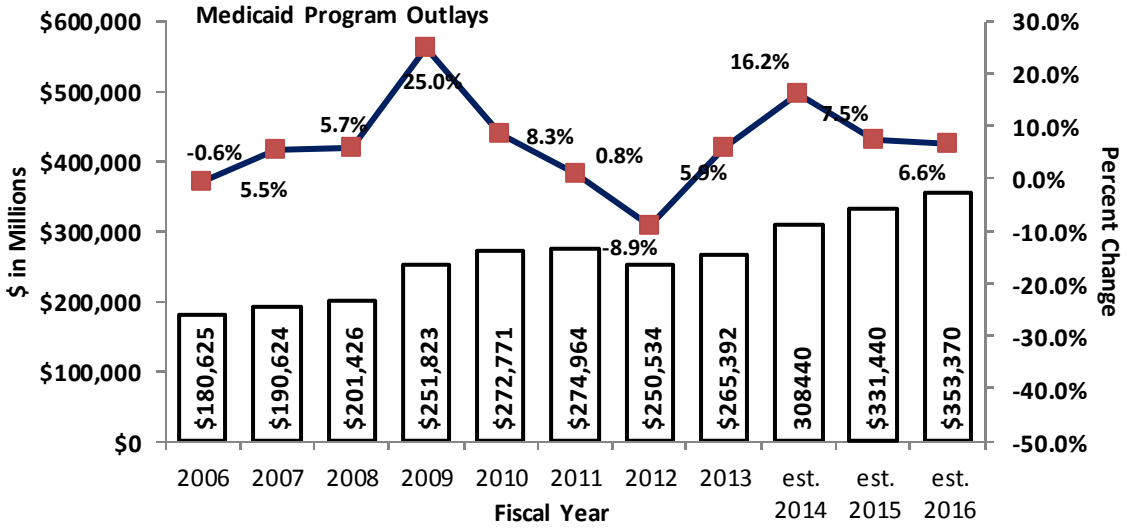
Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2013 State estimates. These adjustments reflect actuarial estimates, legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2013 State estimates for MAP in FY 2015 are the first State-submitted estimates for FY 2015. Typically, State estimation error is most likely to occur early in the budget cycle because States are most focused on their current year budget and have not yet focused on their projections for the Federal budget year.

OACT developed the MAP estimate for FY 2015. Using the last three quarters of FY 2013 State-reported expenditures as a base, expenditures for FY 2014 and FY 2015 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by the OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the November 2013 State-submitted estimates.



Factors Impacting Medicaid Expenditure Growth

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 increase in the unemployment rate, driven by the recession.

Federal Medicaid spending grew much faster than total Medicaid spending in FY 2009 due to the substantially higher Federal match rate provided in ARRA. The match rate increase and continued faster enrollment growth led to relatively strong growth in Federal Medicaid spending in FY 2010, although this rate grew only slightly faster than total Medicaid spending. After the first quarter of FY 2011, the ARRA temporary increases in the Federal match rates were phased down to lower levels in the second and third quarters, leading to slower growth in Federal Medicaid spending for FY 2011 and a decline in Federal spending for FY 2012. In addition, enrollment has slowed as the economy has expanded and employment levels have increased.

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

In 2014 and 2015, CMS will continue to work with States to implement provisions of the Affordable Care Act which simplify Medicaid eligibility. For example, section 1413 directed the Secretary to establish a streamlined eligibility and enrollment system for individuals to apply for and be enrolled in an insurance affordability program including Medicaid, CHIP and Basic Health Program (if applicable), as well as, enrollment in a qualified health plan. Section 2201 establishes simplified and coordinated Medicaid and CHIP eligibility and enrollment processes, under which States will use modified adjusted gross income (MAGI) based standards to determine eligibility for most populations. State Medicaid and CHIP agencies have made significant changes to their eligibility verification procedures to align with these provisions.

CMS has already provided a series of training opportunities (such as webinars and teleconferences) to State Medicaid and CHIP agencies on implementing new business practices, data systems and staff training on the Affordable Care Act eligibility changes. We also developed and distributed model on-line and paper applications for states.

CMS is taking the following actions as part of our ongoing effort to promote and facilitate the expansion of Medicaid and CHIP:

- Continue guidance and technical assistance to states to develop paper and online applications that are consistent with statutory and regulatory requirements, and to implement the Medicaid and CHIP eligibility simplifications.

- Provide technical assistance to states in coordinating eligibility determinations for Medicaid/CHIP with eligibility for premium tax credits and cost sharing reductions available through the Health Insurance Marketplace.

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

- Develop and disseminate informational bulletin, model forms and training materials to assist states in redetermination of Medicaid/CHIP eligibility consistent with new regulations.

- Provide training and technical assistance (including state-specific calls, webinars, written guidance, tools, etc.) to facilitate states' implementation of hospital presumptive eligibility.

Please refer to the Program Management chapter for more information.

<u>Adjustments to the Actuarial Estimates for Medical Assistance Payments for Recent Legislation</u>
(Estimated FY 2015 costs are $221 million)

Pathways for SGR Reform Act of 2013
(P.L. 113-67)

- Extension of the Qualified Individual (QI) Program

  The Qualified Individual (QI) program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. In addition, QI beneficiaries are deemed eligible for the Medicare

Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. This provision extended the QI program from January 1, 2014 through March 31, 2014.

- Extension of Transitional Medical Assistance (TMA)

  TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This provision extended the TMA program from January 1, 2014 through March 31, 2014.

- Delay of Rebasing of Reductions to Medicaid Disproportionate Share Hospital Allotments (DSH)
  This law repealed the Medicaid DSH reductions scheduled for FY 2014 and delayed the DSH reductions scheduled for FY 2015 until FY 2016. It also made technical adjustments to the calculation of future Medicaid DSH allotments.

- Strengthening Medicaid Third Party Liability

  Section 202 of this law affirms Medicaid's position as the payer of last resort for medical treatment by strengthening third-party liability to improve states' and providers' abilities to receive payments for beneficiary services, as appropriate.

Iraqi Special Immigrant Visa Extension
(P.L. 113-42)

- The law extended the period during which certain Iraqis may be granted special immigrant status.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2015 savings are $85 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $85 million in FY 2015. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure State compliance with Federal regulations governing Medicaid and State financing. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific high-risk areas, and other ongoing oversight and enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2015 estimate of $6.6 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2014 to September 30, 2015. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the

States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Vaccines for Children (VFC) Program

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

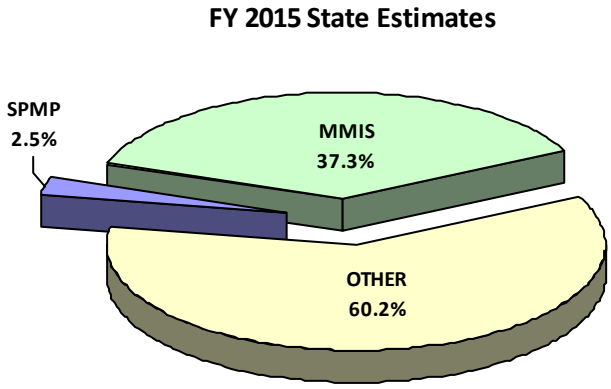
The current FY 2015 estimate for the VFC program is $4.1 billion, which is $514.1 million above the FY 2014 estimate. This estimate includes vaccine-purchase contract costs and related costs, such as costs of vaccine ordering and distribution on behalf of States. The net increase includes an increase for vaccine purchase and a decrease for vaccine management business improvement plan contractual support. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget is used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of States; immunization grantee vaccine management activities, quality assurance and quality improvement site visits to VFC enrolled providers, immunization coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2015, based on recent actual data and the November 2013 State estimates, CMS estimated the Federal share of State and local administration costs to be $18.8 billion. This estimate is composed of $18.3 billion for Medicaid State and local administration and $.5 billion in additional funds for Medicaid State survey and certification and State Medicaid fraud control units.

State and Local Administration

In November 2013 the States estimated the Federal share of State and local administration outlays to be $13.5 billion for FY 2015. State and Local Administration monies provide funding for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing



activities; skilled professional medical personnel (SPMP); salaries, fringe benefits, training; and other State and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

CMS adjusted the FY 2015 State-submitted estimates of $13.5 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when States submitted estimates. In addition, the State estimates were adjusted to reflect improvements to Medicaid eligibility determination systems and the enrollment activities and administrative costs associated with implementing the ACA. These estimates were also adjusted to reflect the estimated costs of providing incentives to eligible providers and hospitals for the adoption and meaningful use of electronic health records (EHR), described further below. After these adjustments, the FY 2015 estimate for State and local administration is $18.3 billion.

- Health Information Technology Meaningful Use Incentive Program

  FY 2015 estimate is $3.2 billion for provider incentives payments and $241.0 million for State and Local Administration to administer the incentives program)

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

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for individuals with intellectual disabilities in FY 2015 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2015 estimate for Medicaid State survey and certification is $242.4 million. This represents an increase of $7.7 million above the current FY 2014 estimate of $235.4 million. This increased funding level includes monies to support increasing workload requirements (i.e. increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 21,000 Medicaid participating facilities with nearly 22,000 health and life safety code annual certifications, as well as over 48,000 complaint survey investigations; and direct State survey costs associated with nursing home quality.

State Medicaid Fraud Control Units (MFCUs)

In FY 2015, State Medicaid fraud control unit operations are currently estimated to require $234.0 million in Federal matching funds. This represents an increase of $9.5 million over the FY 2014 funding level of $224.5 million. Forty-nine States and the District of Columbia participate in the program. Estimated increases are due to increases in staff and related expenses as MFCUs invest resources into curtailing Medicaid fraud and patient abuse and neglect.

The MFCU's mission is to investigate and prosecute provider fraud in State Medicaid programs as well as patient abuse and neglect in health care facilities. In FY 2013, States reported $2.5 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

Impact of Proposed Legislation

1. Extend the Medicaid Primary Care Payment Increase through CY 2015 and Include Mid-Level Providers (Workforce Initiative)

   Effective for dates of service provided on January 1, 2013 through December 31, 2014, states are required to reimburse qualified providers at the rate that would be paid for the primary care service under Medicare. The Federal government covers 100 percent of the difference between the Medicaid and Medicare payment rate. This proposal would extend the enhanced rate through December 31, 2015, expand eligibility to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care.

   Five-year budget cost: $5.4 billion

2. Rebase Future Disproportionate Share Hospital (DSH) Allotments

   As the number of uninsured people decreases due to the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of DSH funding needed. Legislation has extended DSH reductions through FY 2023, but in FY 2024, allotments revert to levels that had been in effect prior to the Affordable Care Act. This proposal would determine future allotments off states' actual DSH allotments reduced by ACA.

   Five-year budget savings: $0 billion

3. Permanently Extend Express Lane Eligibility (ELE) for Children (Medicaid Impact)

   Express Lane Eligibility allows Medicaid and CHIP agencies to rely on the findings of other government agencies to simplify eligibility determinations and facilitate enrollment. The authority for Express Lane Eligibility, which was first authorized in 2009 as a part of the Children's Health Insurance Program Reauthorization Act, expires in September 2014. This proposal permanently extends the authority for states to use the Express Lane Eligibility option for children.

   Five-year budget costs: $380 million

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

   Through the DME Competitive Bidding Program, Medicare is in the process of implementing innovative ways to increase efficiency for DME payments, which is expected to save Medicare approximately $27 billion, and Medicare beneficiaries approximately $18 billion, over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting federal reimbursement for a state's Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services.

   Five-year budget savings: $1.3 billion

5. Make Psychiatric Residential Treatment Facilities Eligible for Home and Community-Based Services Waivers

   This proposal would provide states with additional tools to manage their children's mental health care service delivery systems by expanding the non-institutional options available to these Medicaid beneficiaries. By adding psychiatric residential treatment facilities to the list of qualified inpatient facilities, this proposal provides access to home and community-based waiver services for children and youth in Medicaid who are currently institutionalized and/or meet the institutional level of care. Without this change to provisions in the Social Security Act, children and youth who meet this institutional level of care do not have the choice to receive home and community-based waiver services and can only receive care in an institutional setting where residents are eligible for Medicaid. This proposal builds upon findings from the five-year Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program authorized in the Deficit Reduction Act of 2005 that showed improved overall outcomes in mental health and social support for participants with average cost savings of $36,500-$40,000 per year per participant.

   Five-year budget costs: $770 million

6. Clarify the Medicaid Definition of Brand Drugs

   Currently, the statutory definition of single source and innovator multiple source drugs include the reference to the term "original" new drug application (NDA). This has created ambiguity as to whether a product approved under an original NDA should be considered a generic product. This proposal removes the word "original" from the definition of single source and innovator multiple source drugs and clarifies that over-the-counter (OTC) drugs that are approved under a new drug application are considered brand drugs.

   Five-year budget savings: $100 million

7. Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits

   Current law requires that the FUL be calculated as "no less than 175 percent" of the weighted average of monthly AMP in a FUL group "for pharmaceutically and therapeutically equivalent multiple source drug products." In addition, brand and authorized generic drugs are included in the calculation of the FUL. This proposal removes brand name drugs (innovator multiple source drugs) from the weighted average used to calculate FULs and removes the words "no less than" from the current law FUL methodology.

   Five-year budget savings: $430 million

8. Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations

   With the change to the definition of wholesaler under the ACA to include "manufacturers acting as wholesalers," the primary manufacturer includes the sale of the drug (transfer price) to the secondary manufacturer in the primary manufacturer's Average Manufacturer Price (AMP). This proposal revises section 1927 of the Social Security Act to exclude sales of authorized generics from the primary manufacturer's Average Manufacturer Price (AMP) calculations.

   Five-year budget savings: $100 million

9. Correct the ACA Medicaid Rebate Formula for New Drug Formulations

   The Affordable Care Act provided that the rebate obligation for line extension drugs is the greater of the basic and additional rebate for the original drug or the highest additional rebate (calculated as a percentage of average manufacturer price) under section 1927 of the Act for any strength of the reformulated single source drug or innovator mulitple source drug. This proposal makes a technical correction to the rebate calculation for the treatment of new formulations (line extension drugs) to include the basic unit rebate amount for consistency with other drug rebate calculations.

   Five-year budget savings: $2.6 billion

10. Apply Inflation-Associated Medicaid Rebate to Generic Drugs

    Under Section 1927 of the Act, the rebate calculation for brand name drugs includes the base unit rebate amount plus an additional rebate component tied to the amount, if any, by which the price of the drug has grown faster than inflation. However, there is no inflation adjustment applied to the rebate amount for generic drugs. This proposal would apply the inflation-associated rebate that applies to brand drugs to generic drugs.

    Five-year budget savings: $150 million

11. Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program

    Medicaid authority under the Social Security Act limits states' authority to restrict coverage of prescription prenatal vitamins and fluoride preparations. However, there is a lack of clarity as to whether these products would be considered covered outpatient drugs, given the lack of such products characterized by the FDA as "prescription." This proposal would resolve statutory ambiguity over whether prenatal vitamins and fluoride preparations are covered outpatient drugs and clarifies that states must cover these products under the Medicaid Drug Rebate Program if prescribed by a physician.

    Five-year budget impact: $0

12. Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters

    Currently, there is no time limitation for when a manufacturer can dispute a state's claim for rebates due under the MDR program. Manufacturers can dispute as far back as when the rebate program first started in 1991. This proposal would establish a time limit for manufacturers to dispute state utilization data and also provide an incentive to manufacturers and states to resolve outstanding disputes instead of letting them linger.

    Five-year budget impact: $0

13. Require Manufacturers That Improperly Report Items for Medicaid Drug Coverage to Fully Repay States

    This proposal would require manufacturers to make the drug rebate equal to the entire amount that the State has paid for the drugs in cases where the state improperly reported non-drug products to CMS as covered outpatient drugs or reported drugs that the Food and Drug Administration (FDA) has found to be less than effective under the Drug Efficacy Study Implementation as if they were not found to be less than effective. By requiring full reimbursement, this proposal eliminates the incentive for manufacturers to improperly report information about drugs in these situations.

    Five-year budget savings: $5 million

14. Enforce Manufacturer Compliance with Drug Rebate Requirements

    Under current law, CMS has authority to survey drug manufacturers, and OIG has authority to audit drug manufacturers. This proposal would allow more regular audits and surveys of drug manufacturers to ensure compliance with requirements of Medicaid drug rebate agreements to the extent they are cost effective.

    Five-year budget impact: $0

15. Require Drugs Be Electronically Listed with FDA to Receive Medicaid Coverage

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

    Five-year budget impact: $0

16. Increase Penalties for Fraudulent Noncompliance on Rebate Agreements:

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

    Five-year budget impact: $0

17. Provide Continued Funding for Survey of Retail Pharmacy Prices

The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) provided five years of funding to survey pharmacy prices, but the funding expired in FY 2010 and did not clearly authorize the use of funds for determining wholesale acquisition costs. This proposal provides a five-year mandatory funding stream ($6 million annually) to sustain a nationwide retail pharmacy survey incorporating prices paid by cash-paying, third-party insured, and Medicaid insured consumers. The proposal also funds the collection of the actual invoice prices from retail community pharmacies to enable states to set reasonable payment rates to pharmacies based on the true, uninflated ingredient cost of outpatient drugs.

Five-year budget costs: $30 million

18. Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS

While section 1927(b)(3)(B) of the Social Security Act gives the Secretary the authority to survey wholesalers to verify manufacturer prices when necessary, the statute does not provide the authority to collect such prices on a regular basis nor does the authority apply to all Medicaid-covered drugs. Providing the authority to survey wholesale acquisition costs on a regular basis, and for all Medicaid-covered drugs, will enable CMS to verify average manufacturer prices (AMP) that are currently being reported through these wholesalers or to set accurate Upper Payment Limits (UPL).

Five-year budget impact: $0

19. Expand State Flexibility to Provide Benchmark Benefit Packages

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

Five-year budget impact: $0

20. Extend Transitional Medical Assistance (TMA) through CY 2015

The TMA program extends Medicaid coverage for at least 6 months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. This proposal extends authorization and funding of the TMA program through December 31, 2015. States that adopt the Medicaid expansion will be able to opt out of TMA, consistent with a Medicaid and CHIP Payment and Access Commission recommendation. Current law extends this program through March 31, 2014.

Five-year budget costs: $1.6 billion

21. Extend the Qualified Individuals (QI) Program through CY 2015

    The QI program provides states 100 percent federal funding to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. This proposal extends authorization and funding of the QI program through December 31, 2015. Current law extends this program through March 31, 2014.

    Five-year budget costs: $960 million

22. Support Medicaid Fraud Control Units for the Territories

    Medicaid Fraud Control Units have demonstrated success recovering Medicaid dollars. This proposal would encourage territories to establish Medicaid Fraud Control Units to protect their Medicaid programs by exempting federal support for Medicaid Fraud Control Units from the cap on Medicaid funding for the territories and by exempting territories from the statutory ceiling on quarterly federal payments for the units.

    Five-year budget cost: $5 million

23. Track High Prescribers and Utilizers of Prescription Drugs in Medicaid:

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

    Five-year budget savings: $240 million

24. Expand Medicaid Fraud Control Unit Review to Additional Care Settings:

    The Budget proposes to allow Medicaid Fraud Control Units to receive federal matching funds for the investigation or prosecution of abuse and neglect in non-institutional settings, such as home-based care—in which a beneficiary may be harmed in the course of receiving health care services. The current limitation on federal matching was logical when the program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting, but has become outmoded as the delivery and payment for health services has increasingly shifted to in-home and community based settings.

    Five-year budget impact: $0

25. Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP**:**

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

    Five-year budget impact: $0

26. Consolidate Redundant Error Rate Measurement Programs**:**

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

    Five-year budget impact: $0

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

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

    Five-year budget savings: $40

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

    This proposal would expand the current authority to exclude individuals and entities from federal health programs if they are affiliated with a sanctioned entity by: eliminating the loophole in current law that allows an officer, managing employee, or owner of a sanctioned entity to evade exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity.

    Five-year budget impact: $0

29. Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers:

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

    Five-year budget impact: $0

30. Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees (Medicaid impact)

    Medicare and Medicaid have different appeals processes governed by different provisions of the Social Security Act, resulting in different requirements related to timeframes and limits, amounts in controversy, and levels of appeals. At times, these requirements may conflict and can result in confusion for beneficiaries and inefficiencies and administrative burdens for states and providers. This proposal provides authority for the Secretary to implement a streamlined appeals process to more efficiently integrate Medicare and Medicaid program rules and requirements.

    Five-year budget impact: $0

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

    This proposal would allow CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed. This plan would serve as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. These beneficiaries are assigned at random under current law to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under this proposal, the plan would be paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. A current demonstration, set to expire in December 2014, has shown the proposed approach to be more efficient and less disruptive to beneficiaries.

    Five-year budget impact: $0

32. Pilot the Program of All-Inclusive Care for the Elderly (PACE) to Individuals Between Ages 21 and 55 (Medicaid impact)

    PACE program provides comprehensive long-term services and supports to Medicaid and Medicare beneficiaries through an interdisciplinary team of health professionals who provide coordinated care to beneficiaries in the community. For most participants, the comprehensive service package includes medical and social services and enables them to receive care in the community rather than to receive care in a nursing home or other facility. Under current law, the program is limited to individuals who are 55 years old or older and who meet, among other requirements, the state's nursing facility level of care. This proposal would create a budget neutral pilot demonstration in selected states to expand eligibility to qualifying individuals between 21 years and 55 years. This pilot demonstration would test whether the Program for All-Inclusive Care for the Elderly can effectively serve a younger population without increasing costs.

    Five-year budget impact: $0

33. Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (Medicaid Impact)

The Budget proposes to authorize a five-year demonstration in partnership with the Administration for Children and Families beginning in FY 2015 to address the over-prescription of psychotropic medications for children in foster care. States would receive performance-based Medicaid incentive payments to improve care coordination and delivery for foster care children with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people. This investment is paired with $250 million in the Administration for Children and Families to support State efforts to build provider and systems capacity.

Five-year budget costs (outlays): $675 million (Medicaid), $390 million (State Grants and Demonstrations)

34. Establish Hold-Harmless for Federal Poverty Guidelines

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

Five-year budget impact: $0

35. Extend Special Immigrant Visa Program

This proposal extends the Special Immigrant Program for Afghans by one year, through FY 2015.

Five-year budget costs: $17 million

36. Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees

Beginning in FY 2015, this proposal would extend the SSI for qualified refugees under the Elderly and Disabled Refugees Act for two years.

Five-year budget costs: $23 million

37. Eliminate Medicaid Recoupment of Birthing Costs from Child Support

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.

Five-year budget impact: $0

38. 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 2015, it would award brand biologic manufacturers seven years of exclusivity rather than 12 years under current law and prohibit additional periods of exclusivity for brand biologics due to minor changes in product formulations, a practice often referred to as “ever greening.”

Five-year budget savings: $50 million

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

Beginning in FY 2015, 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: $860 million

MEDICAID PROGRAM

Proposed Law
Dollars in Thousands

Legislative Proposal	FY 2015
Extend the Medicaid Primary Care Payment Increase through CY 2015 and Include Mid-level Providers (Workforce Initiative)	$4,060,000
Rebase Future Disproportionate Share Hospital (DSH) Allotments	$0
Permanently Extend Express Lane Eligibility (ELE) for Children (Medicaid Impact)	$20,000
Limit Medicaid Reimbursement of Durable Medical Equipment (DME) Based on Medicare Rates	-$195,000
Make Psychiatric Residential Treatment Facilities Eligible for Home and Community-Based Services Waivers	$75,000
Clarify the Medicaid Definition of Brand Drugs	-$16,000
Exclude Brand and Authorized Generic Drug Prices from Medicaid Federal Upper Limits	-$30,000
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations	-$20,000
Correct ACA Medicaid Rebate Formula for New Drug Formulations	-$270,000
Apply Inflation-Associated Medicaid Rebate to Generic Drugs	$0
Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program	$0
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters	$0
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
Provide Continued Funding for Survey of Retail Pharmacy Prices	$6,000
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS	$0
Expand State Flexibility to Provide Benchmark Benefit Packages	$0

MEDICAID PROGRAM

Proposed Law
Dollars in Thousands

Legislative Proposal	FY 2015
Extend Transitional Medical Assistance (TMA) Through CY 2015	$920,000
Extend the Qualified Individuals (QI) Program through CY 2015	$760,000
Support Medicaid Fraud Control Units in the Territories	$1,000
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-$20,000
Expand Medicaid Fraud Control Unit Review to Additional Care Settings	$0
Prevent Use of Federal Funds to Pay State Share of Medicaid or CHIP	$0
Consolidate Redundant Error Rate Measurement Programs	$0
Retain a Portion of Recovery Audit Contractor Recoveries to Implement Actions That Prevent Fraud and Abuse	$0
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	$0
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	$0
Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees (Medicaid impact)	$0
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries (Medicaid impact)	$0
Pilot the Program of All-Inclusive Care for the Elderly (PACE) to Individuals Between Ages 21 and 55 (Medicaid Impact)	$0
Demonstrations to Address Over-Prescription of Psychotropic Medications for Children in Foster Care (Medicaid Impact)	$130,000
Establish Hold Harmless for Federal Poverty Guidelines	$0
Extend Special Immigrant Visa Program	$0
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees (Medicaid Impact)	$11,000
Eliminate Medicaid Recoupment of Birthing Costs from Child Support	$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)	-$150,000
SUBTOTAL	**$5,281,000**
Extend the Qualified Individuals (QI) Program through CY 2014 (Medicaid Part B Transfer)	-$760,000
TOTAL	$4,521,000

FY 2015 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	Difference +/- 2014
Alabama	$3,592,161	$4,038,932	$4,150,563	$111,631
Alaska	$848,492	$971,967	$1,063,215	$91,248
Arizona	$5,886,360	$7,031,141	$8,143,611	$1,112,470
Arkansas	$3,120,980	$3,763,171	$4,795,134	$1,031,963
California	$34,097,644	$40,414,562	$42,794,819	$2,380,257
Colorado	$2,703,190	$3,410,048	$4,035,135	$625,087
Connecticut	$3,419,943	$3,823,446	$4,065,480	$242,034
Delaware	$938,144	$1,065,976	$1,061,575	-$4,401
District of Columbia	$1,661,305	$1,860,261	$1,986,316	$126,055
Florida	$11,175,808	$12,928,986	$13,709,082	$780,096
Georgia	$6,196,251	$6,557,803	$6,286,750	-$271,053
Hawaii	$906,575	$1,134,225	$1,190,426	$56,201
Idaho	$1,261,790	$1,362,962	$1,078,553	-$284,409
Illinois	$8,493,218	$8,797,755	$8,924,200	$126,445
Indiana	$5,620,463	$6,187,877	$6,354,567	$166,690
Iowa	$2,317,170	$2,359,857	$2,343,845	-$16,012
Kansas	$1,557,549	$1,753,761	$1,707,029	-$46,732
Kentucky	$4,191,916	$5,231,083	$5,971,179	$740,096
Louisiana	$4,701,417	$4,967,009	$5,313,150	$349,141
Maine	$1,871,045	$1,614,851	$1,619,208	$4,357
Maryland	$4,123,553	$4,197,991	$4,470,215	$272,224
Massachusetts	$6,937,940	$8,093,951	$8,778,588	$684,637
Michigan	$8,592,519	$10,296,076	$11,730,180	$1,434,104
Minnesota	$4,266,632	$5,479,858	$5,979,104	$499,246
Mississippi	$3,605,171	$3,872,071	$4,090,642	$218,571
Missouri	$5,715,711	$6,129,503	$6,449,550	$320,047
Montana	$726,015	$759,897	$779,432	$19,535
Nebraska	$1,078,951	$1,087,755	$1,106,131	$18,376
Nevada	$1,164,922	$1,455,714	$1,739,104	$283,390
New Hampshire	$673,089	$737,530	$712,566	-$24,964
New Jersey	$5,639,230	$8,133,851	$9,692,983	$1,559,132
New Mexico	$2,438,571	$3,037,937	$3,378,177	$340,240
New York	$27,310,551	$34,832,162	$35,540,893	$708,731
North Carolina	$8,211,889	$8,590,452	$8,532,084	-$58,368
North Dakota	$451,079	$619,824	$747,998	$128,174

FY 2015 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	Difference +/- 2014
Ohio	$11,004,596	$12,602,073	$13,070,288	$468,215
Oklahoma	$3,092,307	$3,400,658	$3,432,119	$31,461
Oregon	$3,492,929	$4,390,416	$4,765,715	$375,299
Pennsylvania	$11,850,308	$12,234,661	$12,545,979	$311,318
Rhode Island	$1,060,709	$1,210,047	$1,245,153	$35,106
South Carolina	$3,473,332	$4,109,935	$3,770,684	-$339,251
South Dakota	$499,361	$498,301	$506,268	$7,967
Tennessee	$6,004,552	$7,009,416	$7,652,922	$643,506
Texas	$17,427,927	$21,513,259	$21,272,086	-$241,173
Utah	$1,545,776	$1,659,668	$1,730,784	$71,116
Vermont	$853,313	$893,747	$832,070	-$61,677
Virginia	$3,910,875	$4,381,411	$4,575,125	$193,714
Washington	$4,272,311	$4,096,632	$4,595,080	$498,448
West Virginia	$2,289,012	$2,664,681	$2,751,446	$86,765
Wisconsin	$4,455,583	$4,617,953	$4,830,309	$212,356
Wyoming	$312,094	$334,858	$327,745	-$7,113
Subtotal	**$262,042,229**	**$303,217,961**	**$318,225,257**	**$15,007,296**
American Samoa	$14,471	$15,898	$15,898	$0
Guam	$35,230	$35,036	$35,036	$0
Northern Mariana Islands	$19,677	$17,338	$17,338	$0
Puerto Rico	$973,694	$1,030,029	$1,075,697	$45,668
Virgin Islands	$16,213	$26,675	$19,797	-$6,878
Subtotal	**$1,059,285**	**$1,124,976**	**$1,163,766**	**$38,790**
Total States/Territories	**$262,101,514**	**$303,342,937**	**$319,389,023**	**$16,046,086**
Survey & Certification	$226,878	$235,400	$242,400	$7,000
Fraud Control Units	$222,201	$224,479	$233,977	$9,498
Vaccines For Children	$3,607,016	$3,562,470	$4,076,617	$523,645
Medicare Part B Transfer	$477,445	$755,000	$760,000	$5,000
Incurred But Not Reported	$0	$4,211,000	$6,641,000	$2,430,000
Undistributed	$20,285,442	$1,250,129	$12,026,953	$10,776,824
TOTAL RESOURCES	**$286,920,496**	**$313,581,415**	**$343,369,970**	**$29,788,555**

[1] Represents current law baseline projections of obligations.

Medicaid Program
Budget Authority by Object
(Dollars in Thousands)

	2014 Estimate	2015 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$306,806,095	$334,004,622	$27,198,527
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,562,470	$4,076,617	$514,147
Total Budget Authority	$310,368,565	$338,081,239	$27,712,674

Medicaid Program
Medicaid Requirements
(Dollars in Thousands)

	2014 Estimate	2015 Estimate
November 2013 State Estimates	$303,342,937	$319,389,023
State Certification	$235,400	$242,400
Fraud Control Units	$224,479	$233,977
Total Unadjusted Estimates	$303,802,088	$319,865,400
Legislation	$610,200	$224,200
State and Local Administration	$4,352,194	$4,832,396
Obligations Incurred But Not Reported	$4,211,000	$6,641,000
Financial Management Reviews	-$79,000	-$85,000
Medical Assistance Payments	-$3,418,265	$2,533,026
Total Adjustments	$5,676,129	$14,145,622
Vaccines For Children Program	$3,562,470	$4,076,617
Current Law Requirement	$313,041,415	$338,087,639
Unobligated Balances		
Start of Year	-$2,282,850	$0
End of Year	$0	$0
Recoveries	$0	$0
Gross Budget Authority	$310,758,565	$338,087,639
Offsetting Collections	-$390,000	-$6,400
Appropriation/Net Budget Authority	$310,368,279	$338,081,239

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. The Affordable Care Act (ACA) extends, at the State's option, Medicaid eligibility to non-elderly individuals with family incomes up to 133 percent of the Federal poverty level (FPL), with the Federal government paying most of the costs of coverage for newly eligible adults. 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 identified a measure set to track the quality of care provided to adults and we measure the number of Medicaid beneficiaries who receive home and community-based services. In addition, we measure the percentage of section 1115 Demonstration budget neutrality reviews completed to ensure that State demonstrations maintain the requirement to not create new costs for the Federal government.

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

Enrollment in CHIP or Medicaid should be viewed in the context of overall children's enrollment in both programs. Many factors will affect enrollment in CHIP and Medicaid, including States' economic situations and programmatic changes and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In previous years, CMS set separate targets for Medicaid and CHIP. Beginning in FY 2013, CMS began to track combined Medicaid and CHIP Enrollment. The FY 2015 target is to increase CHIP and Medicaid enrollment to 47,642,385 children, (Medicaid: 38,920,959/CHIP: 8,721,426), nearly 28 percent more children than were covered in FY 2008**.**

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

Given the approximate two-year lag in the recovery of State budgets post-recession, growth in enrollment may be difficult. Although enrollment increased by 19 percent between

FY 2008 and FY 2009, we expect little growth in the next few years. In addition, the latency of State's data submissions has resulted in a delay in reporting results for FY 2010 through FY 2013. Our FY 2014 target is to maintain enrollment between FY 2013 and FY 2014. The FY 2015 target is to be determined.

MCD5 Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed: CMS measures the percentage of section 1115 demonstration budget neutrality reviews completed out of the total number of operational demonstrations that have scheduled, targeted, budget reviews. Under section 1115 of the Social Security Act, the HHS Secretary has the authority to grant waivers to allow States to test innovative reforms such as new health care delivery systems. State demonstrations are generally held to a standard of budget neutrality, meaning that the demonstration should not cost the Federal government more than what it would cost absent the demonstration. The number of demonstration administrative actions (e.g., renewals and amendments) processed during the year provides an opportunity to perform reviews on a fair portion of all operational demonstrations. Through these processes every demonstration is reviewed at least every three years. The result for percentage of targeted reviews completed has been 100 percent since FY 2006. In FY 2012, CMS completed 100 percent of scheduled reviews (19 of the 19). The 2015 targets is to complete 100 percent of the targeted budget neutrality reviews to help ensure the demonstrations are operating within the agreed upon budget neutrality limits.

MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance (T/A) that will be provided for voluntary State collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and States, CMS identified and published an initial core set (Child Core Set) of twenty-four children's quality measures. Section 1139A9b)(5) of the Social Security Act provides that , beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the initial Child Core Set. In 2013, based on stakeholder feedback, CMS added three measures (HPV vaccinations for female adolescents; medication management for people with asthma, and behavioral risk assessment for pregnant women) and retired one measure (otitis media with effusion).

While the use of the Child Core Set is voluntary for States, CMS encourages all States to use and report on the Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2012, 92 percent of States reported on at least five quality measures, exceeding the CMS target to work with States to ensure that 80 percent of States report on at least five quality measures in the children's core set of measures. The FY 2015 target is to work with States to ensure that 90 percent of States report on at least nine measures in the Child Core Set.

CMS will continue to work with our Technical Assistance and Analytic Support Program (TA/AS) to provide States with specific clarifications on measurement collection questions; hold all- state webinars around specific measurement challenges; and publish T/A briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing T/A, CMS targets States that are already reporting multiple measures, as well as those that are just beginning to understand how to collect and report the measures. Further, as the TA/AS program continues to mature, CMS is also expanding the scope of the T/A to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

MCD7.1 Increase the National Rate of Low Income Children and Adolescents, who are Enrolled in Medicaid, who Receive Any Preventive Dental Service: This measure seeks to improve access to and utilization of oral health care services for children enrolled in Medicaid. Preventive dental services are those procedures, performed by a dentist or under the supervision of a dentist, that are primarily conducted to keep dental disease from occurring. Services can include prophylaxis, placement of dental sealants and application of topical fluoride. States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid. Between 2007 and 2011, almost half of all States achieved at least a 10 percentage point increase in the proportion of enrolled children, who received a preventive dental service during the reporting year. Despite this improvement, fewer than half of enrolled children nationally are receiving at least one preventive dental service in a year, and there remains a wide variation across States.

CMS is committed to providing technical assistance to States as they work to reach this goal. The FY 2011 national baseline for Medicaid is 43 percent. We fell short of our FY 2012 target of 45 percent, with an actual result of 44 percent. The FY 2015 Medicaid target is to increase the national rates of preventive dental service to 51 percent, 8 percentage points over the FY 2011 baseline.

MCD8 Improve Adult Health Care Quality Across Medicaid: The Affordable Care Act called for the establishment of an adult quality measures program in Medicaid. Similar to the children's quality goal, this goal focuses on creating a core set of adult quality measures for voluntary use by States to report in a standardized manner. Through a partnership with the Agency for Healthcare Research and Quality and States, CMS identified an initial set of core measures (Medicaid Adult Core Set) that were published in the *Federal Register*. The Medicaid Adult Core Set, which includes measures like "Controlling High Blood Pressure" and "Flu Shots for Adults Ages 50 to 64", is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf. CMS has also been working with States over the past year to help them prepare to report data on the measures by January 2014. Beginning in 2014, the Secretary will publish annual updates to the Medicaid Adult Core. The FY 2015 target is to work with States to ensure that 70 percent of States report on at least seven quality measures from the Medicaid Adult Core Set. CMS will continue to provide technical assistance and analytic support to States collecting and reporting the measures. As with the Child Core Set, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

PHI4.2/4.3 Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion: The Affordable Care Act (ACA) makes significant improvements to the Medicaid and CHIP Programs through the creation of a seamless system of coverage. The ACA expands access to Medicaid for certain low-income adults in States that take up the option, simplifies Medicaid and CHIP eligibility rules and processes, and ensures coordination between Medicaid, CHIP and the newly-established health Insurance Marketplace.

Our 2014 and 2015 targets are for 100 percent of States to be using streamlined application to enroll individuals in Medicaid and CHIP. We have also targeted that 100 percent of States to have an approved implementation Advanced Planning Document (APD) for enhanced funding for eligibility and enrollment systems that have a dynamic electronic application by June 2014. Technology enables the online application process to offer a number of

advantages over a paper process. Made available on an interactive web site, the online application will feature a dynamic or "smart" process that poses questions to the applicant based on the responses to previous questions and available verification information

This process ensures that only relevant questions are asked and any non-relevant questions do not appear on the application. A dynamic electronic application will populate relevant data and entries as the individual completes the application. Based on the information already entered, and available data sources, the application will automatically complete some information for the individual.

Please see the Performance Measurement Section and the Outputs and Outcomes table in the Program Operations narrative for additional information about the Marketplace performance measure (PHI4.1).

Key Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
CHIP3.3[1] Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid and CHIP	Combined Target begins FY2013 FY 2012: 44,453,639 children (CHIP: 8,148,397/ Medicaid: 36,305,242) Historical Actual	+25% over baseline 46,617,385 children (CHIP: 8,533,789/ Medicaid: 38,083,596)	+28% over baseline 47,642,385 children (CHIP 8,721,426/ Medicaid 38,920,959)	+1,025,000 children
MCD4 Percentage of Beneficiaries who Receive Home and Community-Based Services	FY 2009[2]: 19% over prior FY (1,253,689 beneficiaries) Target: 3% over prior FY (Target Exceeded)	Maintain over prior year	TBD	N/A
MCD5 Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed	FY 2012: 100% Target 98% (Target Exceeded)	100%	100%	Maintain

[1] The enrollment counts reflect an unduplicated number of children ever enrolled during each year.
[2] FY2010 Data is still being compiled for MCD4.

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2012: 92% of States reported on at least five quality measures Target: 80% of States report on a least five quality measure (Target exceeded)	Work with States to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90 percent of States report on at least nine quality measures in the CHIPRA core set of quality measures	+1 Measure
MCD7.1 Increase the national rate of low income children and adolescents, who are enrolled in Medicaid, who receive any preventive dental service.	FY 2012: 44%[3]/ +2 percentage points over FY 2011 baseline/ Target 45% (Target not met)	+6 percentage points over FY 2011 baseline 49%	+8 percentage points over FY 2011 baseline 51%	+2 pp
MCD8 Improve Adult Health Care Quality Across Medicaid	FY 2012: Target Met Target: Publish core set of adult quality measures in the Federal Register. (Target Met)	Work with States to ensure that 65 percent of States report on at least five quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 70 percent of States report on at least seven quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	+2 measures
PHI4.2: Percentage of States Using Streamlined Application to Enroll Individuals in Medicaid and Children's Health Insurance Program.	New for 2014	100%	100%	Maintain

[3] As final FY 2012 data from Connecticut (CT) were not available at the time of publication, CMS substituted FY 2011 data for CT in calculating this result. FY 2012 data were used for all other states.

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY2014
PHI4.3 Percentage of States with an Approved Implementation Advanced Planning Document (APD) for Enhanced Funding for Eligibility and Enrollment Systems that have a Dynamic Electronic Application	New for 2014	100%	100%	Maintain

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, ***[****$255,185,000,000****]*** *$259,212,000,000.*

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.

Payments to the Health Care Trust Funds

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $259,212,000,000.	Provides a one-year appropriation from general revenues to make the HI and SMI Trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match, and provides resources for the Part D prescription drug benefit program in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds

Amounts Available for Obligation

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Appropriation: Annual	$234,082,000,000	$255,185,000,000	$259,212,000,000
Indefinite Annual Appropriation, for SMI Premium Match	---	---	---
Indefinite Annual Appropriation, for Part D Benefits	---	---	---
Lapse in Supplemental Medical Insurance	($157,515,000)	($2,074,000,000)	---
Lapse in General Revenue Part D: Benefits	($1,344,702,000)	($3,997,000,000)	---
Lapse in General Revenue Part D: Federal Administration	($14,551,000)	---	---
Lapse in Program Management	($182,699,000)	($579,000,000)	---
Lapse in Transfer for HCFAC Reimbursement	($105,109,000)	($2,000,000)	---
Lapse in Quinquennial Adjustment	---	---	---
Adjustment from Expired Accounts *(FY09-11 HCFAC, FY11 PM – non-add)*	---	---	---
Total Obligations	$232,277,424,000	$248,533,000,000	$259,212,000,000

Payments to the Health Care Trust Funds

Summary of Changes

2014 Enacted

Total Budget Authority $255,185,000,000

2015 President's Budget

Total Budget Authority - $259,212,000,000

Net Change, Total Appropriation - + $4,027,000,000

Changes	FY 2014 President's Budget	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance (SMI)	$194,565,000,000	($22,000,000)
Indefinite Annual Appropriation, SMI	---	---
Hospital Insurance for Uninsured Federal Annuitants	$204,000,000	($17,000,000)
Program Management Administrative Expenses	$1,319,000,000	($556,000,000)
General Revenue for Part D (Drug) Benefit	$58,596,000,000	+$4,746,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---
General Revenue for Part D Federal Administration	$373,000,000	+$45,000,000
Part D: State Low-Income Determination	---	+$6,000,00
Reimbursement for HCFAC	$128,000,000	+$25,000,000
Net Change	$255,185,000,000	+ $4,027,000,000

Payments to the Health Care Trust Funds

Budget Authority by Activity (Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Presidents Budget
Supplementary Medical Insurance (SMI)	$181,351,000	$194,565,000	$194,343,000
Indefinite Annual Appropriation, SMI	---	---	---
Hospital Insurance for Uninsured Federal Annuitants	$228,00	$204,000	$187,000
Program Management Administrative Expenses	$750,00	$1,319,000	$763,000
General Revenue for Part D Benefit	$51,245,00	$58,596,000	$63,342,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
General Revenue for Part D Federal Administration	$382,00	$373,000	$418,000
Part D: State Low-Income Determination	---	---	$6,000
Reimbursement for HCFAC	$126,00	$128,000	$153,000
Total Budget Authority	$234,082,000	$255,185,000	$259,212,000

Payments to the Health Care Trust Funds

Authorizing Legislation

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$234,082,000,000	$255,185,000,000	$259,212,000,000
Total Budget Authority	$234,082,000,000	$255,185,000,000	$259,212,000,000

Annual Budget Authority by Activity

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
BA	$234,082,000,000	$255,185,000,000	$259,212,000,000	+$4,027,000,000

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. This account has no sources of funds - rather, it is a source of funds to the HI and SMI trust funds. These payments make the Medicare trust funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to general funds under current law, including amounts due the SMI Trust Fund with the general fund contribution for the cost of the Part B and Part D programs.

Through this appropriation, the trust funds are made whole for:

Hospital Insurance for Uninsured Federal Annuitants: This includes costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

This appropriation also reimburses the HI Trust Fund for:

Program Management Administrative Expenses: This includes that portion of CMS' administrative costs, initially borne by the Hospital Insurance Trust Fund, which is properly chargeable to general funds, e.g., Federal administrative costs for the Medicaid program, and for the Center for Consumer Information and Insurance Oversight (CCIIO).

Health Care Fraud and Abuse Control (HCFAC) account: The HCFAC program pays for program integrity activities for Original Medicare, Medicare Advantage, Medicare Part D, Medicaid, and the Children's Health Insurance Program. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance trust funds, which are properly chargeable to the general funds.

This appropriation also includes the Federal Contribution for SMI. This reflects a Federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is currently set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

Finally, as a result of enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this account includes General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these new Medicare Prescription Drug Account costs. Most of these activities started in FY 2006.

Funding History

The appropriated funding history for Payments to the Health Care Trust Funds is represented in the chart below:

FY 2009	$195,383,000,000
FY 2010	$207,286,070,000
FY 2011	$229,464,000,000
FY 2012	$230,741,378,000
FY 2013	$234,082,000,000
FY2014	$255,185,000,000

Budget Request

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2015 President's Budget of $187 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $17 million under the FY 2014 enacted of $204 million.

Program Management Administrative Expenses

The FY 2015 President's Budget of $763 million is used to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare Trust Fund activities. The Program Management Administrative cost is a net decrease of $556 million under the FY 2014 enacted amount of $1.3 billion.

Federal Contribution for SMI

The FY2015 President's Budget of $194.3 billion for SMI is a net decrease of $222 million under the FY 2014 enacted amount of $194.6 billion. The cost of the Federal match decreased due to the lower than expected actual costs.

General Revenue for Part D (Benefits)

The FY 2015 President's Budget of $63.3 billion for General Revenue for Part D (Benefits) is a net increase of $4.7 billion more than the FY 2014 enacted amount of $58.6 billion. This benefit contribution rises with Part D Prescription Drug program population and cost growth.

General Revenue for Part D Federal Administration

The FY 2015 President's Budget of $418 million for General Revenue for Part D Federal Administration is a net increase of $45 million over the FY 2014 enacted amount of $373 million.

General Revenue for Part D State Eligibility Determinations

The FY 2015 President's Budget for General Revenue Part D State Eligibility Determinations has increased by $6 million.

Reimbursement for HCFAC

The FY 2015 budget request of $153 million for reimbursement for HCFAC has a net increase of $25 million over the FY2014 enacted level of $128 million. This reimbursement amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI trust funds, but which are properly chargeable to the general funds. The FY 2015 increase reflects higher estimated non-Medicare trust fund burdens not included in FY 2014, due to CMS investment in activities related to program integrity in the private insurance market. These activities will include CMS program integrity responsibilities within the private market, including the Health Insurance Marketplaces.

Permanent Budget Authority

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Tax on OASDI Benefits	$14,310,000	$18,114,000	$20,956,000	$2,842,000
SECA Tax Credits	$18	---	---	---
HCFAC, FBI	$128,150	$127,319	$140,491	$13,172
HCFAC, Asset Forfeitures	$30,166	$27,000	$28,000	$1,000
HCFAC, Criminal Fines	$708,406	$1,140,856	$1,155,687	$14,831
HCFAC, Civil Penalties and Damages: Administration	$40,973	$31,934	$32,600	$666
Total BA	$15,217,713	$19,441,108	$22,312,778	$2,871,670

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. In addition, the following permanent indefinite appropriations associated with Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: FBI funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D). FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and again are permanent indefinite appropriations from the general funds, transferred to the HI Trust Fund.

Payments to the Health Care Trust Funds

Budget Authority by Object

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Grants, subsidies and contributions: Non-Drug	$181,351,000,000	$194,565,000,000	$194,343,000,000
Indefinite Annual Appropriation	---	---	---
Grants, subsidies and contributions: Drug	$51,245,000,000	$58,596,000,000	$63,342,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
Insurance claims and indemnities	$228,000,000	$204,000,000	$187,000,000
Administrative costs-General Fund Share	$1,258,000,000	$1,820,000,000	$1,334,000,000
General Revenue Part D: State Eligibility Determinations	---	---	$6,000,000
Total Budget Authority	$234,082,000,000	$255,185,000,000	$259,212,000,000

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

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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, [$293,588,000] $318,588,000, to remain available through September 30, [2015] 2016, 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 [$207,636,000] $262,344,000 shall be for [the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in Section 1893(b) of such Act,] Centers for Medicare and Medicaid Services program integrity activities; of which [$28,122,000] $28,122,000 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 [$29,708,000] shall be for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities,]; and of which [$28,122,000] $28,122,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year [2014] 2015 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.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$293,588,000] $318,588,000, to remain available through September 30, [2015] 2016, 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 [$207,636,000] $262,344,000 shall be for Centers for Medicare and Medicaid Services program integrity activities;	Provides funding for Centers for Medicare and Medicaid Services for program integrity activities.
of which [$28,122,000] $28,122,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act;	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which [$28,122,000] $28,122,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Discretionary /1				
CMS Program Integrity	$237,343	$237,344	$262,344	$25,000
Medicare Integrity(non-add)	*$207,984*	*$207,636*	*$207,636*	*$0*
Medicaid Integrity(non-add)	*$29,359*	*$29,708*	*$29,708*	*$0*
Private Insurance Integrity(non-add)	*$0*	*$0*	*$25,000*	*$25,000*
OIG	$28,122	$28,122	$28,122	$0
DOJ	$28,122	$28,122	$28,122	$0
Subtotal, Discretionary	$293,587	$293,588	$318,588	$25,000
Mandatory /1				
CMS Program Integrity **/1 2**	$851,509	$858,346	$1,095,801	$237,455
Additional Medicare Integrity(non-add)	*$0*	*$0*	*$192,029*	*$192,029*
Additional Medicaid Integrity(non-add)	*$0*	*$0*	*$21,966*	*$21,966*
FBI **/2**	$128,150	$127,319	$139,118	$11,799
OIG **/1 2 3**	$186,287	$184,979	$285,129	$100,150
Additional OIG(non-add)	*$0*	*$0*	*$84,796*	*$84,796*
DOJ Wedge **/1 2**	$58,164	$57,756	$142,171	$84,415
Additional DOJ(non-add)	*$0*	*$0*	*$79,621*	*$79,621*
HHS Wedge **/2**	$35,630	$35,379	$38,316	$2,937
Subtotal, Mandatory	$1,259,740	$1,263,779	$1,700,535	$436,756
Total Funding	**$1,553,327**	**$1,557,367**	**$2,019,123**	**$461,756**

/1 The FY 2015 Budget request provides $318.6 million for CMS, OIG, and DOJ through discretionary appropriations. This Budget also assumes a dedicated, dependable source of additional mandatory funding.
/2 Mandatory HCFAC funding includes the traditional Mandatory base and additional mandatory funding.
/3 Mandatory funding for OIG does not include $0.8 million in FY 2013 HCFAC funding allocated to OIG by HHS.

Authorizing Legislation – Social Security Act, Title XVIII, Section

1817K FY 2015 Authorization – Public Law 104-191

Allocation Method – Other

OVERVIEW

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse.

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides a stable stream of mandatory funds. In FY 2009, discretionary funding was appropriated to increase program integrity efforts and the discretionary appropriation was authorized to be available for obligation over two fiscal years beginning in FY 2010. In FY 2011, in a show of bipartisan support for combating health care fraud, waste, and abuse, and in recognition that program integrity efforts are paying off, the Budget Control Act of 2011 created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021.

Despite enactment of these multi-year discretionary cap adjustments, annual appropriations bills have not provided the full amount of program integrity funding authorized in the Balanced Budget and Emergency Deficit Control Act (BBEDCA). Billions of dollars in savings over the next ten years from curtailing improper payments will not be realized if consistent, additional funding for program integrity is not provided.

The Budget proposes to continue discretionary funding levels of $294 million in base discretionary funding for the Department of Health and Human Services (HHS) and the Department of Justice (DOJ), and the Budget proposes $25 million in new discretionary HCFAC funding for program integrity activities in private insurance, including the Health Insurance Marketplaces. Additionally, the Budget proposes to provide a dedicated, dependable source of additional mandatory funding beginning in FY 2015 that ensures HHS and the DOJ have the resources that they need to conduct necessary program integrity activities and make certain that only the right people receive the right payment for the right reason at the right time.

Discretionary funding has allowed HCFAC to expand its activities to include strengthened program integrity activities in Medicare Advantage (MA) and Medicare Part D; program integrity staffing and support; funding for program integrity initiatives; preventing excessive payments; and program integrity oversight efforts. Discretionary funds allow CMS to make traditional HCFAC actions such as Medical Review and Provider Audits more robust and all encompassing.

Additionally, CMS is committed to fighting fraud, waste and abuse in the Medicaid program. HCFAC activities associated with Medicaid program integrity work in tandem with the activities of the Medicaid Integrity Program, which is detailed in the State Grants and Demonstrations chapter of this document, to protect Medicaid by improving Federal oversight, support and technical assistance of state Medicaid programs. These activities enhance the Federal-State partnership.

Since its inception in 1997, HCFAC has grown steadily and has returned over $25.9 billion to the Medicare Trust Funds. The return on investment (ROI) from various HCFAC activities ranges from nearly $8 to $1 expended for audit, investigative, and prosecutorial work

performed by the Department of Health and Human Services Office of Inspector General (HHS/OIG) and DOJ to $14 to $1 for the Medicare Integrity Program's activities. The ROI for the HCFAC program (2011-2013) is $8.10 for every $1.00 expended. Since the annual ROI can vary from year to year depending on the number of cases that are settled or adjudicated during that year, DOJ and HHS use a three-year rolling average.

CMS is committed to working with law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Medicare Fraud 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 Force teams were reorganized under the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

HEAT is a cabinet-level commitment to combating fraud which coordinated the efforts of the DOJ's Civil Division and U.S. Attorneys' Offices, the HHS/OIG, and CMS. Strike Forces are located in nine cities: Miami-Dade, FL; Los Angeles, CA; Houston, TX, Brooklyn, NY; Detroit, MI; Chicago, IL; Tampa, FL; South Louisiana and Dallas TX. Since their inception in March 2007, Strike Force operations have charged more than 1,700 defendants who collectively have falsely billed the Medicare program for more than $5.5 billion. CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

In addition, CMS has been working with its private and public partners to build better relationships and increase coordination. CMS has co-hosted a series of regional fraud prevention summits on health care fraud in Miami, FL; Los Angeles, CA; Brooklyn, NY; Boston, MA; Detroit, MI and Philadelphia, PA bringing together federal and state officials, law enforcement experts, private insurers, health care providers, and beneficiaries. CMS also participates in the Healthcare Fraud Prevention Partnership, launched in July 2012 by HHS and DOJ, which is a collaboration of the Federal government, private health insurers, and other health care and anti-fraud groups and associations to combine the best health care fraud prevention and detection efforts in the public and private arena.

In 2010, the passage of the Affordable Care Act (ACA) provided an additional $350 million over ten years and an inflationary adjustment to the mandatory HCFAC base. In addition, the ACA provided a comprehensive set of tools to strengthen CMS' program integrity efforts. This funding has allowed CMS to develop and implement activities to prevent and find fraud such as the following:

- Enhanced Provider Screening – Risk-based screening of categories of providers for Parts A and B before enrolling in Medicare.
- National Site Visit Contractor Procurement – This contract has been awarded to conduct on-site visits (except for durable medical equipment suppliers) to increase efficiency and standardize site visits.
- Enrollment Revalidation Project – CMS has embarked on an ambitious project to revalidate the enrollments of all 1.5 million existing Medicare suppliers and providers by 2015 under the new ACA screening requirements.
- Termination of Medicaid Providers – The ACA requires states to terminate relationships with Medicaid providers or suppliers who have been revoked by Medicare for cause or terminated for cause by another state's Medicaid program or Children's Health Insurance

Program (CHIP). Similarly, under current authority, Medicare may also revoke providers or suppliers that have been terminated by state Medicaid agencies or CHIP. To support state efforts to share such information, CMS implemented a web-based application that allows states to share information regarding terminated providers and view information on Medicare providers and suppliers that have had their billing privileges revoked for cause.

- Law Enforcement Access to Data – CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. The IDR is currently populated with eight years of historical Medicare Parts A, B, Durable Medical Equipment (DME) paid claims, along with Part D drug events since Part D's inception. Preliminary MA claims processed will also be available in the IDR by the middle of 2014. In addition, the IDR contains pre-payment claims data for Medicare Parts A, B and DME beginning with FY 2012. CMS has built the OnePI portal to provide centralized access to the IDR data and regular collaboration with its users.

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

CMS' approach to program integrity is guided by four major principles:

- Prevention - Increase CMS' capability to stop fraudulent claims before they are paid by enhancing existing processes and increasing predictive analytic capabilities.

- Detection - Foster collaboration with HEAT, of HHS/OIG, various components of HHS, DOJ, states, and other stakeholders with a shared interest in the integrity of the national health care system.

- Recovery - Identify and recover overpayments to reduce improper payments. CMS will continue to work with its contractors and partners, including the HHS/OIG, DOJ, state agencies for survey and certification, and state Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

- Transparency and Accountability - Develop and deploy a comprehensive program integrity communication plan to share key messages and information with internal and external stakeholders. Performance measures are also being developed to evaluate operations and outcomes against other CMS reporting activities.

Funding History

FY 2011	$	1,707,995,000
FY 2012	$	1,599,611,000
FY 2013	$	1,553,327,000
FY 2014	$	1,557,367,000
FY 2015	$	2,019,123,000

Budget Request

The FY 2015 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2015 budget request is $2.02 billion, $461.8 million above the FY 2014 Enacted Level.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include both traditional methods such as Medical Review (MR), Benefits Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education. CMS is also using innovative approaches to prevent fraud, such as predictive analytics in both claims processing and provider enrollment. These new approaches require the use of in-house personnel, contractor, law enforcement, and auditors to identify, investigate, and prosecute individuals committing fraud, waste, and abuse. Importantly, these initiatives move CMS beyond "pay and chase" toward preventing fraud before it happens.

Specific steps CMS is taking with the current authorities and resources available include: more stringent scrutiny of applicants seeking to bill the Medicare program, increased collaboration with law enforcement in the application of payment suspensions, enhanced oversight of MA and Part D Prescription Drug Plans (PDPs), and testing new methods to detect and deter potential fraudulent behaviors before and after providers and suppliers are enrolled in the Medicare program.

In FY 2015, the major initiatives CMS will fund under MIP include Provider Audit, Medicare Secondary Payer, Medical Review, Data Matching, Provider Education & Outreach, and Error Rate Measurement. These activities will be discussed in more detail throughout this section.

CMS Program Integrity Budget Request

The FY 2015 CMS base discretionary request level of $237.3 million, as well as an additional $214.0 million in proposed mandatory funding, and $25.0 million in new discretionary funding for private insurance program integrity, will fund the activities listed in the table at the end of this chapter.

I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D:

Medicare Drug Integrity Contractors (MEDICs): Approximately 14.5 million beneficiaries are currently enrolled in the MA program and nearly 36.6 million beneficiaries are covered by a Prescription Drug (Part D). CMS has a fiduciary responsibility to safeguard these programs and the Medicare Trust Funds from fraud, waste and abuse (FWA).

In FYs 2014 and 2015, CMS plans to have the National Benefit Integrity (NBI) MEDIC focus on the continual development and improvement of their data analysis capabilities to proactively fight FWA. In order for the NBI MEDIC to improve their ability to perform data analysis by building potential fraud detecting profiles and algorithms, the NBI MEDICs must have the resources to increase their ability to store, mine and manipulate data. Also, CMS

intends to enhance the NBI MEDICs effectiveness by increasing program; oversight, vulnerability detection, and FWA audits of MA and Part D plan sponsors. Finally, in FY 2015, CMS plans to re-compete the NBI MEDIC scope of work.

Part C & D Contract/Plan Oversight: Oversight efforts assess whether an entity is qualified to contract with Medicare. CMS determines the qualifications of an entity through the Health Plan Management System (HPMS). HPMS is a web-enabled information system that supports the ongoing business operations of the MA and Part D programs. HPMS software modules collect data for and manage the following MA and Part D plan enrollment and compliance processes: application, formulary, bid and benefit package submissions, marketing material reviews, plan monitoring and oversight, marketing surveillance, complaints tracking, medication therapy management, plan connectivity, financial reporting, financial and plan bid audits, plan surveys, operational data feeds for enrollment, payment, and premium withhold, and data support for the Medicare & You handbook and the medicare.gov website.

In FY 2015, CMS will continue implementation of an audit redesign initiative in HPMS, to integrate the MA and Part D audit functions and establish new workflows for audit scheduling, recording of audit findings, uploading of supporting documentation in a centralized repository, automated letters, and corrective action plan submission and monitoring. MA and Part D plans use this functionality to enter audit data and upload supporting files and documentation, and track the status of an audit via data views and reports. CMS will automate other parts of this process, including full integration of the monitoring worksheets as online tools, utilization of systematic risk assessment mechanisms, and automated sampling of universe files.

CMS will also develop a new Network Management Module to further integrate health service delivery and retail pharmacy automated reviews and perform additional network reviews for renewing networks, plan benefit package-specific networks and other specialized networks, such as provider-specific networks.

Monitoring, Performance Assessment, and Surveillance: This category emphasizes the day-to- day use of plan-reported data, CMS data, and data received from outside sources to ensure accurate payment and compliance with program requirements. Technical, clinical, compliance and enforcement audit support is provided to assist CMS in conducting MA and Part D audits. More specifically, clinical experts conduct program and compliance audits, ensure a sponsor's readiness to participate in the MA and Part D programs, and conduct compliance program effectiveness audits and core performance audits for parent organizations.

In FY 2013, CMS conducted 30 program audits of sponsors. CMS increased the scope of its audits to better evaluate whether beneficiaries are receiving access to the care and medication to which they are entitled in the MA and D programs.

In an effort to ensure accurate payment, CMS has enlisted the help of a Reconciliation Support contractor to analyze Part D reconciliation calculations, which helps CMS to understand plan impacts and to support decision-making about potential major adjustments to Part D payments. Through this contractor, CMS also receives, tracks, and analyzes any issues raised by plans with respect to reconciliation after its completion, including appeals. In addition, this project analyzes Prescription Drug Event (PDE) data and other relevant payment information to support correct Part D payment.

Under Part D reconciliation, CMS must calculate the overall profit or loss of each Part D plan for risk sharing purposes, as well as each of the Part D plan's actual costs for low-income cost sharing and reinsurance. These calculations are dependent on the accuracy of numerous variables that affect payment (e.g., enrollment information, up-to-date- risk scores, plan-submitted cost information). The final reconciliation amounts and how these amounts are determined, are of significant interest to Part D sponsors, CMS' auditors and other interested stakeholders.

In FY 2015, the work of the Reconciliation Support contractor will continue. CMS will also augment the contract to support our effort to collect Part D overpayments in accordance with section 6402 of the Affordable Care Act, which established new section 1128J(d) of the Social Security Act entitled "Reporting and Returning of Overpayments". This will be a significant undertaking requiring that the contractor run reconciliation simulations to verify each overpayment reported by each of the Part D sponsors.

Program Audit: Sections 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of the Medicare Advantage Organizations (MAOs) and PDPs offering plans. These audits enable CMS to review and assess previously submitted information to ensure compliance with program requirements. During the audits, auditors review costs associated with the MA and PDPs, identify internal control deficiencies, and make recommendations for compliance with Medicare regulations and accurate reporting to CMS. Some of the specific areas of review include plans' solvency; related party transactions; administrative costs; direct medical costs; and Part D costs and payments, including direct and indirect remuneration and true out-of-pocket costs. To meet the one-third audit requirement, CMS conducts approximately 250 audits of MAOs and Part D sponsors per year.

In response to the Improper Payments Information Act (IPIA) of 2002, as amended by Improper Payments Elimination and Recovery Act (IPERA) of 2010, CMS enhanced its efforts to address improper payments. One such activity promotes the integrity of risk adjusted MA payments to MAOs through risk adjustment data validation (RADV), a rigorous payment validation process which measures the payment error estimates at the national and contract level. Diagnosis data submitted by plans is validated to check for incorrect reporting of diagnoses which can lead to overpayments and underpayments. RADV involves conducting medical record reviews, estimating contract level payment errors with the intent of conducting payment recovery, and implementing an appeals process. Error rate targets for the MA program are described in more detail in the Performance Measurement section near the end of this chapter.

Compliance and Enforcement: CMS provides audit compliance training, technical assistance, education, and outreach to the managed care industry, MAOs, PDPs, and audit assistance contractors. These training, education, and outreach models extend to internal and external stakeholders via webinars, compliance conferences, and on-line training sessions.

In addition, IT infrastructure plays a large role in supporting CMS' efforts of compliance and enforcement to safeguard the Trust Funds. For example, the Risk Adjustment System produces the risk adjustment factors to calculate beneficiary level payments. The factors are created by analyzing the history of diagnoses for each beneficiary and executing statistical models to adjust the risk experienced by each plan with regard to each individual beneficiary.

Multiple risk adjustment factors are generated for each Medicare beneficiary that supports both the payments to MA and Part D plans. Another example involves the collection of encounter data from MA organizations. In January 2012, the agency launched the Encounter Data Processing System (EDPS) to collect encounter data ("no pay") claims that detail each item and service provided to enrollees of MA organizations. This information is comparable to the data collected on an FFS claim. With encounter data, CMS will have a much more detailed and comprehensive profile of the health care services provided to MA enrollees and CMS will be able to more accurately make risk adjusted capitated payments. This encounter data will also inform MA oversight, program integrity and compliance. This will allow CMS to analyze, compare and better manage the health care being provided to beneficiaries in both MA and FFS.

Likewise, the Medicare Advantage Prescription Drug (MARx) application is the enterprise system of record supporting daily nationwide operations of the Medicare MA and Part D programs. MARx primary system functions include processing transactions for enrollment/disenrollment of Medicare beneficiaries into/from MA and Part D health plans, and calculating monthly capitated payments to MA and Part D plans. Under CMS' current Enterprise Systems Development (ESD) model, MARx requires three separate IT support service contracts which include the following: (1) systems development and maintenance, (2) testing services, and (3) business operations services.

The implementation of the Managed Care Payment Validation Contractor is another measure CMS instituted to ensure the accuracy of payments to MAOs and PDPs. The contractor processes retroactive requests in accordance with CMS guidelines that reinforce the requirement for MAOs and Part D plans to adhere to CMS policies and procedures and improves payment accuracy. The data analysis conducted by the contractor allows CMS to take proactive measures to address vulnerabilities affecting payment accuracy and the implementation of other Parts C and D programmatic requirements. Furthermore, the information provided by the contractor assists the Regional Office Account Managers with their monitoring and oversight responsibilities.

II. Program Integrity Staffing & Support:

Field Offices/ Rapid Response/ and Oversight Staffing: This funding includes staffing for CMS' Central Office and three field offices in areas of the country that are highly vulnerable to fraud, waste, and abuse in Medicare and Medicaid (New York City, Los Angeles, and Miami). The staff possesses the required skills to perform detailed analytic and investigative work, fraud prevention and detection outreach, and policy development relating to all of CMS' program integrity activities. In addition, this funding provides support services for IT infrastructure, data communications, security, and administrative services.

III. Program Integrity Initiatives:

Automated Provider Screening (APS): In FY 2013, CMS made significant advancements to fully automate the manual checks performed by the Medicare Administrative Contractor's (MACs) provider enrollment specialists and facilitated their use of the system during the enrollment process. In FY 2014, CMS continues to do data analysis and monitoring of licensure and will expand efforts to all deployed screening assessments. CMS will also expand the use of the APS to all MACs. In FY 2015, CMS will add new functions, enhancements and data sources to screen providers, and expand its user base across all MACs which will facilitate their use of the system during the enrollment process.

1-800-MEDICARE Integration: In an effort to fight fraud, waste, and abuse in the Medicare and Medicaid programs, suspected fraud can be reported to both the HHS/OIG Hotline and 1-800- MEDICARE. In FY 2014 and FY 2015 the consolidation of the HHS/OIG Hotline and 1-800- MEDICARE complaints into the Next Generation Desktop (NGD) will be completed. The NGD allows a 1-800-MEDICARE customer service representative to escalate a reported instance of Medicare fraud when reported by a beneficiary. Once this instance is escalated, only investigators are able to access the report. NGD uses the National Data Warehouse to track and compile the reported Medicare instances by providers, and the original complaint, providing a useful investigative tool to law enforcement.

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. The increased FY 2015 request reflects the cost of issuing more licenses and gaining valuable law enforcement specific upgrades to enable near real-time retrieval of data.

Case Management System: In FY 2013, CMS has done an assessment of the business needs and a market scan of available products. On July 26, 2013, CMS held an Industry Day describing its plans for the establishment of Unified Program Integrity Contractors (UPICs) to perform many of the tasks currently contracted to the Zone Program Integrity Contractors (ZPICs) and the Medicaid Integrity Contractors (MIC). The plan is for the UPICs to use a centralized case management capability provided by CMS, as well as centralized data (via OnePI and the IDR) and some centralized analytic capability. This tasking will help ensure that appropriate case management and analytic capability is in place when the new UPIC contracts are established.

In FY 2015, CMS will enhance its case management and analytical capabilities for health care fraud detection and prevention as well as improve integration across programs (Medicare, Medicaid) and with CMS contractors (UPIC's and ZPICs) allowing for more comprehensive, timely and accurate health care fraud prevention modeling and reporting.

Technology and Strategic Decision Support: This project will capitalize on the investment in multiple technologies and pilot programs. CMS is testing and planning multiple pilots to prevent and detect fraud, waste, and abuse. This project will create the infrastructure to provide key strategic support for each pilot project, while maintaining a high-level vision for such pilots. This effort will identify vulnerabilities to be addressed at the policy level, as well as prevent duplication of effort through tracking. CMS is also evaluating innovative technologies for implementation, and the system will be able to perform comparisons and evaluations of the potential technology solutions. This tool will also be used to conduct analysis of risk and development of rules for provider screening.

Moving forward, this project will coordinate with the Case Management System and readily provide metrics reflecting the results of these efforts. CMS' broad performance metrics initiative will facilitate legislative and regulatory reporting, and institutionalize CMS transparency and accountability. The strategic decisions and appropriate procurement actions are planned to begin in FY 2014. Continued support for this project throughout FY 2014 and FY 2015 is crucial to accomplishing this goal.

Beneficiary Fraud Outreach and Fraud Early Warning System (FEWS): Educating and empowering Medicare health care consumers to identify, report, and prevent Medicare fraud is an essential strategy in the arsenal of fraud-fighting efforts. The activities proposed in this project achieve this goal in a cost-effective manner by leveraging existing programs and partnerships and utilizing 1-800-Medicare and NGD complaint databases to develop a FEWS to warn beneficiaries and their caregivers and prevent additional losses. This project consists of a number of activities to engage beneficiaries in fighting fraud. The Beneficiary Fraud Outreach and FEWS empower Medicare healthcare consumers to identify and report fraudulent activities and prevent Medicare fraud by alerting consumers as quickly as possible about fraudulent schemes. The activities proposed in this project achieve this goal in a cost-effective manner by leveraging existing partnerships, such as Senior Medicare Patrol (SMP), AARP and Medicare contractors to develop an organized system that will:

1) Extract leads from1-800 Medicare, NGD, OIG and local hotlines that will systematically organize and then triage all complaints to identify fraudulent activities including state-specific, regional and national emerging fraud threats. Other activities include coordinating with HEAT partner agencies in high fraud areas.

2) Design thresholds that determine whether fraud complaints qualify for the development of a Fraud Alert and subsequently trigger automated Fraud Alerts to public and private partners.

3) Draft and distribute Fraud Alerts and expand consumer outreach efforts, such as increased media outreach, Public Service Announcements, develop multi-cultural materials and targeted outreach to "mymedicare.gov" registered users who are able to see their claims within 24 hours of the claim being processed.

4) Provide specialized training to selected SMP volunteers for additional fraud control activities, including in-depth casework, research, and investigation of complaints, provider education and relations.

5) Distribute Fraud Alerts to law enforcement and Medicare contractors for further investigation and administrative action.

This funding will allow CMS to acquire the services of a contractor to assist in developing and implementing a beneficiary-focused strategy.

Joint Hospice Project: This project would conduct hospice investigations in California and Nevada. The LA Field Office is presently field testing the project with one hospice in Southern California that is a top Medicare and Medicaid biller with long lengths of stay, which utilizes nebulous diagnoses such as debility and dementia as evidence of a terminal illness. A Best Practices approach needs to be established for joint investigations between Medicare and Medicaid or with a Healthcare Fraud Prevention Partnership (HFPP) partner as a participant. This could be replicated in Nevada and other states, with other provider types, and with HFPP partners once a Best Practices model is established.

Southern California Rapid Response Team: The Southern California Rapid Response project will collaborate with Survey & Certification State Agency partners. CMS is currently field-testing this project in its Los Angeles Field Office (LAFO), which has partnered with two state agency district offices (L.A. county and Orange county). This will provide a vehicle for surveyors to call in referrals regarding suspicious practices and documentation indicative of

fraud that they witness, uncover or observe in the field during the course of certification, recertification, complaint and /or licensing surveys.

IV. Prevent Excessive Payments:

Fraud Prevention System (FPS): In FY 2013, FPS continued to add and refine existing models to better detect and prevent fraud. There are over 700 users of the FPS system including data analysts, law enforcement, policy experts and clinicians. Modifications were made to the FPS system to integrate the system into the Fee for Service claims processing stream. This ability allows CMS to identify fraud and prevent improper payments. A proof of concept was established that immediately rejected claims prior to the claims finalizing, resulting in immediate savings. Other efforts were also focused on implementing a fraud data analytics framework to expand capabilities of identifying complex social network of fraudulent providers. The implementation has carried into FY 2014 and expanded access to the Medicare Administrative Contractors (MACs) to resolve and reduce improper payments.

By 2015, the FPS will be supporting 1,250 users with potential to increase to approximately 2,000. It will be utilized to focus on preventing payments prior to claims finalizing, creating complex algorithms, identifying fraudulent social network activities with the new framework. With this new framework, FPS will be user friendly and have an increased number of valid data elements that increases search capabilities, therefore enabling more robust identification of fraudulent cases. This effort will increase return on investment and bring dollars back into the Medicare budget.

Fraud System Enhancements: This project will continue to provide support for the FPS, National Coding Corrective Initiative (CCI) and analytic investigations to detect and prevent fraud, waste and abuse.

In FY 2015, this work will continue to support the CMS program integrity strategic plan and CMS priorities for data analytics to improve detection and prevention to streamline and enhance the benefit of fraud, waste and abuse.

Command Center: In FY 2012, CMS established the Command Center as the center for excellence for detection and investigation, driving program integrity innovation and improvement. The Command Center is a paradigm shift in the way CMS conducts its program integrity work by supporting multi-party working sessions among Federal program staff, contractors, and law enforcement to identify emerging fraud schemes, identify program vulnerabilities, prioritize and develop approaches to address high priority issues, and resolve leads from the Fraud Prevention System faster. The Fraud Prevention System applies predictive analytic technology to Medicare claims prior to payment to identify aberrant and suspicious billing patterns.

In FY 2013, the Command Center hosted ninety-three collaborative sessions in which CMS staff, anti-fraud contractors, law enforcement partners, State Medicaid Agencies, and other federal partners participated. Significant outcomes have been achieved through these collaborative sessions. In addition, using the collaborative tools of the Command Center, many CMS staff and law enforcement partners have been trained on the use of the FPS to conduct and enhance investigative work. CMS has also used the space to develop additional models used in the FPS and has held collaborative sessions with the Zone Program Integrity Contractors (ZPICs). In these sessions, the ZPICs shared best practice with the other zones to improve their ability to rule on ASR's from the FPS.

The FY 2015 ongoing funding will support this effort to effectively share and present findings, display data, and make determinations and decisions on a system-wide basis across various fraud detection and prevention efforts.

Benefits Integrity (BI): Benefit Integrity activities deter and detect Medicare fraud through concerted efforts with the CMS, HHS/OIG, DOJ, and other CMS partners. Nearly all of the BI funding is directed to the 10 ZPICs/PSCs that operate throughout the United States. In FY 2015, ZPICs/Program Safeguard Contractors (PSCs) will continue to conduct proactive and reactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement, a major component of BI activities. ZPICs/PSCs also evaluate and investigate complaints that indicate potential fraud and support law enforcement during the development and prosecution of cases.

The ZPICs/PSCs are now using FPS as an additional source of leads to identify, prevent and investigate potential fraud. The FPS screens claims data before payment is made, allowing the ZPIC/PSCs to rapidly implement administrative actions, such as prepayment review, revocation, or payment suspension, as appropriate. The FPS generates a prioritized list of leads for ZPIC/PSCs to review and investigate potential Medicare fraud in their designated region. When suspect behavior or billing activity is identified, the ZPICs/PSCs investigate to determine if appropriate administrative actions should be taken and/or if it should be referred to law enforcement.

The continuum from detection to prosecution of fraudulent activity requires complete coordination among CMS, its contractors, and law enforcement partners. The ZPICs/PSCs meet on a regular basis with the HHS/OIG and DOJ staff to share information on active cases and new leads. CMS participates in fraud task forces, educational sessions and formal meetings to review the status of cases, and discuss identified fraud schemes. The ZPICs/PSCs also frequently perform medical review or data analysis for cases initiated by HHS/OIG or the FBI.

The ZPICs/PSCs currently support many of the antifraud initiatives in the Field Offices, including HEAT activities. In FY 2014, funding continues to be used for ZPICs/PSCs to perform data analysis projects and to support immediate and real-time requests for information from the field offices special projects. The Field Offices have notably strengthened the revocation process by improving the manner in which substantiating documentation is obtained. Moving forward into FY 2015, there will be an increased need for rapid response activities to quickly investigate new leads to further identify and prevent potential fraud.

In addition to using the FPS system, ZPICs/PSCs will continue to participate in Command Center Missions, at which CMS leadership, ZPIC/PSC representatives, CMS Contracting Officer Representatives (CORs), predictive modeling experts, and clinicians work collaboratively with the ZPICs/PSCs on model development, investigative techniques, resolving specific leads, and training opportunities.

CMS has undertaken an aggressive strategy to address the high risk or fraud that the DME suppliers pose to the Medicare Program. Through the DME Stop Gap Project, initiated in 2009, ZPICs/PSCs have increased site visits and interviews of DME suppliers, providers, and beneficiaries receiving DME products in high billing areas for DME supplies and products. In FY 2015, additional funds are necessary to support DME investigations that will include site visits to, and interviews of, suppliers, doctors and patients that have been identified as potentially suspicious or high risk.

In FY 2015, CMS plans to begin implementation of the Unified Program Integrity Contractor (UPIC) initiative. The transition is consistent with the CMS agency-wide strategic plan for program integrity and combines the audit and investigation work currently conducted by the ZPICs, including the Medicare-Medicaid Data Matching Contractors (Medi-Medi) and their responsibilities, and the Audit Medicaid Integrity Contractors (Audit MICs) to form the UPIC. CMS expects contracts with ZPICs/PSCs and MICs to end as the UPIC is implemented in specific geographic regions. CMS anticipates implementation of the UPICs over a multi-year period in order to complete the entire transition.

Streamlining to the UPIC initiative will provide benefits that will ultimately enhance CMS ability to aggressively combat fraud, waste, and abuse by consolidating the separate funding sources into a single contract. Benefits to the UPIC strategy can include reduced state and provider burden, increased contractor accountability, reduced overhead and administrative costs over time, enhanced data and reporting capabilities, and improved program oversight. The UPIC initiative is the next logical step in the transition to an integrated program integrity strategy and is a key milestone supporting the CMS' strategic goal of improving contractor accountability.

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 appropriate conditions. Currently, CMS only conducts complex medical review on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements. CMS also conducts pre-payment medical reviews to prevent improper payments from being made. Both types of medical reviews help reduce the Medicare fee-for-service error rate. Additional funding would support an increased level of prepayment review on those claims that local or national data suggest are leading to Medicare improper payments.

Provider Audit: Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report.

In FY 2013, approximately 45,000 Medicare cost reports were accepted by the MACs, and tentative settlements were completed for 23,000 cost reports. In addition, approximately 18,000 desk reviews and 2,000 audits were completed. CMS completed contractor monitoring activities on all MACs during the year and plans to maintain similar levels of effort for FY 2014 and FY 2015.

Medicare Secondary Payer (MSP): MSP efforts ensure 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. When mistaken Medicare primary payments are identified, recovery actions are undertaken.

On February 1, 2014, CMS completed the transition of its MSP contracting strategy to fully integrate pre-payment coordination of benefits activities with MSP debt recovery activities. During FY 2014 and 2015, significant enhancements will be implemented to take advantage of combined MSP operations. Once complete, the public will have one primary point of contact for all MSP coordination of benefits and recovery activities.

Medicare-Medicaid Data Match Project (Medi-Medi): Medi-Medi, authorized by the Deficit Reduction Act (DRA) of 2005, is a voluntary partnership between CMS and participating states where data is collected and analyzed from both programs with the intent of detecting potential fraud, waste and abuse that may otherwise go undetected in each program. The Medicare and Medicaid programs share many common beneficiaries and providers. Matching claims helps identify billing patterns that might be indicative of potential fraud, waste, and abuse and could otherwise go undetected if viewed in isolation. Analysis performed in the Medi-Medi program can reveal trends that are not evident in claims data from each program alone, making the Medi-Medi program an important tool in identifying and preventing fraud. The Medi-Medi program has grown to 20 states.

CMS will continue to expand this program in FY 2015. CMS is in the process of developing an updated comprehensive strategy for the Medi-Medi program with a focus on encouraging state participation. Through this strategy, CMS plans to reduce provider and state audit burden, provide better access to improved data, and establish better collaboration between the Medicare and Medicaid investigations and audits. The Medi-Medi program will become increasingly more effective as more states participate. Program participation is optional for the states; however, the ZPICs/PSCs work diligently to encourage each individual state's participation. The Medi-Medi program will be able to further Federal- State collaboration in analyzing trends to identify potential fraud, waste, and abuse in the Medicare and Medicaid programs throughout the country. CMS has partnered with some of the larger states in the country as it relates to expenditures; the 20 states that are in the Medi-Medi program account for a majority of total Medicaid expenditures. At least 12 additional states have expressed an interest in participating. CMS is also working to identify ways the program can be improved and be more beneficial to states.

V. Program Integrity Oversight Efforts:

Overpayments and Payment Suspension: In FY 2013, CMS began developing instructions and implementing a standardized process for Medicare contractors to deny Medicare billing privileges if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing overpayment that has not been repaid in full at the time an enrollment application is filed. This includes denying new enrollments or change of ownership applications from a current owner of an enrolling provider or supplier or a physician or non-physician practitioner.

CMS anticipates this standardized process to be fully implemented and operational in FY 2014. Also in FY 2014, CMS will develop further-instructions and implement a process to deny Medicare billing privileges if the current owner of an enrolling provider or supplier or the enrolling physician or non-physician practitioner has been placed under a Medicare payment suspension. Funding in FY 2015 will allow CMS to continue these efforts.

Compromised Numbers Checklist (CNC): CMS continues to refine the national CNC of Medicare provider and beneficiary identification numbers known or suspected to be compromised. In FY 2015, CMS will continue the ongoing process of redefining the entries in the CNC database to facilitate its incorporation into the FPS and other program integrity predictive analytics. In addition to assigning risk levels (high, medium, low) to each beneficiary Health Insurance Claim Number (HICN) and provider National Provider Identifier/Provider Transaction Access Number (NPI/PTAN), the ZPICs/PSCs are designating the specific reason code indicating why the number was determined to be

compromised and eligible to be entered into the database. CMS and the CNC contractor will continue to operate, maintain, and upgrade the web-based system, allowing PSCs, ZPICs, the MEDIC and law enforcement real-time access and updating capability. The CNC is used to identify investigative leads, provide background information to justify implementation of claims processing edits, and share corrective actions taken against providers and individuals. The CNC has helped CMS identify and track false front providers and other providers submitting claims for stolen or compromised beneficiary numbers and stolen or compromised rendering or ordering provider numbers, and implement timely corrective actions such as revoking Medicare billing privileges, resulting in significant savings to the Medicare Trust Fund.

CMS will continue to focus on developing and refining a more robust process to provide comprehensive data quality validation and to include additional information on the providers and beneficiaries included in the database. The expectation is that the database will continue to grow as new compromised numbers are identified and added. Additional funding will support continued refinement and ongoing maintenance.

National Supplier Clearinghouse (NSC): The NSC activity is a continuing contractual arrangement for the receipt, review and processing of applications from organizations and individuals seeking to become suppliers of DMEPOS in the Medicare program. The NSC is responsible for conducting on-site visits, enrolling the DMEPOS supplier and implementing safeguards to ensure only legitimate suppliers enter and/or remain in the Medicare program. In FY 2014, CMS plans to implement a new fraud and abuse index of risk (FAIR) and to transition to a new contractor, if applicable. This work will continue in FY 2015.

OnePI Data Analysis: In order to fight fraud, waste and abuse in Medicare and Medicaid, CMS has built the OnePI portal to provide Program Integrity contractors, Law Enforcement and HHS/OIG with centralized access to multiple analytical tools and data sources. Through this investment, CMS will continue to train and support a multitude of contractors and law enforcement users for using these tools and the IDR to fight fraud, waste, and abuse.

CMS will also continue to implement the loading and matching of Medicaid data with the historical Medicare Parts A, B, and D and provider enrollment data in the IDR. CMS will continue to integrate the receipt and loading of Medicaid and CHIP state data through the T-MSIS data exchange. The investment will continue to promote the efficient expansion of the agency's Medi-Medi data match project and data sharing requirements as required in the DRA and Section 6402a of the ACA. CMS will continue to transition ZPIC, PSC, and MEDIC data analytic access through the ONE-PI to the IDR allowing the discontinuance on separate regional contractor data repositories.

OnePI provides access to current and historical Medicare data that is used to develop and refine predictive analytic models prior to integration into the FPS. Program Integrity analysts and investigators rely on the data available via OnePI to further develop the leads identified by FPS.

Health Care Fraud Prevention & Enforcement Action Team (HEAT) Support / Strike Force Teams: The first Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse amont DME suppliers and Human Immunodeficiency Virus (HIV) infusion therapy providers in South Florida. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that

interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of these efforts and increased appropriated funding for the HCFAC program from Congress and the Administration, DOJ and HHS expanded the Strike Force to include teams of investigators and prosecutors in a total of nine cities – Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; South Louisiana; Tampa, FL; Chicago, IL; and Dallas, TX.

Since their inception, Strike Force operations have charged more than 1,700 defendants who collectively have falsely billed the Medicare program for more than $5.5 billion. In addition, CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers. In FY 2013, CMS awarded a contract for the HEAT Strike Force Data Compendium Project. This contract is a multifaceted approach to build investigative guides and templates for CMS, CMS contractors and Law Enforcement partners as well as a library compendium of training materials for the same audience. The funding request for FY 2015 will allow CMS to continue its joint efforts with law enforcement to support the HEAT initiatives such as the HEAT Strike Force Data Compendium Project as well as investigations in Strike Force cities.

Appeals Initiatives: In FY 2013, CMS developed an interagency workgroup to improve the appeals process to reduce the number Medicare contractor decisions that are overturned. In FY 2014, CMS will expand the presence of the Program Integrity contractors at Administrative Law Judge (ALJ) hearings so that they can present CMS's reasoning for the determination being appealed. CMS will also continue to collaborate with the Office of Medicare Hearings and Appeals to identify training and educational opportunities for appeal adjudicators to ensure there is a proper understanding of Medicare policies and regulations.

In FY 2014, CMS created the ZPIC Appeals Contractor (ZAP) that will review and analyze ZPIC appeal vulnerabilities, collect information to develop a best practices document and provide data analysis and recommendations for improvements to the ZPIC approach to appeals in an effort to improve results of reviewed and overturned appealed decisions.

CMS's Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) activities for Medicare fee-for-services (FFS) Parts A & B claims. CMS currently contracts with two QICs to perform Medicare Part A reconsideration activities, and three QICs to perform Medicare Part B reconsideration activities. The QICs are required to participate as "non-party participants" in 10 percent of ALJ hearings. CMS anticipates that by invoking party status in more hearings, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Funds expenditures.

In the past, funding had been provided to the QICs to participate in ALJ hearings as a party. FY 2015 funds will support continued activities and efforts in QIC participation. In addition, the ZAP contractor will create a best practices document, recommend fixes to vulnerabilities and provide data and statistical analysis of the current appeal upheld/overturn rate.

Healthcare Fraud Prevention Partnership (HFPP): This project is split- funded between mandatory funding associated with the Medicare Integrity Program and HCFAC discretionary funding associated with Medicaid program integrity. The funding table at the end of this chapter displays the estimated share covered by Medicaid.

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care system. As part of this initiative, CMS launched the Healthcare Fraud Prevention Partnership with HHS/OIG, DOJ, FBI, private health insurance companies, and other health care and anti-fraud groups and associations. The mission of the HFPP is to exchange data and information between partners to help improve capabilities to detect and combat fraud, waste and abuse. These exchanges of data and information take the form of targeted data exchange studies.

A Trusted Third Party (TTP) contractor will be in place by the end of FY 2014 to perform duties associated with standing up and running joint public-private data analytics in a secure environment. CMS has also launched a public website (hfpp.cms.gov) in FY 2014 to share various information and lessons learned from the partnership as well as a secure partner portal for sharing of sensitive partnership information. Products and communications materials will continue to be added to this site in FY 2015. Additionally, CMS will continue to invest in analytic capabilities specific to HFPP data, ensuring that CMS both contributes effectively to the partnership and can act on HFPP data to realize cost savings.

The FY 2015 funding request represents the estimated cost of maintaining and expanding the partnership, maintaining systems in place to support the partnership, and continuing to expand fraud prevention and detection capabilities through public and private sector data exchanges.

Funding for this project is also being requested under Section VI of the Medicaid program integrity initiatives.

Probable Fraud Measurement Pilot (PFMP): Through the PFMP, CMS aims to estimate the rate of probable fraud in Medicare fee-for-service payments for home health agencies (HHAs). CMS designated HHAs as having a "high" categorical risk in the final rule on the implementation of ACA screening provisions [CMS-6028-FC amending adding 42 CFR 424.518]. 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.

A preliminary test is planned for FY 2014 to examine one geographical area and a limited number of home health claims. This test is designed to test the study design and ensure that it is robust. In FY 2015, CMS plans to complete the nationwide field portion of the pilot. This portion of the pilot will examine 2,030 home health claims through personal interviews of beneficiaries, home health agencies, and attending providers related to claims throughout the country. At the conclusion of the nationwide interviews, analysis of the results will provide CMS with a rate of probable fraud.

Provider Outreach and Education (POE): POE funding is used by the Medicare FFS claims processing contractors (MACs, 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, Comprehensive Error Rate Testing (CERT) data and Recovery Audit Contractor data. The primary goal of the POE program is to reduce

the CERT error rate by giving Medicare providers the timely and accurate information they need to understand the Medicare program, be informed about changes and correctly bill Medicare claims. Medicare contractors utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms such as educational events and webinars.

Provider Enrollment, Chain and Ownership System (PECOS): PECOS is the national enrollment system for Medicare providers and suppliers. Providers and suppliers submit one or more enrollment forms to CMS either via paper or electronically in PECOS. Medicare providers and suppliers may also use PECOS to view and update their existing information. PECOS centralizes the enrollment data collected from the forms into one system and is used by Medicare contractors to enter, update, and review data. Increased funding in this category will be used to enhance the usability to align with regulations, statutes and agency needs; and provide training to the Medicare contractors and the provider and supplier community. In addition, the consolidation and redesign of enrollment forms and PECOS enhancements will streamline the process; reduce the amount of paperwork processed, and provide clearer guidance to providers on what they need to submit.

In FY 2014, key PECOS updates are focused on improving customer service, increased connectivity within CMS, and greater data integrity. Work will commence on moving the system and others to a Virtual Data Center (VDC). The enterprise Master Data Management system (MDM) will be used for analytical reporting and data extracts. Finally, work will begin to transition the National Provider Identifier Crosswalk System (NPICS) to PECOS. For FY 2015, funding will be needed to continue enrollment data collection and management, integrate NPICS into PECOS, and integrate provider enrollment data in the enterprise MDM system and with other systems within CMS.

Comprehensive Error Rate Testing (CERT): CMS developed the CERT program to produce a Medicare FFS improper payment rate to comply with the requirements of the Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). The IPIA requires Federal agencies to annually identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments in those programs, and report the estimates and actions the Agency is taking to reduce improper payment review and measure for the programs they oversee that are at risk for high levels of improper payments.

During FY 2015, CMS expects to accomplish the following:

- Measure and report improper payments in the Medicare FFS program; develop corrective actions; and report this information in the HHS Annual Financial Report as required by IPERIA;
- Conduct accuracy reviews for the MAC Medical Review Accuracy Award Fee Metric;
- Develop a CERT Live Data Dashboard to provide MACs with their current CERT data to focus their actions to reduce improper payments;
- Participate in the Electronic Submission of Medical Documentation (esMD) for CERT to allow CERT contractors to accept documents electronically; and
- Conduct a Security Control Assessment (SCA) on each of the CERT contractors' systems as required and providing contractors with additional funding to meet the information technology security requirements, if necessary.

VI. Medicaid Program Integrity Initiatives:

Payment Error Rate Measurement (PERM) in Medicaid and CHIP: CMS developed the PERM program to produce a Medicaid and CHIP improper payment rate to comply with the requirements of IPIA of 2002, as amended IPERA of 2010 and IPERIA of 2012. The IPIA requires Federal agencies to annually identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments in those programs, and report the estimates and actions the Agency is taking to reduce improper payment review and measure for the programs they oversee that are at risk for high levels of improper payments.

During FY 2015, CMS expects to accomplish the following:

- Measure and estimate the improper payments in the Medicaid and CHIP programs; develop corrective actions; and report this information in the HHS Annual Financial Report as required by IPERIA;
- Provide support to states, as needed, to conduct targeted reviews on areas at risk for improper payments (i.e., Mini-PERMs, which are voluntary smaller scale measurements of state improper payments during years when a state is not being measured under PERM);
- Participate in the Electronic Submission of Medical Documentation (esMD) for PERM to allow PERM contractors to accept documents electronically;
- Implement an interim methodology to conduct PERM eligibility reviews for FYs 2014 - 2016. Given the changes required by the Affordable Care Act, all states will participate in Medicaid and CHIP eligibility review pilots to provide targeted, detailed information on the accuracy of eligibility determinations. The pilots will provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors. The pilots will also help inform CMS' approach to rulemaking prior to the resumption of the PERM eligibility measurement component in FY 2017;
- Conduct a Security Control Assessment (SCA) on each of the PERM contractors' systems as required and provide contractors with additional funding to meet the information technology security requirements, if necessary;
- Develop a state policy database to collect states' policies for PERM;
- Procure an Eligibility Support Contractor to assist CMS with developing an updated PERM eligibility measurement process. The Eligibility Support Contractor's activities will include conducting research, developing program eligibility review guidance, conducting
- In August 2013, HHS released guidance announcing temporary changes to future PERM eligibility reviews, starting in 2014, in light of changes to the way States adjudicate eligibility for Medicaid and CHIP. HHS is working with states to implement changes, including PERM model eligibility review pilots with select states to test the revised PERM methodology.
- Developing options for harmonizing PERM and MEQC eligibility reviews.

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 accuracy of the measurement. This proactive measure helps CMS achieve a more accurate improper payment rate measure for the Medicaid and CHIP programs. The FY 2015 increase is due to increases in our operational contractors' costs (PERM Review Contractor, PERM Statistical Contractor).

National Correct Coding Initiative (NCCI): The goal of this statutory program is to protect Medicaid funds by reducing the number of improperly paid Medicaid claims through the use of standard methodologies, which include edits for state Medicaid claims. This initiative was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payments of Medicaid claims. Procedure-to-procedure (PTP) edits are automated prepayment edits that prevent improper payments when certain codes are submitted together. In addition to the PTP edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a single date of service for a single beneficiary. MUEs specify the number of times a procedure can be performed on the same beneficiary on the same date of service by the same provider without denying payment of all UOS on the claim line. New edits are continually developed in the NCCI program for states to use to screen Medicaid claims for codes that should not be submitted together and for UOS that should not exceed a certain limit on one claim line for that code.

In FY 2014 NCCI and MUE Program includes:

- A first time ever MUE Savings and Appeals Reports since the implementation of MUEs, January 1, 2007, which will capture contractor savings as well as vulnerabilities.
- Implementation of date of service (DOS) edits to prevent claim line and claim splitting, duplicate billing and overpayments.
- Assignment of the newly implemented MUE Adjudication Indicators (MAIs) for effective and appropriate processing claim based on "per day edits based on policy" and "per day edits for clinical benchmarks", which will decrease the amount of unnecessary appeals.

In FY 2015, the Medicare NCCI and MUE program, the CMS NCCI Workgroup and CMS Contractor will create a large volume of national procedure to procedure (PTP), and unit of service (UOS) edits, by assigning the appropriate code pairs, modifiers indicators, units values, MUE adjudication indicators (MAIs), consulting with national healthcare organizations and specialty societies, etc. The NCCI/MUE Workgroup and Contractor will continue to use a variety of valuable criteria such as certified data, clinical judgment, CPT code descriptions, CMS policy, supporting documentation, vignettes, etc.to validate the assignment of the PTP and UOS, to prevent overpayments and fraud and abuse.

State Readiness, Enrollment and Eligibility: Under the Affordable Care Act, states will be required to implement significant and substantial changes to their Medicaid programs, including eligibility determinations, plan management, financial management, customer service, and integration with new affordable insurance programs from health insurance exchanges. The Government & Accountability Office (GAO) has identified Medicaid as a

program at significant risk for overpayments. Eligibility is the major contributor to the payment error rate in Medicaid, as calculated by CMS. Implementation of the changes required by the Affordable Care Act presents an opportunity to address some of the long-standing problems identified in the PERM process through simplified business rules, automated verifications of submitted data, modernized systems, and associated changes in other areas of the Medicaid program.

Additionally, the Act presents some significant challenges and opportunities in ensuring that changes in the Federal Medical Assistance Percentage (FMAP) for the newly eligible Medicaid population are implemented by states in accordance with the statute and regulations. In order to ensure proper implementation of these and other changes, CMS has developed a technical assistance model to work closely with states as they implement the new requirements. A contractor will support the teams in the model as well as provide necessary short-term resources who can work directly with states.

Medicaid and CHIP Business Information Solutions (MACBIS): Begun in 2009, MACBIS is a CMS enterprise-wide initiative to ensure the data infrastructure and information technologies that support Medicaid, CHIP and the Basic Health Program (BHP) are commensurate to their role as the nation's largest health insurer. Today, the data that is available at the federal level for the Medicaid and CHIP programs is incomplete, not timely, and of questionable quality. To address the well-documented issues with Federal Medicaid and CHIP data, the CMS MACBIS Council implemented several short and medium term efforts to incrementally improve both the data and access to the data as well as explore long term opportunities to make radical improvements. The MACBIS Council identified two key transformational efforts:

- The Medicaid and CHIP Program (MACPro) System modernizes the work flows and business processes that support online submission, review and approval of State Plan Amendments (SPAs), waivers, and Advance Planning Documents (APDs). Once in place, the system will provide up-to-date data on programmatic features of Medicaid and CHIP as implemented by states.

- Transformed Medicaid Statistical Information System (T-MSIS) modernizes and enhances the way states submit operational data about beneficiaries, providers, claims, and encounters and will build a robust state and national analytic data infrastructure. Future releases of T-MSIS will incorporate calculation of quality measures and performance indicators.

Robust and timely data of this nature is crucial to identifying potential fraud, waste and abuse in the Medicaid, and CHIP programs. In addition, the transformed infrastructure will offer states, CMS, and others the ability to do the following at the national level:

- Study encounters, claims, and enrollment data by claim and beneficiary attributes;

- Analyze expenditures by medical assistance and administration categories;

- Monitor and track review processes for state submissions such as SPAs and waivers;

- Monitor expenditures within delivery systems and assess the impact of different types of delivery system on beneficiary outcomes;

- Examine the enrollment, service provision, and expenditure experience of providers who participate in our programs (as well as in Medicare);
- Observe trends or patterns indicating potential fraud, waste, and abuse in the program so we can prevent or mitigate the impact of these activities.
- Use informatics to improve program oversight and inform future policy and operational decisions.

Physician Transparency: This project is split- funded between mandatory funding associated with the Medicare Integrity Program and HCFAC discretionary funding associated with Medicaid program integrity. The funding table at the end of this chapter displays the estimated share covered by Medicaid. In February 2013, CMS published a final rule that require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. CMS will post that data to a public website. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests.

These organizations, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication. Data collection began on August 1, 2013. Applicable manufacturers and applicable GPOs will report the data for August through December of 2013 to CMS by May of 2014 and CMS will release the data on a public website by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process. This process of reporting and public posting will be an annual process. This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers. During FY 2014, CMS developed the technical capabilities for registration, data submission, data review and dispute and reporting capabilities for public posting. The public website was prepared for public posting and public query into the data. In order to verify the accuracy of the data and that it is matched to the correct covered recipient (physician or teaching hospital), CMS also with a technical contractor to monitor and validate the data prior to public posting.

During FY 2015, the program will shift from initial implementation to an operational mode. The ongoing operations of the program will require funding for system operations, expanding the reporting capabilities on the Open Payments website, ongoing data validation, auditing strategy and some education and analytics support. Communications, outreach and education are also vital to this program as there are millions of potential users of the system who must be educated about the program and rules of participation.

IT Shared Services: In FY 2015, CMS will create operational efficiencies while reducing long- term costs through the adoption of enterprise and shared services. This will lead to increased economies of scale through centralization of data, infrastructure and business applications. The shared service strategy will reduce costs associated with redundant development of capabilities and increase reliability, consistency, and repeatability of service outcomes. Shared services will improve customer satisfaction through timely delivery and

assessment of services that will be measured rigorously through performance management. Shared services will also implement the "architect before investment" principle that will promote better government practices. Four shared services strategies being implemented are as follows:

- Master Data Management (MDM) comprises processes, policies, and tools that consistently define master data. MDM links and aggregates beneficiary, provider, program, and organization data from multiple disparate sources across the agency creating a trusted authoritative data source.

- Enterprise Identity Management (EIDM) provides remote identity proofing (persons are who they say they are) via a single sign on, while meeting federal security requirements.

- The Enterprise Portal provides a framework for integrating information and processes onto a single platform and entry point for beneficiaries, providers, organizations, and states to receive CMS information, products, and services.

- Business Rules Enterprise Services (BRES) describe the operations, definitions and constraints that apply to CMS systems enterprise-wide.

VII. PRIVATE INSURANCE PROGRAM INTEGRITY:

Program Description and Accomplishments

In FY 2015, the Budget includes additional discretionary HCFAC funding for CMS to invest in activities related to program integrity in the private insurance market. These activities will include CMS program integrity responsibilities within the private market, including the Health Insurance Marketplaces. The additional funding will be available for spending over two years.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. Each of the 56 FBI field offices has personnel assigned specifically to investigate health care fraud matters. With national health care expenditures projected to exceed $2.9 trillion dollars in FY 2013, it is especially important to coordinate all investigative efforts to combat the significant fraud and abuse within the health care system. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as HHS/OIG, the FDA, the DEA, the Defense Criminal Investigative Service, the Office of Personnel Management-OIG, the Internal Revenue Service-CI, State Medicaid Fraud Control Units, and other state and local agencies. On the private side, the FBI is actively involved in the Healthcare Fraud Prevention Partnership, an effort to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. These efforts will enable members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud. In addition, the FBI maintains significant liaison with private insurance national groups, such as the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, other professional associations, and private insurance investigative units.

In FY 2013, the FBI initiated 674 new health care fraud investigations and had 2,868 pending investigations. Investigative efforts produced 794 criminal health care fraud convictions and 1,023 indictments and informations. In addition, investigative efforts resulted in over 425 operational disruptions of criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 115 health care fraud criminal enterprises.

FBI Budget Request

The FY 2015 FBI budget includes mandatory funding in the amount of $139.1 million, an increase of $11.8 million above the FY 2014 Enacted Level. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year CPI-U Annual Averages and Percent Change.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS/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 2013, OIG's Medicare and Medicaid oversight efforts resulted in 849 criminal actions and 458 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS/OIG excluded a total of 3,214 individuals and entities. For FY 2013, potential savings from legislative and administrative actions that were supported by HHS/OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $19.4 billion in Medicare savings and $834 million in savings to the Federal share of Medicaid.

OIG Budget Request

The FY 2015 OIG budget includes $200.3 million in base mandatory funding. The FY 2015 Budget also proposes an additional mandatory investment of $84.8 million for OIG. The FY 2015 discretionary request is $28.1 million and is equal to the FY 2014 Enacted Level. This request will support the joint HHS and DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and related program integrity efforts.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The DOJ's litigating components (United States Attorneys, Criminal Division, Civil Division, and Civil Rights Division) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

DOJ Budget Request

The FY 2015 DOJ budget estimate includes $62.5 million in base mandatory funding, which is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations. The FY 2015 Budget also proposes an additional mandatory investment of $79.6 million for DOJ, and the DOJ discretionary request for FY 2015 is $28.1 million, which is equal to the FY 2014 Enacted Level.
HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING

PROJECTS Program Description and Accomplishments

In addition to MIP, CMS also uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2014, negotiated amounts were $35.4 million for distribution among HHS components and $57.8 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, $35.6 million, funded the following activities during FY 2013:

CMS Medicaid Financial FTE: 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. States report an estimated $188 million in questionable reimbursement was averted in FY 2013 due to the funding specialists' preventive work with states to promote proper state Medicaid financing. Additionally, states report that CMS assistance contributed to removing an estimated $2.7 billion (with approximately $375 million recovered and $2.4 billion resolved) of approximately $9.7 billion identified in questionable Medicaid costs.

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds in support of litigation and enforcement activities that assist in the recovery of program funds. In FY 2013, OGC participated in FCA and related matters that recovered over $1 billion for the Government. The types of FCA cases that OGC participated included drug pricing manipulation; illegal marketing activity by pharmaceutical manufacturers that resulted in Medicare and Medicaid paying for drugs for indications not covered; underpayment of rebates to state Medicaid programs; physician self- referral violations; and provider coding cases.

Administration for Community Living (ACL) Senior Medicare Patrol (SMP) Grants & Support: This funding supports infrastructure, technical assistance, and the other SMP program support and capacity-building activities designed to enhance the effectiveness of statewide SMP programs. In FY 2013, the Secretary has provided this funding to enable the provision of grants to help more than 54 SMP programs fight Medicare fraud in high fraud states.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): This PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. In FY 2013, FDA initiated 23 criminal investigations, actively pursued several criminal prosecutions, and conducted a three day training seminar for criminal investigators and supervisors covering PFP related topics.

Office of Inspector General: These funds were used to support OIG mission critical functions, such as audits, evaluations and investigations. Additional information about OIG's FY 2013 activities is included in its budget justification.

HHS Wedge Budget Request

The FY 2015 HHS Wedge request includes mandatory funding of $38.3 million, which is an increase of $2.9 million above FY 2014 Enacted Level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations.

Performance Measurement

Please note: For more information about the Medicare Fee-for-Service, Parts C and D, and Medicaid/CHIP payment error rates, please see the FY 2013 HHS Agency Financial Report, Other Accompanying Information at http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf.

MIP1 Reduce the Percentage of Improper Payments Made under the Medicare Fee-for-Service (FFS) Program: We have made progress on our efforts to reduce the Medicare FFS error rate over the years; however, at a rate of 10.1 percent, we did not meet our FY 2013 target of 8.3 percent. The primary cause of improper payments is Administrative and Documentation errors, in large part due to insufficient documentation. Other notable causes include Authentication and Medical Necessity errors, caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding. Data shows that most improper payments resulted from claims paid for services that are clinically appropriate, if provided in less intensive settings. Physicians and durable medical equipment suppliers contribute substantially to insufficient documentation errors, and hospitals contributed substantially to medical necessity errors. Coding errors were most prevalent in physician services.

CMS is continuing to pursue strategies directed at specific regions, providers, and error types; including developing new data analysis procedures to identify payment aberrancies and using that information to preemptively stop improper payments and directing Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors.

Initiatives aimed at reducing Medicare FFS improper payments include:

- CMS implemented two demonstration projects to test the ability of these programs to reduce the incidence of improper payments in the future: Recovery Audit Prepayment Review and Prior Authorization of Power Mobility Devices.
- CMS implemented two major policies pertaining to inpatient hospital claims that are expected to reduce improper payments.
- CMS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of healthcare fraud, waste, and abuse.
- CMS, in close collaboration with its Regional Offices, holds program integrity education events for physicians and other providers.

- CMS requires its Medicare review contractors to focus their medical review efforts on identifying documentation errors in certain error prone claim types, such as home health, hospital outpatient, skilled nursing facility (SNF), and nonhospital-based hospice claims.
- CMS contracted with a Supplemental Medical Review/Specialty Contractor to perform medical reviews focused on vulnerabilities identified by CMS internal data analysis, the CERT program, professional organizations and Federal oversight agencies.
- CMS implemented the Medicare Part B Outpatient Therapy Cap Exceptions Process, which mandates manual medical review on claims when the beneficiary exceeds the $3,700 therapy annual threshold.
- CMS continues to allow Medicare Administrative Contractors (MACs) and Medicare Recover Audit Contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors.
- CMS continues to develop and issue comparative billing reports to help Medicare contractors and providers analyze administrative claims data.

While many successful initiatives to reduce the improper payment rate have been implemented, the factors contributing to the improper payment rate are complex. It also should be noted that many of CMS' significant corrective payment actions will not show up until future measurement periods. Our FY 2014 and FY 2015 targets are set at 9.9 percent and 9.8 percent, respectively.

MIP5 Reduce the Percentage of Improper Payments Made under the Part C Medicare Advantage Program : In FY 2013, CMS exceeded its Part C error rate target of 10.9 percent with an actual Part C error rate of 9.5 percent. The root cause of FY 2013 Medicare Part C improper payments resulted from administrative and documentation errors due to insufficient documentation to support diagnoses submitted by the plans. CMS has implemented three key initiatives to improve payment accuracy in the Part C program: physician outreach; Medicare Advantage organizational guidance and training; and contract-level audits;. The FY 2015 target is to reduce the Part C error rate to 8.5 percent.

MIP6 Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program: In FY 2013, CMS reported a result for Part D of 3.7 percent, falling short of our target of 3.1 percent. The FY 2013 Part D composite payment error rate amount is the sum of the payment error amounts for four component measures, divided by the overall Part D payments for the year being measured. The four components are: Payment Error related to Prescription Drug Event Data Validation (PEPV), Payment Error related to Low-income Subsidy, (PELS), Payment Error related to incorrect Medicaid Status (PEMS) and Payment Error related to Direct and Indirect Remuneration (PEDIR). The root cause of all improper payments in the Part D program reported in FY 2013 is administrative and documentation errors. The FY 2015 target for the Part D error rate is 3.5 percent.

MIP7 Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data: In their efforts to fight fraud, waste, and abuse in the Medicare program, the HEAT Strike Forces have utilized near real-time, CMS systems data to examine claims payment data for aberrancies, to identify suspicious billing patterns/trends, and to conduct surveillance on target providers and suppliers under investigation for potentially fraudulent practices. The purpose of this measure is for CMS to increase the number of law enforcement personnel with training and access to CMS program integrity data systems and applications. CMS met its FY 2013 target of training 100 percent of Law Enforcement referred for training and access, and will continue to offer and expand training for additional strike force law enforcement personnel.

MIP8 Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment and Payment Safeguard Actions: In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate, and reasonable services for beneficiaries. This goal is aimed at measuring CMS' ability to target high risk providers and suppliers effectively. To reflect statutorily mandated changes in CMS fraud prevention work and because of difficulties and anomalies in the reporting systems and data systems, CMS has redesigned this goal to reflect our direct fraud identification and prevention work—the National Fraud Prevention Program (NFPP). This goal aligns with provisions of the Affordable Care Act and the Small Business Jobs Act (SBJA) which added new requirements to use advanced predictive analytics to identify high risk providers. With funding authorized in the SBJA, CMS developed the FPS which allows for better tracking of administrative actions against high risk providers and suppliers.
Our predictive analytics work using FPS will focus on activities in areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. Our goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

Our FY 2012 baseline is from the first year of the FPS (July 2012) at a rate of 27 percent of Medicare providers and suppliers (identified through predictive analytics) as high risk that received an administrative action. We have set our FY 2013, FY 2014, and FY 2015 targets at a rate of 31 percent, 36 percent, and 42 percent respectively. In 2013, our actual rate of 31.8 percent exceeded our target of 31 percent and reflects success on CMS partnership efforts. CMS is partnering with HHS' Office of General Counsel and the Office of Inspector General, the Department of Justice, and the Federal Bureau of Investigation to implement the full spectrum of administrative actions, including those that result from referrals to law enforcement. Instances of potential fraud identified through predictive analytics are referred to law enforcement for additional civil and criminal remedies, which are powerful tools to assist CMS to protect the integrity of the Medicare Trust Fund and ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries.

MIP9.1 Estimate the Payment Error Rate in the Medicaid Program (previously MCD1.1)
The national rolling Medicaid error rate reported in the 2013 Agency Financial Report (AFR) is based on measurements that were reported in FYs 2011, 2012 and 2013. In FY 2013, CMS made two improper payment rate calculation methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate. These two enhancements include: (1) replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and (2) incorporating prior year state-level improper payment rate recalculations. The current national rolling Medicaid error rate is 5.8 percent. The national Medicaid error component rates are: Medicaid FFS: 3.6 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 3.3 percent. It is important to note that the 17 States measured and reported on in the 2013 AFR were the same States measured and reported on in the 2010 AFR. The Medicaid error rate for these States dropped from 9.4 percent in 2010 to 5.8 percent in 2013, causing the rolling Medicaid error rate to decrease. The re-measurement of this group of States reflects the impact of effective corrective actions implemented to decrease improper payments associated with eligibility errors. Specific corrective action strategies implemented included leveraging technology and available databases to obtain eligibility verification information without client contact; and providing additional caseworker training, particularly in areas determined by the PERM review to be error-prone. Our FY 2014 and FY 2015 targets are 5.6 percent and 5.5 percent respectively.

MIP9.2 Estimate the Payment Error Rate in the Children's Health Insurance (CHIP) (previously MCD1.2): For the CHIP PERM, CMS was required by Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to develop and publish a new final regulation. CHIPRA prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is in effect. Therefore, CMS temporarily suspended the CHIP PERM reviews. In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempted HHS from reporting a 2011 CHIP improper payment rate. As a result, CMS did not report a national improper payment rate for CHIP in the 2009 through 2011 AFRs. CMS resumed CHIP measurement and published a single-year national CHIP error rate in the 2012 AFR. The two Medicaid improper payment rate calculation methodology enhancements described in MIP9.1 also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of States have been measured for CHIP, requiring a slightly different approach to the single-year CHIP rolling improper payment rate. The FY 2013 national CHIP improper payment rate is 7.1 percent based on measurements conducted in FY 2012 and 2013. The national FY CHIP error component rates are as follows: CHIP FFS: 5.7 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 5.1 percent. Setting out-year target rates for CHIP is not possible until all states have been measured and a national CHIP baseline is established. The FY 2014 target is for CMS to report the rolling average error rate in the 2014 AFR. The CHIP baseline and 2015-2017 targets will be reported in the 2014 AFR.

MIP10 Reduce Provider Burden by Increasing the Identification Rate of an Improper Payment by the Recovery Auditors When Additional Documentation is Requested from Providers: As mandated by Section 302 of the Tax Relief and Health Care Act of 2006, CMS implemented the MFFS Recovery Audit Program in all 50 States to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The ACA expands the Recovery Audit Contractor Program to Medicaid, Medicare Advantage, and Medicare Part D. A decreasing overall appeal overturn rate means an increasing level of accuracy in recoveries obtained due to contractor auditing. As part of a demonstration to identify underpayments and overpayments, our FY 2008 appeals overturn rate was 8.2 percent, reported in FY 2010, almost two years after the end of the demonstration. After completion of the demonstration, CMS applied best practices and lessons learned to the national program. The FY 2011 target was to develop the baseline and future targets for the appeals overturn rate; however, as CMS measured FY 2010 and FY 2011, CMS learned that the rate was 2.4 and 2.7 percent, respectively. These rates are significantly lower than the demonstration rate, and show that the changes CMS made were effective in ensuring that only valid claims are denied by the Recovery Auditors. As a result of this low baseline, CMS no longer feels that this measure is appropriate for this program given we have a high level of accuracy.

For FY 2013 going forward, CMS will target reducing provider burden by increasing the identification rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers. CMS exceeded its 2013 target to increase the Recovery Auditor identification rate over the FY 2012 baseline of 28.5 percent with an actual rate of 39.4 percent.

Outcomes and Outputs

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015+/- FY2014
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Outcome)	FY 2013: 10.1% Target: 8.3% (Target Not Met)	9.9%	9.8%	-.1 pp
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program	FY 2013: 9.5% Target: 10.9% (Target Exceeded)	9.0%	8.5%	-.5 pp
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program	FY 2013: 3.7% Target: 3.1% (Target Not Met)	3.6%	3.5%	-.1 pp
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 2013: 100% Target:100%[1] (Target Met)	100%	100%	Maintain

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015+/- FY2014
MIP8: Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Outcome)	FY 2013: 31.8% Target: 31% (Target Exceeded)	36%	42%	+6 pp
MIP9.1: Estimate the Payment Error Rate in the Medicaid Program (Outcome)	FY 2013: 5.8% Target: 6.4% (Target Exceeded)	5.6%	5.5%	-.1 pp
MIP9.2: Estimate the Payment Error Rate in the Children's Health Insurance Program (CHIP)	FY 2013: 7.1% Target: Report rolling average error rate in the 2013 AFR (Target met)	Report rolling average error rate in the 2014 AFR	TBD	N/A
MIP10: Reduce provider burden by increasing the identification rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers	FY 2013: 39.4% Target: Increase the Recovery Auditor identification rate over the FY 2012 baseline by 5% (28.6%) (Target exceeded)	Increase the Recovery Auditor Identification rate by 5% over FY 2013	Increase the Recovery Auditor Identification rate by 5% over FY 2014	N/A

[1] CMS trained 150 new LE personnel

FY 2015 CMS HCFAC Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D			
Medicare Drug Integrity Contractors (MEDICs)	$25,300	$0	$25,300
Part C & D Contract/Plan Oversight	$28,314	$0	$28,314
Monitoring, Performance Assessment, and Surveillance	$55,117	$0	$55,117
Program Audit	$39,283	$0	$39,283
Compliance and Enforcement	$21,377	$0	$21,377
Total	**$169,391**	**$0**	**$169,391**
II. Program Integrity Staffing & Support			
Field Offices/Rapid Response/and Oversight Staffing	$10,726	$23,473	$34,199
Total	**$10,726**	**$23,473**	**$34,199**
III. Program Integrity Special Initiatives			
Automated Provider Screening	$3,519	$6,481	$10,000
1-800 Medicare Integration	$0	$3,200	$3,200
Case Management System	$0	$5,000	$5,000
Technology and Strategic Decision Support	$0	$2,000	$2,000
Beneficiary Fraud Outreach	$0	$4,000	$4,000
Joint Hospice Project	$0	$2,000	$2,000
Southern California Rapid Response	$0	$2,000	$2,000
Total	**$3,519**	**$24,681**	**$28,200**
IV. Prevent Excessive Payments			
Fraud Prevention System	$24,000	$0	$24,000
Fraud System Enhancements	$0	$2,000	$2,000
Command Center	$0	$2,000	$2,000
Benefits Integrity	$0	$29,880	$29,880
Medical Review	$0	$17,250	$17,250
Total	**$24,000**	**$51,130**	**$75,130**
V. Program Integrity Oversight Efforts			
Overpayment/Payment Suspension	$0	$5,000	$5,000
Compromised Numbers Checklist	$0	$1,400	$1,400
National Supplier Clearinghouse	$0	$27,822	$27,822
One PI Data Analysis	$0	$18,869	$18,869
HEAT Support / Strike Force	$0	$2,000	$2,000
Appeals Initiatives	$0	$4,654	$4,654
Healthcare Fraud Prevention Partnership	$0	$29,500	$29,500
Probable Fraud Study Database & Analysis	$0	$3,500	$3,500
Total	**$0**	**$92,745**	**$92,745**

FY 2015 CMS HCFAC Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
VI. Medicaid Program Integrity Initiatives			
Payment Error Rate Measurement (PERM)	$21,000	$0	$21,000
Correct Coding Initiative	$0	$1,500	$1,500
State Readiness, Enrollment and Eligibility	$0	$4,000	$4,000
Medicaid and CHIP Business Information Solutions (MACBIS)	$0	$7,236	$7,236
Physician Transparency	$4,000	$0	$4,000
Healthcare Fraud Prevention Partnership	$0	$4,500	$4,500
IT Shared Services	$4,708	$4,730	$9,438
Total	**$29,708**	**$21,966**	**$51,674**
VII. Private Insurance Program Integrity			
Private Insurance PI	$0	$25,000	$25,000
Total	**$0**	**$25,000**	**$25,000**
HCFAC Summary			
Total Medicare Integrity	**$207,636**	**$192,029**	**$399,665**
Total Medicaid Integrity	**$29,708**	**$21,966**	**$51,674**
Total Private Insurance Integrity	**$0**	**$25,000**	**$25,000**
Total CMS Funding Request	**$237,344**	**$238,995**	**$476,339**

Clinical Laboratory Improvement Amendments of 1988

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
BA	$53,543,000	$46,400,000	$50,000,000
FTEs	68	75	81

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

FY 2014 Authorization - One Year

Allocation Method – Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA strengthens quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens to diagnose, prevent, or treat illness or impairment. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 19,099 laboratories during the FY 2014-2015 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, 237,167 laboratories are registered with the CLIA program. Approximately 193,924 or 81.7 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 118,862 or 50.1 percent, of the laboratories registered under the CLIA program. Approximately 100,294 or 84.4 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of .5 percent for the FY 2014-2015 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 2015 CLIA budget request for CMS is $50 million. The CLIA program is a 100-percent user fee-financed program. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories. CMS then sets the national survey workload at 100 percent of the laboratories to be inspected in a two-year cycle. Workloads projected for the FY 2014-2015 cycle include surveys of 19,099 non-accredited laboratories, State validation surveys of 790 accredited laboratories, and approximately 1,333 follow-up surveys and complaint investigations.

Performance Measurement

CLIA2: Improve Laboratory Safety by Measuring the Outcome of Delivering Educational Materials Prior to an Educational Survey - The Clinical Laboratory Improvement Amendments (CLIA) ensure the quality of laboratory testing by requiring that all laboratories are certified by HHS and meet the CLIA provisions. The CLIA provisions are based on the complexity of tests performed by laboratories. CLIA imparts an exemption or a Certificate of Waiver (CW) of quality provisions to laboratories that perform only simple tests. "Simple" in this context refers to simple laboratory examinations and procedures that have an insignificant risk of an erroneous result, including those that employ methodologies that are so simple and accurate as to render the likelihood of erroneous results by the user negligible, or the Secretary of HHS has determined the test poses no unreasonable risk of harm to the patient if performed incorrectly.

Because of the significant growth of waived tests and laboratories, CMS developed a survey of the nations' waived laboratories. The surveys were designed to educate laboratories on sound laboratory practice, to gather information for CMS, to ensure that personnel conduct in laboratories is protecting patient safety, to determine laboratories' regulatory compliance and to ensure that CW laboratories are not performing more than simple test. 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 33 percent of CW laboratories in the same 20 States were in full compliance.

On January 23, 2012, we implemented a pilot to study the laboratories in the same 20 States to measure the impact of distributing educational materials prior to surveys with the aim of increasing the number of laboratories that are in full compliance with CLIA provisions. As of October 19, 2012, a total of 726 CW laboratories, from the 20 states selected to participate in this study, were sent the "READY, SET, TEST" booklet. This represents 41 percent of the total number of laboratories that were surveyed overall as part of the CW project. In total, 1,758 CW laboratories were identified for a survey (as of July, 2012, there were 153,568 registered CW laboratories). Of the 726 CW laboratories noted above, 318 (44 percent) were in full compliance and were qualified to receive a Letter of Congratulations.

We are pleased to report that we met our expectations for success. Based on the percentage of surveyed waived laboratories provided to waiver laboratories in full compliance with CLIA provisions for fiscal year 2011 (33 percent) compared to the percentage that were in full compliance and were qualified to receive a Letter of Congratulations for fiscal year 2012 (44 percent) we report over a 25 percent increase from 2011 to 2012. We therefore conclude that educational materials, like the "READY, SET, TEST" booklet, are well received by laboratories and serve as an effective means of improving the quality of laboratory testing. However, we recognize that additional efforts are still needed to further raise the compliance rate and will continue to pursue efforts to improve performance.

The FY 2014 target is to increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA by 2 percent over the FY 2013 actual. We remain cautious in our expectations to achieve greater than a 2 percent increase over FY 2012 because of the variability that exists with CW laboratories, high staff turnover, the limitations of human resources to train personnel and monetary considerations. Also, it is important to note that the laboratories surveyed in FY 2012 will not be the same group of laboratories surveyed in FY 2013. The FY 2015 target is to increase the number of States that are in full compliance with CLIA by 2 percent over the FY 2014 actual.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target+/- FY 2014 Target	FY 2015 Alternative Target	FY 2015 Alternate Target +/- FY 2015 Target
CLIA2: Increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA provisions.	FY 2012 44% (Target Exceeded)	+2% over FY 2013	+2% over FY 2014	+2%	N/A	N/A

Quality Improvement Organizations

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Budget Authority	458,600,000	1,648,900,000	724,700,000

Authorizing Legislation – Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended
FY 2015 Authorization – Expired
Allocation Method – Contracts

The 11th Statement of Work (SOW) will begin August 1, 2014 and will end July 31, 2019. The focus of the 11th SOW will expand on work started in the 10th SOW with emphasis on priorities set forth in the Patient Protection and Affordable Care Act of 2010 (ACA).

The 11th SOW will specifically support the goals set forth in the following titles of the Affordable Care Act:

- Title III. Improving the Quality and Efficiency of Health Care requires that the quality of care for seniors drives all of our decisions;
- Title IV. Prevention of Chronic Disease and Improving Public Health requires improved data collection and analysis, facilitates better data sharing, and requires the development of standards for the collection of data regarding the nation's health and the performance of the nation's health care, including health disparities; and,
- Title X: Strengthening Quality and Affordable Health Care for All Americans.

Program Description and Accomplishments

Under the Quality Improvement Organization 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.

- The 11th SOW will expand on work started in the 10th SOW with focus on Clinical Quality Improvement and Value Based Purchasing;
- The 11th SOW seeks to achieve better health care, better health, and lower healthcare costs;
- QIO funding comes directly from the Medicare Trust Funds and is permanently appropriated. Spending levels are controlled by an apportionment negotiated between HHS and OMB; and
- The 11th SOW has significant programmatic and structural improvements.

The 11th SOW will implement several changes to the program as enacted in the Trade Adjustment Assistance Extension Act of 2011 (the "Trade Law"), which provides the Secretary authority to:

- Determine the geographic scope of QIO contracts such that QIO activity is no longer restricted to a single entity in each state or territory;
- Extend the length of QIO contracts from three years to five years;
- Contract with a broader range of entities to perform QIO functions;
- Award certain QIO tasks to specialty contractors; and
- More easily terminate QIO contracts for poor performance in line with other Federal contracting rules and regulations.

CMS will align the 11th SOW with the Secretary's National Strategy for Quality Improvement in Health Care (the National Quality Strategy).

Funding History

FY 2009	$535,400,000
FY 2010	$175,400,000
FY 2011	$1,018,955,000
FY 2012	$372,800,000
FY 2013	$458,600,000
FY 2014	$1,648,900,000

Budget Request

Estimated QIO Funding 11th Statement of Work (2014-2018)

(dollars in millions)

QIO Clinical Quality Improvement	
Healthy People, Healthy Communities	$159.3
Better Healthcare: Patient-centered, Reliable, Accessible, & Safe Care	$325.4
Better Care at Lower Costs	$88.8
Technical Assistance, Phase II and III Tasks, and IT	$266.4
Subtotal, Clinical Quality Improvement	$839.9
Value Based Purchasing Support Contracts and Quality Measures	$1,129.4
Infrastructure, Coordinating Centers, and Special Initiatives	$562.0
Beneficiary and Family Centered Care	$402.5
Other Support Contracts and Staff	$1,061.8
Subtotal Funding	$3,995.6

Performance Measurement

CMS uses performance measures to support its mission and to inform the decision-making process. The following performance measures touch on the themes of the 10th SOW, as well as our efforts to improve oversight of the QIOs. As CMS transitions from the 10th SOW to the 11th SOW, we have developed additional performance measures to evaluate the employment of proven quality improvement techniques and beneficiary satisfaction.

QIO1 - Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those who Receive an Annual Vaccination for Influenza: For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend annual vaccination against influenza. The FY 2012 influenza result will not be available until April 2014. The FY 2011 influenza result of 82.5 percent, for beneficiaries residing in a long term care facility, did not exceed the FY 2011 target of 86 percent. Nationally, there is a 6 percentage point improvement from the FY 2010 result of 76.5 percent. Over the past few years, there has been a national decline of influenza immunization rates seen from 2008 to 2010 reported among the Medicare Current Beneficiary Survey (MCBS) Facility, MCBS Community, and the CDC's Behavior Risk Factor Surveillance System Community data. As a result of the QIO 10th SOW Improving Health for Populations and Communities Aim, eligible professionals will increase Medicare beneficiaries' understanding and utilization of the influenza immunization. Through the use of the Physician Quality Reporting System, electronic health records, this Aim will engage the participating professionals by implementing care management and tracking, and improve their patients' receipt of the influenza vaccine. Participating eligible professionals will utilize their electronic health records to facilitate immunization practices, document vaccination recommendations, and improve compliance with recommendations, allowing them to use decision support tools to improve quality of care, care coordination and better engagement of patients and families in making health care decisions. In CDC's Recent Influenza Vaccination Trends across Influenza Seasons, there have been changes in data sources, time periods, and vaccination recommendations across seasons. The 2009-10 influenza seasons were unique for several reasons: two vaccines were offered during two vaccination periods, and there was greater availability of information for more high risk conditions. It is expected that rates will improve over time, resulting in an 84.8 percent target for 2013, 85 percent in 2014, and 85.4 percent target for 2015.

QIO3 - Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol Testing: CMS is committed to improving care for its diabetic beneficiaries by increasing the rate of hemoglobin A1c (HbA1c) and cholesterol (LDL) testing. Multiple studies have demonstrated a relationship between well-controlled blood sugars as measured by HbA1c and protection against the development and/or progression of the

devastating complications of diabetes. Cardiovascular complications of diabetes are common and cause heart attacks, strokes and lower extremity amputations. Cardiovascular disease is the number one cause of death for diabetic patients. CMS improved over the previous year; however, the agency fell just short of its CY 2012 target of 89.5 percent (HbA1c) at a rate of 88.29 percent. The CY 2012 rate of 82.05 percent (LDL) no change from previous year and the 84.1 percent target was not met. We set the FY 2014 targets for HbA1c at 90.5 percent and (LDL) cholesterol testing at 86 percent. Recent evidence suggests that HbA1c is not as powerful a target as is effective blood pressure and lipid management in averting macro-vascular events and disease. CMS will continue to track this measure and consider it for modification as evidence emerges. We will set FY 2015 targets based on the QIO 11th SOW. In the 11th SOW, QIOs will recruit a subset of practitioner-owned/operated clinics or offices who will report on hypertension and other cardiovascular measures via the Physician Quality Reporting System (PQRS) measures via the CEHRT. Additionally, in the 11th SOW, the QIOs focus on recruitment shall be on those providers who manage patients with the greatest cardiovascular health needs and those most challenged to succeed in implementing evidence-based practices to improve cardiovascular health and support the Million Hearts® initiative.

MCR28 - Reduce Healthcare-Associated Infections: The QIOs play an important role in the Agency Priority Goal to reduce Central Line-Acquired Bloodstream Infections and Catheter-Acquired Urinary Tract Infections. For more information, please see measure MCR28in the Performance Measurement Section of the Program Operations chapter.

QIO5 - Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis: Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD) with approximately 372,000 Medicare beneficiaries receiving this treatment. The three current types of vascular access are: arteriovenous fistula (AVF), catheter, and graft. For many ESRD patients, an AVF is the preferred type of vascular access due to lower rate of infection and clot formation, resulting in greater longevity than other types of vascular access. As a result of increasing AVF prevalence, CMS has taken great strides in improving the quality and safety of dialysis-related services provided for individuals with ESRD, as well as reducing the long-term resources required to maintain the health of these individuals. Based on our results to date, our FY 2013, FY 2014 and FY 2015 targets reflect a continuation of improvement from 2012, while acknowledging that performance is progressing towards maintaining previous achievements. Reporting for FY 2013 indicates achievement of 61.6 percent, exceeding the FY 2013 target of 61 percent. Moving the target to a percentage greater than 62 percent may not represent significant change. Clinically viable vascular accesses have been achieved with a national level of less than 10 percent of ESRD patients utilizing a catheter as their primary access point. An additional increase in the target may cause negative unintended consequences for this population. .

QIO6 - Improve Oversight of Quality Improvement Organizations: The purpose of this goal is to ensure that CMS' efforts in overseeing the QIOs are aligned with the performance targets in the QIO 10th SOW. These targets are important as they are designed to measure improvements in the quality of care for Medicare beneficiaries at a national level. QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The 9th SOW ended July 31, 2011, and represented a change from previous QIO contracts, since it held all QIOs accountable for meeting specific, predefined performance targets under four major themes. CMS was successful in improving QIO 9th SOW oversight by conducting routine quarterly monitoring of the metrics, and requesting immediate correction of identified problems. Under the 10th SOW, which began August 1, 2011, QIOs will be evaluated on achievement associated with meeting the "Drivers" performance expectations and contract monitoring evaluation targets; for FY 2012, CMS has achieved all four of its targets. The "Drivers" for performance are: a) Supporting and Convening Learning and Action Networks, b) Providing Technical Assistance, and c) Care Reinvention through Innovation Spread Model. Please note that CCSQ will be transitioning from the 10th SOW to the 11th SOW, and will use this goal to evaluate the transition of the new QIOs to the new contracts.

QIO7- Make Care Safer via Recruitment of Low Performing Nursing Homes (NH) (One-Star NH) through the National Nursing Home Quality Care Collaborative (NNHQCC): More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the Nation's 15,600 nursing homes on any given day. The Affordable Care Act called for CMS to develop a strategy that will guide local, state and national efforts to improve the quality of care in nursing homes. In December 2008, CMS added a star rating system to the Nursing Home Compare (http://www.medicare.gov/nursinghomecompare/search.html) website. This rating system serves three purposes: to provide residents and their families with an assessment of nursing home quality, to make a distinction between high and low performing nursing homes, and to provide incentives for nursing homes to improve their performance. The one star hospital rating is the lowest rating and the five star rating is the highest. The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of Nursing Homes and other activities, shall support the creation of a National Nursing Home Quality Care Collaborative (NNHQCC). The purpose of the NNHQCC is for it, along with its partners, to ensure that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO shall support the Collaborative objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction." Although the QIN-QIO will recruit one-star nursing homes, all nursing homes or facilities providing long term care services to Medicare beneficiaries are eligible to participate in the Collaboratives and the QIN-QIO will encourage them to participate. One-star nursing homes face specific challenges including lack of understanding of quality improvement processes; lack of resources to implement the processes; poor understanding of the data for use in improvement; lack of leadership; and patient and family engagement. Participation in the NNHQCC will entail peer-to-peer learning activities in an "all teach/all learn" environment involving virtual, face-to-face meetings, and quality improvement activities which help guide the

nursing home to engage in the use of facility specific data for rapid-cycle-PDSA activities to improve systems-level improvement in the individual nursing home. Recruitment goals are measured at the start of each collaborative and continued engagement in collaborative activities is monitored throughout the life of each collaborative via the facilities' individual Composite Scores and outcome measures, such as the decreased use of antipsychotic medication in residents with dementia. This measure will assess the ability of the QIN-QIO to gain participation, in peer to peer quality improvement activities as measured by the percentage increase of one-star nursing homes participating in the NNHQCC through 2018 and therefore ensure safer care received by Medicare beneficiaries. While we plan to begin with measuring participation in the early years of the project, the goal is to move toward measuring improvement utilizing the composite score of each participating nursing home as the project matures.

QIO8 - Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Complaint Resolution: The primary focus of the Beneficiary and Family Centered Care (BFCC) QIO work is to improve healthcare services for Medicare beneficiaries, through the QIO-performance of statutory review functions. This includes, but is not limited to, quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment & Labor Act reviews. Beneficiary satisfaction with the review process has been mixed with concerns regarding the quality of the reviews and the impartiality of the reviewers. CMS has implemented several process improvements that will begin in 2014. As a result of the flexibilities provided by the Trade Bill, CMS has restructured the program to address these concerns. The BFCC QIOs will develop activities that engage patients and families, with the goal to increase patient knowledge, skill, and confidence in taking an active role in managing patient health and health care. Patient and family engagement in these activities will be captured on the Beneficiary Satisfaction surveys. This measure evaluates beneficiary satisfaction with the QIO's resolution of quality of care complaints. The measure also holds QIOs accountable for engaging patients and families to ensure that the review process is continuously improved. CMS has begun to measure beneficiary satisfaction with the quality of care complaints process. Our FY 2015 target is to increase the percentage of beneficiaries who are satisfied with the resolution of their complaint. We will set our FY 2015 target once the baseline has been established from 10th SOW data.

Outputs and Outcomes

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
QIO1 Increase influenza immunization (nursing home subpopulation) (Outcome)	FY 2011: 82.5% Target: 86% (Target Not Met but Improved)	85%	85.4%	+.4%
QIO3.1 Increase hemoglobin A1c (HbA1c) testing rate (Outcome)	FY 2012: 88.29% Target: 89.5% (Target Not Met but Improved)	90.5%	TBD	N/A
QIO3.2 Increase cholesterol (LDL) testing rate (Outcome)	FY 2012: 82.05% Target: 84.1% (Target Not Met)	86%	TBD	N/A
QIO5 Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis (Outcome)	FY 2013: 61.6% Target: 61% (Target Exceeded)	62%	62%	0

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
QIO6.5a Improve Health for Populations and Communities (Outcome)	FY 2013: 100% of pertinent QIOs populated the DDST Quality Data Reporting system with data that demonstrated provider assistance on EHR implementation. Target: 100% of the QIOs will populate the DDST Quality Data Reporting system with data that demonstrates provider assistance on EHR implementation (Target Met)	80% of the QIOs will meet the overall performance expectations for the 10th SOW	100% of new QIOs will have completed a successful transition to the 11th SOW	N/A

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
QIO6.5b Improve Individual Patient Care (Outcome)	FY 2013: 83% of the QIOs met the expectations towards the 18th month targets for HAIs. Target: 80% of the QIOs will meet expectations towards the 18th month targets for Urinary Catheter Utilization Rates, CLABSI (Central Line-Associated Bloodstream Infection), CAUTI (Catheter-Associated Urinary Tract Infection), CDI (Clostridium difficile Infection), pressure ulcer prevention treatment practices and reduction of adverse drug events (Target Exceeded)	80% of the QIOs will meet expectations towards the overall 10th SOW targets for Urinary Catheter Utilization Rates, CLABSI, CAUTI, CDI, pressure ulcer prevention treatment practices and reduction of adverse drug events.	100% of new QIOs will have completed a successful transition to the 11th SOW	N/A

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
QIO6.5c Integrate Care for Populations and Communities (Outcome)	FY 2013: 90% of communities' demonstrated improvement based on 4 time series graphs showing improvement s. Target: The QIOs will demonstrate that 25% of communities are demonstrating improvement based on 4 time series graphs showing improvement towards all targets (Target Exceeded)	80% of the QIOs will meet the overall performance expectations for the 10th SOW	100% of new QIOs will have completed a successful transition to the 11th SOW	N/A
QIO6.5d Beneficiary and Family Centered Care (Outcome)	FY 2013: 87% of the QIOs met performance expectations. Target: 80% of the QIOs will meet the 18th month (quarter 6) performance expectations (Target Exceeded)	80% of the QIOs will meet the overall performance expectations	100% of new QIOs will have completed a successful transition to the 11th SOW	N/A

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Target +/- FY 2014 Target
QIO7 Making Care Better and Safer - Improve nursing home safety by recruiting under-performing nursing homes via collaboratives to provide peer to peer improvement of Medicare beneficiary healthcare. Baseline: Zero (0)	N/A	N/A	Recruitment of 50% of One-Star category target count by the end of FY 2017.	N/A
QIO8 Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints. Baseline (2014) - TBD	N/A	N/A	TBD—FY 2015 Target set when FY 2014 baseline is available	N/A

Medicare Benefits
(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	$589,475,000	$598,611,000	$611,985,000	$13,374,000
Outlays	$586,877,000	$598,545,000	$611,919,000	$13,374,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process. The estimates are based on the FY 2015 President's Budget, and include the effects of the sequester orders for FY 2013 and FY 2014. They do not include expected savings from Program Integrity initiatives.

Authorizing Legislation - Title XVIII of the Social Security Act
FY 2015 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 55.2 million beneficiaries in FY 2015.

The Medicare Hospital Insurance program, also known as Medicare Part A or HI, is normally provided automatically to people aged 65 and over who qualify for Social Security benefits. This program is also extended to most disabled people who are entitled to Social Security or Railroad Retirement benefits. The Hospital Insurance program pays for inpatient 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 these taxes are primarily used to pay benefits for current beneficiaries, funds not currently needed to pay benefits and related expenses are held in the Hospital Insurance 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 92 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 must provide all Medicare covered services. Further, MA plans assume financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services to beneficiaries, such as vision and dental benefits, which are not available under Part A or Part B; many also offer Part D coverage of prescription drugs in addition to medical benefits. MA plans have an estimated 15.8 million enrollees in FY 2015.

The Prescription Drug Benefit Program, also created by the MMA, is funded through the SMI Trust Fund, and provides 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 41 million in FY 2015, including 39.8 million enrolled in Part D plans and 1.7 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, the Act offers a discount for prescription drugs in 2011 and beyond, to applicable beneficiaries who reach the coverage gap before the end of each calendar year after 2010.

Outlays History

FY 2009	$497,635,667,000
FY 2010	$518,948,805,000
FY 2011	$557,732,000,000
FY 2012	$549,311,000,000
FY 2013	$586,877,000,000
*FY 2014	$598,545,000,000
*Estimate Under Current law	

Budget Estimates

The budget estimates for Medicare benefit outlays for FY 2015, by trust fund account, are shown in the following table.

	FY 2015	+/- from FY 2014
HI	$280,599,000,000	+$1,782,000,000
SMI – Part B	$254,946,000,000	+$2,435,000,000
SMI – Part D	$76,374,000,000	+$9,157,000,000
Total	$611,919,000,000	+$13,374,000,000

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

The estimate for FY 2015 is an increase of $13,374,000,000 from FY 2014. This increase is due to higher enrollment, and increasing medical service utilization and costs.

Performance Measurement

MCR1 Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive: CMS has monitored Medicare Fee-for-Service (FFS) and Medicare Advantage access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. As the Affordable Care Act (ACA) is implemented, we will continue to include measures to monitor FFS and MA access to care in order to maintain the same high rates for our beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: "Percent of persons with FFS (or MA Plans) report they usually or always get needed care right away as soon as they thought they needed it." CMS met or exceeded our FY 2013 targets reflecting beneficiary experience in FFS and MA access to care in 2012. For FY 2014 and FY 2015, we want at least 90 percent of beneficiaries surveyed to report that they have access to care in the FFS and MA programs.

MCR23 Reduce the Average Out-of-Pocket Share of Prescription Drug Costs While in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non Low- Income Subsidy (LIS) Medicare Beneficiaries Who Reach the Gap and Have No Supplemental Coverage in the Gap: CMS will measure the success of the Affordable Care Act (ACA) Coverage Gap Discount Program, which reduces the amount Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap, by measuring the average percent of drug costs beneficiaries must pay while in the coverage gap. Discounts are provided through a combination of rebate checks for 2010, and significant manufacturer discounts and increased

Medicare coverage according to a predetermined scale for years 2011 through 2020. CMS exceeded its FY 2012 target of 58 percent with an actual result of 57 percent. In FY 2013, beneficiaries in the coverage gap saw their average out-of-pocket share of prescription drug costs reduced to 47.5 percent for brand drugs and 79 percent for generic drugs. To reflect current analysis using baseline data and applying the discounts that will be available to beneficiaries through 2015, CMS set the FY 2013 target at 55 percent, FY 2014 target at 53 percent, and the FY 2015 target at 50 percent.

MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit: CMS measures 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 ACA added this benefit with no copayments or other cost-sharing on the part of the beneficiary if the doctor or other health care provider accepts assignment. The AWV includes elements that focus on (1) assessing health risks, (2) furnishing personalized health advice and referrals, as appropriate to health education and preventive counseling services, and (3) creating a screening schedule for the next five to ten years and a list of risk factors and conditions as well as ongoing and/or recommended interventions. CMS developed the baseline with CY 2011 data of 2.3 million beneficiaries, and set the CY 2013 target at 2.8 million and the CY 2014 target at 3.2 million. After FY 2014, we will no longer set targets for this measure, but will report the trend annually as a contextual measure. Additional information about preventive services provided to Medicare beneficiaries is available at http://www.cms.gov/apps/files/MedicareReport2012.pdf.

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Outcomes and Outputs

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/-FY 2014 Target
MCR1.1a Maintain or Exceed Percent of Beneficiaries in Medicare Fee-for-Service (FFS) Who Report Access to Care (Outcome)	FY 2013: 91% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR1.1b Maintain or Exceed Percent of Beneficiaries in Medicare Advantage (MA) who Report Access to Care (Outcome)	FY 2013: 91% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR23 Reduce the Average Out-of-pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have No Supplemental Coverage in the Gap (Outcome)	FY 2011: 57% (Historical Actual)	53.0%	50%	-3 percentage points
MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Outcome)	FY 2012: 3.2 million Target: Set baseline (Baseline)	3.2 million	N/A	N/A

Children's Health Insurance Program

	FY 2013 Actual	FY 2014 President's Budget	FY 2015 Estimate
State allotments (CHIPRA of 2009, P.L. 111-3) ; P.L 111-148)	$17,406,000,000	$19,147,000,000	$21,061,000,000
CHIP Performance Bonus Payments [1] (P.L. 111-3)	$6,656,869,000	$8,387,568,000	$1,751,000,000
Child Health Quality Improvement (P.L. 111-3)	$45,000,000	$0	$0
Total Budgetary Resources	**$24,107,869,000**	**$27,534,568,000**	**$22,812,000,000**
Total Outlays	**$9,468,580,000**	**$10,189,000,000**	**$10,521,000,000**

[1] Funding levels reflect carry-forward balances from prior years and rescissions enacted in each current year and do not represent new appropriations. The FY 2015 level for CHIP Performance Bonus Payments is subject to change due to adjustments throughout the year.

FY 2015 Authorization – Public Law 111-148
Allocation Method - Formula Grants

Authorizing Legislation - The Balanced Budget Act of 1997 (BBA) (P.L. 105-33), the Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113), the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3), and the Patient Protection and Affordable Care Act (P.L. 111-148)

Child Enrollment Contingency Fund

(The Child Enrollment Contingency Fund is set up as a separate interest-bearing account in the United States Treasury Department)

	FY 2013 Actual	FY 2014 President's Budget	FY 2015 Estimate
Child Enrollment Contingency Fund	$2,092,718,000	$2,095,784,000	$2,098,648,000
Interest Estimate	$3,066,000	$2,864,000	$0
Total Budgetary Resources	**$2,095,784,000**	**$2,098,648,000**	**$2,098,648,000**
Total Outlays	**$13,508,624**	**$100,000,000**	**$100,000,000**

FY 2013 - FY 2015 figures reflect carry-forward balances from previous year and do not represent new appropriations.

Authorizing Legislation - The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3).

Program Description and Accomplishments

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a Federal-State matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program was the largest single expansion of health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States have the option to expand Medicaid (title XIX) coverage, set up a separate CHIP program, or have a combination of Medicaid expansion and separate CHIP programs.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44 billion through FY 2013 to maintain State programs and to cover more insured children. More recently, the Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $28.8 billion in budget authority over the baseline.

Since September 1999, all States, Territories, Commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review States' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibility to make innovative changes. As of July 31, 2013, CMS has approved a total of 479 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 enrollment increase on a per child basis equal to a portion of the State's annual per capita Medicaid expenditure on children. In order to receive a performance bonus payment, States must implement 5 of 8 enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation and in future years any unobligated national allotments, and excess funds beyond the aggregate cap for Child Enrollment Contingency Fund amounts may be transferred to this account.

- 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 $3,066,000 in interest in FY 2013 and is estimated to accrue $2,864,000 in FY 2014. To date, only one state (Iowa) has received shortfall funds through the Contingency Fund.

- Child Health Quality Improvement in Medicaid and CHIP – Section 1139A of the Social Security Act requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. Other CHIPRA requirements include developing a standardized reporting format that encourages States to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the State plan under Medicaid or CHIP, and several grants and contracts to develop and test these quality measures. A total of $225 million ($45 million per year for FYs 2009-2013) was appropriated for the Secretary to carry out these activities. Funds for these activities are available until expended. This initiative is also discussed in the performance measurement section of this chapter.

  The current status of Child Health Quality Improvement activities in Medicaid and CHIP include:

  CHIPRA Pediatric Quality Measures Program:

  - A State Health Official Letter was issued February 14, 2011 outlining the initial core set of children's health care quality measures and reporting guidance. Since spring 2012, CMS and the Agency for Healthcare Research and Quality (AHRQ) have collaborated to identify an improved core set of children's health care quality measures, as required by CHIPRA. CMS released the first set of improvements to the Core Set in a January 2013 State Health Official Letter which outlined the updates to the Child Core Set, including the retirement of one measure and the addition of three new measures (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf). In December 2013, CMS released the 2014 updates to the Core Set via informational bulletin (three measures were retired), available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf. In 2014, we are continuing to work with AHRQ and are contracting with the National Quality Forum's Measures Application Partnership to serve as the multi-stakeholder group that will suggest ways to strengthen the 2015 Child Core Set.

  - Over the past two years CMS has held multiple technical assistance calls, webinars and released issue briefs for states to provide clarification and guidance about collecting and reporting the Child Core Set measures.

  - To increase the number of States consistently collecting, reporting, and using the Child Core Set measures, CMS established a national "Technical Assistance and Analytic Support Program" with an award of a contract to Mathematica Policy Research in May 2011. Over the past three years CMS has held multiple technical assistance calls, webinars and released issue briefs for states to provide clarification and guidance about collecting, reporting, and using the Child Core Set measures to drive improvements in health care. As part of these activities, CMS also

releases an annual technical specification and resource manual for states. CMS sponsored a three session quality improvement series to increase states' knowledge about how to design and implement quality improvement projects. Building off of the quality improvement series, CMS is currently running a second, more targeted series with 10 Medicaid agencies that are focused on improving maternal and infant health.

- State data derived from the voluntary core measures are part of the Secretary's Report on the Quality of care for Children in Medicaid and CHIP (link to 2013 report: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf) published annually. Over the next year, CMS with the support of its technical assistance contractors will continue to conduct additional analyses on data submitted by states.

- On March 1, 2011, CMS, in collaboration with the AHRQ, awarded $55 million dollars in four year cooperative agreement grants to seven Centers of Excellence with diverse talents and expertise that will develop measures of healthcare quality for children. In 2011 and 2012, the Centers of Excellence received measurement development assignments covering maternal/infant, child and adolescent health measurement priority topics such as: care coordination, content and follow-up of well-care visits, sickle cell, pediatric readmissions, cost and efficiency. The Centers of Excellence will continue to develop measures over the next year and a half on a rolling basis. Likewise, the Office of the National Coordinator, working through an IAA with CMS, will continue to develop a small set of measures for inclusion in future stages of the Health Information Technology for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) Incentive Program.

- The Centers of Excellence meet monthly via conference call to discuss measurement activities, early challenges, and receive updates from each other.

CHIPRA Electronic Health Record Program:

- CMS and the AHRQ completed an initial inter-agency agreement (IAA) to develop a children's (EHR) format, released publically in February 2013 (http://www.ahrq.gov/news/newsroom/press-releases/2013/childehrpr.html).

- The format includes a minimum set of data elements and applicable data standards that can be used by EHR developers seeking to create a product that can capture the types of health care components most relevant for children. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting. The format allows for interoperable exchange of data, is compatible with other EHR standards, and facilitates quality measurement and improvement through collection of clinical quality data.

- The format was transitioned to the United States Health Information Knowledgebase (USHIK) website in 2013, an on-line, publicly accessible registry and repository of healthcare related data, metadata, and standards. USHIK is funded and directed by AHRQ with management support and partnership from CMS and CDC's National Center for Health Statistics.The format is currently available for viewing at: http://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf

- Two CHIPRA Quality Demonstration Grantees, Pennsylvania and North Carolina, continue testing the impact of the Children's EHR format.

- CMS and AHRQ will assess additional opportunities for enhancing the format through a new IAA in 2014, including wider use of interoperable data collected across school-based, primary, and inpatient care settings.

CHIPRA Quality Demonstration Grants:

- CMS awarded the first $20,000,000 in demonstration grants to ten States on February 22, 2010. All grantees continue to meet expectations and will be awarded fifth year demonstration awards in February 2014.

- As outlined in the Special Terms and Conditions, all grantees are required to submit semi-annual progress reports. The first report was submitted to CMS on August 1, 2011. Grantees will continue to submit semi-annual progress reports through the end of the grant program.

- CMS continues to host monthly all-grantee calls. CMS staff facilitates calls and grantees present early successes and challenges on topics identified by the grantees. The 2012-2013 call topics include asthma management best practices, integration of EHRs to support medical home transformation, improving access to oral health; and methods for engaging patients in their care and self-management. The 2014 call topics will delve into topics such as sustainability and spreading best practices.

- In August 2013, CMS hosted five, two-hour national webinars highlighting early lessons learned from the Grantees.

- The National Evaluation of the CHIPRA Quality Demonstrations is led by Mathematica Policy Research and funded by CMS through an interagency agreement with the AHRQ. National evaluation activities for 2012 included site visits to all 10 Grantee states. The National Evaluation website, which is hosted by the AHRQ website, launched in August 2012. In early 2013, the National Evaluation team released its first evaluation highlight, entitled "How are CHIPRA demonstration States approaching practice-level quality measurement and what are they learning?" (http://www.ahrq.gov/policymakers/chipra/demoeval/highlights/highlight01.pdf). Over the past year, CMS has partnered with AHRQ and the National Evaluation team to complete seven more evaluation highlights covering topics such as: how grantees are implementing medical home models and strategies grantees are using to improve adolescent health care. Over the next year, the National Evaluation team will continue to work with AHRQ and

CMS to develop additional evaluation highlights and strategy guides for states based on lessons learned from the grantees.

Performance Measurement

CMS is committed to improving quality of care and to increasing enrollment of eligible children in the CHIP program, as illustrated by our efforts to track and improve performance in those areas. Our past efforts have resulted in dramatic improvement in States' reporting of CHIP health quality performance information.

MCD6 Improve Children's Health Quality Across Medicaid and CHIP through Implementation of the CHIPRA Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary State collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and States, CMS identified and published an initial core set (Child Core Set) of twenty-four children's quality measures. Section 1139A9b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the initial Child Core Set. In 2013, based on stakeholder feedback, CMS added three measures (HPV vaccinations for female adolescents; medication management for people with asthma, and behavioral risk assessment for pregnant women) and retired one measure (otitis media with effusion).

While the use of the Child Core Set is voluntary for States, CMS encourages all States to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2012, 92 percent of States reported on at least five quality measures, exceeding the CMS target to work with States to ensure that 80 percent of States report on at least five quality measures in the children's core set of measures. The FY 2015 target is to work with States to ensure that 90 percent of States report on at least nine measures in the Child Core Set.

CMS will continue to work with our Technical Assistance and Analytic Support (TA/AS) Program to provide States with specific clarifications on measurement collection questions; hold all-state webinars around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance, CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. Further, as the TA/AS program continues to mature, CMS is expanding the scope of the technical assistance to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

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

Enrollment in CHIP or Medicaid should be viewed in the context of overall children's enrollment in both programs. Many factors will affect enrollment in CHIP and Medicaid, including States' economic situations, and programmatic changes, and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In previous years, CMS set separate targets for Medicaid and CHIP. Beginning in FY 2013, we began to track combined Medicaid and CHIP enrollment. The FY 2015 target is to increase CHIP and Medicaid enrollment to 47,642,385 children, (Medicaid: 38,920,959/CHIP: 8,721,426), nearly 28 percent more children than were covered in FY 2008**.**

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/-FY 2014 Target
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2012: 92% of States reported on at least five quality measure Target: 80% of States report on at least five quality measure in the CHIPRA core set of quality measures (Target exceeded)	Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90% of States report on at least nine quality measures in the CHIPRA core set of quality measures	+ 1 Measure

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 Target +/-FY 2014 Target
CHIP3.3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid[1]	Combined target begins FY2013 FY 2012: 44,453,639 children (CHIP: 8,148,397/ Medicaid: 36,305,242) Historical Actual	+25% over baseline 46,617,385 children (CHIP: 8,533,789/ Medicaid: 38,083,596)	+28% over baseline 47,642,385 children (CHIP: 8,721,426/ Medicaid 38,920,959)	+1,025,000 children

[1] The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

State Allotment Funding History

FY 2005	$4,082,400,000
FY 2006	$4,365,400,000
FY 2007	$5,690,000,000
FY 2008	$6,640,000,000
FY 2009	$10,602,000,000
FY 2010	$12,518,000,000
FY 2011	$13,459,000,000
FY 2012	$14,982,000,000
FY 2013	$17,406,000,000
FY 2014	$19,147,000,000
FY 2015	$21,061,000,000

Budget Request

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) authorized and appropriated $40 billion for CHIP allotments to States, Territories, Commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113) authorized and appropriated additional funding for CHIP allotments to Commonwealths and Territories. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) authorized funding for States, Commonwealths, and Territories. Under this appropriation, funding to States increased by $44.0 billion above the baseline over five years. Additional provisions added through CHIPRA include Performance Bonus Payments, the Child Enrollment Contingency Fund, and Child Health Quality Improvement in Medicaid and CHIP (discussed earlier in this chapter). Information regarding additional provisions provided by CHIPRA can be found in the State Grants and Demonstrations chapter. In addition to CHIPRA, the Affordable Care Act extends Federal funding for CHIP through FY 2015, appropriating $19,147,000,000 in FY 2014 and $21,061,000,000 in FY 2015.

CHIP Proposals

Permanently Extend Express Lane Eligibility for children

The authority to operate Express Lane Eligibility expires at the end of FY 2014, and the Budget supports an extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP-eligible children. See the Medicaid chapter for additional information on this proposal [$1.1 billion including $345 million in CHIP costs over 10 years].

Extend the CHIP Performance Bonus Fund

The Administration remains committed to providing affordable, comprehensive coverage for children covered by CHIP and the budget proposes to extend the CHIP performance bonus fund in anticipation of our work with Congress to ensure their coverage. The last bonus payment for enrollment performance during FY 2013 was made in December of 2013. The Budget supports a one-year extension of payments made for enrollment gains in FY 2014 as well as new programmatic requirements for states to qualify for payment.

FY 2013 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	**FY 2013 Actual**	**FY 2014 Estimate**	**FY 2015 Estimate**	**Difference +/- 2014**
Alabama	$162,846,151	$173,058,845	$218,095,431	$45,036,586
Alaska	$20,557,808	$21,847,065	$25,900,460	$4,053,395
Arizona	$25,391,861	$27,043,257	$79,920,333	$52,877,076
Arkansas	$103,117,581	$109,672,923	$114,588,132	$4,915,209
California	$1,296,015,369	$1,377,293,364	$1,715,706,729	$338,413,365
Colorado	$131,840,929	$140,521,788	$143,544,595	$3,022,807
Connecticut	$41,328,391	$43,920,250	$41,961,253	-$1,958,997
Delaware	$15,738,408	$16,740,286	$17,863,075	$1,122,789
District of Columbia	$14,867,242	$16,307,193	$16,863,032	$555,839
Florida	$359,046,879	$382,280,490	$445,772,419	$63,491,929
Georgia	$282,708,900	$300,850,804	$357,190,287	$56,339,483
Hawaii	$25,809,390	$27,464,952	$25,157,469	-$2,307,483
Idaho	$35,957,213	$38,212,225	$45,831,656	$7,619,431
Illinois	$275,565,527	$292,847,277	$378,522,700	$85,675,423
Indiana	$144,858,329	$153,942,939	$142,338,818	-$11,604,121
Iowa	$92,496,029	$98,296,803	$108,585,966	$10,289,163
Kansas	$55,399,040	$58,873,322	$66,921,211	$8,047,889
Kentucky	$147,885,689	$157,160,156	$159,088,250	$1,928,094
Louisiana	$171,875,479	$182,927,060	$172,703,949	-$10,223,111
Maine	$31,478,783	$33,452,936	$31,583,853	-$1,869,083
Maryland	$160,474,590	$170,538,555	$199,632,905	$29,094,350
Massachusetts	$330,876,333	$351,626,832	$332,774,998	-$18,851,834
Michigan	$54,796,891	$58,233,410	$104,658,176	$46,424,766
Minnesota	$32,081,683	$34,093,646	$33,251,251	-$842,395
Mississippi	$176,877,077	$187,969,703	$192,919,742	$4,950,039
Missouri	$122,947,949	$130,658,477	$146,936,118	$16,277,641
Montana	$59,390,226	$63,114,810	$81,172,202	$18,057,392
Nebraska	$42,464,124	$45,293,512	$54,366,135	$9,072,623
Nevada	$31,453,948	$33,497,360	$43,240,782	$9,743,422
New Hampshire	$18,195,349	$19,336,448	$18,004,496	-$1,331,952
New Jersey	$640,184,412	$680,332,783	$328,294,597	-$352,038,186
New Mexico	$124,225,549	$132,016,200	$66,743,738	-$65,272,462
New York	$579,750,975	$616,109,338	$715,077,771	$98,968,433
North Carolina	$304,200,528	$323,738,478	$452,600,932	$128,862,454
North Dakota	$17,311,376	$18,787,251	$21,277,502	$2,490,251

FY 2013 MANDATORY STATE/FORMULA GRANTS
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(dollars in thousands)

STATE/TERRITORY	FY 2013 Actual	FY 2014 Estimate	FY 2015 Estimate	Difference +/- 2014
Ohio	$336,051,140	$357,126,170	$387,144,497	$30,018,327
Oklahoma	$114,192,613	$121,936,988	$144,423,524	$22,486,536
Oregon	$143,895,447	$152,919,671	$173,907,793	$20,988,122
Pennsylvania	$305,717,683	$324,890,388	$355,279,025	$30,388,637
Rhode Island	$39,506,690	$41,984,303	$57,940,217	$15,955,914
South Carolina	$98,283,399	$104,749,415	$113,055,753	$8,306,338
South Dakota	$19,438,235	$20,761,872	$18,517,554	-$2,244,318
Tennessee	$200,234,597	$212,945,074	$241,024,511	$28,079,437
Texas	$891,517,738	$955,760,207	$1,087,738,537	$131,978,330
Utah	$62,494,237	$66,844,336	$43,426,085	-$23,418,251
Vermont	$13,036,843	$13,854,432	$14,498,604	$644,172
Virginia	$186,575,583	$198,337,665	$220,768,293	$22,430,628
Washington	$96,942,063	$103,282,871	$101,580,282	-$1,702,589
West Virginia	$48,275,692	$51,303,242	$53,890,215	$2,586,973
Wisconsin	$103,003,114	$109,462,826	$105,769,775	-$3,693,051
Wyoming	$10,763,808	$11,522,755	$12,422,188	$899,433
Subtotal	**$8,799,944,890**	**$9,365,742,953**	**$10,230,477,816**	**$864,734,863**
Commonwealths and Territories				
American Samoa	$1,302,079	$1,383,737	$1,470,796	$87,059
Guam	$4,531,881	$4,816,092	$5,118,029	$301,937
Northern Mariana Islands	$934,129	$992,712	$1,055,275	$62,563
Puerto Rico	$132,659,456	$140,979,029	$149,820,323	$8,841,294
Virgin Islands	$0	$0	$0	$0
Subtotal	**$139,427,545**	**$148,171,570**	**$157,464,423**	**$9,292,853**
TOTAL RESOURCES	**$8,939,372,435**	**$9,513,914,523**	**$10,387,942,239**	**$874,027,716**

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

State Grants and Demonstrations

(Budget Authority Dollars in Thousands)

Program	FY 2013	FY 2014 President's Budget	FY 2015 Estimate[1]	FY 2015 +/- FY 2014
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$0	$0	$0	$0
Subtotal – TWWIIA	**$0**	**$0**	**$0**	**$0**
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Alternatives to Psychiatric Residential Treatment Facilities for Children	$0	$0	$0	$0
Money Follows the Person (MFP) Demonstration[2]	$426,006	$416,579	$448,900	$32,321
MFP Research & Evaluations[3]	$1,044	$1,021	$1,100	$79
Medicaid Transformation Grants	$0	$0	$0	$0
Medicaid Integrity Program[4]	$76,123	$71,834	$78,491	$6,657
Subtotal – DRA	**$503,173**	**$489,434**	**$528,491**	**$39,057**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment[5]	$0	$0	$0	$0
Application of Prospective Payment System	$0	$0	$0	$0
Subtotal – CHIPRA	**$0**	**$0**	**$0**	**$0**
Affordable Care Act				
Medicaid Emergency Psychiatric Demonstration Project	$0	$0	$0	$0
Medicaid Incentives for Prevention of Chronic Diseases	$0	$0	$0	$0
Subtotal – Affordable Care Act	**$0**	**$0**	**$0**	**$0**
Appropriations/BA	**$503,173**	**$489,434**	**528,491**	**$39,057**

[1] Reflects current law budget authority. Please see the end of this chapter for proposed law descriptions.
[2] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2013 and FY 2014 column reflects post-sequestration amounts.
[3] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2013 and FY 2014 column reflects post-sequestration amounts.
[4] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2013 and FY 2014 column reflects post-sequestration amounts.
[5] P.L. 111-148 extended the availability of these funds through FY 2015.

Authorizing Legislation - Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170; Medicare Modernization Act of 2003, Public Law 108-173; Deficit Reduction Act of 2005, Public Law 109-171; Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3; Affordable Care Act, Public Law 111-148 together with Public Law 111-152

Allocation Method - Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The grants assist in providing State-infrastructure support and services to targeted populations. Targeted populations include working individuals with disabilities, undocumented aliens, and other eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight to combat fraud, waste and abuse, improving the effectiveness and efficiency in providing Medicaid, establishing alternate non-emergency service providers, and modernizing Medicaid programs to be more sustainable while helping individuals achieve independence. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two 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 programs, the Medicaid Emergency Psychiatric Demonstration Project and Incentives for Prevention of Chronic Diseases in Medicaid and extended several existing programs.

Funding History

FY 2009	$632,763,000
FY 2010	$621,763,000
FY 2011	$807,816,000
FY 2012	$528,334,000
FY 2013	$503,173,000
FY 2014	$489,434,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration programs, determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT GRANT PROGRAMS

Program Description and Accomplishments

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA - P.L. 106-170) established two grant programs starting in FY 2001: the Medicaid Infrastructure Grants and the Demonstration to Maintain Independence and Employment (DMIE). By statute, funding for new grant awards for the DMIE program ended on September 30, 2009.

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants (MIG), section 203 of the TWWIIA, provides funding to States to build the infrastructure necessary to support working individuals with disabilities. These infrastructures include:

- Increased outreach on Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs on Medicaid and other work incentives.

A major goal of the program is to support the expansion of Medicaid coverage for workers with disabilities (also known as “Medicaid buy-in”). With this infrastructure funding, States make systemic changes to help individuals with disabilities gain employment and retain their health care coverage. These changes include, but are not limited to, creating Medicaid buy-in programs and enhancing State personal assistance service programs.

Through FY 2010, a total of 50 entities (49 States and the District of Columbia) had been approved for Medicaid Infrastructure Grants. Thirty-eight of these States had created Medicaid buy-in programs for working adults with disabilities. As of December 2010, there were approximately 177,000 workers receiving Medicaid benefits under the buy-in options. A total of 18 States applied for and received 2011 MIG continuation grant awards. Twenty-five States and the District of Columbia received new 2011 MIG competitive grant awards. FY 2011 marked the final year for this program.

Budget Overview

The Medicaid Infrastructure Grant Program (section 203) was authorized for 11 years beginning in fiscal year 2001 with an appropriation of $150,000,000 for the first 5 years. Beginning in FY 2006, the funding level is tied to the consumer price index for all urban consumers (CPI-U). Of the $42.8 million appropriated for FY 2007, $35.6 million had been granted to the States as of July 30, 2007. Of the $44 million appropriated for FY 2008, $40.3 million had been granted to States. Of the $45 million appropriated in FY 2009, $64.5 million had been granted to States (which included $19.5 million in carryover funding from previous years). In FY 2010, section 203 of TWWIIA authorized and appropriated $46 million, $74.6 million was granted to States (which includes 28.6 million in carryover funding from previous years). In FY 2011, section 203 of TWWIIA authorized and appropriated $46.5 million for 100 percent Federally-funded Medicaid Infrastructure Grants to States. There is no new appropriation for this activity.

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Grant Awards*
Alabama	$3,625,000	$500,000	$500,000	$750,000
Alaska	$3,675,000	$750,000	$700,000	$750,000
Arizona	$500,000	$750,000	$750,000	$750,000
Arkansas	$1,544,950	$682,000	$745,116	$633,556
California	$10,099,274	$2,640,006	$4,028,900	$3,166,715
Colorado	$500,000	$0	$750,000	$743,328
Connecticut	$14,510,205	$4,631,665	$7,260,844	$5,666,161
DC	$3,400,860	$750,000	$750,000	$750,000
Delaware	$1,000,000	$0	$0	$0
Florida	$1,650,000	$750,000	$750,000	$750,000
Georgia	$1,125,000	$0	$0	$500,000
Hawaii	$2,000,000	$750,000	$750,000	$750,000
Idaho	$1,625,000	$500,000	$750,000	$750,000
Illinois	$3,725,001	$500,000	$500,000	$500,000
Indiana	$2,450,000	$750,000	$1,443,000	$1,443,000
Iowa	$5,533,450	$744,000	$750,000	$750,000
Kansas	$4,815,277	$750,000	$959,627	$1,139,136
Kentucky	$500,000	$0	$0	$0
Louisiana	$3,600,000	$750,000	$1,700,000	$900,000
Maine	$4,702,003	$750,000	$870,000	$750,000
Maryland	$2,525,440	$600,000	$750,000	$750,000
Massachusetts	$14,236,084	$5,600,409	$6,353,521	$4,993,868
Michigan	$2,262,000	$750,000	$1,320,000	$1,320,000
Minnesota	$14,256,400	$5,434,648	$6,089,210	$4,605,603
Mississippi	$500,000	$0	$0	$0
Missouri	$3,125,000	$0	$0	$0
Montana	$1,000,000	$750,000	$750,000	$750,000
Nebraska	$4,175,000	No-cost extension	$750,000	$750,000
Nevada	$4,175,000	$500,000	$750,000	$750,000
New Hampshire	$7,033,998	$1,480,863	$2,357,893	$2,033,304
New Jersey	$3,775,000	$500,000	$1,754,890	$1,482,451
New Mexico	$5,356,068	$1,592,000	$1,540,000	$1,500,000
New York	$1,811,689	$5,992,413	$5,992,413	$4,710,037
North Carolina	$2,349,339	$600,000	$600,000	$750,000
North Dakota	$359,177	$750,000	$750,000	$750,000
Ohio	$2,786,416	$500,000	$500,000	$653,500
Oklahoma	$1,045,053	$0	$0	$0
Oregon	$4,373,563	$750,000	$935,000	$1,500,000
Pennsylvania	$2,946,470	$5,327,141	$5,327,000	$4,187,133
Rhode Island	$3,625,000	$750,000	$750,000	$750,000
South Carolina	$1,799,647	$0	$0	$0
South Dakota	$3,500,000	$500,000	$581,289	$520,600
Texas	$1,500,000	$750,000	$750,000	$750,000
Utah	$4,225,000	$750,000	$750,000	$750,000
Vermont	$4,505,000	$750,000	$750,000	$750,000
Virginia	$3,500,000	$750,000	$750,000	$750,000
Washington	$3,100,000	$750,000	$750,000	$750,000
West Virginia	$3,625,000	$750,000	$750,000	$750,000
Wisconsin	$22,253,336	$9,881,187	$12,846,137	$7,635,582
Wyoming	$2,050,000	$750,000	$750,000	$750,000
TOTAL	**$202,355,700**	**$64,456,332**	**$79,904,840**	**$67,083,974**

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Program Description and Accomplishments

Authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA), Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, provides funding to hospitals, physicians, and ambulance suppliers for their un-reimbursed costs of furnishing emergency health services to undocumented and certain other aliens. Payment of Section 1011 funds is limited to services required by section 1867 of the Social Security Act (Emergency Medical Treatment and Labor Act (EMTALA))[6] and related services. Section 1011 provided $250 million per year during each of Federal fiscal years 2005 through 2008.

As of November 2013, Section 1011 provided funding to a total of 2,265 hospitals, 49,505 physicians, and 538 ambulance providers. Since inception of the program in May 2005 through November 2013, Section 1011 has disbursed $961 million in provider payments, in response to 1,452,090 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.

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[6] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals participating in Medicare to medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those having an emergency condition, regardless of an individual's method of payment or insurance status.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Program Description and Accomplishments

Section 6043 of the DRA enacted Emergency Room Co-Payments for Non-Emergency Care. This provision added a new subsection 1916A(e) to the Social Security Act and provided funding in the amount of $50 million in Federal grant funds to States. This funding provides State options to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver. This provision also added a new subsection 1903(y) authorizing Federal grant funds for States to use for the establishment of alternative non-emergency service providers, or network of such providers. States were encouraged to apply for grant funds to implement projects that would create new primary care access points (such as additional evening and weekend hours or new primary care sites closely located to large hospitals), target chronic disease management and outreach to high-emergency department users, utilize mental health triage nurses, and use health information technology to streamline and support emergency department referrals to the beneficiaries' medical homes.

States may not use funds as the State's share of the Medicaid program costs or to supplement disproportionate share hospital (DSH) payments. Grant applicants are limited to the 51 State Medicaid agencies and the Medicaid agencies in the Federal territories.

Budget Overview

The DRA made available a total of $50,000,000 per year (FY 2006-2009) for the establishment of alternate non-emergency service providers or networks of such providers to provide non-emergency care. CMS released one solicitation on August 15, 2007 available for all four years (FY 2006, FY 2007, FY 2008, and FY 2009). On April 17, 2008, Emergency Room Diversion Grants were awarded to 20 State Medicaid agencies, for a total of 29 projects (Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, and Washington). Priority was given to applicants targeting medically-underserved areas whose emergency department utilization rate for non-urgent issues exceeded the State average and to those States who proposed collaboration with local community hospitals. The grants help to align States with CMS efforts to avoid unnecessary emergency room visits through improved physician care and implementation of strategies to slow spending growth while maintaining and even improving access to coverage.

On April 13, 2010, all 20 grantees were granted a 12 month no-cost-extension to spend down their remaining grant funds and to complete their projects. The goal for the extension period was to provide the grantees additional experience delivering the full array of services within the program structure they have been developing. The grantees needed additional time to develop a sustainable base for emergency department diversion services. Grant extensions also increased improvement in beneficiary satisfaction in relationships and access to their primary care medical home. The grant extension allowed grantees to collect, measure, and evaluate behavior changes by trending Medicaid claims history before and after redirection management.

In FY 2011, a third no-cost-extension was requested and approved for North Carolina and Pennsylvania to spend-down their remaining unobligated funds totaling $1,032,600.00. For

both States, the grant ended on January 14, 2012. The final Progress Report for the State of North Carolina was submitted to CMS on September 30, 2011, and the State of Pennsylvania submitted their final Progress Report on April 11, 2012.

On March 21, 2012, CMS held a teleconference with grantees to discuss a CMS Draft Report on the results of the ER Diversion Grant program, based on final reports submitted by the States. Twenty-three grantees representing 13 of the 20 participating States took part in the in the teleconference. Attendees discussed with CMS various ER diversion strategies implemented during the performance period, including urban versus rural approaches. Towards the end of the teleconference, a grantee suggested—and all agreed—that CMS would design and provide a single page template for each of the 20 States to complete as a high level summary on the strategies, findings and sustainability of their individual grant programs. Three States: Colorado, Indiana, and Tennessee submitted additional report information or clarifications advocating a more positive review of their respective results in the summary report, which CMS agreed were pertinent to the final draft report.

CMS posted individual State summaries with contacts on Medicaid.gov located at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/ER-Diversion-Grants.html in April 2013. In January 2014, CMS issued a Center Information Bulletin (CIB) entitled, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings*, that provides various methods that health providers may employ for the reduction of nonurgent treatment in emergency departments (EDs), including ways to establish pathways to primary care access when needed. The bulletin is available at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVE TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Program Description and Accomplishments

Over the last decade, psychiatric residential treatment facilities (PRTFs) have become the primary provider for children and youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities, States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to institutional care which would provide services that would enable children and youth to be diverted from institutionalization or transition out of PRTFs back to their homes and with their families.

Section 6063 of the DRA addressed this issue by authorizing up to ten States to develop demonstration programs that provide home and community-based waiver services to youth as alternatives to institutionalization in PRTFs. To participate in this demonstration, Medicaid eligible individuals must be 21 years of age or younger and require the need for a PRTF level of care as defined in the State's Medicaid State plan.

This demonstration program has been evaluated and has improved or maintained functional outcomes for children and youth participating in the demonstration. The common

theme across all state grantees is that children and youth with the highest level of needs at baseline benefited the most from participating in the Demonstration waiver. These children showed the most improvement, across the most domains, and over the most follow-up periods. The demonstration was also cost effective. The savings have been consistent across all state grantees and through all waiver years. In July 2013, CMS issued a Report to Congress highlighting the evaluation results, including an average savings of 68 percent with waiver services costing only 32 percent of comparable services provided in PRTFs. These findings are quite positive and reflect the need for a more permanent format for HCBS mental health programs for children and youth.

The ten participating States submitted a 5-year, web-based 1915(c) demonstration waiver application as the grant implementation plan. Nine States have approved 1915(c) demonstration waivers. While Florida was awarded a grant, due to budget cuts in the State, Florida rescinded their grant and their grant award was returned to the demonstration grant appropriation. All nine States with approved waivers have provided waiver services 3,875 children and youth as of September 30, 2011. It is estimated that approximately 6,000 children and youth will be served by the end of the demonstration.

The table below shows the total five year commitment for the grant awards funded in FY 2007-2011 by State.

Budget Overview

The DRA provided ten States with up to $218 million for a period of five years (appropriations through FY 2011) to develop demonstration programs. One million dollars of the project funding is made available for required interim and final evaluation reports.

CMS has made awards totaling $194 million to participating States for the demonstration project period less the rescission by Florida of $2.1 million, leaving a total awarded to States of over $191.9 million. CMS also awarded a contract for the national evaluation in April 2007 for $904,422 and a modification in the amount of $93,690 in FY 2008 totaling $998,112.

The DRA authorized and appropriated $37 million for FY 2008, $49 million in FY 2009, $53 million in FY 2010, and $57 million in FY 2011. CMS also provided grant funding matching the increased FMAP provided for in the American Reinvestment and Recovery Act (ARRA) of 2009 during the recovery period. States received their final supplemental funding award in September 2011 that covered the period October 1, 2011 through September 30, 2014. Funding provided in FY 2011 is available to serve children and youth in FY 2012 and claims for services provided in FY 2012 will require funding from the FY 2011 appropriation through FY 2014 (federal assistance is available for up to two years from the date of service for claims).

State	Total PRTF Appropriation	Original Program Funding Commitment	FY 07-11 Supplemental Awards
AK		$8,927,571	$7,165,217
IN		$25,139,967	$41,652,061
MT		$5,184,455	$8,848,070
MS		$56,603,183	$63,396,017
VA		$18,705,337	$5,580,920
KS		$17,978,247	$5,940,574
MD		$10,410,333	$30,441,069
SC		$22,808,864	$9,226,436
GA		$22,614,239	$19,708,997
Totals	**$218,000,000**	**$188,372,196**	**$191,959,361**

Some States received larger supplemental awards to serve additional children and youth as they amended their 1915(c) demonstration waiver unduplicated counts.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of Section 6071 of the DRA, as amended by Section 2403 of the Affordable Care Act, States now have new options to rebalance their long-term support programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve independence. Specifically, the MFP demonstration supports State efforts to:

- Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
- Transition individuals from institutions who want to live in the community.
- Implement a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

The demonstration provides for enhanced Federal Medical Assistance Percentage (FMAP) for 365 days for qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. Eligibility for participation in the demonstration was modified by the Affordable Care Act. Individuals must reside in a qualified institution for at least 90 days before they transition to the community, with the exception that any days an individual resides in an institution solely for the purpose of short-term rehabilitative services for which payment is limited under Medicare are excluded. In addition, States must continue to provide community-based

services after the 365 day demonstration period for as long as the individual needs community services and is Medicaid eligible.

The table on the following page shows all grant awards that were made in FY 2007-FY 2013. 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.

The CMS Money Follows the Person (MFP) Tribal Initiative (TI) offers existing MFP state grantees and tribal partners the resources to build sustainable community-based long term services and supports (CB-LTSS) specifically for Indian country. The TI may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives (AI/AN) using a single, or a variety of applicable Medicaid authorities. Applications to participate in the MFP TI were due October 17, 2013. Five qualified applications were received by CMS totaling $1.48 million for the first pase of the program development. CMS anticipates making awards in March 2014. The amounts in the chart on the following page will be adjusted once awards are made.

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 FY 2011. 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. In accordance with the sequestration report dated March 1, 2013, the funding for the MFP demonstrations and evaluation was reduced by 5.1 percent in FY 2013 and 7.2 percent in FY 2014. The adjusted FY 2013 appropriation is $427 million and the FY 2014 appropriation is $418 million. The FY 2015 appropriation is $450 million. 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 through no cost extensions.

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 July 2013, CMS obligated $2,945,767,399 in grants to 44 States and the District of Columbia. Grantees have transitioned over 31,000 individuals as of December 2012. The 44 participating States and DC have proposed to transition an additional 51,253 individuals out of institutional settings through 2016. As grantees continue to make progress in

implementing their projects, there is reduced funding available to expand the program beyond the 44 states and DC.

Money Follows the Person Rebalancing Demonstration			
State Name	***Cumulative Award Total 2007-2013***	***Budget Projections 2014-2020***	***Total Project Funds*** *(cumulative award plus budget projections)*
Alabama	**$3,949,097**	**$21,819,996**	**$25,769,093**
Arkansas	**$23,768,960**	**$38,367,116**	**$62,136,076**
California	**$82,782,164**	**$211,901,289**	**$294,683,453**
Colorado	**$3,325,553**	**$28,533,162**	**$31,858,715**
Connecticut	**$63,434,749**	**$113,269,270**	**$176,704,019**
District of Columbia	**$21,593,213**	**$10,937,868**	**$32,531,081**
Delaware	**$3,504,849**	**$3,092,871**	**$6,597,720**
Georgia	**$84,740,171**	**$369,308,730**	**$454,048,901**
Hawaii	**$4,791,841**	**$10,517,542**	**$15,309,383**
Idaho	**$4,707,696**	**$7,387,132**	**$12,094,828**
Iowa	**$24,735,735**	**$18,136,740**	**$42,872,475**
Illinois	**$16,441,495**	**$64,548,507**	**$80,990,002**
Indiana	**$27,330,045**	**$82,350,030**	**$109,680,075**
Kansas	**$31,682,606**	**$8,248,158**	**$39,930,764**
Kentucky	**$46,582,264**	**$178,207,958**	**$224,790,222**
Louisiana	**$15,047,246**	**$63,720,631**	**$78,767,877**
Maine	**$2,468,541**	**$4,807,762**	**$7,276,303**
Maryland	**$86,290,330**	**$83,535,371**	**$169,825,701**
Massachusetts	**$31,973,167**	**$160,123,797**	**$192,096,964**
Michigan	**$39,371,045**	**$35,488,125**	**$74,859,170**
Minnesota	**$20,262,703**	**$200,429,367**	**$220,692,070**
Mississippi	**$7,955,346**	**$29,114,578**	**$37,069,924**
Missouri	**$35,675,393**	**$34,686,962**	**$70,362,355**
Montana	**$2,684,302**	**$9,812,318**	**$12,496,620**
North Carolina	**$15,559,004**	**$26,985,618**	**$42,544,622**
North Dakota	**$13,363,594**	**$44,101,319**	**$57,464,913**
Nebraska	**$10,324,279**	**$19,061,977**	**$29,386,256**
Nevada	**$4,989,657**	**$5,402,999**	**$10,392,656**
New Hampshire	**$9,173,323**	**$8,860,468**	**$18,033,791**
New Jersey	**$37,517,165**	**$82,986,721**	**$120,503,886**
New York	**$70,042,860**	**$156,000,749**	**$226,043,609**
Ohio	**$131,008,152**	**$131,217,974**	**$262,226,126**
Oklahoma	**$21,585,288**	**$11,651,163**	**$33,236,451**
Oregon	**$31,269,191**	**$52,554,896**	**$83,824,087**

Money Follows the Person Rebalancing Demonstration			
State Name	***Cumulative Award Total 2007-2013***	***Budget Projections 2014-2020***	***Total Project Funds*** ***(cumulative award plus budget projections)***
Pennsylvania	**$35,072,785**	**$159,503,649**	**$194,576,434**
Rhode Island	**$3,617,749**	**$21,329,677**	**$24,947,426**
South Carolina	**$2,270,084**	**$15,023,324**	**$17,293,408**
South Dakota	**$1,323,044**	**$2,828,328**	**$4,151,372**
Tennessee	**$29,842,234**	**$142,368,312**	**$172,210,546**
Texas	**$213,836,170**	**$119,385,630**	**$333,221,800**
Vermont	**$4,520,128**	**$11,906,656**	**$16,426,784**
Virginia	**$25,978,265**	**$27,967,993**	**$53,946,258**
Washington	**$80,672,829**	**$136,090,794**	**$216,763,623**
West Virginia	**$4,842,896**	**$32,779,491**	**$37,622,387**
Wisconsin	**$17,407,956**	**$22,124,801**	**$39,532,757**
	$1,449,315,164	**$3,018,477,819**	**$4,467,792,983**

NOTE: States may exceed their original request for funding by exceeding their benchmarks and transitioning additional participants into home and community-based services.
*New Mexico rescinded the grant in January 2012
*Florida rescinded the grant in August 2013

MEDICAID TRANSFORMATION GRANTS

Program Description and Accomplishments

This program is authorized by Section 6081 of the DRA which added another subsection, 1903 (z) to title XIX of the Social Security Act. This section provided new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates through health information technology, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual Payment Error Rate Measurement program, implementing medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and developing methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Grantees must report on cost savings, use of the grant funds and any clinical improvements in beneficiary health status, as appropriate.

There is no requirement for State matching funds in order to receive payments for transformation grants.

Budget Overview

The DRA authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008. CMS released a State Medicaid Director Letter/Grant Solicitation to States on July 25, 2006. On January 25, 2007, CMS awarded 32 Medicaid Transformation Grants to 26 States totaling $97,040,144. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $52,959,856. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

The primary focus of these projects is for the States to adopt innovative methods to improve the effectiveness and efficiency in providing Medicaid through the development, implementation and the use of electronic health records (EHR), Health Information Exchanges (HIE), electronic clinical decision support tools, and e-prescribing programs in an effort to reduce healthcare costs and improve overall patient quality.

Table A and Table B on the following pages lists all of the Medicaid Transformation Grants awarded in the two rounds of applications.

Table A: FY 2007 Medicaid Transformation Grants, Round 1

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Alabama	Together for Quality - Health Information Systems (HIE/EHR)	$7,587,000	Health Information Technology
Arizona*	Medicaid Health Information Exchange and Utility Project	$11,749,500	Health Information Technology
Arkansas	Electronic Verification of Proof of Citizenship	$285,513	Fraud, Waste & Abuse
Connecticut	Health Information Exchange and e-Prescribing	$5,000,000	Quality & Health Outcomes
District of Columbia	Comprehensive Medicaid Integration (HIE/EHR)	$9,864,000	Health Information Technology Quality & Health Outcomes
Florida	GenRx Expansion (e-Prescribing)	$1,737,861	E-Prescribing
Hawaii*	Open Vista ASP Network (HIE/EHR)	$3,188,535	Health Information Technology Quality & Health Outcomes
Illinois	Predictive Modeling System	$4,849,200	Quality & Health Outcomes Fraud, Waste & Abuse

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Indiana*	Medicaid Estate Recovery Centralization and Automation Project	$124,880	Health Information Technology Medicaid Estate Recovery
Kansas	Using Predictive Modeling Technology to improve Preventive Health Care in the Disabled Medicaid Population	$906,664	Quality & Health Outcomes
Kentucky	Health Information Partnership (HIE/EHR)	$4,987,583	Health Information Technology
Maryland	Automated Fraud and Abuse Tracking	$576,228	Fraud, Waste & Abuse
Massachusetts	Secure Verification of Citizenship through Automation of Vital Records	$3,950,440	Citizenship
Michigan	One Source Credentialing	$5,208,759	Quality & Health Outcomes
Michigan	Expansion of Vital Records Automation and Integration into Medicaid	$3,929,317	Citizenship
Minnesota	Communication and Accountability for Primary Care Systems (HIE/EHR)	$2,843,340	Quality & Health Outcomes
Mississippi*	As One - Together for Health (HIE/EHR)	$1,688,000	Health Information Technology
Montana*	Enhancing EHR - Clinical Decision Making	$1,481,152	Quality & Health Outcomes
New Jersey	Medical Information for Children (HIE/EHR)	$1,516,900	Health Information Technology
New Mexico	e-Prescribing	$855,220	e-Prescribing
New Mexico	Electronic Health Record Project	$712,301	Health Information Technology
North Dakota	Web-based Electronic Pharmacy Claim Submission Interface	$75,000	e-Prescribing
Rhode Island*	IT Infrastructure Transformation	$725,253	Fraud, Waste & Abuse
Tennessee	E-Prescription Pilot Project	$674,204	e-Prescribing
Texas	Electronic Health Passport for Foster Care	$4,000,000	Health Information Technology
Utah	Developing a Pharmacotherapy Risk Management System with an Electronic Surveillance Tool	$2,881,662	Risk Management
West Virginia	Healthier Medicaid Members through Personal Responsibility	$917,560	Quality & Health Outcomes
West Virginia	Healthier Medicaid Members through a Stronger Medicaid Program	$1,731,680	Health Information Technology
West Virginia	Healthier Medicaid Members through Health Systems Improvement (HIE/EHR)	$3,895,730	Health Information Technology

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
West Virginia	Healthier Medicaid Members through Applied Technology	$1,766,280	Health Information Technology
West Virginia	Healthier Medicaid Members through Enhanced Medication Management	$4,287,110	Health Information Technology Quality & Health Outcomes
Wisconsin*	Health Information Exchange Initiative	$3,043,272	Health Information Technology
	Round 1Total Funding Awarded	$97,040,144	

*Received MT Grants in both Round 1 and Round 2

Table B: FY 2007 Medicaid Transformation Grants, Round 2

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Arizona*	Transparency - Value Driven Decision Support Tool Box	$4,411,300	Health Information Technology Quality & Health Outcomes
Arkansas	Touch: Telemedicine Outreach Utilizing Collaborative Health Care (Neonatal Outcomes)	$1,458,826	Quality & Health Outcomes
Delaware	Delaware e-Prescribing Pilot	$1,018,065	e-Prescribing
Georgia	Health Information Transparency Website	$3,929,855	Health Information Technology
Hawaii*	Enhanced Electronic Health Record and Information Exchange	$1,815,000	Health Information Technology
Indiana*	Health Information Exchange Services to Improve the Effectiveness and Efficiency in Providing Medical Assistance Under Medicaid	$1,294,689	Health Information Technology Quality & Health Outcomes
Mississippi*	A Healthy Mississippi - Moving Forward Enhancing Program Integrity	$1,750,700	Fraud, Waste & Abuse
Missouri	Web-Based Tool for Home and Community Based Services	$1,940,175	Health Information Technology Quality & Health Outcomes
Montana*	Improving Lien and Estate Recoveries	$601,126	Medicaid Estate Recovery
Nevada	Building Value Through a Nevada Medicaid Data Warehouse	$29,207	Health Information Technology
North Carolina	Neonatal Outcomes Improvement Project	$1,019,550	Quality & Health Outcomes
Ohio	Neonatal Outcomes Improvement Project	$2,154,948	Quality & Health Outcomes

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Oklahoma	Online Enrollment Process	$6,146,640	Health Information Technology
Oregon	The Health Record Bank of Oregon (HIE)	$5,500,093	Health Information Technology Quality & Health Outcomes
Pennsylvania	Implementing Predictive Modeling For High Risk Populations	$4,811,320	Risk Management
Puerto Rico	Reduction of Fraud and Abuse through Validation of Demographic and Socioeconomic Data with the Use of Electronic Data Exchanges	$4,267,231	Fraud, Waste & Abuse Health Information Technology
Rhode Island*	Medicaid Health Information Exchange Integration Initiative	$2,765,265	Health Information Technology Quality & Health Outcomes
Washington	Second Generation Fraud and Abuse Detection System	$5,948,000	Fraud, Waste & Abuse
Wisconsin*	Health Care Quality and Patient Safety - Value Driven Health Care Initiative	$2,097,866	Health Information Technology Quality & Health Outcomes
	Round 2 Total Funding Awarded	$52,959,856	
	Total 2007 Medicaid transformation Grant Awards	$150,000,000	

*Received MT Grants in both Round 1 and Round 2

In FY 2010, CMS approved 32 no-cost extensions through March 31, 2011 for 24 States to spend-down their remaining unobligated funds totaling $44,347,657 and to complete their projects. In FY 2011, a third no-cost-extension was requested and approved for the following States to spend-down their remaining unobligated funds totaling $3,434,245.20: Mississippi, Missouri, North Carolina and Rhode Island. In FY 2012, a final no-cost extension for 12 months was approved for Mississippi to spend down the approximately $606,000 of unobligated funds remaining in their grant.

As of February 2013 all Medicaid transformation grants have been closed.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171) established the Medicaid Integrity Program (MIP) in Section 1936 of the Social Security Act (the Act). With the passage of this legislation, Congress provided the Centers for Medicare and Medicaid Services (CMS) with increased resources to prevent, detect, and

reduce fraud, waste, and abuse in the Medicaid program. While the MIP represents CMS' first national strategy to detect and prevent Medicaid fraud, waste, and abuse, other Medicaid program integrity activities are funded through the Health Care Fraud and Abuse Control Program (HCFAC) and are discussed in the HCFAC chapter.

CMS collaborates with other components within the Department as well as other Departments within the Federal Government and State Medicaid program components to determine if fraud, waste, or abuse has occurred. These collaborations have produced several projects in various phases of implementation to move Medicaid program integrity from continued reliance on a "pay and chase" model toward a more proactive, preventative environment. CMS is working with states to avoid overpayments before they happen.

CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste, and abuse beginning in Fiscal Year (FY) 2006. The first CMIP was published in July 2006, and covered FYs 2006 through 2010. The most recent CMIP was released in July 2009 and covers FYs 2009 through 2013. CMS is working to develop the new CMIP and anticipates completing this effort in the near future.

Congress mandated that CMS enter into contractual agreements with eligible entities to:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and
- Conduct education of State or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

The contractors that perform these functions are known as Medicaid Integrity Contractors (MICs). In December 2007, CMS awarded umbrella contracts, and contractors began conducting provider reviews and audits in September 2008 as part of the National Medicaid Audit Program (NMAP). In collaboration with the United States Department of Justice (DOJ), CMS also established the Medicaid Integrity Institute (MII) to provide state employees with a comprehensive program of course work encompassing numerous aspects of Medicaid program integrity.

The MIP has achieved a number of clear successes since the start of the program in 2006. The MII has been praised repeatedly by states, Congress, the Government Accountability Office (GAO), and Medicaid and CHIP Payment and Access Commission (MACPAC) as making a substantial contribution to state efforts to combat fraud and improper payments. From its inception in 2008 through the end of FY 2013, MII has trained state employees from all 50 states, the District of Columbia, and Puerto Rico through more than 4,000 enrollments in 95 courses and 6 workgroups. In FY 2013 alone, MII conducted 18 courses and one workgroup with 895 enrolled. States have reported $36 million in cost avoidance and identified overpayments as the direct result of the training they received at MII. The MII developed a distance learning program in addition to its classroom activities, and sponsored 11 webinars in FY 2013 to extend its training capacity to even more state program integrity staff. MII

also began offering a credentialing program for state Medicaid program integrity employees to certify their professional qualifications. By the end of FY 2013, 59 state employees in 28 states had received the credential of Certified Program Integrity Professional. In addition, MII supports a secure, web-based information sharing system called the Regional Information Sharing System (RISS) that all states use to exchange documents, questions and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance within the DOJ. In the coming years, CMS plans to enhance the educational opportunities provided through MII by expanding course offerings and other training opportunities.

Since 2007, CMS has conducted triennial comprehensive state program integrity reviews, which assess each state's Medicaid program integrity vulnerabilities and best practices. By the end of FY 2013, CMS completed 110 comprehensive program integrity reviews, including each state, Puerto Rico and the District of Columbia at least twice. In FY 2013, comprehensive reviews were conducted for 14 states. FY 2014 represents a transition period in the assessment of state program integrity activities. During FY 2014 CMS will conduct focused reviews of high-risk program integrity areas rather than comprehensive state reviews. Focused reviews will examine areas such as managed care in Medicaid expansion states, enhanced provider screening and enrollment activities required by the Affordable Care Act, and personal care services. CMS plans to assess the comprehensive state program integrity review process and possibly implement a new process beginning in FY 2015. CMS has hosted conference calls with states to discuss program integrity issues and best practices, issued guidance on policy and regulatory issues, and published annual reports of program integrity best practices that have been of considerable value to states.

The MIP provides additional support to states through technical assistance from CMS staff and through contracted educational activities. For example, CMS has provided personnel and other resources to augment state Medicaid staff during field investigations designed to target identified and documented high-risk fraud and abuse situations with saturated enforcement actions. CMS also assists in the education of providers and beneficiaries on program integrity efforts by employing an Education MIC to develop materials, conduct training, and encourage Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. In early September 2013, CMS launched a new online resource for Medicaid program integrity education (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html). The website includes educational toolkits using a variety of media and covers topics such as managed care, drug diversion, dental compliance, identity theft, beneficiary card sharing, and fraud awareness and reporting. In addition to these online resources, the CMS education contractor has conducted webinars on these topics which have been attended by program integrity staff from Medicaid programs from all 50 states and the District of Columbia. State staff are trained to use the above resources to conduct ongoing education of providers and beneficiaries in their states.

In the last few years, CMS has redesigned the National Medicaid Audit Program (NMAP) and significantly increased identified overpayments by focusing on collaborative audit projects with the states. This approach replaced an earlier type of federal audit, and instead uses more timely claims data residing with each state's Medicaid Management Information System (MMIS). Collaborative audits using state-level data have proven to be an effective way to coordinate federal and state audit efforts and resources to better meet states' needs, resulting in more timely and accurate audits. By the end of FY 2013, CMS exceeded its goal of expanding collaborative audits to 30 states, by assigning a cumulative total of 516

collaborative audits with 32 states that represent approximately 72 percent of Medicaid program expenditures. As a result of these improvements in the audit program, CMS identified $25.4 million in overpayments in FY 2013.

For FY 2014 and FY 2015, CMS is reconfiguring its approach to the review and audit of Medicaid providers through CMS contractors by developing a Unified Program Integrity Contractor (UPIC) strategy that restructures and consolidates the current Medicare and Medicaid program integrity audit and investigation work. This reconfiguration focuses on efficient contractor structure, better Medicaid claims data, and improved coordination between Medicare and Medicaid contractors and states. The UPIC concept consolidates the work of the MICs and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data Match activities. The overarching goal of the UPIC is to integrate these program integrity functions by implementing a contracting strategy that rationalizes our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners, including states.

The reconfiguration of the MIP will also expand the review of Medicaid providers to include improved oversight of managed care entities and enhancements to the Medicaid data strategy and information technology infrastructure in conjunction with the Center for Medicaid and CHIP Services. To address the program integrity challenges of the expansion of Medicaid, CMS will leverage DRA funding to support the coordination of Medicaid program integrity initiatives across the agency.

In FY 2014, CMS will begin a cross- component review of states' rate setting in managed care and home and community based services, including assessment of the accuracy and quality of data used by states to support rate setting. The results of these reviews will be used for CMS oversight of states' rate setting to ensure that appropriate mitigation strategies are developed and to provide information for subsequent approvals of rates for Medicaid waivers. In addition, CMS will leverage resources of the MIP during FY 2014 to improve state accountability for upper payment limit demonstrations and supplemental provider payments, including Medicaid disproportionate share hospital payments. CMS will also use a portion of DRA funding to support the development of the information technology infrastructure necessary to provide reliable data for CMS to assess expenditures, measure performance, and prevent improper payments.

FY 2015 Budget Justification

The Budget includes a proposal to increase the Medicaid Integrity Program by $25 million per year (adjusted by the Consumer Price Index for All Urban Consumers) and to expand the statutory authority for the Medicaid Integrity Program to increase program flexibility in protecting state and federal resources. Investments in Medicaid program integrity support critical state program integrity efforts and save money by reducing fraud, waste, and abuse. Additional funding is needed to support state program integrity efforts as the Medicaid program undergoes changes. CMS will be able to use this new funding for a wide variety of new program integrity activities that may include, but is not limited to, expansion of the Medicaid Financial Management program (currently funded under the Health Care Fraud and Abuse Control Program) and technical assistance to states on the following topics: oversight of managed care entities, claims processing improvements, cutting-edge fraud prevention analysis, and provider screening.

Budget Overview

The DRA appropriated $5 million in FY 2006, $50 million in FYs 2007 and 2008 respectively, and $75 million in FY 2009 and each year thereafter for the Medicaid Integrity Program. Beginning in FY 2011, Section 1303(b)(3) of P.L. 111-152 adjusts this funding by the percentage increase in the CPI-U annually. The FY 2011 appropriation was $76.3 million, and the appropriation for FY 2012 is $78.3 million. The FY 2013 enacted appropriation was $78.3 million with a CPI-U adjustment of 2.4 percent bringing the total to $80.2 million. Sequestration reduced the FY 2013 total by 5.1 percent, bringing the new budget authority to $76.1 million. Consequently, the FY 2014 enacted appropriation was $76.1 million with a CPI-U adjustment of 1.6 percent bringing the total new budget authority to $77.4 million. The FY 2014 budget authority was reduced by 7.2 percent due to sequestration, bringing the final budget authority to $71.8 million. The FY 2015 appropriation is $77.4 million with a CPI-U adjustment of 1.4 percent bringing the budget authority to $78.5 million. The CPI-U adjustments are based on the current FY 2015 President's Budget Economic Assumptions. In addition, the FY 2015 President's Budget includes an additional $25 million per year (adjusted by the Consumer Price Index for All Urban Consumers) for the Medicaid Integrity Program to increase the program's ability to protect state and federal resources. The FY 2015 President's Budget includes a total of $103.5 million for the Medicaid Integrity Program. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

Section 201 of CHIPRA provided $100 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Affordable Care Act increased the appropriation to $140 million. These programs will conduct outreach and enrollment efforts designed to increase the enrollment and participation of children who are eligible for Medicaid or CHIP but not enrolled.

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.

Of the $100 million provided by section 201 of CHIPRA, $80 million was appropriated for the Outreach and Enrollment Grants. The first $40 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40 million in Federal funds across 41 States and the District of Columbia. On August 18, 2011 CMS awarded the remaining $40 million in grant funds to 39 grantees across 23 States. These grants, entitled CHIPRA Outreach and Enrollment Grants (Cycle II) encouraged applicants to take a more systematic approach to outreach, enrollment and retention. Grantees focused on five specific areas that have been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

CMS awarded a third round of outreach and enrollment grants entitled Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) in July 2013 from the $32 million appropriated through the Affordable Care Act. These grants will build on the successes of the first two cycles of CHIPRA grants and then further promote outreach and enrollment activities encouraged by the Affordable Care Act. Grantees will again focus on five specific areas. These areas will support outreach strategies similar to those conducted in Cycles I and II but will also fund activities designed to help families understand new application procedures and health coverage opportunities, including Medicaid, CHIP and insurance affordability programs under the ACA.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Outreach to Indian Children

The authorizing statute for the program sets aside ten percent of appropriations to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible American Indian and Alaska Native children in Medicaid and CHIP. On April 15, 2010, CMS awarded 41 grants for a total of $9,902,105. CMS expects to award a second round of Outreach and Enrollment Grants to organizations serving Indian children in by July 2014 from the $4 million appropriated through the Affordable Care Act. These grants will also build on the successes on the first round of grants for the outreach to Indian children but will further complement outreach and enrollment activities promoted by the Affordable Care Act.

National Enrollment Campaign

The statute set aside 10 percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. To date, the campaign has focused on a call to action and providing technical assistance to States, grantees, and other groups to help enroll more children in Medicaid and CHIP and keep them covered. The campaign, referred to as the Connecting Kids to Coverage National Campaign, seeks to create opportunities for families to sign up their eligible children and motivate parents to enroll and renew their coverage. Additionally, the campaign is building a set of activities that can be easily replicated or adapted in multiple state and community settings by providing resources to support these efforts.

A suite of general campaign materials were developed in 2013 around three waves of outreach to engage national, State and local partners to reach out to families with eligible children and teens: Winter Wave (February to March, 2013), Allergies and Asthma (April to May, 2013) and Back-to-School (July to August, 2013). The waves were designed to focus on enrollment and retention of coverage and are adaptable so that they can be used in a variety of settings. CMS launched an Oral Health Initiative and set goals for improvement by FY 2015. Materials, including an oral health tear pad for pregnant women and a flyer for parents of infants and toddlers, were developed. Additional materials are planned for 2014, including a flyer featuring teens and oral health tear pad for school-aged children.

CMS continues to provide grantee and partner training activities, including technical assistance to States through a variety of strategies, including on-going webinars and providing supplemental toolkit materials.

CMS launched Connecting Kids to Coverage National Campaign television and radio public service announcements in May 2013. Messaging was framed around giving parents the peace of mind and security that comes from knowing they can find quality, affordable health coverage for their children. Core messages are aimed at educating families about the availability and affordability of health coverage, the valuable benefits offered (e.g., check-ups, hospital visits, emergency services, prescriptions, etc.) and how to get coverage. The PSAs have been distributed nationally and have aired more than 66,000 times in the first six months of placement. The PSAs will be re-distributed in June 2014.

Remaining FY 2014 and FY 2015 funds will be used to extend the Connecting Kids to Coverage National Campaign through August 2015. CMS will use outreach and enrollment tactics that have worked well throughout the campaign. Those tactics include conducting a paid radio media buy in targeted markets and releasing the spot as a public service announcement in the markets not included in the media buy; increasing the number of training webinars; and continuing to refresh content on InsureKidsNow.gov, the National Campaign's home for tools and resources. During this period, CMS will also conduct a final analysis of activities and prepare reporting documentation, as appropriate.

Budget Overview

CHIPRA appropriated a total of $100 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the Affordable Care Act provided an additional $40 million in fiscal year 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, ten percent is set-aside for the national enrollment campaign and another ten percent is for Indian outreach. CMS awarded $40 million in FY 2009 for outreach grants and approximately $10 million in FY 2010 for general outreach to Indian children. CMS awarded an additional $40 million of the remaining grants funds on August 18, 2011.

For the national enrollment campaign, a contract was awarded in June 2009 with a total contract value of $6.575 million. The original contract ended in July 2012, and a new contract was awarded in August 2012. The remaining portion of the $10 million appropriated through CHIPRA in combination with the $4 million appropriated through the ACA have been used for campaign efforts between FY 2012 and 2015. A FY 2012 contract for $2.437 million was awarded in August 2012 to build and expand upon existing campaign efforts; a contract modification was executed on August 30, 2013 adding $1.243. The remaining funding combined with the ACA appropriation (approximately $2.451 million) will be applied to on-going National Campaign efforts to enroll eligible children between FY 2013 and FY 2015; the remaining $1 million will be split in half for Indian outreach in FY 2014 and FY 2015.

APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Program Description and Accomplishments

Section 503 of CHIPRA establishes transition grants to states to apply in their CHIP programs the prospective payment system (PPS) established under section 1902(bb) of the Social Security Act to services provided by federally-qualified health centers (FQHCs) and rural health clinics (RHCs). State CHIP programs that contract with FQHCs are required to

develop a prospective payment system or an alternative payment methodology (APM) agreed to by the FQHCs and RHCs to pay for these services provided to CHIP beneficiaries.

The CHIPRA transition grants provided funding to states that operated either a separate CHIP or combination CHIP (i.e., had both a separate CHIP and a Medicaid expansion) to assist them in transitioning to a PPS for the FQHC/RHC payments. The goals of this grant appropriation were to assist states in applying the PPS requirements for this purpose as required by CHIPRA.

Budget Overview

The statute appropriated $5 million for fiscal year 2009. In June 2010, a total of five grants were awarded. However, one grantee declined the award. The four grantees in 2010 to 2011 were: California, Michigan, Colorado, and Pennsylvania, representing $1,934,345 of the appropriated funds. CMS released a second solicitation on January 11, 2012 for another round of these transition grants. On July 1, 2012, CMS awarded the second round of grants to three states: Montana ($500,000), Iowa ($200,000), and Pennsylvania ($426,170), for a combined total of $1,126,170 in grant funding. After all awards, a total of $1,939,485 remains unawarded from the appropriation; however, CMS does not intend to release another round of grants. Currently, all grant projects have been closed-out, and CMS is actively working to finalize the required Report to Congress on the effect these grants may have had on access to benefits, provider payment rates, or scope of benefits offered by states.

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 psychiatric emergency medical condition, defined as expressions of suicidal or homicidal thoughts or gestures or is determined to be dangerous to themselves or others. The demonstration project shall be conducted for a period of three consecutive years (July 1, 2012 – June 30, 2015). Each eligible State shall be paid an amount each quarter equal to the FMAP of expenditures in the quarter. An evaluation of the demonstration shall be conducted to determine the impact on Medicaid beneficiaries and the health and mental health service system.

On August 9, 2011, a solicitation to participate in the demonstration was distributed to all State Medicaid Directors. Application proposals from the States were received by October 14, 2011. CMS announced the final selection of eleven States and the District of Columbia on March 12, 2012. Participants in the Demonstration are: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, West Virginia and the District of Columbia. All of the participants began implementing their programs during 2012.

The ACA required that the Secretary of the Department of Health and Human Services (DHHS) submit a Report to Congress on the demonstration, which was submitted on January 8, 2014. The report indicated there were 2,791 participants in the program

constituting 3,458 admissions to Institutions for Mental Disease through June 30, 2013. Data continue to be collected on outcomes for the enrolled participants and impacts on Medicaid costs; the Department will conclude an updated evaluation of the demonstration in 2016.

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 December 31, 2015.

MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES

Section 4108 of the Affordable Care Act (ACA) authorizes CMS to provide grants to States to provide incentives to Medicaid beneficiaries who successfully participate, complete, and maintain healthy behaviors by meeting the specific targets of a comprehensive, evidence based, widely available, and easily accessible program designed to help individuals achieve one or more of the following:

1. Ceasing the use of tobacco products
2. Controlling or reducing their weight
3. Lowering their cholesterol
4. Lowering their blood pressure
5. Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

The Funding Opportunity Announcement (FOA) was released to States on February 23, 2011 and grants were awarded to New York, Texas, Hawaii, Minnesota, New Hampshire, California, Montana, Nevada, Wisconsin, and Connecticut on September 13, 2011. All ten MIPCD State grantees are operational and currently enrolling beneficiaries.

CMS awarded an evaluation contract in May 2012. This evaluation focuses on: 1) the effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program; 2) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; 3) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and 4) the administrative costs incurred by state agencies that are responsible for administration of the program.

The ACA requires that the Secretary of the Department of Health and Human Services (DHHS) submit an initial Report to Congress on the progress of the initiatives established under this program, based on information provided by States, which was submitted to Congress on December 16, 2013. According to this initial report, there were 7,936 participants across the 10 states as of August 31, 2013.

Data continue to be collected on satisfaction and outcomes for the enrolled participants and impacts on state agency administrative costs. A final Report to Congress, including results of the independent evaluation described above and any recommendations for

administrative action or legislation determined appropriate by the Secretary, is due not later than July 1, 2016.

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.

Legislative Proposals

Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care

The Budget proposes to authorize a five-year joint Medicaid demonstration in partnership with the Administration for Children and Families beginning in FY 2015 to address the over-prescription of psychotropic medications for children in foster care. States would receive performance-based Medicaid incentive payments to improve care coordination and delivery for foster care children with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people. This investment is paired with $250 million in the Administration for Children and Families (ACF) to support state efforts to build provider and systems capacity.

Five year budget costs: $390 million (State Grants and Demonstrations), $199 million (mandatory ACF child welfare), and $675 million (costs to Medicaid not scored under PAYGO)

Medicaid Integrity Program Investment and Expanded Authority

This proposal increases the Medicaid Integrity Program by $25 million per year (adjusted by the Consumer Price Index for All Urban Consumers). This proposal also expands the statutory authority for the Medicaid Integrity Program to increase program flexibility in protecting state and federal resources. These important reforms will support activities that protect the integrity and sustainability of Medicaid and will allow the program, in coordination with states, to strengthen initiatives that prevent fraud, waste, and abuse.

Five year budget costs: $131 million (State Grants and Demonstrations)
Five year budget savings: $87 million (savings to Medicaid not scored under PAYGO)

Extend and Improve the Money Follows the Person (MFP) Demonstration Program

This proposal would extend the demonstration period from 2016 to 2020 to enable states to continue to provide benefits. Currently, individuals must enter institutions to qualify for MFP-covered home and community-based services. To support individuals remaining in the community, this proposal would modify the demonstration to allow funds to be used for diversion services to keep individuals from entering an institution in the first place, as well as for transition services. This proposal would also reduce the MFP institutional

requirement from 90 to 60 days and allow skilled nursing facility days to be counted towards the institutional requirement. This proposal would allow individuals in certain mental health facilities to be eligible to transition to home and community-based services under MFP.

No budget impact over 5 years.

State Grants and Demonstrations
Proposed Law Outlays
Dollars in Thousands

Legislative Proposal	FY 2015
Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care	$0
Medicaid Integrity Program Investment and Expanded Authority	$25,000
Extend and Improve the Money Follows the Person (MFP) Demonstration Program	$0
TOTAL	$25,000

Affordable Insurance Exchange Grants

(Dollars in Millions)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Obligations	$2,148	$1,319	$836	($483)
Outlays	$963	$2,447	$1,899	($548)

Authorizing Legislation – Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

Allocation Method – Direct Federal, Competitive Grant, and Co-operative Agreements

Program Description and Accomplishments

The Affordable Care Act (ACA) gives States the option of establishing a Health Insurance Marketplace. The Marketplace facilitates the purchase of qualified health plans (QHPs), provides for the establishment of a Small Business Health Options Program (SHOP) designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered through the SHOP, and meets other requirements specified in 1311(d) of the ACA and in the Exchange final rule (77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, and 157)). A Federally-facilitated Marketplace (FFM) or State-Partnership Marketplace (SPM) operates in those States that elect not to pursue a State-based Marketplace (SBM).

The Marketplaces began operating in October 2013, and as of February 1, 2014, nearly 3.3 million individuals are receiving coverage through QHPs. The Marketplaces are helping individuals and small employers better understand their insurance options, and assisting individuals in shopping for, selecting, and enrolling in high-quality, competitively-priced private health insurance plans. The Marketplaces also facilitate receipt of tax credits to offset premium costs and cost-sharing assistance, as well as help individuals enroll in other Federal or State insurance affordability programs. By providing one-stop shopping, Marketplaces have made purchasing health insurance easier and more understandable, giving individuals access to increased options for and control over their health insurance purchases.

Section 1311 of the ACA provides such sums as necessary to enable the Secretary to award grants to States to support their roles in establishing Marketplaces. Grants may be awarded through December 31, 2014 for all Marketplace models. Grant funds are available for permissible and approved Marketplace establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment and start-up year. Funding can also be used to support States that wish to transition from an SPM or FFM to an SBM. States may continue to spend grant funding in 2015 and beyond. Territories that commit to establishing a Marketplace may also receive grant funding.

The Centers for Medicare & Medicaid Services (CMS) has used a phased approach to provide States with funding for implementing Marketplaces. In 2010 and 2011, CMS awarded Exchange Planning Grants to 49 States and the District of Columbia. These grants assisted States with initial planning activities related to the implementation of the Marketplaces in key areas, including background research, stakeholder involvement, governance, program

integration, technical infrastructure and business operations. CMS also awarded initial Exchange Grants (similar to planning) to four Territories that indicated their intent to establish Marketplaces.

In February 2011, CMS awarded Early Innovator funding to six States and one consortium of States to develop Exchange Information Technology (IT) systems that would serve as models for other States. This approach reduced the need for each State to "reinvent the wheel" and aided States in establishing Marketplaces by accelerating the development of Exchange IT systems. There are currently four Early Innovator States (i.e., Maryland, Massachusetts, New York, Oregon) that are actively participating in this process.

In 2011 and 2012, CMS awarded Exchange Establishment Grants to 34 States and the District of Columbia. These grants provided States with support for establishment of Exchange IT systems, outreach and education, necessary testing and improvement, as well as other activities related to the establishment of the Marketplaces. These other activities include the development of major business processes such as plan management, eligibility and enrollment, and financial management. States have used these monies to make demonstrable progress toward Marketplace establishment.

In 2013, CMS awarded Exchange Establishment Grants to 25 States and the District of Columbia. In January, CMS conditionally-approved 17 States and the District of Columbia as SBMs. These States were: California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. Three States were conditionally approved as SPMs: Arkansas, Delaware, and Illinois. In March 2013, CMS conditionally- approved SPMs in Iowa, Michigan, New Hampshire and West Virginia.

In 2014, CMS has awarded two application cycles of Exchange Establishment Grants and five administrative supplements to 15 States and District of Columbia for a total of $583m. CMS has four remaining application cycles under this program through calendar year 2014.

Funding History

Section 1311(a) of the Affordable Care Act appropriated such sums as are necessary for the Secretary to award grants under this account. The fiscal year obligations for each year are listed below.

FY 2010	$49,321,679
FY 2011	$478,373,712
FY 2012	$1,655,000,000
FY 2013	$2,147,742,000
FY 2014	TBD

Budget Overview

Open enrollment of consumers into qualified health plans (QHP)s began on October 1, 2013, for coverage beginning January 1, 2014. States that did not have a fully approved SBM on January

1, 2013 may continue to qualify for and receive a Cooperative Agreement award in connection with its activities related to establishment of the FFM or the SPM, subject to the Funding Opportunity Announcement eligibility criteria. Grants will be awarded through December 31, 2014, as provided for in Section 1311 of the ACA and Funding Opportunity Announcement. States have opportunity to submit application for establishment grants on October 15 and November 14, 2014 to support further refinement of the Exchange IT systems, outreach and education, necessary testing and improvements, and other approved establishment activities.

The establishment of a Marketplace and activities related to such establishment included start-up year expenses to allow outreach, testing, and necessary improvements. States have used grant funding to undertake critical activities, including procuring contracts for IT systems development and consultant services, and performing the necessary analyses to ensure that Marketplaces are equipped for open enrollment activities. Other examples of State activities include:

- Developing, implementing, testing, improving and strengthening of the IT infrastructure, including systems for:
    - Eligibility and premium tax credit determination;
    - Web portal design;
    - Data security and back-up systems;
    - Accounting and financial systems;
    - Interfaces with other partners such as State Medicaid agencies;
- Developing advertising, marketing, and outreach campaigns;
- Analyzing and implementing key policy and operational processes;
- Ensuring capabilities are in place to provide assistance to individuals and small businesses;
- Procuring vendor assistance to enroll individuals in plans, establishing call centers, and developing financial systems;
- Finalizing eligibility and premium tax credit determination guidelines; and
- Hiring key executives, including a chief executive officer, chief information officer, and chief financial officer to oversee operations and policy development.

The budget also funds activities to support State establishment of Marketplaces through the grant's performance period. These administrative costs include an estimated 76 full- time equivalent staff to serve as project officers, grants management staff, technical assistance teams and managers to oversee State progress toward achieving their milestones under their cooperative agreements. Funding will also be used for contracts to provide technical assistance to States on Marketplace business functions (e.g., eligibility, plan management) and to help States use their grant funding to implement programmatic components that are in line with Federal policy.

Grant Table Size of Awards*

(Whole dollars)	FY 2013 Actual	FY2014 Enacted	FY 2015 Request
Number of Awards	26	50	35
Average Award	$23,641,000	$25,840,000	$5,727,245
Range of Awards	$1,000,000 - $674,000,000	$400,000 - $450,000,000	$400,000 - $300,000,000
Total Obligations:	$2,175,000,000	$1,292,000,000	$200,453,571

*FY14 award through end of January 2014.

- **This table references only grants, not any administrative costs**

Grant Table - Total Award by State

	FY10	FY11	FY12	FY13	FY14*	Total
Alabama	1,000,000		8,772,451			$ 9,772,451
American Samoa		1,000,000				$ 1,000,000
Arizona	999,670		29,877,427			$ 30,877,097
Arkansas	1,000,000		26,461,483	16,470,852	14,217,496	$ 58,149,831
California	1,000,000	39,421,383	196,479,629	673,705,358	155,076,686	$ 1,065,683,056
Colorado	999,987		61,685,359	116,245,677		$ 178,931,023
Connecticut	996,848	6,687,933	108,880,176	27,599,500	20,302,003	$ 164,466,460
Delaware	999,999		3,400,096	8,536,543	8,321,608	$ 21,258,246
District of Columbia	999,999	8,200,716	72,985,333	16,969,089	34,418,790	$ 133,573,927
Florida	1,000,000					$ 1,000,000
Georgia	1,000,000					$ 1,000,000
Guam		1,000,000				$ 1,000,000
Hawaii	1,000,000		76,255,636	128,086,634		$ 205,342,270
Idaho	998,220		20,376,556		48,019,031	$ 69,393,807
Illinois	1,000,000	5,128,454	32,861,161	115,823,521		$ 154,813,136
Indiana	1,000,000	6,895,126				$ 7,895,126
Iowa	1,000,000		34,376,665	6,844,913	17,462,311	$ 59,683,889
Kansas	1,000,000	31,537,465				$ 32,537,465
Kentucky	1,000,000	7,670,803	62,319,810	182,707,738		$ 253,698,351
Louisiana	998,416					$ 998,416
Maine	1,000,000		5,877,676			$ 6,877,676
Maryland	999,226	33,464,203	123,048,693	24,670,310		$ 182,182,432
Massachusetts	1,000,000	35,591,333	62,219,472	80,225,650	27,841,050	$ 206,877,505
Michigan	999,772		9,849,305	30,667,944		$ 41,517,021
Minnesota		5,168,071	68,674,821	39,326,115	41,851,458	$ 155,020,465
Mississippi	1,000,000	20,143,618			21,569,043	$ 42,712,661
Missouri	1,000,000	20,865,716				$ 21,865,716
Montana	1,000,000					$ 1,000,000
Nebraska	1,000,000		5,481,838			$ 6,481,838
Nevada	1,000,000	4,045,076	69,709,209	9,020,798	6,998,685	$ 90,773,768
New Hampshire	1,000,000			6,267,088	2,048,237	$ 9,315,325
New Jersey	1,000,000		7,897,316			$ 8,897,316
New Mexico	1,000,000		34,279,483	18,600,000	69,402,117	$ 123,281,600
New York	1,000,000	38,206,330	143,971,309	245,887,768		$ 429,065,407
North Carolina	999,999	12,396,019		73,961,296		$ 87,357,314
North Dakota	1,000,000					$ 1,000,000
Ohio	1,000,000					$ 1,000,000
Oklahoma	1,000,000	54,608,456				$ 55,608,456
Oregon	1,000,000	57,065,907	8,877,701	238,262,979		$ 305,206,587
Pennsylvania	1,000,000		33,832,212			$ 34,832,212
Puerto Rico		917,205				$ 917,205
Rhode Island	1,000,000	5,240,668	58,515,871	19,073,635	27,672,020	$ 111,502,194
South Carolina	1,000,000					$ 1,000,000
South Dakota	1,000,000		5,879,569			$ 6,879,569
Tennessee	1,000,000		8,110,165			$ 9,110,165
Texas	1,000,000					$ 1,000,000
US Virgin Islands		1,000,000				$ 1,000,000
Utah	1,000,000			1,000,000	3,247,987	$ 5,247,987
Vermont	1,000,000		122,269,334	49,371,747		$ 172,641,081
Virginia	1,000,000			5,567,803		$ 6,567,803
Washington	996,285	22,942,671	127,852,056	29,601,287	84,633,761	$ 266,026,060
West Virginia	1,000,000	9,667,694		10,165,134		$ 20,832,828
Wisconsin	999,873	38,058,074				$ 39,057,947
Wyoming	800,000					$ 800,000
TOTAL:	**$48,788,294**	**$466,922,921**	**$1,631,077,812**	**$2,174,659,379**	**$583,082,283**	**$4,904,530,689**

Pre-Existing Condition Insurance Plan Program

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	$0	$0	$0	$0
Gross Outlays	$2,353,000	$1,027,000	$0	($1,027,000)
Offsetting Collections	$212,000	$75,000	$0	($75,000)
Total Net Outlays	$2,141,000	$952,000	$0	($952,000)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), Section 1101

Allocation Method – Contracts

Program Description and Accomplishments

In July 2010, the Secretary launched the Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to uninsured individuals who have been denied coverage by private insurance companies due to a pre-existing condition. This temporary program was launched on July 1, 2010, just 90 days after the law's enactment and has provided covered services to over 130,000 enrollees in the PCIP program.

Funding for this unique, temporary Federal program is limited to $5 billion to pay claims and administrative costs that are in excess of the premiums collected from enrollees in the program. The Affordable Care Act (ACA) provides the Secretary of HHS broad authority to manage program funding so that expenditures do not exceed the appropriated level, including explicit authority to stop taking enrollment applications. States may operate the program directly, while CMS operates the program in the remaining states and the District of Columbia.

Per Section 1101 of the ACA, CMS is required to establish oversight procedures, including appeals procedures and protections against fraud, waste, and abuse. CMS awarded a support services contract in FY 2012 to support these activities and efforts are currently underway to review compliance with contractual and regulatory requirements in the state-run and federally- run PCIP programs.

Eligibility and Benefits

An individual is eligible to enroll in a PCIP if he or she:

(1) Is a citizen or national of the United States or is lawfully present in the United States as determined in accordance with section 1411 of the ACA;

(2) Has not been covered under creditable coverage, as defined in section 2701(c)(1) of the Public Health Service Act as of the date of enactment, during the six-month period prior to the date on which he or she is applying for coverage through the PCIP; and,

(3) Has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

Additionally, an individual must be a resident of a State that falls within the service area of a PCIP.

Individuals who enroll in a PCIP are entitled to limited out-of-pocket costs. A plan's average share of total allowable costs must be at least 65 percent and enrollee out-of- pocket expenses cannot exceed the amount available to individuals with a high deductible health plan linked to a health savings account (this amount is currently $6,250).

All PCIP programs cover a wide range of health benefits, including primary and specialty care, hospital care, diagnostic testing, prescription drugs, home health and hospice care, skilled nursing, preventative health, and maternity care. The benefits reflect services most commonly covered by existing State High Risk pools (based on a survey conducted by the National Association of State Comprehensive Health Insurance Plans (NASCHIP) in 2009. Premiums are capped at 100 percent of the standard individual market rate in the State. By law, premiums charged in the pool may vary only on the basis of age, but not by a factor greater than four to one.

CMS took several steps to ensure that program costs remained within the original $5 billion appropriation including: a suspension of enrollment in all PCIP programs on February 15, 2013 and a regulation limiting provider payments to Medicare-equivalent levels effective June 15, 2013.

Based on available funding, CMS decided to offer the option of PCIP coverage throughout the open enrollment period for Qualified Health Plans in the Marketplaces (January through March 2014) for PCIP enrollees who had not yet obtained coverage in the Marketplaces in order to ensure a successful transition of every PCIP enrollee to Marketplaces before open enrollment ends.

State-administered PCIP Programs

HHS signed contracts with twenty-seven States to operate their own State PCIP programs. Many of these programs began accepting applicants on July 1, 2010. Based on contract negotiations in the final option year, 17 State contractors opted to terminate contracts and enrollees from the 17 State-run PCIPs were transitioned to the Federal PCIP effective July 1, 2013.

Federally-administered PCIP Program

For those States choosing not to operate their own PCIP program, HHS established the Federal PCIP program on July 1, 2010. The Federal PCIP program began operating in twenty-three States and the District of Columbia in October 2010 and provided coverage to enrollees from an additional 17 States beginning July 1, 2013. HHS entered into agreements with the U.S. Office of Personnel Management (OPM) and the U.S. Department of Agriculture's National

Finance Center (NFC) to run the program. The Government Employees Health Association (GEHA) administers the health plan benefits for the Federal PCIP program.

Funding History

FY 2010	$5,000,000,000
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0

Budget Overview

In FY 2014, CMS will continue paying claims and administrative costs (in excess of the premiums collected from enrollees in the program) at a diminishing rate, given that the program is in its last year of operations. CMS will continue to monitor and audit the State-administered PCIP programs, working with contractors to use anti-fraud detection methods related to providers and enrollees, similar to those employed in their commercial products. In FY 2014, CMS will also be closing out and reconciling funds for contracts and interagency agreements and continuing to pay claims for dates of service prior to March 31, 2014.

Early Retiree Reinsurance Program

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	-	-	-	-
Gross Outlays	$80,000	$71,000	$1,000	($70,000)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), Section 1102

Allocation Method – Contract

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.

ERRP was designed as a temporary program to provide needed financial help for employer-based plans to continue to provide valuable coverage and financial relief to plan participants, before health insurance programs created in the Affordable Care Act, such as Health Insurance Marketplaces, became available in 2014. ERRP provided 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 were 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 or other out-of-pocket relief to workers and families, or both.

The program provided $4.87 billion in financial help to approximately 2,800 sponsors offering valuable health benefit coverage to early retirees and other plan participants. Additionally, according to voluntary survey responses from plan sponsors that received ERRP funds, a minimum of 26 million plan participants have benefitted, or will benefit by the end of 2014, from the ERRP, either directly or indirectly as their plan sponsors apply the ERRP funds to offset the plan's increased costs, plan participants' costs, or both.

The Affordable Care Act appropriated $5 billion for this program. It became effective on June 1, 2010, pursuant to the interim final rule published on May 5, 2010.

In October 2010, sponsors with approved applications began to receive reinsurance payments. CMS approved applications from sponsors from all sectors of the economy and from all areas of the country. Sponsors of certified plans include entities such as businesses, schools and other educational institutions, religious groups, unions, and local governments, and non-profit organizations. By FY 2012, ERRP paid out all of the funds initially planned to go to participating plan sponsors and also initiated the overpayment collection process. Overpayment collection activities continued into FY 2013 and recovered funds were used to pay plan sponsors, in the order reimbursement requests were received. These operations will continue into early-mid FY 2014, pending the availability of recovered funds. Only reimbursement requests received prior to July 31, 2013, will be considered for reimbursement.

Funding History

FY 2010	$5,000,000,000
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0

Budget Overview

In FY 2014, CMS is continuing its program integrity work to audit the claims and enrollment data submitted by plan sponsors. If ERRP recoups any funds from program integrity related work, ERRP may redistribute some or all of such funds as reimbursements to sponsors with pending reimbursement requests (received prior to the program sunset date and in the order received). Other program operations will include system maintenance, technical support, responding to inquiries, and financial reporting. In FY 2015, ERRP will wrap up program closeout activities, such as closing out support contracts, responding to any remaining program inquiries, archiving program data and systems, and collecting remaining debts.

Consumer Operated and Oriented Plan Program and Contingency Fund

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Appropriation (rescission)	($2,278,544)	$0	$0	$0
Program Account (10% Transferred to the Contingency Fund)				
Net Outlays	$277,398	$240,639	$146,748	($93,891)
Program Account Contingency Fund				
Net Outlays	$3,043	$54,870	$10,531	($44,339)
Total Outlays	$280,441	$295,509	$157,279	($138,230)

Authorizing Legislation - Patient Protection and Affordable Care Act (ACA), Public Law 111-148, Title I, section 1322, and Public Law 111-152.

Allocation Method – Direct Loans and Contracts

Appropriating Legislation: Patient Protection and Affordable Care Act, Public Law 111-148, Title I, section 1322, and Public Law 111-152. Amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10, Title VIII, section 1857; the Consolidated Appropriations Act, 2012, Public Law 112-74, Division F, Title V, section 524, the American Taxpayer Relief Act of 2012, Public Law 112-240, Title VI, Subtitle C, section 644; and a sequester pursuant to the Balanced Budget Act and Emergency Deficit Control Act, as amended, section 251A.

Program Description and Accomplishments

The Affordable Care Act required HHS to establish the Consumer-Operated and Oriented Plan (CO-OP) Program to foster the creation of CO-OPs that will offer non-profit qualified health plans in the individual and small group health insurance markets. The program provided start-up loans (repayable in 5 years) for start-up costs and Solvency loans (repayable in 15 years) to meet State reserve and solvency requirements to support the development of CO-OPs. Priority for the award of loans was given to applicants that will offer Qualified Health Plans (QHPs) on a State-wide basis, use an integrated care model, and have significant private support. Recent data indicate that as much as 99 percent of insurance markets in metropolitan areas are highly concentrated[1]. CO-OPs therefore will provide much needed choice to customers and improve competition both inside and outside

[1] American medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets. February 23, 2010.

the Marketplaces, help constrain the growth of healthcare costs, and keep premiums down. The program helps foster competition in states like Maine, where the CO-OP is one of only two issuers offering plans on the Marketplace, and offers the lowest cost plans in almost all metal categories. A McKinsey and Company report examining new entrants to the Marketplaces determined that in the states with a CO-OP, 37 percent of the lowest-priced plans are offered by CO-OPs.

A 15-member GAO-appointed Federal Advisory Committee was established as required by statute for the purpose of making recommendations to the Secretary on program implementation. The Committee issued a final report to the Secretary with recommendations for establishing the program in April 2011. The CO-OP Program issued a final rule on governing the award of loans and the operation of the Program in December 2011.

Award of CO-OP Loans

The CO-OP Program has awarded $2.1 billion in loans to 23 organizations in 23 states, (AZ, CO, CT, IA, IL, KY, LA, MA, MD, ME, MI, MT,NE, NJ, NM, NY, NV, OH, OR, SC, TN, UT, VT, and WI). To solicit applications from organizations, the CO-OP Program published a Funding Opportunity Announcement in July 2011 (revised in December 2011). Applications were accepted on a quarterly basis, with the first round being received in October 2011, and with additional quarterly rounds through December 31, 2012.

The CO-OP Program contracted externally for expert objective reviews of the loan applications. The expert reviewers provided recommendations on awarding loans to the CMS Selection Committee, which made the final awards. CMS made initial loan awards in February 2012 and continued to accept applications and award loans in FY 2013.

With the passage of the American Taxpayer Relief Act of 2012, CMS retains the ability and funding to assist and oversee the existing CO-OPs, including the award of additional loan funding to existing borrowers. Since the passage of that Act, 11 of the CO-OPs have received a total of $30 million in additional start-up funding for operations in their existing states, and 3 CO-OPs have received a total of $113M in Start-up and Solvency funding to expand operation into new states in 2015 (KY into WV, MA into NH, and MT into ID). CMS made the first award of additional loan funding in June 2013, and will continue to accept and review requests for additional funding in FY 2014.

Loan Servicing and CO-OP Monitoring

CMS has begun disbursing Start-up and Solvency loan funds and established an infrastructure to support the awarding and monitoring of CO-OP funding. Start-up loan funds are disbursed in installments based on loan disbursement schedules that reflect the specific business plan of each CO-OP. Disbursements are contingent upon documented completion of key milestones in the business plan. Solvency loan funds are disbursed as needed to meet State licensing and solvency reserve requirements.
CO-OPs in 23 states are now licensed and offering coverage to consumers, and in 22 of those states the CO-OPs offers coverage both inside and outside of the new Marketplaces. Only one CO-OP (VT) failed to become licensed, and was subsequently terminated from the program.

During FY 2014, CMS will continue to actively monitor the loan portfolio and support the

development of the CO-OPs during their initial year as operating insurance providers. CO-OP monitoring includes regular financial reporting, coordination with the State Department of Insurance, calls with an Account Manager, audits and site visits, and increased oversight as required. The CO-OP Program has contracted with a vendor for the provision of technical assistance to CO-OPs. In addition, an independent auditor has been retained to perform compliance audits.

Funding History

FY 2010	$6,000,000,000
FY 2011	-$2,200,000,000
FY 2012	-$400,000,000
FY 2013	-$2,278,544,136

The Affordable Care Act appropriated $6 billion for the program. In FY 2011 Congress rescinded $2.2 billion; in FY 2012 Congress rescinded an additional $400 million; and the American Taxpayer Relief Act rescinded $2.3 billion, leaving $253 million in a contingency fund for oversight and assistance to existing loan entities.

Budget Overview

FY 2015 Administrative Funding for CO-OP Program ($9 Million)

The program will continue to require contract-funded technical assistance to program staff and CO-OPs as the CO-OPs build up enrollment in their health plans. Program efforts will also continue towards the development of internal IT systems for loan servicing systems and monitoring performance. The program staff will provide program management, oversight of contractors, and ensure program integrity. Funding for program integrity allows CMS to adequately identify, prevent, and prosecute fraud, abuse and/or misuse of CO-OP funds. CMS will continue to support program integrity by monitoring activities of recipient organizations, collecting documentation, conducting site visits, and engaging vendors for audits. Based on the scale of loans for this program, CMS must ensure that loan recipients meet quality and performance standards, engage in proper use of Federal funds, and reinvest profits to the benefit of the members. The CO-OP loan program requires account management, program controls, and program integrity activities.

Health Insurance Rate Review Grants
(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	-	-	-	-
Outlays	$26,476	$80,000	$50,000	($30,000)

Authorizing Legislation - PPACA, Section 1003, Section 2794 of the Public Health Service Act

FY 2010 Authorization - Public Law 111- 148

Allocation Method –Grants

Program Description and Accomplishments

In 2010, HHS established a grant program to States, the District of Columbia, and the U.S. territories to enhance the health insurance rate review process. The five-year grant program of $250 million began in fiscal year 2010. In accordance with the Affordable Care Act (ACA), no State qualifying for a grant shall receive less than $1 million or more than $5 million for a single grant year. Grants assist States in improving their rate review processes and/or establishing Data Centers that enhance the transparency of medical prices. Each grant recipient is required to provide the Secretary with information about trends in premium increases in health insurance coverage. The final rate review regulations, which were promulgated in the spring of 2011, fall of 2011, and spring of 2013, provide Federal guidance on the definition of "unreasonable" rate increases, as well as guidance on the justifications for such unreasonable increases.

FY 2010

Cycle I grants for FY 2010 were awarded on August 9, 2010. $51 million was made available to States in FY 2010. 46 States applied and were awarded $1 million each. $5 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 million.

Grant funding for Cycle I of the Health Insurance Rate Review Grant Program was awarded to:

- Enhance the current rate review process in the States;
- Increase consumer transparency and outreach efforts in the States;
- Report data to the Secretary on premium trends; and,
- 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. Cycle I grants limited funding for data centers to five percent of the total award.

FY 2011- FY 2013

In FY 2011 grant funding was opened 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 were awarded to further enhance a recipient's rate review process, building upon what they accomplished with the Cycle I grant (if the recipient was a Cycle I grantee) and working towards the continued improvement, or development, of an "effective rate review program" as outlined in Federal regulation. The Cycle II grant funding opportunity was designed to provide States with multiple opportunities (referred to as "phases") to apply for funding, depending on the status of their progress toward meeting the criteria for an effective rate review program.

In Phase II of Cycle II, a total of $8 million was awarded to one state and three territories on September 21, 2012. In Phase III of Cycle II, $2 million was awarded to one state on March 15, 2013. The Cycle II awards are multi-year grants, with periods of performance continuing through Federal Fiscal Year 2014 for Phases I and II, and with a period of performance for Phase III ending in FY 2015. States were awarded Cycle II funds to implement extensive enhancements to their rate review programs, ultimately facilitating saving money for consumers and small businesses.

In FY 2013, the Rate Review Grant Program issued a Cycle III Funding Opportunity entitled, "Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing." The purpose of Cycle III was to continue the rate review successes of Cycle I and II as well as to provide greater support to Data Centers. By increasing support to Data Centers through the Cycle III Funding Opportunity Announcement (FOA), HHS hopes to increase the transparency of the prices that are paid for medical services.

As in Cycle II, the Cycle III grants provided resources to states to achieve or maintain their "Effective Rate Review" Program status. Any state applying for a Cycle III grant to develop or enhance its rate review activities was required to demonstrate that, as of the Cycle III grant application due date, the state either: (i) met the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle III grant funds, would have the resources to meet those criteria within the twelve month period following the receipt of the Cycle III Notice of Award.

In addition, the Cycle III FOA differed from the Cycle II FOA, providing greater support to Data Centers to ensure greater public access to health pricing data. First, the Cycle III FOA eliminated the funding cap on Data Center-related activities. Second, the FOA permitted agencies other than state departments of insurance to submit applications. Third, the FOA clarified conflict of interest requirements established under section 2794(d)(2) of the Public Health Service Act. Fourth, the FOA permitted previous recipients of Cycle II funds to reapply for funds if they planned to a) establish or enhance a Data Center under section 2794(c)(1)(C); and/or b) use and disseminate pricing data as part of their rate review activities under section 2794(c)(1)(A).

Cycle III awards were made in Fiscal Year 2013, with $67.6 million awarded to twenty states and one territory.

The funding formula was consistent in Cycles II and III. In both cycles, States and Territories received a Baseline Grant Award. For Cycle II, the Baseline Grant Award was up to $3 million,

and for Cycle III up to $2 million. In addition to the Baseline Grant Award, two additional segments of funds were available under the Cycle II and III grants. "*Workload"* funds were available to States based on population and the number of health insurance issuers in the State. While the rate review regulation does not require that a State have the authority or ability to disapprove rates in order to be considered a State with an effective rate review program, the "*Performance"* funds were 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 were eligible for both the "*Workload*" and the "*Performance*" funds, in addition to the Baseline award that all awarded States receive. The segments of funding were pooled together to make a State's total award amount. The length of the project period varies between one, two, and three years, depending on when the State applied for and was awarded a grant.

Funding History

FY 2010	$250,000,000
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0

Budget Overview ($190 million)

CMS projects to outlay $80 million in FY 2014, with the remaining approximate $110 million to be outlaid in FY 2015 and FY 2016. The funding will continue to support the distribution of grants to States for two purposes: 1) enhancing rate review processes; and 2) establishing Data Centers to enhance pricing transparency.

The first authorized purpose of funds permits States, in collaboration with HHS, to 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.

The second authorized use of funds will permit States to establish "Data Centers" that collect, analyze, and disseminate health care pricing data to the public. By publishing medical claims reimbursement data, Data Centers enhance health care pricing transparency for consumers, businesses, and other stakeholders. Their publications help the public to better understand the comparative price of procedures in a given region or for a specific hospital, insurer, or provider. Businesses and consumers alike can use this data to drive decision-making and reward cost-effective provision of care. In addition, claims data can be used to better understand cost drivers, evaluate quality improvement initiatives, and better understand utilization of services.

Transitional Reinsurance Program Payments

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	-	-	$10,020,300	+$10,020,000
Outlays	-	-	$10,020,300	+$10,020,000

Appropriations – Funding Available for Obligation

Authorizing Legislation – Affordable Care Act (P.L. 111-148 & 111-152)

Allocation Method - Direct Federal

Program Description and Accomplishments

Section 1341 of the Affordable Care Act establishes a transitional reinsurance program in effect for expenditures incurred during calendar years 2014 through 2016 in which contributions are collected from health insurance issuers and group health plans to fund payments to issuers of non-grandfathered individual market plans that enroll high-cost individuals. In addition to contributions, the statute authorizes collection of an administrative fee to support program operations. HHS will collect all reinsurance contributions nationwide. In the event a state does not operate its own transitional reinsurance program, the federal government will make reinsurance payments directly to issuers in that state.

Budget Overview ($10,020 million)

CMS will assess all health insurance issuers and group health plans a per enrollee fee to fund the reinsurance contributions, which are estimated to equal over $10.02 billion in FY 2015 for the 2014 plan year. Of those contributions, $10 billion will be used to make reinsurance payments to eligible issuers in the individual market, and $20 million will be used for costs to administer the program.

Risk Adjustment Program Payments

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	-	-	$3,378,000	+$3,378,000
Outlays	-	-	$3,378,000	+$3,378,000

Appropriations – Funding Available for Obligation

Authorizing Legislation –Affordable Care Act of 2010 (P.L. 111-148 & 111-152)

Allocation Method - Direct Federal

Program Description and Accomplishments

Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program in which charges are collected from health insurance issuers that enroll healthier than average enrollees and redistributes those funds to health insurance issuers that enroll sicker than average enrollees. These provisions apply to non-grandfathered individual and small group market plans inside and outside of the Marketplace. The program is designed to reduce premium differences resulting from risk selection. Risk adjustment will be operated by a State or by the Federal government in the event the State does not establish a Marketplace or chooses not to operate a risk adjustment program. When the Federal government operates the risk adjustment program, charges will be collected and payments made for the 2014 benefit year in mid-2015.

Budget Overview ($3,378 million)

CMS will use funding received from lower than average risk plans to compensate higher than average risk plans. The CMS risk adjustment payment transfer methodology ensures that the program will remain budget neutral, such that all risk adjustment payments may be funded through risk adjustment charges. CMS plans to spend risk adjustment user fees collected under the authority 45 CFR 153.610(f) on CMS risk adjustment program administration (see discussion in Program Operations narrative).

Center for Medicare and Medicaid Innovation

(Dollars in Thousands)

	FY 2013 Actual	FY 2014 Current Law	FY 2015 Estimate
BA	$0	$0	$0
Obligations	$952,800	$1,637,400	$1,522,400

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010, Section 3021

Allocation Method - Contracts, Cooperative Agreements, Grants

Program Description and Accomplishments

The Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by Section 3021 of the Affordable Care Act for the purpose of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

The CMS Innovation Center is an integral part of CMS's efforts to transform itself from a claims payer in a fragmented care system into a health care partner in a more integrated health care environment. The CMS Innovation Center supports the development of a health care system that is integrated, accountable, and equitable; that monitors and promotes health; that continuously improves care; and that reduces unnecessary costs through adoption of new payment and service delivery models. Since its launch in November 2010, the CMS Innovation Center has sought to identify, test, evaluate and expand, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and CHIP while improving or preserving beneficiary health and quality of care.

As required by statute, the CMS Innovation Center consults with stakeholders, draws on ideas received from the health care community, including health care providers, analysts, and clinical researchers, and consults with representatives of relevant Federal agencies.

To serve as a good steward of health care dollars, the CMS Innovation Center rapidly and rigorously evaluates each new payment and service delivery model being tested, assessing the quality of care furnished, patient outcomes, and patient-centeredness, as well as return on investment and impact on total cost of care. The emphasis in evaluation is on identifying as quickly as possible best practices and successful programs to determine which new models of health care service delivery and payment are worth pursuing further.

In addition to the rigorous evaluation of the impact of each model on outcomes of interest, the CMS Innovation Center maximizes the likelihood of success through continuous quality improvement—refining promising model tests through rapid cycle evaluation and feedback to achieve better value and facilitate greater improvements in health and access to quality care. Insights into best practices identified during the test are spread as quickly, widely, and effectively as possible.

The CMS Innovation Center has developed an extensive portfolio of promising initiatives—involving a broad array of health care providers, states, payers, and other stakeholders—that are serving Medicare, Medicaid, and CHIP beneficiaries in all fifty states and the District of Columbia. In addition, to better coordinate initiatives, demonstrations, and research projects at CMS and to prevent duplication of effort and expense, the CMS Innovation Center also manages activities under other provisions of the Affordable Care Act and other laws, and certain projects authorized under section 402 of the Social Security Amendments of 1967 as amended.

Initiatives launched by the CMS Innovation Center under the authority of Section 3021 of the Affordable Care Act include:

Partnership for Patients: CMS has dedicated up to $500 million in CMS Innovation Center funding to test Partnership for Patients (PfP), a model to reduce hospital-acquired conditions and to reduce preventable readmissions. PfP, which began testing in 2011, represents a "full-court press", combining the efforts of multiple partners and federal and non-federal programs, in an aligned effort to improve patient safety by reducing Hospital Acquired Conditions (HACs) by 40% and readmissions by 20%. PfP participants include more than 3,700 participating hospitals distributed throughout all 50 states that have committed to improve care by participating in one of 26 hospital engagement networks (HENs). To facilitate this effort, the HENs have established infrastructure to support these hospitals in improvement, measurement, engaging with patients and families, learning, reporting and generating results. The goals of the PfP initiative include reducing inpatient adverse events, such as adverse drug events, central line-associated blood stream infections, catheter-associated urinary tract infections, and obstetric events such as early elective deliveries, as well as reducing readmissions through better care transitions and reducing obstetric adverse events. An important part of the Partnership is the Community-Based Care Transitions program, authorized by Section 3026 of the Affordable Care Act, which provides financial assistance to community-based organizations working closely with hospitals and other health care providers to improve transitions in care and reduce preventable rehospitalizations.

Health Care Innovation Awards: The CMS Innovation Center is committed to providing up to $1.8 billion in funding to providers and other stakeholders to implement the most compelling new ideas to deliver better health, better care, and lower cost to people enrolled in Medicare, Medicaid, and CHIP, particularly those with the greatest health care needs. These funds will be distributed in two rounds of cooperative agreements. The first round of awardees was announced in 2012; CMS is currently reviewing applicants for the second round of funding. This latter funding opportunity will support a diverse portfolio of new and innovative payment and service delivery models focused on several key areas, including outpatient and post-acute care, populations with specialized needs, and population health. Awardees for this second round of funding will be announced in early 2014.

Pioneer Accountable Care Organizations (ACO): The Pioneer ACO model, which is intended to be complementary to the Medicare Shared Savings Program (MSSP), is designed to test the ability of health care providers to rapidly transition to a population-based model of care. An independent preliminary evaluation of the Pioneer ACO Model showed that Pioneer ACOs generated gross savings of $147 million in their first year while continuing to deliver high quality care. Results showed that eight Pioneer ACOs had significantly lower spending growth relative to Medicare fee for service while exceeding quality reporting requirements. Only one Pioneer ACO had significantly higher spending growth. In the first year, all 32 Pioneer ACOs

successfully reported quality measures and achieved the maximum reporting rate for the first performance year, with all earning incentive payments for their reporting accomplishments. Overall, Pioneer ACOs performed better than comparable providers in fee-for-service Medicare for all 15 clinical quality measures for which comparable data are available.

Advance Payment ACO Model: The Advance Payment Model provides support to certain ACOs, such as physician-based and rural ACOs, that have the potential to deliver better care at lower costs but need access to seed capital in order to invest in care coordination infrastructure. Designed for organizations participating in the Medicare Shared Savings Program, the Advance Payment Model tests whether providing up-front payments to providers, to be repaid through the shared savings that participating ACOs earn, will increase participation in the Medicare Shared Savings Program, allow ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and increase the amount of Medicare savings. Thirty-six ACOs participating in MSSP have been selected for this model.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: This model tests (1) the impact that additional financial support has on FQHCs' ability to transform their practices into Patient-Centered Medical Homes (PCMHs), and (2) the effect of this transformation on quality of care, health outcomes, and expenditures. More specifically, the goal of the demonstration is for its participants to achieve NCQA Level 3 recognition as Patient Centered Medical Homes (PCMH). This entails a practice transformation process that strengthens both infrastructure, including information technology systems, and the quality of care; ultimately improving the health of the patients and the overall quality of care offered. In evaluating this model, the CMS Innovation Center will consider the impact of cost and quality of care for Medicare beneficiaries. Currently, there are 473 FQHCs participating in this Demonstration. Targeted technical assistance is provided to assist participating FQHCs with their practice transformation.

State Demonstrations to Integrate Care for Dual Eligible Individuals: The CMS Innovation Center and the Medicare-Medicaid Coordination Office awarded design contracts to fifteen States to design new approaches to better coordinate care for Americans enrolled in both the Medicare and Medicaid programs – beneficiaries sometimes described as "dual eligibles." Based on the design proposals, these States are eligible for awards of additional implementation support funding via separate cooperative agreements. All approved State demonstrations will establish new methods of payment and care integration for some of Medicare and Medicaid's most vulnerable and most costly beneficiaries.

Medicare-Medicaid Financial Alignment Initiative: The CMS Innovation Center, in collaboration with the CMS Medicare-Medicaid Coordination Office, is providing opportunities for states to implement payment and service delivery reforms to better coordinate care for Medicare-Medicaid enrollees. Eligible states are pursuing one of two models: (1) a capitated managed care model or (2) a managed fee-for-service model. Implementation of the first financial alignment models began in 2013. As indicated above, the CMS Innovation Center and the Medicare-Medicaid Coordination Office awarded design contracts to fifteen States to design new approaches to better coordinate care for this population, many of which are pursuing these models. As of February 2014, CMS has approved capitated financial alignment models in California, Ohio, Illinois, Massachusetts, New York, South Carolina, Virginia, and Washington and a fee-for-service model in Washington.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: The CMS Innovation Center, in collaboration with the Medicare-Medicaid Coordination Office, has

launched a demonstration focused on reducing preventable inpatient hospitalizations among residents of nursing facilities. CMS competitively selected seven independent organizations that are providing enhanced clinical services to people in approximately 150 nursing facilities. Participants were announced in fall of 2012, and the first sites began serving beneficiaries in February 2013.

Bundled Payments for Care Improvement: The CMS Innovation Center is testing four models of episode-based (bundled) Medicare payments in partnership with hospitals, physician groups and post-acute care providers. Under the current fee-for-service (FFS) system, separate FFS payments to numerous providers for a single episode of care may result in fragmentation of care and duplication of services. Payment models that provide a single bundled payment to providers for an entire episode of care, and that hold the same group of providers accountable for the cost, quality, and patient outcomes of that episode, may spur hospitals, physicians, and other providers to better coordinate care, improve quality of care, and reduce costs. CMS has developed four distinct models of bundling payments, varying by the types of health care providers involved and the services included in the bundle. Participation in Model 1, which tests bundled payments for acute care hospital stays, began between April 2013 and January 2014. Models 2-4 participants began a data and shared learning phase in January 2013, and many participants began the risk-bearing phase effective either October 1, 2013, or January 1, 2014. Remaining participants must advance to the risk-bearing phase by January 1, 2015.

Comprehensive Primary Care (CPC) initiative: This CMS-led, multi-payer initiative fosters collaboration between public and private payers to strengthen primary care. Health plans which cover only a small segment of a primary care practice's total patient population have historically struggled to provide enough resources to support the transformation of primary care practices in proving higher-quality, more coordinated care. The CPC initiative attempts to break through this historical impasse by inviting payers to join together with Medicare to invest in primary care. Seven markets have been chosen for investments by CMS and 492 practices are participating in the Initiative, representing a total of almost 2,500 providers serving over 330,000 Medicare fee-for-service beneficiaries and over 50,000 Medicaid beneficiaries.

Strong Start for Mothers and Newborns: The CMS Innovation Center is pursuing two complementary strategies as part of a national initiative to improve birth outcomes. First, the CMS Innovation Center partnered with providers and hospitals to improve perinatal safety by reducing early, elective deliveries prior to 39 weeks. Second, the CMS Innovation Center is testing three models of enhanced prenatal care services for women enrolled in Medicaid or CHIP who are at high risk for having a preterm birth. Awardees were announced in February 2013.

State Innovation Models: The State Innovation Models initiative is supporting the development and testing of state-based models for multi-payer payment and delivery models that deliver high-quality health care and improve health system performance for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Awards were announced in February 2013 to support both the design and implementation of state models. The CMS Innovation Center plans to make additional funds available to States on a competitive basis during 2014.

Comprehensive End-Stage Renal Disease (ESRD) Care: The new Comprehensive ESRD Care model will test the effectiveness of a new payment and service delivery model for Medicare beneficiaries with ESRD. Through this initiative, CMS will enter into agreements with groups of health care providers and suppliers called ESRD Seamless Care Organizations who will work together to provide beneficiaries with a more patient-centered, coordinated care experience. These participating organizations will assume clinical and financial responsibility for a group of beneficiaries with ESRD, and those organizations that are successful in improving beneficiary health outcomes and lowering the per capita cost will have an opportunity to share in Medicare savings with CMS.

Maryland All-Payer Model: Maryland's all-payer rate setting system for hospital services presents an opportunity for Maryland and CMS to test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health and reduced costs. Under an agreement signed between CMS and Maryland in January 2014, Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate.

Funding History (Budget Authority)

FY 2010	$5,000,000
FY 2011	$10,000,000,000
FY 2012	$0
FY 2013	$0
FY 2014	$0

Section 3021, which created Section 1115A of the Social Security Act, provides $10 billion in budget authority for activities initiated in fiscal years 2011 through 2019, with not less than $25 million to be made available each year for the design, implementation, and evaluation of innovative payment and service delivery models.

Operational Activities

The process of model testing generally requires the following operational activities:

- Data Sharing
- Implementation assistance
- Learning & diffusion activities, including Advanced Development Learning Sessions, associated with the model;
- Payment administration and/or reconciliation
- Performance monitoring and evaluation

The appropriation also supports CMS Innovation Center operational activities that are not specific to each model, including:

- Establishing and evaluating the effectiveness of Center-wide learning systems that facilitate the testing of models and the rapid and widespread diffusion of best practices and validated service delivery and payment models;
- Harvesting best practice models and identifying need gaps for designing new innovations in care delivery improvement and sustainability;
- Assessment of planning, design, and business process requirements for an information systems environment;
- Data management activities;
- Project management support; and
- Operations management and oversight.

Finally, appropriated funding is used for routine administrative costs at the CMS Innovation Center, including personnel and benefits.

Performance Measurement

CMS has developed representative performance measures that will highlight CMMI's efforts to optimize the portfolio of models; accelerate spread of successful model practices, and enhance model execution. These will include measures of beneficiary and provider reach, effective engagement in learning activities, and enhanced evaluation and research activities.

ACO1[1]: Reduce the Growth of Health Care Costs while Promoting Better Health and Health care Quality through Delivery System Reform: Delivery system reform will potentially include a very broad array of interventions, but this measure focuses on Accountable Care Organizations (ACOs), which are groups of physicians, providers and suppliers that work together to coordinate care for beneficiaries with original Medicare fee-for-service health coverage. These ACOs enter into agreements with CMS, taking responsibility for the quality of care they provide to Medicare beneficiaries in return for the opportunity to share in savings realized through care improvement. Data for this measure will be collected and aggregated across the following initiatives: Medicare Shared Savings Program (including advance payment and non-advance payment ACOs), the Pioneer ACO model, and the Comprehensive ESRD Care Initiative. This measure represents efforts across CMS, not just CMMI, to promote better health and health care quality through delivery system reform.

As part of the delivery system reform process, we will aim to increase the number of Medicare beneficiaries who have been aligned with ACOs, the number of physicians participating in ACOs, and the percentage of ACOs that share in savings (ACO measures 1.1-1.3). In CY 2013, we set the baseline and targets for measures ACO1.1 and ACO1.2 and in CY 2014, we will develop a baseline for measure ACO1.3.

CMMI 2: Identify, test, and improve payment and service delivery models

At the core of the Innovation Center's work is a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

[1] In FY 2014 budget/performance documents, these goals were numbered CMMI1.1, CMMI1.2, and CMMI1.3. They were renamed ACO1.1, ACO1.2, and ACO1.3

CMMI 2.1 Increase the percentage of active model tests that are on track to demonstrate 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost, based on interim analyses of key leading indicators: Ensuring that active model tests are on track to improve quality of care, while reducing costs, goes to the heart of the Innovation Center's daily work, the goal of measure CMMI2.1. The specific key leading indicators upon which the determination of whether a model test is on track is based on the unique needs of each CMMI model test. For instance, a shared savings model, such as a Pioneer ACO, may have different success indicators in comparison to a care coordination payment model. This measure is valuable in that it will provide frequent feedback from an organizational perspective to decision makers on whether models are being implemented well and in a way that allows for effective evaluations.

CMMI 3: Accelerate the Spread of Successful Practices and Models

Every Innovation Center test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both CMS and the health care system at large. The Innovation Center also strives to understand the level of participation from beneficiaries, providers, states, payers, and other stakeholders in order to effectively design, test, and evaluate its portfolio of models.

CMMI 3.1: Percentage of Medicare beneficiaries aligned with Innovation Center models: To date, the Innovation Center has introduced a wide range of Medicare initiatives – involving a broad array of Medicare beneficiaries, health care providers, states, payers and other stakeholders. This measure is intended to show the scope and impact of the Innovation Center's portfolio of models on Medicare beneficiaries.

CMMI 3.2: Number of states with health system transformation and payment reform plans: States play a critical role in determining the effectiveness of the health care system and the health of their population. In addition to being health care payers for the Medicaid, CHIP and state employee populations, states impact the delivery of care through their licensing and public health activities. The Innovation Center offers grant support to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP. Participating states must develop and implement a strategy of health system transformation and payment reform, including a plan for multi-payer delivery system and payment reform and community-integrated health care. This measure seeks to increase the number of states that have developed health system transformation plans.

CMMI 3.3: Number of health care professionals directly participating in Innovation Center models: To accelerate the development and testing of new payment and service delivery models, the Innovation Center recognizes that many of the best ideas will come from external partners and health care professionals in communities across the country. This contextual indicator seeks to understand the level of interest and participation among health care professionals in the Innovation Center's model portfolio.

CMMI 3.4: Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities: Every Innovation Center test of a new service delivery or payment models also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as

possible to support improvement for both CMS and the health care system at large. The Innovation Center has also created learning collaboratives for providers in its models to promote broad and rapid dissemination of evidence and best practices that have the potential to deliver higher quality and lower cost care for Medicare, Medicaid and CHIP beneficiaries. Because evidence and best practices will likely not reach beneficiaries unless model participants and providers first learn about them, this measure seeks to gain insight into the intensity of engagement in these learning activities among model participants.

CMMI 4: Enhance evaluation and research capabilities

Each new payment and service delivery model tested must be evaluated, to include an analysis of the quality of care furnished under the model, as well as changes in spending. To evaluate models, the evaluation group employs advanced statistical methods, carefully defines and selects comparison groups and applies conservative evidence thresholds to assure that programs deemed to be successful represent high-value investments of taxpayer dollars.

CMMI 4.1: Increase the percentage of models with performance plans for continuous improvement operationalized within 3 months of launch: To effectively evaluate each of the Innovation Center's model tests, it is essential to ensure that all of its models are well designed from the outset. For this reason, the Innovation Center requires that all of its models include performance plans for continuous improvement that are operationalized within three months of launch. Performance plans allow program participants to develop a clear logic model for action, identify barriers/risks in implementation, and develop clear measures for monitoring improvement over time. Additionally, these plans ensure not only that evaluators, to include the CMS Chief Actuary, will have the raw material they need to make informed and timely model determinations, it also ensures that CMS leaders will have the necessary performance information on hand to conduct interim analyses of key leading indicators for each model on a regular basis. Our FY 2015 target is for 95 percent of models with performance plans for continuous improvement are operationalized within three months of launch.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	CY 2014 Target	CY 2015 Target	CY 2015 Target +/- CY 2014 Target
ACO1.1 Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations:	CY 2013 Baseline – 4,200,000	5,600,000	7,000,000	1,400,000
ACO1.2 Increase the number of physicians participating in an Accountable Care Organizations:	CY 2013 Baseline – 100,000	131,000	161,000	30,000

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	CY 2014 Target	CY 2015 Target	CY 2015 Target +/- CY 2014 Target
ACO1.3 Increase the percentage of Accountable Care Organizations that share in savings	CY 2014 Baseline Available September 2014	Collect CY 2012 and CY 2013 data on savings and measures of quality to determine shared savings to develop baseline.	TBD: Target set when CY 2014 baseline is available	N/A
CMMI2.1 Increase the percentage of active model tests that are on track to demonstrate 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost, based on interim analyses of key leading indicators	FY 2014 Baseline Available September 2014	Collect data to develop baseline.	TBD: Target set when FY 2014 baseline is available	N/A
CMMI3.1 Percentage of Medicare Beneficiaries aligned with Innovation Center models	FY 2014 Baseline Available September 2014	Collect data to develop baseline.	Contextual Indicator	N/A
CMMI3.2 Increase the total number of states developing and implementing a health system transformation and payment reform plan	Baseline - TBD	Collect data to develop baseline.	TBD: Target set when baseline is available	N/A
CMMI3.3 Number of Health Care Professionals Directly Participating in Innovation Center models	FY 2014 Baseline Available September 2014	Collect data to develop baseline.	Contextual Indicator	N/A
CMMI3.4 Increase the percentage of active model	FY 2014 Baseline Available	Collect data to develop baseline.	TBD: Target set when FY 2014 baseline	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	CY 2014 Target	CY 2015 Target	CY 2015 Target +/- CY 2014 Target
participants who are engaged in Innovation Center or related learning activities	September 2014		is available	
CMMI 4.1 Increase the percentage of models with performance plans for continuous improvement operationalized within 3 months of launch.	FY 2014: Baseline Available September 2014	Collect data to develop baseline.	95%	N/A

Information Technology
(Dollars)

Fund Source	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Program Operations	$ 698,148,381	$1,008,837,692	$ 970,546,560
Federal Administration	49,081,000	42,613,000	42,569,000
Survey & Certification	1,695,000	1,926,000	2,034,000
Subtotal, Program Management Appropriation	**$ 748,924,381**	**$1,053,376,692**	**$ 1,015,149,560**
Coordination of Benefits (COB) User Fee	$ 7,074,790	$ 6,904,715	$ 19,970,288
CLIA User Fees	4,750,000	4,400,000	5,100,000
ESRD Network	1,200,000	1,400,000	-
Program Integrity (MIP/HCFAC)	178,762,117	214,166,005	255,397,505
ARRA/HITECH	95,552,452	92,950,000	56,037,590
Quality Improvement Organizations 1/	189,265,789	195,957,444	281,235,010
CMMI (ACA §3021)	106,879,894	114,730,855	113,173,439
Subtotal, Additional Funding Sources	**$ 583,485,042**	**$ 630,509,019**	**$ 730,913,832**
Total, CMS IT Portfolio	**$ 1,332,409,423**	**$1,683,885,711**	**$ 1,746,063,392**

1/ QIO estimates are currently being developed for the 11th scope of work

Program Description and Accomplishments

CMS's information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, HCFAC, and QIO programs. IT activities support various programs that CMS oversees, including Medicare, Medicaid, CHIP, the Affordable Care Act provisions, Private Insurance Market and associated quality-assurance and program safeguards. This chapter provides an overview of IT activities funded and discussed in various other parts of this budget submission.
Additional information can be found in those specific narratives. Further information on specific IT projects can be found within the Exhibit 53 and CMS Exhibit 300s, which can be viewed at http://www.itdashboard.gov/portfolios/agency=009,bureau=38

CMS Program Management Appropriation

CMS's IT investments support a broad range of business operational needs, as well as implementing provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. The following investments are organized similarly to the exhibit 300 portfolios, with an explanation of the type of investments in each.

Program Operations

IT Investment portfolios and activities include:

- *Beneficiary Enrollment and Plan Payment, and Beneficiary E-Services* includes the Medicare Advantage enrollment and plan payment systems such as the premium withhold system, risk adjustment system, and the Medicare Advantage Prescription Drug Payment System (MARx). Our public internet sites www.cms.hhs.gov, www.medicare.gov, and the virtual call center operations are also included.

- *Data Management Operations* supports the beneficiary enrollment database; Medicare beneficiary database suite of systems; and CMS enterprise data administration.

- *Claims Processing* operates and maintains the Medicare fee-for-service claims processing systems and the Common Working File (CWF), a major component of the Medicare claims adjudication function.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* includes development, operational, and maintenance costs for CMS's financial management system.

- *Modernized IT Infrastructure* includes Enterprise Data Centers (EDCs), providing a standardized infrastructure and network platform to process over 1 billion FFS claims.

- *Infrastructure* provides the IT business platforms for CMS and includes the Consolidated Information Technology Infrastructure Contract (CITIC), which maintains numerous Medicare program applications, CMS mid-tier and mainframe operations at the CMS data center; and ongoing systems security activities at Medicare contractors.

- *Claims Interoperability and Standards* provides for the continued standardization of certain electronic transactions required by HIPAA-enacted administrative simplification provisions.

- *Other Investments* includes:

  - *ICD-10* **-** this investment will replace the International Classification of Diseases, 9th Revision with the 10th Revision for diagnosis coding and the International Classification of Diseases. This change will have a major impact on virtually every aspect of CMS' systems and operations. This change will provide long-term benefits to the agency as the provider community and internal operational areas become familiar with the increased granularity of ICD-10 Clinical Modification and Procedure Coding. This increased granularity improves the quality of health data needed for quality measurement, pay-for-performance, medical error reduction, public health reporting, biosurveillance, actuarial premium setting, cost analysis, and more accurate reimbursement. CMS continues to perform major systems modifications, business operations updates and testing over the next several years for the implementation date of October 1, 2014.

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

Federal Administration

The Federal Administration portion of the Program Management appropriation funds a variety of IT activities that support CMS's IT infrastructure and daily CMS operations, including:

- Voice and data telecommunication costs;
- Web-hosting and satellite services;
- Ongoing systems security activities across the CMS enterprise; and
- Systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

In addition, the service and supply fund activity within Federal Administration includes CMS' share of costs for HHS enterprise activities, including payroll and email services.

Survey and Certification

Under Survey and Certification, IT funding primarily covers operations and maintenance of systems that approximately 7,000 State surveyors use to track and report the results of healthcare facility surveys. The FY 2015 request supports the continued implementation of the Quality Indicator Survey (QIS), an initiative that will utilize information technology to support quality improvements in the survey process.

Additional IT Funding Sources

Part D Coordination of Benefits (COB) and CLIA User Fees

A portion of the COB user fees will be used to fund Part D systems. CLIA user fees are collected to fund the Information Technology portion of the CLIA program.

End Stage Renal Disease (ESRD) Network

With the passage of the Medicare Improvements for Patients and Providers Act of 2008, CMS launched the first End Stage Renal Disease Pay-for-Performance Program. Section 153 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the establishment of a quality incentive payment program for ESRD providers, effective January 1, 2012. In FY 2015, this project will be funded by the Quality Improvement Organizations.

Program Integrity (HCFAC/MIP)

IT funding from the Medicare Integrity Program (MIP) budget within the HCFAC account pays for a portion of CWF operating costs, as well as the ongoing operations and

maintenance of systems related to audit tracking, Medicare secondary payer work, medical review, and other benefit integrity activities. Examples of MIP-funded systems include the fraud investigation database and the Medicare exclusion database. This funding also includes MIP- Discretionary systems costs and the One-PI system.

Quality Improvement Organizations

IT activities funded from the QIO program budget include the QIO Standard Data Processing System (SDPS), the Quality Improvement & Evaluation System (QIES), and QIO-related operations at the CMS data center and other sites.

Center for Medicare and Medicaid Innovation

The Center for Medicare and Medicaid Innovation (the Innovation Center), established by Section 3021 of the Affordable Care Act, tests new payment and service delivery models to deliver better care, better health, and reduced costs through improvement to Medicare, Medicaid, and CHIP.

IT activities funded from the CMMI appropriation include support for general center IT infrastructure and model-specific IT needs. These activities also include Innovation Supports such as learning, diffusion and stakeholder engagement.

Budget Request

CMS Program Management Appropriation

The FY 2015 request for Program Management Information Technology is $1.01 billion, a $38.2 decrease from FY 2014 Enacted level. The demand on the CMS IT portfolio continues to grow with the enactment and implementation of the Affordable Care Act. The Program Operations line within Program Management will fund extensive systems changes, enhancements and development of new systems for these new program areas. These changes include hardware/software purchases, enhanced network connectivity, and new reporting features. These funds will also support data extraction, validation of business and system needs, website redesigns, system and security documentation and additional capacity for storage.

In addition, the Program Operations funds will provide for foundational IT needs related to private insurance market oversight and the Health Insurance Marketplace. These funds will specifically support tools for consumer support, infrastructure investments, an enrollment system for the Marketplace, a data collection system for insurance and market oversight, and data reporting tools for Medical Loss Ratio oversight.

The Program Management IT Portfolio also supports numerous investments to support existing CMS functions, mostly through program operations. Some of the larger investments in program management are Enterprise Identity Management, Healthcare Integrated General Ledger (HIGLAS), Information management, HIPPA Claims based transaction/ICD-10, Master Data Management and Infrastructure. The larger investments represent about 70 percent of the total program operations spending. Some of the other investments are Medicare claims processing, Coordination of Benefits, Disaster Recovery, Physician Feedback Program, Drug and Durable Medical Equipment claims.

Funding will also support the sound management and operations of our legacy programs as CMS expands its role in the health industry. As CMS continues to modernize its IT infrastructure, managing workloads across these programs is essential to ensuring a smooth transition to newer, better systems.

Shared Services

Our FY 2015 request supports the development of IT shared services. In FY 2015, CMS will continue to implement the Agency's and Department's approach to shared services. Shared IT services include common IT applications and infrastructure technologies that deliver specific capabilities to multiple business units. Shared services are reusable and scalable and reduce costs, redundancies and required governance.

The shared services strategy will reduce costs associated with development and maintenance of duplicative capabilities. It will increase reliability and promote better government practices that will be measured rigorously through performance and earned value management.

There are five shared services strategies being implemented:

Master Data Management (MDM) - MDM comprises processes, policies, and tools that consistently define master data. MDM links and aggregates beneficiary, provider, program, and organization data from multiple disparate sources across the agency creating a trusted authoritative data source.

Enterprise Identity Management (EIDM) - EIDM provides remote identity proofing by confirming persons are who they say they are and secure systems access via a single sign-on, while meeting federal security requirements.

Enterprise Portal - The Enterprise Portal provides a framework for integrating information and processes onto a single platform and entry point for beneficiaries, providers, organizations, and States to receive CMS information, products, and services.

Business Rules Enterprise Services (BRES) – a business rules system enables policies and other operational decisions to be defined, tested, executed and maintained separately from application code, which facilitates enterprise consistency and efficiency.

Enterprise Eligibility Service (EES) – Enterprise Eligibility Service is a consistent and re-usable way for business applications to access beneficiary eligibility data for a variety of uses (e.g., claims processing, providers and plans, and external programs).

CMS will use multiple funding sources to support the Shared Services environment. Using a cost allocation methodology, CMS will utilize funds from the Program Management, HCFAC, CMMI, and QIO accounts. These funds will support critical Agency priorities, including Affordable Care Implementation.

Additional Sources of IT Funding for CMS Programs

Note that various other funding sources may be used to support CMS IT functions, depending on need and availability.

The other (non-program management) areas of IT spending are estimates and are subject to change as CMS continues the Information Technology Investment Review Board (ITIRB) process. The ITIRB was established to form a more integrated agency-wide IT approach to manage budgetary resources.

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Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of National Drug Control Policy

Resource Summary
(Dollars in Millions)

	Budget Outlay Estimates		
	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Drug Resources by Decision Unit and Function:			
Medicaid Treatment	$2,700	$3,400	$4,100
Medicare Treatment	$920	$950	$970
Total	$3,620	$4,350	$5,070
Drug Resources by Decision Unit:			
Centers for Medicare & Medicaid Services			
Total	$3,620	$4,350	$5,070
Drug Resources Personnel Summary			
Total FTEs (direct only)	0	0	0
Drug Resources as a Percent of Budget			
Total Agency Budget (in Billions)	TBD	TBD	TBD
Drug Resources Percentage	TBD	TBD	TBD

Program Summary

Mission

As an effective steward of public funds, the Centers for Medicare and Medicaid Services (CMS) is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.

Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by continuing to meet the challenges of providing drug abuse treatment care benefit payments to eligible beneficiaries.

ONDCP and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) co-sponsored recently completed research to determine what the total Federal drug treatment outlays under Medicaid were in CY 2008, and what those estimates could tell us about equivalent spending in FY 2011. The estimates displayed in the resource table were developed by the CMS Office of the Actuary (OACT) based on the research results.

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2014 CMS budget submission to the Congressional Appropriations Committees included a budget decision unit (Resource Summary table). However, because CMS has not been tasked with a drug control initiative for which budgetary resources are sought from the Congress, our resource summary reflects outlay estimates.

CMS continues to work with ONDCP to identify ways in which CMS contributes to the National Drug Control Strategy. This includes periodic briefings on CMS programs and program performance.

Methodology

Medicaid Estimate

These projections were based on the estimates in the report "Medicaid Substance Abuse Treatment Spending: Findings Report"[1], which was written at the request of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health & Human Services (HHS) and the Office of National Drug Control Policy (ONDCP).

The projections relied on the estimates of substance abuse treatment expenditures within core services (inpatient and outpatient hospital services, residential care services, prescription drugs, and substance abuse treatment services provided through managed care plans) for calendar year 2008 by state, service, and eligibility category. Those estimates were trended forward to fiscal year 2012 using the growth rate of expenditures by state, service, and eligibility category from the CMS-64, the Annual Person Summary files from the Medicaid Statistical Information System, and the estimates of enrollment growth consistent with the President's FY 2015 Budget. The annual growth rates were multiplied by 98 percent, consistent with the findings of Bouchery et al. (2012) that substance abuse treatment expenditures grew on average at the 98 percent of the rate of all Medicaid services in the same service categories. For residential care services, because neither the CMS-64 nor the Annual Person Summary files provides detail on this service, the growth rate in total Medicaid benefits (by state and eligibility category) was used.

The projections for fiscal years 2013 through 2015 were then developed from the fiscal year 2012 estimates multiplied 98 percent of the growth rate in expenditures by service and eligibility category from the President's FY 2015 Budget (the Budget does not include projections of expenditures by state). The projections include the impacts of the Affordable Care Act, most notably the Medicaid eligibility expansion in 2014.

For the service categories, because of changes to CMS-64 in 2010 and 2011, some adjustments were made in calculating the growth rates for 2008 through 2012. For inpatient hospital services, expenditures for critical access hospitals, emergency hospital services, inpatient hospital supplemental payments, and inpatient hospital graduate medical education payments were included to calculate the growth rate in inpatient hospital services. For outpatient hospital services, outpatient hospital supplemental payments were included. Additionally, consistent with the estimates in Bouchery et al. (2012), these projections do not include any prescription drug rebates collected by Medicaid; the prescription drug rebates substantially reduce net Medicaid expenditures on prescription drugs.

[1] Bouchery E, Harwood R, Malsberger R, Caffery E, Nysenbaum J, and Hourihan K, "Medicaid Substance Abuse Treatment Spending: Findings Report," Mathematica Policy Research, September 28, 2012.

Medicare Estimate

The estimates of Medicare spending for the treatment of substance abuse are based on the FY 2015 President's Budget baseline. These projections reflect estimated Part A and Part B spending and are based on an analysis of historical fee-for-service claims through 2011, using the primary diagnosis code[2] included on the claims. The historical trend of substance abuse spending was used to make projections into the future.

An adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage plans, since their actual claims are not available. It was assumed that the proportion in costs related to substance abuse treatment was similar for beneficiaries enrolled in Medicare Advantage plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Part D of Medicare because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat substance abuse are also used to treat other conditions.

Budget Summary

The total FY 2015 drug control outlay estimate for the CMS is $5,070 million, a net increase of $720 million above the FY 2014 outlay estimate. This estimate reflects Medicaid and Medicare benefit outlays for substance abuse treatment. Overall year to year growth in substance abuse spending is a function of estimated overall growth in Medicare and Medicaid. Some of the FY 2014 to FY 2015 growth is attributable to the Medicaid expansion assumed to begin in 2014.

Medicaid
FY 2015 outlay estimate: $4,100 million
(Reflects $700 million increase from FY 2014)

Medicaid is a means-tested health care entitlement program financed by States and the Federal government. States have considerable flexibility in structuring their Medicaid programs. Medicaid mandatory services include substance abuse services for detoxification and treatment for substance abuse needs identified as part of early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21 years of age. Additional Medicaid substance abuse treatment services may be provided as optional services.

Medicare
FY 2015 outlay estimate: $970 million
(Reflects $20 million increase from FY 2014)

Medicare provides hospital, supplemental medical and prescription drug insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance abuse treatment benefits payments are made for Medicare Part A inpatient hospital care, Medicare Part B outpatient treatment, Medicare Part B preventative substance abuse treatment, and Medicare Part D prescription drugs for substance abuse.

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 disease categories.

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

Supplementary Materials **Page**

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CMS Program Management
Budget Authority by Object

	2014 Base	2015 Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$455,886,000	$486,480,000	$30,594,000
Other than full-time permanent (11.3)	$10,188,000	$10,551,000	$363,000
Other personnel compensation (11.5)	$7,929,000	$8,178,000	$249,000
Military personnel (11.7)	$14,811,000	$14,993,000	$182,000
Subtotal personnel compenstion	**$488,814,000**	**$520,202,000**	**$31,388,000**
Civilian benefits (12.1)	$131,515,000	$146,206,000	$14,691,000
Military benefits (12.2)	$7,630,000	$7,724,000	$94,000
Total Pay Costs	**$627,959,000**	**$674,132,000**	**$46,173,000**
Travel and transportation of persons (21.0)	$6,753,000	$6,753,000	$0
Rental payments to GSA (23.1)	$5,000,000	$5,100,000	$100,000
Communication, utilities, and misc. charges (23.3)	$305,000	$310,000	$5,000
Printing and reproduction (24.0)	$3,506,000	$3,506,000	$0
Other Contractual Services:			
Other services (25.2)	$2,118,285,000	$2,123,160,000	$4,875,000
Purchase of goods and services from government accounts (25.3)	$3,055,000	$3,882,000	$827,000
Research and Development Contracts (25.5)	$20,054,000	$15,967,000	($4,087,000)
Medical care (25.6)	$1,136,660,000	$1,365,681,000	$229,021,000
Subtotal Other Contractual Services	**$3,278,054,000**	**$3,508,690,000**	**$230,636,000**
Supplies and materials (26.0)	$1,063,000	$1,153,000	$90,000
Equipment (31.0)	$100,000	$100,000	$0
Grants, subsidies, and contributions (41.0)	$50,420,000	$0	($50,420,000)
Total Non-Pay Costs	**$3,345,201,000**	**$3,525,612,000**	**$180,411,000**
Total Budget Authority by Object Class	**$3,973,160,000**	**$4,199,744,000**	**$226,584,000**

American Recovery and Reinvestment Act (ARRA)

Personnel compensation:			
Full-time permanent (11.1)	$13,764,000	$17,399,000	$3,635,000
Other personnel compensation (11.5)	$227,000	$278,000	$51,000
Civilian benefits (12.1)	$3,983,000	$5,231,000	$1,248,000
Other Contractual Services:			
Other services (25.2)	$122,026,000	$117,092,000	($4,934,000)
Total Budget Authority by Object Class	**$140,000,000**	**$140,000,000**	**$0**

CMS Program Management
Salaries and Expenses

	2014 Base	2015 Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$455,886,000	$486,480,000	$30,594,000
Other than full-time permanent (11.3)	$10,188,000	$10,551,000	$363,000
Other personnel compensation (11.5)	$7,929,000	$8,178,000	$249,000
Military personnel (11.7)	$14,811,000	$14,993,000	$182,000
Subtotal personnel compensation	**$488,814,000**	**$520,202,000**	**$31,388,000**
Civilian benefits (12.1)	$131,515,000	$146,206,000	$14,691,000
Military benefits (12.2)	$7,630,000	$7,724,000	$94,000
Total Pay Costs	**$627,959,000**	**$674,132,000**	**$46,173,000**
Travel and transportation of persons (21.0)	$6,753,000	$6,753,000	$0
Communication, utilities, and misc. charges (23.3)	$305,000	$310,000	$5,000
Printing and reproduction (24.0)	$3,506,000	$3,506,000	$0
Other Contractual Services:			
Other services (25.2)	$2,118,285,000	$2,123,160,000	$4,875,000
Purchase of goods and services from government accounts (25.3)	$3,055,000	$3,882,000	$827,000
Research and Development Contracts (25.5)	$20,054,000	$15,967,000	($4,087,000)
Medical care (25.6)	$1,136,660,000	$1,365,681,000	$229,021,000
Subtotal Other Contractual Services	**$3,278,054,000**	**$3,508,690,000**	**$230,636,000**
Supplies and materials (26.0)	$1,063,000	$1,153,000	$90,000
Total Non-Pay Costs	**$3,289,681,000**	**$3,520,412,000**	**$230,731,000**
Total Salary and Expense	**$3,917,640,000**	**$4,194,544,000**	**$276,904,000**
Direct FTE	**4,542**	**4,738**	**196**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$13,764,000	$17,399,000	$3,635,000
Other personnel compensation (11.5)	$227,000	$278,000	$51,000
Civilian benefits (12.1)	$3,983,000	$5,231,000	$1,248,000
Other Contractual Services:			
Other services (25.2)	$122,026,000	$117,092,000	($4,934,000)
Total Salary and Expense	**$140,000,000**	**$140,000,000**	**$0**
Direct FTE	**130**	**161**	**31**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2013 Actual	2014 Estimate	2015 Estimate
Office of the Administrator			
Direct FTEs	17	19	19
Reimbursable FTEs	0	0	0
Subtotal	17	19	19
Center for Clinical Standards and Quality			
Direct FTEs	204	198	206
Reimbursable FTEs	34	34	37
Subtotal	238	232	243
Center for Consumer Information and Insurance Oversight			
Direct FTEs	289	289	301
Reimbursable FTEs	0	0	0
Subtotal	289	289	301
Center for Medicaid and CHIP Services			
Direct FTEs	313	304	317
Reimbursable FTEs	0	0	0
Subtotal	313	304	317
Center for Medicare			
Direct FTEs	669	649	677
Reimbursable FTEs	5	5	8
Subtotal	674	654	685
Center for Medicare and Medicaid Innovation			
Direct FTEs	21	8	8
Reimbursable FTEs	0	0	0
Subtotal	21	8	8
Center for Program Integrity			
Direct FTEs	3	3	3
Reimbursable FTEs	0	0	0
Subtotal	3	3	3
Center for Strategic Planning			
Direct FTEs	9	10	10
Reimbursable FTEs	0	0	0
Subtotal	9	10	10
Office of Acquisition & Grants Management			
Direct FTEs	172	167	174
Reimbursable FTEs	2	2	2
Subtotal	174	169	176
Office of the Actuary			
Direct FTEs	83	80	83
Reimbursable FTEs	0	0	0
Subtotal	83	80	83
Office of Communications			
Direct FTEs	215	211	220
Reimbursable FTEs	0	0	0
Subtotal	215	211	220
Office of Enterprise Management			
Direct FTEs	151	147	154
Reimbursable FTEs	0	0	0
Subtotal	151	147	154
Office of Equal Opportunity and Civil Rights			
Direct FTEs	33	31	32
Reimbursable FTEs	0	0	0
Subtotal	33	31	32
Office of Federal Coordinated Health Care			
Direct FTEs	28	25	26
Reimbursable FTEs	0	0	0
Subtotal	28	25	26
Office of Financial Management			
Direct FTEs	260	227	237

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2013 Actual	2014 Estimate	2015 Estimate
Reimbursable FTEs	27	27	30
Subtotal	287	254	267
Office of Hearings and Inquiries			
Direct FTEs	0	108	112
Reimbursable FTEs	0	0	0
Subtotal	0	108	112
Office of Information Services			
Direct FTEs	415	412	429
Reimbursable FTEs	3	3	4
Subtotal	418	415	433
Office of Legislation			
Direct FTEs	44	39	41
Reimbursable FTEs	0	0	0
Subtotal	44	39	41
Office of Minority Health			
Direct FTEs	10	14	14
Reimbursable FTEs	0	0	0
Subtotal	10	14	14
Office of Operations Management			
Direct FTEs	295	250	261
Reimbursable FTEs	0	0	0
Subtotal	295	250	261
Office of Public Engagement			
Direct FTEs	73	0	0
Reimbursable FTEs	0	0	0
Subtotal	73	0	0
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	149	145	151
Reimbursable FTEs	0	0	0
Subtotal	149	145	151
Consortia			
Direct FTEs	1,237	1,209	1,260
Reimbursable FTEs	34	41	44
Subtotal	1,271	1,250	1,304
Total, CMS Program Management FTE 1/	**4,794**	**4,654**	**4,863**
Total, CMS Military Staffing (Non-Add) 1/	*138*	*163*	*164*
American Recovery and Reinvestment Act (ARRA)			
Total, CMS Program Management FTE 1/	**124**	**130**	**161**

1/ FY 2013 reflects actual FTE consumption. Reflects discretionary Program Management staffing, except for ARRA staffing.

Average GS Grade

FY 2011	**13.4**
FY 2012	**13.3**
FY 2013	**13.4**
FY 2014	**13.4**
FY 2015	**13.4**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2013 Actual	2014 Base	2015 Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$165	$165	$165
Subtotal	75	75	75
Total - ES Salaries	$12,384	$12,477	$12,602
GS-15	548	545	570
GS-14	639	636	665
GS-13	2,052	2,042	2,135
GS-12	764	761	795
GS-11	216	215	225
GS-10	1	1	1
GS-9	168	167	174
GS-8	7	7	7
GS-7	62	61	64
GS-6	43	43	45
GS-5	55	54	57
GS-4	41	41	43
GS-3	19	19	20
GS-2	1	1	1
GS-1	0	0	0
Subtotal 1/	4,615	4,593	4,801
Total - GS Salary 1/	$452,719	$453,596	$484,399
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$98.097	$98.758	$100.895

1/ Reflects direct discretionary 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.

FTEs Funded by the Affordable Care Act

Center for Medicare & Medicaid Services

Program	Section	FY 2011			FY 2012			FY 2013			FY 2014			FY 2015		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated																
Health Insurance Consumer Information	1002		2			0			0			0			0	
Rate Review Grants	1003		0			0			0			0			0	
Pre-existing Condition Insurance Plan Program	1101		13			18			12			14			0	
Reinsurance for Early Retirees	1102		2			4			11			8			0	
Affordable Choices of Health Benefit Plans	1311	$478,373,714	28		$1,654,595,531	44		$2,750,521,000	56		$1,342,521,000	65		$250,974,000	76	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP)	1322	-$2,200,000,000	1		-$400,000,000	6		-$2,278,500,000	18		$0	18		$0	16	
CO-OP Contingency Fund	1322/644	$0	0		$0	0		$253,171,570	0		$0	0		$0	0	
Adult Health Quality Measures	2701	$60,000,000	2		$60,000,000	5		$60,000,000	10		$60,000,000	11			11	
Medicaid Emergency Psychiatric Demonstration	2707	$75,000,000	0			0			0			0			0	
Quality Measurement	3014	$20,000,000	2		$20,000,000	4		$20,000,000	6		$20,000,000	7			7	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021	$10,000,000,000	68			163			258			412			443	
Independence At Home Demonstration	3024	$5,000,000	0		$5,000,000	3		$5,000,000	2		$5,000,000	2		$5,000,000	2	
Community Based Care Transitions	3026	$500,000,000	0			2			1			1			1	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			2			1			1			1	
Medicaid Incentives for Prevention of Chronic Disease	4108	$100,000,000	0			1			1			2			2	
Community Prevention and Wellness	4202		0			1			1			1			1	
Graduate Nurse Education	5509		0		$50,000,000	1		$50,000,000	0		$50,000,000	0		$50,000,000	0	
Sunshine Act	6002		0			0		$16,050,000	11		$1,024,000	24		$21,399,000	24	
LTC National Background Checks	6201		2			3			4			5			5	
Provider Screening & Other Enrollment Requirements/1	6401		5			8		$5,000,000	10			15		$18,035,000	15	
Enhanced Medicare/Medicaid Program Integrity Provisions/1	6402	$10,000,000	2		$10,000,000	2		$13,000,000	1		$3,000,000	2		$27,377,000	2	
Expansion of the Recovery Audit Contractor Program/1	6411		2			2		$3,300,000	1		$3,783,000	2		$3,975,000	2	
Termination of Provider Participation under Medicaid/1	6501		0			0			0			0		$0	0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	10323	Such Sums	0		Such Sums	2		$0	1		Such Sums	1		Such Sums	1	
Total ACA Direct Appropriated FTEs			**129**			**271**			**405**			**591**			**609**	

/1 From FY 2011 through FY 2016, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

Physicians' Comparability Allowance (PCA) Worksheet

DHHS: Centers for Medicare and Medicaid Services

Table 1

		PY 2013 (Actual)	CY 2014 (Estimates)	BY 2015* (Estimates)
1) Number of Physicians Receiving PCAs		40**	45	48
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		40	45	48
4) Average Annual PCA Physician Pay (without PCA payment)		$155,500	$155,500	$155,500
5) Average Annual PCA Payment		$27,000	$27,000	$27,000
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	48

**** PY 2013 totals were generated on August 8, 2013 prior to the end of the fiscal year. Please note that this number is subject to change. We recently had 42 Medical Officers and 2 recently left (one at the end of May and the other at the beginning of August).**

***CY 2014 data will be approved during the FY 2015 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.

CMS currently has a freeze for all existing PCA contracts and when they are eligible for a renewal, the PCA amount cannot be increase in the amount unless they went from less than 24 months as a Government Physician to more than 24 months as a Government Physician. The maximum amount of PCA varies depending on the GS level, the number of years as a Government physician, if they sign a one year or multi-year contract, board certified and mission-specific which is a factor based on the physician's duties that are directly related to the strategic mission and goals of CMS. The maximum for less than 24 months as a Government Physician is $14,000 and for more than 24 months as a Government Physician is $30,000. Each time that the physician is eligible for a new contract, the package is reviewed to see if they meet the criteria for additional money due to the number of years as a Government Physician.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

In order to attract and retain highly skilled and qualified Medical Officers, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) and Physician's and Dental Pay (PDP.) CMS Medical Officers are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. Positions recruited and filled by Medical Officers require the knowledge and skills of a licensed physician to perform such duties as, evaluation of medical technology, Medicare coverage decisions, advising the Regional Offices on Medicare coverage and claims, women and children's health issues, managed and long term care coverage decisions, hospital and physician reimbursement and payment policy.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

With the implementation of the Affordable Care Act, CMS had to set up several new program offices to implement new programs. CMS is still currently staffing up to meet the aggressive deliverables and fast approaching deadlines for ACA. Some of these mandates require establishing additional new Medical Officer positions or quickly filling vacated Medical Officer position 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.

CMS currently has three Medical Officer positions that will be filled in FY14.

Two of the positions are being recruited for the Centers for Medicare & Medicaid Innovation (CMMI). One will be a Supervisory Medical Officer at the GS-15 level and the other will be a Medical Officer at the GS-14 level. The GS-15 Supervisory Medical Officer is currently posted in CMS and will be performing work related to overseeing the clinical and medical aspects of all the Advanced Primary Care models that are tested or are proposed for inclusion in the Center's portfolio. They will also oversee and direct medical aspects of the evaluation that Advanced Primary Care models will undergo. Specifically, they will provide authoritative medical advice and guidance in the development of policies incorporating the operational aspects of the CMMI as well as achieve progress in achieving the goals of better care, better health and lower cost through improvements. The GS-14 position is currently with Human Resources for review.

The Center of Clinical Standards and Quality (CCSQ), Quality Improvement Group (QIG), in the Division of Value Incentives and Quality Reporting anticipates recruiting for a GS-13 Medical Officer. The Medical Officer will provide clinical advice to inform policy making for Value Based Purchasing (VBP) and Quality Reporting programs. The selectee will represent the group and CCSQ in clinical discussions about Value Based Purchasing and Quality Reporting programs. The selectee will advise OIG and CCSQ leadership on VBP quality reporting program clinical quality content to inform quality improvement and quality measurement priorities. Advice reflects clinical expertise and current guidelines, and CMS' and HHS Quality Strategy framework.

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

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SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2015 CONGRESSIONAL JUSTIFICATION

Item

Budget Request —The agreement expects the Centers for Medicare & Medicaid Services (CMS) to provide the detailed plans for all of the agency's mandatory and discretionary resources. The CMS tables should include the prior year actual, current year request level, current year actual (based on the operating plan) and budget request year level. Further, please include a description in the fiscal year 2015 budget request on CMS's fiscal management processes in place.

Action Taken or To be Taken

CMS will follow up with the Appropriations Committees to provide additional information on the agency's mandatory and discretionary resources. CMS' fiscal management process requires that funds allocated for all accounts be subject to a strict apportionment/allotment/allowance accounting control structure. Detailed operating plans for use of the resources are reviewed and approved by Department and OMB officials prior to the provision of funding. An internal budget execution and accounting process ensures that no funds are comingled with other funding that has been provided to CMS. The internal controls for the execution of funds are subject to audit by an independent verification and validation accounting firm. An annual CMS Chief Financial Officer audit is performed by a separate accounting firm. The results of these audits have provided that CMS is 100 percent compliant with internal cost allocation and the process for control of funds is sound, and fully meets generally accepted accounting principles.

Item

CMS Policy Guidance —The CMS uses Medicare Administrative Contractors (MACs) as its agent in lieu of Federal employees to process reimbursement activity. It is understood that the MACs may develop and implement independent policies, which can be perceived as being inconsistent with CMS guidance. The CMS is requested to provide a detailed description in the fiscal year 2015 budget request of the mechanisms CMS has in place or plans to put in place to ensure its contracting agents consistently adhere to CMS policies.

Action Taken or To be Taken

As CMS contractors, MACs are contractually required to implement policies that are consistent with CMS guidance. The MACs were authorized in their current form by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, PL 108-173 (MMA). Under that law, CMS contracts with MACs using the Federal Acquisition Regulation (FAR). The FAR gives contracting officers the authority to enter into, administer, or terminate contracts. The contracts that CMS has with the MACs have numerous requirements dictating to the MACs how they must follow CMS guidance. Every year the MACs are evaluated as to whether or not they meet the performance requirements of their contract and if they deviate from any CMS guidance. Under the MMA and the FAR, CMS has the authority to terminate a MAC contract.

MAC policies may include Local Coverage Determinations (LCDs), which must follow section C.5.6 of the MAC's statement of work, chapter 13 of the Medicare Program Integrity Manual, and section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (codified at section 1869(f)(2) of the Social Security Act). In order to ensure that all LCDs remain accurate and up-to-date, MACs are required to review and appropriately revise annually LCDs based upon CMS National Coverage Determinations, coverage provisions in interpretive manuals, national payment policies, and national coding policies. This process

includes a review of the LCDs in the Medicare Coverage Database and on each MAC's Web site. Thus, mechanisms are already in place to ensure that the MACs adhere to CMS policies.

Item

CMS Testing Industry Solutions Initiative —The agreement continues support for this initiative and requests an update in the fiscal year 2015 congressional budget request on the status of the initiative.

Action Taken or To be Taken

CMS continues to take steps to make its program data more accessible to outside users/researchers. However, these increased demands can place additional stress on CMS' existing infrastructure. As a result, CMS continues to make investments in its IT infrastructure, especially in the areas of data capacity and identity management. In FY 2012, CMS invested an additional $3M in two ongoing projects: the Integrated Data Repository (IDR) and Enterprise Identity and Access Management (EIAM), which, together, are CMS' enterprise data warehouse. EIAM strengthens remote identity proofing for potential users of our data. The IDR consolidates CMS' data in one place, ensures its integrity, quality, and consistency, and enables shared access with external business partners. Both of these projects support the success of this initiative, also known as the "data sandbox".

Item

Critical Access Hospitals —It is expected that CMS will provide a list of critical access hospitals that would be re-designated under the Administration's proposal to remove critical access hospital status from facilities located less than 10 miles from another hospital. The CMS is encouraged to work with the Office of Rural Health Policy at Health Resources and Services Administration to ensure that rural patients maintain access to necessary health services.

Action Taken or To be Taken

CMS will work with the Committee to provide the requested information. Currently, when making a determination of a Critical Access Hospital's (CAH) satisfying the statutory location requirements concerning proximity to another CAH or a hospital, CMS starts by using online driving directions programs (such as google maps) to calculate the number of driving miles to other CAHs or hospitals. CMS also considers any evidence to the contrary that the CAH chooses to submit before making its determination. Any list would preliminary estimate only based on the initial policy proposal. A final determination of the effect on the status of any particular CAH would be determined on a case-by-case basis and would depend on the legislative language and implementing regulations.

Item

Fraud, Waste, and Abuse —The agreement urges CMS to implement a process across all operations to increase its focus on preventing improper payments and paying claims right the first time. A 2010 GAO report found that CMS had no formal process in place to ensure that vulnerabilities identified by the Recovery Audit Contractor (RAC) program are addressed. The CMS is directed to include in its annual report to Congress the steps it has taken to implement a systematic process across all operations to prevent fraud, waste, and abuse in both federal and contractor-operated program and administrative activities and an accounting of RAC-reported vulnerabilities.

Action Taken or To be Taken

CMS strives to protect the Medicare Trust Fund and routinely deploys various internal and external processes to implement corrective actions and address improper payments. Collective efforts between CMS and various entities uncover improper payment vulnerabilities, leading to implementation of systematic processes across all operations to prevent fraud, waste, and abuse in both federal and contractor-operated programs and administrative activities. Where relevant, recommendations are identified for program implementation, monitoring, and management via reports issued by the Office of the Inspector General (OIG) and the Government Accountability Office (GAO), reviews performed by Recovery Auditors and Medicare Administrative Contractors (MACs), and other sources.

In FY 2013, CMS developed the Program Vulnerability Tracking System (PVTS). The main purpose of PVTS is to document and track associated corrective actions implemented for Recovery Audit-identified vulnerabilities that meet the $500K collected amount threshold. PVTS provides a searchable database of Recovery Audit issues and corrective action responses, serves as a channel for OIG/GAO recommendations and data requests, and minimizes reporting errors by centralizing data and reports within a single system.

CMS will report the information the Committee requested in the annual Recovery Audit Report to Congress beginning with the FY 2012 report.

Item

Food Allergies and Disease Management —In the United States, a patient visits an emergency department every three minutes for the treatment of a food-related allergic reaction. Proper management of food allergies could improve patient outcomes, reduce costs, and decrease the incidence of preventable death. The CMS is encouraged to consider food allergy patients in other disease management pilot programs.

Action Taken or To be Taken

CMS appreciate the importance of proper management of food allergies. The Center for Medicare and Medicaid Innovation (Innovation Center) was created by the Affordable Care Act to test innovative payment and delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. Currently, the Innovation Center does not have any initiatives specifically focusing on disease management for beneficiaries with food allergies. CMS will keep the management of food allergies in mind as it further develops the Innovation Center's portfolio of initiatives.

Item

Hospital Outpatient Prospective Payment System —There continues to be concern regarding how the CMS 2014 Hospital Outpatient Prospective Payment System rule may expand packaged payment policies. Recognizing the need to increase efficiency and decrease cost, there is specific concern regarding the criteria under which a drug or biologic associated with a hospital outpatient procedure would be packaged. It is expected that within 90 days after enactment of this act, CMS will provide a briefing for Senate and House Appropriations Committees on the criteria used to form the new rule, specifically how a drug or biologic associated with a hospital outpatient procedure was packaged together.

Action Taken or To be Taken

In the CY 2014 OPPS proposed rule, CMS did not propose revisions or expansions to our payment policy for drugs and biologicals, CMS continued to pay separately for drugs and biologicals with a per day cost higher than the established drug packaging threshold based on our 2007 methodology. For CY 2014, this threshold is $90. We did propose and finalize packaging a very specific set of drugs and biologicals that function as supplies in a surgical procedure or diagnostic tests, which is consistent with prior policies, such as our policy to package diagnostic radiopharmaceuticals and contrast agents with the associated diagnostic test.

Item

Recovery Audit Contractors (RACs) —There is concern that the CMS RAC program has created incentives for RACs to take overly aggressive actions. Information received from the Office of Medicare Hearings and Appeals (OMHA) indicates that about 50 percent of the estimated 43,000 appeals were fully or partially overturned at its level. The fiscal year 2015 budget request should include a plan with a timeline, goals, and measurable objectives to improve the RAC process. In addition, CMS is expected to work with Congress and stakeholders to identify challenges and additional reforms. Further, CMS should establish a systematic feedback process with the OMHA, CMS programs, and the RACs to prevent the appearance that RACs are selecting determinations to increase their fees. The CMS is urged to stay focused on improvements to all operations that prevent improper payments in lieu of chasing dollars after the fact.

Action Taken or To be Taken

CMS has several policies in place to oversee and limit Recovery Auditor actions. Many of these requirements have been in place since the national program began. First, CMS approves all RAC review methodologies prior to allowing RACs to identify improper payments. To receive approval from CMS, the RAC must submit evidence that it will be selecting appropriate claims for review and applying CMS policies correctly.

Second, an independent validation contractor then selects a random sample of claims, from each RAC, on a monthly basis. The results of these validation reviews are compiled to create an annual “accuracy” score for each RAC which is published in the Recovery Audit Programs’ Report to Congress. Any concerns regarding how a RAC is performing a particular review is addressed immediately, the result of which may be as simple as a revision in the RAC’s claim selection criteria, or as significant as a complete rescinding of the review (with closure of all related claims). A “Special Study”, which targets claims from a specific review area, can also be done, at CMS discretion. These are generally used when RAC denial rates appear different (much higher, or much lower) than those from other contractors, for example the CERT contractor. Very few of these studies have been done.

Third, per the RAC SOW, the RAC loses their contingency fee for any claim denial that is overturned in the appeal process, at any level.

CMS acknowledges that the increased review by the RACs causes increased appeals. Historically the RACs are upheld at the first two levels of appeal. Administrative Law Judges (ALJs) adjudicate the third level of appeal and have discretion regarding the use of CMS manuals and Local Coverage Determinations. ALJs also sometimes have hearings where the beneficiary and/or physician are testifying to the need and/or level of care provided. This is the first opportunity for this type of discussion and may lead to reversals. Those reversals are not

necessarily indicative of incorrect decisions being made by the RACs. CMS is working with OMHA to coordinate as much as possible on upcoming appeal volume, proactive policy changes and rulings which could decrease the volume of appeals. In addition, CMS routinely requests additional funding for more educational efforts to help providers bill accurately as well as functionalities such as prior authorization which would allow providers to have a payment decision prior to rendering the service.

Item

Rural Policy Decisions —There is concern that CMS does not sufficiently account for the realities of rural health care in rule making. Small and rural hospitals, where medical workforce shortages are most severe, need reasonable flexibility to appropriately staff their facilities so they can continue to provide a full range of services to their communities. It is expected that within 90 days of enactment CMS will brief the House and Senate Appropriations Committees on how they will coordinate with HRSA's Office of Rural Health Policy to balance proper care while allowing small and rural hospitals more flexibility in CMS' rule making process.

Action Taken or To be Taken

CMS has been working closely with stakeholders to address the medical workforce shortages impacting small and rural hospitals while ensuring access to high-quality health services. To this end, CMS coordinates with HRSA's Office of Rural Health Policy and routinely receives and addresses the recommendations of the White House Rural Council. CMS has publicly solicited comments for future rulemaking from rural providers about additional regulatory or other requirements that could reduce barriers to the provision of telehealth, hospice or home health services.

Item

Medicare Fraud Prevention —The agreement urges CMS to develop a more robust set of tools to prevent fraud, such as using the latest technology to ensure only valid beneficiaries and valid providers receive benefits. The statement directs GAO to review the feasibility, cost, benefits, and barriers for CMS to implement a Medicare transactional system with "smart card" type technology. The review must examine technology related to beneficiary and provider validation and authentication at point of entry for provider care within the Medicare program and consider ease of implementation, impact on the beneficiary, provider, ease of use, cost attributes (long and short term), and other criteria relevant to decision making, sourcing, and implementation. The GAO is expected to publish a report within one year of enactment. The CMS is expected to provide a report on its plans for implementing the GAO recommendations within 90 days after the report is published.

Action Taken or To be Taken

CMS will review the GAO report and respond when the report is completed.

Item

Antimicrobial Stewardship- The Committee continues to be concerned by the growing problem of antimicrobial resistance. The Committee encourages CMS to collaborate with participating health care institutions to develop and implement antimicrobial stewardship programs in all health care facilities, including hospitals, long-term care facilities, long-term acute care facilities, ambulatory surgery centers, and dialysis centers.

Action Taken or To be Taken

CMS recognizes the critical problem of antimicrobial resistance as well as the important role that antimicrobial stewardship programs can play in addressing this growing problem. CMS is currently engaged with the CDC and other professional infection control/epidemiological organizations to gather supporting evidence and information on effective actions and interventions and to focus on the development of regulatory changes to the CMS requirements that would promote antimicrobial stewardship programs in hospitals and long-term care facilities. As this effort progresses, CMS plans to also focus on including other healthcare facilities, such as long-term acute care hospitals, ambulatory surgery centers, and dialysis centers.

Item

Community Living- The Committee encourages CMS and ACL to continue their joint expansion and support of home and community-based services for individuals with disabilities through the Money Follows the Person program, the Community First Choice Option, and other programs. In support of this effort, the Committee encourages CMS and ACL to provide regulatory guidance and technical assistance to States and other interested parties regarding the various Federal tools that have been created to help them expand access to home-and community-based long-term services and supports. In addition, the Committee encourages CMS and ACL to create an interagency task force on implementing the Olmstead decision.

Action Taken or To be Taken

CMS and ACL are participating in a cross federal agency working group to specifically develop opportunities for states to develop strategies for enhancing their community integration efforts that will promote the principles of the American with Disabilities Act. In addition, CMS is actively engaged in a broad range of activities in support of expanding the home and community-based service delivery infrastructure. To date, 16 states are participating in the Balancing Incentive Program, which was authorized in the Affordable Care Act under Section 10202. Forty-four (44) states participate in the Money Follows the Person program, and under both of these provisions, states are investing significant state and federal resources to expand home and community-based services, and balance/rebalance their long-term services and supports systems. Under a recently issued funding opportunity announcement, CMS is poised to make awards to states under Section 2701 of the Affordable Care Act, for the Testing Experience of Care and Functional Assessment Tool grant program (see http://www.medicaid.gov/AffordableCareAct/Downloads/TEFT-FOA-9-10.pdf). CMS actively participates on the HHS Community Living Council, which was convened earlier this year by the Secretary. CMS is closely reviewing and monitoring states move towards Managed Long-term Services and support, and has issued well-received guidance on the Medicaid.Gov website (see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html). CMS actively participates in the Olmstead Federal Partners activities, which was originally convened by SAMHSA and OCR. This is a broad group of federal partners, and it includes HUD, DOJ, ASPE, DOL and many different federal agencies.

CMS recently published regulations describing the characteristics of home and community-based settings to assist states in ensuring that individuals receive services in the most integrated community setting. We currently provide technical assistance and training to states through Regional and Central Office analysts, as well as through available contracts, to design and implement programs in areas such as supported employment, individual budgeting, person-

centered systems, establishment of a fair and equitable level of need assessment, positive behavioral supports and the development of structures to create community integration.

Item
Dental Services- The Committee commends CMS on its plan to clarify dental payment policy through a State Medicaid Director Letter in 2013. CMS is directed to notify the Committee when the letter is issued.

Action Taken or To be Taken
The State Medicaid Director guidance letter is in development for dissemination in 2014. CMS will forward the SMD to the Senate Committee when released.

Item
Frontier Health- The Committee notes that the Frontier Extended Stay Clinic Demonstration program reached its statutorily mandated completion in April 2013. The Committee directs CMS to submit a report on the outcomes of the demonstration no later than 90 days after enactment of this act. In addition, the Committee includes $150,000 for the planned implementation of the Frontier Community Health Integration Demonstration program, slated to begin in fiscal year 2014.

Action Taken or To be Taken
CMS appreciates the Committee's interest and support in continuing the Frontier Extended Stay Clinic Demonstration. We are on track to submit an evaluation report to Congress by April 15, 2014. We are moving forward with planned implementation of the Frontier Community Health Integration Demonstration.

Item
Hepatitis C Screening- The Committee is aware that the U.S. Preventive Services Task Force recently recommended that all Americans born between 1945 and 1965 receive one-time screening for hepatitis C. Given that this population is currently aging into Medicare, the Committee urges CMS to include this one-time screening in the Welcome to Medicare physical exam.

Action Taken or To be Taken
CMS appreciates the Committee's interest in this issue. On September 5, 2013, CMS opened a national coverage analysis to thoroughly review the evidence and to make a national coverage determination on screening for Hepatitis C. CMS is currently in the process of reviewing the evidence on screening for Hepatitis C in adults. CMS expects to post a proposed decision on this issue by March 5, 2014, and a final decision within 90 days of the posted proposed decision.

Item
Immunization Payment- The Committee strongly supports efforts to vaccinate Americans for preventable conditions. The Committee is concerned that a new coding rule for preventive services when administered in conjunction with immunization may undermine such efforts by discouraging the provision of immunizations at well baby and well child visits. The Committee

urges CMS to submit a report no later than 180 days after the implementation of the new coding rule on the impact of the change in policy on immunization rates.

Action Taken or To be Taken
CMS shares the Committee's strong support of efforts to vaccinate Americans for preventable conditions and the provision of immunizations at well-baby and well-child visits. The American Medical Association's (AMA's) new CPT coding rule for preventive services when administered in conjunction with immunization went into effect January 1, 2013. The AMA has retained this requirement for 2014. CMS's National Correct Coding Initiative (NCCI) methodologies are based on the AMA's CPT coding rules. In 2013, CMS allowed states to unilaterally deactivate the Medicaid NCCI edits when the codes for these two services are billed on the same date of service without modifier 25. Most states did not do so, believing that provider education and assistance concerning modifier 25 are sufficient to ensure Medicaid payment of both services when provided on the same date of service. Data on rates of immunization are not yet available for 2013 to determine whether or not this new AMA coding rule has led to a decline in the rates of immunization.

Item
Influenza Vaccine for Health care Workers- The Committee supports the new requirement for acute care hospitals participating in the CMS Inpatient Prospective Payment System Hospital Inpatient Quality Reporting Program to submit summary data on influenza vaccination of health care personnel via CDC's National Health care Safety Network. The Committee encourages CMS to expand required reporting to all hospitals, skilled nursing facilities, and nursing facilities.

Action Taken or To be Taken
CMS appreciates the Committee's recommendation to expand required reporting to all hospitals, skilled nursing facilities and nursing facilities. CMS encourages and supports the commitment of all health care personnel that receive payment from our programs including, but not limited to, dialysis facility and nursing home staff to promote, track and trend staff influenza vaccination rates.

Item
Infusion Pumps- The Committee encourages CMS to conduct further research and analysis that will determine whether small volume infusion pumps could be used to improve patient care and reduce health care costs.

Action Taken or To be Taken
CMS does not have the capability to conduct clinical research. Rather, we review the best available evidence from clinical trials and other studies conducted by other governmental and non-governmental entities as part of Medicare's National Coverage Determination (NCD) process. CMS issued an initial NCD on "Continuous Subcutaneous Insulin Infusion (CSII) Pumps" in 1999, with updates issued in 2001, 2002, and 2004. Medicare also covers other uses of CSII under regulations governing clinical trials involving devices with an FDA-approved investigational device exemption (IDE) that are categorized as non-experimental/investigational (Category B) (see 42 CFR 405.201), or as a routine cost under the Medicare clinical trials policy. Any person or organization may request that CMS open a new coverage analysis or

reconsider an existing NCD including on small volume infusion pumps. CMS would consider any further research that may be relevant to changes in its coverage policy.

The Center for Medicare and Medicaid Innovation's authority is limited to testing innovative payment and service delivery models.

Item

Integrative Medicine- The Committee is aware of controlled clinical trials that have shown promising results for mind-body approaches to preventing and treating hypertension, other cardiovascular risk factors, and cardiovascular disease. Additional research is warranted to determine if integrative medicine interventions offer a unique opportunity to improve the quality of care while reducing health care costs from the Nation's leading causes of death. The Committee encourages CMS to test integrative health interventions to determine health outcomes and the potential for health care savings. In particular, the Committee is supportive of research into mind-body interventions for cardiovascular disease that have been previously shown in peer-reviewed publications of clinical trials to reduce cardiovascular risk factors, mortality, myocardial infarction and stroke.

Action Taken or To be Taken

CMS has the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. CMS will consider the available evidence regarding the use of integrative medicine concepts as it develops payment and service delivery models for testing under the authority of the Center for Medicare and Medicaid Innovation.

Item

Outpatient Drug Dispensing- The Committee is strongly committed to eliminating waste in Medicare part D and believes more should be done to reduce wasteful spending on outpatient prescription drugs in long-term care facilities. The Committee directs the Administrator of CMS to develop additional proposals designed to encourage short-cycle dispensing of outpatient prescriptions drugs in long-term care facilities and investigate the effects of dispensing fee changes on cost savings in the short-cycle dispensing program. These proposals should be submitted to the Committee no later than 180 days after enactment of this act.

Action Taken or To be Taken

CMS understands the Committee's concerns over eliminating waste in Medicare Part D and is working diligently to address those concerns. In the final Contract Year 2014 Call Letter, CMS addressed that some Part D sponsors are prorating dispensing fees as part of implementing the short cycle dispensing requirement in long-term care (LTC) facilities in 2013. CMS stated that nothing in current Part D regulations or guidance required the proration of dispensing fees. CMS emphasized our concerns that Part D sponsors would reimburse dispensing fees in a way that incentivizes wasteful dispensing of the maximum amounts allowed under current short cycle dispensing regulations and simultaneously penalizes the most efficient dispensing methodologies. In the Contract Year 2015 Policy and Technical changes to the Medicare Advantage and the Prescription Drug Benefit Programs published January 10, 2014, NPRM CMS proposed a prohibition on payment arrangements that penalize the offering and adoption of more efficient long term care dispensing techniques and other regulatory changes to reduce wasteful dispensing in the long term care setting.

Item

Provider Nondiscrimination- Section 2706 of the ACA prohibits certain types of health plans and insurers and issuers from discriminating against any health care provider who is acting within the scope of the provider's license or certification under applicable State law, when determining networks of care eligible for reimbursement. The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad "market considerations" rather than the more limited exception cited in the law for performance and quality measures. The Committee believes that insurers should be made aware of their obligation under section 2706 before their health plan begins operating in 2014. The Committee directs HHS to work with DOL and Department of Treasury to correct the FAQ to reflect the law and congressional intent within 30 days of enactment of this act.

Action Taken or To be Taken

The Departments of Health and Human Services, Labor, and the Treasury continue to consider additional guidance on the Public Health Service Act section 2706.

Item

Research- The Committee strongly supports the research activities that CMS undertakes to improve the efficiency of payment, delivery, access and quality of Medicare, Medicaid, and ACA programs. In particular, the Committee supports the proposed increase for the Chronic Conditions Data Warehouse, which makes data on chronic disease rates and health utilization trends within the beneficiary population available to researchers. In addition, the Committee recommendation includes sufficient funding to fulfill the President's request for the Medicare Current Beneficiaries Survey, the Research Data Assistance Center, public use data files, and Medicaid Analytic data.

Action Taken or To be Taken

CMS will continue to leverage and expand use of the Chronic Condition Data Warehouse, Medicare Current Beneficiary Survey, the Research Data Assistance Center, public use data files and Medicaid Analytic data as critical tools for monitoring, evaluating and improving how care is delivered and financed under Medicare and Medicaid. These data and information products were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs.

Item

Treatment of Hard-to-Heal Wounds- The Committee Recommendation includes $500,000 for CMS to initiate a pilot study on the health outcomes of new medical technologies for treating hard-to-heal wounds. The pilot study should focus on medical technologies that are not currently eligible for reimbursement in CMS programs.

Action Taken or To be Taken

Wound care treatment is an important topic to CMS and the Medicare beneficiaries we serve. CMS has commissioned several technology assessments to assess the current evidence base of different wound care treatments in order to inform coverage and payment policy. However, CMS does not itself have the capability to conduct clinical research. Rather, we review the best available evidence from clinical trials and other studies conducted by other governmental and non-governmental entities as part of Medicare's National Coverage Determination (NCD) process. CMS would consider any pilot studies on new technologies for treating hard-to-heal wounds in considering any changes to its coverage policy.

The Center for Medicare and Medicaid Innovation's authority is limited to testing innovative payment and service delivery models.

Item

Infection Control Surveillance in Ambulatory Surgery Centers- The Committee recommendation includes full funding the President's requested increase for surveying ambulatory surgical centers (ASCs), particularly in the area of infection control surveillance. In response to a July 2012 GAO report, CMS committed to collecting data using the agency's ASC Infection Control Surveyor Worksheet. The Committee supports this effort and encourages CMS to continue collecting and analyzing the findings from this surveillance tool to inform the agency's education and surveillance efforts moving forward. In addition, the Committee encourages CMS to make the aggregate data publicly available to build a better understanding of current and future injection practices in ASCs.

Action Taken or To be Taken

Consistent with the GAO's recommendation, in FY 2013, CMS collected data using the agency's ASC Infection Control Surveyor Worksheet on a representative sample of ASC's nationally, and will continue to do so every other year.

Item

Secure Medicare Card Pilot Project- The Committee commends CMS on the completion of a Medicare smart card pilot project for providers. When analysis of the data is complete, CMS is directed to submit a report of the findings of this project to the Committee on Appropriations. The report should include recommendations on further study of smart card use in the beneficiary context. Smart card technology may hold promise for reducing identity theft and increasing the accuracy of Medicare billing.

Action Taken or To be Taken

In May 2011, CMS initiated a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Swipe Card Pilot as an anti-fraud initiative in Indianapolis, IN. The pilot studied the feasibility of swipe cards aiding in the matching of when a provider prescribes DMEPOS and when it is filled by a supplier. Physicians and other suppliers that participated in the pilot on a voluntary basis used swipe magnetic cards, and entered a code into existing credit card terminals when placing or filling DMEPOS orders. This differs from Smart Card technology, which uses embedded integrated circuits and requires a separate card reader. CMS found that the voluntary nature of the pilot led to low participation, and that a significant number of providers do not have swipe terminals in their office. CMS is evaluating these results to identify opportunities for future pilots.

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

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FY 2015 Health Insurance Marketplace Reporting

(*Dollars in Thousands*)

Marketplace Spending	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014 Spending Plan 1/	FY 2015 President's Budget
CMS Program Operations 2/			$ 268,137	$ 451,631	$ 633,630	$ 544,190
CMS Federal Administration			$ 39,046	$ 68,429	$ 77,000	$ 85,000
Secretary's Transfer Authority				$ 113,531	$ 109,432	
General Departmental Management		$ 23,797				
Non-Recurring Expenses Fund				$ 299,664	$ 350,000	
$1B Health Insurance Reform Implementation Fund 3/	$ 4,654	$ 99,620	$ 20,943	$ 158,471	$ 20,000	
Prevention and Public Health Fund 4/				$ 453,691		
Marketplace User Fees 5/					$ 200,000	$ 1,159,300
Reinsurance Administrative Collections 6/						$ 20,300
Risk Adjustment User Fees 7/						$ 20,400
Total Marketplace Funding	**$ 4,654**	**$ 123,417**	**$ 328,126**	**$ 1,545,419**	**$ 1,390,062**	**$ 1,829,190**

NOTE: FY 2010, FY 2011, FY 2012, and FY 2013 reflect actual obligations (as of 12/31/2013). FY 2010 obligations and $9.2 million of FY 2011 obligations occurred when Marketplaces were operated under the Office of Consumer Information and Insurance Oversight in the HHS Office of the Secretary.

1/ Final FY 2014 Marketplace Spend Plan is still under development.
2/ FY 2014 Reflects Marketplace budget authority, as well as $100 million in budget authority that was made available by offsetting base costs through Nonrecurring Expenses Fund obligations on non-Marketplace activities.
3/ Appropriated by Section 1005 of Public Law 111-152
4/ Appropriated by Section 4002 of Public Law 111-148
5/ Appropriated by Sections 1311 and 1321 of Public Law 111-148
6/ Appropriated by Section 1341 of Public Law 111-148
7/ Appropriated by Sections 1311 and 1343 of Public Law 111-148

FY 2015 Health Insurance Marketplace Reporting
(continuation)

Marketplace Data Services Hub Milestones

Federal Data Services Hub (DSH) Description and Time Line

Data Services Hub (DSH) Description:

The Data Services Hub is a single interface to the States and Federal partners to provide information exchange and business functionality in support of Marketplace operations; it interfaces with many Federal entities and perform multiple tasks including verifying citizenship, immigration status, and tax information with the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS). This Data Services Hub delivers information to the States for Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP). The Data Services Hub reduces costs and improves reliability by organizing a single set of interfaces that would otherwise require multiple point-to-point interfaces.

Data Services Hub (DSH) Timeline:

- 09/30/2011 – Contract Kick-Off
- 09/30/2011 – CMS awards Data Services Hub (DSH) Contract to QSSI vendor. The QSSI contractor began program setup, engaging CMS stakeholders, and gathering system requirements.
- 10/13/2011 – CMS issues a Stop Work Order for the Data Services Hub (DSH) contract due to award protests.
- 01/18/2012 – CMS lifts the Stop Work Order to the Data Services Hub (DSH) contract due to the closing of the protest.
- 01/30/2012 - Project Startup Review including revised program scope, project schedule, and revised initial requirements; development started.
- 03/31/2012 - Began development for Data Services Hub to verify Social Security Number (SSN) and Citizenship with Social Security Administration (SSA), verify Advance Premium Tax Credit (APTC) and Family Size with the Internal Revenue Service (IRS), and to verify lawful presence with the Department of Homeland Security (DHS).
- 09/30/2012 - Development begins for connecting Federal Marketplace Eligibility and Enrollment (E&E) functionality with Hub services. The Eligibility and Enrollment functionality verifies

consumer information in the process of eligibility determination for premium tax credits, Qualified Health Plans (QHPs) and the Medicaid/Children's Health Insurance Program (CHIP).

- 01/25/2013 - Test Plan, Testing Schedule, and Test Data delivered to States for the start of State testing.

- 05/31/2013 - Development for Enrollment Transactions sent from Federal Marketplace to health plan providers to initiate enrollment for consumer policy or to cancel/terminate enrollment.

- 06/06/2013 - Start testing with health plan providers.

- 06/30/2013 - Marketplace online application fully integrated with Hub Verification Services (Social Security Administration (SSA), Internal Revenue Service (IRS), Department of Homeland Security (DHS), and other sources including States.

- 08/19/2013 - DSH Security Control Assessment (SCA) testing conducted. The Security Control Assessment (SCA) requires that controls supporting the Data Services Hub are tested every 3 years by a third party vendor. And at least 1/3 of the controls are tested on a yearly basis. An Authority To Operate (ATO) is not granted unless a Security Control Assessment (SCA) is performed, all controls have been tested, and is signed off by the CMS Chief of Information Security Officer (CISO).

- 09/06/2013 – CMS Chief Information Officer granted, as well as approval by the CMS Administrator, DSH Authority To Operate (ATO) the Federal Marketplace Go-Live after passing security testing. This process is an essential part of the CMS enterprise-wide information security program used in making a risk determination decision for the operation of the subject system. When the level of risk to the CMS enterprise is deemed acceptable, the system is granted an Authority To Operate (ATO for up to three years).

- 09/16/2013 - Operational Readiness Review (ORR) conducted to review Federal Marketplace and Hub systems, Operations support, Help support, etc. for Go-Live readiness. The purpose of the Operational Readiness Review (ORR) is to conduct a formal inspection to determine if the final information technology (IT) solution or automated system that has been developed, implemented and tested is ready for release into the production environment for sustained operations and maintenance support.

- 10/01/2013 - Start of Open Enrollment

Discontinued Performance Measures

Clinical Laboratory Improvement Amendments (CLIA) Discontinued Measures

Measure	FY	Target	Result
CLIA1: Percent of pathologists receiving an initial passing score of 90% or greater in gynecologic cytology proficiency testing.	*2012*	96.9%	97.3% (Target Exceeded)
	2011	95.0%	97.1% (Target Exceeded)
	2010	94.5%	97.0% (Target Exceeded)
	2009	94.0%	96.75% (Target Exceeded)
	2008	93.0%	96.6% (Target Exceeded)
	2007	Promulgate appropriate regulatory changes to address issues based on formal recommendations from the Secretary of HHS' Clinical Laboratory Improvement Advisory Committee and analysis of 2005 and 2006 data.	Target Partially Met (Target Not Met but Improved)

CLIA1: Improve Cytology Laboratory Testing

A proposed rule for Gynecologic Cytology PT under CLIA was published on January 16, 2009. The proposed rule requested comments for changes recommended by the Clinical Laboratory Improvement Amendments Advisory Committee (CLIAC) and addressed concerns made by the cytology community. The closing date for comments was March 17, 2009. The greater percentage of comments received in response to the proposed rule conflicted with the current CLIA statute by requesting replacement of the Cytology PT program with a continuing education program. In response to the public comments requesting a change to cytology PT that is in conflict with the current CLIA statute, CMS has withdrawn the proposed rule and will maintain the current robust cytology PT requirements. CMS will continue to monitor performance as currently mandated and report performance indicators to CLIAC who continues to endorse monitoring of individual performance. Additionally, CMS will continue to work closely with the cytology community and monitor current and future quality initiatives and issue guidance, when necessary. As a result of the decision to withdraw the proposed rule, we are discontinuing this goal after FY2012.

Medicare Survey and Certification Discontinued Measures

Measure	FY	Target	Result
MSC4: Decrease the percentage of long-stay nursing home residents who have experienced one or more falls with major injury.	*2014*	Discontinue	N/A
	2013	3.2%	Feb 28, 2014
	2012	Baseline	3.3%

MSC4: Decrease the percentage of long-stay nursing home residents who experience one or more falls with major injury

Research focused on nursing home falls suggests that reducing falls and major injuries from falls is a very complex issue. While certain interventions may be beneficial in the community setting, less is known about which interventions are effective in preventing falls with injury in nursing homes. We would not want providers to implement interventions that are ineffective, harmful, or not feasible for that setting. Current research indicates that generally, multi-dimensional interventions to prevent major injury from falls in nursing facilities would be required to have a significant impact on this measure. However there is not clear evidence for the effectiveness of any one type of intervention. Starting from a baseline of 3.3%, it would be difficult to reduce the percentage of falls with injury without clear evidence as to what intervention works.

As a current priority, CMS' intervention to reduce the unnecessary use of antipsychotics is continuing to make progress and has the active involvement and support of advocates, medical directors and nursing facility providers. Therefore at this time, CMS will not be undertaking a specific large-scale intervention around falls that would require the ongoing measurement that the GPRA goal and tracking provide. We anticipate that based on the literature, a significant reduction in the use of antipsychotic medications may lead to a reduction in nursing home falls (there is some data to suggest that reducing overall psychopharmacological medication use may lead to fewer injurious falls).

Program Operations Discontinued Measures

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

MCR3.1b, 3.1c Implement the Medicare Prescription Drug Benefit
These measures are being retired. CMS has consistently met or exceeded targets for these measures and rates appear to have stabilized at a relatively high level of awareness, given the standard outreach campaigns.

Measure	FY	Target	Result
PHI1: Percent of required individual health plans reporting data that is accurate and displayed on HealthCare.gov FY 2010 Baseline = 56%	2014	85%	Oct 1, 2014
	2013	82%	68% (Target not met)
	2012	85%	80% (Target not met)
	2011	80%	71% (Target not met)
	2010	Baseline	56%

PHI1: Percent of required individual health plans reporting data that is accurate and displayed on HealthCare.gov

CMS may propose new metrics based on the results of the independent data quality contract at future times. At minimum, the current metric does not reflect the collection of details on small group insurance products which are undertaken by the collection efforts. Additionally, progress on such issues as the incorporation of the Summary of Benefits and Coverage to provide insurance information in a consistent manner, and providing the public automatic programming interface (API) are not recognized.

Measure ID	FY	Target	Result
MCR28.1: Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013.	Out-Year Target	Discontinued as HAI Agency Priority Goal (see discussion below)	N/A
	2014	Discontinued-Further movement and reduction of hospital-acquired CLABSI is felt to optimally benefit from targeted intervention in areas where NHSN hospital and unit data show rates to be highest. As such, this goal is not recommended for continuation as a broader HAI high priority goal however is being recommended for close monitoring and continued reporting as a CDC GPRA goal.	N/A
	2013	25%[1]	Mar 31, 2014
	2012	12.5%	17% reduction (Target Exceeded)

MCR28.1: Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013

The HAI workgroup has decided not to recommend CLABSI for inclusion in FY2014. Although the workgroup did not recommend continuation of CLABSI as part of the FY 2014-15 HAI APG, there are and continue to be significant, evidence-based interventions that when implemented in units, can prevent infection and further drive down CLABSI incidence. The impact of on-going CLABSI prevention work will be monitored as a CDC GPRA goal for FY 2014-15.

[1] 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).

CHIP and Medicaid Discontinued Measures

Measure	FY	Target	Result
CHIP3.1: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP	*2012*	+11% over FY 2008 8,179,012 children	+10.6 % over FY 2008 8,148,397 children (Target not met)
	2011	+9% over FY 2008 8,031,642 children	+8.1% over FY 2008 7,970,879 children (Target not met)
	2010	+5% over FY 2008 7,736,903 children	+4.6% over FY 2008 7,705,723 children (Target not met)
	2009	+1% over FY 2008 7,442,164 children	+5% over FY 2008 7,717,317 children
	2008	6,732,000 children	+11% over baseline 7,368,479 children (Target Exceeded) (New baseline established FY 2009)
	2007	N/A	7,100,000 children (Historical Actual)
	2006	Set Baseline	6,600,000 children (Baseline)

CHIP 3.1 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP:

In prior years, we set separate targets for Medicaid and CHIP. Beginning in FY 2013, we will track combined Medicaid and CHIP enrollment in order to provide a fuller picture of children's access to health care coverage; therefore, we are discontinuing measure 3.1

Measure	FY	Target	Results
CHIP3.2: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid	*2012*	+17% over FY 2008 35,033,500 children	+21% over FY 2008 36,305,242 children (Target exceeded)
	2011	+11% over FY 2008 33,236,910 children	+18.8% 35,571,506 children (Target exceeded)
	2010	Historical actual	34,441,217 children (+15% over FY 2008) (Historical Actual)
	2009	N/A	32,292,253 children (+7.8% over FY 2008) (Historical Actual)
	2008	Baseline	29,943,162 children

CHIP 3.2: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid

In prior years, we set separate targets for Medicaid and CHIP. Beginning in FY 2013, we will track combined Medicaid and CHIP enrollment in order to provide a fuller picture of children's access to health care coverage; therefore, we are discontinuing measure 3.2.

Measure	FY	Target	Result
MCD7.2: Increase the national rate of low income children and adolescents, who are enrolled in the **Children's Health Insurance Program** (CHIP), who receive any preventive dental service.	*2012*	Set baseline	N/A

MCD7.2 – Increase the National Rate of Low Income children and Adolescents, who are Enrolled in Medicaid, who Receive any Preventive Dental Service

Beginning in 2012, States were asked to report a complete set of data on preventive dental services provided to enrollees of separate CHIP programs in Section IIIG of the CHIP annual report. Although most States did attempt to report the data, the FY 2012 data are inaccurate in a number of respects and baselines could not be set as planned in 2013. While technical assistance is available to States to address the data reporting issues, it is not expected that enough States will have the resources to correct their data, due to competing priorities at the State level, chiefly ACA implementation. Given our concerns about the accuracy of the data reported, and our limited ability to address these concerns at the present, we will discontinue MCD7.2 CHIP Dental and instead focus our efforts fully on MCD7.1 Medicaid Dental, until we feel more confident in our ability to improve the quality of the information reported for CHIP.

Quality Improvement Organizations Discontinued Measures

Measure	FY	Target	Result
QIO4: Increase percentage of timely antibiotic administration	*2014*	99.0%	Jun 30, 2015
	2013	98.5%	Jun 30, 2014
	2012	98.0%	98% (Target met)
	2011	97.5%	97.8% (Target Exceeded)
	2010	92%	97% (Target Exceeded)
	2009	89%	95.6% (Target Exceeded)
	2008	85%	91.6% (Target Exceeded)

QIO4: Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

This goal has reached its upper-limits. Also, due to the possibility of negative consequences (antibiotic overuse) continuing to increase the target, causing additional negative health consequences to the beneficiary, we propose discontinuing after FY 2014.