DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2017

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2017 performance budget. Millions of Americans rely on the programs CMS administers, which include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces.

Our programs will touch the lives of over 125 million Americans enrolled in Medicare, Medicaid, and CHIP in FY 2017. Currently Medicaid, our country's largest insurance program, and CHIP care for over 71 million Americans and one-third of our children; Medicare covers virtually every senior in America; and together these programs provide care to nearly 10 million disabled Americans.

The CMS remains committed to creating a better health care system, with smarter spending and healthier people. As more consumers gain access to care, we must continue to focus on the quality of care they receive and ensure that we are spending taxpayer dollars appropriately. Building on our success in transforming America's health care system and making quality, affordable health insurance available to millions of Americans continues to be our priority in FY 2017.

One key to advancing health care is the creation of a more modern health care infrastructure and a better technical infrastructure in critical places like the Medicaid program. CMS continues to work with states to streamline application and eligibility determination processes and improve consumer experiences in Medicaid.

More recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) helps transform the Medicare program to a system based on quality and healthy outcomes. CMS is building a better Medicare payment system for physicians and beneficiaries. This includes large-scale healthcare delivery system reform efforts such as implementing the new Merit-based Incentive Payment System (MIPS) to help reward physicians and other practitioners for high quality care and removing Social Security numbers from Medicare cards to reduce both Medicare's and beneficiaries' exposure to fraudulent activity. The implementation of MACRA is a CMS priority that moves the Medicare program to a health care system focused on the delivery of safe, quality care, and value.

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 for all Americans. Wherever possible, CMS will leverage its experience and existing systems and programs to achieve efficiencies and avoid duplication of effort.

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2017 performance budget.

Andrew M. Slavitt

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

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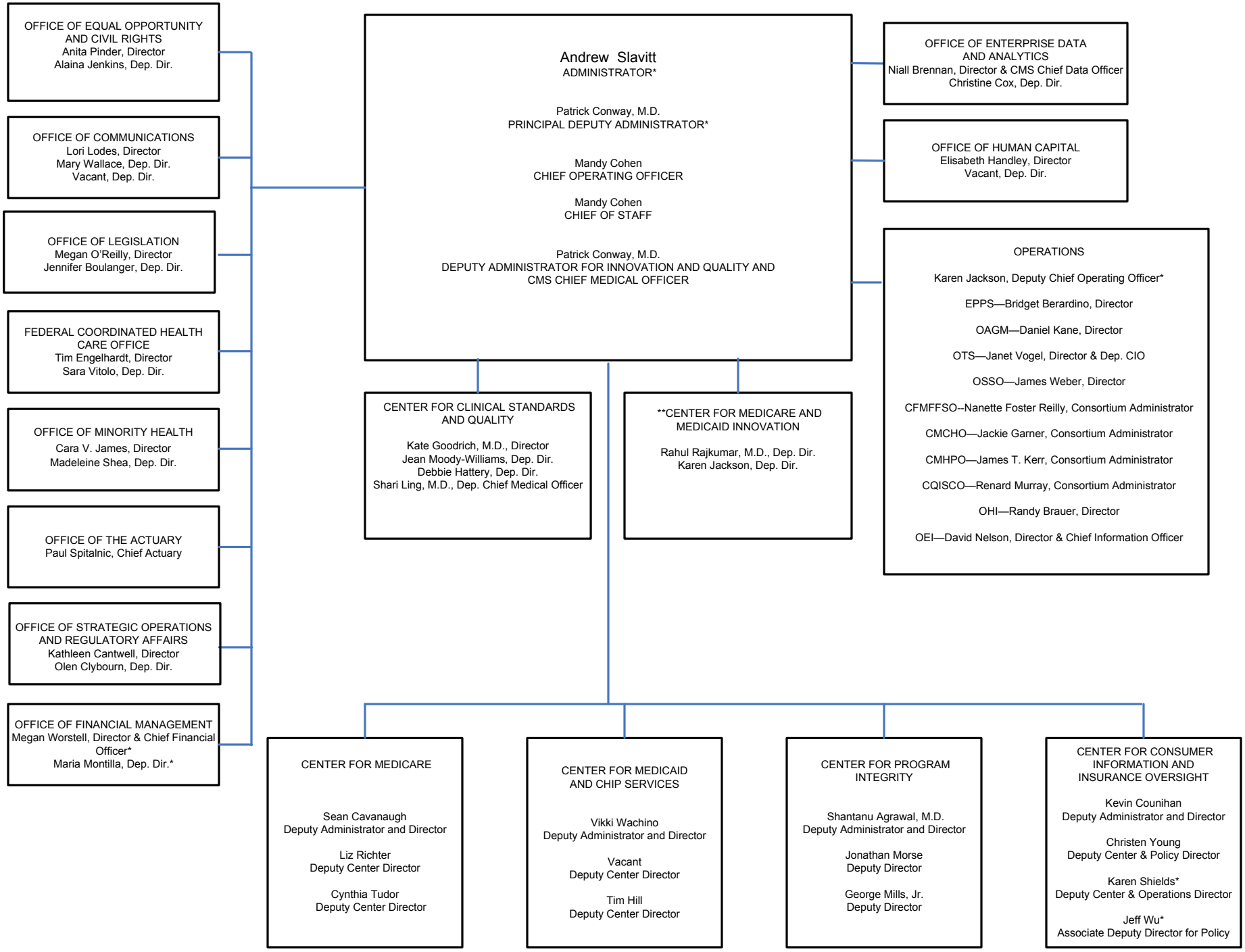
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
As of February 1, 2016
*** Acting**
****Reports to Deputy Admin. for Innovation and Quality**



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EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). 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. CMS' programs will touch the lives of more than 125 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2017. CMS takes its role very seriously, as CMS' oversight responsibilities impact millions of citizens and continue to grow dramatically.

In the past decade, legislation has significantly expanded CMS' responsibilities. 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 law contains numerous provisions that 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. 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. In 2014, CMS worked with states to create new competitive health insurance markets that will operate through Health Insurance Marketplaces and provide millions of Americans with access to affordable health coverage.

More recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) includes a number of provisions focused on transforming the Medicare program to a system based on quality and healthy outcomes. MACRA also extended CHIP funding, ensuring comprehensive coverage for low-income children through FY 2017. CMS is building a better Medicare payment system for physicians and beneficiaries alike. This includes large-scale healthcare delivery system reform efforts such as implementing the new Merit-based Incentive Payment System (MIPS) to help reward providers for high quality, efficient care and removing Social Security Numbers from Medicare cards to reduce both the Agency's and beneficiaries' exposure to fraudulent activity. The successful and timely implementation of MACRA is a CMS priority, as this aligns with the broader Department effort to move the Medicare program to a health care system focused on the delivery of safe, quality care, and value.

The performance budget proposes improvements to CMS' programs that directly contribute to significant savings and deficit reduction. CMS uses performance measures to track our progress toward meeting our goals.

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 CMS' commitment to the Medicare, Medicaid and CHIP programs, while highlighting progress in the continued implementation of the Health Insurance Marketplace and consumer protection programs. Building on CMS' success in transforming America's health care system and making quality, affordable health insurance available to millions of Americans continues to be the priority in FY 2017.

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 a lower cost.

Overview of Budget Request

CMS requests funding for 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. The table on the next page displays CMS' FY 2015 Final, FY 2016 Enacted, and FY 2017 President's Budget request for these accounts.

CMS' resource needs are principally driven by workloads that grow annually and by its role in leading national efforts to improve efficiency, health care quality and access to care. CMS' FY 2017 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.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Management	$3,974.7	$3,974.7	$4,109.5	$134.8
HCFAC – Discretionary	$672.0	$681.0	$725.0	$44.0
Grants to States for Medicaid 1/	$354,916.8	$356,817.5	$377,586.5	$20,769.0
Payments to Health Care Trust Funds 1/	$268,212.0	$283,171.8	$299,187.7	$16,015.9
Grand Total 1/	**$627,775.5**	**$644,645.0**	**$681,608.7**	**$36,963.7**

1/ Totals may not add, due to rounding. The FY 2016 enacted amount excludes indefinite authority.

Key Initiatives

Health Insurance Marketplace

CMS is responsible for operating the Health Insurance Marketplace in states that elect not to set up their own Marketplace, as well as for operating many other functions that support Marketplaces in all states. The Marketplace gives millions of Americans and small businesses access to affordable coverage. Administration of the Federally-facilitated Marketplace continues to be an Agency priority. CMS' FY 2017 Program Management request includes $535.0 million in appropriated funding for the Marketplaces, along with $1.6 billion in projected user fee collections from all sources to fund the Marketplaces at a program level totaling $2.1 billion.

CMS Workforce

CMS is seeking to invest in enterprise workforce management and planning tools which provide the strategy to attract talented and qualified candidates, as well as manage the existing workforce. The tools automate the Human Resources (HR) administrative processes through workflow capabilities, increasing the efficiency of HR operations, and

enable sophisticated HR analytics that support evidence-based decision-making. This broad talent initiative will enable CMS to strategically recruit, hire, and develop employees, as well as enhance its ability to provide succession planning

Improve CMS Systems and Infrastructure

CMS needs to invest in the future of the Agency. Looking at the next 10 years, CMS' total Medicare outlays grow from $695 billion in FY 2016 to $1.3 trillion in FY 2026. The average monthly enrollment will expand from 57 million beneficiaries in FY 2016 to 75 million by FY 2026.

As compared to the total program benefit dollars CMS manages, CMS' main administrative budget is less than one-half of one percent of those benefits. CMS also receives resources to implement and administer new legislation, but in some cases, without an additional investment to enhance the necessary infrastructure. Given CMS' expanding programs and future statutory responsibilities, CMS requests funding to invest in updating the IT environment.

Proposed Law

1. Implementation Funding for Administration Proposals

CMS' request includes $400 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 CMS' traditional Program Management request.

2. Extend Funding for Medicaid Adult Health Quality Measures

The Affordable Care Act established the Medicaid Adult Health Quality Measures Program which requires CMS to develop and annually revise a set of Adult Health Quality Measures and encourages states to voluntarily report information regarding the quality of health care for Medicaid-eligible adults. Additionally, there are standardized reporting requirements, including an annual Secretary's report for quality of care for adults enrolled in Medicaid and a report to Congress every three years. The Affordable Care Act provided funding for this program from 2010-2014. This proposal would extend funding for the Adult Health Quality Measure Program for five years at $14.0 million per year, from FY 2017 through FY 2021.

3. Establish a Refundable Filing Fee for Medicare Parts A & B Appeals

This proposal would institute a filing fee for providers, suppliers, and state Medicaid agencies, including those acting as a representative of a beneficiary, to pay a per-claim filing fee at each level of appeal. This filing fee would allow HHS to invest in the appeals system to improve responsiveness and efficiency. This proposal additionally returns all filing fees to an appellant who receives a fully favorable appeal determination. Collections are estimated at $4 million in FY 2017.

4. 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 2017 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 2017.

5. 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 2017.

6. Allow Collection of Application Fees from Individual Providers

This proposal would allow CMS to collect a fee from individual providers to cover the costs of conducting necessary provider screening and program integrity efforts associated with enrolling providers in Medicare and keeping bad actors out of the program. Hardship exemptions would be available for providers based on needs, as determined by CMS. Collections are estimated at $9.0 million in FY 2017.

7. Establish Registration Process for Clearinghouses and Billing Agents

This proposal expands the provider screening authorities included in the Affordable Care Act by establishing a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers. This proposal would provide CMS the authority to charge application fees to screen billing agents and clearinghouses. Collections are estimated at $15.0 million in FY 2017.

8. Retain a Percentage of Recovery Audit Contractor (RAC) Recoveries to Implement Actions that Prevent Fraud and Abuse

This proposal would allow CMS to retain a portion of all RAC recoveries to implement corrective actions that prevent improper payments and fraud, thus helping to avoid costs associated with pursuing recoupment after payments have been made. Net costs are estimated at $110 million in FY 2017 ($130 million in retained recoveries and $20 million in subsequent savings from corrective actions).

FY 2017 Budget Request

Program Management

In FY 2017, CMS requests $4,109.5 million in appropriated funding, a $134.8 million increase above the FY 2016 enacted level. CMS' request reflects funding needed to support Marketplace operations, process Medicare claims payments, upgrade IT systems, and maintain unprecedented growth in CMS' traditional programs, particularly Medicaid. CMS' budget request supports the Agency's priorities such as improving the quality of care for beneficiaries, reforming healthcare delivery systems, expanding Marketplace and Medicaid coverage, and reducing Medicare appeals.

- Program Operations:

  CMS' FY 2017 budget request for Program Operations totals $2,936.5 million. 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 systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), maintain the 1-800 call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2017 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. CMS' discretionary Program Operations request includes $513.8 million to partially fund Marketplace operations in FY 2017, including enrollment, outreach and education for a new and diverse cohort of consumers. In addition, CMS anticipates collecting $1.6 billion in user fee revenue from all sources to support Marketplace operations for a program level of $2.1 billion (including $535 million in discretionary budget authority consisting of $513.8 million in Program Operations and $21.3 million in Federal Administration).

- Federal Administration:

  CMS requests a total of $735.9 million for Federal Administration in FY 2017. Of this request, $629.2 million supports 4,112 direct FTEs. The request includes $21.3 million to support the Health Insurance Marketplace. The payroll estimate assumes a 1.6 percent civilian and military cost of living allowance (COLA).

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

- Survey and Certification:

  CMS' FY 2017 request includes $437.2 million for state survey and certification activities. Approximately 84 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 and End Stage Renal Disease (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 promote gains in efficiency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

Health Care Fraud and Abuse Control

CMS requests $725.0 million in discretionary HCFAC funding in FY 2017. 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.

Grants to States for Medicaid

The FY 2017 Medicaid request is $377.6 billion, an increase of $20.8 billion above the FY 2016 enacted level. Continued increases in grants to states are required as more individuals enroll in Medicaid, particularly as a result of Medicaid expansion. This appropriation consists of $262.0 billion for FY 2017 and $115.6 billion in an advance appropriation from FY 2016. These funds will finance $378.5 billion in estimated gross obligations in FY 2017. These obligations consist of:

- $354.2 billion in Medicaid medical assistance benefits;
- $1.0 billion for benefit obligations incurred but not yet reported;
- $19.0 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.3 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2017 request for Payments to the Health Care Trust Funds account totals $299,187.7 million. 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. The change in CMS' request for FY 2017 is largely driven by increases for the General Fund contributions for the SMI Trust Fund.

Conclusion

CMS' FY 2017 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 $681.6 billion in FY 2017, and increase of $37.0 billion above the FY 2016 enacted level.

CMS' FY 2017 total appropriated request for Program Management is $4.1 billion. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs, fund many provisions enacted in FY 2010 as part of the Affordable Care Act, including the Federally-facilitated Marketplace.

CMS requests $725.0 million in discretionary HCFAC funds. 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 PERFORMANCE

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. We continue to track many of the measures included in the FY 2016 plan, with new FY 2017 targets consistent with the President's goals and priorities. We have also introduced new performance measures that reflect some of our expanding responsibilities.

Our plan is also structured to reflect the CMS 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 HHS Strategic goals to "Strengthen Health Care" and "Increase Efficiency, Transparency, Accountability and Effectiveness of HHS Programs".

Consistent with the GPRA Modernization Act of 2010 (GPRA-MA), CMS is developing a rigorous, integrated, data-driven performance management process that includes regular progress reviews of its priorities by CMS leadership. In addition, CMS identified the need for enterprise risk management (ERM) and has developed a broad strategy to promote an integrated, enterprise approach for effectively identifying, managing, reporting and governing risks at CMS. The CMS Strategy Management Framework also incorporates performance management and risk management into the fabric of planning and decisions.

Together with HHS, we developed new HHS Agency Priority Goals (APGs) for the FY 2016 – FY 2017 cycle. CMS is the lead on the "Shift Medicare Health Care Payments from Volume to Value" APG and supports other HHS APGs, including "Combating Antibiotic-Resistant Bacteria", "Reduce Tobacco Consumption", "and "Reduce Opioid-Related Morbidity and Mortality". CMS has been an active participant in the HHS Agency Priority Goals for FY 2015 – 2016. CMS led a successful 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 has also been 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 was a contributor to the tobacco cessation priority goal led by the ASH.

CMS uses performance information to identify opportunities for improvement and to shape and improve 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

	FY 2015 Final 1/	FY 2016 Enacted 1/	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Operations	$2,824,823	$2,824,823	$2,936,499	$111,676
Federal Administration	$732,533	$732,533	$735,850	$3,317
State Survey & Certification	$397,334	$397,334	$437,200	$39,866
Research 2/	$20,054	$20,054	$0	($20,054)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$3,974,744**	**$3,974,744**	**$4,109,549**	**$134,805**
MIPPA (Mandatory; P.L. 110-275)	$2,781	$2,796	$3,000	$204
ARRA (P.L. 111-5)	$129,780	$60,580	$0	($60,580)
ACA (P.L. 111-148/111-152)	$51,534	$329	$600	$271
PAMA (P.L. 113-93)	$6,000	$5,592	$6,000	$408
IMPACT (P.L. 113-185)	$107,333	$19,882	$21,333	$1,451
MACRA (P.L. 114-10)	$204,500	$216,000	$211,000	($5,000)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$501,928**	**$305,179**	**$241,933**	**($63,246)**
Total, Appropriation/BA Current Law (0511)	**$4,476,672**	**$4,279,923**	**$4,351,482**	**$71,559**
Proposed Law Appropriation (Mandatory) 3/	$0	$0	$414,000	$414,000
Total, Appropriation/BA Proposed Law (0511)	**$4,476,672**	**$4,279,923**	**$4,765,482**	**$485,559**
Est. Offsetting Collections from Non-Federal Sources:				
User Fees and Reimbursements, C.L.	$215,825	$209,114	$232,419	$23,305
Marketplace User Fees, C.L.	$887,529	$1,225,017	$1,604,456	$379,439
Risk Corridors, C.L.	$0	$362,000	$362,000	$0
Recovery Audit Contracts, C.L.	$481,294	$151,932	$190,873	$38,941
Subtotal, New BA, Current Law 4/	**$6,061,320**	**$6,227,986**	**$6,741,230**	**$513,244**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2011) 5/	$189,843	$436,840	$0	($436,840)
Program Level, Current Law (0511)	**$6,251,163**	**$6,664,826**	**$6,741,230**	**$76,404**
Proposed Law User Fees 6/	$0	$0	$201,000	$201,000
Program Level, Proposed Law (0511)	**$6,251,163**	**$6,664,826**	**$7,356,230**	**$691,404**
HCFAC Discretionary	**$672,000**	**$681,000**	**$725,000**	**$44,000**
Non-CMS Administration 7/	**$1,906,681**	**$1,949,125**	**$2,315,534**	**$366,409**
CMS FTEs:				
Direct (Federal Administration)	4,485	4,378	4,112	-266
Reimbursable (CLIA, CoB, RAC, Marketplace)	103	125	542	417
Subtotal, Program Management FTEs	**4,588**	**4,503**	**4,654**	**151**
Affordable Care Act (Mandatory)	28	18	19	1
ARRA Implementation (Mandatory)	81	87	40	-47
Other Direct (PAMA, IMPACT, MACRA) (Mandatory)	0	13	13	0
Total, Program Management FTEs, Current Law	**4,697**	**4,621**	**4,726**	**105**
Program Management, Proposed Law	0	0	20	20
Total, Program Management FTEs	**4,697**	**4,621**	**4,746**	**125**
Affordable Care Act (Mandatory)	552	693	705	12
HCFAC Mandatory	222	248	248	0
HCFAC Discretionary	203	329	345	16
Medicaid Integrity (State Grants; Mandatory)	86	97	96	-1
Demonstrations	3	3	3	0
QIO	204	226	227	1
Total, CMS FTEs 8/	**5,967**	**6,217**	**6,370**	**153**

1/ The FY 2015 and FY 2016 columns are shown as enacted, net of rescissions, transfers, reprogrammings and the sequester, where applicable.

2/ In FY 2017, CMS proposes to fund activities previously funded through the Research line in the Program Operations line.

3/ CMS' FY 2017 request includes $400.0 million in administrative funding to implement the Administration's health care proposals, and $14.0 million for the Medicaid adult health quality measures initiative.

4/ Includes user fees and reimbursables supporting CMS program management. The FY 2015 amounts reflect actual collections.

5/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.

6/ CMS' FY 2017 request includes proposals for new six new offsetting collections.

7/ Includes funds for the SSA, DHHS/OS, the Medicare Payment Advisory Commission (MedPAC).

8/ Excludes staffing funded from indirect cost allocations. The FY 2015 column reflects actual FTE consumption. In FY 2016 and FY 2017, 14 FTEs included in the direct Program Management line and the Affordable Care Act (Mandatory) line will be funded from other sources.

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Program Management

Appropriations Language

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**]** *$4,109,549,000*, 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 will 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;**]** *1893(h) of the Social Security Act*, 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, 2021**]** *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 **[**2016**]** *2017* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare **[**and**]*&*** Medicaid Services, not to exceed **[**$3,669,744,000**]*$4,109,549,000***, 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 a one-year 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;**]** *1893(h) of the Social Security Act,* 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, 2021**]***expended*:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2016**]** *2017* 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.

General Provision

Language Provision	**Explanation**
Section 1864(e) of the Social Security Act (42 U.S.C. 1395aa(e)) is amended to read as follows: "*(e) FEES FOR CONDUCTING REVISIT SURVEYS.— The Secretary may impose fees upon facilities or entities referred to in this section for conducting revisit surveys in cases where such facilities or entities have been cited for deficiencies during initial certification, recertification, or substantiated complaint surveys. Such fees shall be established and collected in accordance with regulations prescribed by the Secretary that provide for a gradual phase-in of the fee amounts, and collected funds shall be available to supplement funding appropriated for such surveys. Fee amounts assessed upon an entity in an entity class shall not exceed the estimated average cost of performing such surveys for an entity in such class. Such fees shall be collected and available only to the extent and in such amounts as provided in advance in appropriations acts."* Sec. 219	Authorizes the collection of user fees from providers who had previously been cited for deficiencies in care, and required a revisit. Since this is proposed as an amendment to the Social Security Act, the authority to collect fees is contingent on their appropriation, so that collections will be classified as discretionary.

CMS Program Management
Amounts Available for Obligation

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,974,744,000	$3,974,744,000	$4,109,549,000
Trust Fund Mandatory Appropriation:			
ACA (PL 111-148/152)	$5,592,000	$353,000	$600,000
PAMA/SGR (PL 113-93)	$6,000,000	$6,000,000	$6,000,000
IMPACT Act (PL 113-185)	$107,333,000	$21,333,000	$21,333,000
MACRA (PL 114-10)	$204,500,000	$216,000,000	$211,000,000
Sequester	($408,000)	($1,883,000)	$0
Subtotal, trust fund mand. appropriation	$323,017,000	$241,803,000	$238,933,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$50,000,000	$0	$0
Sequester	($3,869,000)	($204,000)	$0
Subtotal, trust fund mand. appropriation	$49,131,000	$2,796,000	$3,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$52,028,000	$50,000,000	$50,000,000
Coordination of benefits user fees	$48,057,000	$30,000,000	$30,000,000
MA/PDP user fees	$76,500,000	$85,500,000	$83,300,000
Sale of data user fees	$12,370,000	$7,526,000	$7,661,000
Provider enrollment user fees	$31,214,000	$30,000,000	$30,000,000
Marketplace user fees	$916,099,000	$1,212,000,000	$1,472,000,000
Risk adjustment administration	$12,024,000	$29,700,000	$48,000,000
Recovery audit contracts	$519,195,000	$163,017,000	$190,873,000
Risk corridors	$0	$362,000,000	$362,000,000
Nursing home CMPs/Other	$3,776,000	$12,359,000	$23,604,000
Sequester 2/	($121,238,000)	($109,655,000)	$0
Budget Authority previously unavailable	$34,116,000	$75,617,000	$92,310,000
Subtotal, offsetting collections 1/	$1,584,141,000	$1,948,064,000	$2,389,748,000
Unobligated balance, start of year	$1,012,093,000	($1,320,458,000)	($4,124,960,000)
Unobligated balance, end of year 1/, 2/	$1,320,458,000	$4,124,960,000	$6,758,667,000
Prior year recoveries	$57,972,500	$0	$0
Unobligated balance, lapsing	($32,908,500)	$0	$0
Total obligations 1/, 2/	**$8,288,648,000**	**$8,971,909,000**	**$9,374,937,000**
American Recovery and Reinvestment Act (ARRA):			
Mandatory Appropriation:			
ARRA (PL 111-5)	$140,000,000	$65,000,000	$0
Sequester	($10,220,000)	($4,420,000)	$0
Unobligated balance, start of year	$193,790,000	$229,194,000	$145,524,000
Unobligated balance, end of year	($229,194,000)	($145,524,000)	($72,538,000)
Prior year recoveries	$959,000	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$95,335,000**	**$144,250,000**	**$72,986,000**

1/ Current law display. Excludes the following amounts for reimbursable activities carried out by this account: FY 2015: $220,111,000. Reflects actual budget authority enacted in FY 2015.

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

Summary of Changes

2016				
Total estimated budget authority 1/				$3,974,744,000
(Obligations) 1/				($3,976,957,000)
2017				
Total estimated budget authority 1/				$4,109,549,000
(Obligations) 1/				($4,109,549,000)
Net Change				**$134,805,000**

	2016 Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Pay Raise				$7,768,000
2. Annualization of Pay Raise				$2,363,000
Subtotal, Built-in Increases 1/				**$10,131,000**
B. Program:				
1. Program Operations		$2,824,823,000		$444,775,000
2. Federal Administration		$732,533,000		$38,152,000
3. State Survey & Certification		$397,334,000		$41,794,000
Subtotal, Program Increases 1/				**$524,721,000**
Total Increases 1/				**$534,852,000**
Decreases:				
A. Built-in:				
1. One Day Less Pay				($4,939,000)
Subtotal, Built-in Decreases 1/				**($4,939,000)**
B. Program:				
1. Program Operations		$2,824,823,000		($333,099,000)
2. Federal Administration	4,378	$732,533,000	(266)	($40,027,000)
3. State Survey & Certification		$397,334,000		($1,928,000)
4. Research 2/		$20,054,000		($20,054,000)
Subtotal, Program Decreases 1/				**($395,108,000)**
Total Decreases 1/				**($400,047,000)**
Net Change 1/				**$134,805,000**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.
2/ In FY 2017, ongoing research activities will be funded from the Program Operations line.

American Recovery and Reinvestment Act (ARRA):

2016				
Total estimated budget authority 1/				$60,580,000
(Obligations)				($144,250,000)
2017				
Total estimated budget authority				$0
(Obligations)				($72,986,000)
Net Change 1/				**($60,580,000)**
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT	87	$60,580,000	(47)	($60,580,000)
Net Change 1/				**($60,580,000)**

1/ Displayed net of sequester in FY 2016.

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

	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget
1. Program Operations	$2,519,823	$2,519,823	$2,936,499
Additional Medicare Operations Funding	$305,000	$305,000	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$6,000	$6,000	$6,000
IMPACT Act (PL 113-185)	$88,000	$13,000	$13,000
MACRA (PL 114-10)	$204,500	$216,000	$211,000
Sequester	($219)	($1,496)	$0
Subtotal, Program Operations	**$3,126,104**	**$3,061,327**	**$3,169,499**
(Obligations)	($2,886,174)	($3,215,399)	($3,182,509)
2. Federal Administration	$732,533	$732,533	$735,850
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$732,533**	**$732,533**	**$735,850**
(Obligations)	($766,594)	($783,854)	($782,647)
3. State Survey & Certification	$397,334	$397,334	$437,200
IMPACT Act (PL 113-185)	$19,333	$8,333	$8,333
Sequester	$0	($567)	$0
Subtotal, State Survey & Certification	**$416,667**	**$405,100**	**$445,533**
(Obligations)	($421,266)	($428,368)	($463,233)
4. Research, Demonstration & Evaluation	$20,054	$20,054	$0
ACA (PL 111-148/152)	$55,592	$353	$600
Sequester	($4,058)	($24)	$0
Subtotal, Research, Demonstration & Evaluation	**$71,588**	**$20,383**	**$600**
(Obligations)	($121,673)	($88,225)	($48,800)
5. User Fees	**$1,152,066**	**$1,457,085**	**$1,744,565**
Sequester	($83,337)	($98,571)	$0
Budget Authority previously unavailable	$34,116	$75,617	$92,310
Subtotal, User Fees	**$1,102,845**	**$1,434,131**	**$1,836,875**
(Obligations)	($1,080,310)	($1,434,131)	($1,836,875)
6. Recovery Audit Contracts	**$519,195**	**$163,017**	**$190,873**
Sequester	($37,901)	($11,085)	$0
Subtotal, Recovery Audit Contracts	**$481,294**	**$151,932**	**$190,873**
(Obligations)	($143,098)	($151,932)	($190,873)
7. Risk Corridors	**$0**	**$362,000**	**$362,000**
Sequester	$0	$0	$0
Subtotal, Risk Corridors	**$0**	**$362,000**	**$362,000**
(Obligations)	($2,869,533)	($2,870,000)	($2,870,000)
Total, Budget Authority 1/, 2/	**$5,931,031**	**$6,167,406**	**$6,741,230**
(Obligations) 1/, 2/	**($8,288,648)**	**($8,971,909)**	**($9,374,937)**
FTE 2/	**$4,616**	**$4,534**	**$4,686**

1/ Excludes $220,110,000 in collections for other reimbursable activities carried out by the Program Management account. Of the amount collected, $219,404,000 was obligated in FY 2015.

2/ Reflects CMS' current law request.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$140,000**	**$65,000**	**$0**
Sequester	($10,220)	($4,420)	$0
Subtotal, ARRA	**$129,780**	**$60,580**	**$0**
(Obligations)	($95,335)	($144,250)	($72,986)
FTE	**$81**	**$87**	**$40**

CMS Program Management
Authorizing Legislation

	FY 2016 Amount Authorized	FY 2016 Enacted	FY 2017 Amount Authorized	FY 2017 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. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. 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/
7. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
8. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
9. Marketplace:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
10. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2017.
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)	$65,000,000	$65,000,000	$0	$0

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
Transfers (P.L. 113-76)	$0	$0	$0	$118,582,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$25,341,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$48,500,000
Sequestration	$0	$0	$0	($1,825,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,163,758,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)
2015				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Sequestration	$0	$0	$0	($3,869,000)
Trust Fund Appropriation:				
Base	$4,199,744,000	$0	$0	$3,669,744,000
Additional Medicare Ops. (PL 113-235)	$0	$0	$0	$305,000,000
ACA (PL 111-148/152)	$0	$0	$0	$5,559,200
Sequestration	$0	$0	$0	($408,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$204,500,000
IMPACT Act (PL 113-185)	$0	$0	$0	$107,333,000
Subtotal	$4,199,744,000	$0	$0	$4,297,728,200
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,220,000)
2016				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($204,000)
Trust Fund Appropriation:				
Base	$4,245,186,000	$0	$0	$3,669,744,000
Additional Medicare Ops. (PL 113-235)	$0	$0	$0	$305,000,000
ACA (PL 111-148/152)	$0	$0	$0	$353,000
Sequestration	$0	$0	$0	($1,883,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$216,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,245,186,000	$0	$0	$4,216,547,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$65,000,000
Sequestration	$0	$0	$0	($4,420,000)
2017 2/				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Trust Fund Appropriation:				

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Base	$4,109,549,000	$0	$0	$0
ACA (PL 111-148/152)	$0	$0	$0	$600,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,109,549,000	$0	$0	$238,933,000

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

2/ Reflects the FY 2017 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 2016

CMS Program Management has no appropriations not authorized by law.

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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), the Clinical Laboratory Improvement Amendments (CLIA), the Quality Improvement Organizations (QIO), State Grants and Demonstrations, and the Health Care Fraud and Abuse Control (HCFAC) account as well as the Federal Marketplaces and private health insurance provisions and consumer protections enacted by the Affordable Care Act. The FY 2017 request includes funding for CMS' Program Management line items--Program Operations, Federal Administration, and State Survey and Certification.

- Program Operations primarily funds the contractors that process Medicare fee-for-service claims as well as the IT infrastructure and operational support needed to run our programs. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities and ongoing research. It also funds enhancements in the Medicaid and CHIP programs as well as new activities related to insurance market reform and oversight, and consumer information, including the Federal Marketplaces.

- Federal Administration pays for the salaries of CMS employees and for the expenses (rent, building services, equipment, supplies, etc.) associated with running a large organization.

- State Survey and Certification pays state surveyors to inspect health care facilities to ensure that they meet Federal standards for health, safety, and quality. These include initial certification surveys as well as recertification inspections.

CMS' FY 2017 Program Management request is $4,109.5 million, an increase of $134.8 million above the FY 2016 Enacted level. The table below, and the following language, provides additional detail on each of these levels for the FY 2017 request.

Program Management Summary Table
($ in millions)

Line Item	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Operations	$2,824.8	$2,824.8	$2,936.5	$111.7
Federal Administration	$732.5	$732.5	$735.9	$3.3
Survey & Certification	$397.3	$397.3	$437.2	$39.9
Research	$20.1	$20.1	$0.0	-$20.1
Program Management 1/	**$3,974.7**	**$3,974.7**	**$4,109.5**	**$134.8**
Direct FTEs – Federal Administration	4,485	4,378	4,112	-266

1/ Numbers may not add, due to rounding.

FY 2017 Request

Program Management: CMS' Program Management request is $4,109.5 million, an increase of $134.8 million above the FY 2016 Enacted level. The following language provides additional detail on CMS' FY 2017 discretionary request:

- Program Operations:

  CMS' FY 2017 budget request for Program Operations totals $2,936.5 million, an increase of $111.7 million above the FY 2016 Enacted level. The majority of the Program Operations account 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 CMS' 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 2017 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. CMS' discretionary Program Operations request includes $513.8 million to partially fund Marketplace operations in FY 2017, including enrollment, outreach and education for a new and diverse cohort of consumers. In addition, CMS anticipates collecting $1.6 billion in user fee revenue from all sources to support Marketplace operations for a program level of $2.1 billion (including $535 million in discretionary budget authority consisting of $513.8 million in Program Operations and $21.3 million in Federal Administration).

- Federal Administration:

  CMS requests a total of $735.9 million for Federal Administration in FY 2017. Of this request, $629.2 million supports 4,112 direct FTEs. The request includes $21.3 million to support the Health Insurance Marketplace. This estimate assumes a 1.6 percent civilian and military cost of living allowance (COLA).

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

- Survey and Certification:

  CMS requests $437.2 million for state survey and certification activities in FY 2017, an increase of $39.9 million above the FY 2016 Enacted level. Of this amount, $368.8 million will support direct survey costs, $12.9 million will support additional costs related to direct surveys, and $55.5 million will be used for surveyor training, Federally-directed surveys and information technology. The request level maintains statutory survey frequencies at long-term care facilities and home health agencies.

  Approximately 87 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).

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Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2015 Enacted	FY 2016 Enacted	FY 2017 Budget Request
Program Operations	$2,824,823	$2,824,823	$2,936,499
Mandatory Appropriation, Proposed Law 1/	$0	$0	$414,000
Appropriation, Net, Proposed Law	$2,824,823	$2,824,823	$3,350,499
Federal Administration	$732,533	$732,533	$735,850
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$732,533	$732,533	$735,850
State Survey & Certification	$397,334	$397,334	$437,200
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$397,334	$397,334	$437,200
Research, Demonstration & Evaluation	$20,054	$20,054	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,054	$20,054	$0
Discretionary Appropriation, Net	**$3,974,744**	**$3,974,744**	**$4,109,549**
Mandatory Appropriation, Proposed Law	**$0**	**$0**	**$414,000**
Total Appropriation, Proposed Law 2/	**$3,974,744**	**$3,974,744**	**$4,523,549**

1/ Reflects a separate $400.0 million general fund appropriation needed to implement the proposals contained in the President's Budget, along with $14.0 million for Medicaid adult health quality measures.

2/ In addition, CMS is proposing $201.0 million in offsetting collections for the Federal Payment Levy Program, reinvesting home health civil monetary penalties, appeals filing fees, provider application fees, a registration process for clearinghouses and billing agents, and RAC recoveries for preventative action.

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Program Management Proposed Law Summary

The CMS budget request includes proposed appropriations totaling $414.0 million in FY 2017 requested through a General Fund appropriation. Of this amount, $400.0 million would be to implement the Administration's health care proposals. CMS will utilize this funding to implement business process and system changes needed to generate additional savings, improve efficiencies, and enhance program integrity. $14.0 million would be to extend funding for the Medicaid adult health quality measures initiative. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our discretionary request.

CMS' FY 2017 request also includes proposals for offsetting collections. The authority to implement the new collections will be requested through authorizing language proposals, not appropriations language. Some of these proposals are described in more detail below:

- **Establish a Refundable Filing Fee for Medicare Parts A & B Appeals ($4,000,000)**

  This proposal would institute a filing fee for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, to pay a perclaim filing fee at each level of appeal. This filing fee would allow CMS to invest in the appeals system to improve responsiveness and efficiency. This proposal additionally returns all filing fees to an appellant who receives a fully favorable appeal determination. Collections are estimated at $4.0 million in FY 2017.

- **Federal Payment Levy Program Fees ($2,000,000)**

  The Federal Payment Levy Program authorizes CMS to impose a levy on Medicare providers for debt owed to the Federal Government. The FY 2017 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 2017.

- **Reinvesting Home Health Civil Monetary Penalties (CMPs) ($1,000,000)**

  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 2017.

- **Allow Collection of Application Fees from Individual Providers ($9,000,000)**

  This proposal would allow CMS to collect a fee from individual providers to cover the costs of conducting necessary provider screening and program integrity efforts associated with enrolling providers in Medicare and keeping bad actors out of the

program. Hardship exemptions would be available for providers based on needs, as determined by CMS. Collections are estimated at $9.0 million in FY 2017.

- **Establish Registration Process for Clearinghouses and Billing Agents ($15,000,000)**

  This proposal expands the provider screening authorities included in the Affordable Care Act by establishing a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers. This proposal would provide CMS the authority to charge application fees to screen billing agents and clearinghouses. Collections are estimated at $15.0 million in FY 2017.

- **Retain a Percentage of Recovery Audit Contractor (RAC) Recoveries to Implement Actions that Prevent Fraud and Abuse ($110,000,000 in net costs in FY2017)**

  This proposal would allow CMS to retain a portion of all RAC recoveries to implement corrective actions that prevent improper payments and fraud, thus helping to avoid costs associated with pursuing recoupment after payments have been made. Net costs are estimated at $110 million in FY 2017 ($130 million in retained recoveries and $20 million in subsequent savings from corrective actions).

The Budget also includes a comprehensive legistlative package aimed at both helping HHS process a greater number of appeals and reduce the number of appeals filed. Please refer to the Medicare narrative for a comprehensive discussion of the appeals proposals.

Program Operations

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA 1/	$2,824,823	$2,824,823	$2,936,499	+$111,676

1/ The FY 2015 Final and FY 2016 Enacted Level for Program Operations does not include $20.054 million for Research, Demonstrations, and Evaluation - Funding for these FYs are provided under a separate PPA. The FY 2017 Research budget request is included in the Program Operations account.

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 2003.2
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 2017 Authorization – One Year/Multi-Year

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

CMS administers and oversees 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.

CMS is responsible for administering and overseeing private insurance products included in the Affordable Care Act (ACA) in cases where a State elects for CMS to operate a program in addition to national responsibilities for administering health insurance affordability programs. In those cases, CMS is responsible for aspects of regulatory oversight and for operating the individual and small group health insurance exchanges, or Marketplaces. The Marketplaces allow individuals and small businesses to pool their purchasing power; compare health plan options on price and quality; and determine if financial assistance or tax credits are available.

Program Operations primarily funds the contractors that process Medicare fee-for-service claims, as well as the IT infrastructure and operational support. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs as well as insurance market reform, oversight, and operational contracts supporting the Marketplace.

As the primary account funding the operations for CMS' programs, Program Operations plays a direct role achieving the Agency's strategic priorities, by improving quality of care, reforming the health care delivery system, decreasing medical costs and payment error rates, reducing appeals and expanding access to care.

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 58 million beneficiaries expected in FY 2017. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized and are discussed in a separate chapter. The Medicare administrative expenses discussed in this chapter are funded annually through the Program Management appropriation.

For Medicare Parts A and B, CMS pays contractors to process providers' claims, funds beneficiary outreach and education, maintains the information technology (IT) infrastructure needed to support various claims processing systems, and makes 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.

For Medicare Parts C and D, CMS funds certification of payments, and audits Medicare Advantage (MA), joint MA-prescription drug plans (MA-PDP), and standalone prescription drug plans (PDP).

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.

Private Health Insurance Protections and Programs

The Affordable Care Act has made health care more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers. This includes Americans who were previously uninsured or whose insurance did not provide them with adequate coverage and security. CMS determines eligibility for private insurance financial assistance programs and is responsible for operating the Federally-facilitated Marketplace. CMS’ FY 2017 Program Management request includes $535.0 million in appropriated funding for the Marketplaces (including $513.8 million in Program Operations and $21.3 million in Federal Administration), which combined with $1.6 billion in projected user fee collections would fully fund the Marketplace operations at a program level totaling $2.1 billion.

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

Some notable impacts that health care reform has had to date:

- As of the end of the second Open Enrollment period,[1] nearly 10.2 million consumers were enrolled into a 2015 health insurance plan including more than 7.5 million consumers in the 37 states that were using the Healthcare.gov platform.

- As of December 26, 2015, more than 8 in10 individuals (approximately 7.1 million or 83 percent) who selected or were automatically enrolled in a 2016 plan on HealthCare.gov qualified for an advance premium tax credit with an average value of $294 per person per month. The average advance premium tax credit covers about 72 percent of the gross premium for individuals who qualify resulting in a $113 monthly premium.

Funding History

FY 2012	$2,658,900,000
FY 2013	$2,633,412,000
FY 2014	$2,943,405,000
FY 2015	$2,824,823,000
FY 2016	$2,824,823,000

Budget Request: $2,936.5 Million

CMS' FY 2017 budget request for Program Operations is $2,936.5 million, an increase of $111.7 million above the FY 2016 Enacted Level. This request will allow CMS to continue operating Medicare, Medicaid, CHIP, and private health insurance programs. The increase in Program Operations funds critical investments in our traditional programs to address the continued high level of appeals, and the stability and security of IT systems used to process FFS claims.

[1] Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

Program Operations
(Dollars in Millions)

Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$842.193	$944.650	$955.106	+10.456
FFS Operations Support	$55.029	$52.766	$50.749	-2.017
Claims Processing Systems	$74.089	$73.103	$78.891	+5.788
DME/Part B Competitive Bidding	$20.800	$56.200	$23.600	-32.600
Contracting Reform	$13.978	$14.081	$40.263	+26.181
II. Other Medicare Operational Costs				
Accounting & Audits	$104.059	$104.059	$108.750	+4.691
QIC Appeals (BIPA 521/522)	$107.720	$93.392	$142.495	+49.103
HIPAA Administrative Simplification	$29.417	$26.362	$45.218	+18.857
ICD-10/5010	$45.000	$30.000	$20.000	-10.000
Research, Demonstration, & Evaluation[2]	$20.054	$20.054	$21.867	+21.867
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	$24.401	$28.486	$63.605	+35.118
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$52.655	$42.330	$47.857	+5.527
Oversight & Management	$68.386	$59.800	$65.963	+6.164
Federal Marketplace	$749.583	$687.702	$513.750	-173.952
V. Health Care Quality				
Health Care Improvement Initiatives	$57.608	$72.552	$50.236	-22.316
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$265.333	$193.867	$347.350	+153.483
Provider Outreach	$22.454	$20.692	$22.454	+1.762
Consumer Outreach	$4.580	$3.890	$5.080	+1.190
VII. Information Technology				
IT Investments	$287.536	$320.881	$333.265	+12.384
TOTAL[3]	**$2,824.823**	**$2,824.823**	**$2,936.499**	**+111.676**

[2] The FY 2015 Final and FY 2016 Enacted Level of $20.054 million for Research, Demonstrations, and Evaluation is only shown for display comparability purposes and is not included in the total - FY 2015 and FY 2016 funding is provided under a separate PPA.
[3] Totals may not add, due to rounding.

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

This category reflects the Medicare Administrative Contractors' (MACs') ongoing fee-for-service (FFS) workloads, which include processing Part A and Part B claims, enrolling providers in the Medicare program, handling provider reimbursement services, processing first-level 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 MACs are responsible for processing and paying nearly 1.3 billion Part A bills and Part B claims correctly and timely. The MACs handle bills/claims from the wide range of healthcare providers, including hospitals, skilled nursing facilities, home health agencies, physicians, and other providers. Currently, almost all providers submit their claims in electronic format. The MACs also utilize electronic funds transfer to make the vast majority of Medicare benefit payments.

Provider Enrollment – CMS is responsible for both enrolling providers and suppliers into the Medicare program and ensuring that they continue to meet the enrollment 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. Additionally, CMS regulations requiring physicians who write prescriptions for covered Part D drugs to enroll in Medicare and new provider revalidation workloads required by Section 6401(a) of the ACA have increased costs to perform this MAC business function.

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 MACs' 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. The first level of appeal begins at the MAC with a redetermination of the initial decision. MAC personnel not involved in the original determination review the original claim and any new information, make the decision to determine if the original determination should be changed and handle any reprocessing activities. MACs generally are required to 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 2015, the MACs processed 4.1 million redeterminations and are expected to process 4.5 million in FY 2016. CMS estimates the MACs will process over 4.8 million redeterminations in FY 2017 reflecting 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 (QIC). These costs are not part of this Ongoing Operations section and will be discussed later in this chapter.

In addition to handling redetermination requests, the MACs also handle a substantial volume of claims re-openings in accordance with Medicare regulations and CMS instructions. Re-openings may be triggered based on a variety of circumstances, and may result in an adjustment of the original claim. In FY 2014, the MACs processed 9.9 million clerical error re-openings and 3.7 million non-clerical error re-openings.

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 2017, contractors are expected to respond to 34.4 million telephone inquiries and 600,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. The FY 2015 workloads are approximately the same and little to no growth is expected. The contractors utilized Interactive Voice Response (IVR) systems to automate approximately 64 percent of their telephone inquiries. Increased utilization of the IVR frees up customer service representatives to handle the more complex questions. CMS has made a number of efforts that have contributed to decreased volume in FFS provider calls to MAC contractors' toll free lines. These efforts include:

- 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 2011 through FY 2017 (estimated):

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

	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate
Completed Calls	41.1	38.8	35.6	34.4	34.4	34.4	34.4

CMS believes the FFS-related call volume will remain stable through FY 2017, 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 2015, 761,347 physicians "participated" out of 778,060 enrolled physicians (97.8%), and nearly 1.29 million out of a total of 1.3 million physicians, LLPs, and NPPs participated (99.2%).

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 legislative, 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 Healthcare.gov, Medicaid and CHIP Business Information Solutions (MACBIS), and the Open Payments systems. A standardized architecture across eight VDCs allows for consistent and stable operations that are flexible enough to support the business needs of CMS.

Budget Request: $955.1 Million

The FY 2017 budget request for Ongoing Operations is $955.1 million, an increase of $10.5 million above the FY 2016 Enacted Level. The FY 2017 budget assumes small increases for enrolling Part D prescribers, growing MAC workloads, and IT security updates. Adding CMS Regulation 4159 to the MAC contracts creates additional needs in both FY 2016 and FY 2017 as the Rule requirements to enroll Part D prescribers will begin in MAC contracting year 2016. Additionally, CMS expects additional operating costs in FY 2016 and FY 2017 resulting from getting new MAC awards transitioned quickly and effectively while resetting the contract length for these jurisdictions to new 12 month cycles.

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

In FY 2017, CMS' contractors expect to:

- Process nearly 1.3 billion claims;
- Handle 4.8 million redeterminations (does not assume efficiencies from Medicare appeals proposals);
- Answer 34.4 million toll-free inquiries.

The following table displays claims volumes and unit costs for the period FY 2011 to FY 2017. 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' remains committed to achieving greater efficiencies in our fee for service operations.

Claims Volume and Unit Costs
(FYs 2011 – 2017)

Volume (in millions)	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**	**FY 2014 Actual**	**FY 2015 Actual**	**FY 2016 Estimate**	**FY 2017 Estimate**
Part A	199.1	207.3	207.6	210.0	213.3	219.5	224.3
Part B	989.8	1,011.9	1,006.3	1,003.0	1,009.2	1,038.5	1,061.3
Total	**1,188.9**	**1,219.2**	**1,213.9**	**1,213.0**	**1,222.5**	**1,258.0**	**1,285.6**
Unit Cost (in dollars)							
Total	**$0.87**	**$0.83**	**$0.78**	**$0.78***	**$0.78***	**$0.75**	**$0.74**

* Represents estimated costs per claim.

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.

Cost Contract Audits – CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit efforts to comply with the Federal Acquisition Regulations (FAR) and Departmental Supplemental Regulations (HHSAR). The GAO and OIG have identified CMS' lack of compliance with the FAR and HHSAR regarding mandatory audits and proper internal controls. This activity supports the effort needed to perform audits required by law during the contract acquisition life cycle to comply with FAR and HHSAR.

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, and Enterprise Privacy Policy Engine (EPPE).

Claims Surveillance DME Competitive Bidding & Bundled ESRD PPS – This activity supports the following activities and initiatives: End Stage Renal Disease Prospective Payment System (ESRD PPS) Refinement, Partial Hospitalization Program (PHP) Analytic Support, Claims Surveillance of ESRD PPS, the DMEPOS Competitive Bidding Program, SNF PPS, IRF PPS, and other General Program Monitoring Activities. 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.

A-123 Internal Controls Assessment – The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The OMB Circular A-123 and implementing guidance from the Department requires a rigorous assessment of internal controls over financial reporting similar to that imposed on publicly traded companies by the Public Company Accounting Reform and Investor Protection Act of 2002 (the "Sarbanes-Oxley Act") and requires the Administrator to submit a statement of assurance on internal controls over financial reporting.

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, and to provide recommendations for improvement in the administration of the Medicare program. To this end, CMS works internally and with its partners to identify underlying systemic

issues in the administration of the Medicare program, make recommendations for short and long term resolution, and serve as a facilitator for resolutions to these issues that affect people with Medicare.

Actuarial Services – This contract provides additional actuarial services for the numerous ad hoc requests that the office is unable to handle due to time constraints and staff shortages including modeling for numerous health care reform provisions. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other issues required by provisions of the law.

Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures – This contract provides for the proper oversight and management of MA organizations (MAOs) and Special Needs Plans (SNPs) quality performance by developing and improving specific HEDIS measures for MAOs and SNPs and reviewing and approving SNP Models of Care (MOC). In support of the ACA, and as part of the CMS Quality Strategy, CMS is charged with implementing efforts that achieve better outcomes in health care, at lower cost, for the beneficiaries and communities we serve. CMS will work on developing and testing new quantifiable outcome measures that would provide more specific information about MA plans' (including SNPs) ability to provide a high level of care coordination and its impact on enrollee health outcomes.

MAC Provider Internet Transaction Pilots – Medicare Administrative Contractors (MACs) have been in the process of establishing internet-based services for providers. Using these portals to eliminate paper has great savings potential through decreasing the provider inquiries workload by obtaining more information via the Internet instead of strictly providing telephone Interactive Voice Response (IVR) or CSRs. This decreases the number of paper claims and the number of people required to process clerical re-openings and redeterminations. This funding will support the existing portals and ensure continued contractor compliance with Agency standards for security, privacy, systems architecture, and data exchange as well as bring all portals up to consistent acceptable levels of self-service functionality.

Home Health Prospective Payment System (PPS) Refinement – Section 3131(d) of the ACA directed the Secretary of Health and Human Services (HHS) to conduct a study on home health agency (HHA) costs involved in providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas and in treating beneficiaries with high levels of severity of illness. A previous contract funded the analysis and findings that informed the required Report to Congress. The analysis suggested the need for further investigation regarding broad structural changes to improve the current payment system. This current funding request will enable us to further investigate whether changes to the payment system are warranted, and provide contractor support towards proposing and finalizing refinements to the home health prospective payment system (HH PPS).

Budget Request: $50.7 Million

The FY 2017 budget request for fee-for-service operations support is $50.7 million, a decrease of $2.0 million below the FY 2016 Enacted Level. The increase primarily supports the new activities requested in FFS Operations in FY 2017 such as prototypic shared services. The activities that make up this request are as follows:

- *Printing and Postage*: $9.7 million, an increase of $0.4 million above the FY 2016 Enacted Level. This funds CMS' ongoing FFS printing and postage needs. In FY 2017, CMS

anticipates the direct billed beneficiary population will increase by 10 percent over the FY 2016 levels. In addition, we anticipate a 10 percent increase in beneficiaries participating in the Medicare Easy Pay program. In general, beneficiaries receive quarterly notices (4 per year); however, beneficiaries who participate in Medicare Easy Pay or who owe Part A or IRMAA-D receive monthly notices (12 per year). Consequently, the number of billing notices sent in FY 2017 will increase by approximately 10 percent.

- *Cost Contract Audits*: $2.3 million, about the same as the FY 2016 Enacted Level. This funding will be used to enter into agreements with the Defense Contract Audit Agency and contract with CPA firms under an existing contract to continue to aggressively address the backlog of audit efforts. Additionally, the funding will be used to contract with support contractors to provide interim audit support necessary to augment staffing needs as a bridge to hiring full time employees as well as specialized training requirements to handle the complex Cost Accounting Standards issue with many of our major contractors in order to reduce the backlog.

- *Prototypic Shared Services*: $4.8 million, an increase of $4.8 million above the FY 2016 Enacted Level. Funding is requested for contractor support assisting with multiple initiatives, including continued development and expansion of SharePoint, EPPE, and Non-Claims Based Payment. Increasing the availability and adoption of SharePoint across businesses is expected to save costs associated with redundant collaboration software. The EPPE system will allow CMS to more efficiently track and adjudicate requests for PII data, while reducing security and privacy risks.

- *Bundled ESRD PPS*: $3.4 million, about the same as the FY 2016 Enacted Level. This funding allows CMS to complete the analysis required by section 632 of the American Taxpayer Relief Act (ATRA) and section 217 of the Protecting Access to Medicare Act (PAMA) for bundled ESRD PPS refinements resulting in savings to the Medicare program. Additionally, CMS will procure the analytic support needed to explore potential refinements to the Partial Hospitalization Program (PHP) payment system or update sub regulatory guidance on reasonable cost reimbursement issues impacting ESRD, PHP, and other post-acute programs.

- *A-123 Internal Controls Assessment*: $2.0 million, the same as the FY 2016 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.

- *Medicare Beneficiary Ombudsman*: $2.0 million, an increase of $0.4 million above the FY 2016 Enacted Level. The requested funding is for existing contract support for a wide variety of activities, including development of the Medicare Ombudsman annual report to the Secretary and to Congress (provides annual Ombudsman activities and program improvement recommendations), development of the Competitive Acquisition Ombudsman (CAO) annual report to the Secretary and to Congress, issue management and tracking of systemic Medicare Program issues that impact beneficiaries, and establishing and maintaining Ombudsman-focused outreach mechanisms to interactively engage beneficiaries and their advocates/representatives.

- *Actuarial Services*: $1.2 million, about the same as the FY 2016 Enacted Level. Funding is requested for contractor support to produce financial estimates for CMS demonstrations, regulations, and legislative proposals.

- *Medicare HEDIS Quality of Care Performance Measures*: $1.4 million, the same as the FY 2016 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. This activity is critical for CMS to be able to evaluate SNPs' ability to effectively coordinate care for older and/or disabled adults and to develop tangible SNP models of care outcome measures.

- *MAC Provider Internet Transaction Portals*: $0.7 million, about the same as the FY 2016 Enacted Level. This request will support ongoing operations and maintenance of existing MAC provider portals for claims-related transactions and continued compliance associated with security documents and processes.

- *Home Health PPS Refinement:* $1.9 million, about the same as the FY 2016 Enacted Level. Funding supports a home health and hospice refinements contractor to analyze a variety of data to identify program vulnerabilities; engage in stakeholder meetings; develop and conduct statistical modeling of additional payment reform options; provide regulatory support; and, identify operational issues involved with the potential implementation of home health and hospice payment reform.

- *Other Operational Costs:* $21.3 million, a decrease of $7.7 million below the FY 2016 Enacted Level. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

Claims Processing Systems

CMS' claims processing systems currently process nearly 1.3 billion Part A and Part 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. 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.

Fiscal Intermediary Shared System (FISS) – FISS is a critical component of the Fee-For-Service (FFS) program, processing millions of Medicare claims a year. This is the shared system used to process Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the Common Working File (CWF) System for verification, validation, and payment authorization. FISS must also implement changes needed to support the Medicare Administrative Contractor (MAC) authority for the Medicare FFS Program.

Multi Carrier System (MCS) – MCS is the shared system used to process over 1 billion Medicare Part B claims for physician care, durable medical equipment, and other outpatient services nationwide. It interfaces directly with the CWF.

Budget Request: $78.9 Million

The FY 2017 President's Budget request for claims processing systems is $78.9 million, an increase of $5.8 million above the FY 2016 Enacted Level. The increased funding will provide upgrades to the System Integration Testing and Common Working File. Both of these systems are essential to the claims processing shared system infrastructure. This request also reflects the ongoing costs associated with maintaining claims processing systems. This involves integration and regression testing for claims adjudication, payments, and remittance advices that support various system interfaces, which is essential in ensuring accurate payments. Additionally, CMS must make software changes to the claims processing systems including 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. These system changes aid in supporting the Medicare Administrative Contractor (MAC) functionality for the Medicare Fee for Service Program.

DME Competitive Bidding

Competitive Bidding Implementation Contractor (CBIC) – 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, 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.

CMS announced on December 11, 2014, that the Medicare DMEPOS Competitive Bidding Program had saved more than $580 million in the nine markets at the end of the Round 1 rebid's 3-year contract period due to lower payments and decreased unnecessary utilization. Additional savings are being achieved as part of the Affordable Care Act's expansion of the competitive bidding program – at the end of the first year of Round 2 and the national mail-order programs, Medicare had saved approximately $2 billion. Furthermore, the monitoring data

show that the implementation is going smoothly with few inquiries or complaints and no changes to beneficiary health outcomes.

DME Bidding Systems (DBidS) – This system collects bids from DMEPOS for competitive bidding of equipment. The data collected by the DBidS application will be used by the Competitive Bidding Implementation Contractor *(*CBIC) who will make recommendations to CMS on the selection of certain suppliers by DME product and CBA. CMS will use these recommendations to award contractors to DME suppliers to supply DME to Medicare beneficiaries.

Budget Request: $23.6 Million

The FY 2017 budget request for competitive bidding is $23.6 million, a decrease of $32.6 million below the FY 2016 Enacted Level.

- *Competitive Bidding Implementation Contractor (CBIC):* The FY 2017 budget request for competitive bidding operations is $21.8 million, a decrease of $32.6 million below the FY 2016 Enacted Level.

- *DME Bidding Systems*: $1.8 million, the same as the FY 2016 Enacted Level. This system collects bids for certain types of Durable Medical Equipment within certain geographical areas. The funding request supports ongoing operations and maintenance. Funding this system is necessary to ensure beneficiaries maintain access to high quality equipment and supplies at a fair price.

Contracting Reform

Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B fee-for-service claims 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. CMS continues to re-compete the MAC contracts in accordance with Medicare law and the FAR; following are the major funding requirements for this effort:

IT Systems – Funding will be used to support maintenance and enhancements to the Contractor Management Information System (CMIS), 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 operational performance of its Medicare fee-for-service contractors. CMIS is a web-based analytical application that has been deployed on the CMS internal network. The eChimp system is used by CMS, the MACs, and other Medicare FFS Contractors to support the Fee-for-Service Change Management Process. The eChimp includes online forms for the MACs to report the functions involved in reviewing and implementing the requirements in several hundred change requests annually, as well as an electronic approval process. The CEDI front-end system provides a single front-end solution for the receipt of electronic claims-related transactions from Medicare durable medical equipment suppliers.

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 completed in 2013, and most of the second round of MAC procurements was completed by mid-FY 2015, the

MMA also stipulated that the MAC contracts must be re-competed a minimum of every 5 years. Pursuant to the MMA, CMS has already initiated a third generation of MAC procurements.

CMS began to develop detailed acquisition plans and solicitation documents for the third generation MAC contracts in FY 2014. As of mid-FY 2015, CMS has completed and implemented all four second generation DME MAC contract awards and the majority of second generation A/B MAC contracts (eight). Moreover, as of mid-FY 2015, CMS has three third generation DME MAC and one second generation A/B MAC contract procurements in progress.

On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of procurements. CMS' original plan was to reduce the number of A/B MACs from fifteen to ten by 2017. As of February 2014, CMS has consolidated the number of A/B MAC's to twelve. CMS announced in March 2014 that it had decided to postpone the remaining A/B MAC contract consolidations for up to five years. In addition, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the maximum span of a MAC contract, inclusive of all renewal and option periods, to ten years. CMS has begun to develop a plan for implementing the MACRA on a phased basis once current (in-process) procurements are completed in FY 2015 and FY 2016.

Below is the general status of MAC procurements as of January 21, 2016.

MAC Jurisdiction	Previous MAC Juris.	Processes Part A & Part B Claims for the following states:	MAC
DME A	DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	NHIC, Inc. *Awarded to Noridian Healthcare Solutions, LLC; operations begin in May 2016.)*
DME B	DME B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	National Government Services, Inc. *(Awarded to CGS Administrators, LLC; operations begin in June 2016.)*
DME C	DME C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands	CGS Administrators, LLC
DME D	DME D	Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
5	5	Iowa, Kansas, Missouri, Nebraska	Wisconsin Physicians Service Insurance Corporation
6	6	Illinois, Minnesota, Wisconsin	National Government Services, Inc.
8	8	Indiana, Michigan	Wisconsin Physicians Service Insurance Corporation
15	15	Kentucky, Ohio	CGS Administrators, LLC

MAC Jurisdiction	Previous MAC Juris.	Processes Part A & Part B Claims for the following states:	MAC
E	1	California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
F	2 & 3	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian Healthcare Solutions, LLC
H	4 & 7	Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi	Novitas Solutions, Inc.
J	10	Alabama, Georgia, Tennessee	Cahaba Government Benefit Administrators, LLC
K	13 & 14	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	National Government Services, Inc.
L	12	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (includes Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)	Novitas Solutions, Inc.
M	11	North Carolina, South Carolina, Virginia, West Virginia (excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)	Palmetto GBA, LLC
N	9	Florida, Puerto Rico, U.S. Virgin Islands	First Coast Service Options, Inc.

Budget Request: $40.3 Million

The FY 2017 budget request for contracting reform is $40.3 million, an increase of $26.2 million above the FY 2016 Enacted Level. This request includes funding for MAC implementation and transition costs as a result of re-competes, implementation and audit expertise, and three IT systems.

- *IT Systems:* $6.4 million, an increase of $0.3 million above the FY 2016 Enacted Level. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), eChimp system, and Common Electronic Interchange System (CEDI).

- *MAC Transition Costs*: $33.9 million, an increase of $25.9 million above the FY 2016 Enacted Level. CMS' request supports contract termination claims/settlements that will come due in FY 2017 for several large legacy contracts that ended during FY 2013 and will need to be settled out in FY 2017. CMS also anticipates several contract awards in FYs 2016 and 2017. The requested funds support 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.

Contracting Reform contributes to Trust Fund savings by producing more accurate payments as a result of combining A/B workloads under one MAC. For the five year period FY 2013 – FY 2017, the CMS actuary estimates trust fund savings for Medicare contracting reform in the amounts of $660.0 million in FY 2013, $730.0 million in FY 2014, $780.0 million in FY 2015, $840.0 million in FY 2016, and $910.0 million in FY 2017.

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 functions for all of CMS' programs. It reduced 50 separate accounting/payment systems for Medicare and Medicaid into one system. The main objective of this effort was to leverage the use of commercial off the shelf (COTS) software in the federal government to increase automation, increase efficiency, and maximize economies of effort to centralize management and save millions of taxpayer dollars that fund Medicare and Medicaid each year, while at the same time eliminating redundant and inefficient / ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (HHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with HHS 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 HHS.

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 provided the capability for CMS and HHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS was a critical success factor in ensuring HHS met FFMIA compliance requirements. All of CMS' core program dollars are accounted for in HIGLAS. Payment dollars are comprised of all CMS lines of business which include the Health Insurance Marketplace payments beginning January 2014. The FY 2015 gross program dollars processed through HIGLAS exceeded $1.3 trillion. HIGLAS continues to enhance CMS' oversight of all financial operations, in order to achieve accurate, reliable, and timely financial accounting and reporting for all of CMS' programs and activities. In addition, HIGLAS enables CMS to resolve material weaknesses identified in the CFO audits related to the accounting of Federal dollars.

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.

CFO/Financial Statement Audits – CMS is required under OMB Bulletin A-136 to prepare annual and quarterly financial statements. The yearly CMS financial statements must be audited annually in accordance with the Government Management Reform Act of 1994 and

OMB Bulletin No. 07-04. 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: $108.8 Million

The FY 2017 President's budget request for HIGLAS and the CFO audit is $108.8 million, a $4.7 increase from the FY 2016 Enacted. In FY 2017, CMS will support the production and application maintenance of HIGLAS. There is no request for funding in FY 2017 for additional development, modernization, or enhancements to HIGLAS.

- *HIGLAS*: $98.9 million. This request supports operations and maintenance costs for the Healthcare Integrated General Ledger Accounting System. Additionally, CMS expects to finalize plans for transition of the DME MACs to HIGLAS.

HIGLAS Costs - FY 2014 through FY 2017
(Dollars in Millions)

	FY 2014 Actual	FY 2015 Actual	FY 2016 Enacted	FY 2017B PB
Development, Modernization & Enhancement	$8.9	$0.0	$0.0	$0.0
Operations & Maintenance	$85.7	$94.6	$94.2	$98.9
Total	$94.6	$94.6	$94.2	$98.9

- *CFO/Financial Statement Audits:* $9.9 million. This funding is necessary to pay for the CFO audit, a legislative mandate, which ensures CMS financial statements are reasonable, that our internal controls are adequate, and that we comply with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and the Department of Health and Human Services and 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 resulting from an adverse re-determination of a claim by a Medicare Administrative Contractor (MAC) during the first level of appeal. QICs must process Medicare Parts A and B claim appeals within 60 calendar days of receipt. 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)[4].

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

[4] 42 CFR §405.970(c)

hearings to discuss and/or clarify CMS coverage and payment policies. Centralized services are providing for the retention of all completed fee-for-service cases, MAC coordination to issue payments to appellants, and maintaining a website with appeals status information for both the QIC and ALJ levels of appeal, and providing data for quality control purposes.

Another important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). MAS' goal is to support the appeals process for the FFS, Medicare Advantage, and Prescription Drug Programs. MAS is a system that tracks and records Medicare appeals through multiple levels of the appeal process. The system leverages processes and consolidates data to allow users across appeal levels to realize benefits of reusable, centralized data. The system supports standard processing of appeals and availability of data to other appeal levels while allowing stakeholders and user groups to shape procedures at their desired level CMS maintains the system and implements all necessary system changes.

Budget Request: $142.5 Million

The FY 2017 budget request for QIC appeals (BIPA section 521) is $142.5 million, an increase of $49.1 million above the FY 2016 Enacted Level. CMS requests:

- *QIC Operations*: $117.3 million, an increase of $30.1 million above the FY 2016 Enacted Level. This request includes annual operational costs and CMS activities to advance the Departmental priority of adjudicating Medicare appeals at the second level in the appeals process. For FY 2017, CMS anticipates increases above FY 2016 receipts for both Part A and Part B, and larger increases for DME receipts. CMS will continue to monitor and revise workload estimates as new information is received.

  The request also supports greater CMS participation in Administrative Law Judge hearings at the Office of Medicare Hearings and Appeals (OMHA), the third level of appeals, and increases efforts to decrease the OMHA backlog through new adjudication and settlement activities.

- *Medicare Appeals System (MAS)*: $25.2 million, an increase of $19.0 million above the FY 2016 Enacted Level. Expanding MAS to every MAC is a CMS priority. The MAS continues to be an integral part of CMS' management and oversight of MAC and QIC appeals. Access to real-time appeals data allows CMS to closely monitor workload trends and contractor performance. MAS has improved the appeals process by providing one centralized system for processing; reducing time and costs associated with storing, shipping and maintaining paper files and storing reporting metrics to identify and understand processing bottlenecks. There are currently more than 1,300 MAS users, with new user requests coming in daily. To date, users have processed more than 2,300,000 appeals using MAS.

  This request will also provide for the analysis, planning, and development of a strategy to update the MAS to incorporate functions currently performed by the Eligibility Appeals Case Management System (EACMS). This integration will allow for a single CMS-wide appeals system that would store and track Medicare beneficiary claim appeals. In addition to promoting the use of consistent processes in appeals activities across MACs and QICs, implementation of the system at additional MACs will improve accuracy, timeliness, and efficiency in the appeals process.

The number of appeals has consistently increased over the last several years. The overall anticipated workload increase for FY 2016 is 12.7 percent. For FY 2017, we are anticipating a significant increase again in the DME workloads and smaller increases for Part A and B. As in previous years, we will continue to review and analyze workload trends and adjust as necessary.[5]

QIC Appeals Workload

	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Estimated Actual	FY 2016 Estimate[6]	FY 2017 Estimate[6]
QIC Appeals	520,221	758,921	1,000,013	1,112,192	1,116,089	1,260,388	1,382,065
% Increase from Previous Year	5.3%	45.9%	31.8%	11.2%	0.3%	12.9%	9.7%

The following chart details the percentage of appeals completed in the statutory timeline by type from FY 2007 through FY 2015:

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	92.44%	99.89%
2015*	97.56%	97.26%

**Data as of December 31, 2015.*

HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS 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:

[5] These estimates represent the number of claims appealed. Note, these numbers may vary from other documents that estimate the number of appeals (which may include more than one claim).
[6] This estimate does not include efficiencies gained by implementing the Medicare appeals legislative package.

- *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. This project covers the operational support for issuing NPIs, a national customer service call center to assist providers in obtaining their NPI, and operational costs for the National Plan and Provider Enumeration System (NPPES) system. CMS built NPPES to assign NPIs and process NPI applications. Providers are required to keep their NPPES data current by submitting timely updates. Approximately 12.6 percent of the covered health care providers need to furnish updates annually. Non-covered health care providers also furnish updates to their NPI data. As such, the process of assigning NPIs and furnishing updates to the NPI data continues indefinitely. Currently, over 4.3 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers.

- *HIPAA Claims-Based Transactions* – The Medicare program responds to electronic requests for eligibility information from providers and health care institutions using the adopted standard. CMS 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 Enforcement* – CMS manages the administrative simplification enforcement and certification provisions of HIPAA. The administrative simplification enforcement and certification provisions of HIPAA include three activities:

    - establishing the enforcement protocols for the certification of compliance program that includes conducting audits, assessing monetary penalties and managing appeals,
    - processing complaints of noncompliance, and
    - conducting compliance audit reviews.

    The implementation of additional standards and ACA operating rules emphasize the need for more diligent enforcement, and more robust outreach to make the industry aware of the enforcement intake process, and a quicker resolution of outstanding Transactions and Code Sets (TCS) and ACA complaints, including compliance reviews and enforcement audits of covered entities. CMS will require contractor support to conduct ongoing operations and activities for complaints associated with the additional requirements added by ACA.

- *HIPAA Administrative Simplification Enumeration and Audit of Health Plans* – CMS is responsible for driving the enumeration of Health Plans as required by the Affordable Care Act , as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CMS estimates that as many as 130,000 health plans may need to be enumerated. CMS is responsible to ensure that Medicare and Medicaid, other federal payers, as well as commercial payers are progressing towards compliance for Health Plan Identifier (HPID)

enumeration. Funding is required to support the HPID analysis, national enumeration system, enumeration process, and technical guidance to industry on the enumeration policy and implementation.

- *EDI Pilot of Health Care Attachments Standard and Analysis of the Return on Investment of the Electronic Funds Transfers Standard and Operating Rules:* CMS develops and adopts policies pertaining to the ANSI standards for conducting health care financial and administrative transactions on behalf of the HHS Secretary for mandatory use by health plans, health care providers and clearinghouses. These requirements are foundational for healthcare reform and support CMS' E-Health Initiative to achieve better care, better health, and lower costs through greater interoperability, ease of data sharing, and lower costs through operational efficiencies. As the health care industry moves towards a modernized delivery system and meaningful use of electronic health records, there will be an increased need for interoperability and data sharing between payers, providers, and beneficiaries. The adoption of transaction set standards will be necessary to regulate the processing of electronic claim transactions. This pilot project would focus on testing each proposed standard to ensure that it meets the needs of both administrative and clinical consumers while reducing insurance administrative costs by standardizing, eliminating, or automating health insurance administrative and financial transactions.

- *ACA Initiatives Sections 1104 and 10109* – Section 1104 establishes a series of new operating rules and standards for administrative transactions that improve the utility of the existing HIPAA transactions. The ACA mandates additional requirements for all HIPAA covered entities such as industry health plans, providers, and clearinghouses. Additionally, all CMS health care programs 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 reducing 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. The ACA's amended Administrative Simplification requirements help close these gaps and create uniformity.

  - *Section 1104* requires the Secretary to adopt two new standards and eight new sets of operating rules for administrative transactions. 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 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: $45.2 Million

The FY 2017 budget request for HIPAA Administrative Simplification is $45.2 million, an increase of $18.9 million above the FY 2016 Enacted Level. The increase supports CMS' HIPAA administrative simplification efforts as mandated by the ACA. Funding is requested for the following activities:

- *NPI & NPPES*: $9.4 million, an increase of $1.0 million above the FY 2016 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)*: $13.7 million, an increase of $2.6 million above the FY 2016 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 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 Enforcement*: $3.1 million, an increase of $0.8 million above the FY 2016 Enacted Level. The CMS enforcement contractor provides complex, analytical, and technical support for HIPAA administrative simplification enforcement and certification. The contractor's support includes the complete suite of case management services for complaints, managing the certification of compliance process, and monitors compliance with corrective action plans (CAPs) and enforces required timelines. The contractor also maintains and prepares statistical reports and analyses, and periodically performs process upgrades and system enhancements. The contractor is also charged with tracking and monitoring complaint submission, and providing technical assistance in analyzing complex complaints related to the ACA and HIPAA transactions and potential violations.

- *HIPAA Administrative Simplification Enumeration and Audit of Health Plans*: $3.6 million, an increase of $2.6 million below the FY 2016 Enacted Level. Contractor support is needed to assist health plans with the enumeration process, responding to questions, inquiries, complaints or requests for assistance or record maintenance. As new standards are adopted by the Secretary, and health plans make needed changes to their enumeration based upon purchase and sale of health plan components, acquisitions, and mergers, health plans will need continued support with enumeration.

- *EDI Pilot of Health Care Attachments Standard and Analysis of the Return on Investment of the Electronic Funds Transfers Standard and Operating Rules*: $2.5 million, an increase of

$1.5 million above the FY 2016 Enacted Level. The request will support contractor activities to manage the pilot enrollment process, vet possible participants, collect any required documentation, and conduct the regular meetings that would be required with all of the pilot participants. The contractor will also manage the pilot process to ensure that all of the participants are meeting their deliverable goals and are submitting the appropriate reports for use in the eventual pilot report. Finally, the contractor would produce a report containing the complete findings of the pilot. The entire process should take between 18 and 24 months.

- *ACA Sections 1104 and 10109*: The FY 2017 request is $12.5 million, which includes funding for a comprehensive, agency-wide and health care industry-wide implementation infrastructure, risk mitigation efforts, testing and technical assistance for individual project areas and systems across the CMS enterprise to include the MACs, and 56 States and Territories (Medicaid). It also includes monitoring and tracking of industry implementation issues and compliance. Funding is also being requested to continue the development and implementation of an industry-wide outreach and education strategy. Medicare and Medicaid policies, business processes, and systems will require remediation and action to become fully compliant or face significant statutory penalties.

ICD-10 and Version 5010 Regulations

HIPAA requires CMS, along with the entire U.S. health care industry, to transition to the International Classification of Diseases 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9). The more detailed code structure of ICD-10 enhances a provider's ability to more accurately document diagnoses and treatments. In turn, this data enables CMS to accurately measure quality and resource intensity as well as enhance the detection of fraud, waste, and abuse prevention. ICD-10 is not only foundational for health care reform, but is a cornerstone of several integrated programs that build toward a modernized health care system and work in concert to achieve better care, better health, and lower costs. The transition to ICD-10 has significant internal and external impacts on CMS, HHS, and the entire health care industry. All HIPAA covered entities and related programs including Medicare, State Medicaid Agencies, commercial health plans (including plans operating within the Marketplace,); providers, clearinghouses, and vendors are affected. ICD-10 impacts over 176 CMS systems, numerous payment policies and risk adjustment methodologies, quality measurement and reporting, business processes, manuals, and multiple downstream systems.

ICD-10 successfully launched on October 1, 2015, with a dedicated ICD-10 Ombudsman and Coordination Center. The transition to ICD-10 enables providers to capture more details about the health status of their patients to improve patient care and public health surveillance. CMS is carefully monitoring the transition and is pleased to report that claims are processing normally. CMS continues to work very closely with all stakeholders to offer industry support.

Budget Request: $20.0 Million

The FY 2017 budget request for ICD-10/Version 5010 is $20.0 million, a decrease of $10.0 million from the FY 2016 Enacted Level. The funding requested for ICD-10 includes continued post-implementation activities such as monitoring downstream implementation impacts and issues. This funding provides a platform to quickly remediate issues and execute solutions during the post-monitoring phase.

- *Post-Implementation Code Policy Analysis and Evaluation:* $10.0 million, a decrease of $5 million below the FY 2016 Enacted Level. This request supports all activities associated with conducting additional analysis and evaluation of code policies for risk adjustment, quality measures, and national and local coverage determinations after the ICD-10 launch date.

- *Training, Outreach & Education:* $5.5 million, a decrease of $3 million below the FY 2016 Enacted Level. CMS will continue to offer implementation support via an industry-wide outreach and education strategy that focuses on small and rural providers.

- *Post-Implementation Project and Risk Management Requirements:* $4.5 million, a decrease of $2 million below the FY 2016 Enacted Level This request supports CMS' Risk Mitigation and project management strategy to evaluate and manage potential post-implementation issues. Continued monitoring and evaluation of industry adoption will be required.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RDE) 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 128 million beneficiaries in FY 2017. CMS leverages other funding sources, such as ACA section 3021, to support RDE projects wherever possible.

Medicare Current Beneficiary Survey (MCBS) – The MCBS is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through CMS operations/administration. The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries. 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 estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews), and consists of three annual interviews per survey participant.

The primary goals of the MCBS are to:

- provide information on the Medicare beneficiary population that is not available in CMS administrative data and that is uniquely suited to evaluate or report on key outcomes and characteristics associated with beneficiaries treated in innovative payment and service delivery models;
- determine expenditures and sources of payment for all services (including services not covered by Medicare) used by Medicare beneficiaries, including copayments, deductibles, and non-covered services;
- ascertain all types of health insurance coverage among Medicare beneficiaries (e.g., Medigap coverage, retiree coverage) and relate this coverage to payment for specific services; and

- track changes in key beneficiary metrics over time, such as changes in health and functional status, spending down to Medicaid eligibility, access and satisfaction with Medicare programs and providers, and fluctuations in out-of-pocket spending.

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 condition 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 CMS tool that supports external and internal researchers is the Research Data Assistance Center (ResDAC), comprised of a help desk and website. The ResDAC provides technical assistance to researchers on CMS data and data systems. The goal is to increase the number of researchers skilled in accessing and using CMS data for research studies, which may lead to improvements in the Medicare and Medicaid programs. The ResDAC receives approximately 6,800 inquiries a 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 two-year grants to HBCU and HSI investigators to research topics of relevance to CMS African American and Hispanic American Medicare, Medicaid, and CHIP beneficiaries. Through these grants, new pilot interventions to improve the health of minority populations are tested. These projects identify, implement, and evaluate solutions for addressing health disparities among its populations. 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.

Budget Request: $21.9 Million

The FY 2017 budget request for Research, Demonstration, and Evaluation is $21.9 million, an increase of $1.8 million above the FY 2016 Enacted Level. CMS will continue funding ongoing research data analytic activities supporting CMS and split-funding the MCBS with the Innovation Center (ACA Section 3021).

- *MCBS*: $12.0 million, the same as the FY 2016 Enacted Level. CMS requests funding to maintain the survey's content and utility, and support provisions in the ACA. In FY 2017, CMS plans to continue an equal split of the MCBS' total operational cost of $24.0 million between RDE and ACA Section 3021 at $12.0 million each.

- *Other Research*: $9.2 million, an increase of $1.8 million above the FY 2016 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. The requested increase supports the CCW. The CCW needs additional money to support the inclusion of additional data sources and to make enhancements to the existing data. The CCW will be loading encounter data as well as replacing the current Medicaid data with the new T-MSIS data.

- *HBCU Grants*: $0.7 million, the same as the FY 2016 Enacted Level. Funding is requested for new and previously awarded research projects. It is critical for HBCU and Hispanic investigators/researchers from leading minority academic institutions to be able to participate along with majority institutions to develop, implement, and study a range of prevention, screening, self-management, outreach, education, consumer information and other types of studies that offer valuable contributions to the health of minority.

III. MEDICAID, CHIP, and BASIC HEALTH PROGRAM INITIATIVES

Program Description and Accomplishments

Medicaid, CHIP, and Basic Health Program 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, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). 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, following implementation of the Affordable Care Act (ACA), Medicaid is the primary source of health care for a larger population of medically vulnerable Americans. These include 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. Medicaid and CHIP enrollment is expected to be 77.8 million in FY 2017 with more than 1 in 5 Americans enrolled in Medicaid or CHIP.

Summary of Programs:

CMS funds the operations of Medicaid, CHIP, and the Basic Health Program (BHP) in the CMS Program Operations account. These funds support the following priority activities for Medicaid, CHIP, and BHP:

- *MACBIS* – Begun in 2009, MACBIS is a CMS enterprise-wide initiative to ensure the data infrastructure and information technologies that support Medicaid and CHIP are commensurate to their role as the nation's largest health insurer. Described in greater detail in the State Grants and Demonstrations chapter of this document, MACBIS has two parts: First, MACBIS includes efforts to modernize the work flows and business processes that support online submission, review and approval of State Plan Amendments (SPAs), waivers, and Advance Planning Documents (APDs). Second, MACBIS includes Transformed Medicaid Statistical Information System (T-MSIS), which modernizes and enhances systems and data analytics infrastructure for State-submitted operational data about beneficiaries, providers, claims, and encounters. The Program Operations request will support the system modernization and enhancement for T-MSIS. Because MACBIS upgrades are needed for a variety of Medicaid programs, the costs of MACBIS are borne by a variety of accounts in addition to Program Operations.

- *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 and Treatment program, Drug Data Reporting for Medicaid (DDR) web application and the DCCA Data Center (hosting for multiple Medicaid applications), and the Medicaid and State Children Health Insurance Program Budget and Expenditure System (MBES/CBES), a legally mandated system that was created to enable the States to submit budget and expenditure data to CMS. 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.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency* – Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and the Children's Health Insurance Program (CHIP) to design, implement and test new approaches to coverage, payment and service delivery, with the intention of improving whether and how low-income people receive health care, the quality and outcomes of that care, and its cost to the Federal government and to states. Currently three-quarters of states operate at least one demonstration, and a growing number of states operate most or their entire Medicaid program under section 1115 authority. Funding will aid in conducting front-end assessments of 1115 demonstration designs as well as in oversight and management of post-approval state deliverables. This work represents ongoing operational cost.

- *Survey of Retail Prices* – The Survey of Retail Prices initiative involves a pharmacy survey to aid states in efficiently reimbursing pharmacies for prescription drugs. The purpose of this project is to perform a monthly nationwide survey of retail community pharmacy invoice drug prices and to provide states with on-going pricing files. The resulting prices derived from this survey have been developed into the National Average Drug Acquisition Cost (NADAC). The NADAC files are posted on Medicaid.gov and are updated weekly. These files provide

state Medicaid agencies with an array of covered outpatient drug prices concerning acquisition costs for covered outpatient drugs. The state agencies have begun to implement the NADAC as their approved State Plan reimbursement methodology.

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 covered outpatient drugs to serve as a source of information for states to set reasonable payment rates to pharmacies. Facing budgetary limitations, CMS 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 2017 request includes funding for Part II of the survey.

- *Outreach 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.

- *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.

- *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 care services. The Home and Community Based (HCB) Settings Characteristics Contract Project was initiated at the end of FY 2014 and assists CMS in the review and monitoring of Statewide Transition Plans (Plans) designed to bring states into compliance with new regulations published in January 2014 which set forth requirements to ensure HCB settings are integrated and individuals receiving Medicaid HCBS have the same access to the community as everyone else. The HCB Settings Characteristics Contract Project is also the vehicle used to assist CMS in the development of necessary tools, protocols and guidance materials to ensure consistent national implementation of these new requirements. All states must come into compliance with the new regulations by March 2019. In FY 2015, HCB Settings Characteristics Project activities continue to assist states in transforming their systems to comply with the requirements by the March 2019 deadline.

- *Basic Health Program* –The Basic Health Program (BHP) allows states to enroll eligible individuals, with income between 133 percent and 200 percent the Federal Poverty Level (FPL), in lieu of offering such individuals coverage through a Health Insurance Marketplace. States may also enroll lawfully present non-citizens who have income that does not exceed 133 percent, but are ineligible for Medicaid due to their non-citizen status. States electing the BHP option will provide coverage to eligible individuals and receive 95 percent of the Federal funding that would have been provided on behalf of the individuals as premium tax credits and cost-sharing reductions. As states consider the BHP, CMS will be required to provide technical assistance, review and certify state plans for implementation (known as BHP Blueprints), and provide ongoing oversight of state BHPs. CMS must also conduct an annual review of each state program to ensure compliance with federal requirements.

- *Quality Assurance and Improvement, Technical Assistance, and Oversight under the Money Follows the Person (MFP) Demonstration* – Through FY 2016, these activities are being funded via the Money Follows the Person appropriations. Thereafter, states will continue to work on MFP activities, but Program Operations funding is needed for CMS to continue to administer MFP. The purpose of this contract is to provide expert technical assistance to CMS, MFP grantees and their partners, and other relevant state and local agencies/organizations involved in long-term care supports and services. Guidance and consultation will be provided to CMS and MFP grantees to assist in the implementation of the MFP Demonstration program. The national contractor will focus mainly on providing programmatic and quality management technical assistance to the MFP grantees.

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

- *Managed Care Review and Oversight* – CMS began this project in 2013 to advise states with their managed care programs and help CMS monitor new and existing programs. As of 2015, over $150 billion federal dollars is spent annually on Medicaid managed care. As of September 2014, 39 states provide some form of managed care, with 90 percent of Medicaid beneficiaries living in those 39 states. Adding to concerns over monitoring expansion, CMS was cited in GAO report number GAO-10-810 for having inconsistent oversight processes in place for managed care programs. CMS implemented this project to increase our oversight and technical assistance to states to address the new needs created by managed care expansion and GAO concerns.

- *Coordination of Housing and Services Technical Assistance* – The Coordinating Housing and Services Technical Assistance Contract (CHSTAC) builds on work accomplished through the former HHS-HUD Housing Capacity Building Initiative for Community Living Contract. It supports the growing need to develop strategies that will increase the availability of affordable and accessible supportive housing for individuals who require

community-based long-term services. This supports those at-risk for homelessness, and those who are currently living in a residential or institutional setting and have chosen to live more independently. Through FY 2016, these activities are being funded via the Money Follows the Person appropriations.

- *Preadmission Screening and Resident Review (PASRR) Technical Assistance Center* – The PASRR Technical Assistance Center (PTAC) is teaching states how to reverse the plight of 250,000 people with serious mental illness or intellectual disability who live in nursing homes under custodial care without adequate services for their disabilities. The Center works to increase compliance with and the effectiveness of a federally required but neglected state process called Preadmission Screening and Resident Review (PASRR). PASRR should prevent this crisis in insufficient care, by either diverting people to community services or admitting people to nursing homes only if provided with adequate special services for their disability.

  The PTAC operates in close coordination with CMS and Regional Offices, helping states implement CMS policy and informs CMS of challenges and opportunities that States face. Direct contract staff provide first line technical assistance, staff telephone conferences with states, develop materials and webinars, organize the repository of PASRR information, and analyze data sets. Contract subject matter experts are assigned to work with states on an as needed basis.

Budget Request: $63.6 Million

The FY 2017 request for Medicaid, CHIP, and BHP operations is $63.6 million, an increase of $35.1 million above the FY 2016 Enacted Level request. Since the ACA, the Medicaid program has expanded, BHP was created, and other new work has resulted from new legislation. The increase reflects new needs in Program Management such as MACBIS and implementation, expansion, and updates for activities that have not been funded in past years due to budget limitations. Funding in this section includes support for administrative activities necessary to effectively operate Medicaid, CHIP, and BHP.

- *MACBIS:* $15.0 million, an increase of $15.0 million above the FY 2016 Enacted Level. CMS requests funding to transform Medicaid and CHIP information and data gathering, submission, storage and extraction processes from a multi-layered and manual paper based process to an electronic, automated process that provides CMS, its Federal partners, the states and other stakeholders the ability to monitor, evaluate and analyze Medicaid and CHIP program performance. CMS has worked with states to improve Medicaid and CHIP data and data analytic capacity through MACBIS. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which is known as Transformed-MSIS or T-MSIS. The enhanced data available from T-MSIS will support improved program and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

- *Medicaid Systems Support:* $18.6 million, an increase of $1.9 million above the FY 2016 Enacted Level. This request will aid in funding the operation and maintenance for the Medicaid & Child Health Budget and 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.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $8.8 million, an increase of $7.0 million above the FY 2016 Enacted Level. Based on previous contractual proposals to perform this full scope of work, CMS requests an increase in funding to appropriately provide rigorous review and assessment of the entire Medicaid section 1115 demonstration portfolio, and to complete the development and implementation of the suite of tools needed to do that work efficiently and effectively. Additional funding is needed to build-up technical resources to absorb this work.

- *Survey of Retail Prices*: $4.0 million, the same as the FY 2016 Enacted Level. CMS is not requesting any mandatory funding associated with the survey of retail prices in the FY 2017 Budget and requests funding for this activity in Program Operations moving forward. CMS requests ongoing operations funding for this fixed price contract, which collects pharmacy acquisition costs as reflected in Part II of the survey. Part I of the survey, a nationwide survey of consumer prices, will remain suspended under this funding level. The states will rely on these weekly updated pricing files for their covered outpatient drug reimbursement methodology, as approved in their State Plans. The NADAC will also continue to assure that the Federal Medicaid program is paying more accurately for prescription drugs and will help states effectively implement the final outpatient drug rule.

- *Learning Collaborative:* $3.6 million, an increase of $1.7 million above the FY 2016 Enacted Level. The Learning Collaboratives have proven to be a critical element of CMS' overall information exchange and technical assistance efforts with states. On the premise that systems are more likely to be successful when users are integrally involved in their creation and improvement, this engagement between states and key experts has been invaluable. Given the magnitude of the changes that continue to be implemented under the Affordable Care Act, continuing the partnership between state Medicaid agencies and the Federal government in the improvement of existing and development of new tools, materials and monitoring plans is critical.

- *The National Home and Community Based Services (HCBS) Quality Enterprise*: $3.0 million, an increase of $1.0 million above the FY 2016 Enacted Level. CMS requests funds for a contractor to provide support to CMS in the review these 50 Statewide Transition Plans, assisting CMS in the development of criteria and guidance for the submission of environmental scans and other requirements to ensure that states are in compliance with the home and community-based settings characteristics. In addition to reviewing Statewide Transition Plans, contractors will conduct on-site reviews, education and training, and data analysis activities as states implement changes required by the regulation.

- *Basic Health Program*: $2.5 million, an increase of $2.5 million above the FY 2016 Enacted Level. CMS requests funding for the administration of BHP to provide comprehensive assistance and oversight to states trying to execute and operate new BHPs. Contractor support is necessary to provide technical support to calculate State BHP payments, technical support on the development and testing of adjustments to the financing methodology, development of technical assistance tools, performance standards and reporting mechanisms for states implementing a BHP, and assistance with monitoring state implementation of new BHPs, including oversight of states' data collection and reporting on performance standards.

- *Quality Assurance and Improvement, Technical Assistance, and Oversight* under the Money Follows the Person (MFP) Demonstration: $2.5 million, an increase of $2.5 million above the FY 2016 Enacted Level. Program Operations funding is needed to continue technical assistance as States wrap up their MFP programs. More specifically, this funding is for a contract to provide expert technical assistance to CMS, MFP grantees and their partners, and other relevant state and local agencies/organizations involved in long-term care supports and services. Guidance and consultation will be provided to CMS and MFP grantees to assist in the implementation of the MFP Demonstration program. The national contractor will focus mainly on providing programmatic and quality management technical assistance to the MFP grantees. States have the opportunity to receive a final multi-year grant award in FY 2016 that will remain available through FY 2020, which means most of these states are likely to require technical assistance well into FY 2017 and beyond.

- *Medicaid Expansion Oversight and Assistance:* $2.0 million, an increase of $2.0 million above the FY 2016 Enacted Level. The requested increase will provide support to states trying to meet the massive program changes associated with the new Medicaid eligibility requirements and expansion. CMS will continue providing oversight and outreach as states need to make program refinements to ensure that their eligibility and enrollment systems are operating successfully and in full compliance with the ACA.

- *Managed Care Review and Oversight*: $1.7 million, an increase of $0.7 million above the FY 2016 Enacted Level. This activity will continue in 2017. This activity involves providing ongoing operational support and will allow CMS to continue technical assistance and standardizing of tools for states that create/update their managed care delivery systems.

- *Coordination of Housing and Services Technical Assistance*: $1.0 million, an increase of $1.0 million above the FY 2016 Enacted Level. The Housing contract will be critical to advancing the efforts of state grantees to grow and develop their housing operational infrastructure to support individuals transitioning from institutional placements. Funding for this contract for fiscal year 2016 will be provided under the Money Follows the Person (MFP) Demonstration; however, at the end of FY 2016 the funding available for the continuation of this contract will end. States have the opportunity to receive a final multi-year grant award in FY 2016 that will remain available through FY 2020 which means the housing technical assistance will be required for most states well into FY 2017 and beyond.

- *Preadmission Screening and Resident Review (PASRR) Technical Assistance Center*: $0.6 million, an increase of $0.6 million above the FY 2016 Enacted Level. CMS' request funds the PTAC contract. The PTAC operates in close coordination with CMS and Regional Offices, helping states implement CMS policy and informs CMS of challenges and opportunities that States face. Direct contract staff provide first line technical assistance, staff telephone conferences with states, develop materials and webinars, organize the repository of PASRR information, and analyze data sets. Contract subject matter experts are assigned to work with states on an as needed basis.

- *Revisions to Online State Medicaid Manual*: $0.5 million, an increase of $0.5 million above the FY 2016 Enacted Level. This request will purchase all of the support services necessary to update the manual for the first time in 15 years. This contractor will need to provide a project plan and process flow, run the data gathering process, and write the actual updated manual.

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: $47.8 Million

The FY 2017 President's Budget request for Parts C and D IT Systems Investments is $47.8 million, an increase of $5.4 million above the FY 2016 Enacted Level. This request supports ongoing systems maintenance and implementation. The request 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

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

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

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

QIC Appeals Workload for Parts C/D – FY 2012 through FY 2017

	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Estimated Actual	FY 2016 Estimate	FY 2017 Estimate
Part C Appeals	98,464	122,948	72,190	42,500	44,000	45,540
Part D Benefit Appeals	14,879	21,780	23,064	28,000	30,000	33,000
Part D LEP appeals	36,456	38,468	40,639	44,500	46,000	47,550

Prior to FY 2014, CMS had seen a steady increase in the MA appeals workload which we believe was attributable to growth in the Part C program, increased familiarity by Part C enrollees and other applicable appellants (e.g., non-contract providers) with the appeals process, and an increase in Part C health plan retrospective review of paid claims. CMS also realized that dismissed appeals accounted for a large proportion of the Part C reconsideration workload, so changes in the processing of dismissed appeals was initiated with implementation effective for CY 2014.

The large decreases in recent years are attributable to a change CMS made in the processing of dismissals. Beginning in January 2014, MA organizations became responsible for dismissing invalid reconsideration requests, rather than automatically forwarding such reconsideration cases to the Independent Review Entity (IRE) for review and dismissal. Similar to Part C, workload growth is impacted by increases in Part D enrollment, and Part D enrollees and other applicable appellants becoming more familiar with the appeals process. Workload is also driven

by Part D plan sponsors not issuing timely decisions. If decisions are not issued timely, the Part D plan sponsors must auto-forward the requests to the IRE for review. As a result, there has been a 41 percent decrease in workload volume between FY 2013 and FY 2014 and a 41 percent decrease in FY 2015 as compared to FY 2014 as reflected in the Part C Workload Data chart shown above.

- *The Consumer-Operated and Oriented Plan (CO-OP)* – Created by the ACA, this program fosters 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. CO-OPs were envisioned to provide additional competition that could help constrain the growth of healthcare costs, and keep premiums down.

- *Insurance Market Reform* – CMS developed regulations and guidance supporting minimum essential coverage and prohibiting exclusions for the private health insurance market. 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 and will continue working with States to ensure adequate enforcement. Additional details on these regulations and related guidance can be found at: http://cciio.cms.gov/resources/regulations/index.html.

- *Medical Loss Ratio (MLR)* – Health insurance issuers offering group or individual coverage are required to submit an annual report to CMS 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. The annual reports, including information on issuer's rebate payments, are available to the public on the HHS website.

- *Rate Review* – CMS is responsible for monitoring health insurance premium increases and ensuring States have appropriate mechanisms to review potentially unreasonable health insurance premium increases, defined as increases of more than 10 percent over the previous year. Since 2014, CMS has monitored rate increases for private individual and small group markets. To assist in this monitoring function, CMS released final rules that add a reporting threshold for any rate increase above zero as well as amend the standards for health insurance issuers and States regarding reporting, utilization, and collection of data for the program. Proposed rates undergo an actuarial review by either a State, or, if a State is unable to review the proposed increases, then by CMS. Information on all proposed rate increases, as well as any justifications for increases found to be unreasonable, are made available to the public on Healthcare.gov. A copy of the rules and data template can be found at: http://cciio.cms.gov/resources/regulations/index.html.

Budget Request: $66.0 Million

The FY 2017 budget request for Oversight and Management is $66.0 million, an increase of $6.2 million above the FY 2016 Enacted Level.

- *Medicare Parts C and D*: $49.8 million, an increase of $8.3 million above the FY 2016 Enacted Level. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, the Retiree Drug Subsidy (RDS) Program, and the on-going Medicare Part C and Part D reconsideration contracts. This 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.

- *The Consumer-Operated and Oriented Plan (CO-OP)*: $6.0 million in FY 2017, which will allow CMS to actively monitor the loan portfolio and support the continued growth of the CO-OPs 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 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.

- *Insurance Market Reforms*: $4.3 million, the same as the FY 2016 Enacted Level. The funding will be used to leverage a contractor to complete the review of the plan documents submissions, assist with research to investigate complaints, and to conduct market conduct examinations.

- *Medical Loss Ratio (MLR):* $4.0 million, the same as the FY 2016 Enacted Level. CMS is responsible for directly enforcing the regulations with respect to MLR in those states that fail to substantially enforce the federal standards. The funding will be used to leverage a contractor to conduct MLR examinations, analyze allocation of expenses related to MLR calculations, and validate the data reported.

- *Rate Review:* $1.8 million, an increase of $0.3 million above the FY 2016 Enacted Level. Funding supports review of submissions of all rates where CMS is the primary rate review regulator for compliance with federal rating rules. Funding also supports the actuarial review of proposed rate increases of 10 percent or greater in the states where CMS is the primary rate review regulator. The funding will also be used to support the maintenance of the consumer facing rate review tool.

Health Insurance Marketplaces

The Health Insurance Marketplaces are competitive private health insurance markets that have enrolled 10.2 million Americans in affordable coverage as of the end of the 2015 enrollment period. The Marketplaces allow individuals and small businesses to compare health plan options, see if financial assistance with premiums and cost sharing is available, and purchase coverage that is affordable and right for them and their families. The Marketplaces offer a wide range of plans with standard levels of cost sharing and actuarial value divided into four coverage tiers identified as bronze, silver, gold, and platinum. Small business can provide coverage to their employees using a single portal that allows the employer to select coverage options for their employees, provides a mechanism to pay the employer portion of the premiums, and allows employees to enroll in coverage.

States can create a State-based Marketplace (SBM) or can elect to use the Federally-facilitated Marketplace (FFM). SBMs can partner with CMS to use portions of the federal platform, such as enrollment, to leverage functionality and resources and are referred to as

State-based Marketplaces on the Federal Platform (SBM-FP). In an SBM-FP arrangement, a State would retain authority for health plan certification, use the federal enrollment platform, and work in conjunction with CMS on outreach activities. Independently, States can choose to operate or elect for CMS to operate their Small Business Health Option Program (SHOP) and portions of the Premium Stabilization programs. CMS has responsibilities on behalf of all Marketplaces for the following core functions:

- Determining consumers' eligibility for financial assistance through the Marketplace or other health insurance programs, including initial determinations for Medicaid and the Children's Health Insurance Program (CHIP);
- Ensuring proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) and cost-sharing reduction (CSR) to issuers where a consumer is determined eligible;
- Developing and implementing a robust quality rating system and an enrollee satisfaction survey for display on Marketplace websites;
- Conducting certification and oversight of SBMs; and
- Operating the risk corridors program.

If a State elects to use the FFM, CMS oversees these additional functions:

- Reviewing health plan benefits and rates in order to certify qualified health plans (QHPs) and stand-alone dental plans (SADPs);
- Providing consumers the ability to apply for coverage or an exemption from the personal responsibility payment, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating consumers about the Marketplace including the open enrollment periods (OEPs), coverage options, and providing assistance to consumers.

As with the individual Marketplace, States have the option to elect CMS to operate a SHOP on their behalf. When operating as the Federally Facilitated SHOP (FF-SHOP), CMS is responsible for the full range of eligibility determination, enrollment, appeals, and reconciliation activities. These activities are similar to the ones described for the FFM. As SHOP is operationally different than the FFM, CMS works with issuers to educate and train them on policies, technical issues, and provide user manuals. When a State elects to operate a SHOP, CMS provides technical assistance and analytic support including technical guidance materials and analysis. In order to raise awareness and promote the growth of SHOP, CMS works in collaboration with the States to develop outreach and advertising.

For the 2016 OEP, CMS will operate Marketplaces in 34 states and perform enrollment functions under the SBM-FP model in Oregon, Nevada, New Mexico, and Hawaii. For the 2017 OEP, CMS anticipates operating individual marketplaces in 35 States and 32 SHOPs, while supporting SBM-FPs in the same states as during the 2016 OEP.

Since FY 2015, significant investments have improved the stability and usability of the HealthCare.gov website and supporting IT infrastructure, while CMS has continued a dual focus on successfully re-enrolling existing consumers and reaching out to new consumers. As the Marketplaces enter the next phase of maturity, CMS will drive continuous improvements in the efficiency of operations by automating and streamlining processes, increasing the reliability and accuracy of information, and executing a focused approach to operations. CMS will continue our strong consumer focus by continuing to improve the consumer experience through new decision support tools, simplifying consumer communications, and improving coordination throughout the program. CMS is targeting outreach and education efforts for hard to reach

populations that were missed during previous OEPs. CMS will continue to support improving plan value through rate stability, increasing transparency, and improving benefits.

Health Plan Benefit and Rate Review, Management, and Oversight – Certifies that health insurance plans offered through the Marketplace meet coverage standards for essential health benefits (EHBs), cost sharing, coinsurance, and actuarial value. This activity supports issuer oversight, health plan reviews, compliance, and rate analysis as well as ensuring agents and brokers are properly trained and able to navigate the Marketplace.

In order to offer a health insurance policy, an issuer must have the plan certified by the Marketplace. The Marketplace is responsible for ensuring health plans meet certification standards and monitoring issuer compliance. Certified health plans are referred to as qualified health plans (QHPs) and must provide ten EHBs including preventative services, emergency services, hospitalization, maternity, prescription drugs, and rehabilitative services, among others. Issuers can provide stand-alone dental plans (SADPs) that offer dental coverage beyond the scope of QHPs. This activity supports the annual certification, recertification, and updates to QHPs offered in the individual and small group markets, SADP, and plans deemed as QHPs such as Multi-State Plans (MSP) offered under contract with the Office of Personnel Management and Consumer Oriented and Operated Plans (CO-OP). CMS develops operational guidance and provides technical assistance to issuers on certification and submission requirements. CMS monitors issuer data through post-certification assessment (PCA) to ensure plans remain in compliance with certification standards and other operational guidance.

As part of the certification process and in States without an effective rate review program, CMS conducts rate outlier analysis and premium increase justifications. This analysis includes benefit package review to assess potentially discriminatory benefit designs, prescription drug, and cost sharing reviews to ensure plans meet EHB, network adequacy, and actuarial value requirements. To assist issuers, CMS provides a number of rate and benefit review tools. Information reviewed during the certification and rate review processes are displayed on HealthCare.gov to provide consumers with the necessary information to make an informed decision when selecting a plan.

In order to provide additional avenues for consumers to purchase health coverage, CMS works with agents, brokers, and web-brokers to provide plan information to consumers and assist consumers with enrollment in the FFM and SHOP. CMS provides technical assistance, outreach, training, registration, and oversight of agents, brokers and web-brokers. CMS uses an agent-broker vendor models that allows collaborative work with private sector vendors to ensure the training and registration of agents and brokers with approved curriculum and materials. In plan year 2016, the program anticipates supporting over 100,000 agents and brokers registrations.

Payment and Financial Management – Provides oversight and operations that ensure proper payment of APTC and CSR for eligible individuals who have effectuated enrollment in QHPs and SADPs. CMS is responsible for operating these insurance affordability programs and for making payments in all states. The activity also supports the three premium stabilization programs, a permanent risk adjustment program and transitional reinsurance and risk corridors programs which each operate for three plan years.

Each month, CMS receives enrollment information from the Marketplaces, calculates the amount of aggregate APTC and CSR owed to issuers, and distributes payments. At the end of

the year, CMS collects information from issuers to reconcile the advance CSR payments to the actual cost-sharing experienced by the enrollees. APTC is reconciled through the IRS when the consumer files their tax return. Using reconciled enrollment data previously discussed, CMS validates enrollment counts and plan premium information to calculate APTC, CSR, and user fees. CMS has developed strategies to ensure the integrity of payments and conducts audits to ensure issuer supplied data is accurate. These reports and calculations are used as part of the Premium Stabilization Programs described below. CMS provides program information and technical assistance on financial transfers, data submissions, and other payment-related issues to issuers and third party companies. Once payments and collections are calculated, CMS includes the payable and receivable as part of the monthly payment file that allows the Marketplaces to use existing automated functionality of the Healthcare Integrated General Ledger Accounting System (HIGLAS). Once entered into HIGLAS, the activity supports existing processes for processing, reporting, and debt management.

CMS oversees three private insurance premium stabilization programs, a permanent risk adjustment program and two transitional risk-sharing programs – reinsurance and risk corridors. The permanent risk adjustment program applies to all compliant health insurance plans and assists issuers whose health plans provide coverage to individuals with higher health care costs. States that operate a SBM may operate a risk adjustment program using a CMS certified methodology. In states that do not operate a risk adjustment program, CMS operates the program. Currently, CMS operates the risk adjustment program in 49 states, except Massachusetts, and in the District of Columbia. The risk adjustment data validation (RADV) program conducts reviews and audits of issuer provided data on healthcare costs used to calculate the risk score and determine adjustments. The transitional reinsurance program will operate for plan years 2014 to 2016 and is designed to reduce premiums and ensure market stability for issuers. In FY 2017, CMS anticipates making the final year of reinsurance payments and will operate the program in all the states, except Connecticut, and the District of Columbia. The risk corridor program is a temporary program that protects issuers from uncertainty in rate setting during the early years of Marketplace operations by having the Federal government share risk in losses and gains. This program is operated solely by CMS. In addition to the enrollment and payment activities discussed above, CMS provides an EDGE server environment to collect claims-level data that are used in determining premium stabilization program scores and calculating the payments or charges. CMS develops the complex analysis and parameters that determine scores within the programs including modeling the standard populations, calculation of average actuarial risk, specific parameters for each program, and the annual limitation on cost sharing for all non-grandfathered individual and small group plans. To support these programs, CMS conducts outreach and education on operating procedures, data submission requirements, program registration, and resolving payment discrepancies and appeals.

Eligibility and Enrollment – Allows consumers to select a QHP or SADP through the Marketplace and to determine eligibility for financial assistance, qualify for Medicaid or CHIP, or exemptions from the shared responsibility requirements. At the end of the plan year, the Marketplaces provide enrollment and tax reconciliation services to ensure APTC and CSR are appropriately paid and consumers have access to services to resolve any tax reporting issues. Further, consumers and employers have the option to appeal eligibility or financial assistance determinations, and this funding provides support services to ensure appeals are resolved in a timely and accurate fashion.

Eligibility support activities provide core operational activities for consumer entry into the Marketplace. Consumers can submit different applications, depending on their individual

situation, including applying for health insurance or an exemption from the personal responsibility payment. While the vast majority of applications are processed automatically through HealthCare.gov with information verified through up-to-date and real-time links with key Federal databases and commercially available sources, exemptions continued to be processed through paper applications and a small number of consumer choose to submit paper applications for health insurance coverage. However, many applications will generate data match issues, or inconsistencies, with electronic data sources or provided paper documents that require a timely manual documentation review to resolve. In many cases, consumers are required to submit additional documentation, either via mail or electronic upload, to support information provided on their application.

Each month, the Marketplaces and issuers conduct a reconciliation of enrollment and financial information to identify and resolve any discrepancies. Data discrepancies are identified through automatically generated analytic reports or through the issuer dispute process. The resolutions of any enrollment discrepancies resulting in changes are submitted to the Marketplaces and issuers to update their respective data. This process ensures only consumers who continue to pay the monthly premium remain enrolled in coverage and receive ATPC and CSR in the appropriate amount. At the close of the plan year, CMS provides consumers with tax summaries, called a Form 1095-A, for reporting to the Internal Revenue Services (IRS). Where consumers believe information is incorrect, CMS researches and resolves consumer inquiries related to data discrepancies prior to the April 15th tax filing deadline with all tax discrepancy issues needing to be resolved by the end of the filing extension deadline on October 15th.

Consumers have the opportunity to appeal different types of eligibility determinations made by Marketplaces including determinations of eligibility for financial assistance, special enrollment periods, and exemptions from the personal responsibility payment. Employers may also appeal an eligibility determination for an employee who receives Marketplace subsidies. Consumers and employers who are appealing their eligibility determination may be offered the opportunity to resolve their appeal informally and, if they decline to participate in the informal resolution process or remain dissatisfied with its result, they will have an evidentiary hearing of their case before a Federal Hearing Officer. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, general case management and development, writing case summaries, and implementing comprehensive training to ensure staff remain current on relevant laws, policies, and guidelines.

Consumer Information and Outreach – Supports the full range of education, outreach, and consumer assistance activities designed to raise awareness and facilitate enrollment. CMS continues to focus on reaching additional consumers, while encouraging existing enrollees to reevaluate their eligibility for insurance affordability programs and to shop for the best QHP. CMS will continue to target education and awareness activities to eligible but low enrollment populations, improve online consumer tools, and provide local one-on-one assistance to consumers to address their specific coverage situation.

Funding supports a Consumer Call Center (1-800-318-2596) that assists individuals with a broad range of questions and assists with enrollment. The call center supports outbound call campaigns as part of operational and outreach activities. The Navigators and assisters programs perform outreach and education in order to raise awareness and provide on the ground, in-person assistance to facilitate consumer enrollment. Education and outreach campaigns reach the eligible population through national multimedia efforts as well as target hard to reach population segments that have historically been uninsured. In order to keep

consumers informed of their status and provide them with critical updates, CMS generates notices that are printed and mailed to consumers unless they opt to receive electronic communications.

The table below displays estimates of the type of consumer assistance provided through Consumer Information and Outreach.

	2015 Estimate	2016 Estimate	2017 Estimate
Call Center	31.7 million	29.5 million	29 million
Consumer Assistance[1]			
Navigators and Assisters	260,200	260,000	260,000
Certified Application Counselors (CACs)	305,200	305,000	305,000

1/ These numbers reflect information provided by consumers during the application process. Consumers are not required to provide information if or the type of assistance received.

Consumer Call Center – The call center is the primary resource for consumers to ask questions, get help with online tools, complete an application and enroll in a plan as well as get help with tax questions, life changes and inconsistencies. Call Center locations offer support in over 200 languages and are open 24 hours a day 7 days a week. During the OEP, the call center has over 12,000 trained agents in 14 locations across the country. While the call center has high call volume throughout the entire year, our volume spikes are driven by consumer deadlines. Staffing is adjusted based on call patterns, which includes an in-depth approach to workforce management and specialization in large ramp up and ramp down procedures to maintain an effective operation. A specialized center provides complex call resolutions and is staffed by experts in resolving multiple types of enrollment and certain tax issues.

Navigators and Enrollment Assistance – Provides on the ground support and community based education to consumers on their health insurance options as well as assistance in completing enrollment. This activity provides consumers with impartial information on financial assistance and low income support programs and assist with comparisons between QHPs and SADPs.

Navigators are community based and provide linguistically appropriate services. In addition to assisting consumers during OEP, Navigators provide year round assistance with assist consumers with special enrollment periods (SEPs), Medicaid or CHIP eligibility and enrollment, small businesses, eligibility redeterminations, and guidance on taxes. Navigators provide consumers, many of which have limited experience with health insurance, education on understanding their benefits and how to use their coverage.

The Enrollment Assistance Program (EAP) offers broad-based enrollment assistance programs to populations not covered or targeted by the Navigators. EAP offers CMS the flexibility to support enrollment by filling geographic and demographic gaps in in-person assistance ensuring all consumers can receive one-on-one assistance. CMS operates the Assister Help Resource Center (AHRC) to provide assisters help with on policy questions and complex consumer issues.

Consumer Information and Outreach – Supports traditional and digital media, social media, earned media support, email targeting, and outreach analytics for public education and outreach campaigns, leading up to and during the OEP. As part of this campaign, CMS is responsible for communicating with the uninsured as well as those looking to re-enroll in plans, motivating them to purchase for the first time or to come back and update their application and compare plans.

For the 2015 OEP, the multi-media education campaign yielded a 20 percent increase in intent to buy insurance, a 22 percent increase in awareness of HealthCare.gov, and the number of people researching plans doubled.

CMS conducts direct mail activities developing and distributing over 100 educational publications in English and Spanish. Publications were available in both print and electronic version covering a wide variety of topics including enrollment basics, financial assistance, individual responsibility payment, exemptions, and appeals. As part of the 2015 OEP, CMS reached out to 800,000 new consumers to assist them in understanding not only how to purchase health insurance through the Marketplace, but to ensure they maintain and use their coverage.

In 2016, CMS is working with partners from across the government in the "Healthy Communities Challenge" to engage key communities with large numbers or high percentages of uninsured in states across the country where strong federal, state and community collaboration can have a meaningful impact on reaching the uninsured. CMS conducts outreach in these communities to educate individuals on options for coverage and how to use their coverage to gain the care they need at a price they can afford.

Printing and Distribution – Supports various printing and distribution activities for the FFM by providing notices to consumers on their application status, data match issues, appeals, and other information pertinent to their situation. These notices are generated from the various operational areas and consolidated through a single printing action with the Government Printing Office. The length and complexity of these notices varies, but CMS is continuously working on ways to reduce the length and complexity of the notices, while still providing the consumer the necessary information in an easy to read format.

Information Technology (IT) – Provides the information technology infrastructure that supports Marketplace activities. As a primarily web-based system, the vast majority of consumers enroll and have their eligibility determined through electronic systems. The FFM and SHOP system provide the primary entry point not only for consumer, but also for issuers to submit QHPs and SADPs. Supplemental systems provide the necessary analytical tools for determining financial assistance and premium stabilization payments. This infrastructure is supported by a virtual data center (VDC) that houses the various IT systems and provides the supporting network infrastructure to ensure systems are responsive and can support peak volume.

Health Insurance Oversight System (HIOS) – Provides a gateway for issuers to access the FFM and SHOP by providing a single portal with CMS and serves as the primary data collection vehicle for information provided by regulated health insurance companies and the States. HIOS collects information on covered benefits under private and small group plans, the behavior of issuers, and allows issuers to provide QHP and SADP information for display on consumer facing websites. The system provides a mechanism for oversight of issuers including the collection of benefit information, provider networks, rate review justification submissions, and medical loss ratio reporting.

Multidimensional Insurance Data Analytics Systems (MIDAS) – Provides a central repository for capturing, organizing, aggregating, and analyzing data for the Marketplaces. MIDAS ingests data from more than 22 data sources and allows CMS to conduct details analysis of trends across various programs to evaluate Marketplace operations, issuers, and plans.

Data Services Hub – Provides verification services for FFM, SBMs, and SHOP for information attested to by applicants in order to determine eligibility for coverage and financial assistance. CMS, through the Hub, uses data sharing functionality with Federal entities and commercial available sources through a single integrated service. Federal entities include the Social Security Administration (SSA) which verifies citizenship, income information, and enrollment in Medicare, the Department of Homeland Security (DHS) who verifies citizenship and immigration status; the Internal Revenue Service (IRS) which verifies household size and income using tax returns; the Veterans Health Administration (VHA) which verifies eligibility for participation in VA medical care, and the Office of Personnel Management (OPM) which verifies eligibility for federal employee health insurance coverage.

Federal Health Care Marketplaces (HIX) – Provides the core business functions of the FFMs including plan management, eligibility and enrollment, and financial management. The HIX provides the backend functionality for the consumer portal. The HIX includes FF-SHOP functionality for plan management, eligibility and enrollment, and financial management functions including managing employer premium payments.

Cloud Computing – Provides the Virtual Data Center and Disaster Recovery Services for over 30 systems including HealthCare.gov, the HIX, Data Services Hub, and supporting processing systems. For the last two years, CMS has focused on stabilizing the platform and made significant improvements in operational performance. CMS continues to focus on improving disaster recovery capabilities and has expanded capacity, in terms of storage and servers, in response to new development needs and ongoing operations.

Shared Services – The FFM leverages existing CMS enterprise services to manage user accounts, data management, web integration, and other services. The Enterprise Identity Management (EIDM) enables a single online identity for engaging in business with CMS that meets all federal security requirements and includes a Remote Identify Proofing (RIDP) service as well as a Multi Factor Authentication (MFA) solution. The Master Data Management (MDM) is a suite of data records and services that will allow CMS to link and synchronize beneficiary, provider and organization data to, and from, multiple disparate sources. The Enterprise Portal is a central portal that presents consistent web pages for beneficiaries, providers, organizations and States to receive CMS information, products, and services. The Business Rules Enterprise Services (BRES) provides a framework for automating and managing decision logic and routines for reuse across CMS programs. The Enterprise Eligibility Service (EES) is a shared service that provides Medicare Part A eligibility data for the Data Services Hub. EES leverages the BRES.

HealthCare.gov Web Portal – HealthCare.gov is the premier consumer facing online resource to provide consumers with ways to search and compare private plans, learn more about coverage and benefits. This website supports new and returning consumers who may be enrolling in coverage, appealing eligibility determinations, applying for exemptions, and seeking financial assistance. The website offers a variety of static and interactive content to assist consumers. Provides operational support for the FFM website in the areas of software development and maintenance, operational support, web hosting and content delivery network, software and monitoring tools, security, and the Marketplace Operations Center (XOC) support. CMS continues to enhance the consumer experience through a streamlined application (App 2.0), the Scalable Login System (SLS) designed exclusively for Marketplace consumers, a window shopping feature, and new consumer decision support tools including Plan Compare 2.0 with mobile optimization and performance improvements.

Systems Integration, Testing, and Security – Supports systems integration, testing, and security across the Marketplaces to ensure integration and testing of new code, and security standards for consumer and issuer data. System integration provides operations management and integrations management as new technical architecture and software code is introduced into existing production environments. CMS maintains a comprehensive end to end testing methodology that ensures the new development and existing environments are operating properly and performance is maintained. CMS maintains a comprehensive IT security program that is designed to prevent and detect intrusions into the Marketplace environments.

Enterprise Support – Provides activities in support of IT operations to meet existing business and enterprise architecture requirements.

Marketplace Quality – Ensures that consumers can effectively compare the quality of QHPs participating in the Marketplace and aims to drive improvements in quality of care over time. CMS developed easy to compare quality metrics, a quality improvement strategy and patient safety programs that may also be used in the broader private insurance market. In order to provide consumers with an easy way to compare QHPs, CMS created a star rating system based on clinical quality measures and an enrollee satisfaction survey. To ensure data submitted by issuers are reliable and valid, CMS provides training and technical assistance to stakeholders on the calculation and methodology used to create the star rating. Continuous health care quality improvement and patient safety are CMS- wide efforts, and the Marketplaces leverage the successful work already being done at national, regional, and local levels by aligning with value based purchasing concepts and engaging with the Patient Safety Organizations, Hospital Engagement Networks, and Quality Improvement Organizations to broaden the national impact on reducing patient harm and improving health care quality.

Small Business Health Option Program (SHOP) – SHOPs are unique health insurance Marketplaces that give the owners of small businesses more health insurance options by providing a simplified shopping and payment experience that allows them the ability to better control the health insurance options. CMS anticipates that more small employers and agents-brokers will be looking to SHOP for coverage options in Plan Year 2017, as non-compliant small employers plans are phased out by October 1, 2017 and states may choose to increase the size of eligible small businesses to a maximum of 100 employees.

Enrollees in SHOP plans must be an employee of the small business and can select only from the plans chosen by their employer. SHOP enrollees employees are generally not eligible for APTC or CSR since their employers will pay a portion of their premium costs, except in cases where an employee's contribution towards their coverage is deemed unaffordable. Employers with fewer than 25 full-time equivalent employees may be eligible for small business tax credits when purchasing coverage through SHOP.

Unlike the individual Marketplace, SHOP offers employers and employees different options when selecting health insurance. SHOP offers a monthly OEP instead of an annual OEP allowing small businesses and their employees the option of enrolling through the year. Through SHOP, an employer can select a single plan, a single issuer at all metal levels, or all QHPs in a single metal level. Similarly, employers in FF-SHOPs have the option to make available either all SADPs at a single level of coverage – high or low, or a single SADP. State-based SHOPs have the flexibility to make additional employee choice options available to small employers.

Other Activities – Supports a variety of efforts that are necessary to proper functioning of the Marketplaces, including efforts to meet program integrity standards and minimize instances of waste, fraud, and abuse. The activities will include testing improper payment rate methodologies following the completion of comprehensive improper payment risk assessments by the Department and the Department of Treasury in FY 2016 to determine areas that might affect APTC, the premium tax credit (PTC), CSRs, and Basic Health Program payment accuracy. CMS is also applying lessons learned from past data analytics projects under the Health Care Fraud and Abuse Control Program to available Marketplace data. CMS is developing outreach and education campaigns designed to inform consumers, agents, and brokers on the dangers of identity theft as well as engaging in regular ongoing discussions with State-based Marketplaces around best practices to detect and prevent fraud, waste, and abuse.

Budget Request: The total program level for the Health Insurance Marketplaces is $2,145 million. The program level includes $1,610 million in anticipated user fee collections with $1,554.4 million in FFM user fees, $50.0 million in risk adjustment user fees, and $5.5 million in reinsurance user fees. The program level includes $535.0 million in discretionary budget authority consisting of $513.8 million in Program Operations and $21.2 million in Federal Administration.

CMS continues to drive improvements in the efficiency of operations by reducing and streamlining processes. In FY 2017, CMS will introduce the Stand Alone Eligibility System (SES) to allow a more seamless consumer eligibility experience to improve functionality and integration across Marketplace activities. CMS continues to streamline interactions across activities and is working to develop a single consumer record reducing the need for manual interventions. CMS will continue to introduce automation in document and application processing during the eligibility determination and appeals processes.

- ***Health Plan Benefit and Rate Review, Management, and Oversight*:** The total program level is $50.6 million for FY 2017 and includes $50.6 million in anticipated user fees and $0.0 million in discretionary budget authority. This is a $9.8 million increase at the program level from FY 2016 Enacted Level.

  In FY 2017, CMS will continue to ensure QHPs and SADPs on the FFM meet certification standards. CMS will enhance oversight of QHPs by excluding plans where the issuer has a material compliance issue or data errors. CMS is working to develop specific evaluation criteria beyond plan and benefits design including past performance, results of compliance reviews, consumer complaints, data submission errors, and quality factors. CMS will consider options to address network adequacy through common QHP metrics.

  The funding supports the agent and broker infrastructure through the e-mail help desk, outreach, agent/broker training, registration with the FFM, supporting web-brokers, coordinating oversight with the respective State Departments of Insurance, and supporting the agent/broker vendor model. CMS is continuing to review methods to provide for direct enrollment by issuers, agents, and brokers, an additional enrollment channel, and a more seamless consumer experience.

- ***Payment and Financial Management*:** The total program level is $71.0 million for FY 2017 and includes $31.3 million in anticipated user fees and $39.8 million in discretionary budget authority.

In FY 2017, CMS will continue to administer the APTC and CSR payments on behalf of all Marketplaces. In addition, CMS will continue to operate the premium stabilization programs and transfer funds based on the 2016 plan year. CMS will collect reinsurance contributions from all issuers, distribute reinsurance payments, calculate risk scores and make the risk adjustment transfers, and calculate and process risk corridors payments and charges.

- ***Eligibility and Enrollment*:** The total program level is $455.8 million for FY 2017 and includes $306.4 million in anticipated user fees and $149.4 million in discretionary budget authority. This is a $74.1 million increase at the program level from FY 2016.

  In FY 2017, CMS anticipates the FFM will continue handling a large volume of complex eligibility issues, mailing notices, and improving the consumer experience by enhancing access to information for consumers and CMS. While overall handle times for key tasks are expected to continue to decrease as new automated processes, such as data extraction from consumer submitted supporting documents, handle times for exemptions remain high. CMS will continue to address the high number of data matching issues, especially around income verification, by allowing a reasonable standard to apply to variances between trusted data sources and consumer attested values. CMS will complete an evaluation of potential sources that can provide near real-time verification for determining if a consumer is eligible for affordable employer sponsored coverage.

  CMS will continue to ensure the quality of enrollment data through continued technical assistance to issuers and improvements to processing environments. The introduction of policy level payments during FY 2016 will continue to reduce workloads and burden on issuers. Further enhancements to the 1095-A research and resolution processes will continue to improve the consumer experience and maintain costs.

  CMS will continue to operate an appeals process for the individual and SHOP markets. The appeals case load is anticipated to continue to increase based on increases in the number of enrollment and increases associated with conducting large employer appeals for the FFM and several SBMs. CMS anticipates that improvements to the case management system and implementation of the SES will allow for seamless transition of consumer information into the appeals process.

  The Budget would provide CMS with access to the National Directory of New Hires, a database maintained by the Administration for Children and Families, to assist with the eligibility determination and verification process for financial assistance in the Marketplace. To determine eligibility for, and the value of, advance payments of the premium tax credit, CMS currently relies on income tax data, Social Security data, and a commercial source of income data. Access to the NDNH data would provide another source for income information. Please see the Administration of Communities and Families budget request for a complete description of the Administration's proposal.

- ***Consumer Information and Outreach***: The total program level is $744.4 million for FY 2017 and includes $744.4 million in anticipated user fees and $0 in discretionary budget authority. The program level is an increase of $34.1 million from FY 2016. The FY 2017 request supports an anticipated 29 million calls to the Consumer Call Center, reflecting an expectation of continued need for consumers to ask questions, get help with online tools, complete applications and enroll in plans, as well as get help with tax questions, life changes, and eligibility verification inconsistencies.

In FY 2017, CMS will continue targeted education and awareness activities in local communities and provide significant one-on-one assistance for consumers. CMS will continue to support at least two Navigator entities per State and provide EAP coverage to cover geographic and demographic gaps in Navigator coverage.

CMS will continue to support the development and execution of a strategic communications and marketing plan to inform and educate the various segments of the consumer population about health insurance coverage options. Efforts will continue to provide both national and targeted segments, including the currently uninsured and historically hard to reach populations.

CMS will continue to provide the full range of notices to consumers. This funding supports printing and distribution of notices to consumers to mitigate confusion among applicants and enrollees which will limit barriers to enrollment and ensure success of the enrollment process. While 70 percent of consumers elect to receive notices through the mail, CMS will continue to pursue mechanisms to increase consumer use of electronic notices.

- ***Information Technology (IT)****:* The total program level is $657.1 million and includes $379.4 million in anticipated user fee collections and $277.6 million in discretionary budget authority. This is a decrease of $14.3 million at the program level from FY 2016. The decrease reflects movement to a steady state in IT operations and ensures maintenance, operations, and IT development for automated policy-based payments, automated maintenance enrollment records, direct enrollment, and planned management.

  In FY 2017, CMS will continue to automate FFM processes for enrollment reconciliation, case management, and financial assistance calculations through the Federal Health Care Exchange (HIX) systems. CMS will continue to evaluate functionality requirements for FF-SHOP based on enrollment levels in accordance with plans for the gradual accretion of capabilities. Continued development will focus on Plan Management integration with HIOS, Renewals functionality, Agent/Broker Vendor Industry Model, Backend Data Corrections, Employer/Employee UI changes.

  CMS plans to deploy My Account 2.0, a streamlined account experience that will include mobile optimization, a cloud-native scalable architecture, and significantly improved usability and information architecture. This funding will support critical monitoring and analytic tools used by the XOC and senior leadership.

  CMS will continue support and maintenance of the remaining IT systems.

- ***Quality*****:** The total program level is $20.7 million for FY 2017 and includes $0.4 million in anticipated user fees and $20.3 million in discretionary budget authority. This is an increase of $2.7 million at the program level from FY 2016. The increased funding will support further enhancements for the Quality Rating System (QRS).

  CMS will continue to conduct enrollee satisfaction surveys to supplement issuer provided quality data. These enhancements, along with feedback from consumers, will allow CMS to provide improved displays of quality information for the subsequent OEP. As QRS matures, the measure set will evolve to address Marketplace populations and known gaps of the current quality metrics. Therefore, CMS will work with stakeholders on developing quality measures in areas such as patient safety and care coordination with increased support

needed for collection of any new measures. CMS will begin a patient safety initiative including the proposed requirement for QHP issuers that contract with a hospital with more than 50 beds, to verify that the hospital uses a patient safety evaluation system.

- ***SHOP:*** The total program level is $32.3 million for FY 2017 and includes $32.3 million in anticipated user fees and no discretionary budget authority. This is a $2.3 million increase at the program level from FY 2016.

  In FY 2017, CMS anticipates that more small employers and agents/brokers will be looking to SHOP for coverage options as transitional policies sunset October 1, 2017. The SHOP Premium Aggregation Services (PAS) will provide billing and payment functionality in FF-SHOP States and a simplified health insurance administration by providing one monthly invoice and payment, regardless of the number of plans and issuers employees choose.

- ***Other Activities****:* The total program level is $28.0 million for FY 2017 and includes $1.5 million in anticipated user fees and $26.5 million in discretionary budget authority. This is an increase of $15.9 million at the program level from FY 2016. The increase strengthens program integrity efforts in the Marketplace.

  In FY 2017, CMS will continue to build on existing program integrity efforts and identify new ways to address fraud, waste, and abuse in the Marketplaces. The budget assumes as much as $25 million for these activities. First, CMS anticipates testing the improper payment rate methodologies following the completion of comprehensive improper payment risk assessments in coordination with the Department of Treasury. Following this testing, CMS will expand capabilities to support proactive and sophisticated data analysis to identify emerging anomalies and vulnerabilities as the private insurance programs continue to evolve. The funding will support investigations and resolution of issues with referrals to appropriate agencies when necessary. CMS will conduct education and outreach to consumers, agents, and brokers in support of private insurance program integrity activities to raise awareness about fraud and identity theft. CMS will work proactively with issuers, contractors, law enforcement, and federal and state partners to conduct training and education on identified and emerging program integrity issues.

  The remaining request supports enterprise Marketplace planning, strategy, and support activities. These activities ensure CMS can align competing priorities with limited resources and facilitate effective management and oversight.

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 2017, 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* – The Medicare Shared Savings Program was implemented in January 2012 to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). Focusing on the needs of patients and linking payment rewards to outcomes, this leading Affordable Care Act delivery system reform helps improve the health of individuals and communities while lowering the growth in Medicare expenditures. CMS continues to expand the program, which maintains strong industry interest. Currently, there are over 400 ACOs participating in the Medicare Shared Savings Program. An additional application cycle started in May 2015 with a new cohort of ACOs starting in January 2016.

  Recently, the Secretary announced goals to move 30 percent of Medicare FFS payments to alternative payment models by 2016 and 50 percent in 2018. With over 400 ACOs serving over 7 million beneficiaries, we believe the Shared Savings Program plays an important role in meeting these goals.

- *Physician Feedback Improvements* – CMS is statutorily required by Section 3003 of the Affordable Care Act (ACA) to provide reports to physicians and groups of physicians that compare their resource use for 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. For 2014, CMS distributed reports that cover all Medicare-enrolled physicians that furnish services to fee for service beneficiaries and in spring and fall 2015, CMS distributed reports that cover all Medicare-enrolled physicians and eligible professionals. The reports build on lessons learned from prior years and include refinements suggested by stakeholders.

- *Physician Value-Based Purchasing IT* – CMS must invest in data infrastructure necessary to support the value-based payment modifier and physician feedback programs. The purpose of this investment is to enable CMS to provide reports to physicians and physician groups that compare their resource use among Medicare fee-for-service patients with that of similar physicians and physician groups. These feedback reports also include indicators of clinical quality and they are the primary mechanism for informing physician groups of their performance under the VBM. The reports produced and disseminated in FY 2017 and FY 2018 will build on lessons learned from the reports produced in FY 2013 through FY 2016 and include refinements suggested by stakeholders.

- *Physician Value-Based Payment Modifier* – The value-based payment modifier measures cost and quality of care that will be used to adjust physician payments. The modifier will be used to adjust physician payments under the modifier through payment year 2018. 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. 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. Additionally, as specified in the CY 2016 Physician Fee Schedule Final Rule, the value-

based payment modifier will be applied to certain non-physician eligible practitioners for CY 2018. Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the application of the value-based payment modifier will sunset after CY 2018. Starting with CY 2019, eligible professionals who are not qualifying participants of alternative payment models under MACRA will be subject to the newly established Merit-Based Incentive Payment System (MIPS).

- *Medicare Data for Performance Measurement (ACA Section 10332)* – Section 10332 of the Affordable Care Act (ACA) required the Secretary to establish a process to certify qualified entities (QEs) who will combine standardized extracts of Medicare Parts A, B, and D claims data with other sources of claims data to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. This work is statutorily mandated and supports the commitment made by CMS, HHS, and the White House to provide great data transparency. In addition, providing better access to health system information is a key goal of the Secretary's Delivery System Reform Initiative.

- *Hospital Value-Based Purchasing* – The Hospital Value-Based Purchasing Program (HVBP) 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* – Section 3025 of the Affordable Care Act requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning on or after 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 2 years after enactment. Significant cross-component collaboration has been required within the Agency to implement this provision, notably on selecting new conditions and also developing a mechanism to make readmission rates publicly available.

- *Appropriate Use Criteria for Advanced Imaging Services* – The Protecting Access to Medicare Act of 2014, Section 218, established a new program to promote the use of appropriate use criteria for advanced imaging services. PAMA requires that, starting in 2017, suppliers of applicable imaging services must report on the use of appropriate use criteria in order to receive payment under certain fee schedules. In order to implement this program in a manner that has the greatest impact, it is important that we focus appropriate use criteria on clinical areas and imaging modalities of high priority to the Medicare population.

Budget Request: $50.2 Million

The FY 2017 budget request for health care quality improvements is $50.2 million, a decrease of $22.3 million below the FY 2016 Enacted Level.

- *Medicare Shared Savings Program*: $13.5 million, a decrease of $28.9 million below the FY 2016 Enacted Level. The program analysis, monitoring and applications contracts will include multi-year base periods and is planned for FY 2016 so substantially less funding will be needed in FY 2017. FY 2017 funding is required to continue operations of the Shared Savings Program and implement changes finalized in the final rule effective in FY 2017. Additional funds are required to continue support of the payment contractor to assist with shared savings payments, and a contractor that supports ACO application, management and tracking.

- *Physician feedback reports and value-based payment adjustments:* $23.5 million, an increase of $5.9 million above the FY 2016 Enacted Level. In 2017, CMS will issue multiple Quality and Resource Use Reports (QRUR) reports to all physicians, physician groups, and non-physician eligible professionals. This will represent the first time that actual payment adjustment information is provided for non-physician eligible professionals, and we anticipate a significant workload associated with education and outreach and inquiries. CMS will also undertake a significant education and outreach effort to facilitate understanding of the payment information in the QRUR reports.

- *Physician Value-Based Purchasing IT:* $3.0 million, about the same as the FY 2016 Enacted. This funding is required for critical information technology data infrastructure necessary to support the value-based payment modifier and physician feedback programs. Specific IT infrastructure support required to produce and disseminate the reports and calculate the payment modifier include IDR capacity, IDR backup and tape infrastructure, IDR operations and maintenance, testing, IDR development support, IT program management, security control assessments, and SAS data storage.

- *Value-Based Payment Modifier*: $5.0 million, an increase of $3.0 million above the FY 2016 Enacted Level. Funding for FY 2017 is required to exercise the final option year of the program analytics contract responsible for calculating and implementing the value-based payment modifier (VM). The funding will also provide technical support along with research and development support for the refinement of the VM methodology as it is expanded to all Medicare physicians and eligible professionals.

- *Medicare Data for Performance Measurement:* $4.2 million, a decrease of $0.8 million below the FY 2016 Enacted Level. Contractor support will primarily be used in three major areas: program management, data preparation and distribution, and technical assistance. The funding requested will allow for ongoing QE program operations and will provide for planned development work.

- *Hospital Value-Based Purchasing (VBP) Medicare Spending per Beneficiary (MSBP)*: $0.2 million, a decrease of $1.8 million below the FY 2016 Enacted Level. In FY 2017, funding is required to continue procurement of a contract to assist with efficiency measurement, consistent with the National Quality Strategy priority to provide affordable care. The work will include measure development, refinement, calculation, reporting, and potential submission for NQF endorsement and oversight of CMS standardization approach used by

multiple components across the agency. The work being performed under this activity in FY 2016 is non-severable and will cover multiple fiscal years. Therefore, there is no funding required in FY 2017.

- *Hospital Readmission Reduction Program*: $0.6 million, the same as the FY 2016 Enacted Level. Funding is essential to continue with implementation of this provision. The law allows CMS to expand the readmission measures used in the Hospital Readmissions Reduction Program in FY 2015. Funding is required in 2017 for additional measure development should CMS expand the program. Additionally in FY 2017, funding is needed to calculate hospital-specific readmission rates, calculate the hospital-specific payment adjustment factor for excess readmissions and engage in rulemaking in order to maintain the current measures.

- *Appropriate Use Criteria for Advanced Imaging Services:* $0.2 million, about the same as the FY 2016 Enacted Level. The early phase of the project will be to review Medicare claims data to identify clinical priority areas of advanced imaging services and clinical conditions in relation to volume. This will require analyses of procedure codes and diagnosis codes that appear on the claim. In addition, analyses may further evaluate the role that provider specialty may serve in ordering advanced imaging services. Once the clinical priority areas and imaging services are identified, the second phase of the project is to identify and evaluate the provider-led entities whose appropriate use criteria may be consulted to meet the requirements under PAMA section 218.

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 every October. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

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

The chart below displays the actual number of *Medicare & You* handbooks distributed for fiscal years 2011 through 2015 and the estimated distribution for fiscal years 2016 and 2017. 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)

	FY2011 Actuals	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Actuals	FY 2015 Estimated Actual	FY 2016 Estimate	FY 2017 Estimate
Number of Handbooks Distributed	39.3	40.8	42.3	42.0	43.3	44.6	45.9

- *Annual Proof of Insurance Mailing* – 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 of Minimum Essential Coverage (MEC) to furnish statements to covered individuals on an annual basis. Since Medicare Part A (including MA coverage) qualifies as MEC, CMS will furnish a statement to every new beneficiary with Part A, disabled Part A recipients, and all Part A recipients under the age of 65, informing them of the months they had MEC through the Medicare program. Regulations also require the delivery of corrected statements when previously reported information is revised or updated. Beneficiaries may be required to provide the statement to the Internal Revenue Service as proof of coverage for tax purposes. The requirements are effective beginning in 2016 (reporting 2015 coverage) when CMS will begin sending the notice to new beneficiaries with Part A, who are new, disabled, and under age 65. The FY 2017 request continues to fund mailings reporting on the 2016 tax year, to the same group of beneficiaries.

- *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 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 over 200 languages including several native Alaskan languages.

The following table displays call volume experienced from FYs 2011 through 2014 and the number of calls we expect to receive in FYs 2015 through 2017. In FY 2017, CMS expects to receive 27.2 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 2011 Actuals	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Actuals	FY 2015 Estimated Actual	FY 2016 Estimate	FY 2017 Estimate
Number of Calls	25.3	25.6	25.4	25.0	26.2	26.8	27.2

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 2017, CMS estimates 338 million page views to http://www.medicare.gov, approximately a five-percent increase in traffic from the page views anticipated in FY 2016. CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and as CMS continues 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 2011 Estimate	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Actuals	FY 2015 Estimated Actual	FY 2016 Estimate	FY 2017 Estimate
Number of http://www.medicare.gov Page Views	241.0	270.0	266.9	294.0	308.0	323.0	338.0

- *Community-Based Outreach* – CMS relies heavily on community-level organizations, state and Federal agencies, providers, and other partners to serve as trusted sources of CMS administered program information for consumers, particularly for hard-to-reach populations, and must provide these partners with accurate and up-to-date information and tools that equip them to effectively counsel and assist their constituencies. In an effort to reach beneficiaries who need information on the Medicare program and the changes implemented by the Affordable Care Act, CMS continues to cultivate new partnerships with health care providers, State Medicaid agencies and pharmacy assistance programs, community and faith-based organizations, and others. Expanding the CMS partner base challenges the training program to effectively deliver information to groups with little or no knowledge of the CMS administered programs, in formats that can be customized to meet a broad range of needs.

- *Program Support Services* – This activity includes the Multi-Media Medicare Education Campaign, assessment activities, and consumer research addressing both general and Hispanic markets. In addition, it funds the *Medicare & You* handbook support activities such as electronic and composition support, 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, and other localized partners and resource. In 2017, this activity will also include an outreach and education campaign focused on improving awareness and utilization of preventive health benefits. Efforts will include paid digital media, direct mail to providers and beneficiaries, and partnering with national and state-based organizations.

National Medicare Education Program Budget Summary

(Dollars in Millions)

NMEP Category	Funding Source	FY 2015 Final	FY 2016 Enacted	FY 2017 PB	Description of Activity in FY 2017
Beneficiary Materials	**Total**	**$50.9**	**$36.1**	**$76.2**	National Handbook with comparative information in English and/or 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 qualified Part A beneficiaries who are new, disabled, and under age 65 whose minimum essential coverage is provided through Medicare.
	PM	$50.9	$36.1	$58.2	
	User Fees	$0.0	$0.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	**Total**	**$250.8**	**$210.5**	**$306.1**	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.
	PM	$179.6	$125.0	$235.0	
	User Fees	$71.2	$85.5	$71.1	
Internet	**Total**	**$20.5**	**$21.0**	**$25.1**	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.
	PM	$17.3	$17.6	$25.1	
	QIO	$3.2	$3.4	(TBD)	
Community-Based Outreach	**Total**	**$2.4**	**$1.4**	**$1.8**	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 Medicare beneficiaries in their communities.
	PM	$2.4	$1.4	$1.8	
Program Support Services	**Total**	**$15.1**	**$13.8**	**$27.3**	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.
	PM	$15.1	$13.8	$27.3	
	Total	**$339.7**	**$282.8**	**$436.5**	
	PM	**$265.3**	**$193.9**	**$347.4**	
	User Fees	**$71.2**	**$85.5**	**$89.1**	
	QIO	**$3.2**	**$3.4**	(TBD)	

Budget Request: $347.4 Million

The FY 2017 Program Operations budget request for NMEP is $347.4 million, an increase of $154.0 million above the FY 2016 Enacted Level. The following activities are funded under the Program Operations request:

- *Beneficiary Materials*: The FY 2017 budget request for Beneficiary Materials is $58.2 million, an increase of $22.1 million above the FY 2016 Enacted Level. $36.9 million of the budget request funds the Program Management portion of the cost for the Medicare & You handbook. This estimate is based on historical publication usage data and current market prices for printing and mailing.

  CMS also requests $21.3 million to support beneficiary mailings providing proof of enrollment in Medicare for tax year 2016. This request provides funding for the mailing of the annual statement of health coverage to qualified Part A beneficiaries who are new, disabled, and under age 65 and have minimum essential coverage (MEC) through Medicare. All statements must be mailed first class as they contain personally identifiable information (PII). This cost includes three pages for each mailing and assumes a 2 percent increase in postage rates.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The FY 2017 budget request for 1-800-MEDICARE/BCC activities is $235.0 million, an increase of $110.0 million above the FY 2016 Enacted Level. The estimated call volume for FY 2017 is 27.2 million, 300,000 more calls than estimated for FY 2016. CMS expects to operate at no more than a 5-minute ASA in FY 2017, 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 2017 budget request for Internet is $25.1 million, an increase of $7.5 million above the FY 2016 Enacted Level. Investment in additional software and hardware resources, as well as continuous, meaningful improvements to the web services offered online, are critical to the success of the Agency's web program as well as the overall success of the Agency in implementing and operating the growing number of programs we support. 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 2017 budget request for Community-Based Outreach is $1.8 million, about the same as the FY 2016 Enacted Level. In FY 2015 and 2016, CMS is funding the design, build, and maintenance of a new Learning Management System

(LMS) which supports the web-based training courses, and a new webinar platform. FY 2017 funding is for continued support and maintenance of the new LMS and all related tasks. This funding will also provide the resources needed to support face-to-face sessions, web-based training, and regularly scheduled live- and pre-recorded webinars required to educate stakeholders to ensure eligible individuals enroll in CMS programs and make optimum use of their benefits.

- *Program Support Services:* The FY 2017 budget request for Program Support Services is $27.3 million, an increase of $13.4 million above the FY 2016 Enacted Level. This activity provides funding for accessible materials for low vision/blind and disabled beneficiaries (audio, 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 October mailing of the M&Y Handbook, NMEP consumer research and assessment (including consumer testing of the M&Y handbook), a publication ordering web site for partners that support the Medicare education program, 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.

  Under the ACA, most insurers, including Medicare and Medicaid, are required to cover certain preventive services at no cost to patients. These benefits were expanded because chronic diseases, such as heart disease, cancer, and diabetes, are responsible for 7 of 10 deaths among Americans each year and account for 75 percent of the nation's health spending – and often are preventable. The ACA helps make prevention affordable and accessible by requiring health plans to cover recommended preventive services without charging a deductible, copayment or co-insurance. The increase in funding supports an outreach and education campaign targeting providers and beneficiaries with information on important preventive health care benefits and encouraging them to utilize these benefits for better health.

In addition to the Program Management request, the NMEP will receive approximately $89.1 million in user fees bringing the total FY 2017 request level for NMEP to $436.5 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. As part of the Provider Customer Service Program (PCSP), the Medicare Administrative Contractors (MACs) currently handle more than 34 million calls and over half a million written inquiries annually from providers. This request provides funding for the telephone service, technical telecommunications support contracts, quality assurance monitoring, and oversight reporting database maintenance.

National Provider Education, Outreach, and Training – This request supports the development and dissemination of Medicare Learning Network® (MLN) educational information on Medicare policy and operations and other CMS-administered programs. National outreach campaigns and products ensure consistency in the training and resources received by health care providers and their billing and practice administration staff.

Educational products/services are branded as part of the MLN and include MLN Matters® national articles, MLN publications (e.g., fact sheets, quick-reference charts, and booklets), web-based training courses, educational tools and podcasts. MACs and Regional Office (RO) staff are required to use MLN products to promote consistency in their outreach efforts. This promotes consistency and reduces costs associated with MACs and ROs developing their own materials. MLN products are commonly developed in response to recommendations in OIG and GAO reports.

This funding also supports the MLN Learning Management and Product Fulfillment System. This system is the nucleus of all MLN operations and the hub for most MLN product data reporting and administrative functions. The MLN Learning and Management System:

- Provides aggregate data that allows staff to track and evaluate the effectiveness of MLN products and services.
- Assists staff in determining the types of health care professionals who use specific MLN products; and can then evaluate trends as well as target product development efforts to specific audiences.
- Tracks and supports the efforts of CMS' Continuing Education (CE) Program.

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). CMS is responsible for providing States, health plans, and providers with tools to develop programs to better align benefits under the Medicare and Medicaid programs, for supporting State efforts to coordinate and align acute care and long term care services and supports for dual eligible individuals, and for providing support for coordination and contracting/oversight by States and CMS with respect to the integration of the Medicare and Medicaid programs. CMS has established a number of mechanisms to promote better care coordination, improved quality, cost and patient experience for dual eligible beneficiaries through providing technical assistance to States, retaining analytic contract support assigned to aid in policy improvement and model development, and continuing to work with the National Quality Forum (NQF) on meaning duals related quality metrics.

Budget Request: $22.5 Million

The FY 2016 budget request for Provider Outreach is $22.5 million, an increase of $1.8 million above the FY 2016 Enacted Level.

- *Provider Toll-Free Service*: $7.4 million, the same as the FY 2016 Enacted Level. The minutes of telephone service, which drive costs, are projected to remain flat through FY 2017. 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. Additionally, web tools are provided to the MACs to assist them in improving their education websites with the goal being increased provider self-service and reduced overall costs.

- *National Provider Education, Outreach, and Training*: $8.2 million, the same as the FY 2016 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 other operational to support to perform related outreach and education.

- *Federal Coverage and Payment Coordination:* $6.9 million, an increase of $1.8 million above the FY 2016 Enacted Level. In FY 2017, CMS plans to begin work on a two-part initiative to increase Medicare-Medicaid enrollees' understanding and satisfaction with their coverage under both Medicare and Medicaid. Utilizing results of the analytic support contractor and beneficiary materials testing, CMS will develop and send initial introductory mailings to beneficiaries who become newly dually eligible each month. CMS expects beneficiaries and those who serve them to want information on a broad range of areas. To meet that need, the second part of this initiative will develop and make available on the web a range of more targeted materials available upon request (e.g., eligibility, how each program covers specific services such as mental health, durable medical equipment, etc.).

Consumer Outreach

Federal External Review Program – Under the Affordable Care Act (ACA), consumers have a right to appeal a decision by their health plan that denies health care services to an outside, independent review organization. Under Federal regulations, health plans and issuers must comply with either a state's external review process or a Federal external review process, depending on whether state laws meet or fail to meet required consumer protections. For states that fail to meet certain minimum consumer protections, health plans and issuers in that state must participate in either the HHS-administered Federal External Review Process (FERP) or they must contract with privately accredited Independent Review Organizations (IROs) to conduct external reviews for their members. CMS provides consumers with HHS-administered FERP services through a contractor. The contractor conducts standard and expedited reviews of adverse benefit determinations and final internal adverse benefit determinations that are eligible for external review as described in the June 24, 2011 amendment to the July 23, 2010 IFR.

Indian Health Care – Sec 10221 of the ACA contains numerous Indian-specific provisions that expand the reach of CMS programs for American Indian and Alaska Natives. This activity will establish a Tribal Resource Center, or other tribal specific project, where staff would be trained and skilled in responding to inquiries from the tribal community relating to enrollment into the full range of CMS health insurance 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.

Issuer Data Collection and Management – The Plan Finder is an interactive tool that allows consumers to explore and compare their options within an educational framework prior to actually purchasing health insurance in the individual and small group marketplace. CMS

launched the Plan Finder in 2010, phasing in additional features on pricing and benefits information so that the site now includes detailed cost-sharing and benefits information on the individual/family market and the small group market. Insurers update their information in the Plan Finder, through the Rate and Benefit Information System (RBIS) and the Health Insurance Oversight System (HIOS), on a quarterly basis and this information is displayed on HealthCare.gov as required by the Affordable Care Act (ACA). HealthCare.gov offers consumers a trusted, noncommercial, user-friendly environment that allows consumers to compare plans, obtain information about products that was previously unavailable on commercial sites (such as the number of applicants denied for a specific plan), and weigh options related to cost sharing and covered--and not covered--benefits among various plans. This activity supports the data collection and management supporting the before mentioned products.

Budget Request: $5.1 Million

The FY 2017 budget request for Consumer Information and Outreach is $5.1 million, an increase of $1.2 million above the FY 2016 Enacted Level.

- *General Consumer Information on Private Insurance:* $2.0 million, the same as the FY 2016 Enacted Level. Supports a multitude of activities 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. This information is made publicly available at Healthcare.gov. In addition to the above functions, the site has added, and will continue to enhance, functionality for returning enrollees.

- *Consumer Appeals:* $0.5 million, the same as the FY 2016 Enacted Level. The budget amount will allow CMS to operate a federally-administered external review process as required by law; ensure that all consumers, regardless of where they live, have the ability to appeal decisions made by their health plans or insurance companies; provide final external review decisions to consumers timely; and have insight into the process through reported data. As the FERP continues operations, it will improve the consumer experience by making available a web-based portal through which consumers can request a standard external review.

- *Indian Health Care*: $1.1 million, an increase of $0.5 million above the FY 2016 Enacted Level. The increase in funding will aid CMS in establishing a Tribal Resource Center. Funding in FY 2017 and future outlying years is crucial to ensure AI/AN enrollment in State/Federal private health insurance plans, Medicaid/CHIP, and new benefits and services under Medicare. Federal delivery of health services and funding of programs to maintain and improve the health of American Indians and Alaska Natives (AI/AN) are consonant with and required by the Federal Government's historical and unique legal relationship with Indian Tribes, as reflected in the Constitution of the United States.

- *Summary of Benefits and Coverage (SBC)*: $1.0 million, an increase of $0.6 million above the FY 2016 Enacted Level. This request will provide CMS with the ability to ensure that the information in the SBC and uniform glossary are up-to-date, consumer-tested, translated appropriately, and available to best serve consumers as they make critical decisions about selecting and using their coverage

- *Issuer Data Collection and Management:* $0.5 million, in FY 2017, which will support a contract to review and evaluate the data collected from issuers for display on HealthCare.gov in order to:
    - identify differences between data reported by insurers to the Plan Finder from data reported to other reporting agencies (i.e., States' Departments of Insurance);
    - identify technical issues complicating CMS's ability to properly identify benefits and cost sharing based on other summaries of this information;
    - evaluate how closely the collected data reflect marketplace conditions (such as cost sharing and benefits options), to inform CMS of the degree that the Plan Finder is a useful educational tool for consumers;
    - identify trends within data collection periods and compare to other data to understand issuer accuracy of reporting, data consistency over several collection periods, and geographic data analysis; and
    - recommend solutions in the data collection process that will increase participation and compliance in the Plan Finder.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Enterprise IT Activities

Enterprise IT activities encompass CMS' critical systems that support ongoing operations, primarily the Infrastructure Hosting & Centralized Communication Services (IHCCS), the Virtual Data Center (VDC) Infrastructure Enterprise Services (VIES), the CMS Enterprise Compute Services (CECS), and Large Scale Data Repository (LSDR) Task Orders. These VDC task orders support 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 a heightening of 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 Homeland Security Presidential Directive 12 (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

Key IT infrastructure projects include:

- *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, 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 funding level for the FY 2017 request supports current ongoing contract costs.

- *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.

CMS ACA Non-Marketplace IT

This request supports the enterprise architecture and security structure of the Affordable Care Act implementation.

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, Business Rules Enterprise Services, and Enterprise Eligibility Services.

Note that the Program Operations 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, and QIOs.

Budget Request: $333.2 Million

The FY 2017 President's Budget request for information technology investments supporting all Program Operations is $333.2 million, an increase of $13.4 million above the FY 2016 Enacted Level. This category includes four major IT investment activities, as shown in the table below.

FY 2017 IT Investments Request
(Millions of Dollars)

Activity	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Enterprise IT Activities	$238.6	$259.1	$261.6	$2.5
Infrastructure Investments	$24.1	$23.3	$33.2	$9.9
ACA Non-Marketplace IT	$5.3	$14.3	$8.8	-$5.5
Shared Services	$19.6	$23.1	$29.6	$6.5
Total Program Ops Request	**$287.6**	**$319.8**	**$333.2**	**$13.4**

- *Enterprise IT Activities*: $261.6 million, an increase of $2.5 million above the FY 2016 Enacted Level. This increase in funding supports government wide identity initiatives such as eAuthentication and HSPD-12. The increase also supports upgrades to the enterprise approach for Medicare eligibility and enrollment. CMS is also investing in the technology to

automate the Human Resource (HR) administrative processes through workflow capabilities. In addition this funding is necessary to continue ongoing IT operations, including making necessary investments to existing systems that 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.

- *Infrastructure Investments*: $33.3 million, an increase of $9.9 million above the FY 2016 Enacted Level. This increase in funding support the CMS Information Security Program (ISP), which provides services to ensure systems and beneficiary data are protected and meet CMS' federal requirements. The majority of these requirements stem from the Federal Information Security Management Act of 2002 (FISMA), which requires that all agencies have a risk-based information security program that covers all systems and data, and includes contractors and business partners who operate systems on behalf of the agency. The increase in funding also supports the virtual call center project.

- *CMS ACA Non-Marketplace IT*: $8.8 million, a decrease of $5.5 million below the FY 2016 Enacted Level. The decrease can be attributed to finding efficiencies that support the Enterprise Architecture (EA) structure of business processes and align them with the core goals and strategic direction of the Affordable Care Act.

- *Shared Services*: $29.6 million, an increase of $6.5 million above the FY 2016 Enacted Level. Funding is needed to cover the program management allocation for key shared services including Master Data Management, Enterprise Identity Management, the Enterprise Portal, Business Rules Enterprise Services, and Enterprise Eligibility Services. Shared services enable CMS programs to utilize common services, such as Medicare eligibility verification, identity proofing, authentication, and data services, reducing redundant development, and leveraging efficiencies of scale.

Program Operations 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 tasked with implementing ACA. 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) was expanded 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 2015 targets of 90 percent for all 9.1 standards. Standard 9.3 was not met during this reporting period. CMS is attributing the decline in customer satisfaction to increased hold times at the CCO. The CCO funding has remained very constant, while the length of time it takes to resolve inquiries has increased (i.e., the handle time for calls). CMS has not been able to increase the staffing to account for the additional length of calls, and as a result the wait times for Medicare beneficiaries has increased.

CMS will continue to maintain the quality standards target levels at 90 percent for FY 2017. In order to increase CCO quality standards, the CCO 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.

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 2015 target of maintaining an unqualified opinion on four out of the six principal financial statements. During FY 2015 the auditors could not express an opinion on the financial condition of the CMS Statement of Social Insurance (SOSI) as of January 1, 2015 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. During FY 2015, CMS continued its implementation of OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control.* In addition, CMS provided a Statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30. CMS' FY 2017 target is to maintain an unqualified opinion on the CMS financial statements.

MCR20 Implement the International Classification of Diseases (ICD)-10: The Health Insurance Portability and Accountability Act requires Centers for Medicare & Medicaid Services (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. ICD-10 provides a greater specificity of diagnosis-related groups, improves quality measurement and reporting capabilities, enhances fraud, waste and abuse prevention and detection, and reflects greater accuracy of reimbursement for medical services. ICD-10 will also improve data capture and analytics of public health surveillance and reporting, national quality reporting, research and data analysis and provide detailed data to inform health care delivery and health policy decisions.

On October 1, 2015, health systems across the county successfully transitioned to ICD-10, with Medicare claims processing normally. FY 2015 targets were met. CMS are on track to meeting the FY 2016 targets, which demonstrate continued external ICD-10 outreach and communications for post-implementation activities; review and monitoring of ICD-10 industry compliance levels and State Medicaid program baselines; continued post-implementation monitoring and assessment; and monitoring, testing, and remediating ICD-10 claims payment, policy and systems issues. The FY 2017 target will continue external ICD-10 outreach and communications for post-implementation: the reviewing and monitoring ICD-10 industry compliance levels; continued post-implementation monitoring and assessments as well as monitoring and remediating ICD-10 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 or exceeded the FY 2015 targets.
CMS' 2016 and 2017 targets are for 85 percent of the Federal Information System Management Act (FISMA) systems to be scanned and monitored by a vulnerability management system (21.2) and for 100 percent of IT projects to have adapted to the XLC framework (21.3). The FY 2016 and 2017 targets are to also complete PIRs for 75 percent of new IT implementation projects that have been in operations for up to 12 months (21.4) and for 95 percent for the CMS Federal Information Security Management Act (FISMA) systems authorized to operate (21.1).

MCR26 Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Actual 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 For FY 2015 and future years two additional readmissions measures were added to the program: Chronic Obstructive Pulmonary Disease, and Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and future years, CMS established an additional measure for patients readmitted following coronary artery bypass graft (CABG) surgery and we refined the pneumonia readmission measure cohort.

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, beginning with a baseline of 18.7 percent on CY 2010 data set in FY 2012. We exceeded our CY 2015 target to reduce the all-cause hospital readmission rate by 1 percent over the CY 2014 target, with an actual result of 17.6 percent. The CY 2017 target is to decrease all-cause Medicare hospital readmissions to 17.2 percent.

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 (SIR) by 10 percent by September 2015 over the current 2012 baseline of 1.03. Of note, this SIR baseline was recently changed from 1.02 to 1.03 in this goal. This reflects the fact that the Centers for Disease Control and Prevention (CDC) released preliminary final numbers for 2012 in September 2013, the time at which this goal was written. We made this adjustment in the HAI APG to reflect the finalized SIR and to maintain consistency with other HAI reports moving forward. This APG is led by CMS with the Agency for Healthcare Research and Quality, CDC, and the Office of the Assistant Secretary for Health.

The CDC has changed the CAUTI definition in response to input from stakeholders and scientific data. The new definition is designed to improve the clinical relevance while remaining objective. The HAI Workgroup presented full details on the definition change to HHS leadership in May of 2015. Analysis of the CAUTI data continues to reveal marked difference in reductions between intensive care and non-intensive care units. The FY 2014 time period ranging from October 1, 2013 - March 31, 2014 shows a CAUTI SIR of 1.06 which reflects a 10 percent increase (opposite the desired outcome) in CAUTI SIR over the 2012 baseline. The midpoint target goal for the FY2014-2015 national CAUTI SIR reduction in hospitals was 5 percent or a SIR of 0.97. The national CAUTI SIR data, which was reported in March of 2015, reflects a SIR of 0.98, a 4.9 percent reduction just shy of target goal. The final target data will be reported in March of 2016, however preliminary data from the CDC's National Healthcare Safety Network (NHSN), our primary data source for this goal, shows us on track to meet or even exceed the 10 percent reduction target.

Details of the multifactorial root cause of the rise in CAUTI seen in the FY2011-2013 time period are elucidated below but it is also important to note that the rise and now current fall in the national CAUTI SIR can be attributed to the nature and natural progression of the quality improvement process:

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 due to 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.

ICU-focused data: Continued analysis throughout the goal period shows higher CAUTI SIRs in ICUs than in non-ICUs. Data from both settings are reported into NHSN but ICU reporting of CAUTI is incentivized by CMS' Hospital Inpatient Quality Reporting (HIQR) program. This program requires reporting of CAUTI discharges in ICUs as a part of receiving participating hospitals' annual market update. There may be changes in the CAUTI SIR data trends around January 2015 when hospitals begin reporting CAUTI data in non-ICUs as part of CMS' HIQR program, the extent to which is unknown at this time.

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 CUSP should reduce these infections, just as they have been reduced in these prevention projects. CDC and CMS are also actively engaging in targeting CAUTI prevention efforts in those facilities that have a high number of excess CAUTIs through national implementation of the Targeted Assessment for Prevention program. We use CDC's Targeted Assessment for Prevention (TAP) strategy in our quality improvement programs to target healthcare facilities and *specific units* within facilities with a disproportionate burden of HAIs so that gaps in infection prevention in the targeted locations can be addressed and our quality improvement resources are allocated to where need is greatest. (http://www.cdc.gov/hai/prevent/tap.html) It also contains tools and reports for hospitals to implement the most evidence-based HAI prevention strategies and provides an avenue for feedback from hospitals that allow us to continuously tailor quality improvement programs and our targeted assistance to their needs.

We continue to intensify work to reduce CAUTI 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;

- Applying new approaches in ICUs based on some of the potential barriers identified to CAUTI reduction;

- Release new national 5-year HAI targets, including those for CAUTI, as a part of the HHS HAI "National Action Plan to Prevent HAIs: Roadmap to Elimination".

Looking ahead, we have established FY 2016-2017 targets for national CAUTI SIR reductions in hospitals. In discussing these forward target goals, we note that CDC is resetting the national CAUTI SIR baseline back to 1.0 at the end of this year. The 2016 CAUTI SIR target calls for a 5 percent reduction in the national CAUTI SIR which equates to a SIR of 0.95 (from 1.0 to 0.95) and the 2017 target goal is a 10 percent reduction equating to a national CAUTI SIR of 0.90.

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 2017/2018 QIP was finalized in the Federal Register on November 6, 2014. This rule added a new measure risk-standardized hospital readmission ratio and expanded the patient experience of care measure to a clinical measure using this measure's performance to base facility payments.

CMS met its targets for FY 2015 including publishing the PY 2017/PY 2018 rule and adjusting payments for facilities not meeting performance standards (based on 2013 claims data).
FY 2017 targets include publishing the PY 2020 rule, adjusting payments for facilities not meeting performance standards (based on 2015 claims data) and developing and completing the ESRD QIP Final Monitoring Report for PY 2016.

MCR30: Shift Medicare Health Care Payments from Volume to Value: Health care costs consume a significant amount of our nation's resources. In the United States, one source of inefficiency is a payment system that rewards medical inputs rather than outcomes, has high administrative costs, and lacks focus on disease prevention. HHS, through the Innovation Center at CMS, established by the Affordable Care Act, identifies tests, evaluates, and expands, 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. Under this authority, CMS is testing a variety of alternative payment models that create new incentives for clinicians to deliver better care at lower cost. In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care (such as the readmissions/hospital acquired condition reduction program).

These alternative payment models and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction, but increased alignment across payers would be beneficial. To encourage alignment, Medicare is leading the way by publicly tracking and reporting payments tied to alternative payment models. Moving payments to more advanced payment models in an aligned fashion and on an aligned timeframe increases the overall likelihood that new payment models will succeed.

To monitor the movement of payments to more advanced payment models, HHS developed the following payment taxonomy to describe health care payment through the stages of transition from pure fee-for-service to alternative payment models and, ultimately, population based payments. CMS is using this framework to measure Medicare payments tied to alternative payment models. This framework classifies payment models into four categories according to how clinicians and organizations are paid.

- category 1—fee-for-service with no link of payment to quality;
- category 2—fee-for-service with a link of payment to quality;
- category 3—alternative payment models built on fee-for-service architecture; and
- category 4—population-based payment.

CMS has established a baseline of 22 percent of Medicare FFS payments tied to alternative payment models in CY 2014. Due to the growing presence of CMS alternative payment models, CMS has set a CY 2015 target of 26 percent of Medicare FFS payments tied to alternative payment models. To encourage alignment between public and private payers and to help move payment reform along the continuum described above, HHS has set a target for Medicare: to have 30 percent, 40 percent, and 50 percent of Medicare FFS payments tied to alternative payment models by the end of CY 2016, CY 2017, and CY 2018, respectively. Data for this measure will be collected and aggregated across CMS alternative payment models. CMS is currently accounting for beneficiaries who are participating in multiple alternative payment models, however, CMS may explore additional methodologies to account for these overlapping beneficiaries across alternative payment models in future reporting years.

MCR31: Improve Patient and Family Engagement by Improving Shared Decision-Making:
Ensuring that all patients and their family members are engaged in their care is a core priority of the National Quality Strategy (NQS). The National Quality Strategy was first published in March 2011 as the National Strategy for Quality Improvement in Health Care, and is led by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the U.S. Department of Health and Human Services (HHS). Mandated by the Affordable Care Act (ACA), the National Quality Strategy was developed through a transparent and collaborative process with input from a range of stakeholders.

Despite recent efforts to shift our healthcare system to one in which patients are passive recipients of care to one in which they are empowered to actively participate in their care decisions, there is still much work to make this a reality. The purpose of this measure is to help assess an important component of patient experience of care with their provider. Specifically,

shared decision making between patient, caregiver and provider is considered to be a fundamental component of a patient-centered healthcare system that leads to improved health outcomes for patients. The Shared Decision Making section of the Summary Survey Measures (SSM) asks beneficiaries questions such as whether they spoke to their provider about the reasons they may want to take a medicine or why they may not want to take a medicine. It also asks beneficiaries whether the provider had asked them what they thought was best for them regarding potential surgeries or procedures and whether their provider respected their wishes in regards to how much of their personal information could be shared with family or friends. As beneficiaries become more empowered to actively participate in their care, we would expect better performance in the Shared Decision Making section of the SSM, as this section of the CAHPS survey focuses on beneficiary engagement related to their care. And as more beneficiaries actively participate in their care decisions, we should also see improved health outcomes for beneficiaries.

The Shared Decision Making section of the SSM is collected and reported through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting programs and the CAHPS for ACOs Survey administered by ACOs participating in the Medicare Shared Savings Program (Shared Savings Program). The Shared Savings Program was established by section 3022 of the ACA. The Shared Savings Program is a key element of the Medicare delivery system reform initiatives included in the ACA and is a new approach to the delivery of health care. Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

The performance target set for this measure was established using the Shared Savings Program's quality measure performance benchmark distribution. Prior to the start of a performance year, CMS publishes quality measure performance benchmarks that are set using all available Medicare fee-for-service quality data. These data-driven benchmarks are used to assess quality attainment (and more recently, quality improvement) and ultimately translated into points used in the program's financial performance calculations. The 76 percent target set for the Shared Decision Making measure in 2017 (available for reporting in 2018) was set using the 2015 Shared Savings Program quality measure benchmarks, assuming continued improvement in measure performance over the next two years. Specifically, the performance target focuses on measuring continued improvement of the scores related to beneficiary responses to the Shared Decision Making section of the SSM.

To ensure ACOs attain high measure performance, and improve measure performance, CMS provides training webinars, dedicated resource webpages and materials including a CAHPS toolkit to support ACOs and group practices to improve their CAHPS scores.

MMB1: Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees: A "hospital readmission" occurs when a patient, who has recently been discharged from a hospital (such as, within 30 days), is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient's care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable re-hospitalizations. Hospital readmissions may indicate poor care and missed opportunities to better coordinate care, and result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2013, an estimated 10.7 million beneficiaries were dually eligible for Medicare and Medicaid. Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees have higher rates of chronic and co-morbid conditions[7] and higher rates of institutionalization[8], as well as challenges posed by socioeconomic issues. As a result, we seek to assess the impact of interventions on this sub-population.

In calendar year (CY) 2013, CMS' Innovation Center implemented two demonstrations focused on improving care for Medicare-Medicaid enrollees. The first and larger is the "*Financial Alignment Initiative*", in which CMS partners with State Medicaid Agencies to test models for integrated, coordinated care for this population. The second is the "*Initiative to Reduce Avoidable Hospitalizations among Nursing Home Residents*".

This measure will be calculated using the number of readmissions per 1000 eligible beneficiaries. This will be a more sensitive measure for dual eligible beneficiaries than the rate of readmissions (numerator) divided by admissions (denominator) used in other hospital readmissions measures. There has been concern that such a ratio does not accurately capture quality improvement outcomes of decreased readmissions and admissions at any given hospital. For example, such a ratio can remain unchanged if admissions decline at the same rate as readmissions due to hospital quality improvement efforts to reduce both.[9] [10]

This measure will gauge the impact of interventions on reducing unnecessary all-cause hospital readmissions in order to ensure patient quality of care and to reduce unnecessary Medicare spending. The CY 2012 baseline is 91.48 readmissions per 1,000 beneficiaries and the CY 2013 result is 84.61, a 7.5 percent reduction over the CY 2012 baseline. Our CY 2016 and 2017 targets are to achieve a 2 percent reduction over the prior year result.

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 CY 2014, 10.8 million young adults were covered under this regulation, exceeding our target of 9.7 million. 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 2014, we will report this number as a contextual indicator.

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 bring transparency to the market and allow individuals to compare health plans, get answers to questions, find out if they

[7] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf
[8] http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf
[9] Brock, J., Mitchell, J., et al., Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries, *JAMA,* January 23/30, 2013, Vol. 309, No. 4
[10] Jencks, S., Protecting Hospitals That Improve Population Health, http://altarum.org/health-policy-blog/protecting-hospitals-that-improve-population-health, Dec. 16, 2014

are eligible for tax credits for private insurance, and enroll in a health plan that meets their needs. Baseline enrollment data for CY 2014 is 6,337,860. The CY 2016 target is 10 million enrollees.

PHI6 Protect Individuals and Small Businesses from Potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review Program The ACA 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 measure will track how the Effective Rate Review program has deterred issuers from proposing high, potentially unjustified rate increases that would be subject to review for reasonableness. In every State, proposed rate increases of 10 percent or more are now evaluated by independent experts to assess whether the increases are based on reasonable cost assumptions and solid evidence. The review and scrutiny is expected to prevent unjustified premium hikes by insurance companies, cutting costs for individuals, families and small business owners. Since September 1, 2011, health insurers have been required to justify any rate increase of 10 percent or more before the increase takes effect. Additionally, the ACA requires that all rates increases be monitored by the Secretary and the States after January 1, 2014, when the new federal rating rules took effect.

Although CMS does not have the authority to compel issuers to reduce rates, CMS expects that the requirement that issuers justify rate increases of 10 percent or more will exert pressure on issuers to reduce rate increases. We believe that through continued enhancement, States and CMS will have the tools, staff and capabilities necessary to effectively evaluate and monitor rate increases in their markets. This should help limit unjustified rate increases and increase transparency for consumers. CMS has diligently worked to assist States in enhancing their capabilities to effectively monitor and review rate increases, make reasonableness determinations, and review for compliance with federal rating rules. This combination of review and monitoring can lead to lower implemented rate increases. CMS and State efforts have been supported through both regulation and the Rate Review Grants program, which provides States with up to $250 million to improve their rate review capabilities.

CMS has set standards for States by defining what makes a rate review effective, and most States have met those standards. We continue to monitor and assess the effectiveness of State rate review programs. Most States have also utilized grant money to help implement these new national standards to help assure consistency and enhanced competency throughout the country. In CY 2014, of the 4,792 product submissions received from issuers, 590 (12 percent) were subject to review; therefore, our FY 2014 baseline is 12 percent. In 2015 CMS received 3,924 product submissions from issuers. Of those 3,924 products, 1,090 products (28 percent) were subject to review. The CY 2016 and 2017 targets are 10 percent.

PHI7 Maintain or reduce percent of population who are uninsured by providing increased access to coverage through the Marketplace, Medicaid and CHIP: HHS is securing and extending health insurance to the previously uninsured by implementing provisions created by the Affordable Care Act of 2010, such as working with States to set up Health Insurance Marketplaces (Marketplaces), expanding Medicaid coverage to low-income Americans, and prohibiting insurance companies from dropping people when they get sick. Consumers in every State may be eligible for tax credits to lower the cost of their health insurance. We have made significant progress in a short amount of time toward extending affordable coverage to the uninsured. According to National Health Interview Survey (NHIS data), the affordable coverage available through Medicaid expansion and Marketplace coverage contributed to a six percentage point drop in the uninsured rate since the beginning of the first Open Enrollment

Period in October 2013.[11] This contextual indicator tracks the Percentage of the United States Civilian Nonelderly Noninstitutionalized Population who are Uninsured. Our CY 2010 baseline is 18.2 percent and our most recent actual from CY 2014 is 13.3 percent.

The huge increase in coverage comes along with other significant improvements and policy developments including changes in application, verification, eligibility determination, coordination, and renewal of coverage, as well as expansion of Medicaid. In particular, the single, streamlined application for all insurance affordability programs has allowed consumers a more coordinated and consistent process for obtaining coverage. Coverage has not only expanded to more people but it has also become more secure for beneficiaries, particularly those who have Medicaid and CHIP, due to the development of regulations that ensure these beneficiaries remain enrolled in coverage for as long as they are eligible. In addition, Consumers have also gained broader access to coverage – at least one issuer offered coverage in each service area of the Marketplaces, ensuring that all consumers would have qualified health plan access.

The key strategic elements of this initiative necessary to produce successful outcomes include: Operate the Federally Facilitated Marketplace; continue robust outreach and education efforts; ensure consumer protections; implement market stabilization programs to increase competition and keep premiums affordable; and support State's efforts to develop and expand affordable insurance programs.

Now that a significant number of previously uninsured individuals have enrolled in insurance programs, growing total enrollment further will require us to update our previous tactics, as the remaining uninsured are often hard-to-reach.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCR9.1a: Quality Standards: Minimum of 90% pass rate for Adherence to Privacy Act (Outcome)	FY 2015: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1b: Quality Standards: Minimum of 90% expectations for Customer Skills Assessment (Outcome)	FY 2015: 94% Target: 90% (Target Exceeded)	90%	90%	Maintain

[11] http://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_estimates_2010_2015_Q12.pdf, Table 1.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCR9.1c: Quality Standards: Minimum of 90% meets expectations for Knowledge Skills Assessment (Outcome)	FY 2015: 95% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.3: Minimum of 90% pass rate for the Customer Satisfaction Survey (Outcome)	FY 2015: 88% Target: 90% (Target Not Met)	90%	90%	Maintain
MCR12: Maintain an unqualified opinion	FY 2015: Maintain an unqualified opinion Target: Maintain an unqualified opinion (Target Met)	Maintain an unqualified opinion	Maintain an unqualified opinion	Maintain
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2015: 1) Continue external ICD-10 outreach and Communications for pre-implementation. (Target Met) 2) Review and monitor ICD-10 industry compliance level and State Medicaid program baselines (Target Met) 3) Continue pre-implementation monitoring and assessment (Target Met) 4)Monitor and remediate ICD-10 claims payment, policy, and systems issues (Target Met)	1) Continue external ICD-10 outreach and Communications for post - implementation. 2) Review and monitor ICD-10 industry compliance level and State Medicaid program baselines 3) Continue post implementation monitoring and assessment 4)Monitor and remediate ICD-10 claims payment, policy, and systems issues	1) Continue external ICD-10 outreach and Communications for post-implementation. 2) Review and monitor 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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCR21.1: Percent of CMS Federal Information Security Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems.	FY 2015: 92% Target: 90% (Target Exceeded)	95%	95%	Maintain
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution	FY 2015: 87% Target: 85% (Target Met)	85%	85%	Maintain
MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (EXL) framework	FY 2015: 100% Target: 95% (Target Exceeded)	100%	100%	Maintain
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR)	FY 2014: 100%[12] Target: 70% (Target Exceeded)	75%	75%	Maintain
MCR26: Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent from the previous year's actual rate	FY 2015: 17.6%[13] Target: 17.9% (Target Exceeded)	17.4[14]%	17.2%[15]	-.2 pp

[12] The target and result have been revised due to a reporting error. The original target of 65% and result of 89% were originally reported in the FY 2016 Congressional Justification.
[13] Based on CY 2013 data
[14] Target was adjusted downward from 17.7%, as originally reported in FY 2016 Congressional Justification.
[15] The CY 2017 target may be adjusted based on CY 2016 actual results.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCR28.2: Reduce by 10[16] percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2017.	FY 2014: 4.9% decrease Target: 5%[17] (Target Not Met but improved)	5%[18]	10%[19]	5% pp
MCR29.1: Develop drafts and final rules for payment years (PY) 2013, 2014, and 2015	FY 2016: PY 2019 Final Rule Published Target: Publish 2019 Final Rule (Target Met)	Publish PY 2019 final rule	Publish PY 2020 final rule	N/A
MCR29.2: Implementation of ESRD QIP payment reduction (to meet statutory requirement)	FY 2015: Payments adjusted for facilities not meeting performance standards (based on 2013 claims data) Target: Adjust payments for facilities not meeting performance standards (based on 2013 data) (Target Met)	Adjust payments for facilities not meeting performance standards (based on 2014 data)	Adjust payments for facilities not meeting performance standards (based on 2015 data)	N/A
MCR29.3: Obtain monitoring and evaluation contractor and implement monitoring strategy	FY 2015: Developed and completed ESRD QIP Final Monitoring Report for PY 2014 Target: Develop and complete ESRD QIP Final Monitoring Report for PY 2014 (Target Met)	Develop and complete ESRD QIP Final Monitoring Report for PY 2015	Develop and complete ESRD QIP Final Monitoring Report for PY 2016	N/A

[16] The FY 2017 target goal is a 10% reduction equating to a national CAUTI SIR of 0.90 (from 1.0 to 0.90). CDC is resetting the national CAUTI SIR baseline back to 1.0 at the end of FY 2015.
[17] This target represents the FY2014-15 (midpoint) goal; which equates to a SIR of 0.98 (from 1.3 to 0.98).
[18] The FY 2016 (midpoint) target is a 5% reduction in national hospital-acquired catheter-associated urinary tract infections (CAUTI) from a FY2015 reset baseline of 1.0.
[19] Although HAI will not be renewed as an APG for FY 2016-17. It will continue as a CMS GPRA goal with a 10% targeted reduction in national hospital-acquired catheter-associated urinary tract infections (CAUTI) from a FY2015 reset baseline of 1.0.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCR30: Increase the Percentage of Medicare Fee-for-Service (FFS) Payments Tied to Quality and Value through Alternative Payment Models	CY 2014: 22% Baseline	CY 2016 Target: 30%	CY 2017 Target: 40%	+10 pp
MCR31: Improve Clinician and Group-CAHPS Shared Decisions Making Survey Score	CY2014: Baseline MSSP ACO CAHPS 74.6%	N/A	76%	N/A
MMB1: Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees CY 2012 baseline: 91.48 readmissions per 1,000 beneficiaries	CY 2013 Historical Actual 84.61 per 1,000 beneficiaries	2 percent reduction over CY 2015 result	2 percent reduction over CY 2016 result	-2%
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 (contextual indicator)	FY 2014: 10.8 million Target: 9.7 million (Target Exceeded)	Contextual Indicator	Contextual Indicator	N/A
PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces	CY 2014: 6,337,860[20] Baseline	10 million[21]	TBD	N/A

[20] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html
[21] http://www.hhs.gov/about/news/2015/10/15/10-million-people-expected-have-marketplace-coverage-end-2016.htm

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
PHI6: Decrease or Maintain the Percentage of product Submissions for Rate Increases Equal to or Greater than 10%	CY 2015: 28% Target: 11% (Target Not Met)	10%	10%	Maintain
PHI7: Percentage of the Nonelderly United States Population Who are Uninsured (Civilian, Noninstitutionalized) Baseline: CY 2010: 18.2%	CY 2014: 13.3% Historical Actual	Contextual Indicator	Contextual Indicator	N/A

Federal Administration

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$732,533,000	$732,533,000	$735,850,000	$3,317,000
FTE 1/	4,485	4,378	4,112	-266

1/Excludes staffing funded from indirect cost allocations. The FY 2015 column reflects actual FTE consumption. In FY 2016 and FY 2017, 8 FTEs will be funded from other sources.

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2017 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) and the Early Retirement Reinsurance Program (ERRP). In addition, CMS is responsible for enforcing new rights and greater accountability for consumers and providers in the private health insurance market, and disseminates an unprecedented level of consumer information regarding coverage options. As the largest purchaser of health care in the United States, CMS expects to serve almost 125 million beneficiaries in the traditional programs and millions of consumers in the private insurance market in 2017.

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 other 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 currently employs 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 has 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, Marketplace 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. Since 2004, 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); Medicare Access and CHIP Reauthorization Act (MACRA); the Balanced Budget Act (BBA); the Medicare Modernization Act (MMA); the Medicare Improvements for Patients and Providers Act (MIPPA); the American Recovery and Reinvestment Act (ARRA); 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' budget accounts contribute based on usage by the entire agency.

CMS' FY 2017 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 Americans with 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 nearly 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 intra-agency agreement allows CMS to implement policies and run its programs.

- 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.

- 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.

- 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

FY 2012	$772,963,000
FY 2013	$732,533,000
FY 2014	$732,533,000
FY 2015	$732,533,000
FY 2016 Enacted	$732,533,000

Non-comparable values.

Budget Overview and Supported Activities

FY 2017 Request ($735.9 million):

Personnel Compensation and Benefits ($629.2 million): The FY 2017 President's budget request includes $629.2 million to support 4,112 direct FTEs, a decrease of 266 FTEs below the FY 2016 enacted level of 4,378. One of the primary reasons for the decrease in direct FTEs is due to a shift in the funding source used to support Marketplace FTEs. In FY 2017, the program level for Marketplace FTEs is $85.0 million ($63.75 million in anticipated user fees and $21.25 million in discretionary budget authority), which is the same as the FY 2016 enacted level. Staffing funded from the Federal Administration line is necessary to maintain and improve our traditional programs in light of significant beneficiary population growth, as well as to oversee expanded duties resulting from MACRA, ACA, and other legislation passed in recent years.

Rent, Communication & Utilities ($5.1 million): The FY 2017 President's budget supports rent, communications and utilities at $5.1 million. This amount remains the same as FY 2016 enacted level. Our FY 2017 request excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Service and Supply Fund ($4.6 million): The FY 2017 President's budget for the Service and Supply Fund totals $4.6 million in discretionary funds. This estimate is $1.1 million above the FY 2016 enacted level. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Services ($10.9 million): The FY 2016 President's budget for Administrative Services is $10.9 million, a $4.7 million increase above the FY 2016 enacted level of $6.2 million. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Information Technology ($37.6 million): The FY 2017 President's budget for Administrative IT is $37.6 million, a $5.3 million increase above the FY 2016 level of $32.3 million.

Inter-Agency Agreements ($3.7 million): The FY 2017 President's budget for the Inter-Agency Agreement is $3.7 million, a $710,000 increase above the FY 2016 enacted level.

Supplies and Equipment ($1.2 million): The FY 2017 President's budget for supplies and equipment is $1.2 million, the same as the enacted FY 2016 level.

Administrative Contracts and Intra-Agency Agreements ($32.2 million): The FY 2017 President's budget for Contracts and Intra-Agency Agreements totals $32.2 million, a $14.7 million increase above the FY 2016 enacted level. This increase will allow us to continue funding a majority of our mandatory contracts within the Federal Administration line such as legal and security services. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Training ($3.0 million): The FY 2017 President's budget for Training totals $3.0 million in discretionary funds. This estimate is an increase of $1.1 million above the FY 2016 enacted level.

Travel ($5.6 million): The FY 2017 President's Budget for Travel totals $5.6 million, a $1.2 million dollar increase above the FY 2016 enacted level.

Printing and Postage ($2.8 million): The printing and postage President's budget for the FY 2017 request totals $2.8 million, a $400,000 increase above the FY 2016 enacted level.

Federal Administration Discretionary Summary
(Dollars in Thousands)

Objects of Expense	FY 2016 Enacted	FY 2017 Budget Request	FY 2017 +/- FY2016
Personnel Compensation	$655,100	$629,218	($25,882)
Rent, Communications and Utilities	$5,100	$5,100	$0
Service and Supply Fund	$3,526	$4,600	$1,074
Administrative Services	$6,195	$10,906	$4,711
Administrative IT	$32,296	$37,632	$5,336
Inter-Agency Agreements	$2,977	$3,687	$710
Supplies and Equipment	$1,178	$1,178	$0
Administrative Contracts and Intra-Agency Agreements	$17,437	$32,162	$14,725
Training	$1,900	$2,968	$1,068
Travel	$4,400	$5,600	$1,200
Printing and Postage	$2,424	$2,799	$375
Subtotal, Non-Pay Objects of Expense	$77,433	$106,632	$29,199
Total, Federal Administration 1/	**$732,533**	**$735,850**	**$3,317**

1/ Reflects CMS' discretionary Federal Administration request, only, and excludes costs that are borne by other budget accounts.

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Medicare Survey and Certification

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Request	FY 2017 +/- FY 2016
BA	$397,334	$397,334	$437,200	$39,866

Authorizing Legislation - Social Security Act, title XVIII,
Section 1864 FY 2017 Authorization - One Year
Allocation Method – Contract Agreements

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 all facilities seeking participation in Medicare and Medicaid to 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 7,000 surveyors across the country, State Survey Agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards.

Provider Type	Percent of Facilities with Cited Deficiencies, FY 2014	Examples of deficiencies
Nursing Homes	90 percent, with the average number of deficiencies sited per survey of 5.7	Abuse, avoidable injury from falls or pressure ulcers, infection control lapses, and deaths from medication errors.
Dialysis Facilities	74 percent	Infections or hazards to life from poor equipment cleaning or water quality.
Hospitals (non-Critical Access Hospitals)[1]	44 percent	Wrong site surgery, medication errors, poor outcomes, failure to maintain an effective quality improvement system.
Home Health Agencies	51 percent	Plan of Care, Medication Assessments, and Compliance with accepted Professional Standards/Principles.
Ambulatory Surgical Centers	47 percent	Infection control deficiencies, improvement over the 50-59 percent rage in prior years.

[1] Non-Critical Access Hospitals (CAH) only

These examples illustrate the profound importance of regular, comprehensive inspections of health care facilities, as well as timely and effective investigation of complaints.

Forty two recent reports (CY 2010 through CY 2014) 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 Ambulatory Surgery Centers. CMS is 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. OIG and GAO reports emphasize that 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. Three 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; each home health agency must be surveyed at least every 3 years; and hospice facilities must be surveyed at least once 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 9 percent, 4 percent, and 15 percent respectively from FY 2010 to FY 2015).

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 and nursing home quality data for star ratings. Similarly, CMS includes 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 and quality of oversight for non-statutorily mandated facilities decreased in recent years due to a growing number of facilities, demands to survey more facility types, and the Federal and state budget constraints. The budget request for FY 2017 seeks to address these problems.

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, and nursing homes. Since 2008, dialysis facilities have also been surveyed in accordance with the new ESRD regulations that have substantially improved infection control, water quality safety, and internal quality assurance. 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. For ASCs, CMS has, starting in 2010, surveyed 25 percent of non-accredited ASCs each year using a more rigorous survey process that included a significantly increased focus on infection control. By the end of FY 2014, all currently participating non-accredited ASCs had been surveyed using the new process, and a consistently high level of infection control problems had been identified. CMS will not have complete 2015 data until spring 2016. These facilities were required to correct their deficient practices or have their Medicare participation terminated. CMS also conducts periodic surveys of a random sample of ASCs in order to assess whether previously surveyed ASCs have been able to sustain their improved practices.

CMS also implemented onsite surveys of all solid organ transplant centers in the U.S. (beginning in late FY 2007), including enforcement of outcome standards if patient deaths or graft failure exceed 150 percent of the risk-adjusted expected number. Nationally, by the end of FY 2014, both patient and graft survival for all types of solid organ transplants had improved to the highest rates ever recorded, with the substantial improvements achieved in programs that entered into a System Improvement Agreement with CMS after being cited by CMS for substandard patient outcomes.

CMS establishes survey priorities for state survey agencies. Tier I priorities are comprised primarily of statutorily required surveys. For example, for HHAs, in FY 2017, under the proposed budget request, CMS and states will conduct 2,593 Tier 1 HHA surveys (92.5 percent of all HHA recertification surveys). In addition, CMS and states will conduct approximately 1,400 complaint investigations in HHAs each year as Tier I and Tier II priorities. Tiers III and IV include surveys of HHAs that newly seek Medicare participation. While CMS aims to avoid providers waiting to enter CMS programs, recertification surveys and complaint investigations take priority in an environment with competing budget priorities.

Individuals in nursing homes comprise a particularly vulnerable population. Consequently, CMS places a high priority on ensuring nursing home quality. The majority of funding for Nursing Home Oversight Improvement Program (NHOIP) activities is included in state 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 alleged 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 Special Focus Facility (SFF) initiative).

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 evaluation of the Quality Indicator Survey (QIS) and traditional survey processes, and continued focus on the nursing homes judged to have the highest risk of poor quality of care (through the CMS 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 with candidate facilities

that were not surveyed with the same frequency. While the number of SFF facilities that can be accommodated within the budget declined due to sequestration effects (from 153 in FY 2012 to 88 in FY 2014), the SFF initiative remains an important part of the Survey and Certification program. The FY 2017 budget would increase the number of Special Focus Facilities to 132 facilities.

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. Training also helps promote efficient onsite survey process, which is important for containing survey expenses. 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 psychiatric hospitals organ transplant centers), or assist CMS Regional Offices in conducting comparative ("look-behind") surveys designed to check the accuracy and adequacy of surveys done by states. Use of national contractors also permits CMS and states to improve the quality of survey and complaint investigations in specialized areas and in U.S. territories. 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 Minimum Data Set; 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. CMS also applies an algorithm to identify providers with the highest risk of poor care, in nursing homes, dialysis facilities, and home health agencies. CMS also plans to develop a similar survey targeting algorithm for higher risk hospices (pursuant to funding under the IMPACT Act of 2014). 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. Onsite surveys represent the primary source of verifiable information used for the *Five-Star Quality Rating System,* as the survey data come from direct observation of conditions in the nursing home by objective, trained surveyors. Support contracts also enable CMS to publish the reports of onsite surveys for nursing homes and for hospital complaint surveys in a searchable database accessible for public use. In addition to

complaint investigations of acute care hospitals, complaint investigations for Critical Access Hospitals, Long Term Care Hospitals, and Psychiatric Hospitals are also now posted on the website. Support contracts also permit CMS to check on the accuracy of the data reported by nursing homes.

Information Technology

CMS maintains several information technology systems that are necessary for survey and certification activities. The ASPEN suite of the Quality Improvement and Evaluation System (QIES) and the 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. The QIES system records and tracks information on the Survey and Certification process and quality of healthcare for over 316,500[2] Medicare, Medicaid, and Clinical Laboratory Improvement Amendments providers. The system also supports the program through the use of the Certification and Survey Provider Enhanced Reports (CASPER) database which includes all survey findings for all types of surveyed providers and suppliers.

CMS also supports the nursing home Quality Indicator Survey (QIS) which was developed in response to concerns identified by CMS, GAO, and OIG to achieve greater consistency inhow compliance with Federal requirements is assessed for the approximately 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 indicatorsand identifies those areas that are triggered for investigation in the second stage of the survey. There are 26 States that are now either in the process of completing their transition, or have completely transitioned to the QIS. As part of the CMS efficiency and effectiveness initiative, CMS is currently undertaking a review of the QIS and traditional survey processes and is working with stakeholders to identify improvements to the survey process to address state challenges to effective and efficient implementation.

Evidence-Based Practices

CMS Survey and Certification functions have increasingly relied on a foundation of evidence- based practice. For example, with respect to oversight of accrediting organizations, CMS reports to Congress on the performance of CMS-approved accrediting organizations each year. The reports are based on evidence from systematically-collected data from validation surveys (pursuant to new legislation enacted by Congress in 2008). Fornursing homes, data gathered from pilot tests of new techniques has led to many improvedsurvey processes that were later adopted nationwide, including targeted surveys that check on the accuracy of resident assessments and the minimum data set, and targeted surveys that better assess the quality of dementia care. Further, accumulated evidence of nursing home quality of care issues led to creation of the *Five- Star Quality Rating System* that is publicly available on CMS's *Nursing Home Compare* website. 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 on-site survey process. For ESRD, analysis of data on serious deficiencies enabled CMS to

[2] This sum includes 182,700 CLIA Waived Labs which do not receive a survey because Waived Labs are not subject to routine surveys.

design better inspection of infection control practices in ESRD facilities and an entirely new, more efficient and effectiveESRD survey process. In FY 2014, with 72 percent of all state survey teams using the new ESRD survey process, average hours per standard ESRD survey had dropped by 16.4 percent compared to the baseline (from 73.6 hours in FY 2011 to 61.5 hours in FY 2014). For ASCs, the use of checklists (derived from CMS and CDC research) led to improved survey processes for all ASC facilities, with results of the pilot surveys published in the *Journal of the American Medical Association*. The improved ASC surveys were implemented nationally in 2010.

The FY 2017 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 will assess nursing home systems to investigate adverse events and make system improvements based on the results of the investigations. Similarly, CMS expects 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 2012	$375,203,000
FY 2013	$355,578,000
FY 2014	$375,330,000
FY 2015	$397,334,000
FY 2016	$397,334,000

Budget Request

CMS's FY 2017 budget request for Medicare Survey and Certification is $437.2 million, an increase of $39.9 million above the FY 2016 Enacted Level. The requested increase will allow for implementation of both new laws enacted by Congress and final, improved CMS regulations. The Survey and Certification program is faced with significant additionalcosts to implement requirements of such new laws and regulations. Examples of new lawsinclude the improved discharge planning requirements for key providers under the IMPACT Act of 2014, advanced diagnostic imaging oversight, and requirements under the Affordable Care Act for nursing homes to have internal quality improvement processes as well as ethics and compliance safeguards. Examples of new regulations include improved emergency preparedness requirements for most providers, adoption of up-to-date fire safety requirementsfor most providers, and the first comprehensive updating of nursing home regulations in 24 years. In particular, the $39.9 million dollar increase includes $8.8 million to support new survey and certification regulatory workload requirements, particularly costs to implement new LTC standards currently in rulemaking, including supporting the Discharge Planning requirements mandated by the IMPACT Act and Emergency Preparedness, and an increase of $2.4 million to maintain deemed hospital validation surveys at FY 2016 President Budget levels and an increase of $3.6 million to increase survey frequencies for ASCs.

In addition to the impact of new laws, regulations, and similar improvements, other drivers of increased costs include the cumulative impact of more providers, the effects of inflation on travel, state salaries, and other expenses.

The FY 2017 budget provides $4.0 million an increase of $1.6 million above the FY 2016 enacted level for targeted surveys of nursing homes to focus on facilities where there is high

use of anti-psychotics for residents who have dementia, higher risk of adverse events or harm to residents (such as those identified in the OIG Adverse Events report in 2014), and higher risk that resident assessments and quality of care reporting may not be done properly and accurately. The results of resident assessments and data reporting are used in the Quality Measure dimension of CMS' *Five-Star Quality Rating System* upon which the public relies for important information about nursing homes. While CMS believes there has been an increase in quality for the areas measured by the nursing home Quality Measures, in recent years there has been a consistent increase in the Quality Measure scores at a rate CMS believes exceeds the actual improvements made by certain nursing homes. A portion of the targeted surveys discussed here are designed to ensure both accuracy of reporting and effective resident assessments that form the basis for care plans.

Since staffing is associated with quality of care in nursing homes, CMS also publicly reports information on nursing home staffing in the *Five-Star Quality Rating System*. By 2017, CMS plans to have implemented a national system for electronic collection of staffing information on a quarterly basis that is auditable back to payroll, rather than once-per-year self-reporting of staffing data that has been the subject of much concern. Some funding for the staffing data project was included in the IMPACT Act of 2014 and is not part of this request.

Funding is necessary to implement the GAO and OIG recommendations for improvements to oversight and survey processes. CMS has seen a rise in costs associated with the expanded 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 in a multiplicity of provider types, reducing hospital readmissions, and coordinating with the Department of Justice and other agencies to address fraud or poor quality of care.

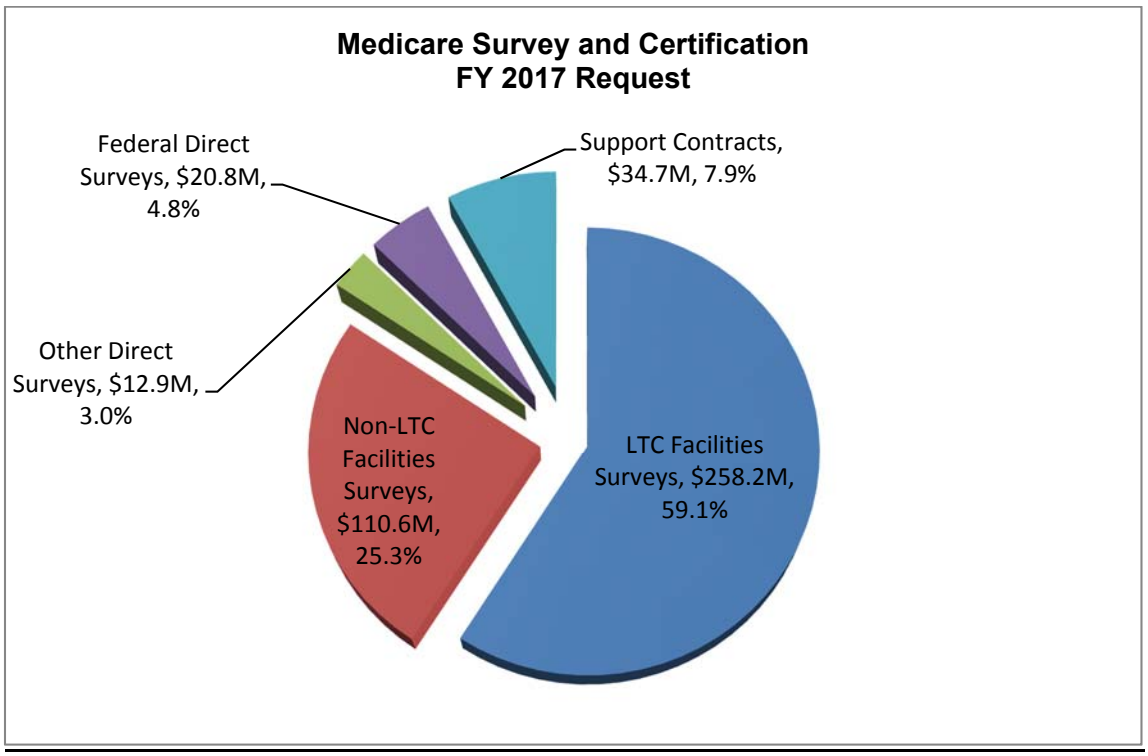
To contain costs in the face of a greater survey workload, CMS' request already assumes administrative efficiencies resulting from the Survey and Certification Efficiency and Effectiveness Initiative finalized in early 2013, with projected savings totaling over $50 million over a 5 year period. Efficiency initiatives include redesigning the procedures for ESRD surveys to take a more risk-based approach that can reduce average onsite survey time. As of FY 2014, the new and more efficient survey process had reduced average hours per standard ESRD survey by 16.4 percent compared to the baseline (from 73.6 hours in FY 2011 to 61.5 hours in FY 2014), allowing the FY 2017 budget request for ESRD surveys to be lower than would otherwise have been needed. For accredited hospitals, fewer full surveys will be conducted following a complaint investigation that finds condition-level deficiencies, in favor of more focused surveys of particular areas of concern. For home health surveys, CMS is testing methods for improved efficiency while maintaining quality of the surveys. The budget also assumes a 3-hour per survey savings from more efficient nursing home surveys that CMS anticipates will result from survey redesign and efficiency efforts initiated in late FY 2015 and FY 2016. In particular, CMS is seeking to improve the nursing home survey process by testing an integrated survey that combines the most useful parts of the higher-cost nursing home Quality Indicator Survey (QIS) with the flexibility of the traditional nursing home survey in such a way as to enable surveyors' greater ability to follow up on complaints that have been identified. The goal is a more efficient survey that improves the survey quality. Nursing home compliance history would also be weighted more heavily in determining the amount of on-site 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. In addition, 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 $368.7 million of this request will support state Direct Survey costs, $12.9 million will support additional costs related to state Direct Surveys, and $55.5 million will support direct surveys by CMS National Contractors (non-State), support contracts, and information technology.

Approximately 84 percent of the requested funding will go to State Survey Agencies, and an additional 4.8 percent will go to national contractors for direct surveys. This funding will be used for performance of mandated Federal inspections of long-term care facilities (e.g., nursinghomes) and home health agencies, as well as Federal inspections of hospitals, ESRD facilities, ambulatory surgical centers, hospices, organ transplant centers, and others. 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, promote gains in efficiency, make oversight of accrediting organizations more effective, and implement key recommendations made by the GAO and OIG.

The revisit user fee proposal for FY 2017 provides CMS with the ability to revisit providers that have been cited for deficiencies and confirm that they have restored their services to substantialcompliance 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 an 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 with no significant revenue projected in FY 2017. 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 while affording providers with optimum opportunity to plan for phased-in fees.



State Direct Survey Costs - $368.7 million

The FY 2017 request includes $368.7 million for State Direct Survey costs. This is an increase of $25.5 million above the FY 2016 Enacted Level. This funding will enable CMS to continue to meet statutory survey frequencies as well as maintain survey frequenciesfor non-statutory facilities at the FY 2016 levels or greater, which are close to CMS policy levels. Hospice surveys are partially funded by the IMPACT Act to enable three-year rather than six-year survey frequency.

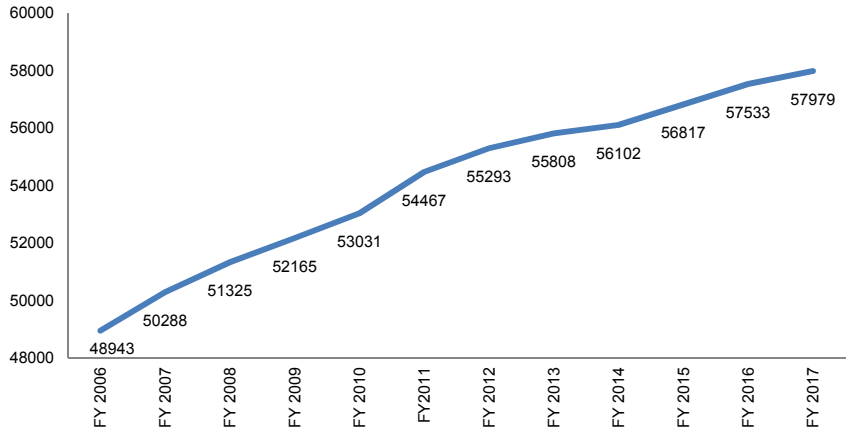
In addition, the funds would enable states to conduct validationsurveys of CMS-approved hospital accrediting organizations (AOs) at a 2.3 percent sample size, an increase of 1.3 percent over the FY 2016 Enacted level.

The Social Security Act provides for CMS to deem the accreditations of such AOs as sufficient for Medicare certification. Accredited providers are then generally not subject tostate or CMS surveys except for complaint investigations. However, CMS is required toconduct an onsite survey within 60 days of the AO survey, on a sample of AO surveys, to check on the adequacy of the AO surveys. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to report its findings to Congress for every approved AO program. CMS requests the funds to raise the sample size to a level that more appropriately enables the required analysis and report to Congress. The CMS FY 2014 Annual Report to Congress outlined the number of facilities participating in Medicare via deemed status increased from 7,128 in FY 2008 to 12,451 in FY 2014, illustrating the importance of CMS AO oversight.

Conditions of Participation (COPs) for Community Mental Health Centers (CMHCs) were published in final form in FY 2014. Funding for state surveys of CMHCs began 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 (LTC) facility surveys (i.e., Skilled Nursing Facilities (SNFs) and dually-certified SNF/NFs). Between FY 2013 and the end of FY 2017, the number of Medicare-certified facilities to be surveyed is expected to have increased four percent, from 55,808 to 57,979 facilities in FY 2017, as shown in the following graph, excluding clinical laboratories. The projections do not include any impact that the expansion of the health care coverage under the Affordable Care Act may have on the number of providers, as there is insufficient information currently available to make reliable projections.

Beginning of Year Number of Participating Medicare Facilities (excluding clinical laboratories)



State Direct Survey Costs (Dollars in Millions)

Provider Type	FY 2015 Final	FY 2016 Enacted	FY 2017Budget Request
Skilled Nursing Home (SNF)	$14.9	$16.8	$16.7
SNF/NF (dually-certified)	$232.2	$228.4	$241.5
Home Health Agencies	$19.4	$17.3	$15.4
Non-Deemed Hospitals	$15.8	$13.1	$15.8
Deemed Hospitals	$25.3	$24.7	$27.7
Ambulatory Surgical Centers	$9.1	$10.9	$14.4
ESRD	$20.6	$25.9	$30.6
Hospice *(net of Impact Act funds)**	0.0*	$1.8*	$1.8*
Outpatient Physical Therapy	$1.3	$1.3	$1.6
Outpatient Rehabilitation	$0.2	$0.2	$0.2
Portable X-Rays	$0.3	$0.3	$0.3
Rural Health Clinics	$2.4	$2.3	$2.5
Organ Transplant Centers**	$0.0**	$0.0**	$0.0**
Community Mental Health Centers	$0.6	$0.4	$0.3
Subtotal, Direct Survey Costs	**$342.1**	**$343.3**	**$368.7**
Other State Direct Survey Costs	$13.2	$9.8	$12.9
Total, State Direct Survey [1]/	**$355.3**	**$353.1**	**$381.7**

1 Total may not add due to rounding.
* Hospice surveys are separately funded (in part) under the IMPACT Act PL 113-185 at $8.3 million beginning in FY 2015 and reduces to $7.8 million in FY 2016 & FY 2017 due to sequester. This chart identifies funds needed in addition to the IMPACT Act funding to meet the statutory frequency. Funding provided by IMPACT in FY 2016 and FY 2017 is not entirely sufficient due to increasing survey costs based on current estimates.
** Excludes approximately $3 million for onsite surveys of organ transplant centers done by national contractor.

CMS' FY 2017 budget request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. CMS continues to advance efforts toaddress healthcare associated infections (HAI) across all providers. The request continuesthe

enhanced survey process in ASCs to target infection control deficiencies, as discussed above, with an average survey frequency that meets the policy levels of every 3 years (an improvement over the FY 2016 four-year average). Individuals in hospices are also highly vulnerable. Based on concerns regarding the quality of care in hospices (such as a 15 percent increase in complaints between FY 2010 and FY 2013), using $7.8 million of IMPACT Act funding, CMS will continue implementing the increased frequency of hospice surveys in FY 2017 from a prior average of once every 6 years to once every 3 years. Additionally a flat budget will not allow CMS to maintain survey frequencies, particularly given consideration to the effects of inflation, updated/improved quality standards, and the increasing number of providers.

The following chart includes updated frequency rates for FY 2015 through FY 2017.

Type of Facility	Recertification FY 2015 Final	Recertification FY 2016 Enacted Level	Recertification FY 2017 Budget Request
Long-Term Care Facilities	Every Year (100%)*	Every Year (100%)	Every Year (100%)
Home Health Agencies	Every 3 Years (33.3%)	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Deemed Hospitals	Every 3.3 Years (30.3%)	Every 3.5 Years (28.6%)	Every 3 Years (33.3%)
Deemed Hospital-Validations	1.6% Year Sample	1.0% Year Sample	2.3% Year Sample
Ambulatory Surgery Centers	Every 4 Years (25.0%)	Every 4 Years (25.0%)	Every 3 Years (33.3%)
ESRD Facilities	Every 3.5 Years (28.6%)	Every 3.5 Years (28.6%)	Every 3 Years (33.3%)
Hospice**	Every 3 Years (33.3%)**	Every 3 Years (33.3%)**	Every 3 Years (33.3%)**
Outpatient Physical Therapy	Every 6 Years (16.7%)	Every 7 Years (14.3%)	Every 6 Years (16.7%)
Outpatient Rehabilitation	Every 6 Years (16.7%)	Every 7 Years (14.3%)	Every 6 Years (16.7%)
Portable X-Rays	Every 6 Years (16.7%)	Every 7 Years (14.3%)	Every 6 Years (16.7%)
Rural Health Clinics	Every 6 Years (16.7%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Organ Transplant Facilities***	Every 5 Years (20%)***	Every 5 Years (20%)***	Every 5 Years (20%)***
Community Mental Health Centers	Every 6 Years (16.7%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)

* Numbers in parentheses indicate the approximate percent of each type of provider that would be surveyed in the FY.
**Hospice surveys are partially funded under the IMPACT Act PL 113-185.
*** Organ Transplant Facilities surveys are contractor performed.

In FY 2017, CMS expects to complete approximately 25,800 initial and recertification inspections, as shown in the Surveys and Complaint Visits table below. Inaddition, CMS estimates 55,600 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2017 are projected to be in nursing homes. These surveys will contribute to achieving CMS' nursing home quality goals

to decrease the prevalence of pressure ulcers in nursing homes and todecrease 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 2016 Enacted Level					
Facility	**Projected # Facility (Beg of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total**
Skilled Nursing Facility (SNF)	795	795	120	975	1890
SNF/NF (dually-certified)	14450	14580	127	44325	59032
Home Health Agencies	12640	2593	65	1545	4203
Non-Deemed	1572	449	18	455	922
Deemed Hospital	4595	46	0	3285	3331
Ambulatory Surgical Centers	5570	954	25	137	1116
ESRD Facilities	6110	1746	255	790	2791
Hospices*	3907	841*	40*	645*	1526*
Outpatient Physical Therapy	2225	318	25	8	351
Outpatient Rehabilitation	265	38	10	7	55
Portable X-rays	574	82	32	5	119
Rural Health Clinics	4030	672	72	35	779
Organ Transplant Centers**	245	0**	0**	0**	0**
Community Mental Health Centers	225	38	22	5	65
Total	**57,203**	**23,152**	**811**	**52,217**	**76,180**

*Hospice surveys are separately funded under the IMPACT Act PL 113-185.

**Organ transplant centers surveys done by the CMS national contractor, do not appear in this chart.

FY 2017 President's Request					
Facility	**Projected # Facility (Beg of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total**
Skilled Nursing Facility (SNF)	795	795	82	975	1852
SNF/NF (dually-certified)	14425	14670	115	48275	63060
HHA	12570	3098	65	1365	4528
Non-Deemed Hospital	1585	528	12	405	945
Deemed Hospital	4675	108	0	2915	3032
Ambulatory Surgical Centers	5490	1248	25	160	1433
ESRD Facilities	6345	2506	325	830	3661
Hospices*	4160	845*	37*	625*	1507*
Outpatient Physical Therapy	2270	359	32	8	399
Outpatient Rehabilitation	250	42	8	7	57
Portable X-rays	565	94	25	5	124
Rural Health Clinics	4175	671	143	35	849
Organ Transplant Centers**	242	0**	0**	0**	0**
Community Mental Health Centers	250	42	5	7	54
Total	**57,979**	**25,006**	**874**	**55,612**	**81,492**

*Hospice surveys are partially funded under the IMPACT ACT PL 113-185.

** Organ transplant centers surveys done by the CMS national contractor, do not appear in this chart.

Other State Direct Survey Costs - $12.9 million

The FY 2017 Other State Direct Survey Cost estimate is $12.9 million, a $3.1 million increase from the FY 2016 Enacted Level. Increases in funding for State Targeted Surveys contributed to the increase, as well as accounting for Medicaid contributions to the cost of MDS and OASIS monitoring and education, and economies in validation surveys. Examples of continuing 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 accredited facilities such as hospitals, 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 - $55.5 million

Federal Direct Surveys - $20.8 million

The FY 2017 request includes $20.8 million for Federal Direct Survey costs. This is an increase of $1.0 million above the FY 2016 Enacted Level and is due to an increase in targeted and performance surveys. 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. The contractors work in areas that are highly specialized or so small in number that states have difficulty maintaining infrequently-used expertise. For example, all organ transplant hospital surveys in FY 2017 will continue to be conducted by a national contractor, as will be the psychiatric hospital special conditions for active treatment, staffing and specialized training. 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 and for nursing home surveys. In addition, prospective improvements in survey processes are often pre- tested with national contractors before enlisting state volunteers for pilot-testing. The FY 2017 budget would aid in restoration of the federal direct survey capability that was substantially reduced pursuant to the FY 2013 budget sequestration.

The FY 2017 budget request includes the continuation of $0.8 million for oversight of territories and islands. This funding promotes improved health care and continued access to health care in both U.S. territories and among Indian tribes where there are often few providers. Providers and suppliers in such areas may face the prospect of Medicare and Medicaid termination due to unresolved safety or quality of care problems. Recent examples of providers CMS has been working with to improve care delivery include: an acute care hospital in the Commonwealth of the Northern Marianas, a hospital and nursing home on one of the Virgin Islands, a dialysis facility in one of the U.S. territories, and tribal and Indian Health Service hospitals.

Support Contracts and Information Technology - $34.7 million

Support contracts and information technology, managed by CMS, constitute $34.7 million of the FY 2017 budget request.

Support Contracts

The FY 2017 request for support contracts totals $32.4 million. This is an increase of $9.9 million above the FY 2016 Enacted Level. The increase is primarily due to the need to implement new laws and regulations, such as the IMPACT Act's improved discharge planning requirements for hospitals, home health agencies, and nursing homes; the statutory requirements for nursing home quality assurance, performance improvement, and ethics systems; the CMS comprehensive update to the overall nursing home regulations; and the CMS improved expectations for emergency preparedness on the part of most institutional providers. The funds also support data analysis of ESRD performance and follow-up actions based on ESRD performance metrics. The requested funds will further strengthen CMS training of surveyors (especially through web-based offerings). Surveyor training continues to be one of the largest categories in support contracts. These contracts enable CMS to fulfill 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, in-person, and case-study training, surveyors gain the skills necessary to perform proficiently and promote 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 fiscal benefit as the reduction in State travel costs and travel time exceeds the increase in CMS expenses.

Turnover in state personnel has also increased the need for CMS training. As states have less experienced surveyors, the hours per LTC survey has increased. CMS believes that improvements in training will increase the ability of state surveyors to identify deficiencies more efficiently.

The FY 2017 request continues to provide funds for operations and maintenance as well as enhancements of the CMS *Nursing Home Compare* website and *Five Star Quality Rating System* for nursing homes. CMS will continue to post, on the *Compare* website, information on deficiencies identified in each nursing home, as well as publishing the full survey reports in a searchable database on the web for all nursing home surveys and for hospital complaint investigations.

CMS also plans to add more Quality Measures to the *Five-Star* system in FY 2017, begin the transition to electronic quarterly reporting of each nursing home's staffing data, and expand thetargeted surveys (discussed previously) that help ensure integrity and accuracy of resident assessments and reporting of data used in the Quality Measures.

Information Technology

The IT funding request for FY 2017 is $2.3 million. This is an increase of $0.4 million over the FY 2016 Enacted Level. This request includes $1.0 million for an IT Learning Management

System for surveyor training as well as the agency's automated oversight and budget systems. The QIS, ESRD surveys and accreditingorganization oversight efforts have been transferred to the QIES system.

Program Level Table

	FY 2015 Final	FY 2016 Enacted Level	FY 2017 President's Request	FY 2017 +/- FY 2016
BA	$397,334,000	$397,334,000	$437,200,000	+$39,866,000
IMPACT P.L. 113-185. Hospice Surveys	$8,333,333	$7,766,666	$7,766,666	-
IMPACT Improve Nursing Home Staffing data	$11,000,000			
Revisit User Fee	N/A	N/A	$0	-
Program Level	$416,667,333	$405,100,666	$444,966,666	+$39,866,000

Survey & Certification Performance Measurement

CMS uses performance measures to support CMS' mission and to inform the decision-making process. For example, CMS developed a measure derived from the CMS national *Partnership to Improve Dementia Care in Nursing Homes*, to improve dementia care and to reduce the use of antipsychotic medications. CMS also evaluates the performance of State survey agencies to 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 in nursing homes in a number of ways. The pressure ulcer measure is clinically significant and is closely tied to the care given to beneficiaries. 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. 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. CMS' 11th Scope of Work for the Quality Improvement Organizations has established the *National Nursing Home Quality of Care Collaborative* and has a specific task related to reducing healthcare acquired conditions in nursing homes, including pressure ulcers. CMS is also collaborating with *the Advancing Excellence in America's Nursing Homes* campaign which lists pressure ulcer reduction and improved mobility as two of its five clinical goals. All of these efforts should help continue the momentum.

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, CMS is reporting the prevalence of pressure ulcers, Stage 2 and greater, in high-risk, long-stay residents. CMS exceeded the FY 2014 target and reported the prevalence of Stage 2 and greater pressure ulcers among high risk residents at 5.9 percent. The FY 2017 target is 5.5 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 their survey partners are meeting the core statutory obligations for carrying out surveys with routine frequency. CMS did not meet its FY 2014 target of 97 percent of States completing all surveys, as only 84 percent of States achieved 100 percent. In addition, only 86 percent of States surveyed all home health agencies at least every 36 months, missing the FY 2014 target of 96 percent. CMS believes that weaknesses in State budgeting and hiring practices continue to impede the ability of State Survey agencies to conduct surveys in a timely manner. An additional factor was the federal government three-week shutdown, which continues to impact the statistics on performance. The FY 2017 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 and Decrease 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 improperly to treat the behavioral and psychological symptoms of dementia. CMS has been working with partners, including State coalitions, provider associations, nursing home resident advocates, and stakeholders to decreasing the use of these drugs and improving dementia care. A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the national Partnership to Improve Dementia Care and have been incorporated into clinical practice guidelines and various tools and resources.

In the three years immediately prior to CMS intervention in March 2012, the prevalence rates had consistently risen each quarter. In the last quarter of CY 2011, CMS' baseline year, 23.87 percent of long stay nursing home residents received an anti-psychotic medication (excluding residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome). By the end of the last quarter of CY 2014, the rate had dropped to 19.1 percent. Progress has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20 percent. In January 2015, the Government Accountability Office (GAO) affirmed that CMS had made clear progress in reducing antipsychotic use in nursing homes and recommended that HHS undertake similar efforts in settings beyond nursing homes, such as assisted living and home and community-based environments. Also in 2015, CMS added the quality measures for long-stay and short-stay nursing home residents (excluding residents diagnosed with schizophrenia, Huntington's disease or Tourette's Syndrome) to the Five-Star Quality Rating system on the *Nursing Home Compare* website. In keeping with CMS' plan to reduce the use of antipsychotic medications for long-stay nursing home residents, CMS set the CY 2017 target at 16.0 percent.

MSC6 Percentage of States that Survey All Hospice Facilities within 36 Months
A hospice is a public agency or private organization that is primarily engaged in providing care to terminally ill individuals. Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative

care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregiver. The emphasis of the hospice program is on keeping the hospice patient at home with family and friends as long as possible. Although some hospices are located as a part of a hospital, nursing home, or home health agency, all hospices must meet specific Federal requirements and be separately certified and approved for Medicare participation. There are approximately 4,000 Medicare certified hospice agencies in the U.S providing care to over 1 million Medicare beneficiaries annually.

The Social Security Act mandates the establishment of minimum health and safety standards for all participating hospice providers. These standards are further defined in the Medicare Conditions of Participation (COPs) which establish the minimum requirements which a hospice agency must meet in order to participate in Medicare. State Survey Agencies, under agreements between the State and CMS, evaluate hospice compliance through the survey and certification process.

The *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act) mandates the frequency of hospice recertification surveys to be not less frequently than once every 36 months. Prior to the IMPACT Act, CMS did not have a legislative or regulatory standard for the frequency of hospice recertification surveys. Annual targets for these surveys were established by agency policy based on available resources each year. The frequency of hospice recertification surveys has been every 72 months. In additional to mandating a 36 month frequency of hospice recertification surveys, the IMPACT Act provides funding to support CMS in meeting this requirement. The shorter duration for hospice recertification surveys mandated by the IMPACT Act will ensure hospice providers are more frequently assessed against the minimum requirements for quality of care, providing greater oversight of these providers by CMS.

The purpose of this measure is to ensure that the new statutory requirements for hospice survey intervals are met by all State Survey Agencies in order to ensure quality of care. Although the CMS target is 100 percent compliance with the statutory requirement, the stated measure represents a realistic expectation considering the resources required to achieve the new survey interval. CMS policy, revised pursuant to the Impact Act, is that the maximum hospice survey interval is 36 months. The data to confirm compliance with the requirements of the Act will not be available until September 30, 2018. This data delay is a result of necessary follow up survey activity and data entry into the ASPEN system. State Survey Agencies that do not comply with the survey interval instructions contained within the Mission and Priority Document, which is issued annually by CMS, are subject to a deduction, from their annual budget projection, of the amount of the costs that would have been incurred had the surveys been completed as required. Starting in April 2018 this deduction will apply for those State Agencies that fail to maintain a 36 month survey interval for hospice agencies.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
MSC1: Decrease the Prevalence of Pressure Ulcers in Nursing Homes	FY 2014: 5.9% Target: 6.7[1]% (Target Exceeded)	5.5%	5.5%	Maintain
MSC2: Percentage of States that Survey Nursing Homes at Least every 15 Months	FY 2014: 84% Target: 97% (Target Not Met)	97%	97%	Maintain
MSC3: Percentage of States that Survey Home Health Agencies at Least Every 36 Months	FY 2014: 86% 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	CY 2014: 19.1% Target: 19.1% (Target Met)	16.7% CY	16.0% CY	-.7 pp
MSC6: Percentage of States that Complete Required Hospice Surveys within 36 months	New for 2016	90% of States Complete 95% of Required Hospice Surveys	95% of States Complete 98% of Required Hospice Surveys	N/A

[1]FY 2014 Target was originally 6.9% in the CMS CJ. The target was reduced to 6.7% when 2012 results were received

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Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$243,545,410,000] *$262,003,967,000* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2016 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] *2017* for the last quarter of fiscal year [2016] *2017* for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*

[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *In addition, for carrying out such titles* for the first quarter of fiscal year [2017] *2018*, [$115,582,502,000] *$125,219,452,000,* 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, *[$243,545,410,000] $262,003,967,000*, to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2017. This appropriation is in addition to the advance appropriation of $115.6 billion provided by P.L. 114-113 for the first quarter of FY 2017. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
[For making,] *In addition, for carrying out such titles after May 31, [2016 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] 2017* for the last quarter of fiscal year *[2016] 2017*, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*	This section provides indefinite authority for payments to states in the last quarter of FY 2017 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. "For carrying out" is substituted for consistency throughout the appropriations language. "To remain available until expended" is included for alignment with other Medicaid appropriations provided in this language.

Medicaid

Language Analysis

Language Provision	Explanation
[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] In addition, for carrying out such titles for the first quarter of fiscal year [2017] *2018, [$115,582,502,000] $125,219,452,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2018 to ensure continuity of funding for activities authorized under titles XI and XIX. This allows the Medicaid program, including the Vaccines for Children program, to continue operating in the event a regular appropriation for FY 2018 is not enacted by October 1, 2017. "For carrying out" is substituted for consistency throughout the appropriations language.
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)

	2015 Actual	2016 Current Law	2017 Estimate
Appropriation Annual	$338,081,239	$356,817,550	$377,586,469
Appropriation Indefinite	$16,835,569	$11,588,668	$0
Unobligated balance, start of year	$1,407,328	$343,000	$0
Unobligated balance, end of year	-$343,000	$0	$0
Recoveries of Prior Year Obligations	$22,150,001	$0	$0
Collections/Refunds	$765,808	$872,000	$957,200
Total Gross Obligations	$378,896,667	$369,621,218	$378,543,669
Offsetting Collections Medicare Part B QI Program	-$748,626	-$872,000	-$957,200
Offsetting Collections and Part D (Other)	-$17,182	$0	$0
Obligations Incurred but not Reported	$0	-$1,520,000	-$996,000
Total Net Obligations	$378,130,859	$367,229,218	$376,590,469

Medicaid Program
Authorizing Legislation

	FY 2016 Amount Authorized	FY 2016 Current Law	FY 2017 Amount Authorized	FY 2017 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$352,656,824,000	Indefinite	$373,199,885,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$4,160,726,000		$4,386,584,000
Total Appropriations		$356,817,550,000		$377,586,469,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
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	1/
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	2/
2012	$270,724,399,000	------	------	$270,724,399,000	
2013	$269,405,279,000	------	------	$269,405,279,000	3/
2014	$284,208,616,000	------	------	$305,843,467,000	4/
2015	$338,081,239,000	------	------	$368,405,940,000	5/
2016	$356,817,550,000	------	------	$356,817,550,000	
2017	$377,586,469,000				

1/ Includes $38,262.4 million under indefinite authority.
2/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
3/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
4/ Includes $21.6 billion under indefinite funding authority obligated during FY 2014.
5/ Includes $16.8 billion under indefinite funding authority obligated during FY 2015.

Medicaid
(Dollars in Thousands)

	FY 2015 Actual	FY 2016 Current Law	FY 2017 Estimate	FY 2017 +/- FY 2016
Medical Assistance Payments (MAP)	$354,767,044	$345,069,859	$354,185,101[1]	$9,115,242
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$0	$1,520,000	$996,000	-$524,000
Vaccines for Children	$3,845,486	$4,160,726	$4,386,584	$225,858
State & Local Administration (SLA), Survey and Certification, Fraud Control Units, and ARRA Health IT provider and admin	$20,284,137	$18,870,633	$18,975,984	-$105,351
Obligations (gross)	$378,896,667	$369,621,218	$378,543,669	$8,922,451
Unobligated Balance, Start of Year	-$1,407,328	-$343,000	$0	$343,000
Unobligated Balance, End of Year	$343,000	$0	$0	$0
Recoveries of Prior Year Obligations	-$22,150,001	$0	$0	$0
Appropriation Budget Authority (gross)	$355,682,616	$369,278,218	$378,543,669	$9,265,451
Collections	-$765,808	-$872,000	-$957,200	-$85,200
Total Budget Authority (net)	$354,916,808	$368,406,218	$377,586,469	$9,180,251
Indefinite Authority	$16,835,569	$11,588,668	$0	-$11,588,668
Advanced Appropriation	-$103,472,323	-$113,272,140	-$115,582,502	-$2,310,362
Annual Appropriation	$234,608,916	$243,545,410	$262,003,967	$18,458,557

1/ Total includes $4 million in Medicaid obligations in FY 2017 due to a proposed change in a mandatory program (CHIMP) for a Department of State proposal.

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152

FY 2016 Authorization - Public Law 113-235, Public Law 114-113

Allocation Method - Formula Grants

Medicaid Program
Summary of Changes
(Dollars in Thousands)

2017 Estimated Budget Authority	$377,586,469
2016 Estimated Budget Authority from PB 2016	$356,817,550
Net Change	$20,768,919

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. This new eligibility group receives benefits through the Medicaid Alternative Benefit Plan. 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 some 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. Some of the 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. Commonly offered optional services for both categorically- and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, services in intermediate care facilities for individuals with intellectual disabilities, and home and community-based long-term care services and supports, such as personal care services and attendant care services provided through the Community First Choice benefit. 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 generally the payer of last resort. If other parties, including Medicare, are 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 streamlines the enrollment process, improves access to home and community-based services, enhances the Federal commitment to assuring program integrity, and makes other program improvements.

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, home health agencies 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 7,500 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 patients in nursing homes and board and care 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 September 2014 over 39 percent of states provided some form of managed care to some or all Medicaid beneficiaries with 90 percent of Medicaid beneficiaries living in those 39 states. 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 goals of expanding health insurance coverage to lower income, vulnerable populations and improving quality of care and health outcomes. Most demonstrations are statewide and many include the majority of the Medicaid population in the state.

Since the enactment of the Affordable Care Act, states have used 1115 demonstrations to promote healthcare transformation in alignment with objectives of Medicaid and CHIP, which are as follows:

1. To increase and strengthen overall coverage of low-income individuals in the state;
2. To increase access to stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. To improve health outcomes for Medicaid and other low-income populations in the state and
4. To increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Several states have recently used this authority to implement innovative new Medicaid financing, such as delivery system reform incentive payment (DSRIP) programs where incentive payments are made to providers based on accomplishments made within approved projects. Other states have used the authority to implement Medicaid financing linked to Medicaid expansion, including premiums and cost sharing arrangements for beneficiaries below the federal poverty line, premium assistance to wrap-around qualified health plans offered in the individual market, and incentives to participate in wellness programs. Several states have also used this authority to move their long-term services and supports into a managed care delivery system. 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 more robust data to assess the performance of these programs relative to their goals, and assist in identifying best practices that can provide value to the continued implementation of service delivery reform and the expanded Medicaid program. The most current fiscal data available indicates the Federal share of obligations for 1115 demonstrations in FY 2014 was $89.2 billion:

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

- 2 non-statewide health reform demonstrations (Louisiana and Missouri) and

- 13 demonstrations specifically targeted to family planning (Alabama, Florida, Georgia, Iowa, Michigan, Minnesota, Mississippi, Missouri, Montana, 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. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment (Person-Years in Millions) /1

	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Aged	5.6	5.7	5.9	0.2
Disabled	10.3	10.4	10.4	0.0
Adults	23.9	25.0	26.3	1.3
Children	27.5	27.4	27.5	0.1
Territories	1.5	1.4	1.4	0
Total/1	68.8	69.9	71.6	1.7

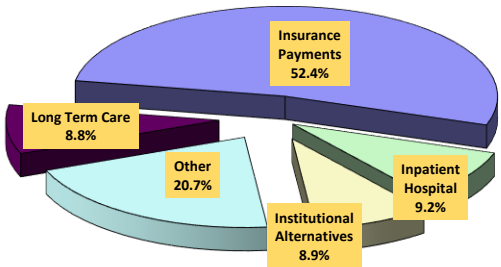
1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2017, 71.6 million of the projected 326.6 million in the total U.S. population will be enrolled in Medicaid for the equivalent of a full year during FY 2017. In FY 2017, Medicaid is projected to provide coverage to more than one out of every five people in the nation.

CMS projects that in FY 2017, non-disabled children and adults under age 65 will represent 77 percent of the Medicaid population (compared to 74 percent in FY 2012), but account for approximately 43 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 over 23 percent of the Medicaid population, yet account for approximately 56 percent of the non-DSH, benefit outlays on the U.S. mainland. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services

FY 2017 STATE ESTIMATES OF BENEFITS



As displayed in the table on the following page, the state estimates for medical assistance payments increased from $362.7 billion for FY 2016 to $365.0 billion for FY 2017.

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 $190.2 billion in funding for FY 2017 representing 65.4 percent of the state-submitted benefit estimates for FY 2017. The

second largest FY 2017 Medicaid category of service is inpatient hospital. It is composed of regular payments to both inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($9.8 billion or 3.4 percent) and mental health facilities. The states have submitted FY 2017 estimates totaling $33.7 billion or 11.6 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2017 are institutional alternatives. It is composed of personal care, home health, and home and community-based services. The states have submitted FY 2017 estimates totaling $32.5 billion or 11.2 percent of Medicaid benefits. Together these three benefit service categories for health insurance payments, inpatient hospital and institutional alternatives account for over 88.2 percent of the state-estimated cost of the Medicaid program for FY 2017.

Estimated Benefit Service Growth, FY 2016 to FY 2017
November 2015 State-Submitted Estimates and Actuarial Adjustments
(Dollars in Thousands)

Major Service Category	Est. FY 2016	Est. FY 2017	Dollar Growth	Annual 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)	$187,136,143	$191,216,365	$4,080,222	2.20%	174.30%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$32,553,126	$32,469,218	($83,908)	-0.30%	-3.60%
Other (Targeted case management, hospice, all other services, and collections)	$27,351,171	$27,501,727	$150,556	0.60%	6.40%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$31,100,498	$32,013,211	$912,713	2.90%	39.00%
Outpatient Hospital	$9,988,505	$9,615,783	($372,717)	-3.70%	-15.90%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$4,998,987	$5,177,598	$178,611	3.60%	7.60%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$35,971,629	$33,677,970	($2,293,659)	-6.40%	-98.00%
Physician/Practitioner/Dental	$13,854,367	$13,867,122	$12,755	0.10%	0.50%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$9,526,041	$9,650,035	$123,994	1.30%	5.30%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$10,209,570	$9,841,992	($367,578)	-3.60%	-15.70%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$362,690.04	$365,031,026	$2,340,989	0.60%	100.00%

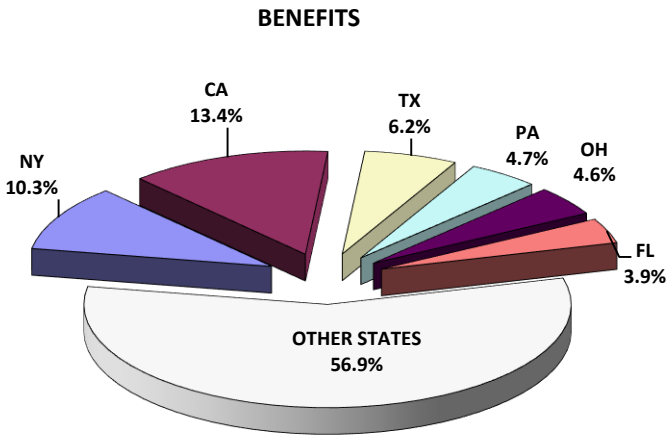
Note: This table reflects current law estimates.

Distribution of Medicaid Funding

The total FY 2017 state-submitted estimates for Medicaid are $381.5 billion, composed of $364.1 billion for Medicaid medical assistance payments and $17.4 billion for state and local administration.

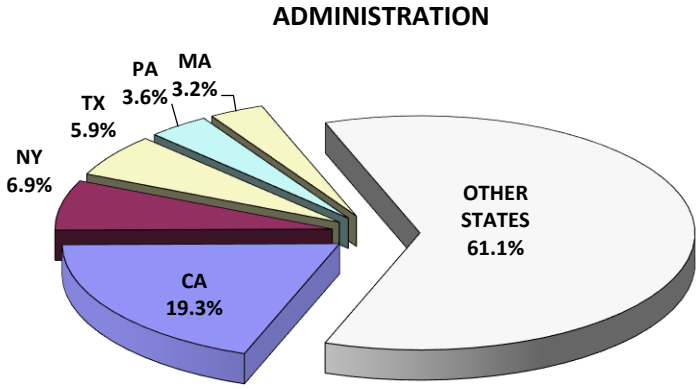
Distribution of Benefit Funding

As displayed, California, New York, Texas, Pennsylvania, Ohio and Florida account for $119.8 billion, or over 43 percent, of the state-submitted estimates for benefits for FY 2017. Ten states represent over 46 percent of these estimates.



Distribution of State and Local Administration Funding

The state-submitted estimates for FY 2017 state and local administration represents about 4.4 percent of the total state-submitted estimates for Medicaid costs for FY 2017. As displayed, California, New York, Texas, Pennsylvania, and Massachusetts account for $6.2 billion or more than 38 percent of the FY 2017 estimates for state and local administration. Ten states represent over 54 percent of these estimates.



Budget Request

CMS estimates its FY 2017 appropriation request for Grants to States for Medicaid is $377.6 billion, an increase of $20.8 billion relative to the FY 2016 level of $356.8 billion. This appropriation is composed of $115.6 billion in authorized advance appropriation for FY 2017 and a remaining appropriation of $262.0 billion for FY 2017.

Resources will fund $378.5 billion in anticipated FY 2017 Medicaid gross obligations. These obligations are composed of:

- $354.2 billion in Medicaid medical assistance benefits;
- $1.0 billion for benefit obligations incurred but not yet reported;
- $19.0 billion for Medicaid administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and

- $4.4 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 CMS using Medicaid expenditure data as recent as the first quarter of FY 2016. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2017 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $376.6 billion in FY 2017. This represents an increase of 2.6 percent relative to the estimated net outlay level of $367.2 billion for FY 2016. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 2.4 percent during FY 2017, which includes the impact of Medicaid expansion enrollment.

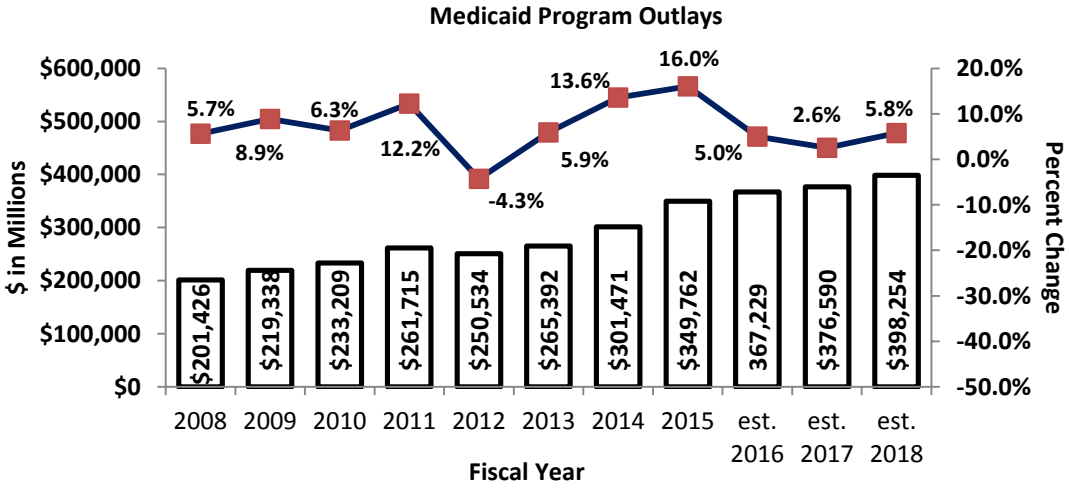
Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2015 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 2015 state estimates for MAP in FY 2017 are the first state-submitted estimates for FY 2017. 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.

CMS' OACT developed the MAP estimate for FY 2017. Using the last three quarters of FY 2015 state-reported expenditures as a base, expenditures for FY 2016 and FY 2017 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 2015 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 FY 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 ushered in major improvements to health care coverage, cost and quality for all Americans. The largest change occurred in 2014 which included 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 increased in FY 2015 due to large increases in enrollment among newly eligible individuals whose medical assistance expenditures were reimbursed at 100 percent Federal match. The newly eligible Federal match rate remains at 100 percent in calendar years 2015 and 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 beyond FY 2016, expenditures are projected to continue to grow accordingly.

In 2016, 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 established 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. CMS 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 and 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 bulletins, 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.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Recent Legislation

- Protecting Americans from Tax Hikes Act of 2015 (P.L. 114-40)

- Bipartisan Budget Act of 2015 (P.L. 114-74)

- National Defense Authorization Act for Fiscal Year 2016 (P.L. 114-92)

- Consolidated Appropriations Act, 2016 (P.L. 114-113)

- Patient Access and Medicare Protection Act (P.L. 114-115)

In additional to the above-mentioned legislation, CMS' estimates were adjusted to assume the following proposed regulations are finalized:

- Medicaid and CHIP Managed Care Proposed Rule (CMS-2390-P)

- The Application of Mental Health Parity Requirements to Medicaid and CHIP (CMS-2333-P)

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2017 savings are $108 million)

Financial management (FM) reviews conducted by CMS are expected to produce additional savings of $108 million in FY 2017. 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 2017 estimate of $996 million represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2016 to September 30, 2017. 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.

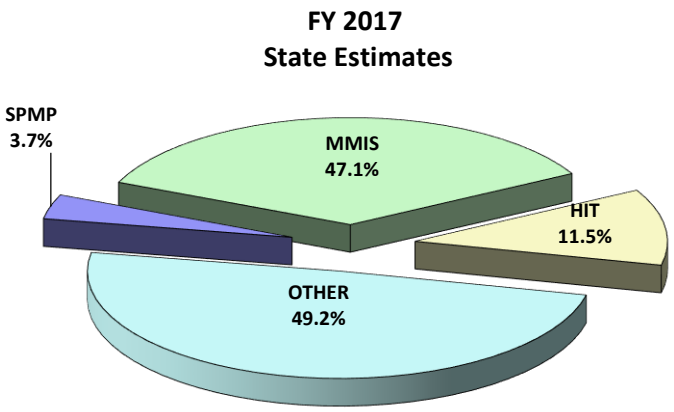
Vaccines for Children (VFC) Program

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 2017 estimate for the VFC program is $4.4 billion, which is $225.9 million above the FY 2016 estimate. This estimate includes an increase for vaccine-purchase contract costs and additional quality assurance and quality improvement site visits to VFC-enrolled providers. 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 coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2017, based on recent actual data and the November 2015 state estimates, CMS estimated the Federal share of state and local administration costs to be $18.9 billion. This estimate is composed of $18.4 billion for Medicaid state and local administration and $0.5 billion in additional funds for Medicaid state survey and certification and state Medicaid fraud control units.



In November 2015 the states estimated the Federal share of state and local administration outlays to be $18.4 billion for FY 2017. State and Local Administration monies provide funding for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems; non-MMIS automated data processing activities; ARRA authorized Health Information Technology Incentive program; skilled professional medical personnel (SPMP); salaries, fringe benefits, and 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 2017 state-submitted estimates of $18.9 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates. These estimates were adjusted to reflect the estimated costs of 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 2017 estimate for state and local administration remains $18.9 billion.

Health Information Technology Meaningful Use Incentive Program

The current FY 2017 estimate for provider incentives payments is $974.2 million. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs), The American Recovery and Reinvestment Act of 2009 (ARRA) authorizes Medicaid to 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 home health agencies and intermediate care facilities for individuals with intellectual disabilities in FY 2017 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2017 estimate for Medicaid state survey and certification is $291 million. This represents an increase of $6 million above the current FY 2016 estimate of $285 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 33,500 Medicaid participating facilities with nearly 24,500 health and life safety code annual certifications, as well as over 55,800 complaint survey investigations; direct state survey costs associated with nursing home and home health agency quality.

State Medicaid Fraud Control Units (MFCUs)

In FY 2017, state Medicaid fraud control unit operations are currently estimated to require $256.2 million in Federal matching funds. This represents an increase of $12.5 million over the FY 2016 funding level of $243.7 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 2015, states reported $745 million in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

FY 2017 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate	Difference +/- 2016
Alabama	$3,815,045	$4,228,202	$4,244,829	$16,627
Alaska	$713,184	$1,060,996	$1,060,996	$0
Arizona	$8,096,247	$9,057,266	$9,530,592	$473,326
Arkansas	$4,566,258	$5,363,228	$5,497,699	$134,471
California	$56,718,405	$55,158,572	$51,911,674	-$3,246,898
Colorado	$4,654,380	$5,063,899	$5,015,922	-$47,996
Connecticut	$4,489,582	$4,582,253	$4,697,747	$115,494
Delaware	$1,235,491	$1,384,096	$1,459,036	$74,940
District of Columbia	$1,852,865	$2,156,918	$2,227,941	$71,023
Florida	$13,242,517	$13,964,879	$14,816,363	$851,484
Georgia	$6,923,753	$6,760,281	$6,675,498	-$84,783
Hawaii	$1,350,700	$1,511,312	$1,505,660	-$5,652
Idaho	$1,305,845	$1,426,622	$1,528,448	$101,826
Illinois	$10,784,849	$8,951,164	$10,022,979	$1,071,815
Indiana	$6,651,152	$9,310,021	$8,844,527	-$465,494
Iowa	$2,999,271	$3,273,678	$3,493,723	$220,045
Kansas	$1,834,014	$2,036,981	$2,042,067	$5,086
Kentucky	$7,678,885	$8,500,784	$8,698,419	$197,635
Louisiana	$5,115,715	$5,611,326	$5,713,288	$101,962
Maine	$1,647,792	$1,729,074	$1,767,526	$38,452
Maryland	$5,937,288	$6,150,223	$6,548,003	$397,780
Massachusetts	$9,117,269	$10,215,520	$9,658,326	-$557,194
Michigan	$12,017,163	$13,481,742	$12,908,713	-$573,029
Minnesota	$6,630,652	$7,036,878	$7,364,525	$327,647
Mississippi	$3,923,916	$4,227,529	$4,279,341	$51,812
Missouri	$6,317,848	$6,789,301	$6,910,308	$121,007
Montana	$821,101	$816,994	$834,514	$17,520
Nebraska	$1,077,254	$1,062,547	$1,095,480	$32,933
Nevada	$2,454,119	$2,672,745	$2,552,113	-$120,632
New Hampshire	$1,102,460	$1,307,665	$1,347,374	$39,709
New Jersey	$9,086,088	$9,351,823	$9,725,370	$373,547
New Mexico	$4,004,881	$4,689,065	$4,714,555	$25,490

FY 2017 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate	Difference +/- 2016
New York	$32,796,826	$38,358,580	$38,523,945	$165,365
North Carolina	$9,228,227	$9,699,984	$10,248,049	$548,065
North Dakota	$328,552	$939,767	$947,413	$7,646
Ohio	$15,332,585	$16,223,349	$17,418,369	$1,195,020
Oklahoma	$3,145,567	$3,382,730	$3,325,345	-$57,385
Oregon	$6,577,879	$7,758,965	$7,978,100	$219,135
Pennsylvania	$13,535,031	$18,195,140	$17,616,263	-$578,877
Rhode Island	$1,629,406	$1,798,758	$1,826,297	$27,539
South Carolina	$4,254,978	$4,576,918	$4,928,208	$351,290
South Dakota	$489,006	$500,872	$543,286	$42,414
Tennessee	$6,345,844	$7,097,070	$7,273,070	$409,504
Texas	$21,402,568	$23,836,973	$23,595,640	-$241,333
Utah	$1,630,660	$1,846,548	$1,957,450	$110,902
Vermont	$1,016,749	$1,255,021	$1,224,382	-$30,639
Virginia	$4,399,927	$4,742,423	$4,905,618	$163,195
Washington	$7,175,800	$9,230,698	$9,560,892	$330,194
West Virginia	$2,929,204	$3,227,817	$2,967,599	-$260,218
Wisconsin	$4,850,942	$5,252,265	$5,378,674	$126,409
Wyoming	$329,118	$354,926	$358,221	$3,295
Subtotal	**$345,386,643**	**$377,212,388**	**$378,093,362**	**$996,974**
American Samoa	$20,696	$16,408	$16,408	$0
Guam	$48,978	$51,042	$51,042	$0
Northern Mariana Islands	$15,839	$19,286	$19,286	$0
Puerto Rico	$1,521,507	$1,604,051	$1,556,290	-$47,761
Virgin Islands	$27,701	$39,548	$34,872	-$4,676
Subtotal	**$1,634,721**	**$1,730,335**	**$1,677,898**	**-$52,437**
Total States/Territories	**$347,021,364**	**$378,942,723**	**$379,887,260**	**$944,537**
Survey & Certification	$244,868	$285,000	$291,000	$6,000
Fraud Control Units	$108,590	$243,715	$256,194	$12,479
Vaccines For Children	$3,845,486	$4,160,728	$4,386,584	$225,856

FY 2017 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate	Difference +/- 2016
Incurred But Not Reported	$0	$1,520,000	$996,000	-524,000
Adjustments	$26,927,733	-$16,399,946	-$9,279,369	$7,120,577
TOTAL RESOURCES	**$378,896,667**	**$369,621,218**	**$378,552,665**	**$8,931,447**

[1] Represents current law baseline projections of obligations.

Medicaid Program
Budget Authority by Object
(Dollars in Thousands)

	2016 Estimate	2017 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$364,245,492	$373,199,885	$8,954,671
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$4,160,726	$4,386,584	$225,858
Total Budget Authority	$368,406,218	$377,586,469	$9,180,529

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.

CHIP3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in Medicaid and CHIP: 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 ACA provided CHIP funding through FY 2015 and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019. In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, which extends CHIP funding for an additional two years, through September 30, 2017.

This measure should be considered in the context of 2013 data that show that in 23 states at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[1] In contrast, in 2008 five states had rates at or above 90 percent. Many factors will affect enrollment figures in CHIP and Medicaid, including states' economic situations, programmatic changes, and the accuracy and timeliness of state reporting. There have also been key legislative changes in recent years, with policy changes directed at eligibility and enrollment. In previous years, CMS set separate targets for Medicaid and CHIP. Beginning in FY 2013, we began to track combined Medicaid and CHIP enrollment. In 2014, 43,689,824 children were enrolled in Medicaid and CHIP for at least one month of the year, falling short of our target of 46,617,385 children (Medicaid 38,083,596/CHIP 8,533,789). The FY 2017 target is to increase CHIP and Medicaid enrollment to 46,062,581 children, (Medicaid: 36,850,065/CHIP: 9,212,516).

MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary state collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and states, CMS 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 December 2014, CMS retired one measure, "Percentage of eligibles that

[1] http://www.insurekidsnow.gov/professionals/reports/index.html

received dental treatment services", and added two measures: "Dental sealants for 6-9 year old children at elevated caries risk"; and "Child and adolescent major depressive disorder: suicide risk assessment".[2]

While the use of the Child Core Set is voluntary for states, CMS encourages all states to use the Child Core Set to collect and report data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2014, 88 percent of states reported on at least eight quality measures, falling just short of our target to have 90 percent of states report on at least eight quality measures in the Children's Core Set. The FY 2017 target is to work with States to ensure that 90 percent of States report on at least eleven measures in the Child Core Set.

In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which extends funding for the Pediatric Quality Measures Program by appropriating an additional $20 million in funding through FY 2017. 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, as well as one-on-one calls with states, 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.

MCD7 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. From FFY 2000 to FFY 2012, the number of Medicaid-enrolled children, ages 1-20, accessing dental services nationally increased 166 percent from 6.3 million to 16.9 million. [3]. Between FFY 2007 and FFY 2014, thirty states achieved at least a 10 percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year.[4] 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 2014 target of 49 percent, with an actual result of 45 percent. Many factors likely

[2] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf
[3] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/dental-trends-2000-to-2012.pdf
[4] The definition of "preventive dental service" differs in this cited analysis from that used in the GPRA goal. The cited analysis includes only preventive dental services performed by, or under the supervision of, a dentist. The GPRA goal includes all preventive dental and oral health services, including those performed by dental professionals not under the supervision of a dentist as well as primary care medical professionals. http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf

contributed to the failure to meet the targets, including staff and resource capacity deficits in states and the inherent complexity of the task. The FY 2017 target is to increase the national rates of preventive dental service to 47 percent, 4 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 (MCD6), 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 includes measures like "Controlling High Blood Pressure" and "Flu Shots for Adults Ages 50 to 64". Findings from state reporting on the Adult Core Set are published in the Secretary's Annual Report on the Quality of Health Care for Adult Enrolled in Medicaid.[5] In December 2014, CMS retired the "Comprehensive Diabetes Care: LDL-C Screening" measure, and added the "Comprehensive Diabetes care: Hemoglobin A1c Poor Control (>9.0 percent)" measure. In FY 2014, 67 percent of states reported on at least five quality measures, exceeding our target to have 65 percent of states reporting on at least five quality measures. The FY 2017 target is to work with states to ensure that 75 percent of states report on at least eleven 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.

MCD9 Improve Capacity to Evaluate 1115 Demonstration Programs: Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant waivers of the Act to states to test innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). States are using 1115 demonstration authority to achieve Medicaid reform through alternative models of service delivery and/or financing aimed at improving the quality of their Medicaid programs and the capacity to serve more people. CMS is making significant investments in these types of demonstrations in order to study results on state based and national levels. However, there is no automated system for data collection of performance metrics, analytics, or reporting to assess quality performance of demonstrations. Additionally, demonstration information provided by states is not captured in a manner that easily permits data collection or manipulation to support program management, oversight, monitoring or evaluation. CMS is focused on improving the quality of evaluations of section 1115 demonstrations through a more automated process that will improve federal monitoring of section 1115 demonstration progress and performance. This initiative aligns with the Agency's Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP related data from states in support of better program oversight, administration, and program integrity; and will be designed for eventual incorporation into MACPro. The FY 2017 target is the submission of data in the reporting platform from a minimum of eight active demonstrations.

[5] http://medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html#SR

MCD10 - Improve Access for People with Disabilities and Older Adults, by Increasing the Proportion of Public Funding Directed to Home and Community-Based Services (HCBS) as a Portion of Long-Term Services and Supports (LTSS) Expenditures: There is evidence that home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries. While services can be provided under many different authorities, most are provided under §1915(c) waivers, which are required to limit aggregate HCBS costs to less than or equal to the average institutional service cost the individual would otherwise receive.

The Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in the community, including a new Community First Choice 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"; and an extension of the "spousal impoverishment" protections to people who receive HCBS. We believe that the new opportunities made available through the Affordable Care Act will further enhance state offerings in HCBS. These programs are driving HCBS expenditures which account for many of the cost effective alternatives to care for individuals. In federal fiscal year (FFY) 2013, Medicaid spent $146 billion on LTSS, which represented 34 percent of all Medicaid spending.[6]

CMS is facilitating state efforts to increase expenditures for beneficiaries receiving HCBS, instead of institutional care, through: the Balancing Incentive Program that provides enhanced funding for structural changes to improve the delivery of HCBS; a revised application process for §1915(c) HCBS waivers, including a web-based application and published, consistent, review criteria; education and technical assistance outreach to help states implement §1915(i) HCBS; enhanced funding and technical assistance under MFP to reinforce and increase state efforts to serve beneficiaries with quality HCBS rather than institutional care; enhanced federal funding for individuals receiving services under the 1915(k) Community First Choice option and, technical assistance and education for states concerning other authorities for HCBS.

The HCBS expenditures have increased by one to three percent per year over the past decade. The Medicaid Budget and Expenditure System (MBES) is used by CMS to capture state expenditures as reported on a quarterly basis. In recent years expenditures have slowed due in large part to the presence of state budget deficits that have reduced the capacity of state governments to appropriate additional funds to serve new waiver participants.

The expenditure growth reflects the percentage of State and Federal funds that will be targeted to beneficiaries who received home and community-based services in the out years. Managed long-term care services and supports (MLTSS) expenditures will initially be estimated in total based on state reporting though a CMS contractor initially. CMS expects to meet or exceed targets by supporting the development of the new programs available under the Affordable Care Act.

[6] Mathematica Policy Research, Inc. and the Centers for Medicare & Medicaid Services (CMS), Medicaid Expenditures for Long-Term Services and Supports in FFY 2013, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf

In FY 2020, CMS targets that 65 percent of long-term expenditures be spent on HCBS as a base outcome, which will be further refined over the coming years to ensure that the growth represents quality outcomes for individuals receiving HCBS. CMS believes that it is important to create a balance of expenditures on a state by state basis. We met the FY 2013 target to increase the percentage of Medicaid spending on LTSS for HCBS to 51 percent. The FY 2017 target is to increase the percentage of Medicaid spending on long-term services and supports for HCBS to 59 percent. We fell short of our 2013 target to have 27 states and the District of Columbia (52.9 percent) utilize at least 50 percent of Medicaid spending on long-term services and supports for HCBS, when 25 states (49 percent) and DC utilized at least 50 percent of Medicaid spending on LTSS for HCBS. The FY 2017 target is for 41 states to utilize at least to 50 percent of Medicaid spending on LTSS for HCBS.

Key Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY2016
CHIP3.3[7] Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid and CHIP FY 2008: 37,311,641 children (baseline)	FY 2014: 43,689,824 children[8] Target: 46,617,385 children (Target Not Met)	45,271,662 children	46,062,581 children	+790,919 children
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2014: 88% of States reported on at least eight quality measures Target: Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA core set of quality measures (Target Not Met)	Work with States to ensure that 90% of States report on at least ten quality measures in the CHIPRA Children's core set of quality measures	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA Children's core set of quality measures	+1 quality measure

[7] The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

[8] The Medicaid and CHIP breakout is not currently available, as one large State reported an unduplicated Medicaid and CHIP combined total, but did not report unduplicated individual totals for Medicaid and CHIP.

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY2016
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid, who receive any preventive dental service.	FY 2014: 45%/ +2 percentage points over FY 2011 baseline/ Target: 49% +6 percentage points over FY 2011 baseline (Target Not Met)	46%	47%	+1 pp
MCD8: Improve Adult Health Care Quality Across Medicaid	FY 2014: 67% of States reported on at least five quality measures. Target: Work with States to ensure that 65% of States report on at least five quality measures in the Affordable Care Act Adult Medicaid core set of quality measures (Target Exceeded)	Work with States to ensure that 70% of States report on at least nine quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 75% of States report on at least eleven quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	+2 quality measures
MCD9: Improve Capacity to Evaluate 1115 Demonstration Programs	New for FY 2016	Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission.	Submission of data in the reporting platform from a minimum 8 active demonstrations	N/A
MCD10.1: Increase the Percentage of Medicaid Spending on Long-Term Services and Supports for Home and Community-Based Services (HCBS) to 65 percent by 2020	FY 2013: 51% Target: 51% (Target Met)	57%	59%	+2 pp

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY2016
MCD10.2: Increase the Number of States that Utilize at Least 50 Percent of Medicaid Spending on Long-Term Services and Supports for Home and Community-Based Services	FY 2013: 25 States and the District of Columbia Target: 27 States and the District of Columbia Target Not Met, But Improved	38 States and the District of Columbia	41 States and the District of Columbia	+3 States

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, [$283,171,800,000] $299,187,700,000.

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, $299,187,700,000.	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 for general fund resources for Part D prescription drug benefit payments in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds

Amounts Available for Obligation

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Appropriation: Annual	$259,212,000	$283,171,800	$299,187,700	$16,015,900
Indefinite Annual Appropriation, for SMI Premium Match	---	---	---	---
Indefinite Annual Appropriation, for Part D Benefits	+$9,000,000	---	---	---
Lapse in Supplemental Medical Insurance	($5,994,794)	---	---	---
Lapse in General Revenue Part D: Benefits	---	---	---	---
Lapse in General Revenue Part D: Federal Administration	---	---	---	---
Lapse in Program Management	---	---	---	---
Lapse in Transfer for HCFAC Reimbursement	---	---	---	---
Lapse in State Low Income Determination	($6,000)	---	---	---
Total Obligations	$262,211,206	$283,171,800	$299,187,700	$16,015,900

Payments to the Health Care Trust Funds
Summary of Changes
(Dollars in Thousands)

2016 Enacted
Total Budget Authority - $283,171,800,000

2017 President's Budget
Total Budget Authority - $299,187,700,000
Net Change, Total Appropriation - $16,015,900,000

Changes	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Federal Payment for Supplementary Medical Insurance SMI)	$194,343,000,000	$198,530,000,000	$214,944,000,000	$16,414,000,000
Indefinite Annual Appropriation, SMI	---	---	---	---
Hospital Insurance for Uninsured Federal Annuitants	$187,000,000	$158,000,000	$147,000,000	($11,000,000)
Program Management Administrative Expenses	$763,000,000	$1,044,000,000	$877,500,000	($166,500,000)
General Revenue for Part D (Drug) Benefit	$63,342,000,000	$82,453,000,000	$82,512,000,000	$59,000,000
Indefinite Annual Appropriation, Part D Benefits	$9,000,000	---	---	---
General Revenue for Part D Federal Administration	$418,000,000	$691,000,000	$405,000,000	($286,000,000)
Part D: State Low-Income Determination	$6,000,000	$4,800,000	$3,200,000	($1,600,000)
Reimbursement for HCFAC	$153,000,000	$291,000,000	$299,000,000	$8,000,000
Net Change	$268,212,000,000	$283,171,800,000	$299,187,700,000	$16,015,900,000

Payments to the Health Care Trust Funds
Budget Authority by Activity
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Supplementary Medical Insurance (SMI)	$194,343,000	$198,530,000	$214,944,000	$16,414,000
Indefinite Annual Appropriation, SMI	---	---	---	---
Hospital Insurance for Uninsured Federal Annuitants	$187,000	$158,000	$147,000	($11,000)
Program Management Administrative Expenses	$763,000	$1,044,000	$877,500	($166,500)
General Revenue for Part D Benefit	$63,342,000	$82,453,000	$82,512,000	$59,000
Indefinite Annual Appropriation, Part D Benefits	$9,000,000	---	---	---
General Revenue for Part D Federal Administration	$418,000	$691,000	$405,000	($286,000)
Part D: State Low-Income Determination	$6,000	$4,800	$3,200	($1,600)
Reimbursement for HCFAC	$153,000	$291,000	$299,000	$8,000
Total Budget Authority	$268,212,000	$283,171,800	$299,187,700	$16,015,900

Payments to the Health Care Trust Funds
Authorizing Legislation
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budgt	FY 2017 +/- FY 2016
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)	$268,212,000	$283,171,800	$299,187,700	$16,015,900
Total Budget Authority	$268,212,000	$283,171,800	$299,187,700	$16,015,900

Annual Budget Authority by Activity

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$268,212,000	$283,171,800	$299,187,700	$16,015,900

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 for 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, including costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

Program Management Administrative Expenses, including 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).

The Health Care Fraud and Abuse Control (HCFAC) account, including program integrity activities for 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.

Federal Contribution for SMI, consisting of 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 generally set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries, including a sufficient contingency margin. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled

beneficiaries. Section 601 of the Bipartisan Budget Act of 2015 (P.L. 114-74) required an adjustment to the calculation of the Part B premium for calendar year 2016 to mitigate a large increase that would otherwise have occurred. It also provided a temporary increase in the general fund's contribution to SMI, to account for resulting lost Part B premium revenue. This temporary increase will be paid back to the Treasury from SMI premiums over the coming few years.

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 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 2013	$234,228,577,491
FY 2014	$255,185,000,000
FY 2015	$268,212,000,000
FY 2016 Enacted	$283,171,800,000
FY 2017 PB	$299,187,700,000

Budget Request

Hospital Insurance for the Uninsured Federal Annuitants:

The FY 2017 President's Budget of $147.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $11.0 million under the FY 2016 enacted amount of $158.0 million.

Program Management Administrative Expenses:

The FY 2017 President's Budget amount of $877.5 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare Trust Fund activities, is a net decrease of $166.5 million under the FY 2016 enacted amount of $1,044.0 million. Administrative expense changes primarily represent the implementation costs of the marketplaces.

Federal Contribution for SMI:

The FY 2017 President's Budget of $214.9 billion for the FY 2017 Federal Contribution for SMI is a net increase of $16.4 billion over the FY 2016 enacted of $198.5 billion. The cost of the Federal match continues to rise from year to year because of beneficiary population and program cost growth.

General Revenue for Part D (Benefits):

The FY 2017 President's Budget of $82.5 billion for General Revenue for Part D (Benefits) is a net increase of $59.0 million above the FY 2016 enacted amount of $82.4 billion. Much like the SMI Federal Contribution, this benefit contribution rises with Part D Prescription Drug program population and cost growth.

General Revenue for Part D Federal Administration:

The FY 2017 President's Budget of $405.0 million for General Revenue for Part D Federal Administration is a net decrease of $286.0 million under the FY 2016 enacted amount of $691.0 million. These are annually revised estimates of the Part D share of Program Management and Social Security Administration.

General Revenue for Part D State Eligibility Determinations:

The FY 2017 President's Budget of $3.2 million is a net decrease of $1.6 million under the FY 2016 enacted of $4.8 million.

Reimbursement for HCFAC:

The FY 2017 President's Budget of $299.0 million for Reimbursement of HCFAC is a net increase of $8.0 million above the FY2016 enacted amount of $291.0. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI trust funds, but which are properly chargeable to the general funds. The FY 2017 request reflects the estimated Medicare non-trust fund burdens only.

Permanent Budget Authority
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Tax on OASDI Benefits	$20,208,000	$23,208,000	$25,987,000	$2,779,000
SECA Tax Credits	---	---	---	---
HCFAC, FBI	$129,217	$130,303	$141,488	$11,185
HCFAC, Asset Forfeitures	$14,792	$29,000	$30,000	$1,000
HCFAC, Criminal Fines	$56,549	$550,000	$590,000	$40,000
HCFAC, Civil Penalties and Damages: Administration	$15,362	$31,500	$32,000	$500
Total BA	$20,423,920	$23,948,803	$26,780,488	$2,831,685

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 the 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
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Grants, subsidies and contributions: Non-Drug	$194,343,000	$198,530,000	$214,944,000	$16,414,000
Indefinite Annual Appropriation	---	---	---	---
Grants, subsidies and contributions: Drug	$63,342,000	$82,453,000	$82,512,000	$59,000
Indefinite Annual Appropriation, Part D Benefits	$9,000,000	---	---	---
Insurance claims and indemnities	$187,000	$158,000	$147,000	($11,000)
Administrative costs-General Fund Share	$1,334,000	$2,026,000	$1,581,500	($444,500)
General Revenue Part D: State Eligibility Determinations	$6,000	$4,800	$3,200	($1,600)
Total Budget Authority	$268,212,000	$283,171,800	$299,187,700	$16,015,900

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, [$681,000,000] $725,000,000, to remain available through September 30, [2017] 2018, 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 [$486,120,000] $486,936,000 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 [$67,200,000] $121,824,000 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)(C) of such Act, [of which $67,200,000 shall be for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities,]; and of which [$60,480,000] $116,240,000 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 [2016] 2017 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: Provided further, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 985, as amended, and [$370,000,000] $414,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act. Provided further, That the Secretary shall support the [full cost of the] Senior

Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account. (Department of Health and Human Services Appropriations Act, 2016.)

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$681,000,000] $725,000,000, to remain available through September 30, [2017] 2018, 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 [$486,120,000] $486,936,000 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 [$67,200,000] $121,824,000 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)(C) 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 [$60,480,000] $116,240,000 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.
Provided further, That the Secretary shall support the [full cost of the] Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account.	Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat health care fraud and abuse.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Discretionary				
CMS Program Integrity	$544,320	$553,320	$486,936	($66,384)
OIG	$67,200	$67,200	$121,824	$54,624
DOJ	$60,480	$60,480	$116,240	$55,760
Subtotal, Discretionary	$672,000	$681,000	$725,000	$44,000
Mandatory				
CMS Program Integrity	$863,773	$866,475	$881,541	$15,066
FBI	$129,217	$130,303	$141,488	$11,185
OIG	$186,066	$187,617	$200,273	$12,656
DOJ Wedge	$58,095	$58,579	$62,531	$3,952
HHS Wedge	$35,587	$35,884	$38,305	$2,421
Subtotal, Mandatory	$1,272,738	$1,278,858	$1,324,138	$45,280
Total Funding	**$1,944,738**	**$1,959,858**	**$2,049,138**	**$89,280**

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817(k)

FY 2016 Authorization – Public Law 104-191 and Public Law 114-113

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 (BCA) created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. The passage of the Consolidated and Further Continuing Appropriations Act of FY 2015 was the first time the HCFAC cap adjustment was appropriated.

The budget proposes to continue funding discretionary cap adjustments aligned with the BCA for the Department of Health and Human Services (HHS) and the Department of Justice (DOJ). This level of funding will ensure HHS and the DOJ have the resources that they need to conduct necessary program integrity activities and make certain that the right people, receive the right payment, for the right reason, at the right time. Billions of dollars in savings over the next ten years, from curtailing improper payments can be realized, if consistent, additional funding for program integrity is provided.

Fighting health care fraud is a top priority for the Administration. In particular, CMS has made it a priority to decrease program payment error rates and increase the program integrity return on investment. Through the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a Cabinet-level commitment to combat health care fraud, waste, and abuse, CMS, HHS-OIG and DOJ carry out a coordinated program to reduce fraud and recover taxpayer dollars. Each HEAT partner plays a critical role in this effort to reduce Medicare and Medicaid fraud, waste and abuse, including the Medicare Fraud Strike Force, CMS's enhanced provider screening and fraud prevention endeavors, the OIG's investigative, audit, evaluation, and data analytic work, and DOJ's investigative and prosecutorial activities and tougher sentencing guidelines. Together, these efforts root out existing fraud and abuse and act as a deterrent for potential future bad actors. This collaboration continues to demonstrate positive results, yielding a $7.7 to $1 return on investment (ROI) for law enforcement and detection efforts in FY 2014.

The HCFAC cap adjustment provided in the Consolidated Appropriations Act, 2016 (P.L 114-113) allows HHS and DOJ to enhance existing, successful healthcare fraud prevention and law enforcement efforts by investing more in proven anti-fraud and abuse strategies. Although the final level of the cap adjustment in 2016 increased from 2015 in nominal terms, the final level was less than the Administration's request for the full allowable cap adjustment by $25 million, respectively. The HCFAC cap adjustment was fully funded at the level in the BBEDCA in 2015. Continuing to fund these efforts in FY 2017 up to the full cap adjustment, as requested in this Budget, will support enhancements in interagency HEAT efforts, strike a proper balance between prevention and enforcement, and return billions of dollars to the federal government.

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, 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. 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.

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 both Federal oversight and support for the program integrity efforts of state Medicaid programs. These activities enhance the Federal-State partnership.

Since its inception in 1997, HCFAC has grown steadily and has returned over $27.8 billion to the Medicare Trust Funds. The 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. Again, the ROI for the HCFAC program (2012-2014) is $7.70 for every $1.00 expended. Since the annual ROI can vary depending on the number of cases that are settled or adjudicated during a given 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).

Strike Forces are located in nine areas: Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; and Dallas TX. Since their inception in March 2007, Strike Force operations have charged more than 2,097 defendants who collectively have falsely billed the Medicare program for more than $6.5 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 authorization. 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– Established a contractor focused on conducting site visits (except for durable medical equipment suppliers) to increase efficiency and standardization of site visits performed in support of various program integrity initiatives.

- Enrollment Revalidation Project – CMS completed the initial revalidation of enrollment for all 1.6 million existing Medicare suppliers and providers in FY 2015. The provider/supplier revalidation effort is ongoing and will continue in FY 2016.

- Sharing of Information about Terminated Providers – CMS will continue the implementation of a standardized process to support the exchange of information between Medicare, State Medicaid programs, and Children's Health Insurance Program (CHIP) about providers and suppliers terminated for cause from those programs.

- 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, provider data and drug information. The IDR is populated with historical Medicare Parts A, B, C and Durable Medical Equipment (DME) paid claims beginning with FY 2006, along with Part D drug events since Part D's inception. Additionally, Medicare Advantage claims processed are now available in the IDR as well as pre-payment claims data for Medicare Parts A, B and DME beginning with FY 2012. In FY 2016, the IDR will continue evaluating with business owners the possibility of adding additional Medicaid claims, providers, and beneficiary data to the IDR. The IDR will continue to support its current user base, projects, programs, and any future needs that will be introduced, such as the Medicare Access and CHIP Reauthorization Act (MACRA) needs.

CMS has been implementing the anti-fraud provisions of ACA since its enactment. Several final rules have been published, and implementation has begun on a number of important new authorities including, but not limited to: provider screening enhancements, National Provider Identifier (NPI) requirements on enrollment applications, physician ordering and recordkeeping requirements, implementation of the provider enrollment moratoria authority

in limited areas, payment suspensions, the Open Payments program, and provider enrollment requirements.

Funding History

FY 2013	$1,553,327,000
FY 2014	$1,557,367,000
FY 2015	$1,944,738,000
FY 2016	$1,959,858,000
FY 2017 PB	$2,049,138,000

Budget Request

The FY 2017 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The total FY 2017 request is $2.05 billion, $89.3 million above the FY 2016 Enacted Level. The FY 2017 discretionary request is $725.0 million, $44.0 million above the FY 2016 Enacted Level, and in line with the incremental increase included in the BCA.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include performing traditional methods such as Medical Review (MR), Benefits Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education, as well as 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, contractors, law enforcement, and auditors to identify, investigate, and prosecute individuals committing fraud, waste, and abuse.

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 2017, the major initiatives CMS will fund under MIP include Provider Audit, Medicare Secondary Payer, Medical Review, Benefits Integrity, Data Matching, Provider Education and Outreach, and Error Rate Measurement. These activities will be discussed in more detail throughout this section.

CMS Program Integrity Budget Request

The FY 2017 CMS allocation of the discretionary HCFAC request is $486.9 million. A table showing this funding by activity can be found at the end of this chapter.

I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D:

Medicare Drug Integrity Contractor (MEDICs): CMS has a fiduciary responsibility to safeguard the Medicare Part C and Part D programs and the Medicare Trust Fund from fraud, waste and abuse. In FY 2015, the MEDIC focused on the continual development and improvement of their data analysis capabilities to proactively fight fraud, waste and abuse. In order for the MEDIC to improve its ability to perform data analysis, by building potential fraud detecting profiles and algorithms, the MEDIC plans to use FY 2016 and FY 2017 resources to increase its ability to store, mine and manipulate data. In addition, CMS plans to enhance the MEDICs effectiveness by increasing program; oversight, vulnerability detection, audits of Part C and D plan sponsors (focused on identifying improper payments), and revocation activity.

Part C and D Contract/Plan Oversight: In FY 2017, CMS will continue its comprehensive oversight efforts to 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 a number of MA and Part D plan enrollment and compliance processes.

CMS will also continue its efforts to proactively monitor and oversee Part C and D contracts. Areas of assessment will include formulary and benefits, MA and PDP reasons for disenrollment, monitoring of plan websites for adherence to marketing guidelines, pharmacy network adequacy, and adherence to medication therapy management requirements. The MA and PDP reasons for disenrollment survey will help CMS identify possible issues that plans are facing, help inform CMS about beneficiary choice of plans, and help drive quality improvement among plans. For FY 2017, in addition to continuing survey administration, CMS will continue to post these data on Medicare Plan Finder and produce plan-specific reports for quality improvement.

In FY 2017, CMS will continue to enhance HPMS' support of Parts C and D contract plan compliance programs. CMS will move forward with additional releases of the Network Management Module (NMM) to support a wide array of network reviews, such as ongoing analysis of networks used by all renewing organizations and specialized analysis for networks supporting the financial alignment demonstrations, including Medicaid providers. CMS will also implement continued enhancements to the redesigned audit functionality in HPMS, including automating the worksheets that support each core performance area, automating the sampling methodologies for each data universe, expanding overall reporting and extracting capabilities, and supporting iterative corrective action plan (CAP) process. Other enhancements include integrating the review protocols for other types of plans, including the Program for All-Inclusive Care of the Elderly (PACE) and financial alignment demonstration programs.

Additionally, CMS plans to focus on improving the quality of supplemental file submissions for formularies. This focus ensures better coordination of the supplemental files with the main formulary file, enhancing quantity limit validations, and exploring changes to the tier structures. As for the Plan Management Dashboard, CMS will pursue the enhancement of improved key performance indicators and expansion of the new Audit Dashboard to include visual and graphic displays of data. CMS will continue to use a support contract to provide technical and analytic assistance with bid review for about 3,600 plans and 17 million

enrollees.

Monitoring, Performance Assessment, and Surveillance: Under this section, 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 2017, funding will continue to be used to monitor Parts C and D reporting requirement data submission, prepare and analyze submitted data, create Public Use Files (PUF), and conduct Disenrollment Reasons Survey. CMS uses this data and the analytical support to monitor and measure compliance of Medicare Advantage Organizations (MAOs) and Part D sponsors with federal regulations, to ensure that Medicare beneficiaries have access to information about their health and drug plans, and to ensure that beneficiaries are provided with care that is of high quality and is safe, effective and timely. The data is also used in the Star Ratings that impact Part C payments and participation/expansion in both the Part C and D programs.

Additionally, CMS conducts program audits that test a variety of core MA, Part D and PACE program functions to determine whether sponsors provided beneficiaries with the services and medication as required under their contract with CMS. The goal of CMS' audit program not only ensures that our beneficiaries are receiving the services and medications they need and are entitled to receive under the program, but also to drive the industry towards improvements in the delivery of health services in the MA, Part D and PACE programs. In an effort to broaden the scope of their program audits in FY 2015, CMS began developing two additional pilot modules to test plan sponsor compliance with medication therapy management and provider network adequacy requirements, and increased their support of PACE audits.

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 support decision-making about potential major adjustments to Part D payments. Through this contractor, CMS receives, tracks, and analyzes issues raised by plans with respect to reconciliation after its completion, including appeals. This contractor will also 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 multiple iterations of reconciliation simulations to verify each overpayment reported by each of the Part D sponsors. In addition, this project analyzes Prescription Drug Event (PDE) data and other relevant payment information to support correct Part D payment.

In FY 2017, the work of the Reconciliation Support contractor will continue. CMS is anticipating an increase in the volume of data analysis, which requires overpayment analysis and analyses associated with direct and indirect remuneration (DIR), a factor in the Part D reconciliations. CMS will also need to develop a new process for collecting DIR, as the current process can no longer adequately manage the volume of DIR submissions. CMS is also projecting increases in the number of PDE's, PDE's with coverage gap discount amounts, and PDE's that need to be identified to be withheld from the Medicare Coverage Gap Discount Program (CGDP) quarterly invoice processor and additional validation and

analysis. This translates into an increase in the number of correctable rejected PDEs and more time assisting with disputes.

In FY 2012, the agency launched the Encounter Data Processing System (EDPS) to collect encounter data that detail each item and service provided to enrollees of MA organizations. This information is comparable to the data collected on a Fee-For-Service (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. CMS is now in the fourth year of data collection and is increasing efforts to analyze the data to ensure it is complete and accurate for program use. Specifically, the encounter data will enable CMS to pay more accurately because the MA risk adjustment model will be calibrated on MA diagnosis and cost data, and 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.

Finally, CMS has collected the first year of Medical Loss Ratio (MLR) data for both Part C and Part D. This data source will provide new information about MA organizations and their revenue profile. CMS is currently developing and implementing an analysis plan for the first year of data, as well as a strategy for monitoring the submitted MLR data.

Program Audit: Sections 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of the MAOs and PDPs offering plans. These audits enable CMS to review and assess previously submitted information to ensure compliance with program requirements. During the audits, auditors review costs associated with the 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.

CMS also engages in Risk Adjustment Data Validation (RADV) activities, for the purpose of measuring the extent to which inaccurate diagnosis codes impact payment for MA beneficiaries. CMS reviews medical record documentation provided by each audited Medicare Advantage organization to substantiate conditions reported by the Medicare Advantage organizations for beneficiaries in each audit sample.

CMS conducts two major types of RADV projects, the National RADV activities and contract-level audits. The National RADV activities are used to compute an error estimate for the Medicare Part C Program to comply with program reporting requirements set forth in the Improper Payments Information Act of 2002 (IPIA), as 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 contract-level audits are used to calculate an error estimate for specific MA contracts and to make payment adjustments to recover amounts paid to MA organizations for unsupported diagnosis data. These contract-level RADV audits are CMS' primary corrective action to recoup improper payments. CMS intends to conduct 60 audits in FY 2017, which is consistent with the number of audits planned in FY 2016, but twice the number conducted in FY 2015. A sentinel effect on the quality of risk

adjustment data submitted for payment has been observed as MA organizations recognize the potential financial impact of the audits.

In order to be in compliance with IPERIA, CMS also routinely measures and reports a Medicare Part D error rate. This error rate includes the annual validation of a sample of Prescription Drug Event (PDE) data submitted by MA organizations and Part D sponsors for payment.

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 Risk Adjustment System plays a key role in recovering overpayments owed by the plans. The recalculation of prior year factors allows CMS to take back funds returned by plans for prior years. Each calendar year, CMS recalculates factors for at least 5 prior years. This effort has increased with the implementation of Section 6402 of the Affordable Care Act, which established Section 1128J (d) of the Social Security Act entitled "Reporting and Returning of Overpayments" which requires MA organizations to report and return overpayments that they self-identify.

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 two separate IT support service contracts which include the following: (1) systems development, maintenance, and testing services, and (2) 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.

Marketing Material Accuracy, Review and Analysis - 42 CFR Section 422.111(b)(3) requires plans to disclose the number, mix and distribution of providers from whom enrollees may reasonably be expected to obtain services. CMS identified inaccurate online provider directories as a vulnerability that can potentially cause beneficiary harm. MAOs are expected to update online provider directory information in real-time and provide complete information regarding providers who are accepting new patients/enrollees. Medicare beneficiaries rely on the accuracy of such information to select and access contracted providers, and often rely on this information to select a plan. This funding supports CMS' analyses of beneficiary

marketing requirements against required documents like provider directories, and may result in identifying areas of potential non-compliance, in which CMS may take compliance actions. These activities increase CMS' ability to: correlate inaccurate provider directories as an indicator of provider network inadequacy; better understand existing marketing practices of MA and Part D; and strengthen the empirical basis upon which we administer the MA and Part D programs.

II. Program Integrity Staffing and 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 possess 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. In FY 2015, CMS increased its staffing level to support expansion of existing programs and to develop new initiatives in order to support its mission, goals and needs in combating fraud and abuse. The FY 2017 budget request is consistent with this strategy.

III. Program Integrity Initiatives

Advanced Provider Screening (APS): In FY 2013, CMS made significant advancements to automate program integrity and screening checks performed during the enrollment process. In FY 2014, CMS performed data analysis, expanded monitoring of licensure, identity management, and government exclusion information. APS expanded efforts to do additional screening assessments for criminal background checks and CMS expanded the use of the APS monitoring to all Medicare Administrative Contractors (MACs). In FY 2015, APS was reengineered, continued to deploy quarterly releases, and expanded the criminal screening process in order to take administrative action against ineligible providers. In FY 2016, APS will continue to deploy screening enhancements to support more functionality, which will include expansion of criminal and geospatial screening efforts. APS also plans to update provider profiles, which may be used by the Zone Program Integrity Contractors (ZPICs)/Unified Program Integrity Contractors (UPICs) and state programs to make screening data relevant to all program integrity efforts across Medicare and Medicaid. This will allow immediate action to recoup inappropriate payments and prevent fraudulent activities. In FY 2017, these efforts will continue, with a focus on growth in the number of reference data sources used to validate information, as well as increased connectivity and integration with state and other program integrity systems. This project is split-funded between mandatory funding associated with the Medicare Integrity program and HCFAC discretionary funding associated with Medicaid program integrity.

Unified Case Management System: CMS plans to provide a centralized case management capability for the Unified Program Integrity Contractors (UPICs) to use, allowing for a centralized data (via OnePI and the IDR) and analytic capability. This will help ensure that an appropriate case management and analytic capability is in place when the new UPIC contracts are established. In FY 2016, funding will be used for additional development work, which will largely consist of system releases and updates, the migration of legacy system data, full integration with additional CMS systems, and performing help desk services. In FY 2017, CMS will continue to enhance its case management and analytical capabilities for

health care fraud detection and prevention and to improve integration across the Medicare and Medicaid programs with CMS contractors (UPIC's and ZPICs). This will allow CMS to provide more comprehensive, timely and accurate health care fraud prevention modeling and reporting.

OIG Hotline: 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 2016, the OIG Hotline interface will be migrated to a Remedy solution. The justification for the system migration is that Remedy is a Commercial Off-The-Shelf (COTS) trouble ticketing and tracking system, is rated as a high quality Federal Information Security Management Act (FISMA) system, is currently approved as the agencies trouble ticketing system, and can better suit the needs for all stakeholders. The current database is an outdated solution that cannot handle entering tickets as they come in and must be taken offline for several hours once a week to upload newly received cases to the OIG Hotline. This OIG application must be properly maintained and FISMA tested yearly. The Remedy solution provides these benefits which are not part of the current system. After migration, CMS will more quickly and efficiently examine and address waste, fraud and abuse. In FY 2017, funding will be used for continued maintenance of the Hotline.

IV. Prevent Excessive Payments

Fraud Prevention System (FPS): The primary focus of the FPS during the first three implementation years, was identifying providers with the most egregious behavior for investigation by the Zone Program Integrity Contractors (ZPICs). During the third implementation year (FY 2014), CMS tested new and innovative ways to leverage the FPS technology and best practices to support additional fraud, waste, and abuse activities. In future years of the program, CMS will continue to expand and improve models to identify bad actors more quickly, identify leads for early intervention by the Medicare Administrative Contractors and more effectively deny or reject claims that are not supported by Medicare policy. Work will begin in FY 2016 and continue through FY 2017 on the creation of the next generation FPS system, known as FPS 2.0, which includes the enhancements mentioned above, as well as enhancements to:

- Stop suspect claims and allow for medical review by the CMS contractors prior to payment;
- Provide technical assistance to states implementing predictive analytics;
- Coordinate with the CMS Program Integrity Board to make sure the highest priority vulnerabilities in the Medicare program are addressed; and
- Share lessons learned and best practices with federal, state, and private partners.

Program Integrity Modeling and Analytics: In FY 2016, Program Integrity Modeling and Analytics continues to provide support for the FPS, the National Correct Coding Initiative (NCCI) and analytic investigations to detect and prevent fraud, waste, abuse, improper payments, and support administrative actions.

Modeling and Analytic support utilizes rigorous statistical methodologies to identify vulnerabilities that are developed into sophisticated algorithms (models) and edits for deployment in the FPS. The output of the models and edits are used to generate leads to support CMS and its investigative contractors' administrative actions (i.e., revocations, payment suspensions, deactivations, medical review) and Return on Investment activities for CMS program integrity efforts. In addition, the modeling and analytic contractor supports data analyses of ad hoc requests for Medicare, Medicaid and Managed Care programs. The primary purpose of these efforts is to identify and stop illegitimate payments impacting improper payment rates. In FY 2017, this activity will continue to support the CMS program integrity strategic plan and CMS priorities for modeling and data analytics.

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 FPS faster. To date, the Command Center has hosted collaborative sessions with both internal and external stakeholders, in which significant outcomes have been achieved. In addition, the collaborative tools of the Command Center have allowed many CMS staff and law enforcement partners to be trained on the use of the FPS to conduct and enhance investigative work. Continued funding in FY 2017 will support this effort and 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 CMS, HHS/OIG, DOJ, and other CMS partners. Nearly all of the BI funding is directed to the Zone Program Integrity Contractors (ZPICs) that operate throughout the United States.

In FY 2016, CMS plans to begin transitioning from the Zone Program Integrity Contractors (ZPICs) to the Unified Program Integrity Contractors (UPICs). 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 and the Medicaid Integrity Contractors (MICs), which are funded by the Medicaid Integrity Program and described in the State Grants and Demonstrations chapter of this document. CMS expects that its contracts with the ZPICs and MICs will 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. CMS expects to have three UPICs operational in FY 2016.

In FY 2017, CMS will continue the implementation of UPICs with two additional UPICs planned to be awarded during the fiscal year. 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 resulting from the UPIC strategy include reduced state and provider burden, increased contractor accountability, 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 CMS' strategic goal of improving contractor accountability.

The UPICs will continue using the FPS as a source for leads to identify, prevent and investigate potential fraud. The FPS screens claims data before payments are made, allowing the UPICs to rapidly implement administrative actions, such as prepayment review, revocation, or payment suspension, as appropriate. The FPS generates a prioritized list of leads for UPICs to review and investigate potential Medicare fraud in their designated region. When suspect behavior or billing activity is identified, the UPICs 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. CMS and our contractors will continue meeting 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 UPICs will continue supporting many of the antifraud initiatives in the field offices, including HEAT activities. The UPICs will continue to perform data analysis projects and to support immediate and real-time requests for information from the field offices' special projects. CMS has notably strengthened the revocation process by improving the manner in which substantiating documentation is obtained through our field office staff. Moving forward, 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, UPICs will continue to participate in Command Center Missions in order to work on model development, investigative techniques, resolve specific leads, and facilitate training opportunities.

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. Complex medical review is conducted 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 conducts pre-payment medical reviews to prevent improper payments from being made and post-payment review to recover improper payments. Both types of medical reviews help reduce the Medicare fee-for-service error rate.

CMS requires the MACs to focus their medical review efforts on areas identified at risk for high improper payments in their jurisdictions. CMS has contracted with a Supplemental Medical Review Contractor to evaluate medical records and related documents to determine whether claims were billed in compliance with Medical coverage, coding, payment, and billing rules. They often perform claims reviews that are national in scope and are often driven by recommendations from the Office of Inspector General. CMS continues to closely monitor the decisions made by these contractors.

In 2015, CMS finalized the rule to require prior authorization of certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) to provide a provisional payment determination before the item is delivered. CMS believes a prior-authorization process will ensure beneficiaries receive medically necessary care while minimizing the risk of improper payments and decreasing the number of appeals. In FY 2017, CMS will continue interventions aimed at reducing improper payments, to include medical review, individualized education, and prior authorization.

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 2015, approximately 49,000 Medicare cost reports were accepted by the MACs, and tentative settlements were completed for 23,000 cost reports. In addition, approximately 20,000 desk reviews and 1,900 audits were completed. CMS plans to award contracts during FY 2016 to assist with selection of cost reports and issues to audit, along with contractor oversight. CMS completed contractor monitoring activities on all MACs during FY 2015 and plans to maintain similar levels of effort for FY 2016 and FY 2017.

Medicare Secondary Payer (MSP): MSP efforts help to make sure that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on situations where Medicare is secondary to other payers to make 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 and when Medicare has made payments conditioned upon repayment, recovery actions are undertaken.

In FY 2015, CMS activities have been focused on operationalizing the legislative requirements per the Strengthening Medicare and Repaying Taxpayers (SMART) Act. These efforts have included the expansion of functionality for timely reporting of settlements, judgments, awards or other payments within the Medicare Secondary Payer Recovery Portal (MSPRP). During fiscal years 2016 and 2017, continued enhancements will be implemented to take advantage of combined MSP operations, along with implementation of additional recovery activities.

Medicare-Medicaid Data Match Project (Medi-Medi): Authorized by the Deficit Reduction Act (DRA) of 2005, Medi-Medi is a voluntary partnership between CMS and participating states where data is collected, matched and analyzed from both the Medicare and Medicaid programs with the intent of detecting potential fraud, waste and abuse. The Medicare and Medicaid programs share many common beneficiaries and providers. Matching claims from both programs help identify billing patterns that might be indicative of potential fraud, waste, and abuse and could otherwise go undetected if viewed in isolation. Accordingly, analysis performed in the Medi-Medi program can reveal trends that are not evident in claims data from each program alone, thereby, making the Medi-Medi program an important tool in identifying and preventing fraud. As of December 2015, there are 19 states participating in the Medi-Medi program.

CMS will continue to expand this program in FY 2017 through the continued implementation of the UPIC. The UPIC strategy allows for a single contractor in a geographic region to look across the Medicare and Medicaid programs and focus on Medi-Medi related fraud, waste and abuse. The Patient Access and Medicare Protection Act (Public Law 114-115) recently broadened the authorities for the Medi-Medi program, and CMS will be incorporating these changes into the continuing process of developing and operationalizing updated comprehensive strategies for the Medi-Medi program with a focus on encouraging state participation. Through these enhanced strategies, CMS plans to reduce provider and state audit burden, provide better access to improved data, and establish enhanced collaboration between the Medicare and Medicaid investigations and audits. CMS continues to explore alternative ways for the Medi-Medi program that would increase efficiency, eliminate

duplication, and produce greater outcomes for both the state and CMS. Through the revised comprehensive strategies, the Medi-Medi program will be able to further Federal-State collaboration in identifying program vulnerabilities and increasing cost avoidance and recoupments on claims identified as potentially fraudulent, wasteful, and/or abusive.

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.

In FY 2015, CMS anticipates finalizing the instructions to begin denying enrollment applications based on overpayments. CMS expects this standardized process to be fully implemented and operational in FY 2016. CMS also anticipates building an interface between the Provider Enrollment, Chain and Ownership System (PECOS) and the Healthcare Integrated Ledger Accounting System (HIGLAS) to automate the process to obtain overpayment information and eliminate the current manual review process. Finally, 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. In FY 2017, these efforts will continue with a focus on preventing provider and supplier enrollment into Medicare when a current overpayment or payment suspension exists.

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 2016, 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 and the MEDIC 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 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, rendering or ordering provider numbers, and also implement timely corrective actions such as revoking Medicare billing privileges, resulting in significant savings to the Medicare Trust Fund.

In FY 2017, 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 2016, CMS plans to modify the fraud and abuse index of risk (FAIR) and to transition to a new contractor, if applicable. The efforts of the NSC will continue in FY 2017, with the added ability of being able to assist with enrollment backlogs at the A/B MAC as needed.

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 on the use of these tools and the IDR to fight fraud, waste, and abuse.

In FY 2016 and FY 2017, CMS will 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. This investment promotes 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 and MEDIC data analytic access through the OnePI to the IDR allowing the discontinuance on separate regional contractor data repositories.

OnePI provides access to current and historical Medicare and Medicaid 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 and 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 in South Florida. The Strike Force teams use advanced data analysis techniques to identify aberrant 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 funding for the HCFAC program, DOJ and HHS expanded the Strike Force to include teams of investigators and prosecutors in a total of nine areas – Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; and Dallas, TX.

Since their inception, Strike Force operations have charged more than 2,097 defendants who collectively have falsely billed the Medicare program for more than $6.5 billion. In addition, CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

Appeals Initiatives: CMS's Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) for Medicare fee-for-service (FFS) Parts A and B claims. CMS currently contracts with two QICs to perform Medicare Part A reconsideration activities, and three QICs to perform Medicare Part B reconsideration activities. The QICs are currently required to participate as "non-party participants" in 10

percent of Administrative Law Judge (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.

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.

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.

CMS employs a Trusted Third Party (TTP) contractor to perform duties associated with running joint public-private data analytics in a secure environment. The HFPP utilizes a secure portal, which provides partners enhanced security for HFPP study-data and additional collaboration capabilities. Products and communications materials will continue to be added to this portal throughout FY 2016 and FY 2017. 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 as a participating entity to realize cost savings. Funding 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.

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 staff 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.

Outreach and education funding will also support the development and dissemination of educational information on policy and operations related to CMS' program integrity (fraud, waste and abuse prevention) initiatives. Program integrity initiatives include CMS' efforts to curtail emerging fraud schemes and creating awareness and adherence to existing and new program integrity policies and regulations. Education and outreach to providers, beneficiaries, partners, and stakeholders are an essential element to the success of program integrity.

Integrity Continuum: The Integrity Continuum activity is part of a CMS effort to define, coordinate, and consolidate activities along the continuum of compliance for providers and suppliers in the Medicare fee-for-service program. A key goal of the activity is to reduce provider burden by consolidating provider portal entry points and allowing for visibility into

their current and historic billings and CMS audit activities. In FY 2016, the portal consolidation will allow entry into a Business Intelligence (BI) tool to allow for review of current billings. In FY 2017, the portal will be expanded to include more robust information for providers and suppliers, including detailed information about the status of claims under review, information on claims that were submitted with the provider listed as the ordering or referring physician.

Provider Enrollment, Chain and Ownership System (PECOS): PECOS is the national enrollment system for Medicare providers and suppliers. PECOS centralizes the enrollment data collected from enrollment forms into one system and is used by Medicare contractors to enter, update, and review data submitted online or via paper applications. Medicare providers and suppliers may also use PECOS to view and update their existing information. Increased funding in this category will be used to enhance the functionality to align with regulations 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 enrollment process; reduce the amount of paperwork processed, and provide clearer guidance to providers on what they need to submit.

In FY 2016, funding will be used to continue enrollment data collection and management and integrate provider enrollment data with other enterprise systems within CMS. This funding will also be used to expand reporting and analytics reporting capability of PECOS to better serve program integrity and operational efforts. Based on current trends, CMS is expecting an increase in the number of online enrollment applications from the current level of 45 percent to a level of 55-60 percent by the end of FY 2016. This is being accomplished by dramatically improving the PECOS provider enrollment interface to a more user centric platform focused on the users that maintain the information, and not just the providers. It will also be accompanied by reducing redundancy in data entry, and improving administrative processing of online applications to ensure online enrollment is significantly faster than submitting standard paper applications. In FY 2015, planning started for the next version of PECOS. Beginning in FY 2016, CMS will design, prototype, and develop the new version of the system. Beyond the core needs around data accessibility, reduction in provider burden, and the need for increased operational efficiency, the new version of the enrollment system will support agency initiatives toward expansion of alternate payer models, increased alignment between Medicare and Medicaid, and enhanced Part C and D oversight - all of which is not possible without redesign. This effort is projected to continue through FY 2017 and beyond. As part of PECOS enhancements, CMS plans to eventually facilitate states' provider enrollment and provider screening efforts by making state Medicaid and CHIP provider enrollment data available to all states.

Probable Fraud Study Database and Analysis: The Probable Fraud Study Database and Analysis aims to estimate the rate of probable fraud in Medicare fee-for-service payments for home health agencies. The goal of the Probable Fraud Study Database and Analysis is to develop the first nationally representative estimate of the extent of probable fraud in payments for home health care services in the Medicare FFS program. The initial focus is on home health agencies (HHAs) because this service area is defined as "high" categorical risk in the final rule on the implementation of ACA screening provisions [CMS-6028-FC amending 42 CFR 424.518].

The Probable Fraud Study Database and Analysis has been split into two parts in an effort to conduct a "pre-test" in one area of the country to test the interview instruments and pilot design. This pre-test will be conducted and lessons learned will be used to refine the larger, nationwide pilot. However, the large nationwide pilot will match, to the fullest extent possible, the design of the pre-test. Healthcare fraud is a big concern in the Medicare program; therefore extending this program to other areas other than home health is being considered.

In FY 2016, the Probable Fraud Study Database and Analysis aims to test instruments and methodologies that could be used to support the implementation of a national statistically valid estimate of the prevalence of fraud in Medicare fee-for-service payments for home health services. The results will be used to inform and guide the development and implementation of a national study and fraud rate in FY 2017, and can then be applied to enhance the detection and prevention of fraud, waste and abuse in the Medicare program.

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, as amended, 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.

FY 2016 and FY 2017 Goals:

- Measure and report improper payments in the Medicare FFS program; compile corrective actions that CMS is implementing to reduce improper payments; and report this information in the HHS Agency Financial Report, as required by IPERIA;
- Conduct accuracy reviews for the MAC Medical Review Accuracy Award Fee Metric;
- Maintain 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 provide contractors with additional funding to meet the information technology security requirements, if necessary.

VI. Administration for Community Living (ACL)

Senior Medicare Patrols (SMPs): Funding will be used by ACL to give 54 grants to states and territories to implement the Senior Medicare Patrol (SMP) program. Each grantee will recruit volunteers to educate Medicare beneficiaries to prevent, detect, and report Medicare fraud. Historically, additional mandatory HCFAC funding has also been provided to support federal SMP infrastructure support costs, including ACL staff, the National SMP resource center and

the SMP data reporting system. The SMP program has saved the government over $122 million dollars since 1997 and annually meets with more than a million people through outreach and education. Similar to FY 2016 policy, the FY 2017 request provides funding for the SMPs and for Federal infrastructure under the HCFAC account. In FY 2017, funding to support the SMP program may be split between discretionary and mandatory HCFAC funding streams.

VII. 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 by IPERA of 2010 and IPERIA of 2012. The IPIA, as amended, 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.

FY 2016 and FY 2017 Goals:

- Measure and estimate the improper payments in the Medicaid and CHIP programs; develop corrective actions; and report this information in the HHS Agency 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;

- Conduct multiple Security Control Assessments (SCAs) on each of the PERM contractors' systems as required and provide contractors with additional funding to meet the information technology security requirements, as the cost of the SCAs continue to increase for the government and contractors;

- In FY 2016 and FY 2017, the PERM program will pilot the use of MACBIS T-MSIS data for the state's universe data for the PERM Medicaid and CHIP improper payment measurement;

- Resume the eligibility component of the PERM. FY 2016 will include the use of Eligibility Review Contractor (ERC) to perform the final round of Eligibility Review Pilots, and in FY 2017, the ERC will be contracted to conduct the PERM eligibility component measurement. In addition, CMS is requesting new Full-Time Employees (FTEs) for ERC contract administration and oversight. These FTEs will oversee the ERC work with review of a round of eligibility piloting, as well as the ensuing 17 state PERM eligibility measurement cycles. Reviews have traditionally been performed by the 17 cycle states, but will now be the responsibility of the ERC. These FTEs will also be required to oversee the appeals process should any ERC eligibility case error be appealed to CMS by a state; and

- Undergo a significant effort, including additional work with states and utilizing new federal contracting strategies, to roll out a new PERM eligibility methodology and implement new processes and procedures to recommence the PERM eligibility component.

In addition, CMS conducts annual site visits to select 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 the accuracy of the measurement. This proactive measure helps CMS achieve a more accurate improper payment rate measure for the Medicaid and CHIP programs.

National Correct Coding Initiative (NCCI): The goal of this statutory program is to protect Medicaid funds by reducing the number of improperly paid Medicaid claims through the use of standard methodologies, which include edits for state Medicaid claims. This initiative was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payments of Medicaid claims.

There are two types of edits:

- Procedure-to-Procedure (PTP) edits, which prevent improper payments when certain codes are submitted together; and

- Medically Unlikely Edits (MUEs) which specify the number of times a procedure can be performed on the same beneficiary on the same date of service by the same provider.

New edits are continually developed in the NCCI program for states use in screening Medicaid claims for codes that should not be submitted together and for units of service that should not exceed certain limits.

FY 2014 and FY 2015 ACCOMPLISHMENTS

- Worked closely with the HHS OIG to develop and implement a detailed study of each state's implementation of the Medicaid NCCI methodologies.

- Developed and implemented 34,740 new Medicaid NCCI PTP edits and MUEs.

- Provided technical assistance to states through regular workgroup calls.

- Responded to state requests for authority to deactivate certain edits, and provided direct technical assistance and policy guidance to states.

FY 2016 AND FY 2017 GOALS

- Develop and implement new Medicaid NCCI PTP edits and MUEs to further strengthen the correct coding of Medicaid claims by providers and to further reduce inappropriate payment of Medicaid claims by states due to improper coding of Medicaid claims by providers.

- Provide technical assistance to states individually and in groups based on the findings and recommendations in the 2015 report of the national study of each state's implementation of the Medicaid NCCI methodologies conducted by the HHS OIG in 2014.

Medicaid Enterprise System: Under the Affordable Care Act, states are required to implement significant and substantial changes to their Medicaid programs, including eligibility determinations, plan management, financial management, customer service, and integration with the affordable insurance programs from health insurance exchanges. The Government Accountability Office (GAO) has identified Medicaid as a program at significant risk for overpayments. Eligibility errors are a contributor to the payment error rate in Medicaid, as calculated by CMS. Implementation of the changes required by the Affordable Care Act present an opportunity to address some of the long-standing problems identified in the Medicaid Payment Error Rate Measurement process through revised business rules, automated verifications of 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 these requirements. A contractor will support the teams in the model and provide resources who can work directly with states. In FY 2016 and FY 2017, CMS is expanding the Medicaid Enterprise System effort to include a new process to pre-certify Provider Screening and Enrollment Medicaid Management Information System modules with the goal of providing ready solutions to help states better comply with Medicaid and CHIP provider enrollment standards.

Section 1115 Financial and Performance Compliance and Oversight: Over the course of the last twenty years there has been a significant increase in the volume and scope of Medicaid section 1115 demonstrations to the point where three-quarters of states now operate at least one demonstration and a growing number of states operate most or all of their Medicaid programs under section 1115 authority. In FY 2014, the federal share of obligations for section 1115 demonstrations was more than $89 billion. Further, with implementation of the Affordable Care Act, there is an increased interest in Medicaid expansion through 1115 demonstrations, in performance based incentive arrangements (e.g., Delivery System Reform Incentive Pools (DSRIPs)) and in Designated State Health Programs (DSHPs). The changes in the nature and the scope of these demonstrations has increased the agency's program integrity risk, so CMS is increasing oversight.

In late FY 2015, CMS added staff to better support federal and state monitoring and oversight of section 1115 demonstrations. The new staff also allows CMS to build program expertise in specific section 1115 demonstration areas such as service delivery reform and Medicaid expansion, and to focus more intensely on monitoring and oversight of finances under section 1115 demonstrations in order to address our fiduciary obligations and ensure that appropriate controls and beneficiary protections are being carried out. In addition, the organization and new staff better equips CMS to ensure that these demonstrations are in compliance with federal requirements and that outcomes align with the level of federal investment in these programs.

Open Payments: 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 requires 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 made to physicians and teaching hospitals to CMS on an annual basis. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests.

Open Payments is a transparency program that is intended to help consumers make informed decisions about their treatment based on knowledge of the financial relationships that physicians or teaching hospitals have with manufacturers. The Open Payments website supports both manufacturers and physicians in registration, data submission, and with data review and dispute. Additionally, the Open Payments website supports public access of all reported payments or transfers of value made to physicians and teaching hospitals. CMS monitors and validates the data prior to public posting. This verifies the accuracy of the data and ensures that each payment is matched to the correct covered recipient (physician or teaching hospital).

In FY 2017, the program will be in an operational mode. The ongoing operations of the program will require funding for system operations, ongoing data validation, auditing and enforcement strategy 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. CMS may audit and impose civil monetary penalties for non-compliance with reporting requirements. This funding will be used to develop, implement, and support an Open Payments compliance strategy. Funds will also be used to make enhancements of the Open Payments data on the public display website to encourage use by the general public and stakeholders. As the data grows and awareness of the availability of the data increases, the Open Payments data will need to be more accessible and user-friendly.

Medicaid Enrollment and Payment Suspension: CMS is establishing a Medicaid Enrollment process that will allow for a more cohesive, robust, and overarching CMS Medicare and Medicaid enrollment program. CMS does not currently have a comprehensive level of involvement in the Medicaid enrollment process. Therefore, in FY 2016, CMS will establish a group to work with states on the Medicaid Provider Enrollment Program. This work may include creating sub-regulatory guidance equivalent to the Medicare Enrollment Program Integrity Manual that clarifies Medicaid regulations and provides the states a centralized resource for Medicaid enrollment policy and providing states technical assistance with provider enrollment questions in managed care and FFS. CMS is also planning to evaluate potential access to care issues and review Medicaid suspension data to determine potential leads in Medicare investigations and administrative actions. CMS will enforce mandated ACA regulations, enhance transparency between both programs and allow for improved oversight of dual providers and suppliers enrolled in both programs.

In FY 2017, these efforts will continue, with a focus on helping states improve provider enrollment, these efforts may include providing technical assistance on streamlining the Medicaid enrollment process and examining Medicare and Medicaid enrollment policies. Many of the screening tools that CMS applies in Medicare such as; revalidation, site visits, payment of application fees, revocations and fingerprint-based criminal background checks

will continue to be leveraged for use in Medicaid to simplify the enrollment process and avoid duplication of work. Utilization of these screening tools will also prevent at-risk and fraudulent providers from entering both programs.

CMS has been conducting a pilot with four states to report Medicaid payment suspensions information to CMS. CMS will be evaluating the effectiveness of the pilot, and if successful, will develop an operational strategy that would require all states to collect and report to CMS detailed information about all Medicaid payment suspensions based upon credible allegations of fraud. FTEs were hired to support the enrollment effort and development of sub-regulatory guidance for enrollment.

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 $3.4 trillion dollars by 2016, 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, private insurance investigative units, and other professional associations.

In FY 2014, the FBI initiated 602 new health care fraud investigations and had 2,771 pending investigations. Investigative efforts produced 730 criminal health care fraud convictions and 849 indictments and informations. In addition, investigative efforts resulted in over 605 operational disruptions of criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 140 health care fraud criminal enterprises.

FBI Budget Request

The FY 2017 FBI budget includes mandatory funding in the amount of $141.5 million, an increase of $11.2 million above the FY 2016 Enacted Level. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year Consumer Price Index-Urban (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 2014, OIG's Medicare and Medicaid oversight efforts resulted in 867 criminal actions and 529 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 4,017 individuals and entities. For FY 2014, 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 $15.7 billion in Medicare savings and $1.3 million in savings to the Federal share of Medicaid.

OIG Budget Request

The FY 2017 OIG budget includes $200.3 million in mandatory funding. The FY 2017 discretionary request is $121.8 million, which represents an increase of $54.6 million above the FY 2016 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 2017 DOJ budget estimate includes $62.5 million in 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 DOJ discretionary request for FY 2017 is $116.2 million, which represents an increase of $55.8 million above the FY 2016 Enacted Level.

HHS WEDGE FUNDING 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 2015, negotiated amounts were $35.6 million for distribution among HHS components and

$58.1 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding.

CMS Medicaid Financial FTEs: 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 $1.0 billion in questionable reimbursement was averted in FY 2015 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 $2.5 billion (with approximately $1.0 billion recovered and $1.5 billion resolved) of approximately $9.4 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 2014, OGC participated in False Claims Act (FCA) and related matters that recovered over $2.2 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 and 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 2014, 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 2014, FDA initiated 24 criminal investigations, actively pursued several criminal prosecutions, and conducted a three-day training seminar for criminal investigators and supervisors covering PFP-related topics.

HHS Wedge Budget Request

The FY 2017 HHS Wedge request includes mandatory funding of $38.3 million, which is an increase of $2.4 million above the FY 2016 Enacted Level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General; therefore, decisions on how this funding 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 2015 HHS Agency Financial Report (AFR).

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. In FY 2015, we reported an error rate of 12.09 percent, which was a decrease of 0.6 percentage points from FY 2014 and below the FY 2015 target of 12.5 percent. The decrease in the error rate was driven by a reduction in improper payments for inpatient hospital and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims. CMS' "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospitals claims, reducing the improper payment rate from 9.23 percent in FY 2014 to 6.18 percent in FY 2015. The improper payment rate for DMEPOS also decreased from 73.80 percent in 2010 to 39.94 percent as of September 2015. Corrective actions implemented over a six-year period, including the DMEPOS Accreditation Program, contractor visits to large supplier sites, competitive bidding, and a demonstration testing prior authorization of power mobility devices, contributed to the reduction in the improper payment rate for these items and supplies.

The primary causes of improper payments were insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 51.38 percent to 58.95 percent in FY 2015, due to non-compliance with documentation requirements to support the medical necessity of the services. Insufficient documentation was also common for Skilled Nursing Facility (SNF) claims. The improper payment rate for SNF claims increased from 6.94 percent in FY 2014 to 11.04 percent in FY 2015.

The factors contributing to improper payments are complex and vary from year to year. CMS is committed to reducing improper payments in the Medicare FFS program. CMS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

CMS believes that five new corrective actions and three continuing corrective actions will have a considerable effect in preventing and reducing improper payments. Detailed information on corrective actions can be found on pages 184 and 185 of the 2015 HHS AFR. Future targets are 11.50 percent for FY 2016 and 10.40 percent for FY 2017.

MIP5 Reduce the Percentage of Improper Payments Made under the Part C Medicare Advantage Program: In FY 2015, CMS fell short of its Part C Medicare Advantage (MA) error rate target of 8.5 percent, reporting an actual improper payment rate of 9.5 percent. The Part C program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS' annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error rate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS implemented two key initiatives to improve payment accuracy in the Part C program. These are (1) contract –level audits and (2) new regulatory provisions. The regulations require MA organizations to report and return identified overpayments. The regulations also require use of payment recovery and appeal mechanisms for erroneous payment data identified by CMS,

which was submitted by an MA organization. In FY 2015, Medicare Advantage Organizations have reported and returned approximately $650 million in overpayments, which appears to be the result of the sentinel effect of the RADV audits, as well as the "report and return" regulatory requirements. The FY 2016 target is 9.14 percent and the FY 2017 target is to reduce the Part C error rate to 8.79 percent.

MIP6 Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program: In FY 2015, CMS reported a Part D error rate of 3.6 percent, falling short of our target of 3.5 percent. The FY 2015 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 primary factor that drove the program's increase from the prior year's reported error estimate was an increase in the prescription drug event data validation component of the error rate.

CMS continues to pursue enhancement of program integrity through national training sessions for Part D plan sponsors on Part D sponsors to update beneficiary Low Income Subsidy statuses prior to reconciliation, and continue formal outreach to plans on invalid/incomplete PDE data submission for PEPV. Lastly, in CMS-4159-F, *Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program* (79 FR 100), HHS codified the Affordable Care Act requirement that Part D sponsors must report and return overpayments that they identify. In *The Calendar Year 2015 OPPS/ASC* Final Rule (79 FR 67032), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor. Accordingly, in FY 2015, approximately $11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the "report and return" requirement. The FY 2017 target for the Part D error rate is 3.3 percent.

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 redesigned this goal in FY 2012 to reflect our direct fraud identification and prevention work —the National Fraud Prevention Program (NFPP). This goal aligns with provisions of the ACA and the Small Business Jobs Act (SBJA), which added new requirements to use advanced predictive analytics to identify high risk providers. With funding authorized in the SBJA, CMS developed the Fraud Prevention System (FPS) which allows for better tracking of administrative actions against high risk providers and suppliers.

Our predictive analytics work using FPS 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.

CMS partners with the 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.

Our FY 2012 baseline is from the first year of the FPS (July 2012). We reported that 27 percent of Medicare providers and suppliers, identified as high risk through predictive analytics, received an administrative action. In FY 2015, our actual rate of 43.63 percent exceeded our target of 42 percent of high-risk Medicare providers and suppliers receiving an administrative action. Our FY 2016 target will be 45 percent and the result will be available in November 2016, at which time the FY 2017 target will be determined.

MIP9.1 Estimate the Improper Payment Rate in the Medicaid Program and MIP9.2 Estimate the Improper Payment Rate in the Children's Health Insurance (CHIP): The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 States each year as a means to contain cost, reduce the burden on States, and make measurement manageable. In this way, States can plan for the reviews and CMS can complete the measurement on time for the HHS AFR reporting. At the end of a three-year period, each State will have been measured once and will rotate in that cycle in future years, (e.g., the States measured in the 2012 AFR were also measured again in the 2015 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2015 HHS AFR.

The national Medicaid error rate (MIP9.1) reported in the 2015 AFR is based on measurements that were conducted in FYs 2013, 2014, and 2015. We fell short of our FY 2015 target of 6.7 percent, as the current national Medicaid error rate is 9.78 percent. The national Medicaid error component rates are: Medicaid FFS: 10.59 percent and Medicaid managed care is 0.12 percent. In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the Affordable Care Act, CMS is updating the PERM eligibility component measurement methodology and related program regulation to reflect these changes. For FYs 2015 through 2018, CMS is not conducting the eligibility measurement component of PERM. During this time, the FY 2014 national eligibility improper payment rate is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: 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.

This improper payment rate increased from prior years due to an increase in the FFS component, driven primarily by state systems having difficulty complying with new requirements. The FY 2016 target is 11.53 percent and the FY 2017 target is 10.48 percent.

The national CHIP error rate (MIP9.2) reported in the FY 2015 AFR is based on measurements conducted in FYs 2013, 2014, and 2015. We did not meet our FY 2015 target of 6.5 percent,

with an actual rate of 6.80 percent. The national FY 2015 CHIP error component rates are as follows: CHIP FFS: 7.33 percent and CHIP managed care: 0.37 percent. The CHIP eligibility: component is held constant at the FY 2014 reported rate of 4.22 percent. The FY 2016 target is 6.81 percent and the FY 2017 target is 6.23 percent. Additional detail about Medicaid and CHIP error rates and underlying components is available in the FY 2015 HHS AFR.

In order to reduce the national Medicaid and CHIP error rates, States are required to develop and submit corrective action plans (CAPs) to CMS. CAPs will focus on helping States comply with new system requirements, provider communication and education to reduce errors related to missing or insufficient documentation and also target eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPs, CMS has implemented additional efforts to lower improper payments rates including provider outreach, mini-PERM audits, best practice calls, and various other methods of state outreach. For more information on corrective actions see the FY 2015 HHS AFR.

MIP11 Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online: The ***Provider Enrollment, Chain and Ownership System (***PECOS) is the CMS national repository and system of record for all enrollment information on Medicare providers and suppliers. Eligible providers and suppliers must enroll in the Medicare program to bill and to be paid for services rendered to program beneficiaries. As an online, electronic application system, PECOS helps to improve operational efficiency in CMS' enrollment process, reduce the cost associated with processing paper enrollment applications, and improve beneficiary access to care by reducing the time needed to issue provider certifications. This measure identifies annual improvement (increases) in electronic applications for initial enrollments that achieve administrative efficiencies.

The purpose of the measure is to track increases in initial enrollment applications submitted online via PECOS. An increase in the proportion of enrollment applications submitted electronically is expected to replace the submission of paper applications. Currently, the average time to process an electronic enrollment application is 45 days, compared to an average of 60 days to process a paper enrollment application. In addition, an estimated 50 percent of initial enrollment applications must be returned to the provider for further information or explanation. Of these returned applications, 70 percent are paper applications. Addressing incomplete paper applications lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications, negatively affecting CMS' operational efficiency and program beneficiaries' access to services. The electronic enrollment process will also enhance CMS' capabilities to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Faster processing and timely updates of enrollment information in PECOS will facilitate data sharing and identifying and determining the program eligibility of the providers and groups in MACRA programs like the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs), thus benefiting multiple CMS programs.

This developmental measure will report a calendar year (CY) 2015 baseline in April 2016. We will set future targets after the baseline data is available.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY2016 Target
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Outcome)	FY 2015: 12.09% Target: 12.5% (Target Exceeded)	11.5%	10.4%	-1.1 pp
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program	FY 2015: 9.5% Target: 8.5% (Target Not Met)	9.14%	8.79%	-.35 pp
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program	FY 2015: 3.6% Target: 3.5% (Target Not Met)	3.4%	3.3%	-.1 pp
MIP8: Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Outcome)	FY 2015: 43.63% Target: 42% (Target Exceeded)	45%	TBD[1]	TBD
MIP9.1: Estimate the Improper Payment Rate in the Medicaid Program (Outcome)	FY 2015: 9.78% Target: 6.7% (Target Not Met)	11.53%	10.48%	-1.05pp
MIP9.2: Estimate the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	FY 2015: 6.80% Target: 6.5% (Target Not Met)	6.81%	6.23%	-.58 pp

[1] Target to be provided in November 2016.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY2016 Target
MIP11: Increase the Proportion of Providers Performing Initial Enrollment in the Medicare Program Online	FY 2015: Result Expected Apr 30, 2016 Target: Set Baseline	TBD	TBD	TBD

Project or Activity	FY 2017 Discretionary Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D	
Medicare Drug Integrity Contractors	$21,555
Part C & D Contract/Plan Oversight	$24,777
Monitoring, Performance Assessment, and Surveillance	$65,773
Program Audit	$59,350
Compliance and Enforcement	$17,600
Total	**$189,055**
II. Program Integrity Staffing and Support	
Field Offices/Rapid Response/ and Oversight Staffing	$57,645
Total	**$57,645**
III. Program Integrity Special Initiatives	
Automated Provider Screening	$18,000
Unified Case Management System	$18,000
OIG Hotline	$1,300
Total	**$37,300**
IV. Prevent Excessive Payments	
Fraud Prevention System	$1,500
Program Integrity Modeling and Analytics	$13,000
Command Center	$950
Benefits Integrity	$11,000
Medical Review	$25,000
Total	**$51,450**
V. Program Integrity Oversight Efforts	
Overpayment and Payment Suspension	$2,350
Compromised Numbers Checklist	$3,000
OnePI Data Analysis	$16,500
Appeals Initiatives	$6,000
Healthcare Fraud Prevention Partnership	$23,849
Provider Outreach and Education	$13,000
Integrity Continuum	$13,000
Provider Enrollment, Chain and Ownership System	$6,038
Probable Fraud Study Database and Analysis	$3,000
Total	**$86,737**
VI. Administration for Community Living (ACL)	
Senior Medicare Patrol	$9,000
Total	**$9,000**

Project or Activity	FY 2017 Discretionary Request
VII. Medicaid Program Integrity Initiatives	
Payment Error Rate Measurement	$30,000
National Correct Coding Initiative	$860
Medicaid Enterprise System	$6,250
Section 1115 Financial and Performance Compliance and Oversight	$4,101
Open Payments	$4,130
Medicaid Enrollment and Payment Suspension	$4,101
Automated Provider Screening	$1,000
Fraud Prevention System	$1,500
Healthcare Fraud Prevention Partnership	$3,807
Total	**$55,749**
HCFAC Summary	
Total HCFAC Discretionary	**$486,936**

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Clinical Laboratory Improvement Amendments of 1988

(Dollars in thousands)

	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget
Obligations	$46,350	$46,350	$50,000
FTEs	81	81	81

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

Allocation Method – Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) established quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. These outcomes are determined by on-site inspections of CLIA-identified laboratories. CMS works with State Survey Agencies and Accreditation Organizations (AOs) who perform inspections to ensure CLIA policies and procedures are followed.

CLIA laboratories are defined as any entity which conducts testing on human specimens for health purposes. CLIA laboratories can include traditional laboratories, hospitals, physician office laboratories, ambulatory surgical centers, rural health clinics, insurance laboratories, Federal, State, city/county laboratories, and community health screenings. CLIA provisions are based on the complexity of performed tests, as defined by the Food and Drug Administration (FDA). Along with the FDA, CMS also has inter-agency agreements with the Centers for Disease Control (CDC) to define quality and safety standards. Laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other sites. The more complex the tests performed, the more stringent the requirements.

The CLIA program approves Laboratory Accreditation Organizations (AOs) such as the Joint Commission and the College of American Pathologists (CAP) as deeming organizations for certification of CLIA testing. AOs must meet the minimum CLIA regulations but can also be more stringent than CMS defined requirements. Laboratories which are accredited or which operate in exempt States are inspected by an AO or State Survey Agency every two years.

Inspection of these laboratories by CMS or by an approved agent applies to all certificate types. Laboratories must allow access in order to assess compliance with requirements and must provide all information required to determine compliance. Failure to permit a survey will result in adverse action by CMS. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance

Currently, almost 253,000 laboratories are registered with the CLIA program. These are classified into five types of certificates provided by CLIA:

Certificate of Waiver (CW) - These laboratories only perform waived tests, which are simple routine testing following the manufacturers' instructions. CW's are exempt from routine surveys but are subject to announced or unannounced surveys under certain circumstances (i.e., complaints). There are no personnel requirements for these certificates as waived labs are required to follow manufacturer instructions for performing a test.

Certificate of Provider-Performed Microscopy (PPM) - Tests that are performed by midlevel practitioners, nurse midwifes, nurse practitioners and physician assistants. These tests include waived and slightly more complex testing. They are exempt from routine surveys are subject to announced or unannounced surveys under certain circumstances (i.e., complaints).

*Certificate of Compliance (CoC) – These laboratories p*erform waived, PPM, moderate and high complexity testing. They must meet regulations under the facility administration agreement which monitors quality systems, personnel, and proficiency testing requirements. They are subject to two-year surveys and complaint surveys.

*Certificate of Accreditation (CoA) – Laboratories that p*erform waived, PPM, moderate and high complexity testing. An AO performs the survey to determine compliance and is subject to validation and complaint surveys by CMS. If labs only perform waived and PPM testing, it cannot have a CoA

Certificate of Registration (CoR) - A certificate is issued that enables a new entity to conduct moderate or high complexity laboratory testing or both until the entity is determined to be in compliance.

The chart below breaks out the number of labs by enrollment.

FY 2015 Laboratories

By Certificates	# of Labs
Waived	177,104
Provider Performed Microscopy	36,882
Compliance	19,793
Accredited	16,588
Registration	2,481
Total Laboratories	252,848

(Source: CMS Database 1/2015) - Includes exempt labs in NY & WA

The chart below breaks out the number of projected laboratory surveys

Projected CLIA Lab Surveys

FY 2015	FY 2016	FY 2017
10,426	10,254	10,256

Budget Request - $50.0 Million

The CLIA program is entirely funded by the user fees that are charged to the laboratories regulated by the program. The FY 2017 President's Budget projection for CLIA is $50.0 million.

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 2015-2016 cycle include surveys of 18,684 non- accredited laboratories, State validation surveys of 806 accredited laboratories, and approximately 1,364 follow-up surveys and complaint investigations.

Performance Measurement

CLIA2: Improve Laboratory Safety for Certificate of Waiver Laboratories The purpose of this measure is to improve laboratory safety for certificate of waiver (CW) laboratories that perform only *simple* tests that meet the statutory criteria for waiver. Simple laboratory examinations and procedures are those 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. The number of CW laboratories has grown to 177,104 (as of January 2015). In comparison to the total number of non-exempt laboratories (241,031 as of January 2015), certificate of waiver laboratories represent 71 percent of laboratories nationwide.

State surveyor data collected from educational surveys has continually substantiated that a significant percentage of these CW laboratories have pre- and post-testing issues, are not performing Quality Control (QC) as instructed by the manufacturer, that testing personnel are not familiar and less-trained in good laboratory practice and that some laboratories are performing testing beyond the scope of their certificate, (i.e. non-waived testing). Due to the growth in waived tests and laboratories and concerns from State agencies and consumers about waived laboratories, CLIA initiated a pilot, which expanded into a nationwide project (CW Project) surveying approximately 2 percent of the nations' waived laboratories annually.

Laboratories that demonstrate full CLIA compliance in a State survey, receive a “Letter of Congratulations”. Educational materials are one means of quality improvement, narrowing the gap in knowledge, understanding and application of laboratory techniques. The CDC, CMS and laboratory experts have published an educational booklet, “READY, SET, TEST”, an on-site educational tool that is designed to promote good laboratory practices in CW laboratories. Individual(s) responsible for performing laboratory testing are encouraged to read the “READY, SET, TEST” booklet in its entirety prior to the survey date and utilize any of the testing information or documents that will enhance the laboratory’s processes and procedures.

This goal tracks two cohorts of laboratories. The first cohort (measure CLIA 2.1), includes the original group of 20 States (19 for fiscal year 2015, due to lack of available staff). The original States receive a copy of the “READY, SET, TEST” booklet prior to the educational survey, along with an introductory letter, which explains the intent of the survey and the purpose of the booklet. The introductory letter requests that the laboratory take time to review the booklet before the educational survey. Post-survey information is collected by the State agency surveyor. Our FY 2014 result was 48 percent, exceeding our target to increase, by 2 percent, the percentage of waiver laboratories qualifying for a Letter of Congratulations over the 2013 actual of 45 percent. The FY 2017 target for CLIA2.1 is to increase the number of States that are in full compliance with CLIA by 2 percent over the FY 2016 actual.

In fiscal year 2015, the universe of States has been expanded to track the second cohort, which includes the remaining 31 States and will be tracked in CLIA2.2, a contextual indicator. The laboratories in 31 States included in CLIA2.2 will receive the “READY, SET, TEST” booklet after the State agency surveyor has completed the onsite educational survey. The primary purpose of taking the booklet to the survey is to assess whether the laboratory has any knowledge of the booklet. This would suggest there was a means available to the laboratory for obtaining a copy of the booklet, (i.e. education and training in laboratory techniques, surfing the internet, or perhaps sharing of knowledge from one laboratory to the next). Regardless of how the booklet was obtained, we want to determine if the outcome of the knowledge of the materials and content of the booklet result in the surveyor finding that the laboratory is in full compliance with the CLIA regulations. For the CLIA2.2 laboratories, two unique questions about the booklet have been added to the end of the State Surveyor Entry form, which will assist with determining whether the laboratory has any knowledge of the “READY, SET, TEST” booklet.

We continue to believe that providing the waived laboratory with an opportunity to review and employ the “READY, SET, TEST” booklet prior to the actual educational survey will result in the observation by the surveyor that the laboratory is compliant with the CLIA standards, as measured by the increase in the percentage of Letters of Congratulations.

Key Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target+/- FY 2016 Target
CLIA2.1: Increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA provisions.	FY 2014: 48% Target: +2% over 2013 % of certificate of waiver laboratories qualifying for a Letter of Congratulations (Target Exceeded)	+2% over 2015 % of the certificate of waiver laboratories qualifying for a Letter of Congratulations	+2% over 2016 % of the certificate of waiver laboratories qualifying for a Letter of Congratulations	+2% over prior year
CLIA2.2 Percentage of Certificate of waiver Laboratories Qualifying for a Letter of Congratulations	FY 2014 Baseline: 47%	Contextual Indicator	Contextual Indicator	N/A

**1 Data updated to reflect results from corrected algorithm for Letter type assignments and additional FY 2012 survey updates between January 2012 and May 2013. Originally reported

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Quality Improvement Organizations
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$695,798	$686,372	$580,000	($106,372)
Outlays	$668,516	$686,372	$580,000	($106,372)

Authorizing Legislation – Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended
Allocation Method – Contracts

The 11th Statement of Work (SOW) began 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 (QIO) program, CMS maintains contracts with independent community-based organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of care, and is provided in the most economical setting. In addition, through the QIOs and other State and local partners, CMS collaborates with healthcare 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;
- The 11th SOW has significant programmatic and structural improvements.

The 11th SOW implemented several changes to the program recommended by the Instititute of Medicine and as enacted in the Trade Adjustment Assistance Extension Act of 2011. CMS also aligned the 11th SOW with the Secretary's National Strategy for Quality Improvement in Health Care (the National Quality Strategy).

In the 11th SOW, there are 14 Quality Innovation Network contracts and five Beneficiary and Family Centered Care contracts. Quality contractors have been working to reduce patient harms such as central-line bloodstream infections, hospital readmissions, and adverse drug events. Beneficiary and Family Centered Care is the program's statutory case review work, including beneficiary complaints, concerns related to early discharge from health care settings, and patient and family engagement. Since August 2014 nearly 200,000 case reviews have been conducted. Effective in January 2016, Quality Improvement Organizations will assume the medical review probe and educate work for short-stay hospital claims that was previously conducted by the Medicare Administrative Contractors (MACs).

Funding History

FY 2012	$372,800,000
FY 2013	$458,600,000
FY 2014	$1,648,900,000
FY 2015	$770,124,706
FY 2016	$686,371,940

Budget Request

Estimated QIO Funding 11th Statement of Work (2014-2018) *(dollars in millions)*	
Clinical Quality Improvement	**$827.4**
Value Based Purchasing Support Contracts and Quality Measures	**$1,110.2**
Infrastructure, Coordinating Centers, and Special Initiatives.....	**$573.6**
Beneficiary and Family Centered Care	**$479.2**
Other Support Contracts and Staff	**$1,065.8**
Subtotal Funding	**$4,056.2**

QIO Performance Measurement

CMS uses performance measures to support its mission and to inform the decision-making process. As CMS transitioned from 10th SOW to 11th SOW, we developed additional performance measures to evaluate the employment of proven quality improvement techniques and beneficiary satisfaction.

MCR28 - Reduce Healthcare-Associated Infections: The QIOs play an important role in the Agency Priority Goal to "Reduce Catheter-Acquired Urinary Tract Infections". For more information, please see measure MCR28 in the Performance Measurement Section of the Program Operations chapter.

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 over 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 website. The one-star rating is the lowest rating and the five-star rating is the highest. 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 Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of nursing homes and other activities, has supported the creation of a *National Nursing Home Quality Care Collaborative* (NNHQCC). Additional information about this topic can be found in the Medicare Survey and Certification chapter of this OMB justification. The purpose of the NNHQCC is to help ensure that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO supports the Collaborative objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction". Although the QIN-QIO is currently working to 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 encourages 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; and lack of leadership and patient and family engagement. Participation in the NNHQCC entails 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 "Plan Do Study Act" 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 one-star recruitment measure assesses 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 NNHQCCs through 2018 and therefore ensure safer care received by Medicare beneficiaries. CMS is currently analyzing One-Star Quality Measure Composite Score data to identify an

evaluation metric, which will measure the progress of One-Star homes participating in the NNHQCC I.

As of March 31, 2015, QIOs recruited 72.1 percent of the total One-Star Category Target Number (SCTN) for the 11th SOW. However with the re-balancing of the Medicare.gov 5-Star Rating system effective February 20, 2015, we will continue to recruit One-star facilities since the total number of One-star homes in the nation increased as a result of the re-balancing. We will again target One-Star homes for participation in NNHQCC during the official recruitment period for Collaborative II from October 1, 2016 – March 31, 2017. The FY 2017 target is to recruit 75 percent of one-star nursing homes to participate in the NNHQCC.

The Quality Measure Composite Score, also referred to as the Composite Score, is used to monitor NNHQCC progress at the national, QIN-QIO, and nursing homes levels. Nursing homes participating in the NNHQCC focus on processes that improve their systems and measure individual tests of change. Specifically, nursing homes look at their Plan-Do-Study-Act (PDSA) improvement cycle results, clinical outcomes measures, and composite scores. The Composite Score is comprised of 13 NQF-endorsed*, publically reported, long-stay quality measures that represent processes and inter-related systems of care within the long term care setting. The accelerated pace and short term nature of the NNHQCC benefit from data that can be monitored on a monthly or quarterly basis, with the most current data available. The Composite Score is calculated and updated more frequently that other data or rating systems, such as the five-star rating system.

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 work 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 began in 2014.

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.

In the 9th SOW, the Beneficiary Satisfaction survey was performed using quality of care cases via a telephone survey. The 10th SOW survey was redesigned to increase efficiency by using a paper based model. We anticipate that the paper (mail) based model may significantly reduce our response rate. To account for a reduction in the response rate, we added an additional high-volume case review type, appeal reviews, to the denominator of cases to be surveyed. In addition to the change in survey delivery method, we were also asked by OMB to score all neutral responses as negative satisfaction responses. These two changes (mail-based surveys and neutral responses scored as negative) dramatically changed and reduced the baseline

satisfaction rate. We observed significant drops in the median satisfaction rate, which we believe are directly related to these changes in the survey delivery method and scoring methodology. For these reasons, we did not use the Beneficiary Satisfaction Survey scores for contract measurement at the end of the 10th SOW.

CMS intends to use the 11th SOW survey scoring methodology for the 2016 target. The Beneficiary Satisfaction survey is part of the Oversight and Review Center contract that was awarded in August of 2015. The FY 2016 baseline will be available in September 2016. We will set 2017 targets when the 2016 baseline is available.

QIO10: Reduce the Risk of Vascular Access-Related Infections By Reducing the Rate of Long-Term Central Venous Catheter (CVC) Use Among Prevalent Patients Nationally with the Placement of an Arteriofistula (AVF) or Graft: Individuals are diagnosed with End-Stage Renal Disease (ESRD) when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD can be cured only with a kidney transplant. ESRD patients who have not received a transplant rely on dialysis to perform the life-saving filtering function. From 2011 to 2012, the estimated number of prevalent Medicare ESRD patients grew by 3.2 percent to 525,481 with a total of $28.6 billion of Medicare claims paid in 2012[1]. Hemodialysis requires repeated vascular access to large blood vessels capable of effectively removing wastes from the blood. The three forms of vascular access are arteriovenous fistula (AVF), arteriovenous graft (AVG), and central venous catheter (CVC). A patient's vasculature and other medical and physical conditions are used to determine access type.

Hemodialysis access-related complications, infection being the most common, remain one of the most important sources of morbidity and cost, with total annual costs exceeding $1 billion annually.[2]. While CVCs have the advantage of immediate use for dialysis after placement, they are associated with a host of complications particularly when used long term. Long term CVC use refers to having a tunneled hemodialysis catheter in place for 90 days or longer. Compared with patients who receive an AVF, patients with a CVC may experience health implications such as higher rates of anemia, with greater rates of infection, including bacteremia, endocarditis, septic shock, septic arthritis, and epidural abscess. Undoubtedly, the CVC is associated with the greatest risk of infection-related and all-cause mortality compared with the AVF and AVG.[3] Because of the risks associated with catheter use, CVCs should be viewed as a "bridge" to an AVF or AVG while a permanent access is maturing or healing or as a permanent access in patients who have exhausted other options or whose clinical condition precludes the placement of an AVF or AVG. It is unclear why high rates of CVC use persist among hemodialysis patients in the United States in view of the clear disadvantages and evidence-based practice guidelines to the contrary.

The previous vascular access measure (QIO 5) pursued strategic efforts to reduce long-term catheter use in order to reduce the risk of mortality and improve the quality of life of hemodialysis patients. Additionally, it served to sustain the progress made under the former measure, which aimed to increase AVF use. By reducing long term CVC use, either AVF or AVG use will be increased. AVF is likely to be preferred as it is the medical gold standard and the vascular access type associated with the highest Medicare compensation. More information about the QIO5 measure is included in the Discontinued Measure section of this document.

In 2013, the Fistula First Catheter Last Workgroup Coalition (FFCL) was established to build on the success of the Fistula First Breakthrough Initiative but with a specific focus on hemodialysis

[1] ***United States Renal Data System*** (USRDS), 2014
[2] Ramanathan V, Chiu E J, Thomas J T, Khan A, Dolson G M, Darouiche R O. Healthcare costs associated with hemodialysis catheter-related infections: a single-center experience. Infect Control Hospital Epidemiology):606–609.[PubMed]
[3] USRDS, 2014

catheter reduction as well as continuing to increase the number and percentage of AVFs in use.

CMS established bold goals for vascular access with the 2013 ESRD Network Redesigned Statement of Work. Specifically, CMS set a target maximum goal of 10 percent for the percentage of patients with tunneled hemodialysis catheters in place for 90 days or longer. The ESRD Network Statement of Work calls for ESRD Networks to increase their efforts to encourage and support the use of AVFs and decrease the use of catheters.

Key Outputs and Outcomes

Measure	Most Recent Result	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
QIO7 Making Care 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)	FY 2015: 72.1% (Historical Actual)	N/A[4]	Recruitment of 75% One-Star Category Target Count	N/A
QIO8 Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints. Baseline: 2016 TBD	N/A	Set baseline (September 2016)	TBD: Target set when 2016 baseline data is available	N/A
QIO10 Decrease the rate of long-term central catheter (CVC) use among prevalent patients	FY 2015 Baseline: 10.8%	1% relative improvement over baseline	TBD	N/A

[4] There are two official recruitment periods for the Collaboratives. Collaborative I was 10/1/2014 – 3/31/2015 (FY15) and Collaborative II is 10/1/2016 – 3/31/2017 (FY17). There is no official recruitment period for FY 2016.

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Medicare Benefits
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Budget Authority	$639,807,000	$688,031,000	$711,394,000	+ $23,363,000
Outlays	$631,852,000	$688,031,000	$711,394,000	+ $23,363,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process. The estimates are based on the FY 2017 President's Budget, and include the effects of the sequester orders for FY2015 and FY2016 and expected savings from Program Integrity initiatives.

Authorizing Legislation - Title XVIII of the Social Security Act
FY 2017 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 have already contributed to significant improvements to the Medicare program.

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 58.4 million beneficiaries in FY 2017.

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. Medicare Part A 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 HI Trust Fund and invested in U.S. Treasury securities.

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. Beneficiaries who choose the optional Part B coverage are subject to monthly premium payments. About 90 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 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 19.2 million enrollees in FY 2017.

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 the Prescription Drug 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 44.5 million in FY 2017, including 42.8 million enrolled in Part D plans and 1.5 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 2012	$549,311,000,000
FY 2013	$586,877,000,000
FY 2014	$597,132,000,000
FY 2015	$631,852,000,000
*FY 2016	$688,031,000,000
*Estimate Under Current Law	

Budget Estimates

The budget estimates for Medicare benefit outlays for FY 2017, by trust fund account, are shown in the following table. (Numbers may not add due to rounding.)

	FY 2017	+/- from FY 2016
HI – Part A	$300,988,000,000	$8,912,000,000
SMI – Part B	$311,882,000,000	$11,586,000,000
SMI – Part D	$98,524,000,000	$2,865,000,000
Total	$711,394,000,000	$23,363,000,000

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

The estimate for FY 2017 is an increase of $23,363,000,000 from FY 2016. This increase is due primarily to higher enrollment estimates and increased medical service utilization/costs.

Medicare Benefits Performance Measurement

MCR1 Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive: CMS has monitored Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. As the ACA is implemented, we will continue 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 2015 targets reflecting beneficiary experience in FFS and MA access to care in 2014. For FY 2015, at least 90 percent of beneficiaries surveyed reported that they have access to care in the MFFS and MA programs. After FY 2015, we will no longer set targets for this measure, but will report the trend annually as a contextual measure.

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: This measure tracks the success of the 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 2013 target of 55 percent, with an actual result of 52 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. Results are still pending for FY 2014. To reflect current analysis using baseline data and applying the discounts that will be available to beneficiaries through 2020, CMS set the FY 2017 target at 43 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 assessing health risks, furnishing personalized health advice and referrals, as appropriate to health education and preventive counseling services, and creating a screening schedule for the next five to ten years. The elements also include a list of risk factors and conditions, as well as ongoing and/or recommended interventions. The CY 2014 target was set at 3.2 million. The FY 2014 result was 4.9 million. After FY 2014, we no longer set targets for this measure, but report the trend annually as a contextual indicator. Additional information about preventive services provided to Medicare beneficiaries is available at Medicare.gov.

Key Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
MCR1.1a Maintain or Exceed Percent of Beneficiaries in Medicare Fee-for-Service (FFS) Who Report Access to Care (Outcome)	FY 2015: 91% Target: 90% (Target Exceeded)	Contextual Indicator	Contextual Indicator	N/A
MCR1.1b Maintain or Exceed Percent of Beneficiaries in Medicare Advantage (MA) who Report Access to Care (Outcome)	FY 2015: 90% Target: 90% (Target Met)	Contextual Indicator	Contextual Indicator	N/A
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 2013: Result 52% Target: 55% (Target Exceeded)	48%	43%	-5 pp
MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Outcome)	FY 2014: 4.9 million Target: 3.2 million (Target Exceeded)	Contextual Indicator	Contextual Indicator	N/A

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Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2015 Enacted	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
State allotments (ACA P.L 111-148 ; P.L. 113-164 MACRA, P.L. 114-10)	$16,512,000	$19,300,000	$20,400,000	$1,100,000
CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235)	$74,215	$74,215	$6,571,852	$6,497,637
Child Health Quality Improvement (P.L. 111-3, 114-10)	$37,050	$53,166	$27,064	($26,102)
Total Budgetary Resources /1	**$16,623,265**	**$19,427,381**	**$26,998,916**	**$7,571,535**
CHIP State Allotment Outlays /2	$9,142,484	$14,400,000	$15,000,000	$600,000
Performance Bonus Payments Outlays	$61,700	$0	$0	$0
Child Health Quality Improvement Outlays	$27,767	$26,102	$15,485	($10,617)
Total Outlays	**$9,231,951**	**$14,426,102**	**$15,015,485**	**$589,383**

1/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions. These funding levels are subject to change due to adjustments throughout the year. The Child Health Quality funding excludes no less than $15 million in resources from the Adult Health Quality appropriation authorized pursuant to P.L. 113-93.

2/ Estimate includes spending from prior year allotments. FY 2015 outlays excludes redistribution funds. The increase in outlays from FY 2015 to FY 2016 is primarily due to the 23 percentage point increase in matching rates, effective from FY 2016 to FY 2019.

Child Enrollment Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2015 Enacted	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Child Enrollment Contingency Fund, Budget Authority /1	**$2,098,437**	**$5,908,337**	**$7,087,332**	**$1,178,995**
Transfer to Performance Bonus Fund	$0	$0	$6,517,332	$6,517,332
Payments to shortfall states	$52,757	$0	$0	$0
Interest Estimate	$2,657	$38,995	$15,561	($23,434)
Total Budgetary Resources, end of year	$2,048,337	$3,898,995	$585,561	($3,313,434)
Total Outlays	**$8,826**	**$52,931**	**$0**	**($52,931)**

1/ Reflects both carryover resources and deposits into the Fund. The Consolidated Appropriations Act, 2016 (P.L. 114-113) makes the carryover balance temporarily unavailable for obligation during FY 2016.

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 Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Program Description and Accomplishments

The Balanced Budget Act of 1997 authorized 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 has improved access to health care and the 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, create separate CHIP programs, or have a combination of the two.

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 flexibilities to make innovative changes. As of July 1, 2015, CMS has approved a total of 783 amendments to CHIP state plans.

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. 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. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides an additional $39.7 billion in budget authority for FYs 2016 and 2017.

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* – Created as an incentive for States to enact policies promoting the 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 transfers of any unobligated national allotments and excess funds exceeding the aggregate cap from the Child Enrollment Contingency Fund. The authority for Performance Bonus payments expired at the end of FY 2013.

- *Child Enrollment Contingency Fund* – This fund is used to provide supplemental funding to States that exceed their allotment due to 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 if its average monthly child enrollment exceeds the targeted average number of enrollees for the fiscal year. MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017.

  The fund received an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2017, Section 2104(n) of the Social Security Act appropriates amounts necessary to make payments to eligible States, not to exceed 20 percent of the total annual allotment appropriation for CHIP. Any amounts in excess of the aggregate cap are made available for CHIP Performance Bonus Payments. In addition, the contingency fund is invested in interest bearing securities of the United States; income derived from these investments constitutes a part of the fund. The fund accrued a total of $2,657,000 in interest in FY 2015 and is estimated to accrue an additional $38,995,000 in FY 2016. To date, two States (Iowa and Michigan) have qualified for payments from 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 authorizing several grants and contracts to develop and test these quality measures. A total of $225 million at $45 million per year for FYs 2009-2013 was appropriated and is available until expended. Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) ensures at least $15 million is transferred from Medicaid Adult Health Quality funding. In addition, MACRA (P.L. 114-10) provides $20,000,000 available for Child Health Quality activities

beginning on October 1, 2015.

The current status of Child Health Quality Improvement activities in Medicaid and CHIP include:

CHIPRA Pediatric Quality Measures Program:

- Beginning in February 2011, CMS and the Agency for Healthcare Research and Quality (AHRQ) have collaborated to identify and improve the core set of children's health care quality measures. During 2013, CMS and AHRQ began releasing improvements to the Core Set (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf) and updates to the 2014 the Core Set. In December 2014, CMS released the 2015 updates to the Core Set via an informational bulletin available at: http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf. For FY 2015, CMS retired one measure, added two measures, and introduced a pilot reporting process for the child version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) in order to assess future inclusion of Child HCAHPS in the Core Set. The FY 2016 child core measure updates were released in December 2015 (informational bulletin available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf) and include the addition of two new 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" in FY 2011. Under this program CMS holds national and individual state technical assistance calls, webinars and has released issue briefs for States to provide clarification and guidance about collecting, reporting, and using the Child Core Set measures to drive quality improvements in health care. As part of these activities, CMS also released an annual technical specification and resource manual for States. Information on the technical support and analytic program is available at: CMS Medicaid Child Core Measures Technical Assistance and Analytic Program Support

- CMS has sponsored a quality improvement series to increase States' knowledge about how to design and implement quality improvement projects. Current information on national quality initiatives, including one focused on oral health for children, is available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html

- State data derived from the voluntary Child Core Set measures are part of the annual Secretary's Report on the Quality of care for Children in Medicaid and CHIP published annually – also available on the Medicaid and CHIP Quality web page: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html

- In FY 2011, CMS, in collaboration with the AHRQ, created seven Centers of Excellence to develop measures of healthcare quality for children. The Centers of Excellence receive prioritized measurement development assignments for maternal/infant, child and adolescent health measures. Measures are focused on care coordination, content and follow-up of well-care visits, sickle cell, pediatric readmissions, cost and efficiency. In 2015, the seven Centers of Excellence submitted 18 measures for National Quality Forum measure endorsement consideration across several clinical areas of focus.

- CMS continues collaboration with the Office of the National Coordinator of Health IT to develop and test a small set of measures for inclusion in the electronic health records certification program. In 2015, one measure on screening for reduction in visual acuity for children (electronically specified for use in electronic health records) was endorsed by the National Quality Forum on a trial basis.

- The Medicare Access and CHIP Reauthorization Act (MACRA) (P.L. 114-10) provides $20,000,000 available for additional Child Health Quality activities beginning on October 1, 2015. These funds will continue to support the CHIPRA Pediatric Quality Measures Program, which will include a new CMS and AHRQ collaboration for a next phase of Centers of Excellence under a new multi-year competitive cooperative agreement program aimed at establishing partnerships with the state Medicaid/CHIP programs to support development, testing, use and implementation of new or enhanced pediatric quality measures (see https://grants.nih.gov/grants/guide/notice-files/NOT-HS-16-002.html).

CHIPRA Electronic Health Record Program:

- CMS and AHRQ jointly released development standards including data elements and standards for EHR developers to ensure relevant elements are captured in a consistent manner. The standards can be found at http://www.ahrq.gov/news/newsroom/press-releases/2013/childehrpr.html. 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 the 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, completed testing the impact of the Children's EHR format.

- In 2014, CMS in collaboration with AHRQ developed and implemented a second phase effort to improve format requirements by obtaining input from a multi-stakeholder workgroup that has included state Medicaid program representatives, a diverse health care providers, and Federal agencies. This project produced the Children's EHR Format 2015 Priority List, and Recommended Uses for the Format, which are designed to provide additional guidance. They are intended to enhance the use of the Format by providing a short list—47 items—for all stakeholders to focus on. The 2015 Priority List and Recommended Uses of the Format are intended to spur dialogue among software developers, practitioners, provider organizations, professional organizations, and other stakeholders working to improve the care of children and the technologies supporting their care.

CHIPRA Quality Demonstration Grants:

- CMS awarded the first $20,000,000 in demonstration grants to ten States in February, 2010. The fifth year of the demonstrations ended February 2015; however final no cost extensions for several states will end in February 2016.

- 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 included asthma management best practices, integration of EHR's 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 included care coordination in rural areas, psychotropic medication prescribing practices for youth, and an update on the Children's EHR format. In 2015, topics included integration of developmental screening into the Electronic Health record, EHR implementation and working with vendors to improve quality reporting, using Health IT to provide information to families and primary care providers in rural states for children with special health care needs. 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. The final report for each grantee is due to CMS 90 days after the grant ends. Final reports have been received from three states, the remaining reports will be completed in 2016 after no-cost grant extensions are completed.

- In December 2014, the CHIPRA Quality Demonstration Grantees attended the CMS Healthcare Quality Conference known as QualityNet. During the conference, grantees attended several sessions focused on sustaining grant activities beyond the grant period. In December 2015, the CMS Quality Conference no longer required CHIPRA grantee attendance but offered an interactive, streaming option for all state representatives (particular those with limited travel funds) to attend several plenary sessions. Information for the 2015 Quality Conference is available here: http://www.cmsqualityconference.com/index.html

- The National Evaluation of the CHIPRA Quality Demonstrations conducted site visits to all 10 Grantee states in FY 2012 and launched The National Evaluation website, which is hosted by the AHRQ website. In early 2013, the National Evaluation team released its first evaluation highlight (http://www.ahrq.gov/policymakers/chipra/demoeval/highlights/highlight01.pdf). CMS has partnered with AHRQ and the National Evaluation team to complete 9 evaluations focused on how grantees are implementing medical home models and strategies to improve adolescent health care, and to support the use of care coordinators. In addition, the National Evaluation team produced two implementation guides titled: Engaging Stakeholders to Improve the Quality of Children's Health Care and Designing Care Management Entities for Youth with Complex Behavioral Health Needs. As the grant comes to a close, the National Evaluation team will work with AHRQ and CMS to develop updated grantee state profiles and a final evaluation report on lessons learned from the grantees.

- In September 2015 The National Evaluation team posted their final evaluation report: http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/final-report/index.html

- State spotlights and toolkits are also posted on this website.

A Knowledge Transfer Plan has been developed by the CHIPRA National Evaluation Team through AHRQ with funding from CMS. This Knowledge Transfer plan will begin in February 2016 with an all states webinar to leverage the knowledge gained from this demonstration program and evaluation, and disseminate lessons learned from the states that participated in the demonstration program to other states, so that all states may benefit from this initial investment. This knowledge transfer will include an opportunity for technical assistance and peer-to-peer learning aimed at States that did not participate in the demonstration so that they may benefit from the experiences of the 18 states that did.

History of Funding for State Allotments

FY 2012	$14,982,000,000
FY 2013	$17,406,000,000
FY 2014	$19,147,000,000
FY 2015 /1	$16,512,000,000
FY 2016 /2	$14,621,500,000
FY 2017	$20,400,000,000

1/ Reflects rescission of $4.5 billion in funding from section 108 of CHIPRA as amended by the ACA, pursuant to Continuing Appropriations Act, 2015 (P.L. 113-164).

2/ Reflects rescission of $4.7 billion in funding from from section 108 of CHIPRA as amended by the ACA, Consolidated Appropriations Act, 2016 (P.L. 114-113).

MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in millions)				
STATE/TERRITORY	**FY 2015 Actual**	**FY 2016 Estimate**	**FY 2017 Estimate**	**Difference +/-**
Alabama	$172,891,139	$267,591,753	$316,354,768	$48,763,015
Alaska	$23,910,732	$20,378,189	$28,767,330	$8,389,141
Arizona	$80,667,272	$123,657,687	$200,909,074	$77,251,387
Arkansas	$93,979,986	$174,523,842	$45,804,729	-$128,719,113
California	$1,744,125,256	$1,995,221,518	$2,898,031,398	$902,809,880
Colorado	$157,511,557	$228,329,398	$234,514,741	$6,185,343
Connecticut	$48,065,486	$61,880,080	$95,121,724	$33,241,644
Delaware	$20,260,583	$38,530,635	$32,078,378	-$6,452,257
District of Columbia	$20,711,492	$25,628,736	$26,074,088	$445,352
Florida	$566,046,165	$594,954,867	$767,031,891	$172,077,024
Georgia	$410,563,877	$418,167,985	$502,470,966	$84,302,981
Hawaii	$46,316,362	$46,342,953	$49,862,474	$3,519,521
Idaho	$66,215,579	$66,419,646	$75,489,206	$9,069,560
Illinois	$361,409,768	$406,233,653	$386,030,722	-$20,202,931
Indiana	$162,870,689	$165,656,663	$191,666,363	$26,009,700
Iowa	$126,011,540	$147,611,275	$155,688,885	$8,077,610
Kansas	$85,145,595	$112,200,762	$122,948,706	$10,747,944
Kentucky	$171,913,833	$232,037,959	$284,635,420	$52,597,461
Louisiana	$180,137,373	$238,942,531	$291,871,912	$52,929,381
Maine	$27,360,784	$32,288,872	$35,593,860	$3,304,988
Maryland	$234,273,651	$290,764,875	$343,156,079	$52,391,204
Massachusetts	$413,777,222	$535,766,712	$604,250,485	$68,483,773
Michigan	$118,574,680	$323,907,001	$286,969,383	-$36,937,618
Minnesota	$41,134,975	$98,575,110	$92,708,404	-$5,866,706
Mississippi	$226,177,241	$246,725,634	$299,251,327	$52,525,693
Missouri	$163,186,707	$172,902,565	$193,052,326	$20,149,761
Montana	$91,735,250	$95,823,327	$103,643,160	$7,819,833
Nebraska	$69,689,494	$78,189,102	$79,911,622	$1,722,520
Nevada	$43,104,975	$63,304,187	$76,312,024	$13,007,837
New Hampshire	$20,001,538	$39,173,598	$32,048,936	-$7,124,662
New Jersey	$344,792,536	$406,769,636	$484,991,018	$78,221,382
New Mexico	$73,634,574	$122,482,774	$149,109,995	$26,627,221
New York	$972,787,164	$1,074,559,391	$1,026,811,556	-$47,747,835
North Carolina	$395,016,255	$448,150,621	$778,531,450	$330,380,829

MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in millions)				
STATE/TERRITORY	**FY 2015 Actual**	**FY 2016 Estimate**	**FY 2017 Estimate**	**Difference +/-**
North Dakota	$20,997,498	$21,240,226	$23,023,989	$1,783,763
Ohio	$342,770,703	$352,648,030	$351,755,273	-$892,757
Oklahoma	$173,065,156	$189,238,252	$223,821,649	$34,583,397
Oregon	$193,533,316	$211,330,598	$238,984,982	$27,654,384
Pennsylvania	$371,121,185	$364,346,720	$397,959,002	$33,612,282
Rhode Island	$45,986,699	$65,427,018	$65,590,893	$163,875
South Carolina	$142,877,941	$162,036,814	$189,481,639	$27,444,825
South Dakota	$18,867,699	$23,572,173	$27,920,154	$4,347,981
Tennessee	$198,088,065	$213,273,226	$287,989,068	$74,715,842
Texas	$1,068,726,722	$1,345,137,792	$1,636,307,896	$291,170,104
Utah	$59,109,378	$148,910,798	$139,688,629	-$9,222,169
Vermont	$15,584,272	$29,298,884	$17,041,802	-$12,257,082
Virginia	$247,585,520	$265,184,717	$313,571,760	$48,387,043
Washington	$128,952,351	$215,289,431	$202,223,020	-$13,066,411
West Virginia	$55,249,339	$65,438,595	$75,094,881	$9,656,286
Wisconsin	$221,241,211	$225,823,633	$198,149,428	-$27,674,205
Wyoming	$11,393,195	$10,917,146	$13,861,514	$2,944,368
Subtotal	**$11,089,151,580**	**$13,302,807,590**	**$15,694,159,979**	**$2,391,352,389**
Commonwealths and Territories				
American Samoa	$1,695,902	$2,135,479	$2,460,843	$325,364
Guam	$5,902,582	$8,003,537	$8,588,884	$585,347
Northern Mariana Islands	$1,156,514	$1,042,711	$1,713,618	$670,907
Puerto Rico	$183,240,747	$179,847,155	$187,986,690	$8,139,535
Virgin Islands	$4,960,412	$5,323,221	$5,778,834	$455,613
Subtotal	**$196,956,157**	**$196,352,103**	**$206,528,869**	**$10,176,766**
TOTAL RESOURCES	**$11,286,107,737**	**$13,499,159,693**	**$15,900,688,848**	**$2,401,529,155**

Note: Allotments to states remain available for Federal payments for two years.

Children's Health Insurance Program (CHIP) 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 December 2014, CMS retired one measure, "Percentage of eligibles that received dental treatment services", and added two measures: "Dental sealants for 6-9 year old children at elevated caries risk"; and "Child and adolescent major depressive disorder: suicide risk assessment".[1]

While the use of the Child Core Set is voluntary for States, CMS encourages all States to use the Child Core Set to collect and report data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2014, 88 percent of States reported on at least eight quality measures, falling just short of our target to have 90 percent of States report on at least eight quality measures in the Children's Core Set. In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which extends funding for the Pediatric Quality Measures Program by appropriating an additional $20 million in FY 2016. The FY 2017 target is to work with States to ensure that 90 percent of States report on at least eleven 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, as well as one-on-one calls with States, 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 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in Medicaid and CHIP: 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 ACA provided CHIP funding through FY 2015 and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019. In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which extends CHIP funding for an additional two years, through September 30, 2017.

[1] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf

This measure should be considered in the context of 2013 data that show that in 23 States at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[2] In contrast, in 2008 five States had rates at or above 90 percent. Many factors will affect enrollment figures in CHIP and Medicaid, including States' economic situations, programmatic changes, and the accuracy and timeliness of State reporting. There have also been key legislative changes in recent years with policy changes directed at eligibility and enrollment. In 2014, 43,689,824 children were enrolled in Medicaid CHIP for at least one month of the year, falling short of our target of 46,617,385 children (Medicaid 38,083,596/CHIP 8,533,789). The FY 2017 target is to increase CHIP and Medicaid enrollment to 46,062,581 children, (Medicaid: 36,850,065/CHIP: 9,212,516).

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2014: 88% of States reported on at least eight quality measures Target: Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA core set of quality measures (Target Not Met)	Work with States to ensure that 90% of States report on at least ten quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA core set of quality measures	+1 quality measure
CHIP3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in Medicaid and CHIP[3] FY 2008: 37,311,641 children (baseline)	FY 2014: 43,689,824 children[4] Target: 46,617,385 children (Target Not Met)	45,271,662 children	46,062,581 children	+790,919 children

[2] http://www.insurekidsnow.gov/professionals/reports/index.html

[3] The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

[4] The Medicaid and CHIP breakout is not currently available, as one large state reported an unduplicated Medicaid and CHIP combined total, but did not report unduplicated individual totals for Medicaid and CHIP.

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State Grants and Demonstrations

State Grants and Demonstrations Budget Authority (Dollars in Thousands)

Program	FY 2015 Enacted	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Money Follows the Person (MFP) Demonstration[1]	$416,130	$418,375	$0	-$418,375
MFP Research & Evaluations[2]	$1,020	$1,025	$0	- $1,025
Medicaid Integrity Program[3]	$76,757	$77,403	$84,047	$6,644
Medicaid Integrity Program-Proposed	$0	$0	$25,000	$25,000
Subtotal – DRA	**$493,907**	**$496,803**	**$109,047**	**-$387,756**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment[4]	$0	$40,000	$0	-$40,000
Subtotal – CHIPRA	**$0**	**$40,000**	**$0**	**-$40,000**
Affordable Care Act (ACA)				
Medicaid Emergency Psychiatric Demonstration Project	$0	$0	$0	$0
Subtotal – ACA	**$0**	**$0**	**$0**	**$0**
Protecting Access to Medicare Act (PAMA)				
Demonstration Programs to Improve Community Mental Health Services[5]	$0	$23,300	$0	-$23,300
Subtotal – PAMA	**$0**	**$23,300**	**$0**	**-$23,300**
Appropriations/BA	**$493,907**	**$560,103**	**$109,047**	**-$451,056**

Authorizing Legislation - 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; Protecting Access to Medicare Act of 2014, Public Law 113-93, Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10.
Allocation Method - Grants, Other

[1] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2015 and FY 2016 columns reflect post-sequestration amounts.
[2] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2015 and FY 2016 columns reflect post-sequestration amounts.
[3] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2015 and FY 2016 columns reflect post-sequestration amounts.
[4] P.L. 114-10 provides new budget authority and extends the availability through FY 2017.
[5] The FY 2016 column reflects the post-sequestration amount.

State Grants and Demonstrations Gross Outlays

(Dollars in Thousands)

Program	FY 2015 Enacted	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$1,541	$1,309	$0	-$1,309
Subtotal TWWIIA	**$1,541**	**$1,309**	**$0**	**-$1,309**
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$1,135	$2,189	$2,000	-$189
Subtotal – MMA	**$1,135**	**$2,189**	**$2,000**	**-$189**
Deficit Reduction Act (DRA)				
Long-Term Care	$1,635	$0	$0	$0
Psychiatric Residential Treatment Facilities (PRTF)	$2,184	$20,000	$0	-$20,000
Money Follows the Person (MFP) Demonstration	$427,094	$461,926	$425,000	-$36,926
MFP Research & Evaluations	$1,128	$1,650	$1,980	$330
Medicaid Integrity Program	$83,996	$82,813	$82,913	$100
Medicaid Integrity Program-Proposed	$0	$0	$25,000	$25,000
Subtotal – DRA	**$516,037**	**$566,389**	**$534,893**	**-$31,496**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment	$17,407	$14,517	$14,745	$228
Subtotal – CHIPRA	**$17,407**	**$14,517**	**$14,745**	**$228**
Affordable Care Act (ACA)				
Medicaid Emergency Psychiatric Demonstration Project	$34,926	$1,558	$0	-$1,558
Medicaid Incentives for Prevention of Chronic Diseases	$18,198	$22,942	$15,584	-$7,358
Subtotal – ACA	**$53,124**	**$24,500**	**$15,584**	**-$8,916**
Protecting Access to Medicare Act (PAMA)				
Demonstration Programs to Improve Community Mental Health Services	$626	$23,761	$429	-$23,332
Subtotal – PAMA	**$626**	**$23,761**	**$429**	**-$23,332**
Total Outlays for State Grants and Demonstrations[6]	**$589,870**	**$632,665**	**$567,651**	**-$65,014**

[6] Amounts on this table include outlays from obligations made in previous fiscal years.

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 undocumented aliens and other eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight and resources to combat fraud, waste and abuse; improving the effectiveness and efficiency in providing Medicaid; 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. The Protecting Access to Medicare Act of 2014 provided funding for Demonstration Programs to Improve Community Mental Health Services. The Medicare Access and CHIP Reauthorization Act of 2015 provided additional funding and extended the CHIP outreach and enrollment activities through FY 2017.

Funding History

FY 2012	$528,334,000
FY 2013	$503,173,000
FY 2014	$1,423,230,000
FY 2015	$493,907,000
FY 2016	$560,103,000

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.

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))[7] and related services. Section 1011 provided $250 million per year during each of Federal fiscal years 2005 through 2008.

As of November 2015, Section 1011 provided funding to a total of 2,276 hospitals, 49,376 physicians, and 538 ambulance providers. Since inception of the program in May 2005 through November 2015, Section 1011 has disbursed $976 million in provider payments, in response to 1,508,320 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 fiscal years 2005 through 2008. Individual state allocations, for each year of appropriation, were based on data provided by the Department of Homeland Security (DHS). Two-thirds of the 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.

The Centers for Medicare & Medicaid Services (CMS) has announced the sunsetting of the Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Program at the end of fiscal year 2016. Providers actively billing Section 1011 were notified on December 28, 2015.

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 have options to rebalance their long-term support programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve

[7] 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.

independence. Specifically, the MFP demonstration supports state efforts to:

- Rebalance their long-term services and supports 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; and
- 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 grant awards that were made in FY 2007-FY 2015. 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 Tribes. 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. In April 2014, CMS awarded a total of $1.48 million to five MFP grantees for the first phase of the program development. The amounts in the chart on the following page are inclusive of these supplemental awards.

According to the December 2014 Overview of State Grantee Progress Report, program transitions for the period from January 1, 2014 through December 31, 2014 numbered 10,983, which represents a 27 percent increase in cumulative transitions over the previous year. To serve a participant in the program costs half as much as the cost of care in an institution. The rebalancing funds that are generated by the program have helped states expand and improve their home and community based service programs.

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 amended the Deficit Reduction Act providing $450 million in each fiscal year from 2012-2016, totaling an additional $2.25 billion. In accordance with various sequestration reports, funding for the MFP demonstrations and evaluation was reduced by 5.1 percent in FY

2013, 7.2 percent in FY 2014, and 7.3 percent in FY 2015. The adjusted FY 2013 appropriation was $427 million; the adjusted FY 2014 appropriation was $418 million; and the adjusted FY 2015 appropriation was $417 million. The FY 2016 appropriation was $450 million. The FY 2016 appropriation was reduced by 6.8 percent due to sequestration, bringing the adjusted appropriation to $419 million. There is no appropriation in FY 2017 for this program. 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. CMS will be awarding multi-year grants in FY 2016 allowing the funds to be expended through FY 2020. CMS will continue to monitor each States' grant activities, progress and expenditures through the entire project period.

CMS has also provided 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, a total of $2.4 million was made available in fiscal years 2007 and 2008 to carry out technical assistance for, and oversight of, states efforts to improve quality under HCBS waivers and $1.1 million per year for evaluation and reporting to Congress. In addition, Section 2403 of the Affordable Care Act authorizes $1.1 million from each year's appropriation in FY 2012 through FY 2016 that may be used to carry out evaluation and a required Report to Congress.

As of December 2015, CMS obligated $2,262,164,048 in grants to 44 States and the District of Columbia (DC). Grantees have transitioned over 51,676 individuals as of December 2014. The 43 participating States and DC have proposed to transition an additional 14,023 individuals out of institutional settings through 2016.

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION			
State	***Cumulative Award Total 2007-2015***	***Budget Projections 2016-2020***	***Total Project Funds (Cumulative award plus budget projections)***
Alabama	11,265,157	62,218,505	73,483,662
Arkansas	38,713,512	63,185,133	101,898,645
California	82,782,164	80,351,757	163,133,921
Colorado	5,693,884	28,533,162	34,227,046
Connecticut	80,508,236	123,996,120	204,504,356
District of Columbia	23,993,706	12,860,015	36,853,721
Delaware	10,081,942	12,376,250	22,458,192
Georgia	107,847,829	127,259,055	235,106,884
Hawaii	7,798,138	9,924,730	17,722,868
Idaho	10,847,636	14,171,375	25,019,011
Iowa	40,278,953	47,085,914	87,364,867

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION			
State	***Cumulative Award Total 2007-2015***	***Budget Projections 2016-2020***	***Total Project Funds (Cumulative award plus budget projections)***
Illinois	25,222,467	20,333,537	45,556,004
Indiana	52,241,640	126,255,079	178,496,719
Kansas	48,020,893	18,614,151	66,635,044
Kentucky	47,438,477	135,239,414	182,677,891
Louisiana	36,727,103	63,720,631	100,447,734
Maine	5,807,423	6,278,259	12,085,682
Maryland	108,197,556	66,003,907	174,201,463
Massachusetts	65,227,193	36,305,383	101,532,576
Michigan	51,507,308	13,803,050	65,310,358
Minnesota	20,559,703	47,086,946	67,646,649
Mississippi	15,706,053	21,740,687	37,446,740
Missouri	51,431,364	23,736,949	75,168,313
Montana	3,999,202	9,244,239	13,243,441
North Carolina	27,404,473	44,922,723	72,327,196
North Dakota	18,473,232	37,487,794	55,961,026
Nebraska	14,116,456	8,675,529	22,791,985
Nevada	4,989,657	7,167,104	12,156,761
New Hampshire	12,137,770	3,314,824	15,452,594
New Jersey	65,018,705	83,290,770	148,309,475
New York	109,245,051	117,972,622	227,217,673
Ohio	177,913,578	113,297,265	291,210,843
Oklahoma	44,942,017	16,278,545	61,220,562
Oregon	31,269,191	8,339,454	39,608,645
Pennsylvania	91,034,834	89,415,880	180,450,714
Rhode Island	6,870,240	10,724,154	17,594,394
South Carolina	2,270,084	6,839,577	9,109,661
South Dakota	1,323,044	2,828,328	4,151,372
Tennessee	53,380,765	73,348,298	126,729,063
Texas	306,741,284	262,543,877	569,285,161
Vermont	7,772,274	5,996,915	13,769,189
Virginia	49,894,990	33,404,548	83,299,538
Washington	120,305,388	80,720,943	201,026,331
West Virginia	9,463,018	14,675,764	24,138,782
Wisconsin	37,092,702	22,726,672	59,819,374
Totals	**2,143,556,292**	**2,214,295,834**	**4,357,852,126**

NOTE: States may exceed their original request for funding by surpassing 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; and Oregon terminated the grant in June 2015.

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 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 Medicaid Integrity Program 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.

The Patient Access and Medicare Protection Act (Public Law 114-115) recently changed the authorities for the Medicaid Integrity Program to allow for greater flexibility in using a mix of contractors and Federal personnel for the activities described in Section 1936. CMS looks forward to using this new flexibility to more quickly adapt to changing Medicaid program integrity needs.

CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste, and abuse beginning in FY 2006. The first CMIP was published in July 2006, and covered FY's 2006 through 2018. The most recent CMIP was released in July 2014 and covers FY's 2014 through 2018. The FY 2014-2018 CMIP is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

The Medicaid Integrity Program has achieved a number of clear successes since the start of the program in 2006.

The National Medicaid Audit Program (NMAP)

Congress originally mandated that CMS enter into contractual agreements with eligible entities to do the following:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and,
- Conduct education of State or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

The contractors that perform these functions have historically been 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 NMAP.

In the last few years, CMS has redesigned the 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 2015, CMS had assigned a cumulative total of 905 collaborative audits with 41 states that represent approximately 89 percent of Medicaid program expenditures. As a result of continued improvements in the audit program, NMAP MICs identified $35.1 million in overpayments in FY 2015, of which $28.1 million were overpayments identified by collaborative audits.

CMS is reconfiguring its approach to the review and audit of Medicaid providers 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 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 UPIC solicitation was released on July 17, 2015 and the first UPIC award is anticipated to be made during the second quarter of 2016.

Medicaid Integrity Institute (MII)

In collaboration with the United States Department of Justice (DOJ), CMS also established the MII to provide State employees with a comprehensive training of course work encompassing numerous aspects of Medicaid program integrity.

The MII has been cited repeatedly by States, the Government Accountability Office (GAO), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association for Medicaid Program Integrity (NAMPI), and the National Association of Medicaid Directors (NAMD) as making a substantial contribution to State efforts to combat fraud and improper payments. From its inception in 2008 through December 31, 2015 the MII has trained State employees from all 50 States, the District of Columbia, and Puerto Rico through more than 6,400 enrollments in 139 courses and 10 workgroups. In FY 2015 alone, the MII conducted 22 courses and 1 workgroup meeting with 1,073 enrollments. The MII developed a distance learning program in addition to its classroom activities, and sponsored 36 webinars between FY 2012 and FY 2015 to extend its training capacity to even more State program integrity staff. The MII also began offering a credentialing program for State Medicaid program integrity employees to certify their professional qualifications. As of August 2015, 226 State employees in 44 States had received the credential of Certified Program Integrity Professional. In addition, the MII supports a secure, web-based information sharing system called the Regional Information Sharing System (RISS) that all States may 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 the MII by expanding course offerings and other training opportunities.

State Program Integrity Reviews

Since 2007, CMS has conducted State program integrity reviews, which assess the operations of each State's Medicaid program integrity unit and report on vulnerabilities and best practices. By the end of FY 2013, CMS had completed 110 comprehensive program integrity reviews, including each State, Puerto Rico and the District of Columbia at least twice. During FYs 2014 and FY 2015, CMS conducted focused reviews of high-risk program integrity areas rather than comprehensive State reviews. Focused reviews have examined areas such as managed care in Medicaid expansion States, enhanced provider screening and enrollment activities required by the Affordable Care Act, non-emergency medical transportation and personal care services. 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.

Technical Assistance to States

The Medicaid Integrity Program 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 has also worked with states to provide technical assistance regarding the procurement of predictive analytics technologies through the review of advance planning documents. CMS has identified criteria to evaluate and improve the states' procurement efforts. Moreover, CMS has also begun granting states' requests for Medicare data to be used in the states' program integrity efforts. CMS intends to continue working with these states while monitoring results in order to inform CMS and other states of positive opportunities for conducting analytics. Additionally, CMS is currently partnering with the Ohio Department of Medicaid (ODM) in a project to combine the state's Medicaid data with the federal Medicare data for proactive data analysis purposes.

CMS also assists in the education of Medicaid providers, beneficiaries and Managed Care Organizations (MCOs) on program integrity efforts by employing an Education MIC to develop materials, conduct training, provide educational resources to educate providers, beneficiaries, MCOs and stakeholders, promote best practices and fraud and compliance awareness, and encourage Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. CMS currently maintains an 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 a wide array of resources using a variety of media including print and electronic formats, toolkits, train- the-trainer guides, webinars, YouTube videos, and other strategies. The current 18 educational toolkits cover topics such as managed care compliance, pharmacy education, drug diversion, off-label pharmaceutical marketing, dental professional compliance, personal care services, nursing home compliance, safeguarding your medical identity, documentation matter, beneficiary card sharing, hospice care, electronic health records, data mining, audit, home and community based services, non-emergency medical transportation 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 47 States, Puerto Rico, and the District of Columbia. State staff are trained to use the above train-the-trainer resources to conduct ongoing education for their co-workers' providers, beneficiaries and MCOs in their States.

In the last few years, CMS has continued to improve and expand support for provider enrollment and screening by State Medicaid programs. The Affordable Care Act and section 1902 of the Social Security Act allow States to rely on Medicare Fee For Service provider enrollment screening and coordination between State programs for Medicaid terminated providers. CMS continues to facilitate the exchange of information between Medicare and all States about providers who have been terminated for cause – allowing Medicare and other State agencies to take action on those providers. To reduce provider burden and avoid duplication of efforts, CMS provides States access to the Medicare Enrollment System (PECOS) and to data files with key information about providers to support State screening and enrollment efforts.The data sharing files are made available for all states to download. These files have been downloaded 584 times by participating States from February 2014 through November 2015, and, at the most recent PECOS training offered by CMS, 143 participants from States were in attendance. CMS is also continually providing States educational support via the monthly provider enrollment technical assistance group (PETAG) call, one on one webinar sessions and the MII.

Budget Overview

The DRA appropriated $5 million in FY 2006, $50 million in fiscal years 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 $80.2 million with a CPI-U adjustment of 1.6 percent, bringing the total new budget authority to $81.5 million. The FY 2014 budget authority was reduced by 7.2 percent due to sequestration, bringing the final budget authority to $75.6 million. The FY 2015 appropriation was $81.5 million with a CPI-U adjustment of 1.6 percent, bringing the total budget authority to $82.8 million. The FY 2015 budget authority was reduced by 7.3 percent due to sequestration, bringing the final budget authority to $76.8 million. The FY 2016 budget authority is $82.8 million with an estimated CPI-U adjustment of 0.3 percent, bringing the total budget request to $83.1 million. The FY 2016 budget authority will be reduced by 6.8 percent due to sequestration, bringing the final budget authority to $77.4 million. The FY 2017 budget authority will be $83.1 million with an estimated CPI-U adjustment of 1.2 percent, bringing the total budget authority to $84.0 million. The CPI-U adjustments are based on the current FY 2017 President's Budget economic assumptions. Funds appropriated remain available until expended. The program integrity chapter of the Budget in Brief describes a proposal to increase the budget for the Medicaid Integrity Program by $580 million over ten years on top of the current funding level.

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 (ACA) provided an additional $40 million. Section 303 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides an additional $40 million for FY 2016 and FY 2017. These programs will conduct outreach and enrollment efforts designed to increase the

enrollment of children who are eligible for Medicaid or CHIP.

Outreach and Enrollment Grants

The grants provide outreach and application assistance to enroll eligible, uninsured children in CHIP and Medicaid, with a particular focus on children who are the most difficult to reach and enroll. Recognizing that traditional methods of outreach had not been effective with these children and families, CHIPRA funding was provided to develop specialized strategies to target these children by organizations that would have access to and credibility with families in the communities in which these eligible but uncovered children resided.

Of the $100 million provided by section 201 of CHIPRA, $80 million was appropriated for the Outreach and Enrollment Grants (with an additional $10 million specifically dedicated to outreach and enrollment of American Indian/Alaska Native children (AI/AN). 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 an additional $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 had 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 (a total of $32 million) entitled Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) in July 2013 from funds provided as part of the ACA appropriation. Grantees will use this funding to focus on five specific areas. These areas continue to support outreach strategies similar to those conducted in Cycles I and II and 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.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40 million of funds, of which $32 million is dedicated to a fourth cycle of general outreach and enrollment grants. On, November 16, 2015, CMS released a funding opportunity announcement for this fourth round (entitled The Connecting Kids to Coverage Outreach and Enrollment Cooperative Agreements grant program). Applications for this Cycle IV funding opportunity are due Janury 20, 2016. CMS expects to announce the Cycle IV awardees on May 20, 2016. These cooperative agreements will continue to support successful outreach strategies and lessons learned from all previous grant cycles.

Outreach to Indian Children

The authorizing statute for this 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 AI/AN children in Medicaid and CHIP. On April 15, 2010, CMS awarded 41 grants for a total of $9.9 million. CMS awarded a second round of Outreach and Enrollment Grants, totaling $3.9 million, from the $4 million appropriated through the ACA, to organizations serving Indian children on November 12, 2014.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40 million of funds, of which $4 million is dedicated to a third cycle of outreach and enrollment of children who are American Indian/Alaska Native. CMS expects to release this funding opportunity announcement, for this third cycle, in FY 2017.

National Enrollment Campaign

The statute sets aside 10 percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. Through the Connecting Kids to Coverage National Campaign (National Campaign), CMS has developed materials, such as posters, palmcards and public service announcements, which include a call to action to enroll and retain children in Medicaid and CHIP, as well as their parents in Medicaid. Campaign efforts have enhanced communications in target markets and with states, grantees, and other groups working on outreach and enrollment efforts through educational webinars and by distributing free tools that can be easily adapted 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. A Spring Wave, launched in May 2014 once the first Marketplace Open Enrollment period ended, promoted year-round enrollment in Medicaid and CHIP and featured a web video, radio public service announcements in English and Spanish, flyer, and social media graphics. 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 developed in FY 2014 include a flyer featuring teens and an oral health tear pad for school-aged children.

In May 2013, CMS launched the National Campaign which provided television and radio public service announcements (PSAs) in English and Spanish. 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 were 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 enrolled. The PSAs were distributed nationally for two years and aired nearly 146,000 times in 202 markets out of 210 combined. These pro-bono airings generated more than $13.4 million in advertising equivalent dollar value.

Through the end of FY 2015, the National Campaign conducted a paid radio media buy in targeted markets; distributed electronic newsletters; conducted training webinars and provided technical assistance to grantees and states; and continued to refresh content on InsureKidsNow.gov, the National Campaign's home for tools and resources. These outreach and enrollment tactics have worked well throughout the National Campaign and CMS expects similar results in the future.

With the funding appropriated under MACRA, CMS awarded a two-year contract in November 2015 to continue the National Campaign. Planning is in place to produce new PSAs, webinars, eNewsletters and other materials to support outreach and enrollment efforts.

In FY 2015, CMS also developed PSAs for tribal communities and aired these on GoodHealth TV®, a health education program serving in tribal hospitals and clinic waiting rooms. CMS will

continue to air PSA's and messaging via GoodHealth TV® in FY 2016 and FY 2017.

Budget Overview

CHIPRA appropriated a total of $100 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the ACA provided an additional $40 million in FY 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, 10 percent was set aside for the national enrollment campaign and another ten percent was for AI/AN outreach. CMS awarded $40 million in FY 2009 for outreach grants and approximately $10 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40 million of the remaining grants funds, under CHIPRA, on August 18, 2011. Under the ACA, in July 2013, CMS awarded a third round of outreach and enrollment grants (totaling $32 million) entitled "Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III)" and then in November 2014, awarded a second round of Outreach and Enrollment Grants, totaling $3.9 million to organizations serving AI/AN children.

The $10 million appropriated through CHIPRA in combination with the $4 million appropriated through the ACA have been used to fund national campaign efforts, as required under the statutes. Two national enrollment campaign contracts have been in place over the last six years. The first contract had a period of performance of June 2009 to July 2012 with a total contract value of $6.575 million. A second contract was awarded in August 2012 and will end in August 2015 with a total contract value of $6.114 million.

MACRA appropriates an additional $40 million in FY 2016. Of this appropriated amount, $32 million is set aside for outreach grants, $4 million is set aside for Indian Health Service Grants, and $4 million is set aside for the national enrollment campaign. These additional funds are available for obligation through FY 2017.

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 diseases 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 a psychiatric emergency medical condition (EMC). The psychiatric EMC is 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 the second half of 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 Medicaid beneficiaries admitted in the demonstration through June 30, 2013 and as of June 30, 2015, 17,758 Medicaid beneficiaries were admitted to the Institutions for Mental Diseases.

Budget Overview

Section 2707 authorized and appropriated $75 million in fiscal year 2011 to carry out this section. The funds appropriated for this demonstration were available until December 31, 2015.

The Medicaid Emergency Psychiatric Demonstration ended on June 30, 2015 with a final payment of claims to the participating states on December 23, 2015. Funds for the demonstraton ended on December 31, 2015. The evaluation of the demonstration will conclude in September of 2016, when the final report will be reviewed.

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) requires the Secretary to publish criteria for a State-certified community behavioral health clinic to participate in a mental health services demonstration program participated in by a State. Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare and Medicaid Services, is required to issue guidance for the establishment of a prospective payment system that shall apply only to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program. It also requires the Secretary to award planning grants to States to develop proposals to participate in two-year demonstration programs not later than January 1, 2016.

Key responsibilities have been identified for the Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Assistant Secretary for Planning & Evaluation (ASPE). Of the $2 million, $1.2 million will be utilized by CMS to procure consultant support for the development of guidance on Prospective Payment Systems for testing under demonstration programs, and CMS will reimburse the remaining $800,000 to SAMHSA under an interagency agreement for the development of eligibility criteria for certified behavioral health centers to participate in the Demonstration. Beginning one year after the first State has been selected for the Demonstration programs, the Secretary will submit an annual report to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

Budget Overview

Section 223 authorized and appropriated $2 million in FY 2014 and $25 million for the planning grants in FY 2016 to carry out this section. Amounts appropriated for this program shall remain available until expended. In FY 2016, $25 million in appropriated planning grant funding for this demonstration underwent a 6.8% sequestration cut which reduced the budget authority available for the planning grants to $23,300,000.

On May 20, 2015, SAMHSA, in conjunction with CMS released a Request for Applications (RFA) for Planning Grants to States that intend to participate in the section 223 Protecting Access to Medicare Act (PAMA), Demonstration Programs to Improve Community Mental

Health Services. Planning Grant applications from States wishing to participate in the 2- year Certified Community Behavioral Health Clinic (CCBHC) Demonstration were due to SAMHSA on August 5, 2015. http://www.samhsa.gov/grants/grant-announcements/sm-16-001. On October 19, 2015, SAMHSA, in conjunction with CMS and ASPE, awarded a total of $22.9 million in planning grants to 24 states to support their effort to improve behavioral health services under the Medicaid program by providing community-based mental health and substance use disorder treatment. SAMHSA, CMS and ASPE are providing robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ends in October 2016, up to eight states will be selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics. The selected states will be authorized to received enhanced federal match for specific behavioral health services over a period of two years.

Affordable Insurance Exchange Grants

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$469,624	$29,514	$31,667	$2,153
Outlays	$1,372,000	$712,015	$319,409	($392,306)

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 primary goal of the Affordable Care Act (ACA) is to ensure that people in every state have access to quality, affordable health care coverage and a fully functional Marketplace in which to purchase such coverage. The ACA gives states the option of establishing a Health Insurance Marketplace. The Marketplace must facilitate the purchase of qualified health plans (QHPs), provide for the establishment of a Small Business Health Options Program (SHOP) designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered through the SHOP, and meet other requirements specified in 1311(d) of the ACA and in the Marketplace final rule [77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, and 157)]. CMS operates a Federally-facilitated Marketplace (FFM) or State-Based Marketplace – Federal Platform (SBM-FP) in those states that elect not to pursue a State-based Marketplace (SBM). SBMs, together with FFM and SPM states, have played a critical role in the Affordable Care Act's success in enabling people to enroll in affordable, high quality private health insurance plans.

Marketplaces provide millions of Americans access to affordable health insurance coverage. Since January 1, 2014, Marketplaces have helped individuals and small employers better understand their insurance options by assisting them 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 for insurance, provide cost-sharing assistance to individuals, and help eligible individuals enroll in other federal or state insurance affordability programs. By providing one-stop shopping, Marketplaces make purchasing health insurance more understandable, giving individuals and small businesses access to increased options for, and control over, their health insurance.

Section 1311 of the ACA provides such sums as necessary to enable the Secretary to award grants to states to support their role in establishing Marketplaces. The final round of grants was awarded in December 2014 for all Marketplace models. States may spend remaining grant funding for permissible and approved establishment activities in 2015 and beyond.

The Centers for Medicare & Medicaid Services (CMS) 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.

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 Marketplace establishment by accelerating the development of Exchange IT systems.

Since 2011, CMS has awarded Exchange Establishment Grants to 37 states and the District of Columbia, totaling over $5 billion. These grants provided states with support for establishment of Exchange IT systems, outreach and education, necessary testing and improvement, as well as other activities (e.g., development of business processes such as plan management, eligibility and enrollment, and financial management) related to the establishment of the Marketplaces. States use these funds to make demonstrable progresstoward Marketplace establishment. CMS supports regular communication with states, monitors progress on Marketplace establishment, and provides financial support, guidance,and technical assistance on programs and operations. For the 2016 plan year, 16 states and the District of Columbia operate State-based Marketplaces. Four of these State-based Marketplaces operate on the federal platform.

Grant Table Size of Awards

(Whole dollars)	FY 2015 Final
Number of Awards	17
Average Award	$26,389,350
Range of Awards	$997,813 – $99,889,291
Total Obligations:	$448,618,949

Funding History

The fiscal year obligations for each year are listed below. Section 1311(a) of the ACA appropriated such sums as are necessary for the Secretary to award grants under this account. These amounts do not include prior year recoveries.

FY 2011	478,373,713
FY 2012	$1,654,595,531
FY 2013	$2,147,593,000
FY 2014	$784,491,000
FY 2015	$469,624,000

Budget Overview

This account funds CMS activities to support state work to establish and operate Marketplaces. Administrative costs include an estimated 50 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 and meeting program requirements. Funding will also be used for contracts to provide states with instruction on establishment of 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.

Although grants will not be awarded after December 31, 2014, state grantees have over $1 billion (as of the end of September, 2015) in grant funds remaining to outlay into FY 2018. To perform its continued grant oversight and monitoring duties, CMS requires $32 million in administrative funds for FY 2017. In addition, as required by the Program Integrity Final Rule Part II, CMS implements the State-based Marketplace Annual Reporting Tool (SMART) as a comprehensive tool to manage grantee oversight reporting requirements for SBMs. CMS will use administrative resources to ensure SBM grantees meet program requirements by evaluating reporting requirements the SBM attested to or submitted through the SMART.

In FY 2017, states will continue to use grant funds on establishment activities to build IT functionality, including consumer assistance tools, institute financial and programmatic audit policies and procedures, and support increasing total enrollment. CMS is expected to have over 30 grants to close out and provide support to states in the process. CMS will continue to support transitions that may occur over the next year and the support needed thereafter.

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Early Retiree Reinsurance Program

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$0	$0	$0	$0
Outlays	($11,233)	$6,638	$6,429	($209)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), Section 1102

FY 2010 Authorization - Public Law 111- 148

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. Early retirees often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable and inaccessible. Additionally, rising health care costs have made it difficult for employers to provide high quality, affordable health coverage for workers and retirees while also remaining competitive in the global marketplace. The proportion of large employers offering retiree coverage declined by half in 25 years, dropping from 66 percent in 1988 to 25 percent in 2012. Health insurance premiums in the individual market for older Americans are over four times more expensive than they are for young adults and the deductible these enrollees pay is, on average almost four times that for a typical employer- sponsored insurance plan.

ERRP was designed as a temporary program that provided 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 the 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 was used to reduce employer health care costs, provide premium or other out-of-pocket relief to workers and families, or both. Results from a voluntary survey of plan sponsors that received ERRP funds indicated that 26 million plan participants benefited from the ERRP (either directly or indirectly) as a result of plan sponsors' use of ERRP funds to offset plans' 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. Per the statute, ERRP ended on January 1, 2014.

Funding History

FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0

*This budget authority was appropriated in FY 2010.

Budget Overview

CMS expects to complete programmatic activities in FY 2017. Such activities include archiving data and records, responding to inquiries about the program, and responding to appeals that occur as a result of audit and debt collection activities. All remaining funds for this program will be returned to Treasury after the final closeout process.

Consumer Operated and Oriented Plan Program and Contingency Fund

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	$0	$0	$0	$0
CO-OP Account (10% Transferred to the Contingency Fund)				
Net Outlays	$211,641	$578,413	$897	($577,516)
CO-OP Account Contingency Fund				
Net Outlays	$138,410	$160,242	$1,673	($158,569)
Total Net Outlays	$350,051	$738,655	$2,570	($737,085)

Discretionary funding will be required in FY 2016 and beyond to fund the administrative budget and the activities necessary to service the $2.5 billion in Federal loans.

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 Consumer-Operated and Oriented Plan (CO-OP) was created by the Affordable Care Act (ACA) 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.

CO-OPs were envisioned to provide much needed choice to customers and improve competition both inside and outside 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 three issuers offering plans on the Marketplace, and offers the lowest cost plans in almost all metal categories.

Award of CO-OP Loans

Currently, 11 CO-OP loan recipients are licensed and have enrolled members for CY 2016 in 13 states. CO-OPs offer coverage both inside and outside of the new Marketplaces. Loan awards were complete as of December 31, 2014 and totaled $2.5 billion. Of the $2.5 billion in total loans awards, approximately $1.09 billion is from the direct appropriation loan subsidy and the remaining $1.4 billion is from Treasury borrowing.

The CO-OP Program contracted externally for expert objective reviews of the loan applications. The expert reviewers provided recommendations on awarding loans to a CMS Selection Committee, which made the final awards. CMS made initial loan awards in February 2012 and continued to accept applications and made final loans awards in December 2014. At this time CMS does not expect to make any additional loan awards.

Eleven CO-OPs are offering plans on the exchange in thirteen states for CY 2016: CT, ID, IL, MA, MD, ME, MT, NH, NJ, NM, OH, OR, and WI. Three CO-OP loan recipients expanded operations into additional States in 2015 including: Montana into Idaho; Massachusetts into New Hampshire; and Maine into New Hampshire.

Loan Servicing and CO-OP Monitoring

CMS began 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. One CO-OP (VT) failed to become licensed, and was subsequently terminated from the program. During CY 2015, CO-OPs entered the health insurance market with a variety of challenges, such as different types of enrollment challenges. Some CO-OPs experienced an enrollment shortage, making it difficult to meet fixed costs and generate revenue through premium payments. Other CO-OPs experienced higher enrollment rates than expected, introducing serious

difficulties in building the capacity to handle the financial and operational stress. The sheer volume of claims in some cases created additional challenges in managing short-term cash flow. Twelve additional CO-OPs entered wind-down and did not sell coverage on the Marketplace for 2016. CMS worked with these CO-OPs and with their State Departments of Insurance to ensure consumers had adequate coverage and the opportunity to transition to another plan through Open Enrollment. Once the wind-down of these CO-OPs is complete, CMS will use every available tool to recoup loan funding based on applicable law, including the loan agreements.

Funding History

FY 2011	-$2,200,000,000
FY 2012	-$400,000,000
FY 2013	-$2,278,544,136
FY 2014	$0
FY 2015	$0
FY 2016	$0
FY 2017	$0

*Budget authority in the amount of $6,000,000,000 was appropriated in FY 2010.

The Affordable Care Act appropriated $6 billion for the program in FY 2010. 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, and required that any unobligated balances be transferred to a contingency fund in 2013. CMS transferred $253 million to a contingency fund for oversight and assistance to existing loan entities. By the end of FY 2016 no funds will remain as the remaining balances will be used to fund FTE, technical assistance and program risk management expenses.

Budget Overview

During FY 2015, CMS converted some start-up loans to surplus notes CO-OPs that applied and met specific criteria were able to have their start-up loans converted to surplus notes. This conversion was intended to stimulate private market investment in the CO-OPs. . During FY 2017, CMS will continue to actively monitor the loan portfolio and support the continued growth of the CO-OPs as operating insurance providers. CO-OP monitoring includes regular financial reporting, coordination with the State Departments of Insurance, calls with Account Managers, audits and site visits, and increased oversight as required. The CO-OP Program contracted with a vendor for the provision of technical assistance to CO-OPs and financial reviews of their operations. In addition, an independent auditor has been retained to perform compliance audits.

CMS will continue to utilize contract-funded technical assistance for program staff and CO-OPs as the CO-OPs continue to grow enrollment and refine their operations on the way to stable profitability and sustainability. Program efforts will also continue the development and maintenance of internal IT systems for loan servicing and monitoring borrower performance and compliance. 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.

Discretionary funding is requested in FY 2016 and beyond to fund the administrative budget and the activities necessary to service the $2.5 billion in Federal loans. Please see the Oversight and Management section in the Program Management chapter for details.

Health Insurance Rate Review Grants

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Budget Authority	-	-	-	-
Outlays	$34,696	$28,702	$38,537	$9,835

Authorizing Legislation - PPACA, Section 1003, Section 2794 of the Public Health Service Act

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Application for Grants

Program Description and Accomplishments

In 2010, HHS established a program of grants to states, the District of Columbia, and the U.S. territories to enhance the health insurance rate review process. The five-year grants program of $250 million began in fiscal year 2010. In accordance with the Affordable Care Act (ACA), no state qualifying for a grant shall receive less than $1 million in overall grant funding or more than $5 million in a single grant year. Grants assist states in improving their rate review processes and/or establishing data centers that enhance the transparency of medical services. Each grant recipient is required to provide the Secretary with information about trends in premium increases in health insurance coverage. States that receive grants for the purpose of improving their rate review activities and/or for required rate reporting are required to establish a process for the review of "unreasonable" rate increases. The final rate review regulations promulgated in the Spring of 2011, Fall of 2011, Spring of 2013, and Spring of 2014 provide federal guidance on the definition of "unreasonable" rate increases, as well as guidance on the justifications for such unreasonable rates that grantees must employ in their annual rate review processes under the grants.

There have been four cycles of grants that have been awarded. Each cycle had a different emphasis on use of funds.

Cycle I funding was used to:

Cycle I Project Period Start Date (States): 08/09/2010
Cycle I Project Period Start Date (Territories): 03/28/2011

- 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 II funding was used to:

Cycle II, Phase I Project Period Start Date: 10/01/2011
Cycle II, Phase II Project Period Start Date: 10/01/2012
Cycle II, Phase III Project Period Start Date: 04/01/2013

- Further assist states in improving and enhancing their health insurance rate review and reporting processes. Specifically, the funds were designated for states to meet the requirements for an "Effective Rate Review Program" as set forth in the Final Rule.
- Establish or enhance a meaningful and comprehensive Effective Rate Review Program that is transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable state law, approved or disapproved.
- Develop an infrastructure to collect, analyze, and report to the Secretary critical information about rate review decisions and trends, including, to the extent permitted by applicable state law, the approval and disapproval of proposed rate increases.
- Provide states with multiple opportunities to apply for funding, depending on the status of their progress toward meeting the criteria for an Effective Rate Review process.

Cycle III funding was used to:

Cycle III Project Period Start Date: 10/01/2013

- Continue the rate review successes of Cycle I and II of the Rate Review Grant Program as well as to provide greater support to data centers that collect, analyze, and publish medical claims data. By increasing support to data centers, HHS hoped to increase transparency in health care pricing, thereby helping consumers and employers make better health care decisions.
- As in Cycle II, the Cycle III grant provides resources to states to achieve or maintain their "Effective Rate Review" Program status.

Cycle IV funding was used to:

Cycle IV Project Period Start Date: 09/19/2014

- Provides states the opportunity to continue enhancing or establishing Effective Rate Review Programs, Required Rate Reporting activities, and/or data center activities.
- Broaden the eligibility criteria for states to receive funding for data center work.
- Continue the rate review successes of Cycle I, II, and III of the Rate Review Grant Program as well as to continue to provide greater support to data centers.

Funding History

FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0

*This budget authority was appropriated in FY 2010.

Budget Overview

The Public Health Service (PHS) Act section 2794(c) appropriated $250 million for the Rate Review Grant Program for grants awarded during the five-year period, beginning with FY 2010. Section 2794(c)(2)(B) provides that any amounts not fully obligated under the $250 million will remain available to the Secretary for grants to states for planning and implementing the insurance reforms and consumer protections under Part A of the ACA (i.e., the market reform rules). As the Rate Review grant program is now over, CMS will use the remaining funds to issue grants to states in support of planning and implementing the health insurance market reforms and consumer protections under Part A of the ACA, pursuant to section 2794(c)(2)(B). The Health Insurance Market Reforms grant will provide states with the opportunity to ensure their laws, regulations, and procedures are in line with federal requirements and that states are able to effectively oversee and enforce the PHS Act's title XXVII Part A provisions with respect to health insurance issuers. The Health Insurance Market Reforms grant is open to all states that are directly enforcing the ACA and also for those states who are not currently enforcing the ACA to assist with their respective transition to primary enforcement. Applicants may use grant funds for a variety of planning and implementation objectives, including but not limited to implementing or enhancing policy form review, market conduct examinations, market analysis, financial examinations, consumer complaint investigations, and increasing regulatory authority with respect to the market reforms and consumer protections under Part A of title XXVII of the PHS Act.

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Transitional Reinsurance Program

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Estimate	FY 2017 President's Budget	FY 2017 +/- FY 2016
Receipts	$8,898,409	$6,521,346	$4,335,352	-$2,185,994
Outlays	$7,307,564	$7,458,894	$4,554,544	-$2,904,350

Outlays in FY 2016 reflect amounts previously unavailable from FY 2015 due to sequestration.

Appropriations – Funding Available for Obligation

Authorizing Legislation – Affordable Care Act (P.L. 111-148 & 111-152)

Allocation Method - Direct Federal

Program Description and Accomplishments

The Transitional Reinsurance Program is a three-year program designed to stabilize premiums in the individual market thereby ensuring market stability for issuers.

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 to fund payments to issuers, the statute authorizes collection of an administrative fee to support program operations and for the General Fund of the US Treasury. HHS collects all reinsurance contributions nationwide while states can operate its own transitional reinsurance program for calculating and dispersing payments to its issuers. 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. Connecticut is the only state that operates its own reinsurance program.

Our preliminary analysis of the transitional reinsurance program for the 2014 benefit year shows that the reinsurance program is working as intended – by providing protection to issuers with exceptionally high costs. CMS will make $7.9 billion in reinsurance payments for the 2014 benefit year.

Funding History (Outlays)

FY 2015	$7,307,564,171

Budget Overview

In FY 2017, CMS expects to collect $4 billion to provide reinsurance payments for the 2016 plan year. These contributions are collected under the authority established in 1341(b)(3)(B) for reinsurance payments to issuers that enroll high-cost individuals, and under the payment parameters described in the applicable Annual Notice of Benefit and Payment Parameters. Additionally, the appropriation would be used to disburse reinsurance collections to state reinsurance entities to make reinsurance payments as required by Section 1341(b)(1)(B) and 45 CFR 153.235. CMS also expects to collect $6 million to support CMS reinsurance program operations and to disburse to states to support their program operations.

Risk Adjustment Program Payments

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Estimate	FY 2017 President's Budget	FY 2017 +/- FY 2016
Receipts	$2,375,645	$3,857,761	$4,638,599	+$780,838
Outlays	$1,759,843	$4,087,787	$4,560,415	+$472,628

Outlays in FY 2016 reflect amounts previously unavailable from FY 2015 due to sequestration.

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 CMS collects charges 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. 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 a program year in the following calendar year.

The primary goal of the risk adjustment program is to spread the financial risk borne by issuers more evenly in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. More specifically, the risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection, or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Marketplace, reducing the potential for excessive premium growth or instability in markets inside or outside the Marketplace.

As described in the HHS Notice of Benefit and Payment Parameters for 2014 Final Rule (78 FR 15410), the risk adjustment methodology developed by the Department of Health and Human Services (HHS) is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency – not the health status of the enrolled population. The HHS-developed risk adjustment methodology determines each plan's risk adjustment transfer amount based on the actuarial risk of enrollees, the actuarial value of coverage, utilization and the cost of doing business in local rating areas, and the effect of different cost-sharing levels on utilization.

Our preliminary analysis of the risk adjustment transfers for the 2014 benefit year shows that the risk adjustment methodology is working as intended – by compensating issuers that enrolled higher risk individuals and protecting against adverse selection within a market within a state. For example, we have found that:

- Issuers that enrolled a large share of HIV/AIDS patients, whether because they offered more robust prescription drug coverage or contracted with the Ryan White Foundation, received risk adjustment payments;
- Issuers that attracted more high-risk patients due to networks that include key specialty hospitals received risk adjustment payments;
- Issuers that had a history of serving high risk individuals as the issuer of last resort and therefore enrolled a disproportionate number of expensive consumers received risk adjustment payments; and
- Small plans with isolated cases of catastrophically ill individuals received risk adjustment payments.

Funding History (Outlays)

FY 2015	$ 1,759,843,006

Budget Overview

In FY 2017, CMS projects $4.6 billion will be collected from plans in the individual and small group markets with healthier than average enrollees in order to make risk adjustment payments, as determined by the risk adjustment methodology described at 78 FR 15417, to plans with higher than average risk. HHS anticipates operating Risk Adjustment in all states in 2017.

Center for Medicare and Medicaid Innovation (CMMI)
(Dollars in Thousands)

	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
BA	$0	$0	$0	$0
Obligations	$1,352,000	$1,828,900	$1,483,400	($345,500)

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 (ACA) "to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" provided to those individuals who receive Medicare, Medicaid, and Children's Health Insurance Program (CHIP) benefits.

The CMS Innovation Center is an integral part of CMS' efforts to transform itself from a claims payer in a fragmented care system into a partner with, and a champion of, a coordinated system. In this role, CMS can help catalyze the development of a health care system that is better, smarter, healthier, accountable, and equitable; that monitors and promotes health, continuously improves care, and 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 develop, test, and evaluate 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 and representatives of relevant federal agencies, drawing on ideas received from members of the health care community, including health care providers, analysts, and clinical researchers.

To serve as a good steward of health care dollars, CMS rapidly and rigorously evaluates each new payment and service delivery model being tested to assess the quality of care furnished, including patient outcomes, and to determine the model's overall impact on total cost of care.

In addition to the rigorous evaluation of the impact of each model on outcomes of interest, the CMS Innovation Center uses continuous quality improvement strategies to help model participants learn, improve, and succeed. Model tests are refined or modified through their learning systems and 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 conducts several activities to ensure the effectiveness of its work, including both model-specific and Center-wide activities:

Model-specific activities:

- data sharing
- implementation assistance
- learning & diffusion activities
- payment administration and/or reconciliation
- performance monitoring and evaluation

Center-wide activities:

- establishing, reporting, and improving the effectiveness of Center-wide learning systems that facilitate cross-model collaboration and the rapid and widespread diffusion of best practices and validated service delivery and payment models
- harvesting best practices 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
- operations management and oversight including monitoring routine CMS Innovation Center administrative costs (e.g., personnel and benefits)

In partnership with a broad array of stakeholders including health care providers, states, and payers, CMS has developed an extensive portfolio of promising initiatives that are serving Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia and Puerto Rico. Furthermore, 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 ACA and other laws, and certain projects authorized under section 402 of the Social Security Act of 1967 as amended.

The CMS Innovation Center Models and Initiatives:

Comprehensive Primary Care (CPC) Initiative: This multi-payer initiative fosters collaboration between public and private payers to strengthen primary care. Health plans that cover only a small segment of a primary care practice's total patient population have historically struggled to provide enough resources to encourage and support the transformation to provide higher-quality, 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. CMS chose seven regions for the CPC intervention. As of October 2015, there are 447 practices participating in the initiative. In total, 2,188 participating providers are serving approximately 2.7 million patients, of which approximately 410,177 are Medicare or Medicaid beneficiaries.

Pioneer Accountable Care Organizations (ACOs): The Pioneer ACO Model was designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. The model tests payment arrangements that hold providers accountable for cost, quality, and patient experience outcomes for a defined population of beneficiaries. It uses a shared savings payment methodology with generally higher levels of shared savings and risk than levels currently used in the Medicare Shared Savings Program (MSSP). The model is also assessing the ability of hospital and physician organizations experienced in care and risk management to achieve savings for Medicare while sustaining or

improving quality of care for beneficiaries. Pioneer ACOs that demonstrated savings during the first 2 performance years and met other criteria were able to transition to a monthly population-based payment starting in performance year 3.

The Pioneer ACO Model was launched in 2012 with 32 ACOs. Organizations agreed to an initial 3-year performance period with the option to extend for 2 additional option years. At present, nine ACOs are continuing in the Model for performance year 5 in 2016. Of those Pioneer ACOs that made the decision to exit the model, each organization did so based on its particular business priorities and concerns. For example, seven Pioneer ACOs are transitioning to the Next Generation ACO Model to continue transforming care and taking on increased levels of financial risk.

In May 2015, HHS announced that the Pioneer ACO model met the stringent criteria for expansion to a larger population of Medicare beneficiaries. The independent evaluation found that the model generated over $384 million in net savings to Medicare over its first two years – an average of approximately $300 per participating beneficiary per year – while continuing to deliver high-quality patient care. The independent Office of the Actuary certified that model would reduce net Medicare spending if expanded. Furthermore, the HHS Secretary determined that an expansion of the model would improve patient care without limiting coverage or benefits. Since the model has proven to be successful, CMS decided to incorporate elements of the model into a new track, Track 3, in the Medicare Shared Savings Program.

Results from the third year were announced in August 2015-- and they continued to show strong performance by Pioneer ACOs. During the third performance year, Pioneer ACOs increased by 24 percent total model savings when compared with the second performance year. Eleven ACOs qualified for shared savings payments of $82 million. The ACO showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures compared to the second year of the model.

Advance Payment ACO Model: The Advance Payment Model provided 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. It was designed for organizations participating in the MSSP. The Advance Payment Model tested whether providing up-front and monthly payments to providers increased participation in the MSSP, allowed ACOs to improve care for beneficiaries while generating Medicare savings more quickly, and increased the amount of Medicare savings. The payments are being repaid through the shared savings that participating ACOs earn. The last payments were made in June 2014. Thirty-six ACOs participating in MSSP selected for this model received payments between 2012 and 2014.

ACO Investment Model: The ACO Investment Model is an initiative developed by the CMS Innovation Center designed for organizations participating as ACOs in the MSSP. It is a new model of pre-paid shared savings that builds on the experience of the Advance Payment Model. The ACO Investment Model tests whether providing up-front and monthly payments to providers will encourage new ACOs to form in rural and underserved areas and motivate current MSSP ACOs to transition to arrangements with greater financial risk. The pre-payment of shared savings has the potential to allow ACOs to improve care for beneficiaries, generate Medicare savings more quickly, and increase the amount of Medicare savings. The pre-paid shared savings are to be repaid through the shared savings that participating ACOs earn. A total of 41 ACOs are participating in the model; two ACOs started in the spring 2015 and 39 more ACOs joined in January 2016.

Next Generation ACO: This new ACO Model is designed to engage organizations with extensive experience both in population care management and management of financial risk. The model offers an array of risk arrangements, including an option that requires ACOs to take on full risk for Part A and B Medicare spending. It also offers several options for alternative cash flow besides the usual fee-for-service (FFS) reimbursement, including monthly infrastructure payments, population based payments, and capitation. The model uses a novel expenditure benchmark methodology that rewards both attainment and improvement in spending performance, and will be truly prospective in nature to give ACOs more predictability in their business decisions. In addition, the model tests several significant benefit enhancements, including waivers of Medicare payment rules to allow home visits for non-homebound patients, admission to a Skilled Nursing Facility without a prior three-day hospital stay, and broader use of tele-health services. Another benefit enhancement is a direct financial reward that CMS will offer beneficiaries who receive a high proportion of their care from the ACO's preferred providers. Lastly, the model tests a more comprehensive form of "voluntary alignment" than was available in the Pioneer ACO Model, for beneficiaries to attest to their care relationships with ACO providers. The first cohort of Next Generation participants was selected in the summer of 2015 and 21 ACOs began participating in January 2016. The model will conduct a second application cycle in spring 2016 for a 2017 start date.

Comprehensive End-Stage Renal Disease Care Model (CEC) Care: The Comprehensive ESRD Care initiative began testing the effectiveness of a new payment and service delivery model for Medicare beneficiaries with ESRD in July 2015. In October 2015, CMS entered into agreements with groups of health care providers and suppliers called ESRD Seamless Care Organizations that 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. 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.

Bundled Payments for Care Improvement (BPCI): CMS is testing four models of episode-based (bundled) Medicare payments in partnership with hospitals, physician groups and post-acute care providers. Under the current 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 bundle payment by holding providers accountable for costs and quality for an entire episode of care may align hospitals, physicians, and other providers to improve care coordination, 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. Evaluation results from the start of the model through June 2014 indicated lower total Medicare episode payments for Model 1 participants. However, the lowered total Medicare episode payments were partially offset by an increase in post episode spending and were largely driven by participants who subsequently exited the model. In December 2015, CMMI announced that Model 1 would conclude at the end of 2016.

Implementation of Models 2, 3 and 4 was divided into two phases. During Phase 1, also referred to as "the preparation period," CMS shared data and engaged in education and shared learning activities with participants as they prepared for assumption of financial risk under Phase 2, the performance, or "risk-bearing implementation," period. CMS announced the first set of BPCI Phase 1 participants on January 31, 2013. By October 1, 2013, some BPCI participants entered into Awardee Agreements with CMS, at which point they became Awardees and began bearing

financial risk with CMS for some or all of their episodes. Additional providers joined BPCI and started bearing financial risk in multiple open periods through July 1, 2015. The models now have more than 1,500 participating hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long term care hospitals, physician group practices, and convening organizations. Early findings from the first program quarter indicate orthopedic surgery episodes initiated by hospitals in BPCI Model 2 decreased unadjusted total Medicare Part A and Part B standardized allowed payments for the anchor hospitalization and the 90-day post-discharge period by more than $3,000, while two out of three claims-based quality of care measures indicated no adverse events.

Oncology Care Model (OCM): The goal of OCM is to align financial incentives to improve care coordination, appropriateness of care, and access to care for Medicare beneficiaries undergoing chemotherapy. OCM encourages participating practices to improve care and lower costs through an episode-based payment model that financially incentivizes practice transformation through high-quality, coordinated care. OCM incorporates a two-part payment system for participating practices, creating incentives to improve the quality of care and furnish enhanced services for beneficiaries who undergo chemotherapy treatment for a cancer diagnosis. In addition to standard Medicare FFS payments, OCM payments include a monthly $160 per-beneficiary-per-month payment for the duration of a 6 month episode, and the potential for a retrospective performance-based payment for participants that reduce spending below a target price and meet quality targets. OCM is a multi-payer model. Non-Medicare payers are encouraged to participate in alignment with Medicare to create broader incentives for care transformation at the physician practice level. The model performance period is expected to start in 2016 and run for five years.

Comprehensive Care for Joint Replacement (CJR) Model: The CJR model is a retrospective bundled payment model for lower-extremity joint replacement (LEJR) or reattachment procedures. The model is scheduled to begin April 1, 2016. LEJR procedures are common in the Medicare population, with approximately 400,000 procedures performed annually among Medicare FFS beneficiaries. Approximately 800 hospitals in 67 CMS-selected metropolitan statistical areas throughout the country will be required to participate and will have costs and quality of care provided during LEJR episodes assessed against benchmarks. Episodes will span the inpatient hospital stay for the LEJR procedure and a 90-day post-discharge period, incorporating all related Part A and Part B spending during the episode. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending. Through bundling payments and targeting care efficiencies within high-volume procedures, the CJR model will provide the opportunity to achieve high quality care, improve health for beneficiaries, and reduce Medicare spending by creating an incentive for hospitals, physicians, and other health care providers to coordinate the care they provide.

Partnership for Patients (PfP): PfP is a national learning collaborative aimed at reducing preventable hospital-acquired conditions (HACs) by 40 percent and reducing preventable 30-day readmissions by 20 percent. PfP combines the efforts of multiple partners, including federal and non-federal programs, in an aligned effort to support rapid action and progress in affiliated hospitals and communities. In addressing preventable HACs, the PfP initiative has prioritized reducing inpatient adverse events, such as adverse drug events, central line-associated blood stream infections, catheter-associated urinary tract infections, falls, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

To date, the PfP has involved more than 3,700 participating hospitals nationwide committed to improving care by teaming in their quality improvement work together with one of 26 Hospital Engagement Networks (HENs). These HENs have established infrastructure and organized technical assistance programs to support these hospitals in improvement and measurement, engagement with patient, caregivers and families, and helped hospitals with learning, reporting, and generating results. Beginning in September 2013, 6 of the 26 HENs also participated in the Leading Edge Advanced Practice Topic (LEAPT) initiative to rapidly test and develop practices to reduce harm in 11 advanced practice areas including: severe sepsis and septic shock, clostridium difficile infection, hospital acquired acute renal failure, airway safety, iatrogenic delirium, procedural harm, undue exposure to radiation, and others. This robust program is aimed squarely at improving the level of patient safety in hospitals across the nation.

The first round of the PfP contracts came to their natural end in December 2014. CMS has awarded a second round of Hospital Engagement Networks (HENS 2.0) as of September 2015 with a focus on the same bold aims as in round one. Seventeen HENs were awarded with engagement of approximately 3,400 hospitals. This period of performance is 12 months in duration. The areas of focus for harm reduction remain the same as during the first round along with an additional requirement to include several other focus areas from the LEAPT initiative with a focus of pursuing a culture of safety in hospitals across the nation. Many of the HENs in round 2 of this effort are pursuing reductions in severe sepsis and septic shock as well as clostridium difficile.

Transforming Clinical Practice Initiative (TCPI): In October 2014, the Secretary announced the Transforming Clinical Practice Initiative, which is testing approaches to help clinicians achieve large-scale health transformation. The Initiative will support 140,000 clinician practices over the next 4 years in sharing, adapting and developing their comprehensive quality improvement strategies in the ambulatory setting. CMS has awarded cooperative agreement funding to 2 network systems under this initiative: Practice Transformation Networks and Support and Alignment Networks. Their periods of performance end July 21, 2018. The Practice Transformation Networks are peer-based learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to practice transformation. The Support and Alignment Networks provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts. In September 2015, the Innovation Center announced awards for 29 Practice Transformation Networks, consisting of medical group practices, regional health care systems, and regional extension centers, and 10 Support and Alignment Networks, which include national organizations and health care professional associations.

Health Care Innovation Awards (HCIA): CMS is providing healthcare and community-based organizations and other providers up to $1.4 billion in funding to implement the most compelling new ideas for delivering better health care at a lower cost to people enrolled in Medicare, Medicaid, and CHIP, particularly to enrollees with the greatest health care needs. These funds were distributed in two rounds of cooperative agreements. The Round One cooperative agreement period began July 1, 2012 and includes 107 awardees. Round One includes a broad range of models with a focus on health care workforce development and deployment, as well as developing enhanced infrastructure to support effective and efficient system-wide function and diffusion of best practices. The period of performance for HCIA Round One ended June 30, 2015, although approximately half of the awardees entered into 3-12 month no-cost extensions that will all conclude by June 30, 2016. The Round Two cooperative agreement period began September 1, 2014 and includes 39 awards. This latter funding opportunity supports a diverse portfolio of new and innovative payment and service delivery models focused on four

categories: rapidly reducing costs for patients in outpatient hospital and post-acute settings, improving care for populations with specialized needs; testing improved financial and clinical models for specific types of providers; and linking clinical care delivery to preventive and population health. The period of performance for HCIA Round Two will end on August 31, 2017.

State Innovation Models (SIM): The SIM initiative is testing the ability of state governments to accelerate health transformation efforts using policy and regulatory levers to provide better care, smarter spending, and healthier people for the majority of the state population, through multi-payer alignment of incentives, useful health information exchange/ technology and development of a modified workforce of healthcare professionals. SIM has provided states with over one billion dollars in funding and coordinated technical assistance from Federal partners and other experts to achieve the delivery system reform goals of HHS, including linking payment to quality through the implementation of alternative payment models. The Round One SIM awards, announced in February 2013, supported both the design and testing of state healthcare innovation plans in 25 states. Round Two SIM awards for 11 test states and 21 design states/territories/DC were announced in December 2014. Currently, the SIM initiative involves a total of 34 states, 3 territories and the District of Columbia, such that more than 60% of the nation is engaged in SIM-supported transformation programs.

Medicaid Innovation Accelerator Program (IAP): The IAP was launched in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting states' efforts to accelerate new payment and service delivery reforms. The Innovation Center is working with CMCS to engage states in developing improved care in the following areas: substance abuse disorders, beneficiaries with complex care needs and high costs, community integration for long-term services and supports, and integrating primary and mental health services. While complementing other federal-state delivery system reform efforts such as the State Innovation Models initiative, IAP shares lessons and practices and provides additional federal tools and resources to support states in advancing Medicaid-specific delivery system reform.

Maryland All-Payer Model: Maryland's all-payer rate setting system for hospital services presents an opportunity 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 achieving better health and access to quality care at lower cost. Under an agreement signed with CMS in January 2014, Maryland hospitals committed to achieving significant quality improvements. These include reductions in both hospitals' 30-day readmissions rate and hospital acquired conditions rate. Maryland also agreed to limit its all-payer total per capita hospital expenditure growth to 3.58 percent per year to produce $330 million in aggregate savings in Medicare hospital expenditures over five years. In the first year of the model, Maryland limited the growth rate in all-payer hospital cost per capita to 1.5 percent and achieved $116 million in Medicare savings. Maryland hospitals also achieved a modest reduction in the 30-day readmissions rate and a 26 percent reduction in hospital-acquired conditions.

Medicare Care Choices Model: Studies have shown that hospice patients receive a higher quality of care and have a higher quality of life compared to terminally ill patients in hospitals. Yet only 44 percent of eligible Medicare patients use Medicare's hospice benefit and most only for a short period of time. Under current payment rules, Medicare beneficiaries are required to forgo curative care in order to receive services under the Medicare Hospice Benefit. The Medicare Care Choices Model provides a new option for Medicare beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. CMS will evaluate whether providing hospice services can improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures.

Participation in the model will be limited to Medicare beneficiaries with advanced cancers, chronic obstructive pulmonary disease (COPD), congestive heart failure, and HIV/AIDS who qualify for the Medicare hospice benefit and meet the eligibility requirements of the benefit. The model will include two cohorts of hospices projected to serve 100,000 beneficiaries by 2020. The first cohort of 71 hospices began to provide services to beneficiaries in January 2016. The second cohort of 70 hospices will start to provide services in January 2018.

Medicare Prior Authorization Model- Repetitive Scheduled Non-Emergent Ambulance Transport: CMS implemented a prior authorization demonstration for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina on December 1, 2014. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. CMS believes that using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid. As required by Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015, CMS expanded the prior authorization program for scheduled repetitive non-emergent ambulance transports to five additional states (North Carolina, Virginia, West Virginia, Maryland and Delaware) and the District of Columbia on January 1, 2016.

Medicare Prior Authorization Model- Non-Emergent Hyperbaric Oxygen Therapy: On March 1, 2015 CMS implemented a prior authorization demonstration for non-emergent hyperbaric oxygen therapy in Michigan. The program was implemented in Illinois and New Jersey on July 15, 2015. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

Home Health Value Based Purchasing (HHVBP): The HHVBP Model will employ a payment adjustment that is tied to the level of quality demonstrated by home health agencies (HHAs) operating in nine states (Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee) and participation will be required for the areas selected. The model will adjust Medicare payments (up or down) by up to three to eight percent, based on quality performance metrics. The model will test whether incentives for better quality care can improve outcomes in the delivery of home health services. The model will begin on January 1, 2016 and operate through December 31, 2022.

Accountable Health Communities (AHC) Model: In January 2016, the Innovation Center announced the AHC model. The AHC model addresses a critical gap in the current health care delivery system by strengthening the links between clinical and community-based resources. The model tests whether a systematic approach to identifying and addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities. CMS will fund up to 44 cooperative agreements to implement one of three different approaches (tracks) to address beneficiaries' health-related social needs and link clinical and community services (Track 1 – Awareness, Track 2 – Assistance, and Track 3 – Alignment). The evaluation of the model will include beneficiary randomization for Tracks 1 and 2 and matched comparison groups for Track 3. Total award amounts will vary between $1 million to $4.5 million.

The Million Hearts® Initiative: CMMI co-leads the Million Hearts initiative and encourages the use of its tools by model participants. The initiative brings together communities, health care professionals, health systems, nonprofit organizations, federal agencies, and private-sector organizations around a common goal: preventing 1 million heart attacks and strokes by 2017.

Million Hearts® calls attention to a small set of changes that can be made in communities and health care systems that support long-term reductions in heart attacks and strokes. Million Hearts® also emphasizes the importance of coordination between public health organizations and clinical systems. CMS does not fund Million Hearts® but supports the Million Hearts® objectives in several other ways. CMS has adopted the Million Hearts® measure set and embedded it across quality reporting programs and models such as Accountable Care Organizations, the Physician Quality Reporting System, and the Comprehensive Primary Care Initiative. CMS also supports Million Hearts® goals by encouraging clinicians who lead CMS Innovation Center models to deploy their electronic health record systems to assess and improve their performance, adopt evidence-based tools like hypertension treatment protocols and patient registries, and reach out to patients to address gaps in care.

Million Hearts; Cardiovascular Disease Risk Reduction Model (MH CVD RR): In May 2015, the Secretary announced the MH CVD RR Model. The MH CVD RR Model promotes cardiovascular disease (CVD) prevention, improved CVD outcomes, and accountability for costs among Medicare beneficiaries through risk assessment and risk management. Financial incentives will be offered to encourage providers to use the American College of Cardiology/American Heart Association (ACC/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) risk calculator to prevent heart attacks and strokes. The model will recruit approximately 500 practices that develop plans to use the ACC/AHA ASCVD calculator to risk stratify Medicare FFS beneficiaries and propose innovative service delivery models that reduce risk across the entire population. Half of all selected applicants will be randomly assigned to the intervention group with the remaining applicants assigned to the control group. Intervention practices will be paid a one-time $10 per beneficiary fee to calculate a beneficiary's 10-year ASCVD risk score and to engage the patient in shared decision-making. In year one, an additional $10 monthly Cardiovascular Care Management (CVD CM) payment per beneficiary will be made for risk management for the highest risk patients. During years two through five, practices can receive a monthly CVD CM payment of up to $10 based on the reduction of their high-risk beneficiary ASCVD risk scores. Control group practices will receive a one-time $20 per beneficiary payment for each successful reporting period. Control group practices will report data to CMS for 4 years.

Part D Enhanced Medication Therapy Management: The Enhanced Medication Therapy Management (MTM) model tests changes to the Part D program aimed at better aligning Part D plan sponsor and government financial interests, while also creating incentives for robust investment and innovation in better MTM targeting and interventions. Participating standalone prescription drug plans (PDPs) can vary the intensity and types of MTM interventions they provide based on beneficiary risk and individualized beneficiary and prescriber outreach and engagement to better achieve the key goals of MTM—i.e., optimized therapeutic outcomes through improved medication use and reduced risk of adverse events—while reducing net Medicare expenditures. CMS will conduct the model test in five Part D Regions: Region 7 (Virginia), Region 11 (Florida), Region 21 (Louisiana), Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming), and Region 28 (Arizona). Participation in the Part D Enhanced MTM Model is not competitive. Participating PDPs will begin offering benefits under authority of the model on January 1, 2017. The model is expected to run for five years.

Medicare Advantage Value-Based Insurance Design (MA-VBID): The MA-VBID model tests the impact of allowing Medicare Advantage and Medicare Advantage-Prescription Drug plans to offer varied plan benefit design for enrollees who fall into certain clinical categories identified and defined by CMS. Participating plans may offer these enrollees extra supplemental benefits or

reduced cost sharing, focused on the services that are of highest clinical value to them. The model will test whether this can improve health outcomes and lower federal Medicare Advantage expenditures. CMS announced the MA-VBID model on September 1, 2015, and is conducting the test in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. Participating plans will begin offering benefits under authority of the model on January 1, 2017. The model's performance period is expected to run for five years.

Strong Start for Mothers and Newborns: The Strong Start Initiative 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. Awards were announced in February 2013. CMS is partnering with the Administration for Children and Families and the Health Resources and Services Administration on a fourth model to test the effectiveness of two evidence-based home visiting models to improve birth and health outcomes. CMS is providing funding to evaluate the Maternal, Infant and Early Childhood Home Visiting Program, which is being implemented by the Nurse Family Partnership and Healthy Families America.

Financial Alignment Initiative: The Financial Alignment Initiative builds upon and, for some states, incorporates funding from its precursor, the State Demonstrations to Integrate Care for Dual Eligible Individuals (see below). Under this initiative and through related work, CMS is partnering with states to test both a capitated model and a managed fee-for-service (MFFS) model. Under the capitated model, the state and CMS entered into three-way contracts with health plans which receive prospective blended payments to provide comprehensive, coordinated care. Under this model, the state and CMS have an agreement which allows state to benefit from a portion of savings from initiatives that improve quality and reduce costs in the FFS delivery system. Although the approaches differ in each state demonstration, beneficiaries are eligible to receive all the standard Medicare and Medicaid services and benefits that they are entitled to outside of the demonstration, as well as additional care coordination, beneficiary protections, and in some cases access to enhanced services.

As of December 2015, CMS has, through the Medicare-Medicaid Financial Alignment Initiative, entered into MOUs with a total of 13 states: 7 states that received awards from the State Demonstrations to Integrate Care for Dual Eligible Individuals (California, Colorado, Massachusetts, Michigan, New York, South Carolina, and Washington) and 6 additional states (Illinois, Ohio, Rhode Island, Texas, Minnesota and Virginia) to integrate care for Medicare-Medicaid enrollees. Ten of these states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, Rhode Island and Virginia) are implementing capitated model demonstrations. Two states (Washington and Colorado) are implementing MFFS model demonstrations. Minnesota is also implementing a demonstration under the Financial Alignment Initiative focused on administrative changes to better align the Medicare and Medicaid operational components of the existing Minnesota Senior Health Options (MSHO) program. In addition to the current FIDA demonstration in New York, CMS and New York State Department of Health are partnering under a separate demonstration, known as the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), to better serve individuals with intellectual and developmental disabilities who are eligible for both Medicare and Medicaid. As of May 2015, approximately 430,000 beneficiaries were enrolled in the combined Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: The Nursing Facility Initiative is focused on reducing preventable inpatient hospitalizations among long-stay dual eligible residents of nursing facilities. CMS competitively selected seven independent

organizations that have contracted with nursing facilities to provide enhanced clinical services to people in approximately 143 nursing facilities. Participants were announced in fall of 2012, and the first sites began serving beneficiaries in February 2013. In fall 2015, CMS released a Funding Opportunity Announcement for a second phase of this Initiative scheduled to begin in fall 2016. Phase Two of this initiative will test a new model of payment to nursing facilities and providers aimed at reducing avoidable hospitalizations.

State Demonstrations to Integrate Care for Dual Eligible Individuals: Through the State Demonstration to Integrate Care for Dual Eligible Individuals, CMS awarded design contracts to 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) in April 2011 to develop new approaches to improve care coordination for beneficiaries enrolled in both the Medicare and Medicaid programs.
Seven of these states are now operating demonstrations under the Financial Alignment Initiative and continue to receive implementation funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals. In addition, CMS and Minnesota have signed an MOU to test an alternative model aimed at administrative simplification within the state's existing Minnesota Senior Health Options integrated managed care program.

Funding History (Budget Authority)

FY 2011	$10,000,000,000
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$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, and enhanced evaluation and research activities.

CMMI Performance Measurement

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. The 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 is collected and aggregated across the following initiatives: Medicare Shared Savings Program (SSP) including advance payment and non-advance payment ACOs, the Pioneer ACO model, the Next Generation ACO model, and the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative. This measure represents efforts across CMS, not just the Innovation Center, to promote better health and health care quality through delivery system reform.

As part of the delivery system reform process, we 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 2013, more than 4 million beneficiaries were aligned to ACOs (3,394,587 Medicare SSP and 607,945 Pioneer), with the expectation of increasing alignment to more than 7 million beneficiaries during the 2015 performance year. Just over 100,000 physicians participated in an ACO in 2013 (83,877 Medicare SSP and 18,840 Pioneer). The Medicare Shared Savings Program has an annual application process and the size of new ACOs varies each year. Though we overestimated the increase in the number of physicians participating in the Program for CY 2014, there was still an increase of 33 percent between CY 2013 and CY 2014. We are encouraged by the number of new applicants for 2016 and published a Final Rule in June 2015 to continue to encourage physicians to participate in ACOs. We also published a proposed rule in January that updates the methodology used to calculate the benchmarks of ACOs that continue their participation in the Medicare Shared Savings program (after an initial 3-year agreement). This proposed rule expands upon issues discussed in the June 2015 final rule, in which CMS committed to engaging in additional rulemaking around modifications to the Shared Savings Program's methodology for resetting benchmarks. In the 2015 performance year, CMS expects physician participation to increase to 178,000 physicians, and further increase to 216,000 physicians in the 2016 performance year.

CMS also established a baseline for the percentage of ACOs that share in savings of 34 percent in 2013. We anticipated modest growth in the total number of ACOs that will share in savings in performance year 2014, and found that 34 percent of ACOs also shared in savings in 2014. However, while the percentage stayed the same, the overall number of ACOs that shared in savings increased, since more ACOs are now participating in the Program. Our participants are continually learning, developing, and implementing best practices that lead to improved quality and savings for Medicare. We continue to be encouraged by the continued interest in the Program as seen by the number of annual applicant ACOs and renewing ACOs, as well as the number of providers participating and beneficiaries assigned to ACOs. We anticipate as ACOs gain more experience with the program, more ACOs will share in savings. As we reconcile additional performance years, we expect for our targets to become more refined, as well. Given the fact that the program is growing rapidly and the number of ACOs beyond their first

[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

performance year is increasing, we anticipate minimal growth in the percentage of ACOs that share in savings in 2015 and 2016, but note that we expect an increase in the number of ACOs that share in savings each year. Therefore, in the 2015 performance year, CMS expects 37 percent of ACOs to share in savings, and 36 percent of ACOs to share in savings in performance year 2016. The CY 2017 targets for ACO measures 1.1-1.3 will be determined by September 30, 2016.

CMMI2: 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.

CMMI2.1 Increase the number of model tests that currently indicate 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost. Designing, implementing, and expanding model tests that improve quality of care, while reducing costs using rigorous evaluation and assessment methodologies, go to the heart of the Innovation Center's daily work. The Innovation Center routinely and rigorously assesses the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies to assess the performance of models and generate value-based payments.

The purpose of measure CMMI2.1 is to identify those models, based on available data that indicate cost savings and/or quality improvements. This measure reflects the documented progress that the Innovation Center is making toward sustainable success of its models. As of September 30, 2015, three Section 1115A model tests (Pioneer ACO, the Maryland All Payer Model, and the Bundled Payments for Care Improvement Initiative [BPCI]) have met this goal according to data to date. The Pioneer ACO model has been certified by the CMS Office of the Actuary to reduce net program spending in an expanded model under Section 1115A of the Social Security Act, and in addition, quality results have been favorable. An actuarial analysis of the Maryland All Payer Model showed that Medicare spending on hospital services decreased $116 million in the first year, achieving more than a third of the state's five-year goal of $330 million in Medicare savings. Hospital acquired conditions also fell by 26 percent, putting the state well-on-track to meeting its goal of a 30 percent reduction by 2019. Preliminary evaluation results from the first performance quarter of BPCI Model 2 (10/01/2013 – 12/31/2013) indicate that the unadjusted average total Medicare standardized allowed payments for orthopedic surgery episodes were significantly lower during the first quarter of the model as compared to the baseline period. Two out of three claims-based quality of care measures indicated no adverse effect under BPCI Model 2 for orthopedic surgery episodes. Evaluation results for other model episodes are still pending.[2]

For other 1115A models, we continue to assemble and assess the evidence as it becomes available. The Innovation Center's targets are to increase the number of models indicating positive results to four in FY 2016 and five in FY 2017, consistent with the evidence available under early model tests.

[2] More information about BPCI can be found at: https://innovation.cms.gov/initiatives/Bundled-Payments.

CMMI3: 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. Information about data sources, data validation and numerators/denominators is available at the end of this section.

CMMI3.1: Percentage of Medicare beneficiaries participating in 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. In FY 2014, nearly 2.7 million Medicare beneficiaries were aligned to Innovation Center models. In FY 2015, the number of Medicare beneficiaries participating in Innovation Center 3021 models increased to over 3 million, representing approximately 6 percent of Medicare beneficiaries. As a contextual indicator, this measure provides a snapshot of Medicare beneficiary model participation at a given point in time (not cumulative participation) in 3021 models that have been operational for more than 6 months.[3] Models that do not have mature data or are national in scope were excluded.

CMMI3.2: 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 several different levers including legislation, policy development and implementation, public payer, educational institutions, public health activities, convening ability and many others. The Innovation Center is providing funding and technical assistance 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. In FY 2014, 25 participating States were designing or implementing a health system transformation and multi-payer payment reform strategy. In FY 2015, an additional 9 States, 3 territories, and the District of Columbia (38 in total) were committed to designing or testing new payment and service delivery models in exchange for financial and technical support. These 38 States are expected to continue in FY 2016. In FY 2017, we expect 17 States to continue testing and improving their health system transformation and payment reform plans; the reduction in number of State Innovation Models (SIM) States is due to the design award project period ending as intended by the program. No decisions have been made about future rounds of SIM grants.

CMMI3.3: Number of providers 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 a broad array of health care providers, States, payers, and other stakeholders in communities across the country. This contextual indicator seeks to understand the level of interest and participation among providers in the Innovation Center's model portfolio. In FY 2014, we estimate that more than 60,000 providers participated in Innovation Center payment and service delivery models. In 2015, we estimate that approximately 61,000 providers participated in Innovation Center payment and service delivery models. As the Innovation Center begins new models and existing models mature, this number is expected to increase.

[3] Individual beneficiaries may be counted in more than one model.

CMMI3.4: Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities: The Innovation Center has created learning collaborative(s) for providers and other model participants in its models to promote broad and rapid dissemination of lessons learned and best practices that have the potential to deliver higher quality and lower cost of care for Medicare, Medicaid and CHIP beneficiaries. Every Innovation Center test of a new service delivery or payment model 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. In FY 2014, 56 percent of 609 participating organizations in three mature models (Pioneer ACOs, the Comprehensive Primary Care initiative, and Health Care Innovation Awards Round 1) engaged in learning activities intended to disseminate best practices. In FY 2015, 58.6 percent of 599 participating organizations in these same three mature models were engaged in learning activities intended to disseminate best practices. Although the target of 61 percent was not attained for the overall participant rate, the data from 2015 showed improvement in participation in learning events across the models. When the data are stratified by specific model, the Pioneer ACOs demonstrated an increased participation rate; the 2014 rate was 62.7 percent and the 2015 rate was 84.5 percent. The participation percentages also increased for CPC from 50.6 percent to 52.3 percent and for HCIA from 77.6 percent to 81.8 percent. We are exploring the ways to enhance engagement to meet or exceed our 2016 targets. As these models mature, they have added other type of learning events that may improve engagement. For future reporting, we will include data on some of these additional activities such as regional webinars, action groups and in-person learning events. A target of 64.5 percent has been set for FY 2016, and a target of 71 percent has been set for FY 2017.

Measure	Data Source	Data Validation
CMMI3.1	Master Data Management system, Integrated Data Repository, CMMI-wide data base currently under development, CMS administrative data, model specific beneficiary alignment files, participant reported alignment files (e.g., from States). Medicare enrollment data were provided by the CMS Office of the Actuary on 11/25/2015 and reflect total FY 2015 Medicare enrollment.	Numerator: The estimated number of Medicare beneficiaries directly participating, or projected to participate, in 3021 model tests that have been operational for more than 6 months as of 9/30/2015. Denominator: The monthly average of enrolled Medicare beneficiaries during FY 2015. CMMI staff and contractors collect beneficiary information from model implementation contractors and submit the results to CMMI after cleaning and verifying the results. CMMI contractors work directly with model participants to collect the data from the appropriate data sources, conducting audit and validation processes to ensure the reliability of the data.

Measure	Data Source	Data Validation
CMMI3.2	CMMI-wide data base currently under development, participant reported alignment files (e.g., from States).	Measure Input: A State or territory participating in State Innovation Models Round 1 or Round 2, or implementing a health system payment reform plan in partnership with CMMI, i.e. the Maryland All Payer model CMS staff relied upon participant agreements and selection documents to obtain a count of States and territories with active multi-payer transformation plans.
CMMI3.3	Medicare Provider Enrollment, Chain, and Ownership System (PECOS), CMMI-wide data base currently under development, CMS administrative data, model specific provider alignment files, participant reported alignment files (e.g., from hospitals).	Measure Input: The number of providers (ACOs, hospitals, physicians, etc.) participating in 3021 models as of 9/30/2015. CMMI staff and contractors collect provider information from model implementation contractors and submit the results to the CMMI-wide data base after cleaning and verifying the results. CMMI contractors work directly with model participants to collect the data from the appropriate data sources, conducting audit and validation processes to ensure the reliability of the data.
CMMI3.4	CMMI-wide data base currently under development; Learning system database.	Numerator: The average number of participants per learning event for 3021 models with available data – Pioneer ACOs, CPC, and HCIA Round 1. Denominator: The number of model participants in 3021 models with an established learning system in place prior to 2014 who also convened multiple learning events during 2015. CMS staff collected the necessary indicators tracking learning activities from the learning system data management (LSDM) contractor who integrated quality control procedures to clean and verify the data.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	CY 2016 Target	CY 2017 Target	FY 2017 Target +/-FY 2016 Target
ACO1.1 Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations: *Calendar Year Measure* CY 2013 Baseline: 4,002,532	CY 2014: Result: 5,954,342 Target: 5,425,000 Target Exceeded	8,200,000	TBD	N/A
ACO1.2 Increase the number of physicians participating in an Accountable Care Organizations: *Calendar Year Measure* CY 2013 Baseline: 102,717	CY 2014: Result: 132,148 Target: 150,000 Target Not Met but Improved	216,000	TBD	N/A
ACO1.3 Increase the percentage of Accountable Care Organizations that share in savings: *Calendar Year Measure* CY 2013 Baseline: 34%	CY 2014 Result: 34% Target: 35% Target Not Met	36%	TBD	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
CMMI2.1 Increase the number of model tests that currently indicate:	FY 2015 Result: 3.0 Target: 3.0	4.0	5.0	+1.0 model

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost. FY 2014 Baseline: 1.0	Target Met			
CMMI3.1 Percentage of Medicare beneficiaries participating in Innovation Center models FY 2014 Baseline: 5%	FY 2015 Result: 6% Contextual Indicator Historical Actual, No Target	Contextual Indicator	Contextual Indicator	N/A
CMMI3.2 Number of States developing and implementing a health system transformation and payment reform plan FY 2014 Baseline: 25	FY 2015 Result: 38 Target: 38 Target Met	38	17	-18 States
CMMI3.3 Number of providers participating in Innovation Center models FY 2014 Baseline < 60,000	FY 2015 Result: 61,000 Contextual Indicator Historical Actual, No Target	Contextual Indicator	Contextual Indicator	N/A
CMMI3.4 Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities FY 2014 Baseline: 56%	FY 2015 Result: 58.6% Target: 61% Target Not Met but Improved	64.5%	71%	+6.5 pp

Information Technology
(Dollars)

Information Technology Portfolio	FY 2015 Operating	FY 2016 Enacted	FY 2017 President's Budget
Medicare Parts A & B	$ 407,794,632	$ 448,448,995	$ 391,280,398
Other Medicare Operational Costs	172,552,493	179,181,342	213,391,038
Medicaid & CHIP	56,082,797	58,137,251	73,327,277
Health Care Planning & Oversight	108,674,503	111,985,383	111,489,977
Health Care Quality	324,142,360	322,800,168	317,343,312
Marketplace IT	370,197,043	475,165,000	298,533,000
Outreach & Education	20,163,000	20,663,000	28,163,000
Enterprise Activities	479,963,029	520,629,464	522,923,222
Total Information Technology Portfolio	**$ 1,939,569,857**	**$ 2,137,010,603**	**$ 1,956,451,224**

Program Description and Accomplishments

CMS' information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, HCFAC, and QIO programs. IT activities support most programs that CMS oversees, including Medicare, Medicaid, CHIP, the Affordable Care Act provisions, Private Market Insurance and associated quality-assurance and program safeguards. CMS' IT investments support a broad range of business operational needs, as well as implement provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. Further information on specific IT projects can be found within the IT Portfolio Summary (formerly known as the Exhibit 53) and the Major IT Business Cases (formerly known as the Exhibit 300s), which can be viewed at the investment tab located at the following address: http://www.itdashboard.gov/portfolios/agency=009,bureau=38

Information Technology Portfolio:

Medicare Parts A & B investments – 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). This category also supports HITECH activities and Fraud Prevention. Activities funded in this category support efforts to stabilize our claims processing systems, as well as strengthen and modernize CMS' IT infrastructure in anticipation of program growth. The Medicare Fee for Service program needs investments in improved infrastructure to continue to operate successfully. Major systems within this category include:

- The Enterprise Data Centers (EDC) provides hosting and support for CMS systems and services.

- CMS Common Working File (CWF) is a single data source for Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs) and Carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the Fee for Service (FFS) claims processing system where full individual beneficiary information is housed.

- Fiscal Intermediary Shared System (FISS) is a critical component of the Fee for Service (FFS) program, processing millions of Medicare claims a year. FISS is the shared systems used to process Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the Common Working File (CWF) System for verification, validation, and payment authorization. FISS must also implement changes needed to support the Medicare Administrative Contractor (MAC) authority for the Medicare FFS Program.

- Multi Carrier System (MCS) is the shared system used to process Medicare Part B claims for physician care, durable medical equipment, and other outpatient services nationwide. It interfaces directly with the CWF.

- The Single Testing Contractor (STC) provides integration and regression testing for the Shared Systems functionality pertaining to claims adjudication, payments, remittance advices, and Medicare Summary Notices (MSN). It also provides testing for various system interfaces outside of the FISS, Medicare Claims System (MCS), ViPS Medicare System (VMS), and the CWF.

- ViPS Medicare System (VMS) is a shared system used to process durable medical equipment (DME) claims for physician services, diagnostic tests, ambulance services and other services/supplies that are not covered by Part A. It interfaces directly with the CWF for verification, validation, and payment authorization.

- HITECH (Health Information Technology for Economic and Clinical Health) - The American Recovery and Reinvestment Act of 2009 (Recovery Act) was signed into law on February 17, 2009. Title IV of the Recovery Act is the provision for Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides for the use of incentive payments to promote the meaningful use of electronic health records by eligible professionals and hospitals. This investment includes all information technology required to implement the program, including development of the National Level Repository (NLR). The NLR will serve as the central system hub for the HITECH EHR Incentive Program. This investment supports the incentive payment program production operations, supports data quality initiatives including data validation, analysis, and investigation.

Other Medicare Operation Costs – IT investments within this category include the Healthcare Integrated General Ledger Accounting System (HIGLAS) Operations, ICD-10, Medicare-Medicaid Financial Alignment Models, Pioneer ACO Models and numerous CMMI activities including the new ACO capitation Model and the Medicare Appeal Systems (MAS). Projects in this category facilitate delivery system reform, and will help provide stakeholders with the tools needed for effective medical decision-making.

- HIGLAS is a national standardized financial system that began operation in 2005. HIGLAS is a component of the Department of Health and Human Services' Unified Financial Management System (UFMS). HIGLAS is a single, integrated dual-entry accounting system that is compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA) that processes the mission critical payment calculation for Medicare benefits to Part A and Part B, Medicaid Grants, and Children's Health Insurance Program (CHIP) for the entire nation. HIGLAS also incorporates internal CMS administrative program accounting transactions.

- The International Classification of Diseases 10th Revision (ICD-10) code sets provide more detailed information concerning diagnoses and procedures for fraud and abuse detection, increased accuracy of claims payment, and support for both the Secretary's and CMS' quality and transparency initiatives, such as Value-Based Purchasing.

- The Medicare-Medicaid Financial Alignment Models project supports CMS work to implement the financial alignment initiative. CMS will need to enhance its systems to support both the capitated and Fee for Service financial alignment models. The capitated model will test new payment, enrollment, oversight, appeals, benefit, network adequacy, marketing, quality, and encounter data mechanisms. In the Fee for Service model, changes are needed to correctly align beneficiaries with the demonstration delivery model as well as to track payments and shared savings.

- The Pioneer ACO Model will test alternative payment models that: (1) include escalating levels of financial accountability (2) provide a transition from Fee for Service to population-based payment and (3) generate Medicare savings.

- The Medicare Appeal Systems (MAS) continues to be an integral part of CMS' management and oversight of Medicare Administrative Contractors (MAC) and Qualified Independent Contractor (QIC) appeals. Access to real-time appeals data allows CMS to closely monitor workload trends and contractor performance.

Medicaid and CHIP – 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 Data Investments establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims for Medicaid beneficiaries. This data is used for the administration of Medicaid at the Federal level; and to produce statistical reports, support Medicaid related research, and assist in the detection of fraud and abuse in the Medicaid and CHIP programs. Given the unprecedented levels of growth in the Medicaid program, Federal and state stakeholders need the ability to handle massive amounts of data, provide real-time eligibility determinations and process thousands of enrollment applications. Activities funded under this category include:

- The Medicaid Statistical Information System (MSIS), which supports much of the Medicaid research and analysis performed by the Congressional Budget Office and the Congressional Research Service. MSIS also captures claims data reported by the States, which allows for the audit of financial payments within the Medicaid and CHIP programs.

- Data storage (flat files, data warehouse, and data marts).

- The Medicaid and Child Health Budget and Expenditure (MBES) system, which enables CMS to support fiscal integrity for both state and Federal components of the Medicaid and CHIP programs by projecting anticipated budget expenditures, managing and supporting tracking of financial operations and actual expenditures related to program operations.

- Unified Case Management system serves as a central repository for tracking leads that contain all contractor workload reporting, dashboards to monitor progress, and outcome measure calculations.

Health Care Planning and Oversight - CMS maintains several major systems needed to run the Parts C and D programs. IT systems within this category support Beneficiary Enrollment and Plan Payment for Medicare Parts C and D along with Encounter Data processing. Key systems include:

- Medicare Advantage Prescription Drug (MARx) and Premium Withhold Systems (PWS) deliver enrollment and health plan payment for Medicare Part C and Medicare Part D benefits. These systems process transactions for approximately 40 million enrollees from more than 800 Part C and Part D plans.

- Retiree Drug Subsidy (RDS) program creates a financial incentive for sponsors of retiree drug plans to continue offering high quality drug coverage to retirees. The RDS IT system gives plan sponsors the flexibility to leverage existing business arrangements with consulting companies to electronically submit required data to CMS. All transactions in the RDS program are performed electronically through the use of the Internet and electronic business technology.

- The Virtual Call Center supports the national system for handling beneficiary inquiries through the 1-800-MEDICARE toll-free lines.

- The Encounter Data System collects health care utilization (encounter) data for the purpose of editing, pricing, and storage of Medicare Advantage (MA) claims data for more than 16 million beneficiaries. CMS would be able to evaluate coverage, profile and analyze service utilization, and assess quality of care, with the goal of reducing fraud, waste and abuse and improving Medicare programs and healthcare in general.

- CMS Plan Enrollment - The Health Plan Management System (HPMS) is a secure web application that serves as the primary plan-based information system supporting the Medicare Advantage (MA) and Prescription Drug (Part D) programs. HPMS manages plan enrollment and compliance business processes for all private health and drug plans participating in the MA and Part D programs.

Health Care Quality - 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. IT systems within this category support Health Care Quality, Quality Improvement Organizations (QIO) and the physician value program.

- Improved Quality-based Accountable Care Organizations ACO's support the functions required to operate and evaluate the effectiveness of care coordination for Fee for Service Medicare beneficiaries. These investments also assist in sharing data, verifying ACO eligibility, assigning beneficiaries, calculating annual expenditures, calculating and applying performance and quality scores, calculating shared savings, and reporting program information. IT systems will support the activities associated with business intelligence development, database development, data dissemination, web portal application development and data analytics to support ACOs current and future program needs. This investment is dependent on shared services data environments within the CMS framework including, Integrated Data Repository (IDR), National Claims History (NCH), Master Data Management, Baltimore Data Center Hosting, and Business Intelligence Software.

- The Standard Data Processing System (SDPS) funds the hospital reporting system and is established for the user community to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

 The Health Care Quality Improvement System (QIES) is a national system that fully supports the Survey and Certification program, fulfills CMS' quality initiatives for select provider settings, aids in managing payment for services to beneficiaries, and assists in the battle against fraud and abuse. QIES supports major initiatives, such as Nursing Home Compare, Home Health Compare, and Hospital Compare. QIES supports over 111,000 users and is used by state survey agencies, Federal agencies, QIOs, beneficiaries, consumers and researchers.

 The Physician Quality Reporting System (PQRS) supports the combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

 Healthcare Quality End Stage Renal Disease (ESRD) Systems consist of the systems and network technology required to facilitate the collection and maintenance of information of the Medicare End Stage Renal Disease (ESRD) program, its beneficiaries, and the services provided to beneficiaries. It includes the network infrastructure needed to facilitate the collection, calculation, transmission, and maintenance of data to initiate performance based payments for ESRD facilities under MIPPA Section153 C.

Outreach and Education - IT systems within this category support National Medicare Education Program (NMEP), Non-Marketplace Healthcare.gov and ACA provider Outreach.

 Beneficiary e-Services create a virtual enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support www.medicare.gov and www.cms.gov websites.

Enterprise Activities - Enterprise IT activities encompass CMS' critical systems that support ongoing operations, primarily the Infrastructure Hosting and Centralized Communication Services (IHCCS), the VDC Infrastructure Enterprise Services (VIES), the CMS Enterprise Compute Services (CECS), and Large Scale Data Repository (LSDR). These VDC TOs support 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. Enterprise Activities also address the protection of information in the face of new cybersecurity threats by completing a transition to an enterprise approach for managing Information Security and Privacy (IS&P). Additional IT systems within this category support Infrastructure Investments, General ACA IT, program administration and Enterprise Shared Services.

 Infrastructure Investments support the cost savings and operational efficiencies of data center consolidation, reliable backup of data through enhanced disaster recovery and maximizes the value of software license costs by transitioning to usage-based enterprise license agreements. Major IT systems within this investment include:

-Baltimore Data Center Operations
-Enterprise Software Licenses
-Medicare DataComm Network (MDCN)
-Integrated Data Repository
-Enterprise Identity and Access Management Service

- IT systems that support voice and data telecommunication costs, web-hosting and satellite services, ongoing systems security activities and systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

- Infrastructure Hosting and Centralized Communication Services (IHCCS) - Includes all activities necessary to provide CMS efficient, effective, and responsive Data Center and network infrastructure. The work performed under this TO includes all necessary aspects of planning, implementing, transitioning, operating, and maintaining CMS's IT Infrastructure and all related hardware and software in support of the BDC.

- VDC Infrastructure Enterprise Services (VIES) – Includes the delivery of Infrastructure Enterprise Services. The VIES Contractor will ultimately be responsible for the development, administration, and management of all of the following enterprise services: Identity Management and Access Control, Enterprise File Transfer (EFT), Sweeps, Remedy, Enterprise Service Desk, and Enterprise Operation Center services.

- CMS Enterprise Compute Services (CECS) – Includes delivery of end-to-end services in support of the unified convergence of voice, video, and data technology to CMS end users in order to ensure a productive and mobile workforce. The CECS task order will include the engineering, implementation, maintenance and operations of all Seat Management Services and end user specific Telecommunications and Network services including network printing, Microsoft Enterprise Lync, Voice over Internet Protocol (VOIP), Video Teleconferencing (VTC), Audio Conferencing Operational Support and Moderator Services.

- Large Scale Data Repository (LSDR) – Includes all activities necessary to provide a robust, stable, and effective data repository environment. The activities include all necessary aspects of planning, implementing, transitioning, operating, maintaining, and procuring all related hardware and software in support of services for the Teradata and Hadoop systems within the BDC.

- Enterprise Shared services include:

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.

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 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 Service (BRES) **–** This 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 Services - 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).

Budget Request

The FY 2017 President's Budget request for Information Technology is $1.96 billion, $180.6 million below the FY 2016 Enacted Level. The decrease can be attributed to finding efficiencies within the Marketplace IT operational strategy and increased user fee funding for Marketplace IT costs.

The FY 2017 request continues to support CMS' IT Shared Services strategy. The Shared Services strategy will reduce costs associated with development and maintenance of enterprise functions. It increases reliability and promotes better government practices that will be measured rigorously through performance and earned value management. CMS will continue to use multiple funding sources to support the Shared Services environment. Using a cost allocation methodology, CMS utilizes funds from the Program Management, HCFAC, CMMI, and QIO accounts. These funds support critical Agency priorities, including Affordable Care Act implementation.

The chart below shows the IT portfolio by funding sources.

Information Technology Portfolio	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
CLIA	$ 5,100,000	$ 5,100,000	$ 5,100,000
CMMI (ACA §3021)	100,803,939	124,161,759	151,963,832
Federal Admin	38,806,000	39,919,000	37,632,000
HITECH ARRA	52,112,942	64,000,742	41,234,223
Program Integrity (MIP/HCFAC)	307,723,359	374,773,880	286,492,876
Program Ops	1,067,667,000	1,185,526,264	1,106,200,107
Quality Improvement Organizations	305,866,839	304,734,434	284,560,451
RAC Collections	15,894,490	18,251,086	18,561,086
Small Business Jobs Act of 2010	24,000,000	-	-
Survey and Certification	1,625,000	1,940,000	2,295,000
User Fee	19,970,288	18,603,438	22,411,649
Total Information Technology Portfolio	**$ 1,939,569,857**	**$ 2,137,010,603**	**$ 1,956,451,224**

The chart below is a breakdown of IT funding within the seven investment categories by funding source.

Information Technology Portfolio	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Program Operations	160,297,227	155,932,883	172,882,888
Program Integrity (MIP/HCFAC)	163,993,663	221,914,284	170,182,201
HITECH ARRA	52,112,942	64,000,742	41,234,223
User Fees	7,390,800	3,900,000	3,900,000
RAC Collections	-	2,701,086	3,081,086
Small Business Jobs Act of 2010	24,000,000	-	-
Medicare Parts A&B, Subtotal	***407,794,632***	***448,448,995***	***391,280,398***
Program Operations	137,998,554	132,790,626	157,319,624
CMMI (ACA §3021)	34,553,939	46,390,716	56,071,414
Other Medicare Operational Costs, Subtotal	***172,552,493***	***179,181,342***	***213,391,038***
Program Operations	12,961,135	16,687,251	33,569,511
Program Integrity (MIP/HCFAC)	35,121,662	34,000,000	24,250,000
CMMI (ACA §3021)	8,000,000	7,450,000	15,507,766
Medicaid & CHIP	***56,082,797***	***58,137,251***	***73,327,277***
Program Operations	52,655,288	42,329,853	47,856,807
Program Integrity (MIP/HCFAC)	43,019,215	54,655,530	44,843,170
Quality Improvement Organizations	1,000,000	1,000,000	1,000,000
User Fees	12,000,000	14,000,000	17,790,000
Health Care Planning and Oversight, Subtotal	***108,674,503***	***111,985,383***	***111,489,977***
Program Operations	24,058,350	19,276,675	32,810,580
Quality Improvement Organizations	294,184,010	297,308,493	278,157,732
CLIA	5,100,000	5,100,000	5,100,000
Survey & Certification	800,000	1,115,000	1,275,000
Health Care Quality, Subtotal	***324,142,360***	***322,800,168***	***317,343,312***
Program Operations	370,197,043	475,165,000	298,533,000
Marketplace IT, Subtotal	***370,197,043***	***475,165,000***	***298,533,000***
Program Operations	20,163,000	20,663,000	28,163,000
Outreach & Education, Subtotal	***20,163,000***	***20,663,000***	***28,163,000***
Program Operations	289,336,403	322,680,976	335,064,697
Program Integrity (MIP/HCFAC)	65,588,819	64,204,066	47,217,505
CMMI (ACA §3021)	58,250,000	70,321,043	80,384,652
User Fees	579,488	703,438	721,649
Survey & Certification	825,000	825,000	1,020,000
Federal Admin	38,806,000	39,919,000	37,632,000
RAC Collections	15,894,490	15,550,000	15,480,000
Quality Improvement Organizations	10,682,829	6,425,941	5,402,719
Enterprise Activities, Subtotal	***479,963,029***	***520,629,464***	***522,923,222***
Total Information Technology Portfolio	**$ 1,939,569,857**	**$ 2,137,010,603**	**$ 1,956,451,224**

Medicare Parts A & B investments

The FY 2017 President's Budget request for Medicare Parts A and B Investments is $391.2 million, $57.1 million below the FY 2016 Enacted Level. The decrease in requested funding can be attributed to increasing returns from program integrity investments made from the Health Care Fraud and Abuse Control program, including the trusted third party infrastructure in FY 2016 for the Healthcare Fraud Prevention Partnership. This decrease will also come from cutting the One PI system, which will not be able fund certain activities including: loading Medicaid data, data matching, and business interfacing with other Program Integrity systems.

Program Operation funding will continue to include system upgrades and maintenance for the claims processing systems which include the Common Working File, systems integration testing, and the ViPS Medicare System. These systems are essential to the claims processing shared system infrastructure. This investment provides infrastructure and program management to: all CMS Medicare Fee-For-Service Part A, Part B, and DME production operations, including the CWF Hosts previously performed by over 20 disparate legacy Medicare data centers; Web Hosting services for Medicare.gov, CMS.HHS.gov, CMSNet, and the Health Plan Management System (HPMS); and, application hosting services for the 1-800 Medicare Next Generation Desktop Data Warehouse.

Other Medicare Operation Costs

The FY 2017 President's Budget request is $213.4 million, $34.2 million above the FY 2016 Enacted Level. In FY 2017, CMS will continue to fund the ACO Capitation Model, as well as the Oncology Care Model (OCM). This increase will also support upgrades to the Shared Systems, Common Working File, Integrated ACO Models, and Medicare Appeals System (MAS). In addition to providing an electronic appeals case file and promoting the use of consistent processes in appeals activities across MACs and QICs, system upgrades will improve accuracy, timeliness, and efficiency in the appeals process.

Medicaid and CHIP

The FY 2017 President's Budget request is $73.3 million, $15.1 million above the FY 2016 Enacted Level. Funding from the FY 2017 request will support the Medicaid and CHIP Business Information Solutions (MACBIS), which transforms the collection and analysis of Medicaid and CHIP Data. CMS will transform Medicaid and CHIP information and data gathering, submission, storage, and extraction processes by utilizing an electronic, automated process that provides CMS, its federal partners, the states, and other stakeholders the ability to monitor, evaluate, and analyze Medicaid and CHIP program performance.

Health Care Planning and Oversight

The FY 2017 President's Budget request is $111.4 million, $0.4 million below the FY 2016 Enacted Level. This decrease reflects the operational efficiencies within the collection of encounter data from the Medicare Advantage plans.

Health Care Quality

The FY 2017 President's Budget request is $317.5 million, $5.4 million below the FY 2016 Enacted Level. The decrease in the request is attributed to the QIO authoring tool for measures that became operationally functional in FY 2016. This request will continue to fund Health Care Quality initiatives.

Marketplace IT

The FY 2017 President's Budget request is $298.5 million, $176.7 million below the FY 2016 Enacted Level. This decrease is based on a steady state assumption within a largely operational environment. Corrective maintenance will still be supported. Please see the Marketplace narrative of the Program Operations chapter for more details.

Outreach and Education

The FY 2017 President's Budget request is $28.2 million, which is a $7.5 million increase from the FY 2016 Enacted Level. The funding increase will upgrade web services offered online and support the functionality of the website interfaces.

Enterprise Activities

The FY 2017 President's Budget request is $523.0 million, $2.2 million above FY 2016 Enacted Level. This increase in funding will be used for the Homeland Security Presidential Directive 12 (HSPD-12) which promotes secure and reliable forms of identification. CMS is also investing in the technology to automate the Human Resource (HR) administrative processes through workflow capabilities. The increase also provides increased funding to support portal expansion and security for health care fraud systems.

Enterprise activities also support the foundational infrastructure for data hosting.

These funds also allow CMS to enhance the protection of information in the face of new cybersecurity threats by completing a transition to an enterprise approach for managing Information Security and Privacy (IS&P). CMS is in the process of automating Governance, Risk Management, and Compliance (GRC) processes, expanding security monitoring across the Agency through the Enterprise Security Operations Center (ESOC), implementing Information Security Continuous Monitoring (ISCM) solutions, and addressing Software Assurance (SwA) across the enterprise. CMS is working towards meeting the elevated requirements introduced by new federal mandates including the Federal Information Technology Acquisition Reform Act (FITARA) and OMB Memorandum M-14-03.

For further detail on the FY 2017 Program Operations IT budget request, the chart on the following page crosswalks IT funding according to the breakout in the Program Operations Chapter.

Program Operations - Information Technology	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Ongoing Operations - MAC & Legac	$ 80,260,399	$ 76,779,470	$ 87,654,196
Claims Processing Investments	$ 74,089,345	$ 73,102,726	$ 78,891,120
Contracting Reform	$ 5,947,483	$ 6,050,687	$ 6,337,572
I. Medicare Parts A&B	$ 160,297,227	$ 155,932,883	$ 172,882,888
HIGLAS Operations	$ 94,159,000	$ 94,159,000	$ 98,850,000
QICs	$ 7,000,000	$ 6,200,000	$ 25,151,195
HIPAA plus NPI	$ 17,231,011	$ 14,931,626	$ 18,318,429
ICD-10 (and Version 5010)	$ 19,608,543	$ 17,500,000	$ 15,000,000
HIGLAS Development	$ -	$ -	$ -
II. Other Medicare Operational Costs	$ 137,998,554	$ 132,790,626	$ 157,319,624
Medicaid & CHIP	$ 11,196,489	$ 14,922,605	$ 30,169,511
ACA Medicaid & CHIP	$ 1,764,646	$ 1,764,646	$ 3,400,000
III. Medicaid & CHIP	$ 12,961,135	$ 16,687,251	$ 33,569,511
Part C/D IT Systems Investments	$ 50,305,288	$ 40,475,908	$ 45,826,284
ACA Part C/D IT Systems Investmen	$ 2,350,000	$ 1,853,945	$ 2,030,523
IV. Health Care Planning & Oversight	$ 52,655,288	$ 42,329,853	$ 47,856,807
ACA Health Care Quality IT	$ 18,665,350	$ 16,572,529	$ 29,747,030
ACA Physician Value	$ 5,393,000	$ 2,704,146	$ 3,063,550
V. Health Care Quality	$ 24,058,350	$ 19,276,675	$ 32,810,580
National Medicare Education Progr	$ 17,309,000	$ 17,809,000	$ 25,309,000
Non-Marketplace Healthcare.gov	$ 2,000,000	$ 2,000,000	$ 2,000,000
ACA Provider Outreach	$ 854,000	$ 854,000	$ 854,000
VI. Outreach & Education	$ 20,163,000	$ 20,663,000	$ 28,163,000
Enterprise Activities	$ 240,357,343	$ 259,076,144	$ 261,682,766
Infrastructure Investments	$ 23,105,943	$ 23,299,647	$ 32,216,680
Other MMA Mandates	$ 1,037,300	$ 1,037,300	$ 1,037,300
General ACA IT	$ 5,271,192	$ 16,139,590	$ 10,563,326
Enterprise Shared Services	$ 19,564,625	$ 23,128,295	$ 29,564,625
VII. Enterprise IT	$ 289,336,403	$ 322,680,976	$ 335,064,697
VIII. Marketplace IT	$ 370,197,043	$ 475,165,000	$ 298,533,000
Total	**$ 1,067,667,000**	**$ 1,185,526,264**	**$ 1,106,200,107**

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 2015 Actual	FY 2016 Estimate	FY 2017 Estimate	FY 2017 +/- FY 2016
Drug Resources by Decision Unit and Function:				
Medicaid Treatment	$7,000	$7,500	$7,800	+$300
Medicare Treatment	$1,230	$1,260	$1,340	+$80
Total	$8,230	$8,760	$9,140	+$380
Drug Resources by Decision Unit:				
Centers for Medicare & Medicaid Services				
Total	$8,230	$8,760	$9,140	$380
Drug Resources Personnel Summary				
Total FTEs (direct only)	0	0	0	0
Drug Resources as a Percent of Budget				
Total Agency Budget (in Millions)[1]	$967,130	$1,058,046	$1,091,454	
Drug Resources Percentage	0.9%	0.8%	0.8%	

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.

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflect the federal share of net benefit outlays and includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

Methodology

Medicaid Estimate

These projections were based on the estimates in the report "Medicaid Substance Abuse Treatment Spending: Findings Report"[2], 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 2014 using the growth rate of expenditures by state, service, and eligibility category from the CMS-64, the Medicaid Analytic Extract (or MAX), and the estimates of enrollment growth consistent with the President's FY 2017 Budget. The annual growth rates were multiplied by 0.98, 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 MAX 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 2015 through 2018 were then developed from the fiscal year 2014 estimates multiplied the 98 percent of the growth rate in expenditures by service and eligibility category from the President's FY 2017 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 2014. 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.

Lastly, CMS notes that these projections are higher than in previous years. This reflects a change to the methodology to use the CMS-64 Net Services, which allocates prior period adjustments to services (whereas prior period adjustments were reported and projected separately in previous budget exercises). This change generally increases the amounts for all services, including substance abuse services. In addition, the change from using the Medicaid Statistical Information System (or MSIS) to using MAX and increases in the budget projections for Medicaid overall contributed to the increase in the projections for substance abuse services.

[2] 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 2017 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 2015, using the primary diagnosis code[3] included on the claims. These projections are slightly higher than those for the 2016 President's Budget, due to the incorporation of another years of actual experience, which was higher than anticipated. The historical trend 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 2017 drug control outlay estimate for the CMS is $9,140 million. 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 2016 to FY 2017 growth is attributable to actual data in Medicare, which was higher than anticipated, and the impact of the Affordable Care Act which included the Medicaid eligibility expansion in 2014.

Medicaid
FY 2017 outlay estimate: $7,800 million
(Reflects $300 million increase from FY 2016)

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 2017 outlay estimate: $1,340 million
(Reflects $80 million increase from FY 2016)

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

[3] 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.

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.

Performance

Both Medicaid and Medicare contain quality measurement programs that relate to substance abuse screening and treatment. However, none of the programs require reporting of specific measures, nor do they set specific performance targets for the measures.

The Department of Health and Human Services established a FY 2016-17 HHS-wide Agency Priority Goal to *Reduce Opioid Morbidity and Mortality* and CMS is a supporting partner in that effort. Additional Information can be seen on Performance.gov.

Medicaid
In FY 2016, states will continue voluntary reporting on a core set of health care quality measures for adults enrolled in Medicaid. CMS released an updated core set of measures for 2016 in December 2015, including a new measure: "Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer." In addition, a measure related to initiation and engagement of alcohol and other drug dependence treatment is maintained from the initial core set. CMS will publicly report state-specific data from the core set for the first time in the 2015 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid.

Medicare
The Physician Quality Reporting System is a Medicare quality reporting program that encourages reporting of quality measures by eligible professionals by applying negative payment adjustments to those eligible professionals that do not meet satisfactory reporting criteria. Eligible professionals may select from a set of approximately 300 quality measures. The number of measures they are required to report in order to avoid a negative payment adjustment varies depending on the reporting method selected.

In November 2015, CMS made available a new interactive online Medicare Part D Opioid Drug Mapping Tool that allows the public to search Medicare Part D opioid prescription claims data at the state, county, and ZIP code levels. By openly sharing data in a secure, broad, and interactive way, CMS is supporting a better understanding of regional provider prescribing behavior variability and is adding insight to local health care delivery. For additional information: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-11-03.html

Clinical Quality Measure Reporting
CMS is working in partnership with the Office of the National Coordinator for Health Information Technology to incorporate clinical quality measures (CQMs) with relevant information into electronic health records (EHRs) to assist in implementing the health care delivery and payment reform provisions of the Affordable Care Act. The data collected will provide insight on a wide spectrum of health care quality issues, including screening and treatment for substance use. Currently, eligible professionals may elect to report on measures related to tobacco cessation and substance abuse screening and treatment as part of the Medicare and Medicaid Meaningful Use incentive programs which aim to increase the use of EHRs. As part of the requirement to qualify as an EHR meaningful user, eligible professionals must report on nine (9) CQMs, covering at least three (3) National Quality Strategy domains.

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CMS Program Management
Budget Authority by Object

	2016 Enacted	2017 Budget	FY 2017 +/- FY 2016
Personnel compensation:			
Full-time permanent (11.1)	$464,896,000	$441,986,000	($22,910,000)
Other than full-time permanent (11.3)	$16,183,000	$16,399,000	$216,000
Other personnel compensation (11.5)	$7,789,000	$7,565,000	($224,000)
Military personnel (11.7)	$17,813,000	$18,084,000	$271,000
Subtotal personnel compenstion	**$506,681,000**	**$484,034,000**	**($22,647,000)**
Civilian benefits (12.1)	$139,243,000	$135,868,000	($3,375,000)
Military benefits (12.2)	$9,176,000	$9,316,000	$140,000
Total Pay Costs	**$655,100,000**	**$629,218,000**	**($25,882,000)**
Travel and transportation of persons (21.0)	$4,400,000	$5,600,000	$1,200,000
Rental payments to GSA (23.1)	$5,100,000	$5,100,000	$0
Communication, utilities, and misc. charges (23.3)	$224,000	$224,000	$0
Printing and reproduction (24.0)	$2,200,000	$2,575,000	$375,000
Other Contractual Services:			
Other services (25.2)	$1,985,767,000	$2,107,077,000	$121,310,000
Purchase of goods and services from government accounts (25.3)	$2,977,000	$3,687,000	$710,000
Research and Development Contracts (25.5)	$20,054,000	$21,867,000	$1,813,000
Medical care (25.6)	$1,297,744,000	$1,333,023,000	$35,279,000
Subtotal Other Contractual Services	**$3,306,542,000**	**$3,465,654,000**	**$159,112,000**
Supplies and materials (26.0)	$1,078,000	$1,078,000	$0
Equipment (31.0)	$100,000	$100,000	$0
Grants, subsidies, and contributions (41.0)	$0	$0	$0
Total Non-Pay Costs	**$3,319,644,000**	**$3,480,331,000**	**$160,687,000**
Total Budget Authority by Object Class	**$3,974,744,000**	**$4,109,549,000**	**$134,805,000**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$9,914,000	$0	($9,914,000)
Other personnel compensation (11.5)	$155,000	$0	($155,000)
Civilian benefits (12.1)	$2,949,000	$0	($2,949,000)
Other Contractual Services:			
Other services (25.2)	$51,982,000	$0	($51,982,000)
Total Budget Authority by Object Class	**$65,000,000**	**$0**	**($65,000,000)**

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Salary and Expenses
CMS Program Management
(Budget Authority in Thousands)

Object Class	FY 2016 Enacted	FY 2017 Budget	FY 2017 +/- FY 2016
Personnel compensation:			
Full-time permanent (11.1)	$ 464,896	$ 441,986	$ (22,910)
Other than full-time permanent (11.3)	$ 16,183	$ 16,399	$ 216
Other personnel compensation (11.5)	$ 7,789	$ 7,565	$ (224)
Military personnel (11.7)	$ 17,813	$ 18,084	$ 271
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 506,681**	**$ 484,034**	**$ (22,647)**
Civilian benefits (12.1)	$ 139,243	$ 135,868	$ (3,375)
Military benefits (12.2)	$ 9,176	$ 9,316	$ 140
Benefits to former personnel (13.0)	$ -	$ -	$ -
Subtotal Pay Costs,	**$ 655,100**	**$ 629,218**	**$ (25,882)**
Travel (21.0)	$ 4,400	$ 5,600	$ 1,200
Transportation of things (22.0)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ 224	$ 224	$ -
Printing and reproduction (24.0)	$ 2,200	$ 2,575	$ 375
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 1,985,767	$ 2,107,077	$ 121,310
Purchase of goods and services from government accounts (25.3)	$ 2,977	$ 3,687	$ 710
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 21,867	$ 1,813
Medical care (25.6)	$ 1,297,744	$ 1,333,023	$ 35,279
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,306,542**	**$ 3,465,654**	**$ 159,112**
Supplies and materials (26.0)	$ 1,078	$ 1,078	$ -
Subtotal Non-Pay Costs	**$ 3,314,444**	**$ 3,475,131**	**$ 160,687**
Total Salary and Expenses			
Rental Payments to GSA (23.1)	$ 5,100	$ 5,100	$ -
Grand Total, Salaries & Expenses and Rent	**$ 3,974,644**	**$ 4,109,449**	**$ 134,805**
Direct FTE	**4,378**	**4,112**	**(266)**

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CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2015 Actual	2016 Enacted	2017 Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$180	$180	$180
Subtotal	72	72	72
Total - ES Salaries	$12,192	$12,356	$12,549
GS-15	573	590	552
GS-14	610	628	588
GS-13	2,091	2,153	2,014
GS-12	656	676	632
GS-11	124	128	119
GS-10	1	1	1
GS-9	196	201	188
GS-8	3	3	3
GS-7	87	90	84
GS-6	8	8	8
GS-5	16	16	15
GS-4	5	5	5
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,370	4,499	4,210
Total - GS Salary 1/	$449,280	$468,540	$445,651
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$102.810	$104.143	$105.855

1/ Reflects direct discretionary staffing within the Program Management account.

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CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

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FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2013			FY 2014			FY 2015			FY 2016			FY 2017		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated																
Health Insurance Consumer Information	1002							-								
Rate Review Grants	1003															
Pre-existing Condition Insurance Plan Program	1101		12			7		-	5			2			0	
Reinsurance for Early Retirees	1102		11			4		-	4			1			1	
Affordable Choices of Health Benefit Plans	1311	$2,147,000	56		$784,000	51		$496,624	49		$29,514	50		$31,667	50	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP)	1322	$ (2,278,544)	18			15			0			0			0	
CO-OP Contingency Fund	1322/644	$ 240,259						-	15			15				
Adult Health Quality Measures 2/	2701	$ 56,940	10		$ 55,680	9			11			0			0	
Medicaid Emergency Psychiatric Demonstration	2707					0			1			10			10	
Quality Measurement 2/	3014	$ 18,980	6		$ 18,560	9			9			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		258			355			479			625			654	
Independence At Home Demonstration 2/	3024	$ 4,745	2		$ 4,640	1		$ 4,635	1			0			0	
Community Based Care Transitions	3026		1			0			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		1			0			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1			1			0	
Community Prevention and Wellness	4202		1			0			0			0			0	
Graduate Nurse Education 2/	5509	$ 47,450	0		$ 46,400	0		$ 46,350	1			1			2	
Sunshine Act	6002	$ 16,050	11		$ 1,024	14		$ 21,399	16		$ 29,075	24		$ 21,400	24	
LTC National Background Checks	6201		4			5			5			6			7	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 5,000	10			12		$ 18,035	13		$ 10,000	14		$ 2,000	15	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 13,000	1		$ 3,000	1		$ 27,377	2		$ 18,077	1		$ 20,000	1	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,300	1		$ 3,783	2		$ 3,975	2		$ 4,530	2		$ 3,600	2	
Termination of Provider Participation under Medicaid 1/	6501					0			0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$418	1		$316	1		$ 549	1		$329	1		$600	1	
Total ACA Direct Appropriated FTEs			**405**			**487**			**615**			**753**			**767**	

1/ From FY 2013 through FY 2017, 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.

2/ Net sequester reductions in FY 2013 (-5.1%), FY 2014 (-7.2%), FY 2015 (-7.3%), and FY 2016 (-6.8%)

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Physicians' Comparability Allowance Worksheet. For agencies that use or are planning to use the Physicians' Comparability Allowance (PCA), please provide a populated PCA worksheet with data for FY 2015 actuals, FY 2016 estimates, and FY 2017 estimates for all items in the worksheet. Information on PCA, including the PCA worksheet and instructions, are available on the Office of Personnel Management's website:
http://www.chcoc.gov/Transmittals/TransmittalDetails.aspx?TransmittalID=4207

Response:

Physicians' Comparability Allowance (PCA) Worksheet
DHHS: Centers for Medicare and Medicaid Services
Table 1

		PY 2015(Actual)	CY 2016 (Estimates)	BY 2017* (Estimates)
1) Number of Physicians Receiving PCAs		50	60	61
2) Number of Physicians with One-Year PCA Agreements		1	1	0
3) Number of Physicians with Multi-Year PCA Agreements		49	60	61
4) Average Annual PCA Physician Pay (without PCA payment)		$149,632	$152,114	$153,284
5) Average Annual PCA Payment		$24,520	$25,540	$26,740
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.	50	61	61

** PY 2015 totals were generated on August 19, 2015 and then revised on January 11, 2016. We currently have 50 medical officers receiving PCA. During 2015, 1 medical officer had a lapse in the PCA and declined the PCA when it was offered. This medical officer was also not included in the estimates for CY 2016 and 2017. The increase from CY 2015 to CY 2016 is primarily based on the 2016 salary increase. The changes in the amounts from CY 2016 to CY 2017 is based on the probability that certain Medical Officers will be eligible for step increases and/or an increase in the PCA.

*CY 2016 data will be approved during the FY 2017 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Additional physician categories have not been designated by CMS.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

The maximum amount of PCA varies depending on the GS level, the number of years as a government physician, if they sign a one year or multi-year contract, if they are 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. CMS completed a new policy to provide guidance which will provide a consistent yet flexible framework for determining recommended amounts for the two discretionary factors in PCA contracts. 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) which is mostly used within CMS and Physician's and Dental Pay (PDP) which is used primarily for dentists. 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. In addition, CMS is also partnering more with the FDA, NIH and CDC on clinical trials. CMS continues to staff up to meet the aggressive deliverables and fast deadlines. 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 11 Medical Officer positions that will still need to be filled in FY16 for CCSQ, CM, CMCS, CMMI, CPI and OFM which is listed below:

CCSQ (4 medical officers):

CCSQ-CAG has been asked to be involved in broad Agency projects that require clinical expertise and experience with systematic evidence reviews including comparative effectiveness analyses and technology assessments. CMS is also partnering more with the FDA, NIH and CDC on clinical trials. We will need at least 2 MOs with a background in clinical research (e.g., biostats or epidemiology). Local coverage paradigm is changing especially with molecular diagnostics. We need at least one additional Medical Officer to assist with all of the Local Coverage Determination work. In addition, we anticipate at least one retirement of a Medical Officer requiring the need to backfill that position with a Medical Officer that specializes in Pathology.

CM (1 medical officer):

The position will be filled in CM, Chronic Care Policy Group (CCPG) and the person would most likely work out of the Central Office in Woodlawn. The position is designed to support the development, evaluation, and implementation of Medicare HCPCS coding; end-stage renal disease (ESRD); skilled nursing facilities (SNFs); inpatient rehabilitation hospitals; religious non-medical health care institutions (RNHCIs); home health agencies (HHAs); hospices; durable medical equipment, prosthetics, and orthotics (DMEPOS); the program of all-inclusive care for the elderly (PACE); community mental health centers (CMHCs); and partial hospitalization. The incumbent will serve as an advisor to the Director, CCPG, conducting studies and making policy recommendations pertaining to the above areas. The incumbent will maintain liaison with the medical, scientific, and health services research communities to exchange information and ideas. The incumbent will also represent the Agency in meetings with these communities as requested. Management will post this vacancy in approximately 4 weeks and hope to hire a Medical Officer by March/April 2016.

CMCS (1 medical officer):

Medical Officer (GS-15 level) to serve as part of the CMCS Leadership team as medical advisor and consultant to the Director and Deputy Directors of CMCS and Group managers and their staff on Medicaid and the Children's Health Insurance Program (CHIP). The advice and consultation will focus on service delivery, impact on the provider community, provider performance, health outcomes, and payment reform as part of the Center's overall efforts to improve the quality of health care delivered through the Medicaid and CHIP programs. CMCS is currently in the process of hiring the individual to fill this position.

CMMI (2 medical officers):

Medical Officer/Senior Technical Advisor, Grade 15 - Provide clinical and other technical support to specialty payment model teams in all divisions of PCMG. Provide clinical and technical expertise with respect to the design or implementation of PCMG models to other groups in CMMI or other CMS components, and represent the Group Directors when necessary.

Medical Officer/Accountable Care Organizations (ACO) Senior Advisor, Grade 15 - Provide clinical and other technical support to ACO model teams, and represent the relevant division directors when necessary

CPI (2 medical officers):

Medical Officer (GS-15 level) in FY-16 to support CMS strategic objective 7.0; Transform Business Operations, specifically the operational objective to enhance data management and analytics. One position will be a clinician with a specialty in clinical informatics to support the payment model initiatives to improve the claims processing and timeliness of payments to providers and States. A second position will support the data standardization and integration effectively to improve care coordination, performance, transparency, and knowledge discovery. In both positions, the Medical Officers will provide clinical advice to inform policy making and decisions impacting the quality of care of beneficiaries.

OFM (1 medical officer):

Medical Officer (GS-14 level): This position will work in the Payment Accuracy & Reporting Group (PARG), with primary responsibility for direction of Medical Review activities of the Comprehensive Error Rate Testing (CERT) and Payment Error Rate Measurement (PERM) program(s) designed to measure Medicare Fee-For-Service (FFS) and Medicaid and Children's Health Insurance Program payment accuracy.

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Summary of Proposed Changes in Performance Measures
Centers for Medicare & Medicaid Services

Unique Identifier	Change Type	Original in FY 2016 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in the Children's Health Insurance Program (CHIP) and Medicaid	Revise 2016 target.	48,667,385 children (CHIP 8,909,064/ Medicaid 39,758,322)	45,271,662 children (CHIP – 9,054,332/ Medicaid – 36,217,330)	CMS has invested considerable effort in improving the quality of the data reported by states in the last two years, which has uncovered a number of systems-related challenges that have resulted in both increases and decreases in reported enrollment. Some of the issues have included duplication of enrollment counts between Medicaid and CHIP and incorrect reporting of children in Medicaid Expansion CHIP Programs. The FY 2016 target has been reduced to reflect data or systems-related challenges.	Yes
CLIA2 Improve Laboratory Safety by Measuring the Outcome of Delivering Educational Materials Prior to an Educational Survey	New - add contextual indicator	N/A	Add contextual indicator	In FY 2015, the universe of States has been expanded to include all States participating in the certificate of waiver project. Two groups will now be measured: CLIA2.1 will remain the original group of 20 states (19 for fiscal year 2015). The original cohort will receive the "READY, SET, TEST" booklet prior to the educational survey. CLIA2.2 will include the remaining 31 states. Labs in the CLIA2.2 cohort will receive the "READY, SET, TEST" booklet after the State agency surveyor has completed the onsite. Regardless of when a laboratory gains access to educational materials, we want the educational information to enhance laboratory safety and prevent patient harm.	No
CMMI2: Identify, test, and improve payment and service delivery models:	Revise measure title for CMMI2.1	CMMI2.1 Increase the number of model tests that demonstrate : 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	CMMI2.1 Increase the number of model tests that currently indicate : 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	This measure has been reworded for the sake of consistency with the other measures included in this goal.	No
MCD7 Increase the National Rate of Low Income Children and Adolescents, who are Enrolled in Medicaid, who receive Any Preventive Dental Service	Change 2016 target	+7 percentage points over FY 2011 baseline (50%)	+3 percentage points over FY 2011 baseline (46%)	We have missed the improvement targets for 2012 and 2013; thus, it is likely that our FY 2016 target was too ambitious. CMS is undergoing a reassessment of our oral health work at this time. We expect to refocus our limited staff resources as well, to identify ways to more actively engage other stakeholders and top State Medicaid leaders.	No

Summary of Proposed Changes in Performance Measures
Centers for Medicare & Medicaid Services

Unique Identifier	Change Type	Original in FY 2016 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
MCD9 Improve Capacity to Evaluate 1115 Demonstration Programs	Revise result availability date.	We have updated this language to reflect the above language.	We have updated this language to reflect the above language.	The Performance Management Database and Analytics (PMDA) system is developed and completed CMS' security controls assessment, however, system release for use by states has been delayed until March 2016 by issues with integrating with other CMS IT systems.	
MCR21.1: Percent of CMS Federal Information Security Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems.	Revise 2016 target.	90%	95%	The goal was changed to continually strive to better the process. The 90% target was successfully met 4 years in a row.	No
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution	Revise 2016 target.	100%	85%	Metric was previously defined as Federally-owned Government Furnished Equipment . This definition has been expanded to include all CMS FISMA system locations at contractor sites. 85% is the new target since the number of systems have increased significantly.	No
MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (XLC) framework	Revise 2016 target.	95%	100%	Target was adjusted upward to meet previous FY actual results. Results have exceeded 95% target for 3 years in a row.	No
MCR26 Reduce All-Cause Hospital Readmissions Rates	Revise 2016 target.	17.7%	17.4%	Target was adjusted downward to be more aggressive.	Yes
MCR27 Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals (EP) and hospitals	Retire	MCR27 Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals (EP) and hospitals	Goal discontinued in FY 2016	Program year 2014 is the last year for Medicare eligible professionals to initiate participation and receive an incentive payment. As providers are counted only in the first year that they receive an incentive payment, the Medicare numbers will stagnate as payments cease. We are requesting this goal be discontinued after FY 2016 because it does not capture providers who begin to demonstrate meaningful use, but are unable to earn an incentive payment due to the initiation year. This information is reported in other venues, therefore this measure represents a duplication of efforts.	No

Summary of Proposed Changes in Performance Measures
Centers for Medicare & Medicaid Services

Unique Identifier	Change Type	Original in FY 2016 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
MIP7 Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data.	Retire after 2015	Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data.	Retire	Since CMS has consistently met or exceeded this goal for five consecutive fiscal years this goal will be discontinued after FY 2015 and replaced with a more meaningful measurement goal. Although this activity will no longer be reported for purposes of GPRA, CMS will continue to train law enforcement personnel referred for training and access in future years.	No
MIP9 Estimate the Improper Payment Rate in the Medicaid and Children's Health Insurance Programs	Goal title change.	Estimate the Payment Error Rate in the Medicaid and Children's Health Insurance Programs	Estimate the Improper Payment Rate in the Medicaid and Children's Health Insurance Programs	We want to be consistent across the board by stating "improper payment rate" for all improper payment rate measurement programs.	Yes
MIP10: Ensure Accuracy of the Medicare Fee-for-Service Recovery Audit Program	Retire after 2015	Increase the Recovery Auditor Identification Rate by 5% over FY 2015	Retire	As the national Recovery Audit Program was being implemented, it was important to establish a performance measure to monitor its progress. However, during the more than five years of active review operations, CMS has implemented additional measures, which are now reported in the program's robust Annual Report To Congress. CMS has also implemented numerous program improvements that will be included in future reports. Therefore, it is recommended that this measure be discontinued.	No
MCR30:Shift Medicare health care payments from volume to value	Revised measure title	MCR30 Delivery System Reform: Provide Better Care at Lower Cost across the Health Care System by Improving the Way Providers are Incentivized	MCR30: Shift Medicare health care payments from volume to value	MCR30 is a proposed Agency priority goal. The measure title has been changed to more accurately reflect the outcomes we hope to achieve through this initiative.	Yes
MCR30: Health Care Payment Reform: Setting clear goals and timeline for shifting health care reimbursements from volume to value	Discontinued measure 30.2	MCR30.2 Increase the Percentage of Medicare FFS Payments Linked to Quality and Value	Discontinue	We will focus efforts on measure MCR30.1 Increase the Percentage of Medicare FFS Payments Tied to Quality and Value through Alternative Payment Models.	Yes.

Summary of Proposed Changes in Performance Measures
Centers for Medicare & Medicaid Services

Unique Identifier	Change Type	Original in FY 2016 CJ	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure
MMB1 Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees	Methodology Change	The formula was the ratio of readmissions (numerator) over admissions (denominator).	Number of readmissions per 1,000 eligible beneficiaries.	This measure will be calculated using the number of readmissions per 1,000 eligible beneficiaries. This will be a more sensitive measure for dual eligible beneficiaries than the rate of readmissions (numerator) divided by admissions (denominator) used in other hospital readmissions measures. There has been concern that such a ratio does not accurately capture quality improvement outcomes of decreased readmissions and admissions at any given hospital. For example, such a ratio can remain unchanged if admissions decline at the same rate as readmissions due to hospital quality improvement efforts to reduce both.	No.
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	Retire	Increase influenza immunization (long term care facility or "institutional subpopulation")	Retire	Due to contractual changes, the results are not due to the interventions of the our efforts. We will discontinue this measure after 2015.	No
QIO3 Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol Testing	Retire	Increase hemoglobin A1c testing rate; Increase cholesterol testing rate	Retire	Although each of the measures are important, we have neither increased nor met the targets in many years. CMS does not directly measure for this in the current SOW and we will discontinue these measures after 2015.	No
QIO6 Improve Oversight of Quality Improvement Organizations	Retire	Measures 6.5a, 6.5b, 6.5c and 6.5d	Retire	This goal will be retired after 2015. 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 consequences in this population.	No

CMS DISCONTINUED PERFORMANCE MEASURES

Healthcare Fraud and Abuse Discontinued Measures

Measure	FY	Target	Result
MIP7: Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data. Baseline (FY 2010): 158 LE personnel with training and access to Near Real Time CMS Systems Data.	*2016*	Discontinued	N/A
	2015	100% up to 200 of the LE personnel referred for training/access	200 trained (Target Met)
	2014	100% up to 200 of the LE personnel referred for training/access	200 trained (Target Met)
	2013	100% up to 200 of the LE personnel referred for training/access	150 trained (Target Met)
	2012	100% up to 200 of the LE personnel referred for training/access	190 trained (Target Met)
	2011	100% up to 200 of the LE personnel referred for training/access	226 trained (Target Met)
	2010	N/A	158 (Baseline)
	2009	N/A	150 (Trend)
	2008	N/A	28 (Trend)

MIP7: Increase Number of Law Enforcement Personnel with Training and Access to Near Real Time CMS Systems Data

Since CMS has consistently met or exceeded this goal for five consecutive fiscal years this goal is discontinued after FY 2015 and will be replaced with a more meaningful goal. Although this activity will no longer be reported for purposes of GPRA, CMS will continue to train law enforcement personnel referred for training and access in future years.

Measure	FY	Target	Result
MIP10: Maintain an appeal overturn rate at, or below, 10%, for overpayments identified by the Recovery Audit Program Reduce provider burden by increasing the identification rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers. FY 2012 Baseline for FY 2013-FY 2014 targets: 28.6% FY 2011-FY 2012: Decrease the appeal overturn rate at the first level of appeal for overpayments identified by the Recovery Audit Program	*2016*	Discontinued	N/A
	2015	Increase the Recovery Auditor identification rate by 5% over FY 2014.	17.9% Target Not Met
	2014	Increase the Recovery Auditor identification rate by 5% over FY 2013	35.7% Target Not Met
	2013	Increase the Recovery Auditor identification rate over the FY 2012 baseline (28.6%) by 5%	39.4% Target Exceeded
	2012	Target at or below FY 2011 appeals overturn rate	2.1% Target Met
	2011	Appeals overturn rate (in favor of provider)	2.7% (Baseline)
	2010	Implement the Recovery Audit program in all 50 States and U.S. Territories	Target met

Measure	Data Source	Data Validation
MIP10	RAC Data Warehouse reports provided to CMS by the Recovery Auditors.	CMS staff will collect and review annual data received from the Recovery Auditors. An annual identification rate will be calculated and compared to the prior fiscal year identification rate.

MIP10: Ensure Accuracy of the Medicare Fee-for Service Recovery Audit Program: As the national Recovery Audit Program was being implemented, it was important to establish a performance measure to monitor its progress. However, during the more than five years of active review operations, CMS has implemented additional measures, which are now reported in the program's robust Annual Report to Congress. CMS has also implemented numerous program improvements that will be included in future reports. Therefore, this measure is discontinued after 2015.

Medicaid Discontinued Measures

Measure	FY	Target	Result
PHI4.2: Percentage of States using streamlined application fully approved to enroll individuals in Medicaid and CHIP	2016	Discontinued	N/A
	2015	100%	45% (Target Not Met)
	2014	100%	27% (Target Not Met)
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	2015	Discontinued	N/A
	2014	100%	27% (Target Not Met)

PHI4.2 – PHI4.3: Increase Medicaid Coverage for Non-disabled Adults under Age 65 in States that Take Up the Option, and Simplify Medicaid and CHIP Eligibility Rules and Processes in all States Forty-four states (86 percent) have a fully approved, paper, single streamlined application, and nearly all States have made significant progress toward establishing a fully approvable online application. For the majority of States, creating a dynamic online application, which includes logic to direct specific questions to specific types of applicants, was a large new undertaking with significant systems implications. At the end of FY 2015, only 45 percent of states had both a fully approved paper and a fully approved online application. However, of the 31 states that still needed to make revisions, several had as few as one remaining change to complete. Progress is ongoing and by the end of December 2015, we expect that 55 percent of states will have fully approved applications. This measure is discontinued after FY 2015.

Measure	FY	Target	Result
MCD5: Percentage of Section 1115 demonstration budget neutrality reviews completed	*2016*	Discontinued	N/A
	2015	100%	March 31, 2016
	2014	100%	100% (Target Met)
	2013	98%	100% (Target Exceeded)
	2012	98%	100% (Target exceeded)
	2011	98%	100% (Target exceeded)
	2010	96%	100% (Target exceeded)
	2009	94%	100% (Target exceeded)
	2008	92%	100% (Target exceeded)
	2006	N/A	100% (Baseline)

MCD5: Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed Out of Total Number of Operational Demonstrations for Which Targeted Budget Reviews are Scheduled: The original purpose of this goal was to ensure State compliance with the Administration's policy of budget neutrality; any state demonstration should not cost the Federal government more than what it would cost absent the demonstration. CMS conducted budget neutrality reviews on a 3-year cycle and exceeded the Agency target by achieving 100 percent. CMS will complete reporting on this goal in 2016, and will then change the focus of this goal to measure development of an automated infrastructure to support current section 1115 Medicaid demonstrations testing innovations focusing on payment and/or service delivery reform. This measure is discontinued after FY 2015 and was replaced with a new measure, MCD9, which is included in the Medicaid chapter of the FY 2017 Congressional Justification.

Program Operations Discontinued Measures

Measure	FY	Target	Result
MCR22 Improve the accuracy of Medicare Physician Fee Schedule (PFS) payments by identifying, reviewing, and appropriately valuing potentially misvalued codes (including high expenditure or high cost services) under the Medicare PFS through the potentially misvalued code analysis process.	*2016*	Discontinued	N/A
	2015	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	27% (3 of 11)[1] (Target Not Met) 23% (3 of 13)[1] (Target Exceeded) 14% (5 of 35) (Target Not Met)
	2014	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	28% (5 of 18)[2] (Target Not Met) 33% (17 of 52) (Target Exceeded) 29% (7 of 24) (Target Exceeded)

[1] In CY 2015 PFS rulemaking, CMS finalized a change in the misvalued code calendar so that all misvalued code changes would occur in annual proposed rulemaking to allow public comment prior to significant changes in payment for particular services. CY 2016 rulemaking represents a transition year during which some misvalued code changes appear in the proposed rule and others in the final rule. Also in the CY 2015 rulemaking, CMS finalized a policy to transition all codes with 90 and 10 day global periods to 0 day global periods. Subsequent to that determination, statutory provisions were enacted that prohibited CMS from undertaking that work, and the review for some procedures with 10 and 90 day global periods was delayed pending the possible change in global period. Both of these factors decreased the total number of codes reviewed in 2015.

[2]As our work on misvalued codes matured, our focus shifted from identifying large sets of individual potentially misvalued codes using broad screens to identifying specific policies that might result in misvalued codes. For example, in 2013 we focused on disparities between physician and hospital payments to identify potentially misvalued codes. \Since this effort did not come to fruition, the number of codes identified as potentially misvalued in 2013 is small. With a small number of misvalued codes, the percentage revalued varies widely based on whether a few additional codes are revalued and thus is affected by slight variations in scheduling of the revaluation.

Measure	FY	Target	Result
	2013	Reviewed & valued appropriately 40% of potentially misvalued codes identified in 2012 Reviewed & valued appropriately 20% of unreviewed potentially misvalued codes identified 2008 to 2011	47% (46 of 98) (Target Exceeded) 20% (232 of 256) (Target Exceeded)
	2012	Reviewed & valued appropriately 20% of potentially misvalued codes identified 2008 to 2011	78% (911 of 1,167 codes)* (Target Exceeded)

*This reflects number of codes originally identified as potentially misvalued and does not reflect any resulting changes in CPT coding structure or description post hoc.

MCR22 Improve the Accuracy of Medicare Physician Fee Schedule Payments: We discontinued this measure after 2015. CMS believes that the GPRA target for misvalued codes has been superseded by the recent statutory target requirement in the Protecting Access to Medicare Act of 2014. Section 220 amends section 1848(c)(2) of the Social Security Act to add a formal target of 0.5 percent of estimated expenditures under the fee schedule of redistributed dollars resulting from the misvalued code initiative. This target applies for the CY 2017 through 2020 fee schedules. Failure to redistribute the target amount of expenditures results in a reduction in overall physician payment for the difference.

Measure	CY/FY	Target	Result
Number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use			
MCR27.1: Medicare	FY2017	Discontinued	N/A
	FY2016	290,000	September 30, 2016
	FY2015	290,000	305,731 (Target Exceeded)
	FY 2014	240,000	279,000 (Target Exceeded)
	FY 2013	138,000***	217,007 (Target Exceeded)
	FY 2012	34,350	93,652 (Target Exceeded)
	FY 2011	**Baseline: 3,700	Baseline set
MCR27.2: Medicaid	FY2017	Discontinued	N/A
	FY2016	75,000	September 30, 2016
	FY2015	65,000	105,009 (Target Exceeded)
	FY 2014	28,000	63,650 (Target Exceeded)
	FY 2013	8,000	23,012 (Target Exceeded)
	FY 2012	5,600	1874 (Target Not Met)
	FY 2011	Baseline: 0	Baseline set

Measure	CY/FY	Target	Result
***Number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use**			
MCR27.3: Medicare	FY2017	Discontinued	N/A
	FY2016	4,550	September 30, 2016
	FY2015	4,500	4,698 (Target Exceeded)
	FY 2014	4,000	4538 (Target Exceeded)
	FY 2013	2,205	3,812 (Target Exceeded)
	FY 2012	650	1,474 (Target Exceeded)
	FY 2011	**Baseline:150	Baseline set
MCR27.4: Medicaid	FY2017	Discontinued	N/A
	FY2016	4,350	September 30, 2016
	FY2015	4,300	4,616 (Target Exceeded)
	FY 2014	2,800	4,307 (Target Exceeded)
	FY 2013	1,000	1,835 (Target Exceeded)
	FY 2012	815	316 (Target Not Met)
	FY 2011	*Baseline: 150	Baseline set

Measure	CY/FY	Target	Result
Number of Providers receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program			
MCR27.5: Eligible Professionals	FY2017	Discontinued	N/A
	FY2016	175,000	September 30, 2016
	FY2015	150,000	153,055 (Target Exceeded)
	FY 2014	110,000	128,451 (Target Exceeded)
	FY 2013	77,295	104,324 (Target Exceeded)
	FY 2012	38,135	58,334 (Target Exceeded)
	FY 2011	**Baseline:6,300	Baseline set

Measure	CY/FY	Target	Result
*MCR27.6: Eligible Hospitals	FY2017	Discontinued	N/A
	FY2016	3,725	September 30, 2016
	FY2015	3,700	3,630 (Target Not Met)
	FY 2014	3,550	3,334**** (Target Not Met)
	FY 2013	3,500	3,281 (Target Not Met)
	FY 2012	450	2,484 (Target Exceeded)
	FY 2011	**Establish:400	Baseline set

*Eligible hospitals may receive incentive payments from both the Medicare and Medicaid incentive programs; therefore the total number of hospitals may contain duplicates.
**The Medicare and Medicaid annual results will always reflect partial year data due to a compressed timeline (does not include the attestation tail period for hospitals or the remaining 3 months of the CY and the attestation tail for the eligible professionals; and for Medicaid the 2011 baselines are not representative of all 50 states, only those that were making payments as of the end of FY 2011. .
*** Due to issues with double counting, the supporting measures do not sum to the key indicators because we do not want to count Eligible professionals twice for AIU and MU.
****This result has been revised due to an accounting error. The original amount of 3,679 was publicly reported in the FY 2016 Congressional Justification.

MCR27: Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals (EP) and hospitals: The current EHR goal measures the number of health care providers who receive EHR Incentive payments under the Medicare or Medicaid EHR Incentive Programs. The last year for Medicare eligible professionals to initiate participation and receive an incentive payment was program year 2014. The last year for Medicare eligible hospitals to initiate participation and receive an incentive payment is program year 2015. The last year for Medicaid providers to initiate participation and receive an incentive payment is program year 2016. As providers are only counted in the first year that they receive an incentive payment, the Medicare numbers will stagnate as payments will cease. This goal has been discontinued after FY 2016 because it will not capture providers who begin to demonstrate meaningful but are unable to earn an incentive payment due to the initiation year.

Quality Improvement Organizations Discontinued Measures

Measure	FY[†]	Target	Result
QIO1: Increase influenza immunization (long term care facility or "institutional" subpopulation)[3]	*2016*	Discontinued	N/A
	2015	85.4%	Dec 31, 2016
	2014	85%	(Pending)
	2013	84.8%	(Pending)
	2012	84%	83.6% (Target Not Met But Improved)
	2011	86%	82.5% (Target Not Met But Improved)
	2010	81.8%	76.5% (Target Not Met)
	2009	80%	84.2% (Target Exceeded)
	2008	79%	81.7% (Target Exceeded)

Notes: [†] There is a 95% confidence interval: ± 0.06) in the reported preliminary influenza vaccination coverage estimate. [††]Fiscal year is equivalent to flu year. For example, FY 2008 (10/07 – 9/08) is equivalent to the flu season starting in October '07 through Winter '08. Data reflect 65 and older population.

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 Due to contractual changes, the results are not due to the interventions of the our efforts. We discontinued this measure after 2015.

Measure	CY	Target	Result
QIO3.1: Increase hemoglobin A1c (HbA1c) testing rate	2015	Discontinued	Discontinued
	2014	90.5%	88.93% (Target Not Met but Improved)
	2013	90%	88.69% (Target Not Met but Improved)
	2012	89.5%	88.29% (Target Not Met but Improved)
	2011	88.5%	87.93 (Target Not Met but Improved)
	2010	87%	87.68% (Target Exceeded)
	2009	86%	88.2% (Target Exceeded)

[3] Long-term care facility residents are Medicare ¬beneficiaries who lived solely in a long-term care facility during the calendar year (see long-term care facility), and who received facility interviews only. A facility interview was conducted whenever a sample person was residing in a facility: 1) that contains three or more beds; 2) that is classified by the administrator as providing long-term care, and 3) whose physical structure allows long-term care residents of the facility to be separately identified from those of the institution as a whole. This broad definition allows analysis beyond traditional views of long-term care, that is, nursing home and related care homes having three or more beds and providing either skilled nursing, or rehabilitative or personal care (other than supervision).
[2] In CDC's *Recent Influenza Vaccination Trends across Influenza Seasons*: http://www.cdc.gov/flu/professionals/vaccination/trends/adults-over65.htm

Measure	CY	Target	Result
	2008	85.5%	86.5% (Target Exceeded)
QIO3.2: Increase cholesterol (LDL) testing rate	2015	Discontinued	Discontinued
	2014	86%	81.74% (Target Not Met)
	2013	85%	82.45% (Target Not Met but Improved)
	2012	84.1%	82.05% (Target Not Met)
	2011	83.1%	82.05% (Target Not Met but Improved)
	2010	82%	82.00% (Target Met)
	2009	81%	82.7% (Target Exceeded)
	2008	80%	81.1% (Target Exceeded)

QIO3: Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol Testing: Although each of the measures are important, we have neither increased nor met the targets in many years. CMS does not directly measure for this in the current SOW and we discontinued these measures after 2015.

Measure	FY	Target	Result
QIO4: Increase percentage of timely antibiotic administration	*2015*	Discontinued	N/A
	2014	99.0%	98.9% (Target Not Met)
	2013	98.5%	98.7% (Target Exceeded)
	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. Moreover, any additional increase could risk encouraging antibiotic overuse without additional benefit. We discontinued this goal after FY 2014.

Measure	FY	Target	Result
QIO5: Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	*2016*	Discontinued	N/A
	2015	62%	62.9% (Target Exceeded)
	2014	62%	62.4% (Target Exceeded)
	2013	61%	61.6% (Target Exceeded)
	2012	60.5%	61.2% (Target Exceeded)
	2011	58%	59.8% (Target Exceeded)
	2010	57%	56.8% (Target Not Met)
	2009	54%	54% (Target Met)
	2008	51%	51%

QIO5: Protect the Health of Medicare Beneficiaries by Increasing the Percentage of prevalent Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis: Development of a new Quality Improvement contract the 11th SOW has caused a delay in FY 2014 results which will now be determined in the summer of FY 2015 (June 30, 2015). This goal is discontinued after 2015. 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 consequences in this population.

Measure ID	FY	Target	Result
QIO6.5a: Improve Health for Populations and Communities (Outcome)	2016	Discontinued	N/A
	2015	100% of new QIOs will have completed a successful transition to the 11th SOW	Target Met
	2014	80% of the QIOs will have met the overall performance expectations for the 10th SOW	Target Met
	2013	100% of the QIOs will populate the DDST Quality Data Reporting system with data that demonstrates provider assistance on EHR implementation	100% of pertinent QIOs populated the DDST Quality Data Reporting system with data that demonstrated provider assistance on EHR implementation (Target Met)
	2012	New for 10th SOW - 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	100% of pertinent QIOs achieved the recruitment goals. (Target Met)

Measure ID	FY	Target	Result
QIO6.5b: Improve Individual Patient Care (Outcome)	2016	Discontinued	Discontinue
	2015	100% of new QIOs will have completed a successful transition to the 11th SOW	Target Met
	2014	80% of the QIOs will have met 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.	Target Met
	2013	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.	83% of the QIOs met the expectations towards the 18th month targets for HAIs. (Target Exceeded)
	2012	New for 10th SOW - 100% of the recruitment goals by the 12th month (quarter 4)	100% of the QIOs have achieved the recruitment goals by the 12th month (quarter 4) per CMS requirements. (Target Met)
QIO6.5c: Integrate Care for Populations and Communities (Outcome)	2016	Discontinued	N/A
	2015	100% of new QIOs will have completed a successful transition to the 11th SOW	Target Met
	2014	80% of the QIOs will have met the overall performance expectations for the 10th SOW	Greater than 80% of the QIOs met the overall performance expectations for the 10th SOW (Target Exceeded)
	2013	The QIOs will demonstrate that 25% of communities are demonstrating improvement based on 4 time series graphs showing improvement towards all targets	90% of communities demonstrated improvement based on 4 time series graphs showing improvement (Target Exceeded)
	2012	New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) 1-4 (interim measure) performance expectations	92% of the QIOs met the 12th month (quarter 4) 1-4 (interim) performance expectations. (Target Exceeded)

Measure ID	FY	Target	Result
QIO6.5d: Beneficiary and Family Centered Care (Outcome)	2016	Discontinued	N/A
	2015	100% of new QIOs will have completed a successful transition to the 11th SOW	Target Met
	2014	80% of the QIOs will have met the overall performance expectations	Target Met.
	2013	80% of the QIOs will meet the 18th month (quarter 6) performance expectations	87% of the QIOs met performance expectations. (Target exceeded)
	2012	New for 10th SOW - 80% of the QIOs will meet the 12th month (quarter 4) performance expectations	97% of the QIOs met the 12th month performance expectations. (Target Exceeded)

QIO6 Improve Oversight of Quality Improvement Organizations: This measure was discontinued because CMS transitioned to the 11th SOW.

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Item –

Access to Home Health Care- The Committee is aware that the current requirement that home health plans be solely certified by a physician has resulted in problems with access to home health care. The Committee urges CMS to insure access to home health care by considering methods to waive the requirement that home health plans be solely certified by a physician.

Action Taken or To Be Taken

CMS appreciates the Committee's interest in ensuring access to home health care. As a condition for home health agencies to receive Medicare payment, current law only allows physicians to certify beneficiary eligibility for the Medicare home health benefit. Statutory changes would be necessary in order to permit other practitioners the ability to certify Medicare home health benefit eligibility.

Item-

Alzheimer's- The Committee is concerned that CMS guidelines limit access to Positron Emission Tomography (PET) scans for diagnosing Alzheimer's disease. The Committee strongly urges CMS to review its reimbursement guidance, based on current scientific information on the value of PET testing for diagnosis of Alzheimer's.

Action Taken or To Be Taken

CMS appreciates the Committee's suggestion to review our current national coverage determination regarding the use of beta amyloid (Aβ) PET imaging in the diagnosis of Dementia and Neurodegenerative Disease, including Alzheimer's disease. In 2013, CMS carefully reviewed the available evidence, including published clinical studies, recommendations of the Medicare Evidence Development & Coverage Advisory Committee, public comments and expert opinion. Based on that review, we concluded that there was sufficient evidence that the use of PET Aβ imaging is promising in two scenarios: (1) to exclude Alzheimer's disease (AD) in narrowly defined and clinically difficult differential diagnoses, such as AD versus front temporal dementia; and (2) to enrich clinical trials seeking better treatments or prevention strategies for AD. Thus, Medicare currently covers PET Aβ imaging under the process known as "coverage with evidence development" (CED). Since issuing the 2013 NCD, CMS has continued to review the medical literature, as well as work with researchers in the design of protocols that might help in generating further evidence. At this time, CMS has approved three protocols for clinical studies under CED.

Item

Colorectal Cancer Screening- The Committee understands that regardless of the fact that colorectal cancer screening by colonoscopy has an A grade from the U.S. Preventive Services Task Force, CMS has determined that it does not have authority to waive Medicare beneficiary coinsurance for a colorectal cancer screening colonoscopy when a polyp or other tissue is removed during the preventive screening. The Committee requests an update in the fiscal year 2017 budget request outlining the rationale for this determination, to include why CMS believe it does not have the waiver authority. Further, the Committee requests the update describe CMS's rationale related to the coverage of virtual colonoscopy.

Action Taken or To Be Taken

Colorectal cancer screening identifies premalignant polyps that can be removed and early-stage tumors that can be treated effectively. Early detection is cost-effective or even cost-saving in comparison with no screening. Under current law, Medicare beneficiaries are not subject to the Part B deductible and coinsurance or copayments for most preventive and screening services, including screening colonoscopies. However, if a screening colonoscopy results in removal of a polyp, ablation or other procedure, current law (1) directs the Secretary to treat it like a diagnostic/treatment procedure for payment purposes, and (2) waives the Part B deductible but does not waive applicable coinsurance or copayments. The President's FY 2017 budget includes a proposal that would address this inequity in beneficiary cost-sharing by amending current law to waive coinsurance or copayments on a scheduled screening colonoscopy even when the procedure actually furnished is considered to be a diagnostic/treatment one. Medicare beneficiaries eligible for screening colonoscopy (every 24 months for individuals at high risk of colon cancer and every 120 months for other individuals or 48 months after a flexible sigmoidoscopy) would benefit from the proposal by not paying coinsurance or copayments on a screening colonoscopy that results in removal of a polyp or other diagnostic/treatment procedures.

Under a National Coverage Determination (NCD) issued in 2009, CMS carefully reviewed the available evidence on Screening Computed Tomography (CT) Colonography for Colorectal Cancer (also known as "virtual colonoscopy") and concluded the evidence did not support coverage of this procedure. Thus virtual colonoscopy is not covered by Medicare at this time. Any party may request reconsideration of an NCD along with submission of appropriate new evidence.

Item-

Coding System- The Committee is concerned that implementation of the ICD 10 coding system will place a hardship on physicians and in particular those in small practices. The Committee urges the Secretary to work with medical providers to establish a hardship exemption for those practices that would be harmed by the change.

Action Taken or To Be Taken

CMS remains committed to ensuring that the adoption of ICD 10 is a smooth and efficient process that does not overburden medical professionals, particularly those in smaller practices. On October 1, 2015, health systems across the county transitioned to ICD-10. Overall, Medicare claims are processing normally.

CMS prepared for the transition with rigorous internal and external end-to-end testing to ensure that Medicare and Medicaid systems would accept and pay provider claims. CMS also established an ICD-10 Coordination Center to actively monitor implementation and respond to any provider issue. In addition, outreach and education to Medicare providers has been extensive. CMS and its partners provided webinars, on-site training, educational articles, national provider calls, and social media campaigns to help providers learn about the updated

codes and prepare for the transition. Moving forward, help remains available to providers through ongoing educational support and the ICD-10 Coordination Center.

Finally, while diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family. However, a valid ICD-10 code is required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy has been adopted by the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

Item

CMS Testing Environment for Testing Industry Solutions- The Committee requests an update in the fiscal year 2017 budget request on how it is using this initiative to test IT solutions.

Action Taken or To Be Taken

CMS continues to test and implement new and innovative IT solutions. CMS recently tested and implemented SAS Grid within the Virtual Research Data Center (VRDC), which has created a highly-available and faster processing environment with a central point of control for administering policies, programs and job prioritization across all users. In addition, CMS has begun working with vendors to investigate the use of cloud-based architectures within its larger systems.

Item

Disproportionate Share Hospital (DSH) - The Committee is concerned with the lack of an appeals process for hospitals on Medicare payment determinations to correct errors with DSH payments for uncompensated care. The Committee requests CMS to provide an update in the fiscal year 2017 budget request on the judicial and administrative review processes available for hospitals to address payment error related to DSH payments.

Action Taken or To Be Taken

Current law precludes administrative and judicial review of estimates made by the Secretary and periods of time selected by the Secretary to determine DSH payments for uncompensated care. When errors have been brought to CMS's attention, CMS has corrected them to ensure accurate Medicare payments to DSH hospitals.

Item

Long-Term Care Hospitals (LTCHs)- The Committee is concerned about recent actions taken by CMS forcing approximately 30 grandfathered LTCHs to abide by costly and inefficient rules, thereby preventing these hospitals from achieving the CMS goal of integrating the delivery of care between hospitals. This is contrary to the intent of the Balanced Budget Act of 1997 that

clearly grandfathered existing co-located LTCHs to be exempt from the hospital within hospital regulations of 1995. The Committee requests CMS to provide justification in the fiscal year 2017 budget request describing why these grandfathered hospitals are held to regulations inconsistent with the intent of the original legislation.

Action Taken or To Be Taken

Recent payment policy actions taken by CMS with respect to grandfathered LTCHs have been to implement the statutory requirements of Section 1206 of the Pathway for SGR Reform Act of 2013 (Pub. L. 113-67). These statutory provisions mandate the implementation of site neutral payment criteria and a permanent exemption from payment reductions under the 25% threshold policy for grandfathered LTCHs. We note that Section 1206 of the Pathway for SGR Reform Act does not contain a statutory exception for the application of the site neutral payment rate to grandfathered LTCHs for discharges not meeting the clinical criteria identified in the statute, nor does it provide CMS with the authority to do so. However, Section 231 of the recently enacted Consolidated Appropriations Act, 2016 provides a temporary exception for certain severe wound discharges from rural grandfathered LTCHs prior to January 1, 2017. CMS will be engaging in rulemaking to implement this provision. However, the statutory site neutral payment rate requirements under Section 1206 of the Pathway for SGR Reform Act will continue to apply to those grandfathered LTCHs from that do not satisfy the temporary exception put in place for rural grandfathered LTCHs for certain severe wound discharges by Section 231 of the Consolidated Appropriations Act, 2016.

Item

Health Insurance Exchange Transparency- The Committee continues to include bill language in section 223 that requires CMS to provide cost information for the following categories: Federal Payroll and Other Administrative Costs; Exchange related Information Technology [IT]; Non IT Program Costs, including Health Plan Benefit and Rate Review, Exchange Oversight; Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Exchange Quality Review; Small Business Health Options Program [SHOP] and Employer Activities; and Other Exchange Activities. Cost Information should be provided for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111-148). CMS is also required to include the estimated costs for fiscal year 2017.

Action Taken or To Be Taken

Health Insurance Exchanges Transparency Table

Dollars in Thousands

Health Insurance Marketplace Activity 1/	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Spend Plan 2/	FY 2017 PB
Health Plan Bid Review, Management and Oversight	$ -	$ 300	$ 21,936	$ 40,595	$ 33,497	$ 43,960	$ 40,754	$ 50,580
Payment and Financial Management	$ -	$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 43,733	$ 48,942	$ 71,042
Eligibility and Enrollment	$ -	$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 363,768	$ 381,730	$ 455,846
Consumer Information and Outreach	$ -	$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 753,238	$ 710,309	$ 744,391
Call Center (non-add)			*$ 22,000*	*$ 505,446*	*$ 545,600*	*$ 566,178*	*$ 538,112*	*$ 546,500*
Navigators Grants & Enrollment Assisters (non-add)				*$ 107,468*	*$ 97,152*	*$ 102,438*	*$ 98,727*	*$ 114,871*
Consumer Education and Outreach (non-add)			*$ 7,043*	*$ 77,436*	*$ 49,334*	*$ 54,897*	*$ 43,000*	*$ 52,550*
Information Technology	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 798,648	$ 671,314	$ 657,051
Quality	$ -	$ -	$ -	$ -	$ 17,189	$ 15,634	$ 18,000	$ 20,700
SHOP and Employer Activities	$ -	$ 366	$ 18,479	$ 25,076	$ 30,541	$ 42,717	$ 30,000	$ 32,347
Other Marketplace	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 3,614	$ 12,140	$ 28,043
Federal Payroll and Other Administrative Activities	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000	$ 85,000
Total	**$ 4,654**	**$ 125,392**	**$ 325,142**	**$ 1,543,461**	**$ 2,032,418**	**$ 2,145,312**	**$ 1,998,189**	**$ 2,145,000**

1/ Fiscal years 2010 through 2015 include obligations as of September 30, 2015.

2/ FY 2016 Spend Plan is an estimate and subject to change.

NOTE: Before the Health Insurance Marketplaces were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

Item

Medicaid 1115 Waivers- The Committee is concerned that CMS has not acted in a timely manner to approve a number of applications for Medicaid 1115 waiver. The Committee requests CMS to report on the status of all pending Medicaid section 1115 waivers in the fiscal year 2015 budget request.

Action Taken or To Be Taken

On July 24, 2015, CMS established a new “fast track” process for reviewing state proposals to extend established Medicaid and CHIP section 1115(a) demonstrations that reauthorize longstanding policies with demonstrated positive program outcomes. The “fast track” approach streamlines the federal review process to render decisions on extension requests in timeframes similar to Medicaid section 1915 waivers or State Plan Amendments, however, states must still comply with the requirements of the April 2012 final transparency regulation. CMS’ aim is to reduce barriers and administrative burden on states seeking to continue programs that have demonstrated that they meet the demonstration’s objectives and the objectives of Medicaid or CHIP as well as to facilitate faster review and approval regarding these state requests. This is an initial step we are taking to meet states’ interest in reducing barriers and furthering support of state initiatives that promote the shared goal of improving the quality and efficiency of Medicaid or CHIP. The CMS Informational Bulletin and the fast track application templates are also available on the section 1115 demonstration homepage on Medicaid.gov.

Additionally, CMS maintains a list of all waiver applications on the Medicaid website, both pending and active, at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.

Item

Fraud, Waste and Abuse- The Committee requests a update in the fiscal year 2017 request on the CMS process, across all operations, to ensure CMS maintains a focus on preventing improper payments and paying claims right the first time. The Committee requests the update

include the metric to measure prevention in lieu of the “pay and chase” typical measures reported by CMS.

Action Taken or To Be Taken

CMS continues to pursue strategies for specific regions, providers, and error types, including the development of new data analysis procedures to identify payment aberrancies to assist with the prevention of improper payments.

These strategies include continued refinement of the Fraud Prevention System (FPS). In CMS’ Report to Congress on the Fraud Prevention System’s Third Implementation Year, CMS calculated adjusted savings, defined as an estimate of those dollars returned to the Medicare Trust Funds or likely prevented from being paid, in accordance with OIG recommendations for adjusting savings to meet financial audit standards. Since CMS implemented the technology in June 2011, the FPS has identified or prevented $820 million in unadjusted inappropriate payments by the identification of new leads or the contribution to existing investigations. During the third year (defined in statute as January 2014 – December 2014), the FPS identified or prevented $454 million in unadjusted inappropriate payments through actions taken due to the FPS or through investigations expedited, augmented, or corroborated by the FPS. Total savings were 80% higher than the identified savings from the previous implementation year, with a nearly 10:1 return on investment (ROI).

To meet the goals related to reducing fraud, FPS developed a new anti-fraud tool using predictive analytics and real-time data to spot abnormalities in Fee-for-Service (FFS) claims. This functional requirement integrates fully with the Medicare FFS claims processing system. Upon completion of a transition to FPS 2.0, the system will be more user-friendly and have an increased number of valid data elements that increases search capabilities, thus enabling the more robust identification of potentially fraudulent cases. FPS 2.0 will be utilized to focus on preventing payments prior to claims being paid, creating complex algorithms, and identifying fraudulent social network activities. These efforts will increase return on investment and achieve efficiencies that will reduce costs in the out-years.

CMS anticipates that the FPS will be able to capture additional savings that CMS is not currently able to measure. For example, information on providers dually enrolled in Medicare and Medicaid in certain states are shared with the states through the Medicare-Medicaid Data Match program (Medi-Medi program). Current savings are not yet captured for actions subsequently taken by the state. Other Medicare savings are not yet captured, including savings from providers that voluntarily withdraw from the program after the start of a targeted investigation.

In 2014, CMS launched the CMS Program Integrity Board (PI Board) to prioritize vulnerabilities and determine strategic direction. The Board identifies and prioritizes improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in the Agency’s programs and directs corrective actions to combat each of the high priority vulnerabilities.

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare claims. The use of the NCCI edits saved the Medicare program $681.9 million in FY 2014. CMS also continues to work with states to fully and correctly implement the NCCI methodologies in their Medicaid programs, to add new Medicare and Medicaid NCCI edits to the quarterly Medicaid NCCI edit files, and to update the technical guidance document for states.

CMS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims. CMS contracted with a Supplemental Medical Review/Specialty Contractor (SMRC) to perform medical reviews focused on vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing program (CERT program), professional organizations, and federal oversight agencies. At the direction of CMS, the SMRC contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. CMS issues Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the state and across the nation. CMS continues to implement corrective actions to address Home Health Agency vulnerabilities, and.
Home Health Eligibility Integrated Interventions.

CMS updated the “Two Midnight” rule, CMS–1633–FC (80 FR70297) regarding when inpatient hospital admissions are appropriate for payment under Medicare Part A. The final rule was published in November 2015. In the proposed update to the “Two Midnight” rule from July 2015, CMS announced that on October 1, 2015, CMS would begin a shift of the initial medical review of short stay inpatient claims from Medicare Administrative Contractors, which were conducting “probe and educate” reviews, to Quality Improvement Organizations (QIOs). QIOs will review a sample of provider claims and focus on educating hospitals about payment policy for hospital admissions. At the direction of CMS, the QIOs will refer providers to the Recovery Auditors for further review if the provider continues to exhibit patterns of practices, such as high rates of claim denials or failure to improve after QIO review and education. Initially, Recovery Auditor medical review of these claims will be limited while QIOs conduct the initial rounds of reviews.

Finally, HHS expanded the use of prior authorization in the Medicare FFS program. In 2014 and 2015, HHS implemented two new demonstration models to test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care for certain non-emergent services. HHS also extended an existing power mobility devices prior authorization model for an additional three years and finalized a rule regarding the implementation of a new prior authorization model for certain durable medical equipment, prosthetics, orthotics, and supplies. These projects will also make sure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims.

Item

Medicare Star Quality Rating System's (Stars)- The Committee understands that the CMS is near finalizing the Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies. The CMS 2017 Call Letter will propose to adjust the methodology for accounting for low-income individuals who represent a significant portion of plan membership. The Committee encourages CMS not to remove plans from markets until they identify a methodology that appropriately judges all plans. Further, concerns are noted that the new methodology may harm plans that have made significant investments in assisting those with high levels of chronic conditions. The Committee urges CMS to address these concerns in the final Call Letter.

Action Taken or To Be Taken

In the draft CY 2016 Call Letter, CMS proposed to take the interim step of reducing the weights on a subset of six Part C measures for MA (MA-only and MA-PD contracts) and 1876 contracts and one Part D measure for Prescription Drug Plan (PDP) contracts for the 2016 Star Ratings where preliminary analyses revealed both practical and statistically significant evidence of differential outcomes for Dual/LIS beneficiaries. Many stakeholders provided comments about the proposed interim step, as well as general feedback about the possible sensitivity of Star Ratings to socio-economic factors in the Star Ratings program. Based on the feedback and the uncertainty about what factors are driving the associations observed in the preliminary research, CMS stated in the final Call Letter that further in-depth examination by CMS, its HHS partners, MA organizations, and Part D sponsors in quality measurement, as well as external measure developers, is warranted before CMS implements any solutions. Upon completion of additional research, potential adjustments for the 2017 Star Ratings or other appropriate adjustments were discussed in the fall Request for Comments. Although the research to date has provided scientific evidence that there exists a within-contract LIS/dual eligible/disability effect for a subset of the Star Ratings measures, the size of the effect differs across measures and is not exclusively negative. As a result, CMS does not need to delay terminations. At this time, CMS has not determined that contracts with significant dual-eligible enrollment face unique obstacles in achieving 3-star ratings. Plans subject to termination show a sustained below-average overall rating for at least three years, and there is no evidence to show that a low-rated plan cannot improve its performance to at least an average (i.e., 3-star) level. Beneficiaries gain value from the higher-quality services that higher-rated plans provide, and beneficiary access to plans with three or more starts remain strong.

Item

Medicare Secondary Payer (MSP) Claims- The Committee notes concern that CMS erroneously refers disputed MSP claims to the Treasury Department to seek repayment of secondary payer funds from small and large businesses and insures for health care payments subject to a secondary source of payment. In some cases the responsibility for or amount of payment is disputed. Rather than permit entities with disputed claims due process and an opportunity to resolve their differences with the Agency, CMS regularly refers the debts to the Treasury for collection as "final claims." The Committee request CMS to provide an update in

the fiscal year 2017 budget request on the process CMS uses prior to submitting such claims and alternative steps that could be used to prevent erroneous referrals to the Treasury.

Action Taken or To be Taken:
CMS regularly reviews its debt collection activities to make sure that the agency is compliant with the Debt Collection Improvement Act of 1996, as amended by the Digital Accountability and Transparency Act of 2014.

CMS routinely works with entities that are primary payers to Medicare to address disputes and other concerns regarding payments responsibility before seeking reimbursement. CMS issues at least four separate communications to an entity before a debt is referred to the Department of Treasury. In such communications, CMS solicits responses and feedback from the recipient regarding the amount and existence of the debt. CMS relies on timely responses from these entities to make sure that CMS does not refer debts inappropriately. If CMS receives sufficient information before it requests repayment that a particular entity should not be the identified debtor, CMS updates its recovery case. If CMS has referred a debt to Treasury and receives information that the debt is in error, CMS will recall the debt and address the issue

As required by the SMART Act and in response to industry concerns, CMS published a final regulation that provides such entities with formal administrative appeal rights on MSP debts. The rights are provided to entities that receive demand letters dated on or after April 28, 2015. For entities that received demand letters dated prior to April 28, 2015, CMS continues to address disputes and other concerns as part of its normal ongoing recovery process.

CMS looks forward to continuing to work with the industry in order to receive and transmit the most current information on the status of debts.

Item
Medicare Survey and Certification- The Committee is concerned by the number of preventable medication errors in hospitals. The Committee encourages CMS to review its guidelines and standards to support the reduction of human error in the medication administration process.

Action Taken or To be Taken:
CMS takes seriously the importance of reducing patient harm and improving the quality of inpatient care. For the past several years, CMS has partnered with medical practitioners, hospitals, patients and their advocates to improve the quality and safety of healthcare via the Partnership for Patients initiative. This partnership is led by Hospital Engagement Networks (HENs) who are partnering with us to identify solutions already working to reduce hospital-acquired conditions and assist other healthcare providers in implementing best practices to ensure the quality and safety of patient care. One of the ten core patient safety areas of focus that the Partnership for Patients has been working on is Adverse Drug Events in hospitals.

To date, there has been substantial national progress in improving patient safety in hospitals. In December 2015, the Department of Health & Human Services announced the results for the period of CY 2010 (baseline year) through the end of CY 2014: a 17 percent reduction in hospital-acquired conditions, 2.1 million fewer hospital-acquired conditions, $20 billion in savings and 87,000 lives saved. As a part of this ongoing effort, CMS awarded contracts to 17 national, regional, or state hospital associations and health system organizations for Round 2 of the HENs and will continue to team with the HENs to identify and implement standards to support further reduction in patient harm.

The CMS hospital Conditions of Participation for nursing services, pharmacy, and quality assessment performance improvement (QAPI) require assessment of and compliance with nationally accepted standards of practice for safe medication practice administration. The Conditions of Participation require that all medication errors be reported, analyzed and tracked. To assess compliance during a survey, State Survey Agency surveyors use a hospital QAPI worksheet, which includes questions specific to activities related to medication errors.

CMS has also started providing training on assessment of compounding practices to surveyors. Further, newly proposed Discharge Planning regulations include requirements for medication reconciliation. Effective medication reconciliation processes reduce medication errors and lead to improved patient safety in hospital and post-hospital settings.

Hospitals can also meet the Conditions of Participation by obtaining accreditation from one of four hospital accrediting organizations (AOs). These four hospital AOs are required to minimally meet (but may exceed) Medicare requirements. These requirements include the Conditions of Participation noted above addressing medication errors in hospitals. We will make the compounding training and future discharge planning training available to AO surveyors and we will review the AO approach to the hospital pharmaceutical services and discharge planning Conditions of Participation as a part of our oversight responsibility.

Item

Mental Health Crisis Stabilization Code- The Committee requests CMS to provide an update in the fiscal year 2017 budget request on the CPT codes for Crisis Stabilization to support. Further the update should describe how the CPT codes can be used to support Psychiatric Emergency Department facilities, to include training.

Action Taken or To Be Taken

There are CPT codes for Psychotherapy for Crisis for which Medicare provides payment. Except under teaching physician rules, payment for these services does not support training, implementation, and operation of staff within appropriately-specified Psychiatric Emergency Departments.

Item

Ophthalmology Services- The Committee request an update in the fiscal year 2017 budget request on how CMS ensures Federally-designated medically underserved areas have access to sufficient ophthalmology services necessary to ensure that at risk individuals do not suffer preventable vision loss and blindness.

Action Taken or To Be Taken

Designations of Medically Underserved Areas (MUAs) are determined by the Health Resources and Services Administration (HRSA) and are based on the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and the percentage of the population age 65 or over. MUAs do not assess the availability of ophthalmologists or ophthalmology services. Please contact HRSA for additional information regarding MUAs and other designations.

Item

Psychotropic Drugs and Children- The Committee is aware of the Department's efforts to reduce the inappropriate use of psychotropic medications with children and adolescents in foster care. In addition to the potential for serious long-term health and developmental problems for children, this alarming pattern has dramatically increased Medicaid costs. CMS is urged to examine research into reasons for this disparity, including whether current reimbursement policy incentivizes reliance on medication rather than evidence-based psychosocial therapies instead of, or in combination with psychotropic medications.

Action Taken or To Be Taken

CMS has been working diligently with Medicaid agencies and federal partners by providing guidance and links to professional clinical websites that provide guidelines and best practices on these topics. CMS, along with Federal partners ACF and SAMHSA, issued a State Medicaid Directors Letter to help assist states in identifying services and Medicaid authorities to address the needs of children who have experienced trauma (and may have been prescribed psychotropic medications to address their complex issues). A copy of the letter can be found at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

In addition, this topic has been included in the Medicaid agencies oversight in their Drug Utilization Review (DUR) programs. Each State Medicaid program is required under Section 1927(g)(3)(D) of the Social Security Act (the Act) to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. States are required to report on their state's prescribing patterns, cost savings generated from their DUR programs and their programs' operations, including adoption of new innovative DUR practices.

The survey queries the states to ascertain if they either manage or monitor the appropriate use of psychotropic drugs in children. Moreover, CMS requests that states briefly explain the specifics of their respective programs. Forty-one states (82%) report that they have programs in place to either manage or monitor the appropriate use of psychotropic medications in children; however, the ages of the children that are monitored by the states vary. These states have

provided a brief synopsis of the specifics of their program. It should be noted that some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions.

It is likely that a number of factors impact the use of psychotropic drugs in children and youth in foster care. While there do not appear to be outright financial incentives to prescribe medication, an over-reliance on medication may reflect a lack of timely access to effective behavioral health care for Medicaid enrollees in some states, as well as fewer evidence-based psychosocial therapies for children than for adults. CMS has encouraged adoption of evidence based practices in this area and has published numerous informational bulletins on trauma informed care, behavioral health coverage and design, and monitoring of psychotropic medications.

Item

Robotic Stereotactic Radiosurgery- The Committee was encouraged by the CMS decision in the fiscal year 2015 Medicare Physician Fee Schedule Final Rule (79 Fed. Reg 67548) to maintain G codes and contractor pricing for robotic stereotactic radiosurgery procedures performed in a freestanding setting. The Committee urges CMS to maintain the current coding and payment methodology for at least three years to provide stability while determining the most appropriate policy for this important treatment option.

Action Taken or To Be Taken

CMS appreciates that the Committee was encouraged by our decisions in the Calendar Year 2015 Medicare Physician Fee Schedule final rule regarding robotic stereotactic radiosurgery procedures performed in a freestanding setting. Although CMS did not take any further action regarding robotic stereotactic radiosurgery procedures in the 2016 Medicare Physician Fee Schedule rulemaking, CMS remains committed to our decision in the 2016 Medicare Physician Fee Schedule final rule to work with stakeholders to identify an alternate approach and reconsider this issue in future rulemaking.

Item

Treatment Resistance Depression (TRD) - The Committee encourages CMS to review available meritorious peer reviewed literature to determine if additional therapies exist for safe and effective treatment of TRD that could be considered for CMS coverage determinations.

Action Taken or To Be Taken

CMS appreciates the Committee's suggestion and is committed to facilitating continued improvements on this important issue. CMS will review and evaluate any new evidence provided to us related to TRD as part of the National Coverage Determination process and is continuing to meet with stakeholders regarding new evidence for treatment of TRD.

Item

Budget Request- The Committee appreciates the information in the CMS Budget request. However, the Committee expects CMS to provide the additional items and enhanced Congressional notice described in the statement accompanying the fiscal year 2015 Appropriations Act. The Committee reminds HHS and CMS to ensure that all tables include the

prior year actual, current year request level, current year actual (based on the operating plan) and budget request year level.

Action taken or to be Taken:
This information will be provided under separate cover.

Item
ACA Internal Controls-The Committee is deeply concerned about the findings in the recent HHS Office of Inspector General [OIG] report (A-02-14-02006) on CMS' lack of oversight over the payments to insurance companies. The OIG reported that CMS failed to implement adequate internal controls to check the accuracy of $2,800,000,000 worth of payments made to the insurers for the advance premium tax credits and cost-sharing reductions for enrollees. This amount only represents the first payment that covered January to April of 2014 and is only a tiny fraction of the vast amount of money at risk. Based on the current internal controls, the OIG concluded that CMS could not make correct payments to providers resulting in improper payments and jeopardizing taxpayer funds. The Committee is specifically concerned that CMS relied primarily on health insurers attestations and that CMS does not plan on reconciling payments until 2016, 2 years after payments were made. The Committee directs CMS to work with the OIG to adopt all the recommendations and expeditiously implement a permanent process that automates enrollment and payment data on a more accurate enrollee-by-enrollee basis. As the OIG pointed out in the report, CMS has the authority to recoup improper payments and offset them against future payments. The Committee expects CMS to use this authority after reconciling payments.

Action Taken or To Be Taken
In January, CMS implemented an automated payment approach, called policy-based payments, in determining an issuer's advance payment using enrollment and payment data in the Federally-facilitated Marketplace (FFM) and will phase out the interim payment process as recommended by the HHS OIG. To ensure payment accuracy, before transitioning to policy-based payments, CMS will evaluate the readiness of issuer enrollment data and data submission processes.

In order for CMS to enhance the accuracy of reconciliation of CSR payments to issuers, and to fully reimburse issuers for reductions in out of-pocket expenses provided to eligible low- and moderate-income enrollees, and American Indian/Alaska Native enrollees in 2014, CMS will reconcile 2014 benefit year cost-sharing reductions for all issuers in the spring of 2016. CMS notes that two recommendations in the OIG's report are not applicable to 2015 or future years due to changes in regulation.

Item
ACA Notifications- The Committee is disappointed that the administration still cannot provide timely Congressional notification for ACA enrollment figures even though the Committee included report language in the fiscal year 2015 requiring such notifications. The Committee continued to receive enrollment data minutes before or even after the administration's public

announcement. The Committee includes new bill language requiring the administration to provide detailed enrollment figures to the Committees on Appropriations of the House of Representatives and the Senate not less than two full business days before any public release of the information.

Action Taken or To Be Taken

The Department is committed to providing the Committees detailed monthly enrollment figures from the Exchanges established under the Patient Protection and Affordable Care Act of 2010 pertaining to enrollments during the open enrollment period. The Department will continue to notify the Committees two business days in advance of any upcoming release of detailed monthly enrollment figures.

Item

Alzheimer's Disease and Dementia Care- The National Plan to Address Alzheimer's Disease includes the goal of enhancing care quality and efficiency and expanding supports for people with Alzheimer's disease and their families. The Committee is aware of promising evidence-based interventions, including the VA's resources for Enhancing Alzheimer's Caregiver Health program and the New York University Caregiver Initiative that has been demonstrated to improve the health outcomes and quality of life of persons with Alzheimer's and others causes of dementia and their caregivers and to have delayed placement of the patient in an institutional care setting. The Committee encourages CMS to evaluate the impact of such interventions in improving health outcomes of Medicare beneficiaries with Alzheimer's and related dementias, including reducing or delaying the use of institutional care services.

Action Taken or To Be Taken

CMS appreciates the Committee's interest in this issue of great importance to Medicare beneficiaries and their families. We welcome the opportunity to work with Congress, stakeholders, and our partner agencies on enhancing access to care for Alzheimer's disease and other forms of dementia. We also encourage interested parties to submit evidence of promising interventions that could be reviewed under Medicare's National Coverage Determination process.

Item

Annual Wellness Exam and Cognitive Impairment- The Committee is aware that the Annual Wellness Exam is required to include an assessment of any cognitive impairment in the Medicare beneficiary. The Committee is concerned about the extent such assessments are occurring within the exams and directs CMS to report in their fiscal year 2017 CJ the rate of provider compliance, including impediments for not conducting the assessment, and to develop a strategy to increase compliance.

Action Taken or To Be Taken

CMS appreciates the Committee's commitment to the success of the Annual Wellness Visit (AWV), and specifically the extent to which cognitive impairment assessments are being

conducted as part of the AWV. CMS is reviewing how we can assess whether providers are including this required element of the AWV.

Item-

Collection Claims- The Medicare Secondary Payer program provides CMS the ability to recover payments it made for beneficiary healthcare costs from third parties which are later found responsible for those costs. CMS is encouraged to review its debt collection process to ensure the agency is providing accurate and complete information about past-due and legally enforceable claims, so that the U.S. Department of Treasury can appropriately identify and adjudicate any appeals.

Action Taken or To Be Taken

CMS regularly reviews its debt collection activities to make sure that the agency is compliant with the Debt Collection Improvement Act of 1996, as amended by the Digital Accountability and Transparency Act of 2014.

CMS routinely works with entities that are primary payers to Medicare to address disputes and other concerns regarding payments responsibility before seeking reimbursement. CMS issues at least four separate communications to an entity before a debt is referred to the Department of Treasury. In such communications, CMS solicits responses and feedback from the recipient regarding the amount and existence of the debt. CMS relies on timely responses from these entities to make sure that CMS does not refer debts inappropriately. If CMS receives sufficient information before it requests repayment that a particular entity should not be the identified debtor, CMS updates its recovery case. If CMS has referred a debt to Treasury and receives information that the debt is in error, CMS will recall the debt and address the issue

As required by the SMART Act and in response to industry concerns, CMS published a final regulation that provides such entities with formal administrative appeal rights on MSP debts. The rights are provided to entities that receive demand letters dated on or after April 28, 2015. For entities that received demand letters dated prior to April 28, 2015, CMS continues to address disputes and other concerns as part of its normal ongoing recovery process.

CMS looks forward to continuing to work with the industry in order to receive and transmit the most current information on the status of debts.

Item

Continuous Glucose Monitors- Diabetes technologies known as continuous glucose monitors [CGM] have been shown in clinical trials to improve health outcomes for people with type 1 diabetes and reduce the risk of low blood sugar emergencies which can lead to hospitalizations and additional expenses to CMS. These technologies are recommended by national diabetes guidelines and covered by 95 percent of private health plans. The Committee urges CMS to modernize its policies to cover CGM technologies to ensure access for those seniors with type 1 diabetes or those entering Medicare who have benefited from the technology under their prior health plan.

Action Taken or To Be Taken

In order for an item to be covered by Medicare, it must meet the definition of a Medicare-covered benefit category. Continuous glucose monitor (CGM) devices do not meet the Medicare definition of durable medical equipment (DME), which requires that the equipment is primarily and customarily used to serve a medical purpose, and do not fall under any other Medicare benefit category. Current CGM systems are FDA-approved only as a secondary source for glucose monitoring. According to the FDA labeled indications, all CGM device readings must be confirmed with a capillary blood glucose monitor and users are cautioned against making insulin dosage changes based solely on CGM system determinations. Consequently, CGM devices are considered precautionary equipment. Therefore, these devices do not meet the definition in Medicare of DME.

Item

Coordinated Pharmacist Services- The Committee encourages CMS to expand efforts that incorporate health information technology to provide integrated pharmacist services across care settings and improve medication reconciliation and management that has been demonstrated to improve outcomes, reduce adverse events, lower costs, and prevent readmissions.

Action Taken or To Be Taken

The Medicare & Medicaid EHR Incentive Programs include objectives and measures specifically designed to facilitate the exchange of health information and electronic prescribing. In recent rulemaking, CMS revised these objectives and measure in response to stakeholder feedback for Stages 2 and 3 of the EHR Incentive Programs.

In order to satisfy the electronic prescribing objective in the EHR Incentive Programs, eligible professionals, eligible hospitals, and critical access hospitals in the EHR Incentive Programs are required to demonstrate that a percentage of all permissible prescriptions written by the eligible professional are queried for a drug formulary and transmitted electronically using certified electronic health record technology . The EHR Incentive Programs also include objectives to facilitate the exchange of health information, which include specific measures for medication reconciliation. CMS believes the refinements to the EHR Incentive Programs we made in recent rulemaking will support provider exchange of health information and provide a more useful interoperable infrastructure for information exchange between providers and with patients.

Item

Critical Access Hospitals [CAH]- The Committee is disappointed that the Administration continues to propose eliminating CAH status from facilities located less than 10 miles from another hospital and reducing the reimbursement rate from 101 percent to 100 percent of reasonable cost. A recent Health Affairs study from April 2015 reviewed the impact of similar minimum distance requirements and found that currently 37.6 percent of CAHs had a negative operating margin, and if such a distance requirement went into effect, it would rise 75.6 percent. If a CAH lost its designation, it would be forced under the applicable prospective payment systems which are designed for larger facilities, not small, low volume rural hospitals. The results of the study underscore the importance of factoring clinical expertise, physician

distribution, availability of telehealth, sufficient volume to maintain key services, and the needs of underserved populations. Coupled with over regulation, decreased reimbursements, and workforce shortages CAHs would be forced to close without their designation, causing patients to travel farther, forego preventative care, and ultimately cost more in CMS health care expenditures.

Action Taken or To Be Taken
CMS appreciates the Committees' continued interest in these issues. These proposals will ensure that only hospitals whose communities depend upon them for emergency and basic inpatient care will be designated as Critical Access Hospitals and receive reasonable cost-based reimbursement without endangering assess to care in rural communities.

Item
Dental Plans- The Committee directs CMS to include in its Exchange enrollment reports data on children (ages 0 through 18 years) enrolled or who have re-enrolled in dental coverage through the Exchange for both stand-alone dental plans and qualified health plans that include pediatric dental benefits. These reports shall include data for each State-based, federally facilitated, and partnership Exchanges.

Action Taken or To Be Taken
The Department is committed to providing the Committees with the most complete enrollment data available on children's dental coverage for states using the HealthCare.gov eligibility and enrollment platform and states using their own eligibility and enrollment platform. The Department will include this data in a future enrollment report.

Item
Healthcare Fraud Prevention Partnership- The Healthcare Fraud Prevention Partnership is a new fraud prevention initiative that includes law enforcement, Federal and State government agencies, private health insurers, and other private organizations. The Partnership has shown successes in preventing improper payment levels clearly indicate the need for stronger action. The Committee urges CMS to work with its partners in expanding and strengthening the current partnerships and directs CMS to provide an update in the fiscal year 2017 CJ outlining its plan for the next 2 years including any legislative barriers for achieving these goals.

Action Taken or To Be Taken
The Healthcare Fraud Prevention Partnership (HFPP) is a collaborative arrangement uniting public and private organizations and is the next step in efforts to combat health care fraud and safeguard health care dollars to better protect taxpayers and consumers. The HFPP is designed to share information and best practices in order to improve detection and prevent payment of fraudulent health care billings across a number of public and private payers. CMS' priorities for building on the successes of HFPP include:

- **Enhance data sharing across public and private payers to identify and prevent potential fraud, waste and abuse in the healthcare arena.** The HFPP has been

successful in assisting public and private payers with sharing intelligence on schemes, over-utilized or abused codes, and suspect providers while partners have joined and actively participated in the HFPP's committees, meetings, and activities.

- **Increase HFPP savings by performing more studies and increasing the sharing of data and data algorithms.** The HFPP plans to increase the number of studies on specific schemes, utilized billing codes, and geographical fraud hotspots so that action can be taken to prevent losses to both government and private health plans before they occur. The HFPP plans to increase the amount of data provided by partners and use it to detect fraud, waste, and abuse that would not be evident without the sharing of the data. For example, the HFPP plans to determine if there are claims that appear fraudulent because they are billed for the same individual on the same date of service in two separate cities. In addition, the HFPP plans to increase the sharing of data algorithms amongst the partners to better detect fraud, waste, and abuse.

- **Continue to expand membership in the HFPP – especially in areas with high fraud rates and to underrepresented regions of the U.S.** As more organizations learn about the work and results of the HFPP, the partnership expects to expand its membership. CMS plans to leverage high value partner experiences by communicating the bottom line impact of the HFPP on preventing and identifying fraud, waste, and abuse, as well as overall HFPP return on investment. CMS plans to expand the HFPP to include associations, task forces, agencies, and other organizations to share information relevant to the HFPP and recruit potential HFPP members. A recruitment priority for the partnership is to increase membership penetration into regions of the U.S. that are now under represented by HFPP in terms of covered lives, and in regions that have particularly high incidences of healthcare fraud, similar to how the Medicare Fraud Strike Forces have been deployed, by focusing the HFPP outreach efforts on these areas of the country. To date there are 45 public and private partners.

The President's FY 2017 Budget includes a legislative proposal that would give CMS the authority to accept gifts made to the Medicare Trust Funds for particular activities funded through the HCFAC Account, such as the HFPP. Currently, the HCFAC Account can only receive gifts that are made for an unspecified purpose. This proposal would allow for gifts to be made to support the Partnership directly, and allow both public and private partners to support the anti-fraud program.

Item

Healthcare.gov Data Privacy- The Committee is disappointed that CMS allowed third party vendors to access unencrypted consumer information such as age, smoking status, zip code, pregnancy status, and income through Healthcare.gov. The Committee directs CMS to encrypt and prevent further sharing of consumer information, to review its current security and privacy guidelines for this type of data, and to implement appropriate security measures. Furthermore, CMS shall include in the fiscal year 2017 CJ an update on these efforts including a timeline for when these activities will be completed.

Action Taken or To Be Taken

CMS takes its responsibility to protect consumers' security and privacy seriously and appreciates the opportunity to address this important issue. No third-party tools have had access to names, addresses, Social Security Numbers, or any of the information entered into the application through HealthCare.gov, and no person or group has maliciously accessed personally identifiable information from the site. CMS does not sell or market any information entered into HealthCare.gov.

Early last year, concerns were raised about the use of third-party tools and, in particular, the information available to these tools through a plain-text URL on the Window Shopping feature on the site that allowed users to estimate plan costs. The inputs that were unencrypted in the URL included zip code, age, smoking status, pregnancy status, and income. The URL never contained names, addresses, or Social Security Numbers. Immediately after these concerns were raised, CMS began reviewing its use of third-party tools and encrypted the text of the Window Shopping URL. CMS has found no evidence that any third-party tool misused the anonymous, unverified information entered into the Window Shopping feature.

The issues raised about HealthCare.gov's use of third-party tools also prompted CMS to conduct a review of the third-party tools. We removed third-party tools we viewed as redundant. Additionally, we are in the process of updating our Privacy Impact Assessments (PIAs) and adding new PIAs to further strengthen our privacy procedures. This process and review includes looking to see how we could strengthen our contracts to further safeguard consumer information.

Item

Home Health- CMS identified the implementation of new home health documentation requirements as a major contributing factor in the fiscal year 2013 improper payment rate. As a result, CMS proposed modifications which became effective in January of 2015, but these changes will not be reflected in the improper payment rate until fiscal year 2017 measurement. The Committee therefore directs CMS to report, no later than 60 days after the enactment of this act to the Committees on Appropriations of the House of Representatives and the Senate, an interim update on the improper payment rate regarding home health documentation requirements.

Action Taken or To Be Taken

The 2016 Medicare FFS improper payment rate, which includes claims submitted from July 1, 2014 through June 30, 2015, will partially reflect the regulatory changes to eliminate the face-to-face encounter narrative as part of the certification of beneficiary eligibility for the Medicare home health benefit and to require that documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records be used as the basis for certification of home health benefit eligibility. These changes were effective for home health episodes beginning on or after January 1, 2015. As a result, the 2016 Medicare FFS improper payment rate calculation will include six months of home health claims using the modified requirements. CMS will report an interim update on the improper payment rate regarding home

health documentation requirements for the 2016 report period in the Department of Health and Human Services' annual Agency Financial Report.

Item

Hospice- In its March 2015 report to Congress, MedPAC notes that CMS expressed concern that some hospice providers may not have the capacity to provide all four levels of care, which is required by the Medicare hospice Conditions of Participation. CMS makes clear that if the patient's condition needs it, hospices are required to provide intensive around-the-clock nursing and other skilled hospice care as necessary, with the goal of having the patient remain in their home if at all possible. Therefore, all hospice providers must have the capacity of providing such care. The Committee directs CMS to ensure that all hospices are complying with the Conditions of Participation and have the capacity to provide all specified hospice services on a 24 hour, 7 days a week basis.

Action Taken or To Be Taken

CMS develops and provides national training for all State and federal surveyors across the nation. This training includes an in-depth discussion of the various levels of care for which the certified hospice agency is responsible as well as the techniques that the surveyors are to employ during the survey process to ensure that the hospice not only makes all levels of care available but provides them as needed.

During on-site reviews, the surveyors review patient plans of care and do patient and family interviews. The surveyors include all levels of required care within their survey sample and any instance of a patient not receiving a level of care needed results in a deficiency citation for the hospice. The surveys are conducted by State Survey Agencies at a maximum three (3) year survey interval. In addition, CMS is conducting periodic quality assurance reviews of hospice surveys nationwide starting in FY 2016. CMS will include evaluation of the assessment of availability of all levels of care in those reviews.

Item-

IT Modernization- Rapid advances in analytical and information technology provide opportunities for CMS to modernize, consolidate, and improve operations with greater efficiency and cost savings over time. CMS has already implemented several such advances, including the Predictive Modeling program, the Healthcare General Ledger Accounting System, and the Unified Case Management System. The Committee encourages CMS to continue to modernize, consolidate, and improve analytics and information technology programs to achieve maximum efficiency and cost savings.

Action Taken or To Be Taken

With a workforce of only 6,000 full time equivalent employees, CMS provides health coverage to 125 million Americans though Medicare, Medicaid, and the Health Insurance Marketplace. CMS' program management appropriation to accomplish this work is less than half of a percent of our total benefits – far less than the administrative costs of even the most efficient private health insurance companies. Thus, CMS relies heavily on IT and its supporting infrastructure to accomplish our widespread business demands. Our IT systems support an array of critical

activities related to eligibility, beneficiary claims, reimbursement, fraud prevention, quality measurement, and coverage determinations. As CMS' mission requires us to frequently take on ambitious projects of significant complexity and tight timeframes, we must continue to be committed to high levels of management excellence, execution, and continuous improvement. CMS continues to seek to manage its IT more effectively, reduce duplication, and achieve cost savings through a series of initiatives, including data center consolidation and optimization, cloud computing, and shared services.

Item

Medicare Advantage- The Committee is aware that the formula to determine Medicare Advantage reimbursement rates is calculated based on the per capita cost of coverage to beneficiaries enrolled in Medicare part A and/or part B. However, where there is high enrollment in Medicare Advantage and a relatively large proportion of Medicare beneficiaries without part B coverage, Medicare Advantage reimbursement rates may be better based on the per capita cost of coverage to beneficiaries enrolled in both Medicare part A and B. The Committee urges CMS to consider more accurate adjustments as soon as practicable in order to include potential changes in its CY 2017 draft Call Letter.

Action Taken or To Be Taken

In the 2016 Medicare Advantage and Part D Rate Announcement and Call Letter, CMS finalized updates to the methodologies used to pay Medicare Advantage plans and Part D sponsors intended to improve payment accuracy and encourage quality. Under the Affordable Care Act, CMS continues to move payments towards aligning Medicare Advantage program payments with payments made for beneficiaries in Fee for Service Medicare, helping to ensure fairness in the program. CMS is continuing to consider updates to the Medicare Advantage payment methodology as it prepares policies for the 2017 Medicare Advantage and Part D Advance Notice and Draft Call Letter.

Item

Medication Synchronization- Programs that promote Medication Synchronization and the Appointment Based Model are an emerging trend in pharmacy practice that improves adherence rates for patients taking multiple medications while reducing unnecessary visits to the doctor. The Committee encourages CMS to consider ways to increase participating in these types of programs and move towards greater adherence to medications.

Action Taken or To Be Taken

Beginning January 1, 2014, Part D sponsors must establish and apply a daily cost sharing rate whenever certain prescriptions (depending on the drug dispensed) are dispensed by a network pharmacy. An example of the benefit of this requirement is that it allows beneficiaries the ability to synchronize their prescription in consultation with their prescriber and pharmacist without having to pay a full month’s cost sharing during this synchronization process until all medications are on the same refill schedule. CMS informed beneficiaries of this benefit in the Medicare & You handbook and the Part D Evidence of Coverage.

Also, performance and quality measures are used by CMS so that Medicare beneficiaries have the information necessary to make informed enrollment decisions by comparing the quality available health and prescription drug plans. They also provide measures of quality across Part D sponsors. As part of this effort, CMS currently calculates and reports on three Part D Star Rating Medication Adherence measures, for Cholesterol (Statins), Hypertension (RAS Antagonists), and Diabetes. The adherence measures are each a weight of 3 as outcomes measures; there is evidence that higher medication adherence rates are linked with improvements in clinical outcomes.

In addition, Part D sponsors currently have access to monthly Patient Safety Reports via the Patient Safety Analysis Website to compare their performance to overall averages and monitor their progress in improving the prescription drug patient safety measures. These actionable reports include contract-level patient safety reports for expanded analyses and information and detailed beneficiary-claim level and outlier reports.

Item

Mental Health Services- The Committee recognizes the need for improved mental healthcare services and directs the CMS to identify potential payment-related barriers to the integration of mental healthcare services into the primary care context in both traditional fee-for-service Medicare and alternative payment models. Specifically, CMS is directed to identify potential payment-related barriers to the adoption of a collaborative care model in which primary care providers treat patients with common mental health disorders, such as depression or anxiety, with help from a care manager and a physiatrist who acts as a consultant. The Committee directs CMS to provide a report within 180 days after enactment of this act to the Committees on Appropriations of the House of Representatives and the Senate with its findings, as well as a proposed plan to address the identified barriers and facilitate more widespread integration of mental healthcare services into the primary care context. The report shall also include recommendations for any legislative changes.

Action Taken or To Be Taken

CMS has been testing models and undertaking programs in which the integration of behavioral health services with primary care services is an important feature. Under the Comprehensive Primary Care Initiative, a multi-payer partnership being tested between Medicare, other public and private payers, and primary care practices, participating practices coordinate care across the medical neighborhood, including behavioral health services. Many participants in the Comprehensive Primary Care Initiative are also focused on the integration of behavioral health services as a care management strategy to support high risk patients. Accountable Care Organizations (ACOs) in models such as the Pioneer ACO Model and in the Medicare Shared Savings Program integrate and coordinate all care, including behavioral health care, for their patients as part of their efforts to deliver better care at a lower cost. In addition, several awards made under the Round 2 Health Care Innovation Awards include projects that are testing the integration of behavioral health services with medical and community services. In the CY 2016 Medicare Physician Fee Schedule Proposed Rule, CMS sought information to assist the agency in considering refinements to coding and payment that could be developed through the

collaborative care model for rulemaking in CY 2016 and implementation in CY 2017. For example, CMS sought comment on how a code similar to the chronic care management code applicable to multiple diagnoses and treatment plans could be used to describe collaborative care services.

Item

Pediatric Dental Reporting- Although CMS has released guidance on CHIP dental reporting, the data from States are unreliable and incomplete. Without consistent, reliable data, it is difficult to evaluate the impact of CHIP dental benefits. The Committee directs CMS to include in the fiscal year 2017 CJ a plan to collect quality reporting data from States regarding their dental benefit.

Action Taken or To Be Taken

CMS appreciates the Committee's support for obtaining consistent, reliable data on dental services delivered to CHIP enrollees. Achieving this would require several steps and additional resources. First, CMS would need to perform a review of each state's dental data to identify the specific errors and inconsistencies in each state's data submission. Second, for those states where problems are identified, CMS would need to develop and deliver state-specific technical assistance to notify the state of the specific errors and inconsistencies found in their data, and then to work with the state to develop a state-specific, targeted plan to improve the quality of the dental data reported by states. Third, after the state has executed the improvement plan and submitted a new year of dental data, CMS would need to re-review each state's submission to confirm that the errors and inconsistencies have been addressed.

Item

Psychotropic Drugs and Children- The Committee is aware of the Department's efforts to reduce the inappropriate use of psychotropic medications with children and adolescents in foster care. In additional to the potential for serious long-term health and developmental problems for children, this alarming pattern has dramatically increased Medicaid costs. The Committee urges CMS to encourage States to provide evidence-based psychosocial interventions to children and youth in foster care to reduce reliance on psychotropic medications. Furthermore, the Committee urges CMS to include in the fiscal year 2017 CJ the reasons for this disparity, including whether current reimbursement policy incentivizes reliance on medication rather than evidence-based psychosocial therapies instead of, or in combination with psychotropic medications.

Action Taken or To Be Taken

CMS has been working diligently with Medicaid agencies and federal partners by providing guidance and links to professional clinical websites that provide guidelines and best practices on these topics. CMS, along with Federal partners ACF and SAMHSA, issued a State Medicaid Directors Letter to help assist states in identifying services and Medicaid authorities to address the needs of children who have experienced trauma (and may have been prescribed psychotropic medications to address their complex issues). A copy of the letter can be found at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

In addition, this topic has been included in the Medicaid agencies oversight in their Drug Utilization Review (DUR) programs. Each State Medicaid program is required under Section 1927(g)(3)(D) of the Social Security Act (the Act) to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. States are required to report on their state's prescribing patterns, cost savings generated from their DUR programs and their programs' operations, including adoption of new innovative DUR practices.

The survey queries the states to ascertain if they either manage or monitor the appropriate use of psychotropic drugs in children. Moreover, CMS requests that states briefly explain the specifics of their respective programs. Forty-one states (82%) report that they have programs in place to either manage or monitor the appropriate use of psychotropic medications in children; however, the ages of the children that are monitored by the states vary. These states have provided a brief synopsis of the specifics of their program. It should be noted that some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions.

It is likely that a number of factors impact the use of psychotropic drugs in children and youth in foster care. While there do not appear to be outright financial incentives to prescribe medication, an over-reliance on medication may reflect a lack of timely access to effective behavioral health care for Medicaid enrollees in some states, as well as fewer evidence-based psychosocial therapies for children than for adults. CMS has encouraged adoption of evidence based practices in this area and has published numerous informational bulletins on trauma informed care, behavioral health coverage and design, and monitoring of psychotropic medications.

Item

Quality Improvement- The Department recently announced payment reform goals that identify a timetable for moving away from Medicare fee-for-service payment. The Committee directs CMS to include in their fiscal year 2017 CJ the quality improvement goals for Medicare.

Action Taken or To Be Taken

In light of the delivery system reform goals announced by the Secretary, CMS is committed to testing new payment models and finding better ways to deliver care. CMS is dedicated to improving the health quality of Medicare beneficiaries, and we are committed to achieving quality improvement goals as set forth in the CMS Quality Strategy. We are guided by the bold goals of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models – such as Accountable Care Organizations, advanced primary care medical homes, or bundled payment arrangements – by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. The Secretary also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. These goals serve to impel and guide quality improvement activities across CMS, including the Partnership for Patients initiative and the Quality Improvement

Organization Program, as well as programs in HRSA, ONC, AHRQ, CDC, OASH, ACL and other Department of Health and Human Services agencies.

Item

Recovery Audit Data Warehouse- The Committee is disappointed that CMS is not properly utilizing the Recovery Audit Data Warehouse [RADW] as highlighted in the GAP report titled, Medicare Program Integrity: Increased Oversight and Guidance Could Improve Effectiveness and Efficiency of Post payment Claims Reviews. CMS developed the RADW to prevent RACs from duplicating audits of the other three contractors' responsible for reviewing post payment claims. By not taking advantage of the RADW, duplicative RAC audits are causing unnecessary burden on providers and wasting federal resources. The Committee directs CMS to implement all the recommendations provided by GAO and to provide an update including a timeline one these efforts in the fiscal year 2017 CJ.

Action Taken or To Be Taken

CMS has taken several steps to ensure that review contractors are not duplicating other review contractors' activities. CMS issued technical direction to the Recovery Auditors to delay sending Additional Documentation Requests (ADRs) until 60 days after the claim paid date. This delay is necessary to minimize the likelihood of Recovery Auditors reviewing a claim that had a prepayment review completed by a Medicare Administrative Contractor (MAC). MACs upload their complex reviews to the Recovery Auditor Data Warehouse (RADW) using a system-generated file, which is generated on a monthly basis. This file is used to exclude the MAC-reviewed claims from potential re-review by a Recovery Auditor. Therefore, CMS has designated this 60-day wait time for Recovery Auditors to allow ample time for MACs to upload their reviews into the RADW. CMS has also modified the Recovery Auditor process for uploading claim review information to require a nightly duplication check before the Recovery Auditor may proceed with its review.

CMS has also more clearly defined the roles of review contractors to reduce the chance for any review duplication. The MACs generally focus on reviewing claims before they are paid. The Supplemental Medical Review Contractor (SMRC) and Recovery Auditors conduct post-payment reviews (that is, reviewing claims after they are paid). CMS is creating a report to monitor the review contractor's file uploads to the RADW. In addition, CMS continues to explore the feasibility of a systems change to require all contractors to upload claims data to the RADW on a nightly basis. CMS is confident that these initiatives will further reduce the chance for any review duplication by our review contractors.

Item

Relative Values under the Medicare Physician Fee Schedule- The Committee encourages CMS to increase representation of primary care physicians who are board certified and actively practicing in family medicine, general internal medicine, general pediatrics, preventive medicine, obstetrics and gynecology, or psychiatry on any advisory board or work group that formulates recommendations regarding any annual updates to the physician work relative values.

Action Taken or To Be Taken

CMS does not have any advisory committees or work groups that make recommendations regarding annual updates to the PFS relative value units. Many non-governmental stakeholder bodies make recommendations that CMS considers in establishing updates to the physician work relative value units as part of the annual Medicare Physician Fee Schedule rulemaking.

Improving payment to assure that Medicare beneficiaries have access to primary care services is a long term priority of CMS. In recent years, CMS has made progress by recognizing and making separate payments for care management services, including transitional care management and chronic care management. In last year's rule, we sought comments on how to recognize the extensive cognitive work that primary care physicians and other practitioners perform in planning and thinking critically about the individual chronic care needs of particular subsets of Medicare beneficiaries. In the CY 2016 PFS proposed rule, we solicited public comments on ways to recognize the different resources (particularly in cognitive work) involved in delivering broad-based, ongoing treatment, beyond those resources already incorporated in the codes that describe the broader range of E/M services. We strongly encouraged stakeholders to comment on this topic to assist us in developing potential proposals to address these issues through rulemaking in 2016 for implementation in CY 2017.

Item

Rural Health- According to the National Rural Health Association, 41 percent of Critical Access Hospitals operate at a loss, and since 2010, 51 rural hospitals have closed while 283 hospitals are in dire financial shape. Almost a quarter of the U.S. population lives in rural areas. The majority of rural residents are older, poorer, and less likely to have employer sponsored health plans. As a result of hospitals closing in rural communities, many patients end up driving long distances to see a doctor, forgo seeking medical care, or even worse, wait until it is too late to seek proper medical attention. These patients spend more money out of pocket to travel, miss out on routine preventative care, and will end up costing taxpayers much more in the long run. The Committee directs CMS to work with HRSA's Office of Rural Health to alleviate the disproportionate impact of regulations, reimbursement cuts, and workforce issues on rural hospitals.

Action Taken or To Be Taken

CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. In addition, staff from the Federal Office of Rural Health Policy (FORHP) take part in the review of all proposed regulations with a specific charge to analyze the impact on small rural hospitals and other providers. CMS and FORHP staff also meet regularly through the year to discuss the impact of current regulations and seek opportunities to reduce the regulatory and administrative burden on small, rural providers.

Item

State-Based Exchanges (SBEs) - CMS shall ensure that SBEs are not using section 1311 funds for operational expenses which is specifically prohibited by law. SBEs were expected to be self-sustaining by 2015 and were specifically prohibited from using these funds for operational costs after January 1, 2015. The agreement directs CMS to implement the

recommendations put forth by the HHS Office of lnspector General (OIG) in their Early Alert Memorandum (A-0 1-14-02509) issued on April 27, 2015, and expects a detailed report providing an update on these efforts 120 days after enactment of this Act. CMS and the OIG shall immediately notify the Committees on Appropriations of the House of Representatives and the Senate of any unauthorized use of section 1311 funds along with a detailed report, which shall include how CMS plans to recoup those funds from the State.

Action Taken or To Be Taken

CMS takes its responsibility to oversee State-based Marketplaces seriously. CMS reviews the State-based Marketplace's proposed operating budgets to confirm funds are allocated according to federal requirements, and follows established processes to monitor grant spending. Should CMS find any misspent funds in its review of grantee spending, CMS will use remedies available under the law and regulations to recover such funds. Additionally, as suggested by the OIG, CMS has issued formal guidance to State-based Marketplaces to further clarify the difference between operational activities and establishment activities costs. Allowable uses of Section 1311 funds after January 1, 2015 are for establishment activities that were specifically described in the grantee's approved work plan. CMS continues to work in close partnership with the states to provide technical assistance on the use of establishment grant funding and continues to provide guidance to states through webinars and state-specific calls.

Item

Traumatic Injury- The Committee is concerned that CMS has not addressed the need to reform the Medicare reimbursement system for hospital trauma care services. Since CMS withdrew a proposal to bundle all Emergency Department [ED] outpatient reimbursement codes 2 years ago, there has been no progress on modeling alternative value-based reforms- such as a proposal to create three ED outpatient facility codes that would incorporate the trauma activation fee. The Committee directs CMS to include in the fiscal year 2017 CJ a detailed evaluation analyzing alternative value-based reforms such as creating ED outpatient facility codes and other potential approaches that could reimburse facilities for life-threatening, time-dependent traumatic injuries based on a facility's readiness level and the nature of the injury.

Action Taken or To Be Taken

In the calendar year (CY) 2014 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Centers (ASC) rule, CMS proposed to streamline the codes for the five level of outpatient visits including ED visits. CMS did not finalize a proposal to collapse the codes for ED visits, after hearing from stakeholders that the proposal did not reflect the level of care furnished in ED visits. At that time, CMS noted that payment for ED visits, including those for the most complex patients, such as trauma patients, was a compelling issue, for which an alternative payment structure, possibly including more than one payment level, may be warranted and thus did not finalize the proposal to create only one code.

In the CY 2014 OPPS/ASC final rule with comment period, CMS stated that additional study was needed to fully assess the most suitable payment structure for ED visits, including the particular number of visit levels that would not underrepresent resources required to treat the

most complex patients, such as trauma patients. Since that time CMS has maintained the coding structure consisting of five levels for each Type A and Type B ED visits. The current policy also recognizes the resources expended by trauma centers in caring for trauma patients when trauma activation is required by making additional payment to hospitals for trauma activation when it is performed in association with critical care. As part of our annual rulemaking process for CYs 2015 and 2016 CMS deliberated on the issue of hospital payment for ED visits and could not identify an alternative way of structuring payment for ED visits that would meet the needs of Medicare beneficiaries and the hospitals that serve them and accordingly have not proposed further changes. CMS is open to feedback from stakeholders on alternative payment methods for these visits.

Item

Use of Social Security Numbers on Medicare Beneficiaries' Cards- Under Public Law 114-10, Congress prohibits the use of Social Security numbers on Medicare beneficiary cards. The Committee urges CMS to work expeditiously to develop and implement a plan to remove Social Security numbers from Medicare cards and to have this process completed by the end of fiscal year 2018. The Committee directs CMS to provide an update on the process of this initiative in their fiscal year 2017 CJ.

Action Taken or To Be Taken

CMS has begun the process to remove the SSN from Medicare cards and replace it with a randomly-generated identification number, the Medicare Beneficiary Identifier (MBI).

CMS is actively engaging our federal partners, taking inventory of our IT systems impacted by the change, planning our acquisition and communication strategy, and establishing an overall governance structure to ensure effective program management of this mission critical project. CMS recently met with the Social Security Administration (SSA) and the Railroad Retirement Board (RRB) to discuss their roles in removing the SSN from Medicare cards and confer on a preliminary strategy, timeline and assumptions for the project. CMS is scheduling regular meetings with SSA and RRB and will also meet with states and private health plans to coordinate new processes for crossover claims.

This initiative requires extensive systems modification and testing to ensure a seamless transition from the SSN-based Health Insurance Claim Number (HICN) to the MBI. CMS and its partners use the SSN-based identifier as a primary key for data exchanges to perform a variety of functions, including eligibility determinations, enrollment, and claims payment. CMS identified over 60 legacy systems that will require modifications to translate the HICN to the MBI. The SSA will need to modify its eligibility and enrollment systems. Our business partners, such as the Medicare Administrative Contractors (MACs), will need to modify systems to authorize coverage and process claims. And private insurers and States will need to modify their systems to process crossover claims.

Initial high level planning efforts have demonstrated that we have to re-evaluate the key assumptions used to develop the HICN replacement cost estimate and the HICN replacement

implementation road map. Additionally, the CMS IT infrastructure has changed over the last few years and we need to revalidate all impacted systems and their costs. CMS anticipates that this overall landscape evaluation effort, including the time required to vet and concur on alternate operational decisions will occur over the next few months. At the same time, we will begin the initial phases of planning and documenting the required system changes, and modify contracts to implement these changes. Execution and testing of these systems modifications will take an additional 12-18 months. In total, planning for and making these system modifications is expected to occur thru 2017. This timeframe is needed to ensure coordination and readiness with the systems of states, insurers, providers, and every other entity that bills Medicare to avoid disruption to payment processes or beneficiaries' access to care.

Once system modifications are in place, issuing the cards will require an extensive and phased outreach and education program for our beneficiaries as well as providers, private health plans, clearinghouse and other stakeholders. Our communications will need to inform beneficiaries that they will be receiving a new card, instruct them on when and how the new card should be used along with disposal of their old card. We will need to properly staff and train our 1-800-MEDICARE call center representatives during the transition period to respond to questions and concerns about the re-issued card. Additionally, we will inform the Medicare providers of these changes and instruct them on how to use the new identifier to submit claims and other transactions. If problems arise for our providers transitioning from the HICN to the MBI, we need to ensure the MACs are well equipped to respond and help resolve the problems. We must also ensure that private health plans and State Medicaid Agencies are instructed on how to use the MBI so that they can continue their coordination of benefits activities. CMS anticipates that communication activities will begin in January 2018 and continue thru April 2019.

CMS established a Program Management Office (PMO) for this large initiative within CMS's Office of Enterprise Information. The PMO is responsible for establishing and executing a coordinated management infrastructure. CMS has also established a governance structure for the project to ensure that results and benefits are delivered within the agreed time frame and funding levels. Based on the systems and card issuance timeline outlined above, CMS anticipates that it will meet the deadline established in the Medicare Access and CHIP Reauthorization Act (MACRA).

Item

Recovery Audit Contractors (RACs) - The agreement reiterates the fiscal year 2015 explanatory statement language directing HHS to take steps to improve consistency, transparency, and processing of appeals. CMS is encouraged, within the existing authorities, to use offsetting collections it maintains from the RAC program to further educate health care providers on how to reduce errors and take other actions aimed at reducing the backlog of appeals at the Office of Medicare Hearings and Appeals. The agreement expects audits to be conducted in a manner that is valid and statistically sound and requests CMS to continue to monitor the return on investment for compensating auditors on a contingency fee basis, review contractor audit practices, and provide an update on actions related to these items in the fiscal

year 2017 budget request. The agreement reiterates its request for CMS's actuarial data to be included in the annual budget request as noted in the fiscal year 2015 explanatory statement. Finally, CMS is expected to provide the Committees on Appropriations of the House of Representatives and the Senate a quarterly update from the inter-agency working group actions taken or planned to address the various issues related to the RAC process.

Action Taken or To Be Taken

CMS agrees that within the existing authorities, Recovery Audit Program collections should be used to educate health care providers on how to reduce errors and to continue pursuing actions to help reduce the backlog of appeals. CMS is also in agreement that audits must be statistically sound and will continue to monitor the return on investment of the contingency fee payments to Recovery Auditors. In addition, CMS has begun enhancing Recovery Auditor practices through contract modifications and additional guidance, and expects to further enhance the program with the procurement of new contracts.