# DEPARTMENT OF HEALTH AND HUMAN SERVICES


## FISCAL YEAR 2020

# Centers for Medicare & Medicaid Services

***Justification of Estimates for Appropriations Committees***

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

## Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year (FY) 2020 performance budget. In FY 2020, over 145 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Exchanges.

This is a critical time in healthcare - if nothing is done to better control healthcare costs by 2026, we'll be spending one in every five dollars on healthcare. CMS's unique position as the nation's largest healthcare purchaser compels us to take a lead role in moving toward a value-based healthcare delivery system. CMS is building on the successes of the last two years to focus all of its authority and programs on one objective: transforming the healthcare system to deliver better value and results for patients through competition and innovation.

CMS's vision for the year ahead is to create a more competitive American healthcare system that delivers affordable, high quality care, at a sustainable cost. To achieve this, CMS is committed to driving structural changes in our healthcare system that will empower consumers, focus on results, and unleash innovation. CMS is using every lever to create payment structures that will move our health care system toward greater value by rewarding quality and improved health outcomes.

This performance budget reflects CMS's vision by investing in our people, processes, structure, and capabilities. The budget will support initiatives to transform Medicare into an affordable, patient-driven program that encourages innovation and competition. The budget supports tools that permit patient control and provider sharing of secure healthcare data, allowing for better coordination of care and less duplication. Additionally, CMS is proposing to further modernize our programs, address the increasing role of technology in seniors' lives, keep their data safe, and upgrade key information technology systems.

CMS continues to promote states' strong lead role in addressing health issues in their states, as well as maximizing consumer choice and engagement, giving people flexibility to make decisions about what care options are best for them. We offer a seamless consumer experience for those who want coverage through the Exchange, including collaborating with our private partners to offer more ways to apply, enroll, and manage their coverage.

For FY 2020, we are encouraging participation by the states in Medicaid innovation models, while providing CMS with the tools needed to hold states accountable for achieving better health outcomes. CMS will continue to evaluate and streamline regulations to reduce unnecessary burden, allowing providers to spend more time with their patients, and allowing states to drive reforms based on the unique needs of their populations. Finally, we will invest in activities that prevent fraudulent or improper payments and other waste and abuse.

We take seriously our role in leading efforts to improve healthcare quality, accessibility, and outcomes in the most cost-effective manner. The investments proposed in FY 2020 will enable CMS to promote the high quality and efficient healthcare that all Americans deserve.

On behalf of all those we serve, I thank you for your continued support of CMS and its FY 2020 performance budget.

Central Office Org Chart Text Version

Consortia Org Chart Text Version

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

## Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). CMS oversees the two largest Federal health care programs - Medicare and Medicaid - as well as the Children's Health Insurance Program (CHIP) and the Exchanges. CMS' programs will touch the lives of over 145 million beneficiaries and consumers in FY 2020. CMS takes its role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

As a committed steward of public funds, CMS is dedicated to moving toward a health care system that will drive down costs, give Americans more choices, and put patients and doctors in control of their health care. To achieve this, CMS will empower patients and doctors to make decisions about their health care while reducing burdensome regulations and building a patient-centered system of care that increases competition, quality, and access.

CMS works closely with its customers and other stakeholders to provide oversight as well as foster innovation and collaboration. Through such collaboration, CMS will usher in a new era of state flexibility and local leadership. Because the states are in the best position to assess the unique needs of their populations and drive reforms, this shift will result in better health care outcomes.

CMS touches the lives of Americans by providing coverage that offers peace of mind, transforming health care by reducing disparities, strengthening program integrity by reducing fraud, waste, and abuse, and by promoting innovation. CMS supports innovative approaches to improve quality, accessibility, and affordability.

## 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 below displays CMS' FY 2018 Final, FY 2019 Enacted, and FY 2020 Request levels 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. The FY 2020 Budget request reflects a level of funding that will allow CMS to focus on base operations and improve its traditional activities in Medicare, Medicaid, and CHIP.

**CMS Annually-Appropriated Accounts**
**(Dollars in Millions)**

| Accounts | FY 2018 Final | FY 2019 Enacted | FY 2020 Request | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Program Management | $3,964.9 | $3,974.7 | $3,579.4 | ($395.3) |
| HCFAC – Discretionary | $745.0 | $765.0 | $792.0 | $27.0 |
| Grants to States for Medicaid 1/ | $410,017.8 | $411,084.0 | $411,120.3 | $36.3 |
| Payments to Health Care Trust Funds 1/ | $352,597.3 | $391,343.8 | $410,796.1 | $19,452.3 |
| **Grand Total** | **$767,325.0** | **$807,167.5** | **$826,287.8** | **$19,120.3** |

1/ Totals may not add due to rounding. The FY 2019 amounts exclude indefinite authority.

**Key Initiatives**

Value-Based Healthcare

The FY 2020 Budget will help CMS promote a more competitive healthcare system that delivers affordable, high-quality care at a sustainable cost. CMS' goal will be to empower consumers, focus on outcomes, and reform payments. The MyHealthEData initiative will develop tools that permit patient control and provider sharing of healthcare data, allowing for better coordination of care and less duplication. This budget will strengthen the Medicare and Medicaid programs by supporting initiatives to transform Medicare into a more affordable, patient-driven program that encourages innovation and competition, while encouraging participation from states in Medicaid innovation models. This budget will also promote price transparency via program reforms that empower patients to drive value, by providing accurate, comprehensive, and actionable cost information.

Medicaid and CHIP Operations

The FY 2020 Budget fully funds the Medicaid and CHIP Scorecard as well as the Medicaid and CHIP Business Information Solution (MACBIS). Both of these efforts aggregate the operational and programmatic data needed for CMS' program monitoring, technical assistance, and oversight activities, and provide the tools needed to hold states accountable for achieving better health outcomes and results.

Invest in Program Integrity

The FY 2020 Budget proposes a $27.0 million increase over the FY 2019 Enacted level to strengthen the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse, while ensuring that CMS oversight supports, and does not impede efficient, high-quality health care. In recent years, additional funding for the HCFAC program has allowed CMS to shift away from a "pay-and-chase" model toward

identifying and preventing fraudulent or improper payments before they happen. The return on investment for HCFAC law enforcement activities was $4 returned for every $1 expended from 2015 - 2017.

User-Friendly, Secure, and Modern Information Technology (IT)

Recognizing the increasing role of technology in seniors' lives, the FY 2020 Budget continues to fund the Digital Seniors initiative, which focuses on updating Medicare beneficiary resources so seniors can more easily access and navigate the program. Simplified and personalized tools for Medicare beneficiaries will increase functionality, improve the customer experience, and allow for beneficiary self-service. Specifically Medicare.gov and MyMedicare.gov will be consolidated into a single website and updated to include improved plan shopping and enrollment tools, improved care choice tools (provider and facility search), improved account management, and a more personalized experience.

As CMS continues to invest in empowering beneficiaries with technology, we are also working to ensure the security of our data and the integrity of our IT infrastructure. CMS faces a growing cybersecurity threat every day and continues to implement Continuous Diagnostic Monitoring and threat mitigation across our IT landscape. The FY 2020 Budget will expand that work and further efforts toward automating the identification of security compromises, bolstering data center security, and increasing the viability of cloud security.

The FY 2020 Budget will also help modernize some of our core IT systems, including the Medicare Fee-For-Service (FFS) Claims processing systems, which were developed over 30 years ago. These systems, which are written in legacy COBOL and Assembler programing languages, require a fundamental technological system change to ensure that they can continue to support Medicare payments. CMS is developing proofs of concepts that explore how to incrementally modernize, reduce the size and complexity of, and create sustainability for these systems.

**Proposed Law**

The Budget includes $200 million in mandatory Program Management funding to implement a comprehensive package of CMS legislative proposals to carry out Administration reforms to Medicare, Medicaid, and CHIP programs.

National Medicare & You Education Program (NMEP) User Fee

The Budget includes a proposal that allows CMS to assess an increased amount of user fees from Medicare Advantage and Part D plans to more equitably support outreach and enrollment assistance activities provided by the National Medicare Education Program.

Change Medicare Beneficiary Education Requirements

The Budget includes a proposal that provides the Secretary with increased flexibility to determine how to most efficiently and effectively communicate Medicare benefits information included in the Medicare & You Handbook with beneficiaries, including providing information through electronic means as opposed to paper copies in some cases.

Tailor the Frequency of Skilled Nursing Facility Surveys to More Efficiently Use Resources and Alleviate Burden for Top Performing Nursing Homes

The Budget includes a proposal that gives the Secretary authority to adjust statutorily required survey frequencies for top-performing skilled nursing facilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities.

Survey and Certification Re-Visit and Complaint Investigation Fee

The Budget proposes a fee for revisits that occur as a result of deficiencies found during initial certification, recertification, or substantiated complaints surveys. In addition, CMS will also charge facilities a fee for substantiated complaint surveys resulting in findings cited at the level of immediate jeopardy or actual harm. The collections would supplement the Program Management funding for the Survey and Certification program.

Two Year Budget Authority for Survey and Certification

The Budget includes two-year budget authority for the Survey and Certification Program.

Availability of CMS Exchange User Fee

The Budget includes a proposal that allows for user fees collected for the operation of Federally-facilitated Exchanges and State-based Exchanges that use Federal Platform to be used towards any Federal administrative expenses associated with operating Exchange activities. These activities include enrollment eligibility verification, issuer payment activities, quality work, and associated IT.

**FY 2020 Budget Request**

Program Management
In FY 2020, CMS requests $3.6 billion in discretionary funding. CMS' request reflects funding needed to process Medicare claims and service the continued growth in CMS' traditional programs. The request supports CMS' priorities of empowering patients and providers, providing flexibility to State and local communities, supporting innovative approaches to improve quality, accessibility and affordability, and improving the customer experience.

- Program Operations:

  CMS' FY 2020 budget request for Program Operations is $2.4 billion, a decrease of $435.1 million below FY 2019 Enacted. This request will allow CMS to continue operating Medicare, Medicaid, CHIP, and basic CMS support programs. The request includes a General Provision to allow Exchange user fees to cover all Federal administrative expenses associated with operating the Federally-facilitated Exchanges (FFE) and federal platforms leveraged by State-based Exchanges using the Federal Platform (SBE-FPs). Additionally, the request allows CMS to reinvent Medicaid operations by improving data systems and increasing transparency about program administration and outcomes through the Medicaid and CHIP Scorecard initiative. It also funds core outreach and education activities that positively impact the beneficiary experience and CMS' customer service goals and invests in

essential cybersecurity activities. Further, the request includes funding for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS) as well as the Chronic Condition Warehouse (CCW) and several other research related activities. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

- Federal Administration:

  CMS' FY 2020 budget request for Federal Administration is $747.5 million, an increase of $15 million above FY 2019 Enacted. Of this request, $693.9 million supports 4,330 direct FTEs. This is 28 FTEs higher than the FY 2019 level of 4,302. This request assumes a 3.1 percent military cost of living allowance (COLA); however, this request does not assume a civilian 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 2020 budget request for Survey and Certification totals $442.2 million, an increase of $44.9 million above FY 2019 Enacted. This request ensures appropriate survey oversight of all Medicare and Medicaid participating providers, including nursing homes, home health agencies, hospices, hospitals, organ transplant facilities, end-stage renal disease (ESRD) providers, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers, and ambulatory surgery centers. The Budget request also supports 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 Government Accountability Office (GAO). The Budget also proposes a new user fee for the Survey and Certification Program.

Health Care Fraud and Abuse Control

CMS requests $792.0 million in discretionary HCFAC funding in FY 2020, an increase of $27.0 million above the FY 2019 Enacted Level. This funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, and CHIP. This includes ongoing investments in the oversight of Medicare Parts C and D; state-of-the-art analytic technology to detect and prevent improper payments; support for Medicare Strike Forces used to identify and prosecute fraudulent providers; and pre-enrollment provider screening.

In FY 2020, CMS plans to place more emphasis in the following areas: pre-pay claims review with the aid of predictive analytic support; streamlining provider enrollment initiatives and simplifying documentation requirements to more efficiently address fraud and improper payments, while also reducing provider burden; increasing communication and data sharing with internal and external stakeholders; and enhancing States' abilities to detect and deter fraud and abuse. Additionally, CMS' request expands the number of Risk-Adjusted Data Validation (RADV) audits over current operating levels. It also expands CMS' work in notifying providers who prescribe drugs or perform procedures in excess of their peers, as

this can be effective in addressing overutilization and waste. The budget also provides increased resources to fund new and expanded activities outlined in the June 2018 Medicaid Program Integrity Strategy.

Grants to States for Medicaid

The FY 2020 Medicaid request is $411.1 billion, an increase of $36.3 million above the FY 2019 Estimate. Continued increases in grants to states are required as Medicaid enrollment and health care costs continue to grow. This appropriation consists of $273.2 billion for FY 2020 and $137.9 billion in an advance appropriation from FY 2019 Enacted. These funds will help finance $466.1 billion in estimated gross obligations in FY 2020. These obligations consist of:

- $438.8 billion in Medicaid medical assistance benefits;
- $22.5 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2020 request for Payments to the Health Care Trust Funds account totals $410.8 billion, an increase of $19.5 billion above the FY 2019 Enacted level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds, including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are properly chargeable to the General Fund. The change in CMS' request for FY 2020 is largely driven by increases for the General Fund contributions for the SMI Trust Fund and Part D benefits.

## Conclusion

CMS' FY 2020 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 $826.3 billion in FY 2020, an increase of $19.1 billion above the FY 2019 Enacted level.

CMS' FY 2020 total discretionary appropriated request for Program Management is $3.6 billion. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs.

CMS requests $792.0 million in discretionary HCFAC funds. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing fraud and all other improper payments.

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

# Overview of Performance

CMS supports the Administration's goals to make government more effective, efficient, and customer-focused in managing and delivering HHS programs by implementing the Government Performance and Results Act of 1993 (GPRA) and GPRA Modernization Act of 2010 (GPRA-MA). CMS performance measures highlight fundamental program purposes and focus on the agency's role as an efficient and effective steward of taxpayer dollars. This performance budget makes recommendations that are consistent with the Administration's work to advance patient-centered health care and putting people first. We continue to work on aligning our performance commitments to the CMS and HHS strategic goals. CMS continues to track many of its established performance measures, and works to introduce improvements that reflect the Administration's priorities.

CMS uses performance information to identify opportunities for improvement and to shape and improve its programs. The use of performance measures also provides a method of clear communication of CMS programmatic objectives to 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.

The CMS FY 2020 Performance section is designed to create a more complete presentation of performance commitments, accomplishments, and trends which reflects the vision of this Administration.

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

| | FY 2018 Enacted | FY 2019 Enacted | FY 2020 Request | FY 2020 Request +/- FY 2019 Enacted |
|---|---|---|---|---|
| Program Operations | $ 2,814.959 | $ 2,824.823 | $ 2,389.702 | $ (435.121) |
| Federal Administration | $ 732.533 | $ 732.533 | $ 747.533 | $ 15.000 |
| State Survey & Certification | $ 397.334 | $ 397.334 | $ 442.192 | $ 44.858 |
| Research /1 | $ 20.054 | $ 20.054 | $ - | $ (20.054) |
| **Subtotal, Appropriation/BA Current Law (Discretionary; 0511)** | **$ 3,964.880** | **$ 3,974.744** | **$ 3,579.427** | **$ (395.317)** |
| MIPPA (Mandatory; P.L. 110-275) | $ 2.802 | $ 2.814 | $ 3.000 | $ 0.186 |
| PAMA (P.L. 113-93) | $ 5.604 | $ 9.380 | $ 10.000 | $ 0.620 |
| IMPACT (P.L. 113-185) | $ 17.396 | $ 17.470 | $ 5.625 | $ (11.845) |
| MACRA (P.L. 114-10) | $ 152.242 | $ 107.870 | $ 20.000 | $ (87.870) |
| CURES (P.L. 114-255) | $ 11.208 | $ - | $ - | $ - |
| BBA (P.L. 115-123) | $ 12.500 | $ 11.725 | $ - | $ (11.725) |
| SUPPORT (P.L. 115-271) | $ - | $ 3.000 | $ - | $ (3.000) |
| **Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)** | **$ 201.752** | **$ 152.259** | **$ 38.625** | **$ (113.634)** |
| | | | | |
| **Total, Appropriation/BA Current Law (0511)** | **$ 4,166.632** | **$ 4,127.003** | **$ 3,618.052** | **$ (508.951)** |
| Proposed Law Appropriation (Mandatory) | $ - | $ - | $ 200.000 | $ 200.000 |
| **Total, Appropriation/BA Proposed Law (0511)** | **$ 4,166.632** | **$ 4,127.003** | **$ 3,818.052** | **$ (308.951)** |
| *Est. Offsetting Collections from Non-Federal Sources:* | | | | |
| User Fees and Reimbursements, C.L. | $ 235.478 | $ 246.270 | $ 259.400 | $ 13.130 |
| Exchange & Risk Adjustment User Fees, C.L. | $ 1,699.737 | $ 1,853.213 | $ 1,842.200 | $ (11.013) |
| Risk Corridors, C.L. | $ 22.001 | $ - | $ - | $ - |
| Recovery Audit Contracts, C.L. | $ 136.485 | $ 304.850 | $ 335.000 | $ 30.150 |
| **Total Offsetting Collections** | **$ 2,093.701** | **$ 2,404.333** | **$ 2,436.600** | **$ 32.267** |
| **Subtotal, New BA, Current Law /2** | **$ 6,260.333** | **$ 6,531.336** | **$ 6,054.652** | **$ (476.684)** |
| No/Multi-Year Carryforward /3 | $ 732.247 | $ - | $ - | $ - |
| **Program Level, Current Law (0511)** | **$ 6,992.580** | **$ 6,531.336** | **$ 6,054.652** | **$ (476.684)** |
| Proposed Law Discretionary | $ - | $ - | $ - | $ - |
| **Program Level, Proposed Law (0511)** | **$ 6,992.580** | **$ 6,531.336** | **$ 6,254.652** | **$ (276.684)** |
| | | | | |
| **HCFAC Discretionary** | **$ 745.000** | **$ 765.000** | **$ 792.000** | **$ 27.000** |
| **Non-CMS Administration /4** | **$ 2,636.000** | **$ 2,703.000** | **$ 2,682.000** | **$ (21.000)** |
| **CMS FTEs:** | | | | |
| Direct (Federal Administration) | 4,341 | 4,302 | 4,330 | 28 |
| Reimbursable (CLIA, CoB, RAC, Exchange) | 252 | 300 | 380 | 80 |
| **Subtotal, Program Management FTEs** | **4,593** | **4,602** | **4,710** | **108** |
| Affordable Care Act (Mandatory) | 13 | 14 | 14 | 0 |
| ARRA Implementation (Mandatory) | 69 | 61 | 61 | 0 |
| Other Direct (PAMA, IMPACT, MACRA) (Mandatory) | 67 | 78 | 78 | 0 |
| **Total, Program Management FTEs, Current Law** | **4,742** | **4,755** | **4,863** | **108** |
| Program Management, Proposed Law | 0 | 0 | 0 | 0 |
| **Total, Program Management FTEs** | **4,742** | **4,755** | **4,863** | **108** |
| Affordable Care Act (Mandatory) | 540 | 600 | 600 | 0 |
| Exchanges | 24 | 0 | 0 | 0 |
| HCFAC Mandatory | 387 | 426 | 426 | 0 |
| Medicaid Integrity (State Grants; Mandatory) | 188 | 205 | 205 | 0 |
| Demonstrations | 12 | 14 | 14 | 0 |
| QIO | 236 | 230 | 168 | -62 |
| **Total, CMS FTEs** | **6,129** | **6,230** | **6,276** | **46** |

/1 In FY 2020, CMS is requesting Research funding within the Program Operations account.

/2 Includes user fees and reimbursables supporting CMS program management. Reflects collections post-sequester and pop up.

/3 Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.

/4 Includes funds for the SSA, DHHS/OS, and SHIPs.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Centers for Medicare & Medicaid Services
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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 *&* Medicaid Services, not to exceed **[**$3,974,744,000**]** *$3,579,427,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;* together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 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 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 [2019] *2020* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: *Provided further, That of the funds made available under this heading, $442,192,000, to remain available until September 30, 2021, shall be available for the Survey and Certification Program*.

# Program Management

## Language Analysis

| Language Provision | Explanation |
|---|---|
| For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,974,744,000**]** *$3,579,427,000*, 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 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 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 **[**2019**]** *2020* 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. |

| **Language Provision** | **Explanation** |
| --- | --- |
| *Provided further,* That of the funds made available under this heading, $442,192,000, to remain available until September 30, 2021, shall be available for the Survey and Certification Program. | Extends the period of availability of Survey and Certification funding to two-year. |

## General Provisions

| Language Provision | Explanation |
| --- | --- |
| *SEC. XXX. Notwithstanding Sec. 1864 (e) of the Social Security Act (42 U.S.C. 1395aa(e)), the Secretary of Health and Human Services shall charge health care facilities or entities fees in cases where such facilities or entities have been cited for deficiencies during initial certification, recertification, or substantiated complaint surveys to cover all or a portion of the costs incurred for conducting substantiated complaint surveys and revisit surveys on such health care facilities or entities. Such fees shall be in addition to any other funds available for conducting such surveys and shall be credited to the "Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management" account, to remain available until expended for such purpose. No such fees shall be charged to an Indian Health Program (as that term is defined in section 4 of the Indian Health Care Improvement Act).* | Authorizes the collection of user fees from providers who had previously been cited for deficiencies in care, and required a revisit, as well as facilities that experience a substantiated complaint survey that result in immediate jeopardy or actual harm. 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. *Collections are not assumed in the budget in FY 2020.* |
| *SEC. XXX. For fiscal year 2020 and each subsequent fiscal year, the notification requirements described in sections 1804(a) and 1851(d) of the Social Security Act may be fulfilled by the Secretary in a manner similar to that described in paragraphs (1) and (2) of section 1806(c) of such Act.* | Authorizes the Secretary to allow beneficiaries to opt to receive the Medicare & You Handbook and the Medicare Advantage open season notification through electronic means rather than through the mail. This is a modernization and efficiency measure that would decrease the number of Handbooks that are mailed and would reduce the substantial cost of mailing Medicare & You Handbooks to millions of beneficiaries annually. Any beneficiary who wants the |

## **General Provisions** (continued)

**Language Provision**

SEC. XXX. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program, in addition to any other purposes authorized by law: Provided, That such collections shall be credited to the "Centers for Medicare and Medicaid Services—Program Management" account and shall remain available until expended for the purposes described in this section.

**Explanation**

This provision allows for user fees collected for the operation of Federally-Facilitated Exchanges and State-Based Exchanges that use the Federal Platform to be used on any federal administration Exchange-related operating activity. Currently, activities that CMS conducts on behalf of all Exchanges are not eligible to be paid for by user fees. These activities include enrollment eligibility verification, issuer payment activities, quality work, and associated IT.

## CMS Program Management
**Amounts Available for Obligation**

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget |
|---|---|---|---|
| **Trust Fund Discretionary Appropriation:** | | | |
| Appropriation (L/HHS) | $3,964,880,000 | $3,974,744,000 | $3,579,427,000 |
| **Trust Fund Mandatory Appropriation:** | | | |
| PAMA/SGR (PL 113-93) | $5,604,000 | $9,380,000 | $10,000,000 |
| IMPACT Act (PL 113-185) | $17,395,750 | $17,470,250 | $5,625,000 |
| MACRA (PL 114-10) | $152,242,000 | $107,870,000 | $20,000,000 |
| 21st Century Cures (PL 114-255) | $11,208,000 | $0 | $0 |
| BBA (PL 115-123) | $12,500,000 | $11,725,000 | $0 |
| SUPPORT (PL 115-271) | $0 | $3,000,000 | $0 |
| Subtotal, trust fund mand. Appropriation 1/ | $198,949,750 | $149,445,250 | $35,625,000 |
| **Mandatory Appropriation:** | | | |
| MIPPA (PL 110-275) | $2,802,000 | $2,814,000 | $3,000,000 |
| Subtotal, trust fund mand. Appropriation 1/ | $2,802,000 | $2,814,000 | $3,000,000 |
| **Offsetting Collections from Non-Federal Sources:** | | | |
| CLIA user fees | $31,165,766 | $32,830,000 | $40,000,000 |
| Coordination of benefits user fees | $42,936,541 | $44,086,000 | $48,000,000 |
| MA/PDP user fees | $82,418,500 | $88,331,200 | $89,400,000 |
| Sale of data user fees | $49,247,383 | $50,000,000 | $50,000,000 |
| Provider enrollment user fees | $29,710,103 | $31,023,106 | $32,000,000 |
| Exchange user fees | $1,662,585,242 | $1,805,204,766 | $1,803,200,000 |
| Risk adjustment | $37,151,591 | $48,007,773 | $39,000,000 |
| Recovery audit contracts | $136,485,420 | $304,850,000 | $335,000,000 |
| Risk corridors | $22,001,246 | $0 | $0 |
| Other | $0 | $0 | $0 |
| Subtotal, offsetting collections 2/ | $2,093,701,792 | $2,404,332,845 | $2,436,600,000 |
| **Total Budget Authority** | **$6,260,333,542** | **$6,531,336,095** | **$6,054,652,000** |

1/ Current law display. Net of sequester in FY 2018 and FY 2019.

2/ FY 2018 and FY 2019 are net of sequester and pop-up authority. FY 2020 show gross estimated collections.

**Summary of Changes**

| | |
|---|---|
| **2019** | |
| Total estimated budget authority 1/ | $3,974,744,000 |
| (Obligations) 1/ | ($3,974,744,000) |
| **2020** | |
| Total estimated budget authority 1/ | $3,579,427,000 |
| (Obligations) 1/ | ($3,579,427,000) |
| **Net Change** | **($395,317,000)** |

| | FTE | 2019 Estimate Budget Authority | FTE | Change from Base Budget Authority |
|---|---|---|---|---|
| **Increases:** | | | | |
| A. Built-in: | | | | |
| 1. Pay Raise | | | | $0 |
| 2. Annualization of Pay Raise | | | | $0 |
| **Subtotal, Built-in Increases 1/** | | | | **$0** |
| B. Program: | | | | |
| 1. Program Operations | | $2,824,823,000 | | $229,057,000 |
| 2. Federal Administration | | $732,533,000 | | $15,000,000 |
| 3. State Survey & Certification | | $397,334,000 | | $45,738,000 |
| 4. Research | | $20,054,000 | | $0 |
| **Subtotal, Program Increases 1/** | | | | **$289,795,000** |
| **Total Increases 1/** | | | | **$289,795,000** |
| **Decreases:** | | | | |
| A. Built-in: | | | | $0 |
| 1. One Day Less Pay | | | | $0 |
| **Subtotal, Built-in Decreases 1/** | | | | **$0** |
| B. Program: | | | | |
| 1. Program Operations | | $2,824,823,000 | | ($664,178,000) |
| 2. Federal Administration | 4,302 | $732,533,000 | 28 | $0 |
| 3. State Survey & Certification | | $397,334,000 | | ($880,000) |
| 4. Research | | $20,054,000 | | ($20,054,000) |
| **Subtotal, Program Decreases 1/** | | | | **($685,112,000)** |
| **Total Decreases 1/** | | | | **($685,112,000)** |
| **Net Change 1/** | | | | **($395,317,000)** |

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.

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

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget |
|---|---|---|---|
| **1. Program Operations** | $2,509,959 | $2,519,823 | $2,389,702 |
| 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 | $10,000 | $10,000 |
| IMPACT Act (PL 113-185) | $13,000 | $13,000 | $0 |
| MACRA (PL 114-10) | $163,000 | $115,000 | $20,000 |
| 21st Century Cures (114-255) | $12,000 | $0 | $0 |
| BBA (115-123) | $12,500 | $12,500 | $0 |
| SUPPORT (115-271) | $0 | $3,000 | $0 |
| Sequester | ($13,002) | ($9,517) | $0 |
| **Subtotal, Program Operations** | **$3,011,457** | **$2,971,806** | **$2,422,702** |
| (Obligations) | ($3,105,899) | ($3,024,823) | ($2,314,702) |
| **2. Federal Administration** | $732,533 | $732,533 | $747,533 |
| Sequester | $0 | $0 | $0 |
| **Subtotal, Federal Administration** | **$732,533** | **$732,533** | **$747,533** |
| (Obligations) 1/ | ($748,619) | ($732,533) | ($747,533) |
| **3. State Survey & Certification** | $397,334 | $397,334 | $442,192 |
| IMPACT Act (PL 113-185) | $5,625 | $5,625 | $5,625 |
| Sequester | ($371) | ($349) | $0 |
| **Subtotal, State Survey & Certification** | **$402,588** | **$402,610** | **$447,817** |
| (Obligations) 1/ | ($408,867) | ($402,610) | ($447,817) |
| **4. Research, Demonstration & Evaluation** 2/ | $20,054 | $20,054 | $0 |
| Sequester | $0 | $0 | $0 |
| **Subtotal, Research, Demonstration & Evaluation** | **$20,054** | **$20,054** | **$0** |
| (Obligations) | ($19,963) | ($20,054) | $0 |
| **5. User Fees** | $1,959,814 | $2,106,100 | $2,101,600 |
| Sequester | ($126,099) | ($127,478) | $0 |
| Sequester Pop-Up | $101,499 | $120,861 | $0 |
| **Subtotal, User Fees** | **$1,935,214** | **$2,099,483** | **$2,101,600** |
| (Obligations) | ($1,498,100) | ($1,895,499) | ($1,424,605) |
| **6. Recovery Audit Contracts** | $146,130 | $325,000 | $335,000 |
| Sequester | ($9,645) | ($20,150) | $0 |
| **Subtotal, Recovery Audit Contracts** | **$136,485** | **$304,850** | **$335,000** |
| (Obligations) | ($89,632) | ($79,750) | ($85,000) |
| **7. Risk Corridors** | $22,001 | $0 | $0 |
| Sequester | $0 | $0 | $0 |
| **Subtotal, Risk Corridors** | **$22,001** | **$0** | **$0** |
| (Obligations) | $0 | $0 | $0 |
| **Total, Budget Authority** /3 | **$6,260,332** | **$6,531,336** | **$6,054,652** |
| **(Obligations)** | **($5,871,080)** | **($6,155,269)** | **($5,019,657)** |
| **FTE** /4 | **4,593** | **4,602** | **4,710** |

1/ Where obligations exceed budget authority, mandatory carryforward is the source of BA which is not reflected on the table.
2/ In FY 2020, the Research request is included in Program Operations.
3/ Reflects CMS' current law request.
4/ Includes direct and reimbursable FTEs only.

**CMS Program Management**
**Authorizing Legislation**

| | FY 2019 Amount Authorized | FY 2019 Enacted | FY 2020 Amount Authorized | FY 2020 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. Exchanges:** | | | | |
| 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 | $ - | $ - | $ - | $ - |
| Total request level against definite authorizations | $ - | $ - | $ - | $ - |

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2020.
2/ Limits authorized user fees to an amount computed by formula.

**CMS Program Management**
**Appropriations History Table**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **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 | $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 | $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 | $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 | $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 | $3,974,744,000 |
| 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 | $4,468,758,000 |
| 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 **1/** | $4,199,744,000 | $0 | $0 | $3,974,744,000 |
| 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 | $4,602,728,200 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| Sequestration | $0 | $0 | $0 | ($10,220,000) |

**CMS Program Management**
**Appropriations History Table**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **2016** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($204,000) |
| Trust Fund Appropriation: | | | | |
| Base **1/ 3/** | $4,245,186,000 | $0 | $0 | $3,970,785,000 |
| 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 | $4,517,588,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $65,000,000 |
| Sequestration | $0 | $0 | $0 | ($4,420,000) |
| **2017** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($207,000) |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $4,109,549,000 | $0 | $0 | $3,974,744,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $21,333,000 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $211,000,000 |
| 21st Century Cures (PL 114-255) | $0 | $0 | $0 | $18,000,000 |
| Sequestration | $0 | $0 | $0 | ($16,444,977) |
| Subtotal | $4,109,549,000 | $0 | $0 | $4,214,632,023 |
| **2018** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($198,000) |
| Trust Fund Appropriation: | | | | |
| Base **1/ 3/** | $3,587,996,000 | $3,451,141,000 | $3,974,744,000 | $3,964,880,000 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $163,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $18,625,000 |
| 21st Century Cures Act (PL 114-255) | $0 | $0 | $0 | $12,000,000 |
| BB Act '18 (PL 115-123) | $0 | $0 | $0 | $12,500,000 |
| Sequestration | $0 | $0 | $0 | ($13,175,250) |
| Subtotal | $3,587,996,000 | $3,451,141,000 | $3,974,744,000 | $4,152,505,000 |
| **2019** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | $0 |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $3,543,879,000 | $3,502,024,000 | $3,974,744,000 | $3,974,744,000 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $10,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $115,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $18,625,000 |
| BB Act '18 (PL 115-123) | $0 | $0 | $0 | $12,500,000 |
| SUPPORT Act (PL 115-271) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($9,679,750) |
| Subtotal | $3,543,879,000 | $3,502,024,000 | $3,974,744,000 | $4,124,189,250 |

**CMS Program Management**
**Appropriations History Table**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **2020** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | $0 |
| Trust Fund Appropriation: | | | | |
| Base **2/** | $3,579,427,000 | $0 | $0 | $0 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $10,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $20,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $5,625,000 |
| Sequestration | $0 | $0 | $0 | $0 |
| Subtotal | $3,579,427,000 | $0 | $0 | $35,625,000 |

**1/** Base appropriation includes $305 million to support Program Management activity related to the Medicare Program.
**2/** Based on Current Law Request
**3/** Reduced to reflect secretary's transfer.

# 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 2020 |
|---|---|---|---|---|

CMS Program Management has no appropriations not authorized by law.

# Program Operations
(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 (+/-) FY 2019 |
|---|---|---|---|---|
| BA | $2,814,959 | $2,824,823 | $2,389,702 | ($435,121) |

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

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

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

**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 2019 Authorization** – One Year/Multi-Year P.L. 115-245

**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; the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels; and the consumer based Health Insurance Exchanges.

Program Operations primarily funds the processing of Medicare Fee-For-Service (FFS) claims, the National Medicare Education program, and information technology (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 and oversight.

As the primary account funding the operations for CMS' programs, Program Operations plays a direct role in funding the operations for CMS' healthcare programs and achieving the Agency's strategic priorities, by promoting efficiency in health care, reforming the health care delivery system, decreasing medical costs and payment error rates, creating a more efficient Medicare appeals system, and reducing burdens and regulations to those who serve our beneficiaries.

## 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 ESRD. 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 a projected 63 million beneficiaries in FY 2020. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized. The Medicare administrative expenses discussed in this chapter are funded annually through the CMS Program Management appropriation.

For Medicare Parts A and B, CMS processes providers' claims, funds beneficiary outreach and education, maintains the IT infrastructure needed to support various claims processing systems, and make improvements to programs 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), and others.

For Medicare Parts C and D, CMS funds certification of payments, operational support for programs such as Medicare claim appeals, oversight and monitoring functions, and audits of 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 provides health care coverage to low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other adults. Medicaid also provides community based long-term care services and supports 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. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid systems support, managed care review and oversight, 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 younger than 19 years of age.

## Private Health Insurance Protections and Programs

CMS conducts market oversight of Qualified Health Plans (QHPs) and works in collaboration with states and issuers on Medical Loss Ratio (MLR) rules, oversight of State-based Exchanges (SBEs), financial assistance eligibility determination, and risk adjustment. In states that have elected not to operate SBEs, CMS operates Federal Exchanges on their behalf.

### Program Operations Funding History

| Fiscal Year (FY) | Budget Authority |
|---|---|
| FY 2016 | $2,824,823,000 |
| FY 2017 | $2,816,393,000 |
| FY 2018 | $2,814,959,000 |
| FY 2019 Enacted | $2,824,823,000 |
| FY 2020 President's Budget | $2,389,702,000 |

### Budget Request: $2,389.7 Million

CMS' FY 2020 Budget request for Program Operations is $2,389.7 million, a decrease of $435.1 million below the FY 2019 Enacted Level. This request will allow CMS to efficiently operate Medicare, Medicaid, CHIP, and other CMS support programs. This request assumes a general provision to expand the purpose of Exchange user fees to cover all federal administrative expenses associated with operating the Federally- Facilitated Exchange (FFE) and federal platforms leveraged by State-based Exchanges on the Federal Platform (SBE-FPs). Additionally, the request allows CMS to reinvent Medicaid operations by improving data systems and increasing transparency about program administration and outcomes through the Medicaid and CHIP Scorecard initiative. The request also funds core outreach and education activities that positively impact the beneficiary experience and CMS' customer service goals and invests in essential cybersecurity activities. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

**Program Operations**
(Dollars in Millions)

| Activity | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 (+/-) FY 2019 |
|---|---|---|---|---|
| **Program Operations** | | | | |
| **I. Medicare Parts A&B** | | | | |
| Ongoing Operations | $884.881 | $865.005 | $865.676 | $0.671 |
| FFS Operations | $89.715 | $107.131 | $74.575 | ($32.556) |
| Claims Processing Investments | $73.490 | $78.946 | $78.946 | $0.000 |
| DME Competitive Bidding | $10.923 | $2.058 | $16.186 | $14.128 |
| **II. Other Medicare Operational Costs** | | | | |
| Accounting and Audits | $122.307 | $99.056 | $99.597 | $0.541 |
| QIC Operations | $87.922 | $80.103 | $85.728 | $5.625 |
| HIPAA Administrative Simplification | $25.389 | $29.387 | $22.212 | ($7.175) |
| Research /1 | $20.054 | $20.054 | $20.054 | $0.000 |
| **III. Medicaid & CHIP** | | | | |
| Medicaid & CHIP Operations | $106.365 | $107.237 | $102.668 | ($4.569) |
| **IV. Health Care Planning & Oversight** | | | | |
| Part C&D IT Systems Investments | $35.935 | $33.409 | $29.792 | ($3.617) |
| Oversight & Management | $54.604 | $58.733 | $60.387 | $1.654 |
| Exchanges | $587.238 | $247.865 | $0.000 | ($247.865) |
| **V. Health Care Quality** | | | | |
| Health Care Quality | $35.201 | $40.018 | $39.021 | ($0.998) |
| Medicare Quality Improvement and Value-Based Transformation | $0.000 | $0.000 | $175.000 | $175.000 |
| **VI. Outreach & Education** | | | | |
| NMEP | $262.768 | $265.294 | $265.294 | ($0.000) |
| Consumer Outreach | $5.627 | $6.670 | $4.500 | ($2.170) |
| **VII. Information Technology** | | | | |
| IT Systems and Support | $427.594 | $556.523 | $440.066 | ($116.457) |
| **VIII. Other Initiatives** | | | | |
| Innovation and Modernization Effort | $0.000 | $232.388 | $0.000 | ($232.388) |
| Opioids | $5.000 | $15.000 | $5.000 | ($10.000) |
| Medicare Device Innovation | $0.000 | $0.000 | $5.000 | $5.000 |
| **TOTAL /2** | **$2,814.959** | **$2,824.823** | **$2,389.702** | **($435.121)** |

**/1** CMS is requesting for research to be funded under the Program Operations account in FY 2020. The FY 2018 and FY 2019 amounts are shown for display purposes only and do not add into FY 2018 and FY 2019 program operation totals.

**/2** Totals may not add due to rounding.

## I. MEDICARE - PARTS A AND B

### Program Description and Accomplishments

**Ongoing Operations**

CMS processes beneficiary claims through Medicare Administrative Contractors (MACs). A MAC is a private healthcare insurer that has been awarded a geographical jurisdiction to process Medicare Part A and B medical claims or durable medical equipment claims for Medicare. In addition to processing Part A and Part B claims, MACs enroll providers in the Medicare program, handle provider reimbursement services, process first-level appeals, respond to provider inquiries, educate providers about the program, and administer the participating physician/supplier program (PARDOC). The MACs are the primary contracts for managing Medicare and are mission critical for the success of CMS.

The following table displays claims volumes for the period FY 2017 to FY 2020.

**FFS Claims Volume**
(Claim Count in Thousands)

| Claims Volume Table | | | | |
|---|---|---|---|---|
| **Activity** | **FY 2017 Actual** | **FY 2018 Actual** | **FY 2019 Estimate** | **FY 2020 Estimate** |
| Part A (in thousands) | 220.969 | 221.783 | 224.001 | 226.241 |
| Part B (in thousands) | 1,001.437 | 1,004.868 | 1,014.917 | 1,025.066 |
| **Total** | **1,222.406** | **1,226.651** | **1,238.918** | **1,251.307** |

**Budget Request: $865.7 Million**

The FY 2020 budget request for Ongoing Operations is $865.7 million, an increase of $0.7 million above the FY 2019 Enacted Level. This request allows the MACs to continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS' program requirements. The funding accounts for a one percent increase in the MAC workload and will also support various provider service operations.

In FY 2020, MACs are expected to:

- Process approximately 1.3 billion claims;
- Handle 2.3 million Medicare first-level appeal redeterminations;
- Answer 22.7 million toll-free inquiries.

The MACs activities are described in more detail below.

*Bills/Claims Payments* – The MACs are responsible for processing and paying approximately 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, durable medical equipment suppliers, clinical laboratories, and other providers and suppliers. 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.

*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, indirect medical education, disproportionate share hospital, and bad debt payments. The MACs perform many other payment review activities, maintain claims information systems, and are responsible for making determinations of status.

*Medicare Appeals* – The Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse 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 to determine if the original determination should be changed, and handle any reprocessing activities as required. The statute contemplates that MACs issue a decision within 60 calendar days of receipt of an appeal request. In FY 2018, FY 2019, and FY 2020, the MACs are expected to process 2.3 million redeterminations each fiscal year. The FY 2020 estimate reflects minimal growth in the number of redeterminations experienced in prior fiscal years.

*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 monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows.

*Provider Inquiries and Toll-Free Service* – 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.

Costs for the Provider Contact Center are primarily driven by the number of minutes of telephone service, which are projected to remain flat in FY 2020. Other costs include toll-free lines, support contracts, answering inquiries and customer service representatives.

In FY 2020, contractors are expected to respond to 22 million telephone inquiries and a half-million written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. In an effort to drive efficiency, the contractors utilized Interactive Voice Response (IVR) systems to automate approximately more than 50 percent of their telephone inquiries. Increased utilization of the IVR frees up customer service

representatives to handle the more complex questions.

The following table displays provider toll-free line call volumes for FY 2017-2018 (actual) and FY 2019-2020 (estimated):

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

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Completed Calls | 25.8 | 22.5 | 22.7 | 22.7 |

*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.

*MAC Transition Cost* – Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B FFS claims contracting under a single contract authority, known as a MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR). CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2020, CMS has scheduled the re-procurements of the A/B MAC Jurisdiction J5, J6, JE, and DME MAC Jurisdiction JC contracts.

*Ongoing Operations Support Activities* – The National Provider Education, Outreach, and Training initiative is responsible for the development of MLN Matters articles and other education products for providers. 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 which results in reduced costs associated with MACs and ROs developing their own materials. MLN products are commonly developed in response to recommendations in OIG and GAO reports. Funding will support the development and dissemination of Medicare FFS educational information on Medicare policy and operations. This funding also supports fulfillment activities related to requests for hard copy products and other operational support to perform related outreach and education.

**Fee-for-Service Operations and System Support**

This account serves as the primary operations support center for the management of Medicare Parts A and B. These contracts support a myriad of critical functions centered on improving Part A and Part B FFS information, education, service initiatives, coverage and payment policies, health care quality, and general administrative and legislative actions. Many of these activities promote accountability, communication, coordination and aid the

decision-making for programmatic and functional issues across the organization. These activities help to ensure the effective management of CMS' programs.

**Budget Request: $74.6 Million**

The FY 2020 budget request for FFS operations support is $74.6 million, a decrease of $32.6 million below the FY 2019 Enacted Level. In FY 2019, CMS is implementing one-time changes to the Medicare Part A and Part B operation support contracts, such as IT Modernization, IT Security, Provider Burden reduction efforts, workload simplification, price transparency, and other priorities to accomplish CMS' mission. These one-time investments represent the decrease from FY 2019 to FY 2020. The FY 2020 request funds several additional critical services supporting the Medicare FFS program. These include:

- *Printing and Postage*: $12.6 million. 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 premiums for beneficiaries who may not receive a monthly Social Security Administration, Office of Personnel Management, or Railroad Retirement Board benefit check from which the premiums are deducted and are not part of a State Buy-in Agreement or Formal Group Payer Arrangement. This funds CMS' ongoing FFS printing and postage needs.

- *IT Systems*: $8.2 million. CMS hosts many systems to aid in managing contracts for FFS, to automate the change management process, and other electronic data interchanges. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), eChimp system, and Common Electronic Interchange System (CEDI).

- *Payment Policy Development Support*: $4.1 million. CMS performs program monitoring and payment system analysis across Medicare programs to monitor the effects of program policy changes on healthcare utilization and outcomes for Medicare beneficiaries, investigate technical payment questions to support policy development and identify aberrant behavior to enhance payment integrity of the Medicare program. This request supports the ongoing analysis of claims data for potential refinements, ad hoc analysis, modeling payments and impacts that may result in policy changes to existing payment systems and support of regulatory development.

- *Minority Health Initiatives:* $1.8 million. The CMS Rural Health Council was established to develop long-term solutions for health care challenges and access issues in rural America. The council developed a strategic plan to make health care in rural America more affordable, accessible, and accountable. The funding supports continued implementation and evaluation of the strategic plan.

- *Medicare Appeals Initiatives*: $7.0 million. As part of the Department's effort to improve the Medicare appeals process and address the pending backlog of appeals at Administrative Law Judge and Departmental Appeals Board levels (levels 3 and 4), CMS continues to explore initiatives to resolve appeals. To effectively manage these initiatives, CMS will require external support and additional funding for its Medicare Administrative Contractors for effectuation.

- *Home Health PPS Refinement*: $1.3 million. Section 5012 of the 21st Century CURES Act introduces a new Medicare home infusion therapy benefit set to begin in 2021. Medicare will make a single payment for professional and nursing services, training and education, remote monitoring, and monitoring services for providing home infusion therapy and drugs. This funding will provide for contractor support to analyze data of the home infusion industry to evaluate the scope of the benefit and identify the best and most efficient way to develop the regulation.

- *A-123 Internal Controls Assessment*: $2.0 million. 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 also requires the Administrator to submit a statement of assurance on internal controls over financial reporting. Funding supports a certified public accountant firm to conduct a rigorous assessment of the CMS internal controls over financial reporting. This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors.

- *Medicare Cures Act Support:* $1.0 million. The 21st Century Cures Act requires expanded use of telehealth technology and home infusion therapy for Medicare beneficiaries. CMS requires support to oversee the national implementation of new regulations promulgated under the Cures Act and contract support to aid in education and training, technical assistance, and an evaluation of the findings.

- *Cost Contract Audits*: $2.4 million. CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit efforts to comply with the FAR and Departmental Supplemental Regulations (HHSAR). The GAO and HHS OIG have identified CMS' lack of compliance with the FAR and HHSAR regarding mandatory audits and proper internal controls. This funding supports the effort needed to perform audits required by law during the contract acquisition life cycle to comply with FAR and HHSAR.

- *Medicare Beneficiary Ombudsman*: $1.9 million. 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, appeals, and to provide recommendations for improvement in the administration of the Medicare program. This 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.

- *Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures*: $1.2 million. This funding provides for the proper oversight and management of Medicare Advantage 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. CMS will work on developing and testing new quantifiable outcome measures that will provide more specific information about Medicare Advantage plans' (including SNPs) ability to provide a high level of care coordination and its impact on enrollee health outcomes. 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.

- *Actuarial Services*: $1.2 million. This contract provides additional actuarial services, including modeling, for the numerous requests that the Office of the Actuary is unable to handle due to time constraints and staff shortages. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other statutorily required issues.

- *Prototypic Share Services:* $0.9 million. The funding is for ongoing operations and licensing costs to launch a single sign-on authorization through integration with CMS Enterprise Identify Management and Enterprise Portal (ePortal) shared services while utilizing the Salesforce platform.

- *Other Operational Costs:* $29.0 million. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

**Claims Processing Systems**

CMS' claims processing systems process nearly 1.3 billion Part A and Part B claims each year. The claims processing systems receive, verify, and log claims and adjustments, perform internal claim edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The requested funding provides ongoing systems maintenance and operations.

**Budget Request: $78.9 Million**

The FY 2020 budget request for claims processing systems is $78.9 million, flat with the FY 2019 Enacted Level. In FY 2020, CMS will continue to 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 MAC functionality for the Medicare Program. During FY 2019, CMS began updating the Medicare Beneficiary Database and the Enrollment Database Suite of Systems legacy application to a modern cloud based architecture. In FY 2020, CMS plans to invest $5.7 million in a micro-modernization strategy for outdated claims processing infrastructure.

The main systems include:

- *Part A, Part B and DME Claims 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 Medicare fee-for-service claims processing systems in a fully-integrated, production-like approach

that includes data exchanges with all key systems. This program 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 FFS program, processing millions of Medicare claims each year. This shared system processes Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the CWF System for verification, validation, and payment authorization. FISS must also implement changes needed to support the MAC authority for the Original Medicare 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.

- *FFS Micro-Modernization* – In FY 2020, CMS will continue to develop a framework for incrementally modernizing all the FFS systems by introducing new tools, technologies, and processes into the FFS ecosystem. In FY 2020, CMS is developing proofs of concepts that explore how to modernize our software on both the mainframe and in the cloud. Our goals are to improve the agility, velocity, and sustainability of FFS Systems. The $5.7 million investment will be used to implement the proofs of concepts that deliver the greatest value to CMS, and implement efforts to reduce the size and complexity associated with these large claims processing systems. CMS will migrate key pieces of software from the mainframe to the cloud. Improving the agility and velocity of this suite of claims processing systems will shift the culture of existing development and change management techniques to a more agile framework.

**DME Competitive Bidding**

Section 302(b)(1) of the Medicare Modernization Act (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. The Medicare Improvements for Patients and Providers Act (MIPPA) and the Affordable Care Act (ACA) subsequently amended and expanded the program to cover 100 MSAs. ACA also mandated that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

**Budget Request: $16.2 Million**

The FY 2020 budget request for DME competitive bidding is $16.2 million, an increase of $14.1 million above the FY 2019 Enacted Level. The DMEPOS Competitive Bidding program is going through technical changes proposed by the Administration. CMS published a final rule on November 1, 2018 that requires changes to the DMEPOS Competitive Bidding Program. CMS is developing a funding plan consistent with the new

program design and in the interim, there will be a temporary gap in the entire DMEPOS Competitive Bidding Program that CMS expects will last until December, 2020.

- *Competitive Bidding Implementation Contractor (CBIC):* $15.0 million. Given the temporary gap in the competitive bidding program, CMS will need to continue the preparation activities for the next round of bidding which is anticipated to begin on January 1, 2021. The FY 2020 budget request represents the estimated need for preparation activities, such as outreach and education, bidding activities to include evaluation, inquiry review, and supplier contract award process, and also the CBIC secure portal and technical help desk for the next round of bidding.

- *DME Bidding Systems (DBidS)*: $1.2 million. CMS will invest in mitigating end-of-life software, addressing aging technologies, and adapting to policy changes and transitions. Transition requirements include development, enhancements, and operations and maintenance.

## II. OTHER MEDICARE OPERATIONAL COSTS

### Program Description and Accomplishments

### Accounting and Audits

The Healthcare Integrated General Ledger Accounting System (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 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.

### Budget Request: $99.6 Million

The FY 2020 budget request for HIGLAS and the CFO audit is $99.6 million, an increase of $0.5 million above the FY 2019 Enacted Level. In FY 2020, CMS will support the production and application maintenance of HIGLAS.

- *HIGLAS*: $88.2 million. This funding supports operations and maintenance costs for HIGLAS. HIGLAS implementation strengthened the federal government's fiscal management and program operations of the Medicare program. HIGLAS was a critical success factor in CMS and HHS achieving compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. In addition, HIGLAS contributes towards HHS' ability to retain a "clean" audit opinion as required by the Chief Financial Officer's (CFO) Act.

HIGLAS is a mission critical application enabling CMS to manage program accounting for its business operations. It is the largest Oracle Federal Financial System based on the 4.5 million transactional claim records and the payments equating to over $1.4 trillion in gross outlays in FY 2018 alone. HIGLAS continues to enhance CMS' oversight of all financial operations in order to achieve reliable, auditable, timely financial accounting, and reporting for all of CMS' programs and activities.

The HIGLAS effort has improved significantly the ability of CMS/HHS to perform Medicare accounting transactions. Some of these improvements 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 overpayments. Moreover, CMS now has better internal financial controls across Medicare contractor operations. Maintaining a state-of-the-art financial system like HIGLAS has a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. In addition, HIGLAS supports the Federal Payment Levy Program (FPLP) operated by Treasury by offsetting payments. Through January 18, 2019 CMS has recouped $651.58 million in federal tax debts and $284.87 million in nontax debts from Medicare Provider Payments under the FPLP.

- *CFO/Financial Statement Audits:* $11.4 million. This funding is necessary for the statutorily required CFO audit which ensures CMS financial statements are reasonable, internal controls are adequate, and CMS complies with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and HHS and is based upon the General Services Administration rate schedules and federal audit requirements.

  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. CMS' goal is to maintain an unmodified 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.

**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 redetermination of a claim by a MAC during the first level of appeal. BIPA contemplates that QICs 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 60 day 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 at the Office of Medicare Hearings and Appeals (OMHA). This program ensures that Medicare beneficiaries' providers have the opportunity to continue seeking

payment for services in the event of an initial adverse claim determination and is essential to maintain provider participation in Medicare.

**Budget Request: $85.7 Million**

The FY 2020 budget request for QIC appeals (BIPA section 521) is $85.7 million, an increase of $5.6 million above the FY 2019 Enacted Level. The request funds a minimal growth in workloads and maintains steady state operations.

- *QIC Operations*: $79.7 million. This request includes annual operational costs and activities to advance the Departmental priority of continuing to timely adjudicate Medicare appeals at the second level in the appeals process.

The table below includes a breakout of the reconsiderations workload for FY 2017 – FY 2020 (estimated). FY 2017 and FY 2018 represent actual counts. FY 2019 and FY 2020 projections were formulated based upon FFS enrollment growth projections from CMS Office of Actuary. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.

**QIC Appeals Workload**
(Volume in Appeals)

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Non-RAC QIC Claims | 424,591 | 324,409 | 273,539 | 279,831 |
| % Increase from Previous Year | -12.48% | -23.59% | -15.68% | 2.30% |

In furtherance of the Departmental priority to improve the Medicare appeals process and address the pending backlog of appeals at Levels 3 and 4, CMS initiated several administrative actions that may have contributed to the decrease in claims following several years of substantial growth. These initiatives include, but are not limited to, the following:

- QIC Discussion Demonstration: In January 2016, CMS launched a demonstration with durable medical equipment suppliers that allows the suppliers the opportunity to discuss their denied claim with the QIC. In addition to the discussion, the appellant has the opportunity to submit additional documentation to support their claim and receive feedback and education on CMS policies and requirements. The Demonstration also gives suppliers the opportunity to have claims currently pending at OMHA reopened and resolved favorably.

  On November 1, 2018 CMS expanded the Demonstration to include DME suppliers within DME MAC jurisdictions A and B, for all claim types, except claims for glucose/diabetic testing strip supplies. As of January 2019, the QIC conducted more than 134,000 discussions and the favorability rate on reconsiderations issued after a discussion was approximately 63 percent (includes fully and partially favorable decisions).

Under this Demonstration, the QIC also has the authority to conduct reopenings on previously adjudicated unfavorable claims that are currently pending ALJ assignment at OMHA, and/or unfavorable reconsiderations that have been decided by the QIC, but not yet appealed to OMHA. As of January 2019, the QIC reopened and resolved favorably more than 95,000 claims previously pending in the OMHA backlog. In addition, the QIC worked with suppliers to submit withdrawals to OMHA on more than 152,000 claims.

- Settlement Facilitation Conferences: OMHA staff who have been trained in mediation techniques are facilitating settlement conferences between CMS and appellants. These conferences bring appellants and CMS together to discuss administratively settling pending appeals at Levels 3 and 4. Beginning in April 2018, OMHA expanded the Settlement Conference Facilitation program to reach additional appellants. Appellants not eligible for the Low Volume Appeals Settlement and other Medicare appeals administrative activities can be eligible to participate in this alternative dispute resolution process for their pending appeals.

- Low Volume Appeal Initiative: Appellants with fewer than 500 appeals pending at Levels 3 and 4, combined, as of November 3, 2017 are eligible to settle the portion of their pending appeals that have total billed amounts of $9,000 or less per appeal in exchange for timely partial payment of 62 percent of the net Medicare approved amount.

The following chart details the percentage of appeals completed timely by type from FY 2014 through FY 2018 to date:

| Fiscal Year | Reconsiderations (2nd Level of Appeal) | |
|---|---|---|
| | Part A | Part B |
| 2015 | 97.89% | 98.46% |
| 2016 | 96.73% | 99.72% |
| 2017 | 92.74% | 99.68% |
| 2018 | 99.74% | 99.78% |

- *Medicare Appeals System (MAS)*: $6.0 million. An 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.

## 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 which serves as one of CMS' long standing goals for the nation's healthcare.

**Budget Request: $22.2 Million**

The FY 2020 budget request for HIPAA Administrative Simplification is $22.2 million, a decrease of $7.2 million below the FY 2019 Enacted Level. Funding is requested for the following activities:

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $12.8 million. 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 which provides eligibility information to FFS providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims. 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.

- *NPI and NPPES*: $7.2 million. 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. In FY 2019, functionality is being expanded to provide for other identifiers outside the NPI and the FY 2020 request largely supports ongoing operations.

- *HIPAA Administrative Simplification Enumeration and Audit of Health Plans*: $1.9 million. CMS is responsible for driving the enumeration of health plans as required by HIPAA. CMS estimates that as many as 130,000 health plans may need to be enumerated. CMS is responsible for ensuring 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. 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.

- *HIPAA Enforcement*: $0.4 million. CMS manages the administrative simplification enforcement and certification provisions of HIPAA. 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 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 submissions, and providing technical assistance in analyzing complex complaints, HIPAA transactions, and potential violations. During FY 2019, CMS increased support for conducting industry compliance reviews and audits, which will enhance existing tools to collect and analyze data, and disseminate information.

**Research, Demonstration, and Evaluation**

The Research, Demonstration, and Evaluation (RDE) program was referred to previously as "Research," and included under its own Program, Project, and Activity (PPA). However, CMS is requesting that this funding be folded under the Program Operations PPA in FY 2020. This 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 146 million beneficiaries in FY 2020. CMS leverages other funding sources, such as Center for Medicare and Medicaid Innovation Center (Innovation Center) funding, to support RDE projects wherever possible.

**Budget Request: $20.1 Million**

The FY 2020 budget request for RDE is $20.1 million, flat with the FY 2019 Enacted Level. CMS will continue funding ongoing research data analytic activities supporting CMS and split-funding the Medicare Current Beneficiary Survey with the Innovation Center. This request represents ongoing maintenance and operations.

- *Medicare Current Beneficiary Survey (MCBS)*: $12.0 million. This funding maintains the survey's content and utility, and supports statutory requirements. In FY 2020, CMS plans to continue an equal split of the MCBS' total operational cost of $24.0 million between RDE and the Innovation Center at $12.0 million each.

  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:* $8.1 million. 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), CER Public Use Data Files, Medicaid Analytic Data, Historically Black Colleges and Universities, and Hispanic-Serving Institutions Research Grant Programs.

## III. MEDICAID AND CHIP

### Program Description and Accomplishments

**Medicaid and Children's Health Insurance Program (CHIP) Operations**

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children program, while the Supplemental Security Income program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a large population of low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services. 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. Medicaid and CHIP enrollment is expected to be

more than 85 million in FY 2020 with more than 1 in 5 Americans enrolled in Medicaid or CHIP.

**Budget Request: $102.7 Million**

The FY 2020 budget request for Medicaid and CHIP operations is $102.7 million, a decrease of $4.6 million below the FY 2019 Enacted Level. This funding supports administrative activities necessary to effectively operate and improve oversight of Medicaid and CHIP programs. The funding increase will allow CMS to reinvent Medicaid operations through improving data systems, and continuing support for the Medicaid and CHIP (MAC) scorecard that will increase transparency and accountability to allow states to better serve the interests of their citizens.

- *Medicaid and CHIP Business Information Solution (MACBIS):* $47.4 million. MACBIS is a CMS enterprise-wide initiative to improve the data infrastructure and information technologies that support Medicaid and CHIP. CMS is working with states and both internal and external stakeholders to improve Medicaid and CHIP data and data analytic capacity through MACBIS. MACBIS upgrades are needed and will be used by a variety of Medicaid programs and mandates. These costs are borne by a variety of accounts in addition to Program Operations. With the contributions from those other accounts, this request fully funds the four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS), building out of public use files and release of TMSIS data to states and other stakeholders. Both GAO and the HHS OIG have identified completion of TMSIS as a top priority for the Medicaid program. Second, the request supports completion of the Medicaid drug rebate system rebuild, which is critical to adequate oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. Finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *MAC Scorecard Initiative:* $24.8 million. The Medicaid and CHIP (MAC) Scorecard is an initiative designed to provide increased transparency about program administration and outcomes for Medicaid and the CHIP Programs and to assist states and CMS in aligning efforts to drive improvements and increase accountability. The MAC Scorecard, released in June 2018, included measures voluntarily reported by states, as well as federally reported measures in three areas: state health system performance; state administrative accountability; and federal administrative accountability. After the successful completion of MAC Scorecard 1.0 in June 2018, CMS will be working towards the releases of the 2019 MAC Scorecard. With each version of the MAC Scorecard, CMS plans to include more robust data interaction and increased web functionality with the goal of releasing an annual MAC Scorecard that more closely aligns with the annual Child and Adult Core Set measures publishing cycle. CMS also plans to develop and add additional quality measures to the MAC Scorecard, leveraging

TMSIS analytic data to identify and provide additional measures. In FY 2020, CMS will continue developing future versions and enhancements for the MAC Scorecard.

The FY 2020 budget request supports the following activities:

- Project management, which includes the stakeholder engagement process;
- Quality measurement, which includes measure development and quality improvement efforts;
- Business re-engineering, which includes the MAC Scorecard IT infrastructure and data access/management; and
- Building CMS's infrastructure to improve state and federal accountability across the Medicaid program.

- *State Demonstration Evaluations:* $6.4 million. Contractor support is required to conduct federal evaluations through meta-analyses of selected types of Medicaid Section 1115 demonstrations including, community engagement strategies and comprehensive treatment strategies for substance use disorder. The analyses provide an evaluation of the impacts of the Section 1115 demonstration waivers, including the significant work that states are doing to implement demonstrations pertaining to substance use disorders and community engagement requirements. The primary sources of information to conduct these analyses will be data reported by states in the monitoring and evaluation reports. The data and reports include performance on quality and other program performance metrics, including Medicaid Adult and Child Core Metrics, implementation costs, regular quarterly and annual monitoring reports, and state interim and summative evaluations. This includes a survey of beneficiary experience with these specific waivers. The contractor will review federal national survey data and state claims and encounter data to compare, among other things, beneficiary participation, continuity of coverage, access to care, and health outcomes.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $6.8 million. Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and 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 42 states operate at least one demonstration under an 1115 waiver, and a growing number of states operate most or all of their 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.

- *Survey of Retail Prices*: $7.5 million. 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. In addition, Value Based Purchasing expertise is needed to assist state Medicaid programs to design and

implement new value based purchasing programs and new payment models for drugs. The FY 2020 request supports the renewal of the contract to meet this statutory requirement.

- *The National Home and Community-Based Services (HCBS) Quality Enterprise*: $2.4 million. The Home and Community-Based (HCB) Settings Project assists CMS in reviewing and monitoring Statewide Transition Plans (Plans) designed to bring states into compliance with the HCB settings requirements, to ensure HCB settings are integrated, and individuals receiving Medicaid HCBS have equal access to community support. The HCB Settings Project will assist CMS in the development of necessary tools, protocols, guidance materials, trainings, and technical assistance to ensure consistent national implementation of new requirements. The Administration has given states additional time to come into compliance with the 2014 HCBS final rule; states must now be in compliance by March 2022. CMS is also continuing its efforts to provide technical assistance to states and training and resources on all other aspects of the HCBS including person centered service planning and conflict of interest among other topic areas. CMS and ACL have also launched a joint funding opportunity for the National Center on Advancing Person-Centered Practices and Systems (NCAPPS). NCAPPS will provide training, an information clearinghouse and in-depth technical assistance to states, territories, and tribes to transform their long-term care service and support systems to implement HHS' policy on person-centered thinking, planning, and practices.

- *Managed Care Review and Oversight*: $0.7 million. Managed care is the dominant delivery system for Medicaid benefits. As of 2016, over $228 billion dollars were spent annually on Medicaid managed care. Currently, there are 48 states and the District of Columbia operating over 170 programs covering roughly 65 million individuals. CMS implemented this project to increase our oversight and technical assistance to states to address the needs created by the growth of managed care and GAO concerns. Under this project, CMS created guidance for Managed Long Term Services and Supports (MLTSS) and encounter data. CMS also produced the 2013 - 2016 Medicaid Managed Care Enrollment Report which provides managed care enrollment information. Each of these deliverables has contributed much needed assistance to states as they work on improving beneficiary health outcomes and generating managed care related savings. The FY 2020 request will support CMS efforts to update guidance to states on encounter data reporting, provide requested technical assistance to states, and update internal monitoring tools for CMS.

- *Learning Collaborative:* $2.0 million. 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 legislation. 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 health care system.

- *Other Medicaid, CHIP, and Basic Health Program Activities*: $4.7 million. CMS has a variety of operational contracts supporting Medicaid and CHIP. These activities provide support for Connecting Kids to Coverage grants, Medicaid Access regulation support, analytics support, systems support, and evaluations and technical assistance for Medicaid related programs. Additionally, Section 12006(a) of the 21st Century Cures Act requires an ongoing electronic visit verification system (EVS) to monitor states, and an ongoing, graduated, Federal Medical Assistance Percentage (FMAP) reduction for states that are not fully compliant. Section 12006(b) requires the collection and dissemination of best practices to state Medicaid directors. EVS tasks include surveying states, tracking/analyzing EVS findings, and conducting training for CMS and states related to EVS in order to share promising practices and promote compliance with guidance/policy.

## 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.

The following material describes 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.

- *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 Medicare Advantage and Part D plans.

**Budget Request: $29.8 Million**

The FY 2020 budget request for Parts C and D IT Systems Investments is $29.8 million, a decrease of $3.6 million below the FY 2019 Enacted Level. This request supports ongoing systems maintenance and operations. 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**

CMS oversees the private health insurance companies that offer health care coverage through private plans. Oversight and management activities needed to run the Part C, Part D, and private insurance programs include obtaining actuarial estimates, reviewing bids from the prescription drug and Medicare Advantage 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. Many of the Parts C and D and private insurance oversight and management activities require contractor support. In addition, CMS funds activities to improve coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits, and helps states innovate using data-driven insights to better serve these individuals. These activities are vital to ensuring that beneficiaries are receiving the health care services that they expect from our programs.

**Budget Request: $60.4 Million**

The FY 2020 budget request for Oversight and Management is $60.4 million, an increase of $1.7 million above the FY 2019 Enacted Level.

- *Medicare Parts C and D*: $46.1 million. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, the Retiree Drug Subsidy Program, and the on-going Medicare Part C and Part D reconsideration contracts. This also funds ongoing initiatives such as closing the Medicare Part D coverage gap, reforming Medicare Advantage plan payments, and making improvements to Part D plan operations.

Oversight and management also includes Part C and Part D appeal reviews. CMS contracts with an independent reviewer to conduct reconsiderations of adverse Medicare Advantage plan determinations, late enrollment penalties (LEP), and coverage denials made by Medicare Advantage and Part D 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 workload history and projection is presented below:

**QIC Appeals Workload for Parts C/D**
(Volume in Appeals)

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Part C Appeals | 63,486 | 82,179 | 96,000 | 108,000 |
| Part D Benefit Appeals | 41,616 | 28,090 | 29,500 | 31,000 |
| Part D LEP appeals | 41,303 | 41,388 | 43,500 | 45,600 |

- *Insurance Market Reforms:* $4.4 million. CMS, on behalf of HHS, is required to enforce market wide protections under Obamacare. To ensure compliance, CMS collects and reviews plan documents from health insurance issuers and conducts investigations and market conduct examinations of non-federal government plans based on complaints received. Funds will be used to continue compliance with market wide requirements, to assist with research to investigate complaints, and to perform market conduct examinations.

- *Medical Loss Ratio (MLR):* $2.6 million. Section 2718 of Obamacare requires an issuer to report annually how it used its premium revenue for the prior calendar year. This ensures that consumers receive value by requiring that plans use enrollees' premium dollars on medical care, quality improvement activities, or to pay rebates to policyholders. This data analysis ensures consumers receive the rebates they are entitled to if their health insurance issuer fails to meet the 80 percent (in the individual and small group market) or 85 percent (in the large group market) MLR standard. CMS is responsible for directly enforcing the regulations with respect to MLR for all issuers in the private health insurance market. The funding will be used to continue contractor support to conduct MLR examinations.

- *Rate Review:* $1.7 million. This request allows CMS to perform statutorily required duties to monitor and review rate submissions from health insurance plans. Rate increases higher than 15 percent must be reviewed and approved by either CMS or the relevant State Department of Insurance. CMS also publically posts all rate changes on the agency's website in order to increase transparency.

- *Federal Coverage and Payment Coordination:* $5.6 million. Federal Coverage and Payment Coordination funds support necessary activities and resources to implement the Medicare-Medicaid Coordination Office's (MMCO's) statutory obligations, as well as the HHS and CMS strategic goals. Each activity is pivotal in CMS' success in improving quality, cost, and care coordination for dually eligible beneficiaries. This work includes navigating a number of very complex operational issues, merging often conflicting

systems, policies, financing, monitoring and oversight protocols, and data requirements across Medicare and Medicaid, and then adapting that work to the unique environment of each state.

**Exchanges**

The FY 2020 budget includes a General Provision to allow user fees collected for the purpose of operating Federally-Facilitated Exchanges and federal platforms leveraged by State-based Exchanges to be available for any federal administrative expenses the Secretary incurs for activities related to the Exchange program, including those activities that CMS conducts on behalf of all Exchanges. For additional information, please refer to the Federal Exchanges section of this FY 2020 Congressional Justification.

**Budget Request: $0.0 Million**

The FY 2020 budget authority request for Exchanges is $0.0 million, a decrease of $247.9 million below the FY 2019 Enacted Level within Program Operations.

## V. HEALTH CARE QUALITY

**Program Description and Accomplishments**

**Health Care Quality**

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through health care quality initiatives, such as the Medicare Shared Savings Program. Value-based programs such as this one not only help our beneficiaries receive high quality of care, but also create a more efficient and better healthcare service experience.

**Budget Request: $39.0 Million**

The FY 2020 budget request for health care quality improvements is $39.0 million, a decrease of $1.0 million below the FY 2019 Enacted Level.

- *Medicare Shared Savings Program*: $30.6 million. 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). Over 10.4 million Medicare fee-for-service beneficiaries receive care from providers participating in ACOs. Physicians continue to join ACOs each year, demonstrating that clinicians are recognizing the value and opportunity of coordinated care, quality improvement, and shared savings. In December 2018, CMS issued a Final Rule known as the 'Pathways to Success' that redesigns the program providing a quicker transition to performance based risk, promotes flexibility for ACOs to innovate, encourages low revenue ACOs to promote competition, ensures rigorous and accurate benchmarks, strengthens program integrity, and reduces burden. CMS plans to continue implementation of this new rule.

- *Medicare Data for Performance Measurement:* $6.0 million. Under current law, the Secretary is required to establish a process to certify qualified entities 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. The funding requested will support contracts for program management, data preparation and distribution, and technical assistance.

- *Hospital Value-Based Purchasing (VBP):* $0.9 million. The Hospital Value-Based Purchasing Program was mandated by Obamacare and provides value-based incentive payments to hospitals based on their performance on quality and cost measures. FY 2020 funding is required to continue payment standardization of Medicare Part A and B claims on a monthly basis. CMS is working toward greater automation of this process, through integration into the shared systems, to support the calculation of resource use measures for VBP programs, and for other agency and external users who leverage this data for their work.

- *Other Health Care Quality Initiatives:* $1.6 million. The request includes funding to support the Hospital Readmission Reduction Program. This provision of the ACA requires the Secretary to make readmission rates for hospitals publicly available and directs the Secretary to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations. Funding is needed so CMS can 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. This request also includes funding for Appropriate Use Criteria for Advanced Imaging Services, a program established by the Protecting Access to Medicare Act (PAMA) of 2014. In order to implement this program effectively, CMS focuses appropriate use criteria on clinical areas and imaging modalities with high Medicare volume. CMS also reviews the evidence-base and variability among competing appropriate use criteria. Funding is required to continue implementing the program in a manner that does not place a substantial burden on providers, while at the same time improving quality of care for patients.

**Medicare Quality Improvement and Value-Based Transformation**

CMS is transitioning quality improvement and value-based transformation support activities from the mandatory Quality Improvement appropriation to CMS Program Management.

**Budget Request: $175.0 Million**

The FY 2020 budget request is $175.0 million, an increase of $175.0 million above the FY 2019 Enacted Level. This funding will support Medicare quality improvement and value-based activities previously funded by the Quality Improvement Organization mandatory appropriation to support increasing patient safety, making communities healthier, better coordinating post-hospital care, and improving clinical quality.

## VI. OUTREACH AND EDUCATION

### Program Description and Accomplishments

**National Medicare Education Program (NMEP)**

The National Medicare Education Program (NMEP) was established to implement provisions of the Balanced Budget Act of 1997 and continues under the MMA of 2003. The program is comprised of five major activities including: beneficiary materials, the beneficiary contact center (1-800-MEDICARE), internet services, community-based outreach, and program support services.

NMEP is CMS' primary vehicle to educate Medicare beneficiaries and their caregivers so they can make informed health care decisions. The NMEP program is vital for the success of our programs and is the basis for providing excellent customer service to our beneficiaries and providers. Additionally, CMS in coordination with the Administration for Community Living and State Health Insurance Assistance Programs (SHIPS), will work to ensure that NMEP activities continue to provide accurate, comprehensive, understandable information to individuals.

**Budget Request: $265.3 Million**

The FY 2020 budget authority request for NMEP is $265.3 million, flat with the FY 2019 Enacted Level. The following activities are funded within the request:

**National Medicare Education Program Budget Summary**
(Dollars in Millions)

| NMEP Category/Description of Activity in FY 2020 | Funding Source | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget |
|---|---|---|---|---|
| **Beneficiary Materials -** 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 funding the Handbook. | PM | $38.85 | $44.64 | $31.14 |
| | Postage | $26.20 | $26.20 | $30.00 |
| | **Total** | **$65.05** | **$70.84** | **$61.14** |
| **Beneficiary Contact Center/1-800-MEDICARE -** Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives. | PM | $164.91 | $155.13 | $183.78 |
| | User Fees | $78.30 | $88.40 | $89.35 |
| | **Total** | **$243.21** | **$243.53** | **$273.13** |
| **Internet -** Maintenance and updates to existing interactive websites to support the CMS initiatives for health and quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov. | PM | $28.53 | $36.62 | $27.81 |
| | QIO | $3.81 | $0.00 | (TBD) |
| | **Total** | **$32.34** | **$36.62** | **$27.81** |
| **Community-Based Outreach -** 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 | $2.45 | $3.00 | $3.01 |
| | **Total** | **$2.45** | **$3.00** | **$3.01** |
| **Program Support Services -** 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 Low Income Subsidy. | PM | $28.03 | $25.90 | $19.55 |
| | **Total** | **$28.03** | **$25.90** | **$19.55** |
| **Funding Source Breakout Total** | **PM** | **$262.77** | **$265.29** | **$265.29** |
| | **User Fees** | **$78.30** | **$88.40** | **$89.35** |
| | **Postage** | **$26.20** | **$26.20** | **$30.00** |
| | **QIO** | **$3.81** | **$0.00** | **(TBD)** |
| | **Total** | **$371.08** | **$379.89** | **$384.64** |

**/1** The User Fees amount reflects total planned obligations.

- *Beneficiary Materials:* The total FY 2020 request is $61.1 million, of which $31.1 million is budget authority. This estimate is based on historical publication usage data and current market prices for printing and mailing. This request supports the printing and

mailing of the Medicare & You handbook. The Medicare & You handbook satisfies numerous statutory requirements 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. The handbook is updated annually and mailed to all current beneficiary households every October. Beneficiaries currently have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/gopaperless for an electronic copy that gets emailed to them each fall. The FY 2020 request includes a proposal to provide flexibility to CMS on distribution of the Handbook that will allow increased electronic distribution of the Handbook and less reliance on mailing paper copies. 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 FYs 2017 through 2018 and the estimated distribution for FY 2019 and FY 2020. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

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

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Number of Handbooks Distributed | 45.8 | 47.2 | 48.6 | 50.1 |

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The total FY 2020 request is $273.1 million, of which $183.8 million is budget authority. 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 comparisons, 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.

The following table displays call volume experienced in FY 2017 through FY 2018 and the number of calls CMS expects to receive in FY 2019 and FY 2020. In FY 2020, CMS expects to receive 23.0 million calls to the 1-800-MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system. Approximately 30 percent of the calls are handled completely by IVR. At the FY 2020 funding request, CMS anticipates an average speed to answer of 5-7 minutes.

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

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Number of Calls | 22.4 | 23.8 | 23.4 | 23.0 |

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

- *Internet: $27.8 million.* The Internet budget funds operations and maintenance for three websites. Increased funding in FY 2020 will provide additional software and hardware upgrades, while providing improvements to the web services offered online and supporting the Digital Senior Initiative.

  The http://www.cms.gov website is CMS's public website for communicating with public stakeholders including 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 CMS'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, update their email address and add emergency contact information. Beneficiaries can also generate an On-the-Go Report which allows them to download personalized health information and share with their healthcare providers.

In FY 2020, CMS estimates 440 million page views to http://www.medicare.gov, approximately a seven percent increase in traffic from the page views anticipated in FY 2018. 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, in support of a patient-centered approach to these online resources.

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

| | FY 2017 Actual | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate |
|---|---|---|---|---|
| Number of Page Views for http://www.medicare.gov | 353.2 | 412.8 | 425 | 440 |

- *Community-Based Outreach: $3.0 million*. 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.

  FY 2020 funding is requested for continued support and maintenance of the new Learning Management System 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: $19.6 million.* 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 Handbook, mail file creation for the statutory October mailing of the Medicare & You Handbook, NMEP consumer research and assessment (including consumer testing of the Medicare & You handbook), a publication ordering web site for partners that support the Medicare education program, support for the Advisory Panel on Outreach and Education, and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

  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 addition to the Program Management budget authority request, the NMEP budget request assumes $89.4 million in user fees and $30.0 million is postage funding bringing

the total FY 2020 budget request for NMEP to $384.6 million, a decrease of $4.8 million below the total FY 2019 level. The FY 2020 request includes a general provision that rebases collections from the Part C and D plans to keep pace with enrollment growth in these plans and the benefit the plans receive from NMEP beneficiary materials and resources. No additional user fee collections are assumed in FY 2020 due to the time it would take to implement this proposal, but additional user fee collections would be assumed in subsequent years.

**Consumer Outreach**

CMS is responsible for performing outreach to all eligible persons who can obtain health insurance through the private market. CMS' outreach activities for consumers are based on proven strategies utilized by the NMEP program to support CMS' Medicare and Medicaid beneficiaries. Each year CMS incorporates best practices from last open enrollment (OE) to make CMS media more efficient and effective. Previous OEs have taught CMS lessons about effective messages and tactics to reach the uninsured Americans who need information and assistance the most. This request provides support to maintain and update general consumer information for private insurance on www.Healthcare.gov and allows CMS to tailor outreach programs to the disenfranchised and minority groups. Ongoing funding will make outreach more effective, helping more people get coverage, stay healthy, and ensure that consumers are receiving up-to-date information regarding their healthcare coverage.

**Budget Request: $4.5 Million**

The FY 2020 budget request for Consumer Information and Outreach is $4.5 million, representing a decrease of $2.2 million below the FY 2019 Enacted Level.

- *Web Operations Support:* $1.7 million. The funding request 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 Obamacare may impact their health care insurance benefits and coverage. This information is made publicly available at of www.Healthcare.gov.

- *General Consumer Outreach*: $2.8 million. The goal of the Indian Health Care activity is to expand the reach of CMS programs for American Indian and Alaska Natives (AI/AN). Federal delivery of health services and funding of programs to maintain and improve the health of AI/AN's are consonant with and required by the federal government's historical and unique legal relationship with Indian Tribes. Ongoing AI/AN outreach contracts will support the continued implementation of a well-developed, flexible and successful quality outreach strategy that provides critically needed and culturally appropriate resource materials to increase the enrollment of AI/AN beneficiaries in CMS programs including private insurance, Medicaid, Medicare, and an increased focus on dually eligible populations.

  CMS also plans to fund the Coverage to Care (C2C) initiative, a health literacy initiative designed to assist consumers with any type of insurance (Medicare, Medicaid, Exchanges, private insurance) to understand their health insurance and how to use it for primary care and preventive services. C2C depends on collaboration with community groups, consumers, and providers to focus on prevention, regular primary

care, and proper utilization of emergency care to encourage reduced costs and better health outcomes. C2C empowers stakeholders by providing digital and print resources and messages to enable a patient-centered approach for accessibility and affordability.

## VII. INFORMATION TECHNOLOGY

### Program Description and Accomplishments

**Systems and Support**

Information Technology Systems and Support activities provide infrastructure and support for applications and operations that are used across the agency. These activities provide CMS the capability to quickly expand to address future system needs, adopt new and more efficient technologies, and support new programs. CMS must continue to invest in expansions of software, licensing and processing capacity to manage system growth, and consolidation and replacement of end of life and/or less efficient equipment in its efforts to modernize its information technology. Enterprise IT activities include security and governance within CMS, which provides the standards and guidelines for compliance and response capabilities. CMS protects our networks and information systems against the continual attacks of malicious cyber actions through a comprehensive 24/7 cyber threat monitoring program.

In FY 2020, CMS will continue to invest in the transition to the Virtual Data Center, which supports Medicare Part C and D operations and enterprise shared services. CMS also continues to fund infrastructure for the HPMS, which ensures that nearly 800 MA organizations and Part D plans are fulfilling the various statutory, regulatory, and administrative requirements of those programs.

### Budget Request: $440.1 Million

The FY 2020 request for Information Technology Systems and Support activities $440.1 million, a decrease of $116.5 million below the FY 2019 Enacted Level. The decrease in funding is attributed to CMS's commitment in FY 2019 to make a critical, one-time investment in the CMS cybersecurity program and the development of a disaster recovery environment that enables CMS to optimize, then migrate systems to the cloud. Funding in FY 2020 is necessary to continue ongoing IT operations, including making necessary investments to existing systems that support improvements in the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies.

In FY 2020, CMS will continue to make substantial investments in security in order to increase the protection of CMS data and processing activities through additional cybersecurity and privacy program actions. While CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center, in order to comply with federal mandates to fully implement CDM across the entire landscape, it will take multiple years and additional resources to expand the CDM footprint, establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs)-sharing with all of CMS' data centers and, increase the viability of cloud security and the DevSecOps

programs. In support of this effort, CMS will continue to develop and rollout the CDM program to all data centers until full implementation is reached.

Recognizing the increasing role of technology in seniors' lives, CMS launched a new initiative called "Digital Seniors" in FY 2018. This initiative focuses on updating Medicare resources so seniors can more easily access and navigate the Medicare Program. Simplified and personalized tools for Medicare beneficiaries will increase functionality and improve the customer experience. This includes foundational work such as beneficiary focus groups and journey mapping, the development of core services to enable cross-channel customer service (i.e., identity management, data warehouse), building towards the implementation of modern tools enabling beneficiary self-service. Specifically, Medicare.gov and MyMedicare.gov will be consolidated into a single website and updated to include improved plan shopping and enrollment tools, improved care choice tools (provider and facility search), improved account management, a more personalized experience providing much greater online self-service than is currently available, and more integrated and proactive electronic communications, notifications, and cross channel services such as email, web chat, and phone. New tools will be mobile optimized and offer application programming interfaces so that third-parties can build additional beneficiary tools on top of our data.

While "Information Technology Systems and Support" describes CMS' investment in enterprise-wide IT, Program Operations funding also supports IT across all of CMS' programs. These amounts are included within the total budget requests for each program, making it potentially difficult to get a sense of how much money CMS spends on IT across them all. Please see the Program Operations IT spending table in the supporting exhibits that shows IT funding requested for each of the categories within Program Operations. For a more complete picture of CMS IT spending from all sources and across all programs, please see the "Information Technology" Chapter of this submission.

## VIII. OTHER INITIATIVES

### Program Description and Accomplishments

Every year CMS and HHS work together to create joint priorities for the Department. These activities reflect Departmental wide concerns, nationwide health issues (i.e. the opioid epidemic), and vulnerabilities in CMS' operations. These activities are mostly new to CMS Program Management and, pending policy decisions and successful outcomes, may become part of CMS' ongoing operations.

### Budget Request: $10.0 Million

The FY 2020 budget request for Other Initiatives is $10.0 million. The request includes the following:

- *Innovation and Modernization Effort*: $0.0 million. During FY 2019, CMS is investing $232.4 million in a CMS-wide Innovation and Modernization effort. This investment will support Administrative priorities such as eMedicare (Digital Seniors), MACBIS, and other IT Modernization and IT Security efforts. This is a one-time investment, and no funding is being requested for this effort in FY 2020.

- *Opioid Data Analytics and Tools*: $5.0 million. CMS plans to launch new care delivery and payment models and demonstrations for the treatment of opioid use disorder as part of CMS' opioid strategy and implementation of the SUPPORT for Patients and Communities Act. These models and demonstrations will address varying populations (e.g. mothers and infants, Medicaid beneficiaries, and Medicare beneficiaries) but all share a goal of increasing access to comprehensive, evidence-based outpatient treatment for Medicare beneficiaries with opioid use disorder. Resources are needed to map investments, analyze claims for beneficiaries participating in the demonstrations to monitor take-up and outputs, and track the results of the demonstrations in an ongoing basis to disseminate results of what is working to other payers. The rapid data analytics capability would be consistent with the urgency of the effort to address the opioid epidemic.

- *Medicare Device Innovation*: $5.0 million. CMS' FY 2020 request includes funding to support enhancements to the pharmaceutical and technology ombudsman role, a role established by section 4010 of the 21st Century Cures Act, which will include providing customer service resources to assist innovators in navigating the process of requesting coverage, coding, and payment determinations for their technology. CMS will also acquire contractor support for covering innovative technologies, LCD modernization, guidance document development, expediting clinical trial reviews, and claims analysis to optimize coverage activities.

# Federal Administration

(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| BA | $732,533 | $732,533 | $747,533 | $15,000 |
| FTE[/1] | 4,341 | 4,302 | 4,330 | 28 |

1/ Excludes staffing funded from indirect cost allocations, directly appropriated funding sources, and reimbursables

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2019 Authorization – One Year
Allocation Method – Direct, Contracts, Other

**Program Description and Accomplishments**

Federal Administration funds the majority of routine operating expenses in support of agency activities for a variety of health care financing programs. Funding covers employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. Many of these costs are determined by policies and agencies beyond CMS, but are essential for carrying out our mission and contribute to the effectiveness of our daily operations.

CMS currently employs Federal employees working in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; ten Regional Offices located throughout the country, and four anti-fraud field offices located in Los Angeles, Miami, Chicago, and New York. Employees write health care policies and regulations; set payment rates; develop national operating systems for a variety of health care programs; provide funding for 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 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, Children's Health Insurance Program (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.

CMS has embarked on an important Back on Campus/Real Estate Consolidation Initiative to accommodate space for all current employees and new hires. This includes replacing existing outdated furniture, following guidance for efficient space management, and over time, bringing as many employees as possible from outlying buildings back to the main campus.

CMS is already making enhancements which include ergonomic workstations, conference rooms, focus rooms, huddle rooms, and collaboration rooms which promote building modernization and improvements in the physical work environment. Funding will enable CMS to continue building upon the progress of this initiative in order to maintain compliance with space utilization policies.

The Homeland Security Presidential Directive 12 (HSPD-12) initiative has continued to evolve this fiscal year. Federal Administration is one of the funding sources that supports this project and funding has helped CMS credential 3,651 employees and contractors so far in FY 2019 with an additional 2,000 projected over the remainder of the fiscal year. The funding that supports HSPD-12 utilizes Federal staff and contract support to ensure timely issuance of credentials following application submission. In FY 2019, the Office of Personnel Management is suppporting CMS in conducting approximately 5,000 background investigations by the end of the fiscal year. Funding has enabled CMS to maintain the lifecycle maintenance program ensuring timely replacement of critical equipment required for the credentialing process and preventing system outages due to hardware malfunction. Additionally, CMS has purchased the supplies required to support the HSPD-12 program including the purchase of PIV card stock, lanyards and credential holders.

Personnel and associated costs for programs and activities where specific funding sources are available are not included in the Federal Administration request. In order to ensure indirect costs are appropriately applied to these funding sources, CMS utilizes a cost allocation methodology to offset some costs that would otherwise be funded out of the Federal Administration account. In FY 2020, CMS estimates that $145.4 million will be available from indirect cost allocations, which is not included in the discretionary funding request level.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2016 | $732,533,000 |
| FY 2017 | $732,533,000 |
| FY 2018 | $732,533,000 |
| FY 2019 Enacted | $732,533,000 |
| FY 2020 President's Budget | $747,533,000 |

**Budget Request: $747.5 million**

CMS requests $747.5 million, $15 million above the FY 2019 Enacted level. The increased funding is for personnel costs, previously funded by the Quality Improvement Organization mandatory appropriation, to support Medicare quality improvement and value-based transformation initiatives.

The requested amount excludes the portion of the total costs that is being covered by CMS' other funding sources through indirect costs allocations. This request fully funds changes to employee benefits and accounts for other inflationary increases. CMS' FY 2020 request has been prepared in accordance with Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs. In FY 2020, this funding continues to provide resources for contracts that support daily operations and associated expenses, as well as focus efforts on HSPD-12 compliance and the Back on Campus/Real Estate Consolidation Initiative.

**Federal Administration Discretionary Summary Table**
(Dollars in Thousands)

| ***Objects of Expense*** | **FY 2018 Final** | **FY 2019 Enacted** | **FY 2020 President's Budget** | **FY 2020 +/- FY 2019** |
|---|---|---|---|---|
| Personnel Compensation and Benefits | $673,850 | $678,850 | $693,850 | $0 |
| Travel | $1,048 | $5,464 | $5,464 | $0 |
| Rent, Communications and Utilities | $5,100 | $5,100 | $5,100 | $0 |
| Printing | $1,671 | $2,453 | $2,453 | $0 |
| Contractual Services | $48,794 | $36,251 | $36,251 | $0 |
| *Service and Supply Fund (non-add)* | *$4,600* | *$4,600* | *$4,600* | *$0* |
| *Administrative Services (non-add)* | *$7,845* | *$4,830* | *$4,830* | *$0* |
| *Administrative IT (non-add)* | *$27,543* | *$18,862* | *$18,862* | *$0* |
| *Inter-Agency Agreements (non-add)* | *$3,187* | *$2,778* | *$2,778* | *$0* |
| *Administrative Contracts and Intra-Agency Agreements (non-add)* | *$5,619* | *$5,181* | *$5,181* | *$0* |
| Supplies | $1,003 | $969 | $969 | $0 |
| Training | $1,067 | $3,446 | $3,446 | $0 |
| **Total, Federal Administration** | **$732,533** | **$732,533** | **$747,533** | **$15,000** |

- *Personnel Compensation and Benefits:* $693.9 million. The requested funding supports 4,330 direct Full-Time Equivalents (FTEs), a increase of 28 FTEs as compared to the FY 2019 Enacted level. This category covers the full range of civilian and Commissioned Corps employees pay, within grade increases, awards, and overtime as well as fringe benefits. Commissioned Corps are entitled to additional benefits including housing and other allowances. The FY 2020 FTE estimates are based on pay inflation assumptions of 0.0 percent for civilian and 3.1 percent for Commissioned Corps staff. CMS' staffing level and related compensation and benefits expense is largely workload-driven. Staffing levels funded from the Federal Administration line will enable CMS to execute Secretarial priorities which include maintaining and improving the performance of our traditional programs, Medicare, Medicaid, and CHIP and ensuring these programs are successfully delivered with the highest quality. Based on the FY 2020 Federal Exchange user fee General Provision proposal, a total of $12.5 million in funding previously covering Federal Exchange FTEs in FY 2019 will become available to support additional hiring of FTEs to implement the Administration's initiatives including, but not limited to, Medicaid and CHIP Oversight, Value-Based Healthcare, Payment Reform, and Price Transparancy. Additional CMS staffing costs are funded through other line items and accounts, including Health Care Fraud and Abuse Control (HCFAC), various user fees, and direct appropriations from recent legislation.

- *Travel:* $5.5 million. 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 our beneficiaries and consumers are receiving quality care and providers are not engaged in fraudulent practices.

- *Rent, Communications, & Utilities*: $5.1 million. This category provides funding for the 30-year loan for CMS' Central Office headquarters building, in addition to rent and building operational costs for CMS' offices in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; the ten Regions; and the four anti-fraud field offices in Los Angeles, Florida, Chicago, and New York. The General Services Administration 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.

- *Printing:* $2.4 million. The largest expense in this category is for printing notices in the Federal Register and Congressional Record. CMS is required 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.

- *Contractual Services:* $36.2 million. Contractual Services include our daily operations, contracts, and agreements with other agencies providing support services, policy support and workforce development. Funding supports critical information technology infrastructure and services which provide CMS employees with a secure and technologically-efficient workplace. Examples include support for data center operations, telephone, voicemail, and cellular services, and physical facility access and security systems. CMS has also made a concerted effort to promote a more user-friendly IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, work stations, and remote locations, allowing the focus to remain on the agency's mission. Additional services funded under this section include comprehensive acquisition lifecycle support services, fleet management, the SharePoint collaboration platform, document management, and workforce planning systems. Essential contracts such as legal services with the Office of General Counsel and security services with the Department of Homeland Security are also included within this category and are crucial in supporting CMS operations. In addition, the CMS share of the Department of Health and Human Services Program Support Center and other shared expenses including payroll, financial management, and e-mail systems are funded within this section. In addition, the HSPD-12 Federal Administration funding provides support for continuous credentialing of employees and to obtain essential resources critical for operations, whereas the Back on Campus/Real Estate Consolidation funding provides the ability to continue the phases of this initiative completing the required renovations for this project.

- *Supplies:* $1.0 million. 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.

- *Training:* $3.4 million. This category supports continuous learning of technical, professional, and general business skills with special emphasis on leadership and management development. This category covers certifications for staff, such as

actuaries, contract specialists, financial managers, nurses, and other health professional specialists. The funding also supports mandatory agency wide trainings such as Reasonable Accommodation, Alternative Dispute Resolution, and Ethics training. Lean training is also funded from this category and is a vital course within our training plans to ensure effective operations and improvements in our daily processes. The Lean training allows CMS to improve current methodologies, influences effective decision making, and developing processes which assists CMS in achieving the agency's mission.

# Medicare Survey and Certification

(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| BA | $397,334 | $397,334 | $442,192 | +$44,858 |

Authorizing Legislation - Social Security Act (SSA), title XVIII, Section 1864

FY 2020 Authorization - Public Law 115-141

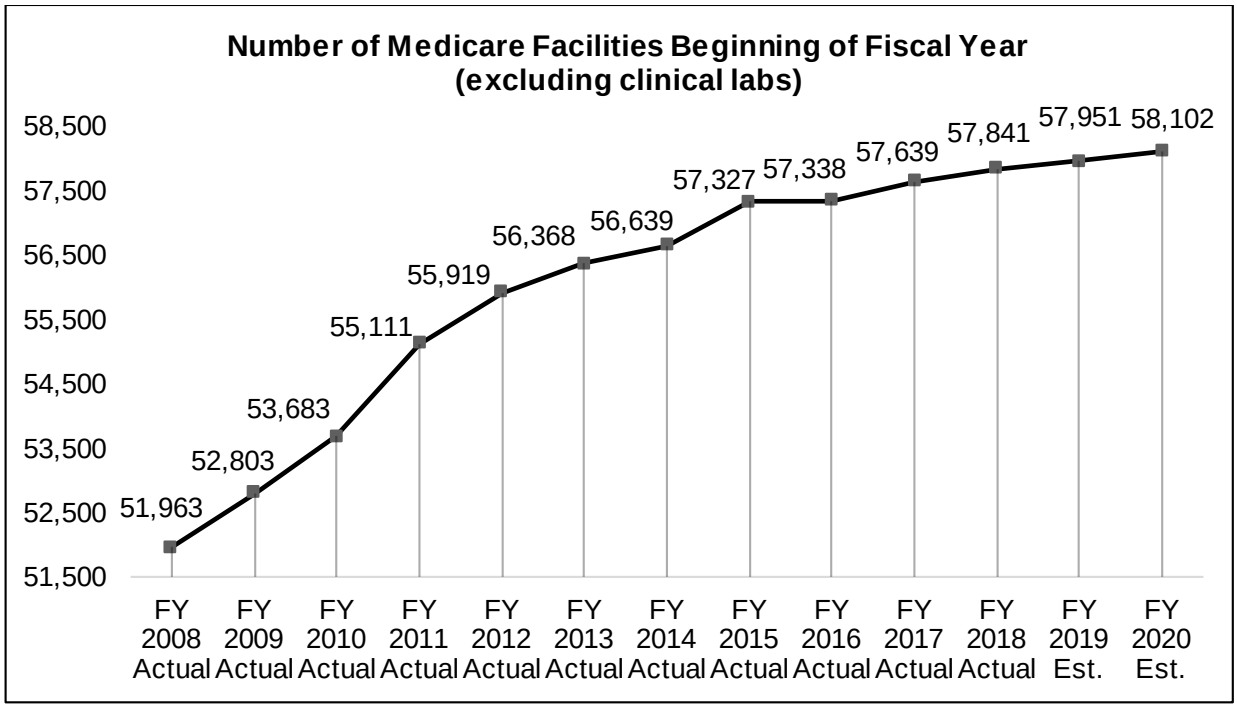
Allocation Method – Contract

**Program Description and Accomplishments**

The mission of CMS' Survey and Certification program is to ensure basic levels of quality and safety for all beneficiaries receiving care at Medicare and Medicaid certified health care facilities. In order to participate in and receive reimbursements from Medicare and Medicaid, health care facilities are required to be certified as meeting minimum quality and safety requirements. The certification of facilities is conducted through an initial survey, or inspection, and on a regular basis thereafter to ensure that the facility meets or continues to meet health, safety, and quality standards as required by CMS.

CMS works in partnership with State Survey Agencies (SA), or directly through national contractors, to ensure that facilities in each of the 50 States, the District of Columbia, and U.S. territories are appropriately certified and recertified for Medicare participation. In addition, CMS allows certain provider types to be certified through private accreditation organizations (AO) in place of SAs; providers that are certified through approved AOs are deemed to be in compliance with Medicare Conditions of Participation (COPs) but are still subject to State or CMS validation surveys. For all facility types, CMS conducts investigations to substantiate reported complaints and takes appropriate action when facilities are found to have health care or safety deficiencies. Collectively, the activities described above are referred to as the survey and certification process.

The total number of Medicare-participating facilities, excluding clinical laboratories, grew by 9.7 percent from the end of FY 2008 to end of FY 2018. Hospice providers, end-stage renal disease (ESRD) providers, and home health agencies (HHAs) exhibited notably high growth rates of 32.4 percent, 28.0 percent, and 27.7 percent, respectively, during this time.




CMS works to continually improve the oversight of facilities through enhanced survey processes and standards that use statistical information to review outcomes and prioritize facilities whose performance data indicate higher risk of poor patient outcomes. A few of these accomplishments are highlighted below:

- CMS places a high priority on ensuring nursing home quality. To safeguard residents, CMS implemented a revised computer-based survey process in November 2017 which incorporated strengthened Medicare and Medicaid requirements of participation. This effort strengthens the consistency of the survey process and provides feedback on survey activities and outcomes to ensure a high-quality nursing home survey process.

- CMS continues to improve the Nursing Home Compare website and Five-Star Quality Rating System, which provides meaningful information for consumers. In 2018, CMS added new staffing information and new quality measures to increase the value of the information available. Additional enhancements planned for FY 2020 will further support consumers' health care decisions.

- CMS continues its Special Focus Facility (SFF) initiative for nursing homes determined to be at highest risk of poor quality. Historically, nursing homes with the SFF designation, and which are surveyed twice as frequently as non-participating facilities, have come into compliance with CMS requirements more quickly than facilities that were surveyed at the normal frequency. The FY 2020 budget would continue to support the SFF efforts.

- Surveys in accordance with the new ESRD regulations have improved supplier focus on infection control, water quality safety, and internal quality assurance at dialysis facilities.

- CMS' infection control worksheet, developed as part of a more rigorous survey process for Ambulatory Surgical Centers (ASCs) is shared with the Centers for Disease Control (CDC) for analysis of deficiencies and trends. This worksheet is then used by CMS to continually refine the ASC survey process, target surveyor training, as well as share with ASC stakeholders for self-assessment and quality improvement opportunities. CMS is tentatively scheduled to collect another random sample in FY 2019, pending completion and readiness of a new data collection system.

- Over several years, as a result of regular, comprehensive surveys, CMS has seen improvements in the number of deficiencies in ASCs and hospitals, and is currently reviewing attribution information in other facility types. The table below provides improvements over time for select facility types from 2015 to 2018:

| Facility Type | National Average Number of Deficiencies per Survey | | | | Examples of Deficiencies |
|---|---|---|---|---|---|
| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | |
| Dialysis Facilities | 5.6 | 5.8 | 5.3 | 4.0 | Hygiene, Infection Control, & Manage Volume Status. |
| Hospitals | 5.7 | 4.9 | 4.2 | 1.6 | Supervision, patient rights, & infection control. |
| Ambulatory Surgical Centers | 4.8 | 4.2 | 4.0 | 3.5 | Sanitary environment, infection control deficiencies & drug administration. |

- One of CMS' performance goals is to decrease the percentage of long-stay nursing home residents receiving antipsychotic medications, which can have dangerous side effects. To achieve this goal, CMS launched a nationwide initiative in 2012 called– the Partnership to Improve Dementia Care in Nursing Homes. In 2011, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then that number has decreased 36.6 percent to a national prevalence of 15.4 percent in 2017. This goal was achieved in part due to CMS' improved surveyor guidance that focused on dementia care. The yearly goals, accomplishments, and future targets of this effort are reported in the Performance Appendix MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2016 | $397,334,000 |
| FY 2017 | $397,334,000 |
| FY 2018 | $397,334,000 |
| FY 2019 Enacted | $397,334,000 |
| FY 2020 President's Budget | $442,192,000 |

**Budget Request: $442.2 million**

The FY 2020 President's Budget request is $442.2 million, $44.9 million above the FY 2019 Enacted Level. This request will allow CMS to maintain statutorily-required survey

frequency rates for nursing homes, HHAs, and hospice facilities. In addition, this increase in funding will enable CMS to increase quality oversight for facility types without statutorily mandated survey frequency standards. Flat survey funding for several consecutive years has meant that, other than investigating complaints, these facility types have limited survey oversight, increasing the risk to beneficiary health or safety. Increased survey funding in this Budget will bring the survey frequency rates for these facilities types closer to more optimal policy levels.

This request also includes funding for ongoing contract support. CMS employs a variety of contracts to strengthen ongoing quality improvement efforts, improve national consistency, improve AO oversight, and implement Government Accountability Office (GAO) and the Office of Inspector General (OIG) recommendations to promote gains in efficiency and effectiveness. The table below provides the program level funding details from FY 2018 to FY 2020.

**Program Level Table[/1]**
(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget[/2] | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Breakout by Survey and Certification Funding Categories | | | | |
| State Direct Survey | $353,394 | $354,477 | $398,314 | $43,836 |
| Other State Direct Survey | $5,263 | $6,370 | $6,920 | $550 |
| Federal Direct Survey | $13,755 | $11,713 | $11,947 | $235 |
| Support Contracts | $24,106 | $23,591 | $24,709 | $1,118 |
| Information Technology | $817 | $1,183 | $302 | ($880) |
| Budget Authority (BA) | $397,334 | $397,334 | $442,192 | $44,858 |
| Proposed Revisit User Fee | $0 | $0 | $0 | $0 |
| **Subtotal: Proposed Law Discretionary Program Level** | **$397,334** | **$397,334** | **$442,192** | **$44,858** |
| IMPACT P.L. 113-185. Hospice Surveys[/3] | $5,254 | $5,276 | $5,625 | $349 |
| IMPACT Improve Nursing Home Staffing data | $529 | $0 | $0 | $0 |
| **Total: Program Level** | **$403,117** | **$402,610** | **$447,817** | **$45,207** |

1/ Figures may not sum as displayed due to rounding.
2/ CMS anticipates enactment of revisit user fee in FY 2020 with collections to start in FY 2021.
3/ Funding provided through IMPACT P.L. 113-185 Section 3 for hospice surveys in FY 2018 and FY 2019 was subject to 6.6 and 6.2 percent sequester respectively.

CMS' FY 2020 request includes the enactment of three proposals:

1. To incentivize facilities to restore and maintain compliance with Medicare COPs, CMS is re-proposing to enact the FY 2019 revisit user fee proposal. If enacted, this proposal will provide CMS the authority to charge providers a fee for revisits as a result of deficiencies found during initial certification, recertification, or substantiated complaints. In addition, CMS will also have the authority to charge facilities a fee for substantiated complaints surveys resulting in findings cited at the level of immediate jeopardy or actual harm. CMS levied a revisit user fee for one year FY 2007, exhibiting the feasibility of such a fee. If enacted, CMS assumes that collections will not start until FY 2021. The collections will supplement the Program Management funding for the Survey and Certification program.

2. To reduce provider burden and make funding to states more efficient, CMS is

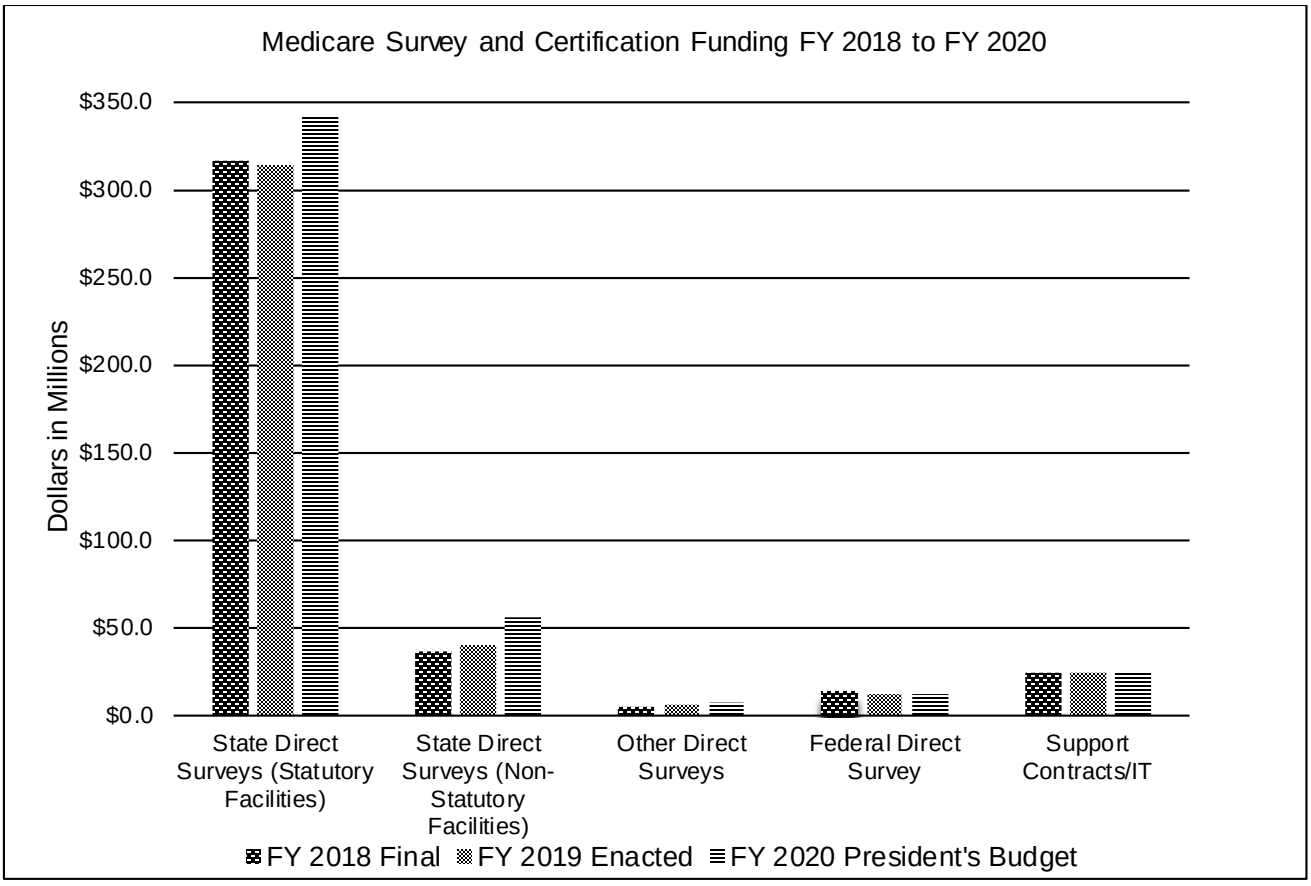
re-proposing a risk-based nursing home survey process. The risk-based nursing home survey would allow CMS to adjust Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) survey frequencies for top-performing nursing homes, not to exceed 10 percent of all Medicare or Medicaid-participating nursing homes in each State in any Federal fiscal year. The top-performing nursing homes would be required to be surveyed on average every 30 months (rather than the current 12 months) with no more than 36 months between surveys of any single facility (compared to the current 15 month individual facility limit). CMS will reinvest the savings resulting from this change to strengthen oversight and quality improvement for Special Focus Facilities and other low performing facilities in an effort to focus additional resources where they are most needed to improve quality and promote patient safety.

3. To improve CMS' administrative flexibility with respect to fund State Survey Agencies and contractors, CMS proposes two year budget authority for the Survey and Certification program. If enacted, this proposal will extend the period of availability for the Survey and Certification Program Management funds by one year and allow CMS to reprioritize funds where needs arise.

CMS' Survey and Certification program strives to maintain survey and certification standards set in statute. Growth in the number of beneficiaries and facilities, inflation, changes in laws, and improvements in quality standards are all factors that increase program costs.

If funding levels do not account for increased program costs, CMS would have to reduce funding for lower risk non-statutory facilities, delay implementation of projects, and reallocate funding to maintain survey frequency rates at statutory facilities and high-priority non-statutory facilities including non-deemed hospitals, ESRDs, and ASCs.

The chart below illustrates portions of CMS' survey and certification budget and a comparison of the funding allocation between the FY 2018 Final, FY 2019 Enacted, and the FY 2020 President's Budget request levels. While most portions of the budget remain relatively steady, funding for overall State direct survey increases as survey costs increase. Most notably, in FY 2018 and FY 2019, funding for non-statutory facilities were reduced and allocated to maintain statutory survey frequencies at nursing homes, HHAs, and hospice facilities, based on availability of funds. However, this reallocation is not as severe in FY 2020, as requested funding more fully accounts for cost increases and will allow CMS to improve upon survey and certification efforts estimated for FY 2019.




The State Direct Survey portion accounts for 90 percent of the total CMS' Survey and Certification budget, which is subdivided into statutory facilities and non-statutory facilities. This funding is provided directly to states to survey, certify, and conduct complaint investigations of Medicare facilities. The following are the details for the State Direct Survey portion of the FY 2020 budget request.

- *State Direct Survey:* $398.3 million. The FY 2020 request includes $398.3 million in discretionary budget authority for State Direct Survey costs, which is $43.8 million above the FY 2019 Enacted.

  Of the total State Direct Survey request for FY 2020, $341.8 million will enable CMS to maintain survey frequencies in nursing homes, HHAs, and hospice facilities as required by statue. With the remaining $56.5 million, CMS estimates the survey frequencies rates for non-statutory facilities will be closer to CMS administrative policy levels. In addition, this increase will enable CMS to provide funding to states to conduct initial, recertification, revisit, and complaint surveys for organ transplant facilities, an effort that was historically conducted by federal contractors.

In addition to the aforementioned cost drivers, this requested increase is needed in part because the mandatory IMPACT Act funding to implement the three year frequency for Hospice facilities is reduced in statute by close to 30 percent beginning in FY 2018 and continuing into FY 2020.

The FY 2020 Budget request supports efforts to find improvements within existing survey processes. One example of this approach is the development and implementation of a revised nursing home survey process which is designed to blend the best features of the traditional and Quality Indicator Survey to maximize survey effectiveness while improving efficiency. The enhancements include:

- Strengthening the focus on residents and their experiences of quality of life and quality of care, in part, by moving away from memorization questions to more conversational style, within the context of a structured interview guide to ensure important topics are discussed. This approach is meant to emphasize the "human element" by sparking more natural conversation and building on surveyor interview skills.
- Clarifying how to consistently and thoroughly investigate care concerns, primarily by using updated Critical Element (CE) Pathways to look at processes and care concerns to guide surveyors more consistently through the investigation.
- Using data to guide surveyors through the process of inspecting and certifying facilities. This will allow surveyors to be more flexible, understand residents' characteristics, and identify facility concerns.

The table below demonstrates which facilities have survey frequency rates that are mandated by statute, and, for those without a statutorily mandated frequency rate, what CMS views as an ideal survey frequency under its administrative policy. In addition, the table provides estimated survey frequency rates for each facility type and associated costs in FY 2018, FY 2019, and FY 2020. In FY 2018 and FY 2019, due to budget constraints, CMS estimates that most non-statutory facilities will not be surveyed at the rates reported in previous years.

## FY 2018 to FY 2020 Survey Frequency Rates and Cost by Facility Type[1]

(Dollars in Millions)

| Type of Facility | Survey Frequencies: Statutory and CMS Policy | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Request |
|---|---|---|---|---|
| Skilled Nursing Home | 1.3 years for individual nursing home with a statewide average interval of 1.1 years | Annually<br>$16.330 | Annually<br>$15.969 | Annually<br>$17.358 |
| SNF/NF (dually-certified) | | Annually<br>$268.918 | Annually<br>$268.627 | Annually<br>$280.264 |
| Home Health Agencies | 3.1 Years | 3 Years<br>$24.537 | 3 Years<br>$24.239 | 3 Years<br>$34.888 |
| Hospices[2] | 3.1 Years | 3 Years<br>$7.166 | 3 Years<br>$5.156 | 3 Years<br>$9.315 |
| **Sub-Total Statutory Facilities** | | **$316.952** | **$313.991** | **$341.825** |
| Deemed Hospitals - Validations | 5% Year Sample | 0.40% Year Sample<br>$23.989 | 0.5% Year Sample<br>$25.808 | 1.5% Year Sample<br>$22.995 |
| Organ Transplant Facilities[3] | 5 Years | 5 Years<br>$0.0 | 12 Years<br>$0.710 | 9 Years<br>$0.840 |
| Non-Deemed Hospitals | 3 Years | [4]<br>$4.087 | [4]<br>$3.890 | 9 Years<br>$8.923 |
| Outpatient Physical Therapy | 6 Years | [4]<br>$0.218 | [4]<br>$0.342 | 15 Years<br>$0.673 |
| Comprehensive Outpatient Rehabilitation Facility (CORF) | 6 Years | [4]<br>$0.044 | [4]<br>$0.038 | 15 Years<br>$0.088 |
| Portable X-Rays | 6 Years | [4]<br>$0.052 | [4]<br>$0.076 | 15 Years<br>$0.140 |
| ESRD | 3 Years | [4]<br>$6.446 | [4]<br>$7.604 | 9 Years<br>$15.719 |
| Rural Health Clinics | 6 Years | [4]<br>$0.308 | [4]<br>$0.518 | 15 Years<br>$1.121 |
| ASCs | 3 Years | [4]<br>$1.237 | [4]<br>$1.452 | 10 Years<br>$5.840 |
| Community Mental Health Centers (CMHC) | 6 Years | [4]<br>$0.062 | [4]<br>$0.050 | 15 Years<br>$0.150 |
| **Sub-total Non-Statutory Facilities** | | **$36.443** | **$40.487** | **$56.489** |
| State Direct Survey Costs | N/A | $353.394 | $354.477 | $398.314 |
| Other State Direct Survey Costs | N/A | $5.263 | $6.370 | $6.920 |
| **Total, State Direct Survey** | **N/A** | **$358.657** | **$360.847** | **$405.234** |

1/ Figures may not sum as displayed due to rounding.
2/ Hospice surveys are partially funded under the IMPACT ACT PL 113-185.
3/ In FY 2018 Organ Transplant Facilities surveys were performed by federal contractors.
4/ Local jurisdictions will continue to respond to complaints, and based on availability of resources, certify new facilities.

In FY 2020, CMS expects to complete approximately 22,000 initial and recertification inspections. In addition, CMS estimates 61,000 visits in response to complaints. The Survey and Complaint Visit Tables below show that the majority of both surveys and complaint visits in FY 2019 and FY 2020 are projected to be in nursing homes. These surveys will contribute to achieving one of CMS' nursing home quality goals to decrease the percentage of long-stay nursing home residents receiving antipsychotic medications.

**Survey and Complaint Visit Tables**

| FY 2019 Enacted | | | | | |
|---|---|---|---|---|---|
| **Provider Type** | **Projected # Facility (Beg of FY)** | **Recertification Surveys** | **Initial Surveys** | **Complaint Visits** | **Total** |
| Skilled Nursing Facility | 783 | 783 | 33 | 1,065 | 1,881 |
| SNF/NF (dually-certified) | 14,515 | 14,603 | 112 | 51,935 | 66,650 |
| Home Health Agencies | 12,284 | 2,805 | 40 | 1,182 | 4,027 |
| Deem Hospital | 4,712 | 24 | 0 | 2,865 | 2,889 |
| Organ Transplant Facilities | 242 | 20 | 2 | 2 | 24 |
| Non-Deemed Hospitals | 1,488 | 30 | 12 | 345 | 387 |
| Hospices/1 | 4,406 | 828 | 28 | 442 | 1,298 |
| Outpatient Physical Therapy | 2,128 | 38 | 39 | 6 | 83 |
| CORF | 205 | 4 | 3 | 1 | 8 |
| Portable X-Rays | 515 | 10 | 18 | 3 | 31 |
| ESRD | 6,719 | 146 | 305 | 942 | 1,393 |
| Rural Health Clinics | 4,249 | 78 | 68 | 33 | 179 |
| ACSs | 5,517 | 73 | 21 | 93 | 187 |
| CMHC | 188 | 4 | 5 | 4 | 13 |
| **Total** | **57,951** | **19,446** | **686** | **58,918** | **79,050** |

1/ A portion of hospice surveys are separately funded under the IMPACT Act PL 113-185.

| FY 2020 President's Request | | | | | |
|---|---|---|---|---|---|
| **Provider Type** | **Projected # Facility (Beg of FY)** | **Recertification Surveys** | **Initial Surveys** | **Complaint Visits** | **Total** |
| Skilled Nursing Facility | 768 | 768 | 31 | 1,015 | 1,814 |
| SNF/NF (dually-certified) | 14,555 | 14,643 | 102 | 53,350 | 68,095 |
| Home Health Agencies | 11,970 | 2,740 | 40 | 1,298 | 4,078 |
| Deem Hospital | 4,745 | 71 | 0 | 3,056 | 3,127 |
| Organ Transplant Facilities | 242 | 27 | 2 | 5 | 34 |
| Non-Deemed Hospitals | 1,425 | 158 | 11 | 315 | 484 |
| Hospices/1 | 4,593 | 829 | 27 | 585 | 1,441 |
| Outpatient Physical Therapy | 2,069 | 122 | 38 | 6 | 166 |
| CORF | 196 | 13 | 3 | 1 | 17 |
| Portable X-Rays | 505 | 34 | 15 | 1 | 50 |
| ESRD | 7,015 | 779 | 278 | 916 | 1,973 |
| Rural Health Clinics | 4,241 | 248 | 70 | 33 | 351 |
| ACSs | 5,620 | 384 | 22 | 139 | 545 |
| CMHC | 158 | 10 | 4 | 12 | 26 |
| **Total** | **58,102** | **20,826** | **643** | **60,732** | **82,201** |

1/ A portion of hospice surveys are separately funded under the IMPACT Act PL 113-185.

The Other Direct Survey portion makes up about 2 percent of the Survey and Certification budget to support costs related to State Direct Surveys such as training, travel, and AO validations surveys. Validation surveys are conducted by SAs to ensure AOs maintain quality standards that are commensurate with, or exceed, CMS COPs. The following are the details for the Other Direct Survey portion of the FY 2020 Budget request.

- *Other State Direct Survey*: $6.9 million. The FY 2020 Other State Direct Survey cost estimate is $6.9 million, $0.6 million above the FY 2019 Enacted level. With the availability of online training, administrative costs for travel, equipment, and training locations for surveyors and training staff will be reduced.

  In addition, this funding will support states program operations or responsibilities that include:

  - Support for validation surveys to assess the performance of CMS-approved accrediting organizations, as required by law.
  - State responsibilities to collect and report survey data 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.
  - Support for the Outcome and Assessment Information Set (OASIS), which serves as the backbone of the home health prospective payment system. This will fund contractors that assist states to address performance issues, emergency preparedness and post-disaster recovery surveys.

The Federal Direct Survey is about 3 percent of the total Survey and Certification budget. These funds are used to hire contractors who support the survey and certification program, nationwide. CMS utilizes contract surveyors to support surveys at psychiatric hospitals, since psychiatric hospitals are small in number and require highly specialized methods and survey expertise to ensure quality of care. CMS also uses contractors to perform comparative surveys with SAs and to mitigate challenges to the Federal and State capacity to oversee and investigate quality of care issues. These contractors maintain oversight for compliance with the Medicare health and safety standards for all facilities and provide support to SAs. They also help mitigate the delay experienced by prospective providers seeking Medicare participation. The following are the details for the Federal Direct Survey portion of the request.

- *Federal Direct Surveys*: $11.9 million. The FY 2020 budget request for Federal Direct Survey is $11.9 million. This funding is $0.2 million above the FY 2019 Enacted level, and continues the oversight of U.S. territories and islands health care facilities. In FY 2020, all initial, recertification, revisit, and complaint surveys for organ transplant facilities will be conducted by state survey agencies instead of federal contractors. Funding for this effort has been reallocated to State Direct Surveys for survey efforts and to Support Contracts for additional training.

  This funding promotes improved health care and continued access to health care in both U.S. territories where there are often few providers. Facilities 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 and a hospital and nursing home in the Virgin Islands.

The Support Contracts and Information Technology (IT) portion comprises nearly 6 percent of the total Survey and Certification budget for various activities that are crucial in meeting program goals. Activities range from providing a standardized training curricula on a newly consolidated platform to a nationwide audience on a 24/7 basis, to improving key survey processes and other targeted interventions, to identifying new methods for collecting and reporting data that are used to evaluate survey variation, State performance and to identify problems more quickly. This activity also supports IT efforts aimed at improving CMS' existing data systems to make program information publicly available, understandable, and more accessible. The following are the details for the Support Contracts and IT portion of the request.

- *Support Contracts and Information Technology*: $25.0 million. Support contracts and information technology constitute about 6 percent of the FY 2020 President's Request.

  The FY 2020 Budget request for support contracts is slightly over $24.0 million, which is $1.1 million above the FY 2019 Enacted level and supports the following:

  - Surveyor training, which continues to be one of the largest categories in other contracts. Training contracts enable CMS to fulfill statutorily required facility staff training mandates of Sections 1819, 1919, and 1891 of the Social Security Act, and will enable CMS to continue to develop an increasing array of online course material in a more efficient manner to maximize the value of training expenditures.
  - Maintenance and upgrades to the Five-Star Quality Rating System on the Nursing Home Compare website. Onsite surveys represent the primary source of verifiable information used for the Five-Star Quality Rating System, as the survey data come from observation of conditions in the nursing homes by trained surveyors. This effort enables CMS to publish the results of onsite certification and complaint surveys in a searchable database, easily accessible for public use, and serves as a market-oriented incentive for nursing homes to improve quality.
  - Improvements in State Performance Standards data allowing State Agencies and CMS Regional Offices to monitor survey and enforcement activities, identify problems, and quickly deploy corrective actions.
  - Contracts to ensure national program oversight and consistency such as the Surveyor Minimum Qualifications Test, and AO oversight, to ensure adherence to established program criteria.
  - Implementation of Homeland Security Presidential Directive 12 (HSPD-12), which is the policy for a common identification standard for federal employees and contractors.

  The IT funding request for FY 2020 is approximately $0.3 million, which is $0.9 million below the FY 2019 Enacted level. IT funds will continue to support maintenance for Survey & Certification / Clinical Laboratory Improvement Amendments Budget and Expenditure (SC/CLIA) Application.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Centers for Medicare & Medicaid Services
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# Grants to States for Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$276,236,212,000] *$273,188,478,000,* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2019, 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] *2020,* for the last quarter of fiscal year [2019] *2020* 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 [2020] *2021*, [$137,931,797,000] *$139,903,075,000,* 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.

# Grants to States for Medicaid

## Language Analysis

| Language Provision | Explanation |
| --- | --- |
| For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *[$276,236,212,000] $273,188,478,000,* to remain available until expended. | This section provides a no-year appropriation for Medicaid for FY 2020. This appropriation is in addition to the advance appropriation of $137.9 billion for the first quarter of FY 2020. 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, [2019, 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] 2020,* for the last quarter of fiscal year *[2019] 2020*, 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 2020 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. |

# Grants to States for 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 [2020] *2021, [$137,931,797,000] $139,903,075,000,* to remain available until expended. | This section provides an advance appropriation for the first quarter of FY 2021 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 2021 is not enacted by October 1, 2020. "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. |

## Grants to States for Medicaid
## Amounts Available for Obligation
(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| **Mandatory Appropriation:** | | | | |
| Advanced Appropriation..... | $125,219,452 | $134,847,759 | $137,931,797 | $3,084,038 |
| Annual Appropriation..... | $284,798,384 | $276,236,212 | $273,188,478 | ($3,047,734) |
| Indefinite Annual Appropriation.. | $0 | $0 | $0 | $0 |
| Subtotal, Mandatory Appropriation | $410,017,836 | $411,083,971 | $411,120,275 | $36,304 |
| **Offsetting Collections from Federal Sources:** | | | | |
| Collection Authority: Medicare Part D…….. | $0 | $3,100 | $5,000 | $1,900 |
| Collection Authority: Medicare Part B…….. | $1,417,385 | $1,030,000 | $1,123,000 | $93,000 |
| Subtotal, Collections Authority | $1,417,385 | $1,033,100 | $1,128,000 | $94,900 |
| **Total New Budget Authority** | **$411,435,221** | **$412,117,071** | **$412,248,275** | **$131,204** |
| **Unobligated Balances:** | | | | |
| Unobligated balance, Start of year..... | $309,808 | $15,402,641 | $16,785,226 | $1,382,585 |
| Unobligated balance, Recoveries of Prior Year Obligations…… | $45,049,989 | $35,570,000 | $37,099,554 | $1,529,554 |
| Subtotal, Unobligated Balances..... | $45,359,797 | $50,972,641 | $53,884,780 | $2,912,139 |
| **Total Amounts Available for Obligations** | **$456,795,017** | **$463,089,712** | **$466,133,055** | **$3,043,343** |
| Gross Obligations..... | $441,392,376 | $446,304,486 | $466,133,055 | $20,908,569 |
| Unobligated balance, end of year…….. | $15,402,641 | $16,785,226 | $0 | ($16,775,226) |
| **Net Obligations:** | | | | |
| Gross Obligations..... | $441,392,376 | $446,304,486 | $466,133,055 | $19,828,569 |
| Actual Collections: Medicare Part D…….. | $0 | ($3,100) | ($5,000) | ($1,900) |
| Actual Collections: Medicare Part B…….. | $0 | ($1,030,000) | ($1,123,000) | ($93,000) |
| Unobligated balance, Start of year..... | ($309,808) | ($15,402,641) | ($16,785,226) | ($1,382,585) |
| Unobligated balance, Recoveries of Unpaid Obligations..... | ($45,049,989) | ($35,570,000) | ($37,099,554) | ($1,529,554) |
| **Total Net Obligations** | **$396,032,579** | **$394,298,745** | **$411,120,275** | **$16,821,530** |

## Grants to States for Medicaid

## Appropriations History Table

| Fiscal Year | Budget Estimate to Congress | Appropriation | |
|---|---|---|---|
| 2011 | $259,933,181,000 | $258,365,747,000 | /1 |
| 2012 | $270,724,399,000 | $270,724,399,000 | |
| 2013 | $269,405,279,000 | $269,405,279,000 | /2 |
| 2014 | $284,208,616,000 | $305,843,467,000 | /3 |
| 2015 | $338,081,239,000 | $368,405,940,000 | /4 |
| 2016 | $356,817,550,000 | $366,672,257,000 | /5 |
| 2017 | $377,586,469,000 | $389,349,760,000 | /6 |
| 2018 | $410,017,836,000 | $410,017,836,000 | |
| 2019 | $411,083,971,000 | $411,083,971,000 | |
| 2020 | $411,120,275,000 | ------ | |

1/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
2/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
3/ Includes $21.6 billion in indefinite funding authority obligated during FY 2014.
4/ Includes $16.8 billion in indefinite funding authority obligated during FY 2015.
5/ Includes $9.9 billion in indefinite funding authority obligated during FY 2016.
6/ Includes $11.8 billion in indefinite funding authority obligated during FY 2017.

## Grants to States for Medicaid

## Budget Authority by Object

(Dollars in Thousands)

| | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|
| **CMS - Grants to States**<br>Grants to States, Subsidies | $407,941,390 | $407,486,867 | (454,523) |
| **CDC - Vaccines For Children**<br>Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance | $4,175,681 | $4,761,408 | $585,727 |
| **Total Budget Authority** | **$412,117,071** | **$412,248,275** | **$131,204** |

## Grants to States for Medicaid
## Budget Authority by Program Activity
(Dollars in Thousands)

| | FY 2018 Actual | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| **1. Medical Assistance Payments** | | | | |
| Medical Assistance Payments..... | $347,926,112 | $348,981,217 | $345,940,325 | ($3,040,892) |
| Benefits Due and Payable (IBNR) | $35,570,000 | $37,099,554 | $39,018,939 | $1,919,385 |
| **Subtotal, Benefits** | **$384,496,112** | **$386,080,771** | **$384,959,264** | **($1,121,507)** |
| **2. Vaccine for Children** | | | | |
| Vaccines for Children..... | $4,388,748 | $4,175,681 | $4,761,408 | $585,727 |
| **Subtotal, Vaccine for Children** | **$4,388,748** | **$4,175,681** | **$4,761,408** | **$585,727** |
| **2. State Administration** | | | | |
| State and Local Administration..... | $19,848,241 | $20,206,134 | $20,812,000 | $605,866 |
| HIT- Incentives..... | $1,202,514 | $272,199 | $152,000 | ($120,199) |
| HIT- Administration..... | $558,895 | $795,971 | $990,853 | $194,882 |
| State Survey and Certification..... | $259,487 | $308,315 | $286,750 | ($21,565) |
| State Fraud Control Units..... | $263,839 | $278,000 | $286,000 | $8,000 |
| **Subtotal, State Administration** | **$22,132,976** | **$21,860,619** | **$22,527,603** | **$666,984** |
| Total Mandatory Appropriation…….. | $410,017,836 | $411,083,971 | $411,120,275 | $36,304 |
| Total Offsetting Collection Authority[1,2]…….. | $1,417,385 | $1,033,100 | $1,128,000 | $94,900 |
| **Total, Budget Authority** | **$411,435,221** | **$412,117,071** | **$412,248,275** | **$131,204** |

1/Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XIX, Section 1933(f).
2/Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XVIII, 1860D-16(b)(2).

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2019 Authorization - Public Laws 115-141 and 115-245

Allocation Method - Formula Grants

## Grants to States for Medicaid
## Appropriated Budget Request[1]

(Dollars in Thousands)

| | FY 2018 President's Budget | FY 2019 President's Budget | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| **Program Activity** | | | | |
| Medical Assistance Payments..... | $384,608,394 | $384,882,625 | $383,836,264 | ($1,046,361) |
| State and Local Administration..... | $20,811,084 | $21,474,885 | $22,522,603 | $1,047,718 |
| Vaccine for Children..... | $4,598,358 | $4,726,461 | $4,761,408 | $34,947 |
| **Subtotal, Medicaid Program Level** | **$410,017,836** | **$411,083,971** | **$411,120,275** | **$36,304** |
| Less funds advanced in prior year. | $125,219,452 | $134,847,759 | $137,931,797 | $3,084,038 |
| **Total, Grants to States for Medicaid** | **$284,798,384** | **$276,236,212** | **$273,188,478** | **($3,047,734)** |
| New advance 1st quarter of subsequent FY..... | $134,847,759 | $137,931,797 | $139,903,075 | $1,971,278 |

[1]Funding represented in the chart equals the respective President's budget requests. This chart does not reflect the most recent data available for FY 2018 and FY 2019 Medicaid expenditures.

# Grants to States for Medicaid

Authorized under title XIX of the Social Security Act, Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults. In addition, Medicaid provides home and community-based services and support to seniors and individuals with disabilities, as well as institutional long-term care services. Medicaid is administered by CMS in partnership with the states.

The table below, and the following language, provides additional detail on each of the Grants to States for Medicaid program activities for FY 2020.

**Summary of Request**
**Grants to States for Medicaid Mandatory Appropriation Request Summary Table**
(Dollars in Millions)

| Program Activity | FY 2018 Actual | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Medical Assistance Payments | $383,496.1 | $385,050.8 | $383,836.3 | ($1,214.5) |
| State and Local Administration | $22,133.0 | $21,857.5 | $22,522.6 | $665.1 |
| Vaccine for Children | $4,388.7 | $4,175.7 | $4,761.4 | $585.7 |
| **Total Mandatory Appropriation Request[1]** | **$410,017.8** | **$411,084.0** | **$411,120.3** | **$36.3** |

1/ Numbers may not add due to rounding.

**FY 2020 Mandatory Appropriation Request: $411.1 billion**

CMS' FY 2020 mandatory appropriation request for the Grants to States for Medicaid account is $411.1 billion, an increase of $36.3 million relative to the FY 2019 request level of $411.1 billion. This appropriation is composed of $137.9 billion in an authorized advance appropriation for FY 2020 and a remaining appropriation of $273.2 billion for FY 2020.

Resources will help fund $466.1 billion in anticipated FY 2020 Medicaid obligations. CMS also anticipates carryover balances and recoveries in the amount of $53.9 billion as well as budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.1 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $438.9 billion in Medicaid medical assistance payments (MAP);
- $22.5 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $4.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recent as the third quarter of FY 2018. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2020 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $426.0 billion in FY 2020. This represents an increase of 1.7 percent relative to the estimated net outlay level of $418.7 billion for FY 2019.

The FY 2020 estimate will be discussed in further detail by the major program activities of the Grants to States for Medicaid account; Medical Assistance Payments, Vaccines for Children, and State and Local Administration.

# Grants to States for Medicaid

# Medical Assistance Payments

(Dollars in Thousands)

| | FY 2018 Actual | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Medical Assistance Payments | $383,496,112 | $385,050,771 | $383,836,264 | ($1,214,507) |

**Program Activity Description and Accomplishments**

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's low-income population.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, benefits, and/or reimbursement, subject to federal standards, at any time.

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 reimbursement. 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.

Medicaid Eligibility and Enrollment

Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults.

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 2018 Estimate | FY 2019 Estimate | FY 2020 Estimate | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Aged | 6.0 | 6.2 | 6.4 | 0.2 |
| Disabled | 10.7 | 10.9 | 11.0 | 0.1 |
| Adults | 28.0 | 28.7 | 29.6 | 0.9 |
| Children | 28.5 | 29.0 | 29.5 | 0.5 |
| Territories | 1.4 | 1.4 | 1.4 | 0.0 |
| **Total/1** | **74.6** | **76.2** | **77.9** | **1.7** |
| | | | | |

1/ Totals may not add due to rounding.

According to CMS projections of Medicaid enrollment, 77.9 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2020. In FY 2020, Medicaid is projected to provide coverage to more than one out of every five people in the nation. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 2.2 percent in FY 2020 from the estimated FY 2019 enrollment level.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, a state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds to provide certain optional services. Following are some of the most common, currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.

- Intermediate care facility services.
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Hospice care.
- Home and community-based care to certain persons with chronic impairments.
- Targeted case management services.

## FY 2020 Estimate

**Budget Estimate: $383.8 Billion**

CMS' Medical Assistance Payments (MAP) budget estimate is $383.8 billion, a $1.2 billion decrease below the FY 2019 estimated level. The following language provides additional detail on CMS' FY 2020 estimate: In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to reflect actuarial estimates developed by CMS' Office of the Actuary (OACT), legislative and regulatory impacts, entitlement benefits due and payable, CMS financial management reviews and estimates of expenditure transfer authority from the Medicare trust funds.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

CMS' OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures and, because of this, CMS' OACT relies more on actual expenditure data than the state-submitted estimates. CMS' OACT developed the MAP estimate for FY 2020 using the last three quarters of FY 2017 state-reported expenditures as a base. Expenditures for FY 2018, FY 2019, and FY 2020 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 OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the state-submitted estimates.

For an in-depth analysis of the actuarial Medicaid cost estimates and financial outlook on the Medicaid program, see the Actuarial Report on the Financial Outlook for Medicaid at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.html

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2020 estimate of $39.0 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2019 to September 30, 2020. This Medicaid liability is developed from estimates received from the states. The incurred but not reported 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.

Medicaid Financial Management Reviews

Financial management (FM) reviews conducted by CMS are expected to produce additional savings of $49.0 million in FY 2020. 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.

Transfer from the Supplementary Medical Insurance Trust Fund for Qualified Individuals

Social Security Act Title XIX Section 1933(f) authorizes a transfer from the Supplementary Medical Insurance Trust Fund to the Grants to States for Medicaid account to account for the Medicare programs costs attributable to state coverage of Medicare cost-sharing for certain low-income Medicare beneficiaries. This estimate is developed by CMS' OACT, which for FY 2020 is estimated to be $1.1 billion. This transfer of funding is used to offset MAP obligations, thereby reducing the overall mandatory appropriation request.

Legislative and Regulatory Impacts to the Medicaid Baseline

The FY 2020 President's Budget for Medicaid also reflects the impact of recent legislative and regulatory actions. Below is a list of recent legislation and regulatory actions that made a significant impact to the FY 2020 Medicaid baseline estimate. In addition to adjusting the state estimates, CMS' OACT also estimates the impact of recent legislative and regulatory actions. Below is a list of recent actions that made an impact to the current actuarial baseline estimate.

**Legislative Actions**

**Medicaid Extenders Act of 2019 (P.L. 116-3)**

This law includes extensions of Money Follows the Person program and spousal impoverishment rules, and reduces the federal match for states that have not implemented asset verification programs.

**SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271)**

This Act contains a number of Medicaid provisions related to coverage and services for beneficiaries with substance use disorders.

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

Section 503 of this legislation authorizes CMS to limit reimbursement on DME to Medicare payment rates.

**HEALTHY KIDS Act of 2018 (P.L. 115-120) and Bipartisan Budget Act of 2018 (P.L. 115-123)**

Sections 3002 and 3005 of HEALTHY KIDS Act of 2018 and Section 50101 of the Bipartisan Budget Act of 2018 extended funding for the Children's Health Insurance Program (CHIP) from FY 2018 through FY 2027. In the absence of federal funding for CHIP, some CHIP beneficiaries that would have otherwise been eligible for Medicaid would have moved to Medicaid, increasing enrollment and expenditures for the Medicaid program. Section 53104 of the Bipartisan budget Act also increased manufacturers' Medicaid drug rebate obligations with respect to line extension drugs.

**Regulatory Actions**

**SMDL #18-011: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance**

This State Medicaid Director's Letter (SMDL) fulfills a requirement of the 21st Century Cures Act by elaborating criteria for granting waivers for states to receive federal financial participation for services to treat Medicaid beneficiaries with serious mental illness (SMI) and serious emotional disturbance (SED) during short-term acute care stays in psychiatric hospitals or in residential treatment facilities that qualify as an Institution for Mental Diseases (IMDs).

**SMDL #18-002: Opportunities to promote work and community engagement among Medicaid beneficiaries**

This SMDL informed states of an opportunity to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act.

**SMDL #18-005: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in section 1115 demonstrations**

This SMDL informed states that CMS will no longer accept state proposals for new or renewing section 1115 demonstrations that rely on federal matching funds for designated state health programs (DSHP) that were previously funded entirely by the state.

**Removal of Safe Harbor Protection Proposed Rule**

CMS proposes to amend the safe harbor regulation concerning discounts. The amendment would revise the discount safe harbor to explicitly exclude from the definition of a discount eligible for safe harbor protection certain reductions in price or other remuneration from a manufacturer of prescription pharmaceutical products to plan sponsors under Medicare Part D, Medicaid managed care organizations as defined under section 1903(m) of the Act (Medicaid MCOs), or pharmacy benefit managers (PBMs) under contract with them. In addition, CMS is proposing two new safe harbors. The first would protect certain point-of-sale reductions in price on prescription pharmaceutical products, and the second would protect certain PBM service fees.

**Administrative Proposals Assumed in the FY 2020 President's Budget**

- Require minimum standards in Medicaid state drug utilization review programs
- Establish unique identifiers for personal care service attendants
- Improve Transparency of Medicaid Supplemental Payments
- Make Medicaid Non-Emergency Medical Transportation optional
- Reduce the Federal Match Rate for Medicaid Eligibility Workers
- Allow States the Flexibility to Complete More Frequent Eligibility Redeterminations
- Test Interventions to Improve Maternal Mortality and Morbidity
- Incentivize States to Address Medicaid Improper Payments Related to Beneficiary Eligibility
- Allow revocation and denial of provider enrollment based on affiliation with a sanctioned entity
- Tighten Medicaid Child Support Enforcement Requirements

Please see the FY 2020 HHS Budget-in-Brief for more detail on legislative and administrative proposals for Medicaid.

# Grants to States for Medicaid

## Vaccines for Children

(Dollars in Thousands)

| | FY 2018 Actual | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY2019 |
|---|---|---|---|---|
| Vaccines for Children | $4,388,748 | $4,175,681 | $4,761,408 | $585,727 |

**Program Activity Description and Accomplishments**

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.

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. Vaccination against diphtheria, *haemophilus influenza* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella is currently recommended. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the Vaccines for Children Program began in 1994. Among children born during 1994–2016, vaccination will prevent an estimated 388.0 million illnesses, 24.5 million hospitalizations, and 855,000 early deaths over the course of their lifetimes, at a net savings of $360 billion in direct costs and $1.65 trillion in total societal costs.[1]

**FY 2020 Budget Estimate: $4,761.4 million**

CMS' Vaccine for Children estimate is $4,761.4 million, a $585.7 million dollar increase over the FY 19 estimated level.

This estimate includes an increase for vaccine-purchase contract costs and additional quality assurance and quality improvement site visits to VFC-enrolled providers. This

[1] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm?s_cid=mm6316a4_w

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.

# Grants to States for Medicaid

## State and Local Administration

(Dollars in Thousands)

| | FY 2018 Actual | FY 2019 Estimate | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| State and Local Administration | $22,132,976 | $21,857,519 | $22,522,603 | $665,084 |

**Program Activity Description and Accomplishments**

State and Local Administration

State and Local Administration funding includes Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems; non-MMIS automated data processing activities; 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.

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

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as neglect or abuse of patients in health care facilities and board and care facilities. The MFCUs are typically a part of the state Attorney General's office or have arrangements with the Attorney General or another office with statewide prosecutorial authority. In FY 2017, MFCUs were responsible for 1,528 convictions, 961 civil settlements, and expected monetary recoveries for both civil and criminal cases of $1.8 billion. MFCU cases in FY 2017 were also responsible for the exclusion of 1,181 individuals and entities from

participation in Medicaid and other federally funded health care programs.

Health Information Technology Meaningful Use Incentive Program

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

**FY 2020 Budget Estimate: $22.5 Billion**

CMS' State Administration estimate is $22.5 billion, a $665.1 million dollar increase over the FY 2019 estimated level.

This estimate is composed of $286.8 million for Medicaid state survey and certification, $286 million for state Medicaid Fraud Control Units, $1.1 billion for the Health Information Technology Meaningful Use Incentive Program, and $20.8 billion for other Medicaid state and local administration,. The estimate is also reduced by the estimated expenditure transfer authority from the Medicare Part D account for state low income determinations.

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 2020 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2020 estimate for Medicaid state survey and certification is $286.8 million. This represents a decrease of over $21.6 million below the FY 2019 estimated amount of $308.3 million. This funding level supports 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; and direct state survey costs associated with nursing home and home health agency quality.

Medicaid Fraud Control Units

In FY 2020, MFCUs in 52 states and territories will investigate and prosecute Medicaid providers and protect beneficiaries from patient abuse or neglect. These operations are currently estimated to total $286.0 million. This represents an increase of $8.0 million over the FY 2019 funding level of $278.0 million. The estimated increase is because of a small net increase to staff and related expenses for the existing MFCUs, as well as the addition of new MFCUs in Puerto Rico and the U.S. Virgin Islands. The MFCUs' 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 2017, states reported $1.8 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

Health Information Technology Meaningful Use Incentive Program

The current FY 2020 estimate for the provider incentives payments and state administrative costs is $1.1 billion. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs). As providers have utilized the incentive payments to enhance their EHRs, states are seeing an increase in the need for ways to securely share these records among health care providers. States are committed to supporting this and other initiatives like the Electronic health information exchange (HIE), which allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Transfer from the Medicare Part D account for State Low Income Determinations

The current FY 2020 estimate for this transfer is $5.0 million, a $1.9 million dollar increase from the FY 2019 estimate of $3.1 million. Social Security Act Title XVIII Section 1860D-16(b)(2) authorizes a transfer from the Medicare Part D account to the Grants to States for Medicaid account to account for state administrative costs relating to Medicare prescription drug low-income subsidies, Medicare transitional prescription drug assistance, and Medicare cost-sharing. This amount is determined by CMS using actual state-submitted expenditure data projected into FY 2020.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2020 is $20.8 billion. CMS adjusted the FY 2019 state-submitted estimates of $20.2 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates.

## FY 2020 MANDATORY STATE/FORMULA GRANTS[1,2]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

| State/Territory | FY 2018 Obligations | FY 2019 Estimate | FY 2020 Estimate | Difference +/- 2020 |
|---|---|---|---|---|
| Alabama | $4,229,615 | $4,527,550 | $4,806,730 | $279,180 |
| Alaska | $1,608,620 | $1,779,375 | $1,860,202 | $80,827 |
| Arizona | $9,903,728 | $10,102,480 | $10,321,899 | $219,419 |
| Arkansas | $5,394,356 | $4,966,157 | $5,078,465 | $112,308 |
| California | $83,952,122 | $61,753,100 | $59,200,006 | -$2,553,094 |
| Colorado | $5,953,835 | $5,555,426 | $5,707,347 | $151,921 |
| Connecticut | $4,703,962 | $5,092,080 | $5,048,291 | -$43,789 |
| Delaware | $2,205,737 | $1,579,215 | $1,607,823 | $28,608 |
| Dist. Of Col. | $2,124,366 | $2,412,352 | $2,492,380 | $80,028 |
| Florida | $16,934,286 | $16,330,957 | $16,448,035 | $117,078 |
| Georgia | $8,155,553 | $7,825,411 | $8,403,867 | $578,456 |
| Hawaii | $1,723,710 | $1,479,734 | $1,427,597 | -$52,137 |
| Idaho | $1,614,932 | $1,601,563 | $1,666,646 | $65,083 |
| Illinois | $14,095,993 | $12,224,914 | $12,345,343 | $120,429 |
| Indiana | $10,198,299 | $11,022,924 | $9,442,569 | -$1,580,355 |
| Iowa | $3,509,678 | $3,725,276 | $3,819,880 | $94,604 |
| Kansas | $2,104,285 | $2,385,911 | $2,523,303 | $137,392 |
| Kentucky | $8,367,569 | $8,532,471 | $8,710,812 | $178,341 |
| Louisiana | $9,015,657 | $9,640,024 | $10,169,465 | $529,441 |
| Maine | $1,896,763 | $1,869,230 | $1,851,427 | -$17,803 |
| Maryland | $7,379,536 | $7,263,597 | $7,306,668 | $43,071 |
| Massachusetts | $10,989,463 | $11,115,727 | $11,170,938 | $55,211 |
| Michigan | $12,585,616 | $13,568,947 | $14,150,659 | $581,712 |
| Minnesota | $8,182,997 | $8,125,767 | $8,804,451 | $678,684 |
| Mississippi | $4,393,502 | $4,534,348 | $4,621,243 | $86,895 |
| Missouri | $7,472,676 | $7,532,605 | $7,597,087 | $64,482 |
| Montana | $1,545,439 | $1,531,613 | $1,594,775 | $63,162 |
| Nebraska | $1,271,073 | $1,288,143 | $1,347,543 | $59,400 |
| Nevada[3] | $3,221,336 | $3,398,732 | $3,225,144 | -$173,588 |
| New Hampshire | $1,396,102 | $1,477,344 | $1,479,632 | $2,288 |
| New Jersey | $9,946,174 | $9,843,621 | $10,067,052 | $223,431 |
| New Mexico | $4,394,913 | $4,573,377 | $4,587,925 | $14,548 |
| New York | $41,463,081 | $46,380,819 | $46,806,990 | $426,171 |
| North Carolina | $10,038,019 | $10,162,345 | $10,475,812 | $313,467 |
| North Dakota | $954,367 | $860,904 | $793,304 | -$67,600 |
| Ohio | $16,549,416 | $16,898,742 | $17,046,433 | $147,691 |
| Oklahoma | $2,957,516 | $3,159,129 | $3,340,436 | $181,307 |
| Oregon | $7,490,519 | $7,917,473 | $8,036,471 | $118,998 |
| Pennsylvania | $18,621,112 | $19,229,771 | $21,551,168 | $2,321,397 |
| Rhode Island | $1,852,642 | $1,872,169 | $2,012,091 | $139,922 |
| South Carolina | $4,629,433 | $4,593,869 | $4,640,072 | $46,203 |
| South Dakota | $595,616 | $561,393 | $567,556 | $6,163 |
| Tennessee | $7,311,062 | $8,101,218 | $8,364,777 | $263,559 |
| Texas | $22,922,756 | $24,703,496 | $24,672,989 | -$30,507 |

| State/Territory | FY 2018 Obligations | FY 2019 Estimate | FY 2020 Estimate | Difference +/- 2020 |
|---|---|---|---|---|
| Utah | $1,873,350 | $1,888,082 | $1,879,262 | -$8,820 |
| Vermont | $1,079,890 | $1,098,178 | $1,075,349 | -$22,829 |
| Virginia | $5,540,650 | $7,648,303 | $9,505,692 | $1,857,389 |
| Washington | $8,220,914 | $8,455,424 | $8,703,285 | $247,861 |
| West Virginia | $3,277,623 | $3,472,403 | $3,689,207 | $216,804 |
| Wisconsin | $5,654,368 | $5,654,390 | $5,857,638 | $203,248 |
| Wyoming | $389,280 | $389,019 | $389,711 | $692 |
| **Subtotal** | **$431,893,506** | **$421,707,098** | **$428,293,447** | **$6,586,349** |
| Amer. Samoa[3] | $20,749 | $19,426 | $18,426 | -$1,000 |
| Guam[3] | $61,698 | $54,484 | $42,406 | -$12,078 |
| N. Mariana Islands[3] | $27,208 | $9,777 | $6,700 | -$3,077 |
| Puerto Rico[3] | $2,927,201 | $2,656,665 | $366,700 | -$2,289,965 |
| Virgin Islands[3] | $97,072 | $80,134 | $43,265 | -$36,869 |
| **Subtotal** | **$3,133,927** | **$2,820,486** | **$477,497** | **-$2,342,989** |
| **Total States and Territories** | **$435,027,433** | **$424,527,584** | **$428,770,944** | **$4,243,360** |
| Survey & Certification | $259,487 | $308,315 | $286,750 | $21,565 |
| Fraud Control Units | $266,558 | $278,000 | $286,000 | $8,000 |
| Vaccines For Children | $4,388,748 | $4,175,681 | $4,761,408 | $585,727 |
| Undistributed | $1,450,150 | $17,024,906 | $24,193,184 | $7,168,278 |
| **Total Obligations** | **$441,392,376** | **$446,314,486** | **$458,298,286** | **$11,983,800** |

[1]The obligation estimates reflect the state and territory reported estimates of Medicaid needs available to CMS in November 2018.

[2]Represents proposed law baseline projections of obligations at the FY 2020 President's Budget.

[3] The FY 2020 estimates for the Territories have been adjusted to account for the limitation on total Medicaid payments to each territory as defined by 42 U.S.C. 1308 as well as funding limitations under 42 U.S.C. 18043. [Note: The limitation on Medicaid payments to territories under 42 U.S.C. 1308 is not yet available for FY 2020, so the FY 2020 column assumes the FY 2019 limitation applies. Funding provided under 42 U.S.C. 18043 expires on December 31, 2019.]

# 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, [$378,343,800,000] $410,796,100,000.*

*In addition, for making adjustments to the allocation of administrative expenses incurred in prior fiscal years pursuant to section 201(g) of the Social Security Act, such sums as may be necessary: Provided, That such amounts shall not be available for obligation until the Office of Management and Budget approves a justification of the adjustments to the allocation of administrative expenses between the Social Security Administration, Railroad Retirement Board, and the CMS Trust Funds.*

*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. | 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 adjustments to the allocation of administrative expenses incurred in prior fiscal years pursuant to section 201(g) of the Social Security Act, such sums as may be necessary: Provided, That such amounts shall not be available for obligation until the Office of Management and Budget approves a justification of the adjustments to the allocation of administrative expenses between the Social Security Administration, Railroad Retirement Board, and the CMS Trust Funds. | Provides indefinite authority for paying the Trust Fund allocation adjustments for administrative expenses attributed to the Social Security Administration's Limitation on Administrative Expenses appropriation. Additional funding related to Part D Administration is subject OMB approval of adjustments to the allocation between Social Security Administration, Railroad Retirement Board and CMS' Part D Administration costs. |
| 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 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Appropriation: Annual | $323,497,300 | $378,343,800 | $410,796,100 | $32,452,300 |
| Indefinite Annual Appropriation, for SMI Premium Match | $17,100,000 | $0 | $0 | $0 |
| Indefinite Annual Appropriation, for Part D Benefits | $12,000,000 | $13,000,000 | $0 | ($13,000,000) |
| Lapse in Supplemental Medical Insurance | $0 | $0 | $0 | $0 |
| Lapse in General Revenue Part D: Benefits | $0 | $0 | $0 | $0 |
| Lapse in General Revenue Part D: Federal Administration | $0 | $0 | $0 | $0 |
| Lapse in Program Management | $0 | $0 | $0 | $0 |
| Lapse in Transfer for HCFAC Reimbursement | $0 | $0 | $0 | $0 |
| Lapse in State Low Income Determination | $0 | $0 | $0 | $0 |
| Total Obligations | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |

## Payments to the Health Care Trust Funds
## Summary of Changes

**FY 2019 Enacted**

Total Budget Authority - $391,343,800,000

**FY 2020 President's Budget**

Total Budget Authority - $410,796,100,000

Net Change, Total Appropriation - $19,452,300,000

| Changes | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Federal Payment for Supplementary Medical Insurance (SMI) | $245,396,000,000 | $284,288,300,000 | $304,044,600,000 | $19,756,300,000 |
| Indefinite Annual Appropriation, SMI | $17,100,000,000 | $0 | $0 | $0 |
| Hospital Insurance for Uninsured Federal Annuitants | $132,000,000 | $127,000,000 | $109,000,000 | ($18,000,000) |
| Program Management Administrative Expenses | $1,104,000,000 | $898,000,000 | $913,000,000 | $15,000,000 |
| General Revenue for Part D (Drug) Benefit | $76,133,000,000 | $92,070,000,000 | $104,539,500,000 | $12,469,500,000 |
| Indefinite Annual Appropriation, Part D Benefits | $12,000,000,000 | $13,000,000,000 | $0 | ($13,000,000,000) |
| General Revenue for Part D Federal Administration | $422,000,000 | $642,000,000 | $861,000,000 | $219,000,000 |
| Part D: State Low-Income Determination | $3,300,000 | $3,500,000 | $5,000,000 | $1,500,000 |
| Reimbursement for HCFAC | $307,000,000 | $315,000,000 | $324,000,000 | $9,000,000 |
| Net Change | $352,597,300,000 | $391,343,800,000 | $410,796,100,000 | $19,452,300,000 |

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

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Supplementary Medical Insurance | $245,396,000 | $284,288,300 | $304,044,600 | $19,756,300 |
| Indefinite Annual Appropriation, SMI | $17,100,000 | $0 | $0 | $0 |
| Hospital Insurance for Uninsured Federal Annuitants | $132,000 | $127,000 | $109,000 | ($18,000) |
| Program Management Administrative Expenses | $1,104,000 | $898,000 | $913,000 | $15,000 |
| General Revenue for Part D Benefit | $76,133,000 | $92,070,000 | $104,539,500 | $12,469,500 |
| Indefinite Annual Appropriation, Part D Benefits | $12,000,000 | $13,000,000 | $0 | ($13,000,000) |
| General Revenue for Part D Federal Administration | $422,000 | $642,000 | $861,000 | $219,000 |
| Part D: State Low-Income Determination | $3,300 | $3,500 | $5,000 | $1,500 |
| Reimbursement for HCFAC | $307,000 | $315,000 | $324,000 | $9,000 |
| Total Budget Authority | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |

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

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| 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) | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |
| Total Budget Authority | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |

**Annual Budget Authority by Activity**

(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Budget Authority | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |

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. These payments make the Medicare trust funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to the General Fund under current law, including amounts due to 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:

Federal Contribution for SMI:

Federal Contribution for SMI consists 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.

The FY 2020 President's Budget request of $304.0 billion, is a net increase of $19.8 billion over the FY 2019 enacted amount of $284.3 billion. The cost of the federal match continues to rise from year to year because of beneficiary and program cost growth.

Hospital Insurance for the Uninsured Federal Annuitants:

Hospital Insurance for Uninsured Federal Annuitants includes costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

The FY 2020 President's Budget request of $109.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $18.0 million from the FY 2019 enacted amount of $127.0 million.

Program Management Administrative Expenses:

Program Management Administrative Expenses includes the portion of CMS' administrative costs, initially borne by the Hospital Insurance (HI) Trust Fund, which is properly chargeable to the general funds, e.g., federal administrative costs for the Medicaid program, and for Center for Consumer Information and Insurance Oversight (CCIIO) related activities.

The FY 2020 President's Budget request of $913.0 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is a net increase of $15.0 million from the FY 2019 enacted amount of $898.0 million.

General Revenue for Part D (Benefits) and Federal Administration:

The Medicare Prescription Drug Plan program was created as a result of the enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning in FY 2006, the reimbursements through the Payments to the Health Care Trust Funds account include 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.

The FY 2020 President's Budget request of $104.5 billion for General Revenue for Part D (Benefits) is a net increase of $12.5 billion over the FY 2019 enacted amount of $92.1 billion. The benefit contribution increases with Part D Prescription Drug program population and cost increases.

The FY 2020 President's Budget request of $861.0 million for General Revenue for Part D Federal Administration is a net increase of $219.0 million above the FY 2019 enacted amount of $642.0 million. These are annually revised estimates of the Part D share of Program Management and Social Security Administration's (SSA) Limitation on Administrative Expenses (LAE). Recently, SSA with assistance from CMS actuaries, concluded that it performed more work in administering Part D in FY 2017 than previously estimated due to updated cost allocation data, resulting in a higher reimbursement needed. The Department is currently working with both SSA and OMB to evaluate the cost-sharing arrangements that inform these estimates.

The FY 2020 President's Budget request for General Revenue for Part D State Eligibility Determinations is $5.0 million. This reflects a net increase of $1.5 million over the FY 2019 enacted amount of $3.5 million.

Reimbursement for HCFAC:

The Health Care Fraud and Abuse Control (HCFAC) account includes program integrity activities for Medicare, Medicare Advantage, 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 charged to the general fund.

The FY 2020 President's Budget request of $324.0 million for reimbursement of HCFAC is a net increase of $9.0 million above the FY 2019 enacted amount of $315.0 million. The

FY 2020 request reflects the estimated Medicare non-trust fund burdens only. This is based on the current allocation of HCFAC spending data for the non-trust fund program integrity activities mentioned above.

**Funding History**

The funding history for Payments to the Health Care Trust Funds is represented in the chart below:

| Fiscal Year | Budget Authority |
|---|---|
| FY 2015 | $268,212,000,000 |
| FY 2016 | $309,943,144,000 |
| FY 2017 | $328,187,700,000 |
| FY 2018 | $352,597,300,000 |
| FY 2019 | $391,343,800,000 |

**Permanent Budget Authority**
(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Tax on OASDI Benefits | $24,192,000 | $24,686,000 | $27,062,000 | $2,376,000 |
| SECA Tax Credits | $0 | $0 | $0 | $0 |
| HCFAC, FBI | $134,920 | $138,344 | $150,733 | 12,389 |
| HCFAC, Asset Forfeitures | $56,000 | $31,000 | $32,000 | $1,000 |
| HCFAC, Criminal Fines | $30,000 | $150,000 | $190,000 | $40,000 |
| HCFAC, Civil Penalties and Damages: Administration | $20,194 | $20,800 | $22,000 | $1,200 |
| Total Budget Authority | $24,433,114 | $25,026,144 | $27,456,732 | $2,430,588 |

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. Additionally, 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: Federal Bureau of Investigation (FBI) funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D) collections. 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 are permanent indefinite appropriations from the general fund, transferred to the Hospital Insurance Trust Fund.

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

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Grants, subsidies and contributions: Non-Drug | $245,396,000 | $284,288,300 | $304,044,600 | $19,756,300 |
| Indefinite Annual Appropriation | $17,100,000 | $0 | $0 | $0 |
| Grants, subsidies and contributions: Drug | $76,133,000 | $92,070,000 | $104,539,500 | $12,469,500 |
| Indefinite Annual Appropriation, Part D Benefits | $12,000,000 | $13,000,000 | $0 | ($13,000,000) |
| Insurance claims and indemnities | $132,000 | $127,000 | $109,000 | ($18,000) |
| Administrative costs-General Fund Share | $1,833,000 | $1,855,000 | $2,098,000 | $243,000 |
| General Revenue Part D: State Eligibility Determinations | $3,300 | $3,500 | $5,000 | $1,500 |
| Total Budget Authority | $352,597,300 | $391,343,800 | $410,796,100 | $19,452,300 |

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

## Centers for Medicare & Medicaid Services

## Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, [$765,000,000]*$792,000,000,* to remain available through September 30, [2020]*2021*, 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 [$599,389,000]*$614,000,000* shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which [$87,230,000]*$98,000,000* shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which [$78,381,000]*$80,000,000* 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 [2019]*2020* 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 1985, as amended, and [$454,000,000]*$475,000,*000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act: *Provided further, that amounts made available under this heading and amounts made available for fiscal year 2020 in section 1817(k)(3)(A) of the Social Security Act shall also be available for the Senior Medicare Patrol program to combat health care fraud and abuse.*

**Language Analysis**

| Language Provision | Explanation |
| --- | --- |
| In addition to amounts otherwise available for program integrity and program management, [$765,000,000] *$792,000,000* to remain available through September 30, [2020] *2021*, 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 [$599,389,000] *$614,000,000* shall be for the Centers for Medicare and Medicaid Services program integrity activities, | Provides funding for Centers for Medicare and Medicaid Services for program integrity activities. |
| of which [$87,230,000] *$98,000,000* shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, | Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute. |
| and of which [$78,381,000] *$80,000,000* 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, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year [2018] *2019* 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: | Specifies reporting requirement. |
| 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 1985, as amended, and [$454,000,000] *$475,000,000* is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act | Specifies that $311 million base amount, necessary for the incremental cap adjustment funds to be appropriated, consistent with the Budget Control Act of 2011. Additionally, specifies that once the $311 million base amount is met, that $475 million is available for appropriation as additional budget authority in FY 2020. The request includes an additional $6 million, which is an inflation adjustment applied to the $311 million base amount. |
| Provided further, that amounts made available under this heading and amounts made available for fiscal year 2020 in section 1817(k)(3)(A) of | |

| | |
|---|---|
| the Social Security Act shall also be available for the Senior Medicare Patrol program to combat health care fraud and abuse. | Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat health care fraud and abuse through either discretionary or mandatory HCFAC funds. |

# Health Care Fraud and Abuse Control

(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 (+/-) FY 2019 |
|---|---|---|---|---|
| **Discretionary** | | | | |
| CMS Program Integrity | $584,766 | $599,389 | $614,000 | $14,611 |
| OIG | $84,398 | $87,230 | $98,000 | $10,770 |
| DOJ | $75,836 | $78,381 | $80,000 | $1,619 |
| **Subtotal, Discretionary** | **$745,000** | **$765,000** | **$792,000** | **$27,000** |
| **Mandatory** | | | | |
| CMS Program Integrity | $877,244 | $897,715 | $938,652 | $40,937 |
| FBI | $134,525 | $138,344 | $150,733 | $12,389 |
| OIG | $190,389 | $195,755 | $213,248 | $17,493 |
| DOJ Wedge | $59,445 | $61,120 | $66,582 | $5,462 |
| HHS Wedge | $36,414 | $37,440 | $40,786 | $3,346 |
| **Subtotal, Mandatory** | **$1,298,017** | **$1,330,374** | **$1,410,001** | **$79,627** |
| **Total Funding** | **$2,043,017** | **$2,095,374** | **$2,202,001** | **$106,627** |

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

FY 2019 Authorization – Public Law 104-191 and Public Law 115-245

Allocation Method – Other

**OVERVIEW**

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.

**A Collaborative Effort**

Fighting health care fraud is a top priority for the Administration. In particular, CMS has made it a priority to strengthen program integrity and increase the program integrity return on investment (ROI). The HCFAC account is structured to ensure resources provided to HHS/Office of Inspector General (OIG), Department of Justice (DOJ), and CMS allow for these entities to coordinate oversight and law enforcement efforts to target bad actors efficiently and effectively. Through collaborations like the Medicare Strike Force teams, all three partners target areas with high incidence of fraud in order to carry out the coordinated effort to reduce fraud and recover taxpayer dollars. Together, CMS' enhanced provider screening and fraud prevention endeavors, the HHS/OIG's investigative, audit, evaluation,

and data analytic work, and DOJ's investigative and prosecutorial activities and tougher sentencing guidelines, 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 $4.2 to $1 ROI for law enforcement and detection efforts over the last three years (2015-2017).

CMS works 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. Strike Forces are located in ten areas: Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; Dallas, TX; and Newark, NJ/Philadelphia, PA. Since their inception in March 2007, Strike Force operations have charged more than 3,490 defendants who collectively billed the Medicare program for more than $13 billion. CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

Building better relationships and increasing coordination with private and public partners is integral to the success of the program. The Healthcare Fraud Prevention Partnership (HFPP), launched in July 2012 by HHS and DOJ, 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 arenas. HFPP partners have voluntarily reported nearly $329 million in savings resulting from their participation in the HFPP to date.

## Funding History

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which continues to provide mandatory funds annually. 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. Discretionary funding has allowed CMS to focus on the priorities set forth by the agency to address improper payment rates, manage provider screening and enrollment, and empower states to build an internal capacity to conduct Medicaid program integrity activities, as well as assists in reducing provider burden to allow providers to focus on providing high quality healthcare.

In FY 2011, 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. Continuation of these funding streams will ensure HHS and the DOJ have the resources needed 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. Since its inception in 1997, HCFAC has grown steadily and has returned over $32.4 billion to the Medicare Trust funds to date and projects to save billions more over the next ten years by curtailing improper payments.

The HCFAC cap adjustment provided in the Consolidated Appropriations Act of 2019 (P.L. 115-245) allows HHS and DOJ to enhance existing, successful health care fraud prevention and law enforcement efforts by investing more in proven anti-fraud and abuse strategies. These efforts will continue into FY 2020 to strengthen the integrity and sustainability of the Medicare and Medicaid programs by investing in activities to prevent fraud, waste, and abuse and promote high quality and efficient health care.

## Program Description and Accomplishments

### Medicare Integrity Program (MIP)

CMS conducts traditional MIP activities 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 legislative authorities and financial 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 Medicare Advantage (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 2020, the major initiatives CMS will fund under MIP include Provider Audit, MSP, MR, Benefits Integrity, Medicare-Medicaid Data Matching, Provider Education and Outreach, and Error Rate Measurement. These activities will be discussed in more detail throughout the chapter.

### Medicaid Integrity Program

CMS uses the resources associated with Section 1936 of the Social Security Act along with discretionary HCFAC funding for Medicaid in a unified, coordinated effort to address fraud, waste, and abuse in Medicaid. Additional details for this combined effort are included in the State Grants and Demonstrations chapter.

There has been a rapid increase in Federal Medicaid spending driven by several factors, including Medicaid expansion, from $265 billion in 2013 to an estimated $426 billion in 2020. With this historic growth comes an equally growing and urgent responsibility to ensure sound stewardship and oversight of our program resources. As part of CMS' plan to reform Medicaid using the three pillars of flexibility, accountability, and integrity, CMS announced a new Medicaid Program Integrity strategy in June 2018 to ensure we are keeping the Medicaid program sustainable for the future.
While states have primary responsibility for combating Medicaid fraud, waste, and abuse, oversight of the Medicaid program requires a partnership, and CMS plays a significant role in supporting state efforts and increasing state oversight, accountability, and transparency. As part of the new Medicaid Program Integrity Strategy, CMS is planning to enable states to improve their program integrity by offering states increased data sharing and robust analytic tools. . The initiatives, which are listed below, include stronger audit functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules:

- Strengthening the program integrity focus of audits of state claiming for federal match funds and rate setting.
- Conducting new audits of state beneficiary eligibility determinations.
- Optimizing state-provided claims and provider data.
- Using data innovation to empower states and conduct data analytics pilots.

- Offering provider screening for states on an opt-in basis.
- Providing enhanced data sharing and collaboration between CMS and the states.
- Publicly report state performance on the Medicaid and CHIP (MAC) Scorecard.
- Providing Medicaid provider education to reduce improper payments.

**Private Insurance Integrity Program**

Program integrity is also a priority in the Health Insurance Exchanges while they continue – both in the Federally-facilitated Exchanges (FFEs) and the State-based Exchanges (SBEs). Using HCFAC Wedge funding, CMS laid the groundwork for investigations to identify areas of fraud and abuse in the Exchanges. CMS is also developing a methodology to measure and report estimated improper payments. In FY 2020, CMS plans to continue supporting these efforts as a result of the new flexibilities provided to CMS in FY 2019 to use discretionary HCFAC funding to conduct program integrity oversight across all CMS programs.

**HCFAC Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2016 | $1,959,858,000 |
| FY 2017 | $1,995,082,000 |
| FY 2018 | $2,043,017,000 |
| FY 2019 Enacted | $2,095,374,000 |
| FY 2020 President's Budget | $2,202,001,000 |

**Budget Request: $2,202.0 Million**

The FY 2020 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The total FY 2020 request is $2,202 million, $106.6 million above the FY 2019 Enacted level. The FY 2020 discretionary request is $792 million, $27 million above the FY 2019 Enacted level, and in line with the incremental increase included in the BCA.

The FY 2020 CMS allocation of the discretionary HCFAC request is $614 million. Consistent with the FY 2019 appropriation, CMS' discretionary request reflects activities that support the emerging needs across all health care programs under CMS' jurisdiction, including private insurance related programs. A table showing this funding by activity can be found at the end of this chapter.

In FY 2020, CMS will balance program integrity activities aimed to protect beneficiaries and the Trust Funds while minimizing provider burden; integrate, analyze, and share data to inform decision making and reduce stakeholder burden; share best practices with states and allow flexibility in program integrity approaches while improving accountability in Medicaid programs. Furthermore, CMS will expand oversight of Medicare Part C and Part D, while clarifying and simplifying program requirements through collaboration, transparency, outreach and education. The following goals direct CMS' overall program integrity strategy and descriptions of the activities performed within each goal are included

below. CMS is including justifications for all activities that make up our discretionary request in FY 2020.

## I. Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Funds while Minimizing Provider Burden

CMS uses a multifaceted approach to target all causes of fraud, waste, and abuse that result in improper payments, with a shifting emphasis towards prevention-oriented activities. CMS has implemented powerful anti-fraud tools and large-scale, innovative improvements to the Medicare program integrity strategy to prevent fraud before it happens. CMS continues to improve its support of and coordination with law enforcement by working closely with the HHS/OIG, DOJ, and the Federal Bureau of Investigation (FBI), to focus on prevention, early detection, and data sharing, moving beyond the paradigm of pay-and-chase, while continuing an aggressive and robust program of criminal investigation and prosecution. The following activities support this goal:

**Program Integrity Administration and Support**: This funding provides support services for IT infrastructure, data communications, security, and administrative services.

- In FY 2020, CMS requests $22.6 million in discretionary funding to support CMS' mission, goals, and needs in combating fraud and abuse. Activities under this initiative support HHS' Office of General Counsel (OGC), HSPD-12, and other investments to help manage information so that CMS employees can protect Medicare, Medicaid, CHIP, and Program Integrity activities, as well as protect CMS Critical Assets (e.g., HIGLAS, Provider Enrollment, Chain and Ownership System (PECOS), Medicare Administrative Contractors (MACs)). Support costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

**Integrity Continuum**: The Integrity Continuum improvement activity is part of a CMS effort to define, coordinate, and consolidate activities for providers and suppliers in Medicare Fee-For-Service (FFS) program integrity to improve operational efficiencies and payment accuracy. As part of agency wide burden reduction efforts, CMS has launched a comprehensive documentation improvement initiative to standardize the process to develop and review new documentation requirements, examine existing requirements for clarity, simplicity, consistency, and need; obtain feedback from external stakeholders; and manage and update the requirements over time while balancing program integrity with provider burden concerns. These efforts aim to reduce improper payments and appeals while also reducing provider burden.

CMS requests $16.4 million in discretionary funding to perform the following:

- CMS Program Integrity Process Improvement: This request provides CMS the ability to improve the process by which clinicians discover coverage and documentation requirements, and order durable medical equipment (DME). It lays the groundwork for the future possible use of Artificial Intelligence tools by providers to "self-check" their medical records for compliance with the Medicare FFS rules. This funding will allow CMS to continue to develop the business requirements for a permanent DRLS to allow providers to access coverage requirements at the time of service within the Electronic Health Record for Medicare FFS items and service.

- CMS Risk Management and Vulnerabilities Support: This request provides CMS with

the support needed to assess and prioritize risks in the Medicare program, including those that may lead to improper or fraudulent payments or adverse impacts on beneficiaries' health. Applying the tenets of the Government Accountability Office (GAO) Fraud Risk Framework, CMS will undertake efforts to identify current and potential vulnerabilities that exist in our processes, policies and programs. CMS will use this information to design and implement strategies that incorporate specific control activities to mitigate these risks, as well as appropriate evaluation approaches. These efforts will further CMS's goal of addressing the full portfolio of vulnerabilities in the Medicare program and strategically target the most significant risks.

**Fraud Prevention System (FPS)**: CMS' sophisticated predictive analytics technology identifies investigative leads to further protect the Medicare program from inappropriate billing practices. CMS is now working to develop next-generation predictive analytics with a new system design that even further improves the usability and efficiency of the FPS. In FY 2017, CMS launched an enhanced version of the system (FPS 2.0), which modernized the system and user interface, improved model development time and performance measurement, and expanded CMS' program integrity capabilities. These enhanced capabilities include better reporting, visualization, and expanding the user base (e.g. the MACs). FPS' range of benefits includes more efficient and operational IT infrastructure; improved cost recovery from administrative actions; and improved prevention and detection of fraud, waste, and abuse in Medicare program spending.

- CMS requests $1.0 million in discretionary funding to expand its current business intelligence capabilities to provide real-time insight into the performance of models and edits, and implement edits that suspend potentially improper claims for review by audit contractors. CMS also plans to enhance FPS edits, provide more functionality for FPS end users, increase the capacity to utilize advanced graphic capabilities, and expand its operations to bring in required additional data sources (i.e., Medicare Part C and Part D) that will allow the program to have a broader view on fraudulent, wasteful and abusive activities. The system enhancement work includes a web service integration with the Unified Case Management (UCM) System and bringing in much needed data to support edit and model development. The FPS system costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

**Program Integrity Modeling and Analytics**: 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 associated with Medicare and Medicaid, including managed care programs.

- In FY 2020, CMS requests $24.0 million in discretionary funding to support ongoing operations for the Program Integrity Modeling and Analytic Support Contractors. CMS will also evaluate, manage, and report on TMSIS data quality issues. The contractor will provide analytics using T-MSIS data to identify fraudulent providers in Medicaid and, when appropriate, link that information to Medicare data about fraudulent

providers.

**One PI Data Analysis**: CMS has built the One PI portal to provide program integrity contractors, law enforcement, and HHS/OIG with centralized access to multiple analytical tools and data sources.

- CMS is requesting $16.0 million in FY 2020 to continue to train and support a multitude of contractors and law enforcement on the use of these tools and the Integrated Data Repository (IDR) to fight fraud, waste, and abuse. One PI provides access to current and historical Medicare and Medicaid data that is used to develop and refine predictive analytic models prior to integration into FPS. One PI costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

**Benefits Integrity**: Benefits Integrity activities deter and detect Medicare and Medicaid fraud through concerted efforts with CMS, HHS/OIG, DOJ, and other CMS partners. The Benefit Integrity funding is directed to the Unified Program Integrity Contractors (UPICs) that operate in various geographic jurisdictions throughout the United States. The UPICs consolidated the work of the Zone Program Integrity Contractors (ZPICs), including the Medicare-Medicaid Data Match (Medi-Medi) program, and the audit Medicaid Integrity Contractors (MICs). 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 is an integrated program integrity strategy and is a key to CMS' strategic goal of improving contractor accountability.

- In FY 2020, CMS requests $28.6 million in discretionary funding to support the UPICs and the UCM. The UCM will improve and enhance management and oversight of CMS contractors and provide direct and transparent access to the program integrity workflow. Now that the UPICs are fully operational, CMS' discretionary request supports ongoing operations. 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. Benefit Integrity activity costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

**Medical Review (MR)**: MR activities can be conducted 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. Through MIP, 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 FFS error rate. CMS also conducts accuracy reviews, prior authorizations, and tasks performed by the Supplemental Medical Review Contractor (SMRC), which provides support for a variety of tasks and lowers the improper payment rate by enhancing medical review efficiencies. These tasks are national in scope and are often driven by recommendations from the Office of Inspector General.

CMS requests $49.9 million in discretionary funding to perform the following:

- In addition to funding MR activities being performed by the MACs, CMS plans to continue a series of activities such as a prior authorization in the Medicare FFS for durable medical equipment prosthetics, orthotics, and supplies (DMEPOS), a probe and educate process for home health claims and the Documentation Requirements

Simplification project which is aimed at lowering the error rate, decreasing appeals and reducing provider burden where possible. Medical Review activities are funded from both the HCFAC mandatory and HCFAC discretionary funding streams.

- The SMRC performs and provides support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of Medicare. Having a centralized medical review resource that can perform large volumes of medical review nationally allows for a timely and consistent execution of medical review activities and decisions. The SMRC supports three initiatives, Specialty Reviews for issues identified by Federal agencies, such as the Office of Inspector General (OIG), Government Accountability Office (GAO), and other CMS groups; HFPP Reviews on providers or service types that have been identified as being aberrant in HFPP studies; and Program Integrity Reviews that will focus on ensuring claims, encounter data, and Prescription Drug Event (PDE) records are paid correctly. More specifically, the Program Integrity Reviews will focus on possible falsification or other evidence of alterations of medical record documentation, evidence that the service billed for was actually provided and/or provided as billed, and patterns and trends that may indicate potential fraud, waste, and abuse.

**Appeals Initiatives**: Appeals Initiatives are critical to CMS' program integrity efforts. CMS' Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) for Medicare FFS Part A and Part B claims. HCFAC funding supports QIC participation as a party, which affords the QIC additional rights to successfully defend a claim denial (i.e., the ability to call witness, provide testimony and evidence, etc.). Based on experience, CMS anticipates that by invoking party status in hearings, the QICs will reduce the Administrative Law Judge (ALJ) reversal rate and lower Medicare Trust Fund expenditures.

- In FY 2020, CMS requests $4.9 million in discretionary funding to support continued activities and efforts in QIC participations and enhancements to CMS' Cases Hearings and Appeals Modernization Project (CHAMP) activity. CHAMP will allow all appeals and case correspondence to be filed through a web-portal, instead of mailing all documents in hard copy to CMS. This capability will allow all parties to a specific appeal to file, view and obtain case information in real time, and will allow CMS staff to view all case correspondence through the electronic system.

**The Administration for Community Living (ACL) Senior Medicare Patrols (SMPs)**: The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In FY 2018, funding was used to provide grants to 54 states and territories to implement the SMP program. The SMP program has saved the government over $126.8 million dollars since 1997 and annually meets with more than 1.8 million people through outreach and education. The Consolidated Appropriations Act of 2019 required the SMP program to be funded from the HCFAC discretionary account.

- In FY 2020, CMS requests $18.0 million in discretionary funding to support ACL's SMP program through HCFAC and requests to change the appropriations language to provide the Secretary of HHS with greater flexibility in determining appropriate levels and sources of funding for this activity (e.g. HCFAC mandatory or discretionary funding).

## II. Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden

CMS continues to expand the ability to use data analytics to protect Medicare and Medicaid from inappropriate billing. CMS will also continue to focus on initiatives related to eligibility for enrollment which requires Medicare and Medicaid providers and suppliers to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and taking action to revoke or deny the enrollment of providers ineligible to participate.

The following activities support this goal:

**Advanced Provider Screening (APS)**: The APS system automatically screens all current and prospective Medicare providers against a number of data sources, including provider licensing and criminal records. APS also identifies and highlights potential program integrity issues that are investigated by CMS.

- CMS requests $47.0 million in discretionary funding to expand the capabilities of the APS system to increase the number of reference data sources used to validate information, as well as increase connectivity and integration with State Medicaid Agencies and other program integrity systems. More specifically, CMS will perform licensure, identity, and criminal screenings of new providers, plus continuous monitoring and annual re-screenings of existing providers. There is an anticipated increase in provider screenings and a need for additional system storage capacity.

**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. This single platform will allow for streamlining and consistency in user workflows, as well as the ability to standardize interfaces with systems internal and external to CMS.

- In FY 2020, CMS requests $40.5 million to support the ongoing development of PECOS 2.0, the new version of the Provider Enrollment Chain and Ownership System (PECOS). The updated system will dramatically improve the user interface for providers, increase operational efficiency through streamlined processing of applications, and support agency initiatives centered on increased alignment of enrollment information for alternate payer models, Medicare, and Medicaid. Work on PECOS 2.0 to date has been focused on: development of underlying system architecture; developing new workflow designs that reflect industry needs; creating a prototype to review with users; establishing data migration strategy; and the initial feature development that will lay a foundation for the new system. Ongoing work is focused on building out the remaining capability needed to support current operational policies; effectively responding to user feedback; establishing necessary connectivity with other internal and external systems; and successfully migrating historic data and all Medicare FFS provider enrollment operations at launch of the new system. Finally, by the end of FY 2020 CMS expects to increase automation that was not included at the launch of PECOS 2.0, and to begin coordination with State Medicaid Agencies and other CMS programs to determine system requirements to expand PECOS beyond core Medicare FFS enrollment. PECOS costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

## III. Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs

CMS assists states in building their internal capacity to conduct program integrity activities for Medicaid. CMS provides education, training, technical assistance, and forums to share best practices and lessons learned. Through reviews of state processes and procedures, CMS identifies areas of improvement and works with the states to make their program integrity activities robust. The following activities support this goal:

**State Medicaid Agency Access to Data and Support**: Medicaid data is critical to state and federal Medicaid program integrity efforts, and CMS is working to operate and improve the systems necessary to share Medicaid data with states and law enforcement partners.

- CMS requests $36.3 million for the Medicaid Data Support activity to support the Medicaid Enterprise System (MES); the Transformed Medicaid Statistical Information System (T-MSIS) and the Medicaid and CHIP Program System (MACPro) portions of the Medicaid and CHIP Business and Information Solution (MACBIS) activity; and the exchange of information between Medicare and State Medicaid Agencies (SMAs). The request also ensures State access to Medicare enrollment related systems such as PECOS and data extracts, and provides funding for data quality initiatives, operational improvement, and systems upgrades efforts to ensure accuracy of provider data within all Medicare systems used by Medicaid programs to enroll or screen providers or suppliers. These activities promote data consistency and transparency, and will allow CMS to increase oversight and improve Medicaid program integrity.

**Oversight, Financial and Performance Monitoring, and Outcomes Modernization**: CMS conducts reviews to determine if state policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states' program integrity best practices, and monitor state corrective action plans. The HCFAC request includes Program Integrity related oversight functions which aid in the State/Federal governance and management of Medicaid. Additionally, CMS engages in various state specific reviews, by providing technical assistance to state Medicaid programs to aid in accurate data collection of Medicaid expenditures and by performing fiscal systems integrity review. Helping states to deliver an efficient and effective Medicaid program is a part of the blueprint for the new CMS Medicaid Program Integrity strategy.

CMS requests $25.2 million in discretionary funding to perform the following:

- Medicaid and CHIP (MAC) Scorecard initiative: The MAC Scorecard initiative is described in the Program Operations chapter. Future versions of the MAC scorecard will include state program integrity performance measures like Medicaid improper payment error rates, and this request will support the adaptation of program integrity measures for the MAC Scorecard.

- Rate Review: This activity is the tool CMS utilizes to improve oversight of rate setting and financial reporting in HCBS and PACE programs. Funding is necessary for ongoing operational support. Tasks include rate reviews, accessing compliance, data compilation, education & training, and health & welfare/scorecard activities.

- Upper Payment Limit - Disproportionate Share Hospital (UPL-DSH): This project provides support for CMS Medicaid program integrity and oversight efforts related to state Medicaid financing methods, oversight of Medicaid payment methodologies which include analysis of Medicaid UPL demonstrations and analysis of supplemental provider payments, including Medicaid DSH. Section 1923(a)(2)(D) of the Social Security Act requires states to submit an annual report to the Secretary describing DSH payments made to each hospital. State Medicaid Director Letter (SMDL #13-003) requires states to submit UPL demonstrations on an annual basis.

- Medicaid Section 1115 Oversight: CMS plans to support the development of a targeted and risk based monitoring approach and related protocols for improving program integrity under the Medicaid Section 1115 waiver program. This will improve federal accountability and CMS monitoring and oversight of the program by strengthening internal controls.

- Special Investigations team: CMS is forming a "Special Investigations Team" to train states and address systemic problems in state implementation of and compliance with health and safety oversight systems for group homes. CMS plans to conduct 10 to 15 state visits in the first year and an additional 30 visits in the second year. During state visits, CMS will conduct trainings regarding compliance and oversight systems, and collect, research, track, and analyze data to assess states' compliance to health and safety requirements.

- Medicaid Implementation Support: Building upon existing program integrity efforts, CMS announced several new and enhanced Medicaid program integrity initiatives in June 2018 that are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net[1]. Examples of these new initiatives include stronger audits of state claims for federal matching funds and managed care plans' medical loss ratios, increased oversight of beneficiary eligibility determinations, and increased sharing of quality claims data and robust analytic tools.

## IV. Medicare Parts C and Part D and Private Insurance

CMS is committed to expanding its program integrity activities in capitated, managed care programs in Medicare. CMS and the Medicare Drug Integrity Contractor (MEDIC) conduct data analyses, audits, and quarterly outlier prescriber reports to help identify the overprescribing of opioids. CMS shares the findings with plan sponsors, and based on the findings, CMS provides education and outreach to plan sponsors. CMS proactively fights fraud and strengthens the Medicare Parts C and D programs by utilizing the Medicare Drug Integrity Contractors, performing plan audits, enhancing data analysis, conducting risk adjustment data validation (RADV) audits, and conducting compliance and enforcement efforts. These efforts aid in the reduction of the error rate. The following activities support our Parts C and D program integrity effort:

**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. The MEDICs assist in the management of CMS' audit, oversight, and anti-fraud and abuse efforts by identifying suspected cases of fraud and seeing cases

[1] CMS announces initiatives to strengthen Medicaid program integrity, press release, June 26, 2018.

through until payment recoupment when applicable. In the first nine months of FY 2018, National Benefit Integrity (NBI) MEDIC Part C referrals resulted in sentences ordering forfeitures of $42.1 million, while Part D referrals resulted in sentences ordering restitution of $10 million. Through data analysis and investigative case development, the NBI MEDIC continued in FY 2018 to assist the HHS-OIG and DOJ in achieving arrests, indictments, and convictions. As a result of the NBI MEDIC's data analysis projects including Part D plan sponsor self-audits, HHS recovered $3.1 million in the first nine months of FY 2018 from Part D sponsors.

- CMS requests $20.0 million in discretionary funding to perform ongoing operations. Contractors will conduct complaint investigations, develop and refer cases, conduct audits, and review abuse compliance programs.

**Part C and D Contract/Plan Oversight**: CMS will continue its comprehensive oversight efforts to assess whether an entity is qualified to contract with Medicare through use of the Health Plan Management System (HPMS). CMS' HPMS is a web-enabled information system that supports the ongoing business operations of the Medicare Advantage (MA) and Part D programs. Over 60 HPMS software modules have been developed to collect data and manage a number of MA and Part D plan enrollment and compliance processes, including a training module plan sponsors can access and system support in the submission of data on providers and pharmacies regarding suspected fraud, waste, or abuse activity.

CMS requests $20.7 million in discretionary funding to perform the following:

- CMS requests funding to maintain network standards to ensure MA plans have adequate networks in place to serve their enrollees and to provide support for network adequacy reviews to check whether MA plans have adequate networks in place, which is critical to assuring the health and satisfaction of MA beneficiaries. The review of HealthCare Delivery (HSD) tables for network adequacy requires nuanced expertise. Developing an empirical mapping-based network adequacy determination methodology is critical to the completion of the automation of the review process.

- In addition, CMS requests ongoing funding to provide technical and analytic assistance with Part C benefits review for more than 4,800 plans and 20.0 million enrollees. This funding provides technical and analytic assistance with bid review, including bid review tools to analyze benefits and evaluate increases in beneficiary cost sharing, or decreases in plan benefits from one year to the next. Plan benefit submissions are reviewed to ensure that benefits and cost sharing do not discriminate against beneficiaries and comply with CMS regulations. The Medicare Modernization Act (MMA) mandated that all Medicare Advantage Organizations (MAOs) must annually submit bids to CMS that specifically define the benefits being offered to their enrollees and must support the actuarial basis of their bid pricing.

- In FY 2020, CMS plans to develop, implement, and maintain adequacy criteria and methodology for the plans and recommend improvements for the HPMS.

**Monitoring, Performance Assessment, and Surveillance**: Under this section, technical, clinical, compliance, and enforcement audit and oversight support is provided to assist CMS in conducting MA and Part D audits, performance reporting, validation studies, the collection of encounter data, and quality analysis of data. This includes

evaluating program effectiveness and compliance for Medicare Parts C and D plans. CMS utilizes several contractors to aid in this effort:

CMS requests $67.0 million in discretionary funding to perform the following:

- CMS uses these funds 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 analytical support to monitor and measure compliance of MAOs and Part D sponsors with federal regulations. This ensures that Medicare beneficiaries have access to information about their health and drug plans, and beneficiaries are provided with timely, safe, high quality and effective care. This data is also used in the Star Ratings that impact Part C payments and participation in both the Part C and D programs.

- CMS conducts program audits that test a variety of core MA, Part D and PACE program functions. The goal of CMS' audit program is to ensure that our beneficiaries are receiving the services and medications they need and are authorized to receive under the program. These audits drive the industry towards improvements in the delivery of health services in the MA, Part D and PACE programs.

- In an effort to ensure accurate payment, CMS has enlisted the help of a reconciliation support contractor to analyze Part D reconciliation calculations, which helps CMS to understand plan impacts to Part D payments. Through the contractor, CMS will continue to review the direct and indirect remuneration (DIR) data submitted by the Part D sponsors. CMS will work with the Part D sponsors to help ensure that the DIR data factored into the final Part D payment reconciliation is accurate. CMS also receives, tracks, and analyzes issues raised by plans with respect to reconciliation after its completion, including appeals. This contractor supports our effort to collect Part D overpayments in accordance with section 1128J (d) of the Social Security Act entitled "Reporting and Returning of Overpayments", and analyzes PDE data and other relevant payment information to support correct Part D payment.

- 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 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 sixth 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 MA and FFS.

**Program Audit**: CMS performs extensive work to monitor and promote the accuracy of the annual Part C risk adjusted payments. CMS conducts two (2) major risk adjustment overpayment recovery RADV projects: the National sample and the contract level RADV audits are targeted audits. The Part C payment error estimate, MA Contract-level extrapolated payment adjustments, and audits represent CMS' response to provisions set forth in law requiring 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. The Central Data Abstraction Tool is the main system that CMS uses to support the RADV audits.

CMS requests $73.5 million in discretionary funding to perform the following:

- This request supports extensive work to monitor and promote the accuracy of the annual Part C risk adjusted payments. In addition to funding the audit contractors, CMS must support the IT systems supporting the completion of RADV audits and calculation of payment error rates.

- CMS will expand the number of RADV audits, investigate pre-payment capitated payment review, and accelerate development of risk adjustment data monitoring. In response to recommendations made in GAO 16-76, CMS developed a methodology to more efficiently target RADV audits on beneficiary diagnoses, plans, and clinical diagnostic cohorts that pose an elevated risk of improper payments due to risk adjustment payments that are not supported by the medical record. CMS would increase the number of plans audited under the new methodology from approximately 190 to 240 per year. Additionally, CMS would investigate the feasibility and leverage technical solutions to expand the scope of improper payment recovery while reducing plan and provider burden.

**Compliance and Enforcement**: This activity funds Parts C and D compliance IT systems and supports program outreach and education activities which are essential for the management of Medicare Parts C and D program integrity. CMS supports ongoing development and maintenance of the Risk Adjustment System (RAS), which produces the risk adjustment factors for use by the Medicare Advantage Prescription Drug System (MARx) to calculate beneficiary level payments. The MARx application validates enrollment-related beneficiary requests and if requests are valid, enrolls and dis-enrolls beneficiaries in Managed Care Plans and/or PDP. Each month, MARx calculates Medicare payments for each Plan, summarizing enrollment and adjusting payments for membership and bene status changes among other critical CMS oversight functions for Medicare Parts C and D.

- CMS requests $18.9 million in discretionary funding to perform operations and maintenance for the MARx system, cloud hosting and modernization, services of the MAPD Business Operations Support Center (MBOSC) to implement critical change requests and provide Help Desk services for MAPD applications. CMS also requests funding to support designing, developing and implementing compliance training to impart clear guidance, and providing interpretations of new rules, models, tools and protocols for HHS/CMS staff, as well as MA and Part D Sponsoring Organizations.

**Private Insurance Program Integrity Activities**: Building on successful efforts addressing fraud, waste, and abuse in Medicare and Medicaid, CMS is doing initial work to identify and address fraud, waste, and abuse in the Exchanges. Specifically, CMS has used Program Management and HCFAC Wedge funding during the first full-scale year of Exchange program integrity operations to work on three pilots to test the value of (1) reviewing and categorizing 7,802 consumer complaints (Dec. 2017 – Nov. 2018) to potentially identify leads involving severe harm to consumers and/or that could result in CMS administrative action against agents, brokers or other assisters, (2) refining internal controls by monitoring the license status of thousands of insurance agents to potentially

identify unlicensed agents/brokers who are unlawfully enrolling consumers into health insurance and financial assistance options on the Federally-facilitated Exchange, and (3) conducting nine data analyses projects to identify data indicators that enable CMS to focus investigations on agents/brokers with the highest risk for potential fraud, waste, or abuse. In 2018 the MPIC identified 216 agents/brokers and initiated 22 investigations. These successful pilot efforts are supported by an Exchange Program Integrity Contractor (EPIC) and Exchange Complaints Review Contractor (ECRC).

- CMS requests $6.0 million in discretionary funding for continued support or expansion of efforts like those described above, in addition to using other available sources for funding. As CMS continues to work with states and private industry leaders in this area, CMS expects to develop a better understanding of potential fraud, waste, and abuse in the Exchanges. CMS also hopes to better address consumer complaints, to protect consumers against individuals posing as insurance agents/brokers, and to prevent inappropriate Advance Premium Tax Credit and Cost Sharing Reductions from being paid out.

## V. Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education

CMS is dedicated to providing greater transparency to our stakeholders, allowing them to better understand program integrity issues through education, outreach, partnership, measuring error rates, strategic communications, and data releases. CMS is well positioned to work with its partners and stakeholders to share best practices and lessons learned in program integrity. Linking financial, programmatic, and performance data helps provide an unprecedented level of transparency and accountability, and upholds program efficiency and effectiveness. HHS regularly shares its findings with its partners, stakeholders, and the public. The following activities support this goal:

**Program Integrity Outreach and Education**: A key component to executing CMS' program integrity mission is through extensive outreach and education efforts to Medicare providers, suppliers, and other relevant stakeholders regarding Medicare payment and coverage rules, as well as communications about the various programs in place to ensure that Medicare payments are made for the right amount, for the right service, and to the right recipient. CMS creates and maintains key relationships, materials, and methods for representatives of the CMS, relevant Federal and State agencies, physicians and clinical staff, hospitals, healthcare industry, private payers, associations, clinical and analytic experts, beneficiaries, and other stakeholders affected by program integrity-related activities conducted within CMS across the continuum of compliance. Program Integrity Outreach and Education costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

- CMS requests $7.0 million in discretionary funding to create and distribute materials, host training events, and execute multiple digital communications.

**Healthcare Fraud Prevention Partnership (HFPP)**: The HFPP is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations that aims to detect and prevent healthcare fraud through data and information sharing. CMS aims to increase collaboration, participation, and scope of the HFPP, ultimately leading to enhanced HFPP-related outcomes, including savings and reductions in opioid abuse. To achieve its goals, the HFPP uses a Trusted Third Party (TTP) which allows for the

exchange of data and information between the public and private sectors, leveraging various analytic tolls using claims and other data provided by HFPP partners, and providing a forum for public and private leaders and subject matter experts to share successful practices and effective methodologies.

- CMS requests $16.5 million in discretionary funding to support the transition to a new TTP contractor. Medicaid funding allows the TTP to use a third-party data source to expand the amount of state Medicaid data that is used for cross-payer studies resulting in the execution of sophisticated analytics using a wealth of data.

**Open Payments**: Open Payments is a Congressionally-mandated, national transparency program, designed to provide the public with information regarding the financial relationships between the health care industry (pharmaceutical and medical device manufacturers and their distributors) and health care providers (physicians and teaching hospitals). Open Payments 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 website provides public access of all reported payments or transfers of value made to physicians and teaching hospitals. CMS ensures that each payment is associated with a valid covered recipient (physician or teaching hospital) prior to publication.

- CMS requests $7.0 million in discretionary funding to support ongoing operations of the program such as system operations, ongoing data validation, auditing and enforcement strategy and analytics support. Funding will support a comprehensive, long-term Open Payments strategy to educate stakeholders and users, create program awareness, and improve data integrity and accuracy. CMS may audit and impose civil monetary penalties for non-compliance with reporting requirements. Funding will also support the implementation of regulatory changes to expand covered recipients to new provider types, as required under the SUPPORT for Patients and Communities Act of 2018. This project is supported by both mandatory and discretionary HCFAC funding streams.

**Improper Payment Rate Measurement Activities**: CMS is required to measure improper payments in order to comply with the Improper Payment Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012. CMS measures Medicare, Medicaid, and Children's Health Insurance Program (CHIP) improper payments through its improper payment measurement programs, which include the Comprehensive Error Rate Testing (CERT) program, Part C and Part D Error Rate measurement programs, and the Payment Error Rate Measurement (PERM) program. Improper Payment Rate Measurement Activity costs are split funded between both the HCFAC Mandatory and HCFAC Discretionary funding streams.

CMS requests $47.0 million in discretionary funding to perform the following:

- In FY 2020, the CERT and PERM programs will produce improper payment rates for Medicare FFS and Medicaid/CHIP, respectively. CMS continues to evaluate the programs' measurements for accuracy and identify vulnerabilities in Medicare FFS and Medicaid/CHIP that require focused corrective actions.

- As required by statute, CMS estimates and reports program-wide error estimates for

Part C and Part D each year. To accomplish this annual activity, we request supporting documentation from MAO and Part D sponsors to substantiate the data upon which they were paid. The systems supporting the work are critical to securely collecting sensitive health records and providing a secure location for our reviewers to conduct their validation activities.

## 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. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as HHS/OIG, the Food and Drug Administration (FDA), the Drug Enforcement Agency (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.

### FBI Budget: $150.0 Million

The FY 2020 FBI budget includes mandatory funding in the amount of $150.0 million, an increase of $12.4 million above the FY 2019 Enacted Level. The mandatory increase reflects an estimated inflationary adjustment based on 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 healthcare-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 2017, HHS/OIG's Medicare and Medicaid oversight efforts resulted in 881 criminal actions and 826 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS/OIG excluded a total of 3,244 individuals and entities from participation in Federal health care programs. For FY 2017, 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 nearly $24.4 billion.

## HHS/OIG Budget Request: $311.2 Million

The FY 2020 HHS/OIG total budget request is $311.2 million. The FY 2020 discretionary request is $98.0 million, which represents an increase of $10.7 million above the FY 2019 Enacted Level.

## 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: $146.6 Million

The FY 2020 DOJ total budget request is $146.6 million. The DOJ discretionary request for FY 2020 is $80.0 million, which represents an increase of $1.6 million above the FY 2019 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 2018, negotiated amounts were $36.4 million for distribution among HHS components and $59.4 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding. The HHS portion of the wedge awards funded the following activities during FY 2017:

CMS Exchange Program Integrity: The HCFAC Wedge supports a variety of pilot program integrity efforts in the Health Insurance Exchanges. Specifically, it supports pilot efforts to apply targeted data analytics to agent and broker licensure requirements; to review Exchange eligibility and enrollment requirements including during Special Enrollment Periods; and to assess consumer fraud complaints.

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 2016, OGC participated in False Claims Act (FCA) and related matters that recovered over $2.0 billion for the Federal 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.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): The PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. In FY 2016, FDA initiated 31 criminal investigations, actively pursued several criminal prosecutions, and conducted a three-day training seminar for criminal investigators and supervisors covering PFP-related topics.

HHS Office of Inspector General (OIG): Wedge funds will allow HHS/OIG to fund new pilot programs and information technology investments that improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These new projects include: A new system to conduct financial analysis during criminal investigations; adding efficiencies to their online portals and business operations; and leveraging the expertise of medical professionals their reviews and evaluations of Medicare and Medicaid.

### HHS Wedge Budget: $40.8 Million

The FY 2020 HHS Wedge request includes mandatory funding of $40.8 million, which is an increase of $3.3 million above the FY 2019 Enacted level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations

# FY 2020 CMS HCFAC Discretionary Table

**(Dollars in Thousands)**

| Project or Activity | FY 2020 CMS Discretionary Request |
|---|---|
| **I. Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden** | |
| Program Integrity Administration and Support | $22,569 |
| Integrity Continuum | $16,362 |
| Fraud Prevention System | $1,000 |
| Program Integrity Modeling and Analytics | $24,000 |
| One PI Data Analysis | $16,000 |
| Benefits Integrity | $28,580 |
| Medical Review | $49,900 |
| Appeals Initiatives | $4,900 |
| Administration for Community Living Senior Medicare Patrols | $18,000 |
| **Total** | **$181,311** |
| **II. Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden** | |
| Advanced Provider Screening | $47,000 |
| Provider Enrollment Chain Ownership System (PECOS) | $40,500 |
| **Total** | **$87,500** |
| **III. Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs** | |
| State Medicaid Agency Access to Data and Support | $36,331 |
| Section 1115 Demonstrations Financial and Performance Monitoring, Oversight, and Outcomes Modernization | $25,202 |
| **Total** | **$61,533** |
| **IV. Medicare Part C and Part D and Private Insurance** | |
| Medicare Drug Integrity Contractor (MEDICs) | $20,000 |
| Part C and D Contract Plan and Oversight | $20,740 |
| Monitoring, Performance Assessment and Surveillance | $67,000 |
| Program Audit | $73,500 |
| Compliance and Enforcement | $18,900 |
| Private Insurance Program Integrity Efforts | $6,000 |
| **Total** | **$206,140** |
| **V. Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education** | |
| Provider Outreach and Education | $7,000 |
| Healthcare Fraud Prevention Partnership | $16,500 |
| Open Payments | $7,000 |
| Improper Payment Rate Measurement Activities | $47,016 |
| **Total** | **$77,516** |
| **HCFAC Summary** | |
| **Subtotal Medicare Program Integrity** | **$476,302** |
| **Subtotal Medicaid Program Integrity** | **$131,698** |
| **Subtotal Private Insurance Program Integrity** | **$6,000** |
| **Total CMS Program Integrity** | **$614,000** |

# Children's Health Insurance Program

Current Law
(Dollars in Thousands)

| | FY 2018 Enacted | FY 2019 Estimate | FY 2020 Estimate | FY 2020 +/- FY2019 |
|---|---|---|---|---|
| State Allotments (Healthy Kids Act P.L. 115-120) | $21,500,000 | $22,600,000 | $23,700,000 | $1,100,000 |
| CHIP Performance Bonus Fund (P.L. 111-3, P.L. 113-235) | $0 | $0 | $10,235,881 | $10,235,881 |
| Child Health Quality Improvement (P.L. 115-120) | $90,000 | $0 | $0 | $0 |
| Redistribution Payments | $0 | $0 | $0 | $0 |
| Performance Bonus Payments Rescission (P.L. 115-141) /1 | ($73,008) | $0 | $0 | $0 |
| Rescission of Unobligated Allotments /2 | ($3,572,000) | ($2,061,000) | $0 | $2,061,000 |
| **Total Budgetary Resources** /3 | **$17,944,992** | **$20,539,000** | **$33,935,881** | **$13,396,881** |
| CHIP State Allotment Outlays | $17,102,795 | $18,412,300 | $16,860,000 | ($1,552,300) |
| Performance Bonus Payments Outlays | $3,627 | $0 | $0 | $0 |
| Child Health Quality Improvement Outlays | $5,581 | $22,000 | $22,000 | $0 |
| Redistribution Payments | $168,949 | $0 | $0 | $0 |
| **Total Outlays** | **$17,280,952** | **$18,434,300** | **$16,882,000** | **($1,552,300)** |

1/ P.L. 115-141 rescinded $89 million from the CHIP Performance Bonus Fund; however, only $73 million was available for rescission. CMS will rescind the remaining $16 million in FY 2020, or once additional funds are transferred into the account.
2/ The Consolidated Appropriations Act, 2018 (P.L. 115-141) rescinded $3.6 billion in unobligated FY 2018 allotments, and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) rescinded $2.1 billion in unobligated FY 2019 allotments.
3/ Funding levels reflect new appropriations net of enacted rescissions. These funding levels are subject to change due to adjustments throughout the year.

**Child Enrollment**
**Contingency Fund**
Current Law
(Dollars in Thousands)

| | FY 2018 Enacted | FY 2019 Estimate | FY 2020 Estimate | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| **Child Enrollment Contingency Fund, Budget Authority** /1 | **$5,442,594** | **$9,990,067** | **$14,975,881** | **($4,985,814)** |
| Temporarily Unavailable /2 | ($3,127,938) | ($5,604,460) | $0 | **$5,604,460** |
| Transfer to Performance Bonus Fund | $0 | $0 | ($10,235,881) | **($10,235,881)** |
| Payments to Shortfall States | $0 | $0 | $0 | **$0** |
| Interest Estimate | $27,472 | $245,814 | $156,420 | **($89,394)** |
| **Total Budgetary Resources, end of year /3** | **$2,342,128** | **$4,631,421** | **$4,896,420** | **$264,999** |
| **Total Outlays** | **$0** | **$199,601** | **$0** | **($199,601)** |

1/ Reflects both carryover resources and deposits into the Fund.
2/ The Consolidated Appropriations Act, 2018 (P.L. 115-141) made $3.127 billion temporarily unavailable for obligation in FY 2018, and the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) makes $5.6 billion temporarily unavailable for obligation in FY 2019.
3/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions.

Authorizing Legislation –
The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Medicare, Medicaid, and SCHIP 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 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),
The Further Additional Continuing Appropriations Act, 2018 (P.L. 115-96),
The Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act) (P.L. 115-120),
The Advancing Chronic Care, Extenders and Social Services Act (ACCESS Act) (P.L. 115-123).

Allocation Method – Formula grants

**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 low-income 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.

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 $68.9 billion through FY 2013 to maintain state programs and to cover more uninsured children. The Patient Protection and Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $40.2 billion in budget authority over the baseline. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) provided an additional $39.7 billion in budget authority for FYs 2016 and 2017. On January 22, 2018, the HEALTHY KIDS Act (P.L. 115-120) appropriated nearly $145 billion to CHIP for six years from FY 2018 through FY 2023. On February 9, 2018, the ACCESS Act (P.L. 115-123) further extended CHIP funding through FY 2027.

CHIPRA also created several new programmatic features of the CHIP program, which are discussed in more detail below.

**CHIP Performance Bonus Payments** — Created as an incentive for states to enact policies promoting the enrollment and retention of eligible children, states received 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 had to implement five of eight enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. The 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. Of these amounts, CMS awarded $1.2 billion in bonus payments to 29 states. 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 HEALTHY KIDS Act (P.L. 115-120) extended the Contingency Fund through FY 2023 and the ACCESS Act (P.L. 115-123) authorized the Contingency Fund through FY 2027.

The Contingency Fund receives an appropriation equal to 20 percent of the Section

2104(a) CHIP national allotment appropriation under the Social Security Act. Any amounts in excess of the aggregate cap are transferred to the CHIP Performance Bonus Fund. 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. To date, three states (Iowa, Michigan, and Tennessee) have met statutory criteria and qualified for payments from the Contingency Fund totaling $309 million. Under current law, states are not required to spend Contingency Fund payments on activities related to children's health, and territories are not eligible to receive Contingency Fund payments.

**CHIP Redistribution Fund –** CHIPRA also amended 2104(f) of the Social Security Act, which permits CMS to recoup unused state allotment funding to redistribute to states facing a funding shortfall if their current allotment is insufficient to meet program demand. A shortfall state is defined as a state that will not have allotment or Contingency Fund resources to meet projected costs in the current year. If there is not sufficient redistribution funding to meet the needs of all shortfall states, each state receives a pro rata share of the total funds available. Since 2012, CMS has redistributed $1.7 billion to 30 states and territories. This includes $1.4 billion awarded to 28 states and territories when CHIP did not have a full-year appropriation at the beginning of FY 2018 that was ultimately returned to the redistribution fund upon enactment of a full-year appropriation. Approximately $2.9 billion in funding is currently available for redistribution.

**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) ensured at least $15 million was transferred from Medicaid Adult Health Quality funding. The transfer occurred in FY 2015 and is available until expended. In addition, MACRA (P.L. 114-10) provided $20 million available for Child Health Quality activities beginning on October 1, 2015. The HEALTHY KIDS Act provided $90 million for child health quality activities for FYs 2018 through 2023, and the ACCESS Act provided $60 million for FYs 2024 through 2027. The ACCESS Act also makes annual state reporting on the Child Core Set measures mandatory starting in FY 2024.

Medicaid and CHIP quality funding supports the Pediatric Quality Measures Program (PQMP), the CHIPRA Electronic Health Record Program, and CHIPRA Quality Demonstration Grants. The status of Child Health Quality Improvement activities in Medicaid and CHIP are discussed below:

*CHIPRA Pediatric Quality Measures Program* — Current efforts in the Children's Health Insurance Program Reauthorization Act Pediatric Quality Measures Program (PQMP) include a collaboration between CMS and the Agency for Healthcare Research and Quality (AHRQ) for a next phase of pediatric measure testing under a new multi-year competitive cooperative agreement program aimed at establishing partnerships with state Medicaid/CHIP programs to support testing, use and implementation of new or enhanced

pediatric quality measures (see https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-16-002.html).

Currently this funding supports six PQMP grants, initially awarded in FY 2016, who are focused on testing and implementing new pediatric quality measures previously developed by the PQMP Centers of Excellence (COE) across various Medicaid and CHIP delivery systems. The grantees are collecting data on measures and testing quality improvement strategies at multiple levels of care, assessing the feasibility and usability of the new measures within the Medicaid/CHIP patient populations at the state, health plan, and provider levels to support performance monitoring and quality improvement. In addition, CMS has funded a PQMP-Learning Collaborative to provide research, implementation, and knowledge-sharing to support the PQMP grantees. The Learning Collaborative is focused on improving understanding of best practices for dissemination and implementation of quality measures to build capacity and sustainability for performance monitoring and quality improvement efforts within the Medicaid/CHIP patient populations at the state, health plan, and provider levels.

*CHIPRA Electronic Health Record (EHR) Program* — HHS 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 https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf. 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.

CMS has been assessing a number of options to test targeted items of the enhanced Format with State Medicaid and CHIP programs. Recent discussions between CMS, AHRQ, the Office of the National Coordinator, and the Office of the Chief Technology Officer have begun to identify a plan for a third phase of the Format. With assistance from stakeholders, CMS plans to move forward with these efforts in FY 2019 that will incorporate health information requirements under recent legislation (e.g., 21st Century Cures Act).

*CHIPRA Quality Demonstration Grants* — In 2010, CMS awarded ten grants for demonstrations in 18 states to improve health care quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Focus areas for the grants included using quality measures, applying health information technology, implementing provider-based service delivery models, investigating electronic health records, and trying other innovative approaches to improve children's health.

CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) to evaluate the demonstration. The evaluation produced several resources for future use, including Spotlights for each state's work, two implementation guides, and a report.

- Spotlights can be found at: https://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

- The final evaluation report, with links to other resources, can be found at: http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/final-report/index.html.

To share the work of CHIPRA Quality Demonstration Grants, CMS is in the process of creating searchable web postings as a resource for States and other stakeholders to learn from the experiences of the grantees. In addition, CMS began a knowledge transfer plan in February 2016 with an all-states webinar to leverage the knowledge gains from this demonstration and disseminate lessons learned. The work culminated in September 2017, when CMS began an affinity group with eight states that focused on Medicaid and school-based health services. Specifically, the affinity group has addressed ways that Medicaid can partner with schools to improve health outcomes, using the Child Quality Measures Core Set to evaluate progress. CMS facilitated expert-moderated webinars on a broad range of topics based on the needs of participating states, one-on-one consultation with states, and peer-to-peer learning. The specific affinity group was completed in fall 2018. Findings from this group are being reviewed and compiled and will be available later in FY 2019.

**History of Funding for State Allotments**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2015/1 | $16,512,000,000 |
| FY 2016/2 | $14,621,500,000 |
| FY 2017/3 | $19,098,000,000 |
| FY 2018/4 | $17,928,000,000 |
| FY 2019/5 | $20,539,000,000 |
| FY 2020 | $23,700,000,000 |

1/ Reflects rescission of $4.5 billion in funding from section 108 of CHIPRA pursuant to the Continuing Appropriations Act, 2015 (P.L. 113-164).

2/ Reflects rescission of $4.7 billion in funding from section 108 of CHIPRA in the Consolidated Appropriations Act, 2016 (P.L. 114-113).

3/ Reflects rescission of $1.3 billion in funding from Section 301 of MACRA (P.L. 114-254, P.L. 115- 31).

4/ Reflects rescission of $3.6 billion in funding from section 2104(a)(21) of the Social Security Act from the FY 2018 omnibus (P.L. 115-141).

5/ Reflects rescission of $2.1 billion in funding from section 2104(a)(22) of the Social Security Act from the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245).

## Mandatory State/Formula Grants[1]
## CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
## (Dollars in Thousands)

| STATE/TERRITORY | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate | Difference +/- |
|---|---|---|---|---|
| Alabama | 338,511,007 | $396,287,811 | $417,307,741 | 21,019,930 |
| Alaska | 34,628,643 | $30,418,062 | $32,031,499 | 1,613,437 |
| Arizona | 388,596,192 | $251,666,019 | $265,343,701 | 13,677,682 |
| Arkansas | 205,813,011 | $167,789,960 | $176,689,888 | 8,899,928 |
| California | 2,825,935,404 | $3,038,424,921 | $3,199,589,298 | 161,164,377 |
| Colorado | 270,402,569 | $298,413,539 | $314,242,014 | 15,828,475 |
| Connecticut | 81,967,959 | $101,404,666 | $106,783,380 | 5,378,714 |
| Delaware | 37,330,085 | $37,871,104 | $39,879,866 | 2,008,762 |
| District of Columbia | 45,825,420 | $49,216,927 | $53,111,385 | 3,894,458 |
| Florida | 734,065,064 | $793,192,228 | $841,092,746 | 47,900,518 |
| Georgia | 429,677,190 | $444,312,831 | $467,880,108 | 23,567,277 |
| Hawaii | 55,379,802 | $63,149,134 | $66,498,695 | 3,349,561 |
| Idaho | 88,438,440 | $78,352,600 | $83,426,254 | 5,073,654 |
| Illinois | 579,662,704 | $392,710,042 | $413,540,199 | 20,830,157 |
| Indiana | 202,327,708 | $261,534,741 | $275,407,088 | 13,872,347 |
| Iowa | 163,436,140 | $130,026,133 | $136,960,366 | 6,934,233 |
| Kansas | 132,007,115 | $119,145,170 | $125,464,878 | 6,319,708 |
| Kentucky | 284,025,468 | $217,999,908 | $229,563,077 | 11,563,169 |
| Louisiana | 379,958,250 | $373,253,823 | $393,051,982 | 19,798,159 |
| Maine | 37,827,331 | $37,049,042 | $39,014,200 | 1,965,158 |
| Maryland | 313,409,295 | $316,638,043 | $333,433,183 | 16,795,140 |
| Massachusetts | 710,909,940 | $724,569,580 | $763,002,258 | 38,432,678 |
| Michigan | 280,389,992 | $273,741,597 | $288,261,421 | 14,519,824 |
| Minnesota | 122,348,292 | $129,392,144 | $136,841,526 | 7,449,382 |
| Mississippi | 335,500,601 | $257,202,392 | $270,844,942 | 13,642,550 |
| Missouri | 233,716,895 | $278,965,358 | $293,762,261 | 14,796,903 |
| Montana | 110,277,901 | $91,427,779 | $96,807,418 | 5,379,639 |
| Nebraska | 77,074,850 | $87,084,462 | $91,945,847 | 4,861,385 |
| Nevada | 74,884,458 | $78,193,592 | $83,137,041 | 4,943,449 |
| New Hampshire | 40,496,084 | $44,854,074 | $47,233,227 | 2,379,153 |
| New Jersey | 490,175,134 | $519,666,956 | $547,231,172 | 27,564,216 |
| New Mexico | 144,059,298 | $101,350,469 | $106,726,309 | 5,375,840 |
| New York | 1,306,260,812 | $1,473,122,909 | $1,551,260,412 | 78,137,503 |
| North Carolina | 508,703,478 | $500,692,417 | $527,752,424 | 27,060,007 |
| North Dakota | 23,423,334 | $26,679,573 | $28,217,376 | 1,537,803 |
| Ohio | 458,707,676 | $520,821,413 | $548,446,864 | 27,625,451 |

| STATE/TERRITORY | FY 2018 Actual | FY 2019 Estimate | FY 2020 Estimate | Difference +/- |
|---|---|---|---|---|
| Oklahoma | 263,995,514 | $233,624,808 | $246,016,754 | 12,391,946 |
| Oregon | 395,925,119 | $370,148,170 | $391,333,419 | 21,185,249 |
| Pennsylvania | 558,435,362 | $668,188,484 | $703,630,591 | 35,442,107 |
| Rhode Island | 77,120,815 | $92,975,451 | $97,907,062 | 4,931,611 |
| South Carolina | 163,983,786 | $184,648,256 | $195,156,134 | 10,507,878 |
| South Dakota | 28,763,089 | $31,232,941 | $33,087,852 | 1,854,911 |
| Tennessee | 493,199,605 | $234,625,282 | $247,534,508 | 12,909,226 |
| Texas | 1,476,320,282 | $1,510,171,867 | $1,600,030,539 | 89,858,672 |
| Utah | 140,549,341 | $135,050,423 | $142,937,976 | 7,887,553 |
| Vermont | 32,026,565 | $28,250,535 | $29,749,002 | 1,498,467 |
| Virginia | 308,267,233 | $378,405,500 | $398,476,915 | 20,071,415 |
| Washington | 259,290,773 | $236,312,742 | $251,080,491 | 14,767,749 |
| West Virginia | 64,647,160 | $77,391,400 | $81,496,401 | 4,105,001 |
| Wisconsin | 237,692,236 | $272,797,995 | $287,267,768 | 14,469,773 |
| Wyoming | 13,392,158 | $13,382,177 | $14,091,996 | 709,819 |
| **Subtotal** | **17,059,762,580** | **17,173,827,450** | **18,111,579,454** | **937,752,004** |
| **Commonwealths and Territories** | | | | |
| American Samoa | $3,072,998 | $4,831,930 | $5,088,226 | 256,296 |
| Guam | $28,144,170 | $32,226,618 | $33,935,985 | 1,709,367 |
| Northern Mariana Islands | $7,101,344 | $11,196,066 | $11,789,929 | 593,863 |
| Puerto Rico | $203,833,700 | $182,575,014 | $192,259,172 | 9,684,158 |
| Virgin Islands | $7,283,119 | $10,947,551 | $11,528,232 | 580,681 |
| **Subtotal** | **249,435,331** | **241,777,179** | **254,601,544** | **12,824,365** |
| **Undistributed** | **0** | **465,651,578** | **0** | **-465,651,578** |
| **TOTAL RESOURCES** | **17,309,197,911** | **17,881,256,207** | **18,366,180,998** | **484,924,791** |

/1 Represents proposed law baseline projections of obligations

Note: Allotments to states remain available for federal payments for two years.

# State Grants and Demonstrations

**Budget Authority**
**(Dollars in Thousands)[1]**

| Program | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Medicaid Integrity Program[2] | $79,911 | $82,179 | $89,538 | $7,359 |
| Grants to Improve Outreach and Enrollment | $120,000 | $0 | $0 | $0 |
| Demonstration Project to Increase Substance Use Provider Capacity - Grants | $0 | $50,000 | $0 | ($50,000) |
| Demonstration Project to Increase Substance Use Provider Capacity - Admin | $0 | $5,000 | $0 | ($5,000) |
| Money Follows the Person Rebalancing Demonstration | $0 | $112,000 | $0 | ($112,000) |
| **Total Appropriation** | **$199,911** | **$249,179** | **$89,538** | **($159,641)** |

Authorizing Legislation - Deficit Reduction Act of 2005, Public Law 109-171; Patient Protection and Affordable Care Act, Public Law 111-148 together with the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; HEALTHY KIDS Act of 2018, Public Law 115-120; SUPPORT for Patients and Community Act, Public Law 115-271; The Medicaid Extenders Act of 2019, Public Law 116-3.

[1] This table reflects new budget authority and does not include carryover resources. This table does not include the following programs/laws: Ticket to Work, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, the Second Emergency Supplemental Appropriations Act to Meet Immediate Needs Arising From the Consequences of Hurricane Katrina, 2005, Katrina Relief - Additional Federal Payments Under Hurricane-related Multi-state Section 1115 Demonstrations, Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics, Medicaid Emergency Psychiatric Demonstration, Medicaid Incentives for the Prevention of Chronic Diseases Model, Psychiatric Residential Treatment Facilities, the National Clearinghouse for Long-Term Care Information, , Grants to Improve Outreach and Enrollment, and Funding for the Territories since the Budget Authority is $0 or the money has been rescinded.

[2] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2018 and FY 2019 columns reflect post-sequestration amounts.

**Gross Outlays[3]**
**(Dollars in Thousands)**

| Program | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| Money Follows the Person (MFP) Demonstration[4] | $381,156 | $359,787 | $470,161 | $110,374 |
| MFP Research & Evaluation | $40 | $940 | $660 | ($280) |
| Medicaid Integrity Program | $82,221 | $80,935 | $86,202 | $5,267 |
| Grants to Improve Outreach and Enrollment | $17,488 | $14,264 | $25,311 | $11,047 |
| Medicaid Emergency Psychiatric Demonstration Project | $18 | $23 | $35 | $12 |
| Medicaid Incentives for Prevention of Chronic Diseases | $13 | $451 | $602 | $151 |
| Demonstration Programs to Improve Community Mental Health Services | $1,204 | $2,563 | $3,113 | $550 |
| Demonstration Project to Increase Substance Use Provider Capacity - Grants | $0 | $15,000 | $22,500 | $7,500 |
| Demonstration Project to Increase Substance Use Provider Capacity - Admin | $0 | $1,000 | $1,000 | $0 |
| **Total Outlays for State Grants and Demonstrations** | **$482,140** | **$474,963** | **$609,584** | **$134,621** |

[3] Amounts on this table include outlays from obligations made in previous fiscal years. These outlay estimates are based on FY 2018 actual activity and PB 2020 baseline estimates.
[4] The Medicaid Extenders Act of 2019 (P.L. 116-3) amends the Deficit Reduction Act to make $112,000,000 available for enhanced FMAP for certain state activities with approved MFP demonstrations for FY 2019 and extends state MFP demonstrations through FY 2021. Of the $112,000,000, $500,000 will be available to carry out funding for quality assurance and improvement, technical assistance, and oversight.

**Program Description and Accomplishments**

The State Grants and Demonstrations account has historically provided federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The activities have empowered states to drive innovation to improve quality and health outcomes and assist in providing state infrastructure support and services to targeted populations, including resources to combat fraud, waste and abuse, and ensuring taxpayer dollars can focus on providing high quality care to beneficiaries.

**Funding History /1**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2016 | $560,102,837 |
| FY 2017 | $78,015,664 |
| FY 2018 | $199,910,665 |
| FY 2019 | $249,178,964 |
| FY 2020 | $89,538,274 |

1/ Reflects new appropriations in a given fiscal year. Does not include balances from previous appropriations.

**Budget Overview**

The various grant and demonstration programs are appropriated federal funds through several legislative authorities. The legislation which authorizes these 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.

## MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

**Program Description and Accomplishments**

Authorized in Section 6071 of the Deficit Reduction Act of 2005 (DRA), as amended by Section 2403 of Patient Protection and Affordable Care Act and the Medicaid Extenders Act of 2019, the MFP demonstration supports state efforts to empower individuals to take ownership of their health and ensure that patients have flexibility and information to make choices as they seek care by:

- Rebalancing their long-term services and supports system so that individuals have a choice of where they live and receive services;
- Transitioning individuals from institutions who want to live in the community; and
- Implementing 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 an enhanced Federal Medical Assistance Percentage (FMAP) for 365 days of qualified home and community-based services (HCBS) for each

person transitioned from an institution to the community during the demonstration period. To be eligible for the demonstration, 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 CMS MFP Tribal Initiative (TI), which received funding under the authority of Section 2403 of Patient Protection and Affordable Care Act 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 $1.5 million to five MFP grantees for the first phase of the program development. The amounts in the table on the following page are inclusive of these supplemental awards.

According to the 2016 Report, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/2016-cross-state-report.pdf), program transitions for the period from January 1, 2016 through December 31, 2016 numbered 11,217, which represents a 19 percent increase in cumulative transitions over the previous year for a total of 75,151. For the period January 1, 2017 through December 31, 2017, grantees self-reported having transitioned an additional 13,181 individuals for a total of 88,332.

**Budget Overview**

Section 6071 of the DRA authorized and appropriated a total of $1.8 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. Section 2403 of Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and for four additional fiscal years. CMS awarded 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. Most recently, the Medicaid Extenders Act of 2019 (P.L. 116-3) amends the DRA to makes $112,000,000 available for enhanced FMAP for certain state activities with approved MFP demonstrations for FY 2019 and extends state MFP demonstrations through FY 2021. Of the $112,000,000, $500,000 will be available to carry out funding for quality assurance and improvement, technical assistance, and oversight. $500,000 of the funding made available in FY 2019 will support technical assistance to and oversight of states to upgrade quality assurance and improvement systems under Medicaid home and community-based waivers.

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. The American Reinvestment and Recovery Act of 2009 authorized an increased FMAP rate to preserve a significant differential between the MFP enhanced FMAP and the increased FMAP that states were

receiving for most other Medicaid funded services under the Recovery Act in order for states to continue to have a financial incentive to meet the goals of the MFP program. This increase is reflected in the chart below.

Of the original DRA appropriation of $1.8 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 Patient Protection and Affordable Care Act authorized $1.1 million from each year's appropriation in FY 2012 through FY 2016 that was used to carry out evaluation and a required report to Congress (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf).

As of September 30, 2016, CMS obligated $3.7 billion in grants to 44 grantee states and the District of Columbia (DC). Grantees have transitioned approximately 88,332 individuals as of December 31, 2017, based on individual state reporting.

| ***State*** | ***Cumulative Award Total 2007-2016*** | ***Initial Award Date*** | ***Date of Last MFP Funded Transition*** |
|---|---|---|---|
| Alabama | $20,110,401 | September 27, 2012 | December 31, 2018 |
| Arkansas | $59,838,949 | January 1, 2007 | December 31, 2018 |
| California | $197,640,171 | January 1, 2007 | December 31, 2018 |
| Colorado | $21,878,138 | April 1, 2011 | December 31, 2018 |
| Connecticut | $234,576,991 | January 1, 2007 | December 31, 2018 |
| Delaware | $14,264,778 | May 1, 2007 | December 31, 2017 |
| District of Columbia | $34,658,883 | May 1, 2007 | December 31, 2018 |
| Georgia | $159,170,550 | May 1, 2007 | December 31, 2018 |
| Hawaii | $7,798,138 | May 1, 2007 | December 31, 2018 |
| Idaho | $21,859,299 | April 1, 2011 | December 31, 2018 |
| Illinois | $45,195,803 | May 1, 2007 | December 31, 2017 |
| Indiana | $92,059,136 | January 1, 2007 | December 31, 2018 |
| Iowa | $77,661,590 | January 1, 2007 | December 31, 2018 |
| Kansas | $65,487,431 | May 1, 2007 | June 30, 2017 |
| Kentucky | $74,068,555 | May 1, 2007 | December 31, 2018 |
| Louisiana | $83,884,594 | May 1, 2007 | December 31, 2018 |
| Maine | $10,371,462 | April 1, 2011 | December 31, 2018 |
| Maryland | $178,803,155 | January 1, 2007 | December 31, 2018 |
| Massachusetts | $95,060,502 | April 1, 2011 | December 31, 2016 |
| Michigan | $88,242,009 | January 1, 2007 | September 30, 2017 |
| Minnesota | $76,608,425 | April 1, 2011 | December 31, 2018 |
| Mississippi | $30,576,695 | April 1, 2011 | April 30, 2018 |
| Missouri | $82,353,917 | January 1, 2007 | December 31, 2018 |

| State | Cumulative Award Total 2007-2016 | Initial Award Date | Date of Last MFP Funded Transition |
|---|---|---|---|
| Montana | $9,306,595 | September 27, 2012 | December 31, 2018 |
| Nebraska | $22,184,278 | January 1, 2007 | December 31, 2018 |
| Nevada | $10,943,591 | April 1, 2011 | December 31, 2018 |
| New Hampshire | $13,972,772 | January 1, 2007 | March 31, 2016 |
| New Jersey | $120,250,213 | May 1, 2007 | December 31, 2018 |
| New Mexico | $595,839 | April,1 2011 | N/A |
| New York | $184,796,857 | January 1, 2007 | December 31, 2018 |
| North Carolina | $46,254,702 | May 1, 2007 | December 31, 2018 |
| North Dakota | $31,340,262 | May 1, 2007 | December 31, 2018 |
| Ohio | $380,488,044 | January 1, 2007 | December 31, 2018 |
| Oklahoma | $52,023,929 | January 1, 2007 | December 31, 2018 |
| Oregon | $22,655,153 | May 1, 2007 | September 30, 2011 |
| Pennsylvania | $153,143,765 | May 1, 2007 | December 31, 2018 |
| Rhode Island | $17,859,069 | April 1, 2011 | December 31, 2018 |
| South Carolina | $8,237,969 | April 1, 2011 | December 31, 2018 |
| South Dakota | $5,959,028 | September 27, 2012 | October 31, 2018 |
| Tennessee | $67,363,025 | April 1, 2011 | December 31, 2018 |
| Texas | $397,958,482 | January 1, 2007 | December 31, 2017 |
| Vermont | $15,862,913 | April 1, 2011 | December 31, 2017 |
| Virginia | $80,380,082 | May 1, 2007 | December 31, 2018 |
| Washington | $190,029,341 | January 1, 2007 | December 31, 2018 |
| West Virginia | $17,283,347 | April 1, 2011 | December 31, 2018 |
| Wisconsin | $64,386,314 | January 1, 2007 | December 31, 2018 |

NOTE: The table represents funding awarded to states. Funding for planning grants, quality initiatives, and reductions associated with sequestration are not reflected.

New Mexico and Florida had no transitions through the MFP program, rescinding grant awards in January 2012 and August 2013 respectively. Oregon deactivated their program in 2011 and officially closed out the grant in September 2016.

## 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. With the passage of this legislation, Congress provided the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, detect, and reduce fraud,

waste, and abuse in the Medicaid program, ensuring that taxpayer dollars can focus on providing high quality care to beneficiaries.

In 2015, the Patient Access and Medicare Protection Act (Public Law 114-115) amended Section 1936, providing CMS with greater flexibility to use a mix of contractors and federal personnel to achieve the objectives of the Medicaid Integrity Program and more quickly adapt to changing program integrity needs. Today, CMS staff and contractors funded by the Medicaid Integrity Program work closely with the Health Care Fraud and Abuse Control (HCFAC) program to address Medicaid fraud, waste, and abuse through a unified and coordinated effort. Some of the key projects included in that unified effort are described below. Other details are included in the HCFAC chapter.

The Deficit Reduction Act directed CMS to establish a Comprehensive Medicaid Integrity Plan (CMIP) every five years outlining its strategy for combating fraud, waste, and abuse in Medicaid. The first CMIP was published in July 2006, and covered FYs 2006 through 2010. CMS released the most recent CMIP in July 2014 for FYs 2014 through 2018, available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf. CMS is now working on the next CMIP and expects to finalize it in FY 2019.

Separate from the statutorily required CMIP, CMS released an interim Medicaid program integrity strategy in June 2018, outlining its program integrity priorities in light of growing Medicaid expenditures and enrollment over the last several years. This strategy also seeks to address Medicaid program integrity challenges identified by the HHS Office of Inspector General and the Government Accountability Office (GAO). The Strategy is available at: https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf

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.

CMS implemented a Unified Program Integrity Contractor (UPIC) strategy that restructured and consolidated Medicare and Medicaid program integrity audit and investigation work. This reconfiguration focused on efficient contractor structure and improved coordination between Medicare and Medicaid contractors and states. The UPIC concept consolidated the work of the previously used Medicaid Integrity Contractors (MICs) and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data match activities. The overarching goal of the UPICs is to integrate these program integrity functions by implementing a contracting strategy that rationalizes CMS's relationships with providers, leverages existing resources, and enhances cooperative efforts with partners, including states. CMS began awarding UPIC contracts in 2016 and to date all five UPICs are fully

operational.

In FY 2018, the UPICs initiated Medicaid provider investigations and audits in 31 states. The most common collaborative investigations and audits have been conducted in the areas of hospice, non-emergency medical transportation and general hospital services.

Medicaid/CHIP Financial Management Project

Previously funded under HCFAC, this project involves Financial Management (FM), including accountants and financial analysts, who work to improve CMS' financial oversight of the Medicaid and CHIP programs. In FY 2018 through the continued efforts of these specialists, CMS removed an estimated $1.0 billion (with approximately $358.0 million recovered and $650.0 million resolved) of approximately $10.2 billion identified in questionable Medicaid costs.

Furthermore, an estimated $507.0 million in questionable reimbursement was actually averted due to the FM staff preventive work with states to promote proper state Medicaid financing. The FM staff activities included reviews of proposed Medicaid state plan amendments that related to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 "Single State" audits; and reviews of sources of the non-Federal share.

Medicaid Integrity Institute (MII)

In collaboration with the United States Department of Justice (DOJ), CMS also established the MII to provide state employees with comprehensive training courses encompassing numerous aspects of Medicaid program integrity.

The MII continues to be 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 2018, the MII has trained state employees from all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands through more than 8,800 enrollments in 187 courses and 17 workgroups. In FY 2018, the MII conducted 17 courses and 3 workgroup meetings with 866 enrollments. The MII developed a distance learning program in 2012, in addition to its classroom activities, and has sponsored numerous webinars. The MII intends to further promote and expand its training capacity to even more state program integrity staff by adding even more distance learning opportunities to the calendar in the upcoming years.

The MII offers the Certified Program Integrity Professional (CPIP); a credentialing program for state Medicaid program integrity employees to certify their professional qualifications. As of July 2018, 393 state employees in 47 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. CMS plans to enhance the educational opportunities provided through the MII by expanding course offerings and other training opportunities. CMS made

the following enhancements in FY 2018:

- In October 2017, the MII held a course entitled "Emerging Trends in Medicaid - Opioids," which brought together CMS, HHS-OIG, CDC, HRSA, SAMHSA, and state program, policy, operational, program integrity, and law enforcement subject matter experts to explore vulnerabilities, mitigation strategies, and challenges/barriers.

- In December 2017, CMS released the resulting white paper entitled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services," which is an account of program integrity professionals' consensus recommendations to help states more effectively protect vulnerable beneficiaries, fight fraud, and reduce improper payments in personal care services. The purpose of this paper is to provide and disseminate a compendium of the program integrity vulnerabilities and mitigation strategies in personal care services developed by MII participants to inform Medicaid programs nationwide.

- In FY 2018, two "Emerging Trends" series courses were conducted: "Emerging Trends in Medicaid - Third Party Liability (TPL)" in February 2018, and the "Emerging Trends in Medicaid – Beneficiary Eligibility and Fraud" course held in March 2018 and again in September 2018.

FY 2019 and 2020 will showcase additional "Trends in Medicaid" series courses. The topics will focus on the latest trends in Medicaid, including discussions on fraud, waste, and abuse, as well as, new regulatory requirements and are selected in consultation with federal and state partners.

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. CMS has completed focused program integrity reviews on specific target areas in 74 states since FY 2014 through FY 2018. These reviews have focused on a number of issues including the enhanced provider screening and enrollment provisions resulting from the Patient Protection and Affordable Care Act, the extent of states' program integrity oversight of the managed care program, the extent of selected managed care organizations' oversight of their own programs, and issues in personal care services. CMS also conducts additional reviews that encompassed a broader assessment of program vulnerabilities and risk of Medicaid improper payments. Known as desk reviews, these reviews allow CMS to increase the number of states that received customized program integrity oversight.

The Medicaid program integrity review strategy includes both focused reviews (conducted onsite) and desk reviews (conducted remotely) of states. Since their inception in FY 2016, CMS has completed 115 desk reviews in at least 45 states and the District of Columbia. The desk reviews allow CMS to increase the number of states that receive program integrity oversight. During FY 2016, CMS awarded a contract to support Program Integrity reviews. CMS has hosted conference calls with states to discuss program integrity issues and best practices, and issued guidance on policy and regulatory issues that have been of considerable value to states. The program integrity reviews provide the opportunity for assistance from CMS.

Technical Assistance and Education to States

The Medicaid Integrity Program provides additional support to states through technical assistance from CMS staff and through contracted educational activities. CMS plans to expand general technical assistance at states' requests on topics such as managed care, Payment Error Rate Measurement (PERM), Medicaid Eligibility Quality Control (MEQC), opioids, and beneficiary fraud.

In FY 2018, CMS released a new Medicaid program integrity strategy that, among other things, highlighted some of the ways in which CMS is extending additional technical assistance to states. More specifically, CMS plans to use data innovation to empower states and conduct data analytics pilots. CMS will share its extensive knowledge, gained from processing and analyzing large, complex Medicare data sets, to help states apply algorithms and insights to analyze Medicaid state claims and encounter data and identify potential areas to target for investigation. CMS will continue to work with States to enhance data sharing and collaboration to tackle program integrity efforts in the Medicaid programs. For example, CMS is now making the Social Security Administration's Death Master File available for States to support provider enrollment activities.

CMS also continues to expand educational opportunities to states by introducing distance-learning opportunities. In February 2018, CMS initiated a webinar series for states to cover topics in program integrity, including Prior Authorization services, Third Party Liability, and Personal Care Services. These webinars provided a platform for states to ask topical questions to subject matter experts within the Center for Program Integrity and hear presentations from both CMS and state speakers. The webinars reached hundreds of state program integrity employees and encouraged utilization of future distance learning. Additionally, to support distance learning efforts, CMS is investigating the possibility of digitizing some vendor courses offered at MII and making more distance learning opportunities available. This will enable CMS to reach a wider audience and provide more participants the opportunity to learn from these courses.

CMS also assists in the education of Medicaid providers, beneficiaries, and Managed Care Organizations (MCOs) on program integrity efforts by developing materials, conducting training, providing educational resources to educate providers, beneficiaries, MCOs and stakeholders, promoting best practices and fraud and compliance awareness, and encouraging Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. CMS maintains this as 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 on relevant fraud, waste, and abuse topics using a variety of media including print and electronic formats, toolkits, train-the-trainer guides, webinars, YouTube videos, and other strategies. State staff has access to train-the-trainer resources to conduct ongoing education for their co-workers' providers, beneficiaries, and MCOs in their states.

Additionally, CMS conducts Technical Assistance Group (TAG) calls with different states. The calls include the following: Program Integrity Director's Fraud, Waste and Abuse, Small States, Data Analytics, Provider Enrollment, Beneficiary Fraud, and Value Based Payments. During these TAG calls, states share resources and best practices, have the opportunity to ask questions to CMS and other states, and discuss trending issues in program integrity.

CMS collects best and promising practices in program integrity from states and shares those practices with states on the RISS and encourages states to exchange documents, tips, and success stories with Medicaid program integrity. CMS will continue to promote the RISS website to states as a collaborative tool and repository for educational program integrity resources.

**Budget Overview**

The DRA appropriated funds yearly beginning in FY 2006, and beginning in FY 2011, Section 1303(b) (3) of Public Law 111-152 adjusted this funding by the percentage increase in the CPI-U annually. The FY 2018 budget authority was $83.8 million with a CPI-U adjustment of 2.1 percent, bringing the adjusted budget authority to $85.6 million. The FY 2018 budget authority was reduced by 6.6 percent due to sequestration, bringing the final budget authority to $79.9 million. The FY 2019 budget authority is $85.6 million with a CPI-U adjustment of 2.4 percent, bringing the adjusted budget authority to $87.6 million. The FY 2019 budget authority is reduced by 6.2 percent due to sequestration, bringing the final budget authority to $82.2 million. The FY 2020 budget authority is $87.6 million with an estimated CPI-U adjustment of 2.2 percent, bringing the adjusted budget authority to $89.5 million. The CPI-U adjustments are based on the current FY 2020 President's Budget economic assumptions. Funds appropriated remain available until expended.

## GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

**Program Description and Accomplishments**

Section 201 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) (P.L. 111-3) provided $100.0 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Patient Protection and Affordable Care Act provided an additional $40.0 million. Section 303 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided an additional $40.0 million in FY 2016 through FY 2017. The HEALTHY KIDS Act of 2018 (P.L. 115-120) and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in P.L. 115-123) provided a combined total of $168.0 million for outreach and enrollment activities for FY 2018 through FY 2027. These programs 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 Medicaid and CHIP, 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 $100.0 million provided by section 201 of CHIPRA, $80.0 million was appropriated for the Outreach and Enrollment Grants with an additional $10.0 million specifically dedicated to outreach and enrollment of American Indian/Alaska Native children (AI/AN) and $10.0 million for a national outreach campaign. The first $40.0 million in grant funds

was awarded on September 30, 2009. CMS awarded 69 grants distributing $40.0 million in federal funds across 41 states and the District of Columbia. On August 18, 2011, CMS awarded an additional $40.0 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 $32.0 million) entitled Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) in July 2013.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million, of which $32.0 million was dedicated to a fourth cycle of general outreach and enrollment grants. On June 13, 2016, CMS awarded 38 cooperative agreements in 27 states totaling just under the $32.0 million. Awards under these cooperative agreements fund activities aimed at educating families about the availability of free or low-cost health coverage under Medicaid and CHIP, identifying children likely to be eligible for these programs, and assisting families with the application and renewal process. The two year performance period for these awards ended June 30, 2018, but 18 grantees have been granted no-cost extensions ranging between 1-12 months. MACRA also provided $4.0 million for outreach and enrollment of AI/AN children and $4.0 million for a national outreach campaign. On June 14, 2017, CMS awarded eight cooperative agreements in six states totaling just under $4.0 million. The two year performance period for these awards will end June 30, 2019.

To date, a total of approximately $162.0 million in total grant funding has been awarded. This total comprises $144.0 million dedicated to the Outreach and Enrollment Grants and $18.0 million dedicated to outreach and enrollment of AI/AN children. All of the outreach and enrollment grants share the common goal to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled.

The Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable (HEALTHY KIDS Act) provided $120.0 million for activities aimed at increasing the participation of eligible children in Medicaid and CHIP. Of the total $120.0 million in funding, 10 percent was set aside for outreach to AI/AN children ($12.0 million), 10 percent was set aside for the National Campaign ($12.0 million), and the remainder ($96.0 million) will be awarded in grants for the outreach and enrollment of uninsured children and their parents. Of the $96.0 million allocated for outreach and enrollment grants, CMS issued a notice of funding (NOFO) opportunity to make available $48.0 million in grants to eligible entities in November 2018, with the intention of announcing awards by June of 2019. The performance period for these awards will be three years. CMS is planning two phases of the outreach and enrollment grants broadly targeted to retaining all eligible children in Medicaid and CHIP from FYs 2019 to 2023.

Outreach to American Indian/Alaska Native Children

Section 2113(b)(2) of the Social Security Act sets aside 10 percent of any amounts appropriated under that section to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible American Indian/Alaska Native (AI/AN) children in Medicaid and CHIP. As noted above, on April 15, 2010, CMS awarded 41 grants for a total of

$10.0 million. On November 12, 2014, CMS awarded a second round of Outreach and Enrollment Grants, from a $4.0 million Patient Protection and Affordable Care Act appropriation, to organizations serving Indian children. On June 15, 2017, CMS awarded eight new AI/AN cooperative agreements with $4.0 million in funds from MACRA. This set-aside also applies to appropriations provided in the HEALTHY KIDS and ACCESS Acts of 2018. Of the total $120.0 million in funding provided by the HEALTHY KIDS Act, CMS plans to issue a notice of funding opportunity in November 2019 to make available $6.0 million to eligible AI/AN entities, with the intention of announcing awards by June 2020. The performance period for these awards will be three years.

National Enrollment Campaign

The statute sets aside ten percent of appropriations (CHIPRA, ACA, MACRA, the HEALTHY KIDS Act, and the ACCESS Act) to develop and implement a national enrollment 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, palm cards, 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. National 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.

With the funding appropriated under MACRA, CMS awarded a multi-year contract in November 2015 to continue the National Campaign; this contract will conclude in May 2019. New TV and radio public service announcements (PSAs) were produced in 2017 in English and Spanish and distributed nationally for two years. The National Campaign also continues to coordinate webinars, distribute newsletters, liaise with partners, and develop other materials to support outreach and enrollment efforts. A new two-year contract will be awarded in May 2019, with future two-year contracts planned for award in FY 2021 and FY 2023.

In FY 2015 - FY 2019, CMS also developed PSAs for tribal communities and aired these on Good Health TV®, a health education program serving in tribal hospitals and clinic waiting rooms.

**Budget Overview**

CHIPRA appropriated a total of $100.0 million for fiscal years 2009 through 2013. Section 10203(d)(2)(E) of Patient Protection and Affordable Care Act provided an additional $40.0 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 $40.0 million in FY 2009 for outreach grants and approximately $10.0 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40.0 million of the remaining grant funds under CHIPRA on August 18, 2011. Under Patient Protection and Affordable Care Act, in July 2013, CMS awarded a third round of outreach and enrollment grants (totaling $32.0 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 $4.0 million to organizations serving AI/AN children.

The $10.0 million appropriated through CHIPRA in combination with the $4.0 million appropriated through Patient Protection and Affordable Care Act have been used to fund National Enrollment Campaign efforts, as required under the statutes.

MACRA appropriated an additional $40.0 million in FY 2016. Of this appropriated amount, $32.0 million was set aside for outreach grants, $4.0 million was set aside for outreach and enrollment grants specifically dedicated to the outreach and enrollment of AI/AN children, and $4.0 million was set aside for the National Enrollment Campaign. These additional funds were available for obligation through FY 2017. For the National Enrollment Campaign, over $3.0 million was obligated in FY 2016. In FY 2017, the remaining funds were obligated.

The HEALTHY KIDS Act of 2018 (P.L. 115-120) appropriated $120.0 million over FY 2018 through FY 2023 to continue support for outreach grants, including grants dedicated to the outreach and enrollment of AI/AN children and the National Enrollment Campaign. The ACCESS Act of 2018 (P.L. 115-123) appropriated an additional $48.0 million from FY 2024 through FY 2027 and established a 10 percent set-aside for evaluation and technical assistance to grantees.

## DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

### Program Description and Accomplishments

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) required the Secretary to establish a two-year demonstration program no later than January 1, 2016 that would increase the Federal Matching Percentages for participating states to improve access to behavioral health services.

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 $2.0 million in FY 2014 and $25.0 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, $25.0 million in appropriated planning grant funding for this demonstration underwent a 6.8 percent sequestration cut which reduced the budget authority available for the planning grants to $23.3 million.

On May 20, 2015, SAMHSA, in conjunction with CMS, released a Request for Applications (RFA) for Planning Grants to States that intended 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 two 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 approximately $22.9 million in planning grants to 24 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance

use disorder treatment. SAMHSA, CMS, and ASPE provided robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ended in October 2016, eight states were selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics.

On October 31, 2016, 19 of 24 planning grant states submitted applications to participate in the two year Demonstration Programs to Improve Community Mental Health Services. Four of the planning grant states including Alaska, Connecticut, Virginia, and Maryland declined to submit applications while Illinois' application was deemed insufficient to score. In December 2016, HHS, based on an application review by SAMHSA, CMS, and ASPE, announced the selection of the following eight states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania to receive enhanced federal match for specific behavioral health services over a period of two years. Demonstration programs in selected states were launched between the months of April 1, 2017 to July 1, 2017. HHS will report to Congress annually with an assessment of the quality, scope, and impact, and use of funds by demonstration programs, with a final report submitted no later than December 2021, which provides recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223.

Minnesota, Missouri, New York, New Jersey, Nevada, and Pennsylvania conclude their demonstration program on June 30, 2019. Oklahoma and Oregon's demonstration programs end March 31, 2019.

In October 2018, SAMHSA released the first annual Report to Congress which focuses on activities surrounding implementation of the demonstration, the one-year planning phase, states selected to participate in the 2-year demonstration and CCBHC program launch in the selected states. ASPE is continuing to conduct evaluations of the demonstration and is developing an Analysis Report to assess access to community-based mental health services under the Medicaid program, the quality and scope of services provided by CCBHCs, and the impact of the demonstration on federal and state costs of a full range of mental health services.

## DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY UNDER THE MEDICAID PROGRAM

### Program Description and Accomplishments

Section 1003 of the SUPPORT for Patients and Community Act (P. L. 115-271) requires the Secretary to create a five-year demonstration for the purposes of increasing the number and ability of providers participating in Medicaid to provide treatment for substance use disorders. The Secretary of HHS shall conduct this demonstration under the authority of Title XIX.

For the first 18-month period of the demonstration project, the Secretary shall award planning grants to at least 10 states (based on geographic diversity, with a preference to states with a prevalence of opioid use disorders comparable to or higher than the national average) to conduct the following activities:

- Activities that support the development of a behavioral health needs assessment

- Activities that, taking into account the results of the assessment, support the development of state infrastructure to recruit prospective providers to treat substance use disorders and training for those providers

For the remaining 36-month period of the demonstration, the Secretary shall select no more than five states (based on information submitted by the state in an application to the Secretary) to continue the demonstration, and to receive an FMAP of 80 percent for expenditures attributable to substance use treatment or recovery services that exceed one-fourth of funds expended by the state in FY 2018.

This provision also requires CMS (in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use) to submit an initial, interim, and final report to Congress based on annual reports received by the states on the outcomes of the demonstration. CMS shall issue the reports by the following dates:

- Initial Report: October 1, 2020
- Interim Report: October 1, 2022
- Final Report: October 1, 2024

**Budget Overview**

Section 1003 authorizes and appropriates $50.0 million for the planning grants and $5.0 million to support the administration of the demonstration in FY 2019 to carry out this section. Amounts appropriated for this program shall remain available until expended.

# Information Technology

(Dollars in thousands)

| Information Technology Portfolio by Funding Source | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| ***Program Management*** | ***1,882,886*** | ***1,711,126*** | ***1,545,152*** | ***(165,974)*** |
| *Discretionary Appropriation* | *1,313,549* | *1,129,252* | *852,350* | *(276,902)* |
| Federal Administration | 27,543 | 18,862 | 18,862 | - |
| Program Operations | 1,280,029 | 1,106,207 | 828,983 | (277,224) |
| Research | 5,161 | 3,000 | 4,203 | 1,203 |
| Survey & Certification | 816 | 1,183 | 302 | (881) |
| *Mandatory Appropriation* | *137,938* | *136,855* | *102,910* | *(33,945)* |
| ACA Section 2701 | *4,832* | *9,913* | *4,500* | *(5,413)* |
| IMPACT Section 2 & 2a | *26,370* | *23,356* | *24,863* | *1,507* |
| MACRA Section 101 | 50,430 | 45,903 | 45,362 | (541) |
| MACRA Section 501 | 37,097 | 38,281 | 18,477 | (19,804) |
| Medicaid (4201) | 3,306 | 3,315 | 3,354 | 39 |
| Medicare (4101, 4102) | 12,481 | 12,812 | 3,354 | (9,458) |
| PAMA Section 210 & 216 | 3,422 | 3,275 | 3,000 | (275) |
| *Offsetting Collections* | *431,399* | *445,019* | *589,892* | *144,873* |
| CLIA | 4,050 | 4,050 | 4,050 | - |
| COB User Fees | 22,795 | 21,453 | 29,568 | 8,115 |
| Exchange Risk Adjustment User Fees | 38,329 | 4,537 | 23,791 | 19,254 |
| Exchange User Fees | 360,787 | 409,541 | 527,045 | 117,504 |
| RAC MSP & Parts A/B | 5,438 | 5,438 | 5,438 | - |
| ***Quality Improvement Organizations*** | ***370,153*** | ***345,659*** | ***376,100*** | ***30,441*** |
| QIO - Programmatic Contracts | 230,592 | 203,287 | 266,254 | 62,967 |
| QIO - Support Contracts | 139,561 | 142,372 | 109,846 | (32,526) |
| **Innovation Center** | ***250,296*** | ***198,266*** | ***211,201*** | ***12,935*** |
| **Health Care Fraud & Abuse** | **440,762** | **418,788** | **416,378** | **(2,410)** |
| Mandatory | 195,087 | 172,517 | 168,282 | (4,235) |
| Discretionary | 245,675 | 246,271 | 248,096 | 1,825 |
| **Total Information Technology Portfolio** | **2,944,097** | **2,673,839** | **2,548,831** | **(125,008)** |

/1 Totals may not add due to rounding.
/2 Pending approval of QIO 12th scope of work

### Program Description

Information technology (IT) encompasses funding for the processing of Medicare Fee-For-Service (FFS) claims, as well as 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 Exchange. A key aspect of administering these programs is to ensure the security of CMS' data and IT infrastructure. In addition, IT supports CMS' efforts to decrease program payment error rates and increase the program integrity return on investment (ROI).

CMS continues to focus on implementing a cloud hosting environment throughout the

agency, while refining the single point of entry. Hosting has been implemented with Amazon Web Services (AWS) and through Microsoft Azure Government (MAG). There are currently 45 different applications running on AWS or MAG throughout the agency. In FY 2018, CMS migrated over 60 Exchange applications to the cloud. CMS has also developed a Data Center Optimization Initiative (DCOI) Strategic Plan. The foundation of the DCOI is to maximize efficiencies through outreach, collaboration, and education to guide stakeholders in the adoption and implementation of cloud offerings.

This chapter covers Agency-wide IT spending across all funding sources and programs. The intention is to provide a portfolio view of major CMS IT investments to show how these investments relate to specific activities. While this chapter focuses on major investments, multiple non-major investments support each of the activities as well. Additional information on specific IT investments can be viewed at the IT Portfolio Dashboard located at the following web address: https://www.itdashboard.gov/drupal/summary/009

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2016 | $2,030,515,000 |
| FY 2017 | $2,581,419,000 |
| FY 2018 | $2,944,097,000 |
| FY 2019 Enacted | $2,673,839,000 |
| FY 2020 President's Budget | $2,548,831,000 |

**FY 2020 IT Funding Level: $2,548.8 million**

The FY 2020 funding level for CMS-wide IT is $2,548.8 million, a decrease of $125 million below the FY 2019 Enacted level. This funding supports all CMS essential IT investments. Below are several of CMS' top priorities within the IT portfolio.

IT Security ($80.6 million): CMS faces a growing cybersecurity threat every day. The threat is increased due to the outdated security infrastructure maintained within the agency. While CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center, it will take multiple years and additional resources in order to comply with OMB's mandate to fully implement CDM across the entire landscape , establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers and, increase the viability of cloud security and the Development Security Operations programs. OMB and DHS have accelerated the timeline for all CDM phases, which means CMS will need to plan and execute multiple CDM phases simultaneously. The FY 2020 request includes $80.6 million for cybersecurity, which will allow CMS to continue to expand on its CDM work at the new accelerated pace. Protecting beneficiary data continues to be a top priority at CMS.

Fee-for-Service (FFS) Micro –Modernization ($5.7 million): The Medicare FFS Claims processing systems, otherwise known as the FFS shared systems, were developed on the Mainframe over 30 years ago and CMS continues to add on to those systems to meet critical Medicare business needs. These claims processing systems were written in legacy

COBOL and Assembler programming languages and have not been modernized since their inception. As the Medicare program continues to evolve, CMS is concerned that these systems will not be able to keep up with the changing needs of the program and regulations. A fundamental technological system change is necessary to support both existing payment models with the influx of covered beneficiaries, and to provide flexibility for various value-based payment models as they are conceived and implemented.

In an effort to develop a framework for incrementally modernizing the current FFS Medicare systems, CMS is engaged with its Medicare Contractor software developers and the Unites States Digital Service (USDS). CMS is developing proofs of concepts that explore how to modernize the software both on the Mainframe and the Cloud, aiming to improve the agility, velocity, and sustainability of FFS Systems. Funding will be used to implement the proofs of concepts that deliver the greatest business value to CMS and implement efforts to reduce the size and complexity associated with these large claims processing systems. The request of $5.7 million will enable CMS to develop the cloud footprint to migrate key pieces of software from the Mainframe to the Cloud.

Digital Seniors ($38.8 million): Recognizing the increasing role of technology in seniors' lives, this initiative focuses on updating Medicare resources so seniors can more easily access and navigate the Medicare Program. Simplified and personalized tools for Medicare beneficiaries will increase functionality and improve the customer experience. This includes foundational work, such as beneficiary focus groups and journey mapping, and the development of core services to enable cross-channel customer service (i.e., identity management, data warehouse), both building towards the implementation of modern tools enabling beneficiary self-service. Specifically Medicare.gov and MyMedicare.gov will be consolidated into a single website and updated to include improved plan shopping and enrollment tools, improved care choice tools (provider and facility search), improved account management, and a more personalized experience providing much greater online self-service than is currently available. This new website will also include more integrated and proactive electronic communications, notifications, and cross channel services such as email, web chat, and phone. New tools will be mobile optimized and offer application programming interfaces (APIs) so that third-parties can build additional beneficiary tools on top of our data. CMS' request includes a $38.8 million investment in this work, building on initial investments made in FY 2017, FY 2018, and FY 2019.

**Information Technology Portfolio Budget**
**by Investment Category**

(Dollars in thousands)

| IT Funding by Category | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 +/- FY 2019 |
|---|---|---|---|---|
| **Medicare Parts A & B** | 671,050 | 651,843 | 754,208 | *102,365* |
| **Medicare Parts C & D** | 160,886 | 158,659 | 116,761 | *(41,898)* |
| **Medicare Outreach & Education** | 60,653 | 78,452 | 65,742 | *(12,710)* |
| **Medicaid and the Children's Health Insurance Program** | 102,259 | 91,140 | 72,242 | *(18,898)* |
| **Federal Exchanges** | 532,263 | 357,927 | 339,566 | *(18,361)* |
| **Health Care Quality** | 310,456 | 219,218 | 204,420 | *(14,798)* |
| **Enterprise IT** | 1,106,530 | 1,116,600 | 995,892 | *(120,708)* |
| **Total IT Portfolio** | **2,944,097** | **2,673,839** | **2,548,831** | ***(125,008)*** |

/1 Totals may not add due to rounding.
/2 Pending approval of QIO 12th scope of work

## Medicare Parts A & B

Medicare Parts A & B investments support the Fee-For-Service (FFS) and durable medical equipment (DME) claims processing operations. For these activities, CMS acts as a traditional insurance company by verifying beneficiary eligibility, enrolling providers and suppliers, and processing and paying out claims. Additionally, CMS administers a number of incentive payment programs that reward eligible providers for improving quality, reducing unnecessarily resource utilization, and adopting new technologies.

### Funding Level: $754.2 million

The FY 2020 funding level for Medicare Parts A and B investments is $754.2 million, an increase of $102.4 million above the FY 2019 Enacted level. This increase is due to investments in Quality Improvement Organization (QIO) activities, specifically continued improvements in hospital quality reporting and quality payment programs.

*Beneficiary Enrollment*: CMS processes Medicare beneficiary enrollment and defines eligibility status. CMS works in coordination with the Social Security Administration (SSA) to verify eligibility, effectuate enrollment, and ensure that premiums are collected. CMS also works with the Railroad Retirement Board (RRB) to manage beneficiaries who receive assistance through those programs. These operations ensure consistent information on enrollment status, including whether premium payments are up-to-date, and that CMS makes appropriate claims payments.

- *Medicare Beneficiary Enrollment Data Management Systems* – These systems provide the authoritative source for Medicare beneficiary eligibility and enrollment status, ensuring that only claims for valid beneficiaries are paid. CMS manages the billing and collection of premiums for both beneficiaries and third party payers. In

coordination with investments in *Beneficiary Enrollment and Plan Payment for Part C & D,* CMS ensures beneficiaries are appropriately enrolled in the various types of insurance coverage offered by the agency.

*Provider Enrollment*: These investments allow providers and suppliers to enroll in Medicare by verifying their eligibility to participate. In addition, they support collecting required information, establishing billing relationships, and screening providers to flag potential fraudulent actors.

- *Interoperability & Standardization Provider Enrollment Chain and Ownership System(PECOS)*– Provides the authoritative national repository of all enrolled Medicare and Medicaid providers and suppliers. Entities providing payment under Medicare are required to verify provider participation before issuing payment. This PECOS investment includes collecting and maintaining data on initial enrollment, changes of information, reassignments, and mandated revalidations or re-enrollments. CMS collects information about ownership, authorized officials, delegated officials, managing employees, practice locations, practice types, and affiliated provider information.

- *Advanced Provider Screening* – Aggregates data from multiple sources to conduct pre- and post-enrollment provider screening. This investment provides the ability to both prospectively and retrospectively assess program eligibility criteria, as well as provide additional data to further assess eligibility in Medicare and Medicaid provider eligibility, such as automatically running criminal background checks. By flagging potentially ineligible providers, CMS can take appropriate action to eliminate a potential source of fraud, waste, and abuse.

*Claims Processing*: Medicare FFS relies on multiple IT investments running on an integrated infrastructure to successfully process and pay claims. Claims processing includes investments that support processing appeals and ensures that Medicare is the most appropriate payer. CMS conducts extensive testing to ensure this suite of investments operates efficiently and effectively.

- *Medicare Shared Systems (MSS)* – Supports a common environment for operating legacy claims processing systems for inpatient hospital services, outpatient services, and DME. A single data source with full individual beneficiary information allows contractors to verify beneficiary eligibility, conduct pre-payment review, and approve claims. These investments support the receipt of claims, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing, and reporting. This investment captures the Certificate of Medical Necessity and supplier interfaces specific to DME claims. Claims are screened through the Fraud Prevention System (FPS), to identify potential waste, fraud, or abuse.

- *Shared Systems Integrated Testing* – Provides integration and regression testing for MSS functionalities including claims adjudication, payments, remittance advices, Medicare Summary Notices (MSNs), and various system interfaces within and between investments.

- *HIPAA Eligibility Transaction System (HETS)* – Allows providers to check

beneficiary eligibility for Medicare Part A and B services using HIPAA-compliant Accredited Standards Committee (ASC) X12 transactions. HETS processes close to 1 billion transactions per year.

- *Medicare Appeals System (MAS)* – Provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data with regard to FFS and Managed Care appeals. MAS is capable of docketing hearings, scheduling expert witnesses for testimony, compiling case notes, and facilitating adjudication. In addition, MAS provides the capability to report on appeals data, enabling more accurate and expedient reporting and allowing for more precise assessments and policy-setting.

- *Medicare Secondary Payer System (MSPS)* – Ensures proper benefits coordination and payment recovery when Medicare is not the primary payer. MSPS collects and processes data from other insurers and employers, allowing CMS to make more accurate primary and secondary payment decisions.

- *Fraud Prevention System (FPS)* – Provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare fee-for-service claims are approved for payment, they are processed through FPS to identify high-risk claims for further review. Proven predictive models are used in risk scoring to generate alerts and triangulate the results to identify high-risk claims and providers.

*Incentive Payment Programs*: Providers and some suppliers can be eligible for payment adjustments based on participation in a variety of incentive programs. The most significant change to these programs in recent years is the Quality Payment Program (QPP), which replaced the previous physician incentive programs with a two-track system designed to modernize provider quality reporting and encourage participation in Alternative Payment Models (APMs).

- *Quality Payment Program (QPP)* – Includes two tracks for clinicians under Medicare, one through the Merit-based Incentive Payment System (MIPS), which adjusts clinicians' payment based on performance on cost, quality, improvement activities, and advancing care information, and one through participation in Advanced APMs. Clinicians who reach a certain level of participation in Advanced APMs are eligible for a 5 percent incentive payment from 2019 through 2024 and a higher payment update under the Medicare physician fee schedule starting in 2026. Implementing the QPP involves a significant investment to develop a single reporting portal that will allow participating clinicians to better understand the program, submit data, and review their information.

- *Hospital Quality Reporting (HQR) System* – Supports the collection and analysis of quality measures from participating hospitals in order to make appropriate payment adjustments based on performance.

- *Accountable Care Organizations (ACOs)* – Support the Medicare Shared Savings Program by providing ACO eligibility verification and beneficiary assignment, and by calculating annual expenditures, performance and quality scores, and shared savings.

- *End Stage Renal Disease (ESRD) Quality Reporting System* – Provides a comprehensive ESRD patient registry that tracks services provided to ESRD beneficiaries for calculating performance-based payments.

**Medicare Parts C & D**

Medicare beneficiaries have the option of purchasing prescription drug coverage or combining some or all of their coverage options through private issuers. Prescription drug coverage (Part D) and Medicare Advantage (Part C) have a different operational profiles and present different challenges than Parts A & B. Instead of interacting with and paying providers through the claims process, CMS interacts and pays private issuers through specifically designed IT systems. Business processes and IT systems are designed to manage beneficiary enrollment, ensure issuer compliance with benefit design parameters, manage special benefits, and balance risk across issuers.

**Funding Level: $116.8 Million**

The FY 2020 funding level for Medicare Part C & D IT investments is $116.8 million, a decrease of $41.9 million below the FY 2019 Enacted level. This funding continues to support the Agency's mission of serving beneficiaries through the investments listed below:

*Beneficiary and Plan Management*: Ensures that beneficiaries are able to enroll in Part C & D coverage. CMS works extensively with private issuers to review their plans, collect data, and ensure proper payment.

- *Beneficiary Enrollment and Plan Payment for Parts C & D* – Delivers enrollment and health plan payment for approximately 40 million Parts C & D enrollees. This investment is dependent upon certain beneficiary demographic and entitlement data in the *Medicare Beneficiary Enrollment Data Management* systems. CMS maintains, updates, tests, and monitors system operations for enrollment and payment functions, and provides technical assistance and customer service associated with audits and compliance.

- *Health Plan Management System (HPMS)* – Manages the day-to-day interactions with private plan issuers who are offering more than 700 plans to beneficiaries. Participating issuers can submit applications, bids, formulary submissions, marketing material reviews, and plan oversight documents, as well as manage complaints, review enrollment and payment data feeds, and maintain data for the Medicare & You handbook and Medicare Plan Finder. This system also supports the annual plan bidding process, ensuring that issuers comply with regulatory requirements such as no-cost preventive services.

*Drug Subsidies*: Many beneficiaries are entitled to discounts and rebates through various programs. These investments ensure that beneficiaries receive the correct discounts, as well as support Part D enrollees in managing out-of-pocket expenses.

- *Drug Claims Processing System (DCPS)* – Collects, processes, and stores data from Part D claims to ensure the appropriate payment of covered drugs. Records are submitted electronically on a monthly basis and validated through automatic and manual edits. The claims are used during the payment reconciliation process

in order to compare actual expenditures, including discounts for applicable drugs provided at the point-of-sale, to prospective payments made during the year. CMS coordinates the collection of discount payments from manufacturers and participating issuers.

- *Coordination of Benefits/True Out-of-Pocket (TrOOP)* – Provides real-time primary and secondary coverage information to pharmacies and Part D plans via pharmacy industry telecommunications systems. This investment provides eligibility and coverage information to pharmacies to enable real-time billing, and routes information on payments made by secondary payers back to the Part D plans.

*Risk Adjustment*: Ensures that each Medicare private plan issuer's risk is adjusted based on the medical experiences of individuals enrolled in their plans. Risk adjustment ensures that participating plans are not incentivized to select for healthier enrollees by transferring premiums from low to high-risk issuers.

- *Risk Adjustment Data Collection* – Calculates the risk scores for over 60 million beneficiaries. Multiple risk adjustment factors are created by analyzing the diagnosis history for each beneficiary and using statistical models to adjust the risk experienced by each Part C & D plan. The risk factors are provided to HPMS for initial, mid-year, and final reconciliation payments, as well as reruns of prior years to process overpayments.

- *Encounter Data* – Collects beneficiary level, per-visit health care encounter data from participating issuers to enable calculation of risk coefficients that accurately reflect the demographics, patterns of care, and the predicted costs of diseases for Part C enrollees.

- *Central Data Abstraction Tool (CDAT)* – Collects diagnosis information from participating issuers to support the risk adjustment data validation (RADV) audits. CMS uses the results of these audits to estimate and recover overpayments.

**Medicare Outreach & Education**

Medicare Outreach and Education IT systems support the National Medicare Education Program (NMEP). Beneficiary e-Services creates a virtual, enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support medicare.gov and cms.gov websites.

**Funding Level: $65.7 Million**

The FY 2020 funding level for Medicare Outreach and Education is $65.7 million, a decrease of $12.7 million below the FY 2019 Enacted Level. The funding will continue to support upgrades and maintenance to the medicare.gov and cms.gov websites to continue system improvements that provide beneficiaries the highest quality information possible.

- *Beneficiary e-Services* – Provides a virtual, enterprise-wide, one-stop service for handling Medicare beneficiary inquiries from multiple channels to meet the unique needs of our beneficiary population. Beneficiaries can contact CMS through beneficiary websites and portals, such as medicare.gov, and the Beneficiary Contact

Center that handles phone, written, and email communications. Using the Next Generation Desktop application, these processes can access CMS data systems to answer Medicare inquiries on enrollment, claims, health care options, preventive services, and prescription drug benefits. The websites offer beneficiaries interactive tools like Medicare Plan Finder and Nursing Home Compare, as well as personalized information such as enrollment, preventive services, claims, and prescription drugs. The Beneficiary Contact Center uses an interactive voice response system to provide beneficiaries with automated self-service information and options. Based on selections made, if the automated system cannot solve the caller's request, they are routed to the next available and best qualified customer service agent to resolve their inquiry.

- *Medicare and Medicaid Financial Alignment* – Supports the implementation of State programs to integrate care for individuals enrolled in both Medicare and Medicaid. This investment focuses on technical assistance to the States who are engaged in this effort by creating and providing necessary Medicare data files, as well as guidance on the request process and the use of Medicare data.

**Medicaid and the Children's Health Insurance Program (CHIP)**

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of national policies and operations for Medicaid and CHIP. Investments in data infrastructure and systems ensure an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims. This data is used to produce statistical reports, support research, and assist in the detection of fraud, waste and abuse.

**Funding Level: $72.2 million**

The FY 2020 funding level for Medicaid and CHIP IT is $72.2 million, an $18.8 million decrease from the FY 2019 Enacted Level. At this funding level, CMS will continue to support the development of public use files and increased data sharing amongst the States within Medicaid and CHIP Business Information Solutions (MACBIS), to work towards completion of the Medicaid drug rebate system work needed to provide adequate oversight of the Medicaid drug rebate program, continue work to replace the aging Medicaid financial system, and build new tools that allow CMS and States to collaborate online to process State Plan Amendments, waivers, reports on quality measures, demonstrations, advance planning documents, and other initiatives. CMS is also deploying a Medicaid and CHIP (MAC) Scorecard Initiative that will consolidate and display State-level performance data in an easy-to-use format allowing for meaningful comparisons.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – Provides the data infrastructure and environment to facilitate collection of State-level programmatic claims data, including managed care options, beneficiary, and provider data. ·MACBIS automates the State plan approval process by collecting programmatic data on State Medicaid and CHIP operations. State plans support evaluation activities and ensure States remain in compliance with policies or waivers. Further, the investment supports a data analytics infrastructure for operational data about recipients, providers, claims, and encounters. This allows the States and CMS to better identify fraudulent activities and to integrate data across programs.

There are four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS), building out of public use files and release of TMSIS data to states and other stakeholders. Both GAO and the HHS OIG have identified completion of TMSIS as a top priority for the Medicaid program. Second, the request supports completion of the Medicaid drug rebate system rebuild, which is critical to adequate oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. Finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *Medicaid Data Information System* – Provides comprehensive data warehouse services with standardized enrollment, eligibility, and paid claims of dual-eligible, Medicare-Medicaid beneficiaries.

**Federal Exchanges**

The Federal Exchanges enable consumers to compare and purchase private health insurance and determine if financial assistance with premiums and cost-sharing is available.

**Funding Level: $339.6 million**

The FY 2020 funding level for Federal Exchange IT is $339.6 million, a decrease of $18.4 million below the FY 2019 Enacted Level. The funding supports:

- *Health Insurance & Oversight System (HIOS)* – Provides participating issuers with a common portal to submit a range of information regarding health plans offered on the Exchanges. Issuers can submit health plan rates, benefits, and supporting information for display on healthcare.gov. Issuers also submit Medical Loss Ratio calculations, rate review justifications, quality information, and state regulatory data.

- *Federally-Facilitated Exchange (FFE)* – Provides a common platform for consumers and issuers to join together to provide coverage. Consumers can shop and enroll in coverage using easy plan compare tools based on price, benefits, services, and quality. The FFE provides comprehensive services to issuers for managing qualified health plan information, reconciling enrollment, and ensuring accurate payments. This investment also provides automated eligibility verification services facilitating access to multiple Federal, Medicaid, and private data sources.

- *Multidimensional Insurance Data Analytics System (MIDAS)* – Provides an integrated data repository for capturing, aggregating, and analyzing information on health insurance coverage. The data is used to monitor, forecast, trend, analyze, and report on the individual and small group health insurance markets.

- *Health Care Web Support* – Supports the individual portal for consumers to access the Health Insurance Exchanges. The systems, tools, and applications included in the investment help users review, enroll in, and change their healthcare plans.

- *Eligibility Appeals Case Management System (EACMS)* – Ensures CMS is able to receive, process, and monitor appeals submitted by individuals, employers, and States who have delegated authority to CMS. EACMS provides a centralized point for the collection and review of appeals requests and supporting documentation including the secure transfer of case data between coordinating entities.

**Health Care Quality**

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through a variety of health care quality initiatives.

**Funding Level: $204.4 million**

The FY 2020 funding level for Health Care Quality IT is $204.4 million, a decrease of $14.8 million below the FY 2019 Enacted Level. This funding continues the development, testing, integration, and maintenance of the physician value requirements. This funding also supports upgrades to the Medicare physician resource reporting system.

- *Health Care Quality Improvement and Evaluation System (QIES)* – QIES is the key source of CMS quality data, aggregating data from State Survey Agencies, Federal contractors, and QIOs to support research, analysis, and beneficiary information such as the Nursing Home, Home Health, and Hospital Compare websites.

- *Quality Enterprise Services* – Provides a common architecture and system for the submission, parsing, staging, and processing of data from multiple quality programs to allow for streamlined measure reporting and calculation.

- *Quality Improvement Organizations (QIO) Information Systems* – Supports collaboration within the QIO community, coordination between CMS and the QIOs, and data collection to support operational analytics to improve the quality of care nationwide.

- *Innovation Core Systems* – Provides core IT systems that support models and demonstrations to manage their specific needs. Investments support a variety of activities, including beneficiary and provider enrollment, managing data collection, conducting analysis, and assisting in model evaluations.

**Enterprise Information Technology**

Enterprise IT encompasses investments which span multiple program areas or provide CMS-wide services. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

**Funding Level: $995.9 Million**

The FY 2020 funding level for Enterprise IT is $995.9 million, a decrease of $120.7 million below the FY 2019 Enacted Level. The decrease in funding can be attributed to CMS's commitment in FY 2019 to apply additional funds to the cybersecurity program and the development of a disaster recovery environment that enables CMS to optimize, then migrate systems to the cloud. Funding in FY 2020 will continue ongoing IT operations, including making necessary investments to existing systems that support improvements in the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies.

This funding also supports necessary investments in existing systems, such as upgrades to key data centers and enterprise-wide software licenses. The increase in funding is attributed to enhancements in cybersecurity and the Digital Seniors initiative. CMS will continue making these functional enhancements designed to optimize user interfaces, while facilitating improved compliance.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* – Provides a centralized and integrated dual-entry accounting system that standardizes financial accounting functions for all CMS programs.

*Infrastructure and Data Management*: Supports core IT infrastructure and data management for use across CMS.

- *IT Infrastructure Ongoing* – Provides vital infrastructure and services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category of investments also supports overall management of data center resources by providing single, virtual entry for accessing hosting and technology offerings, such as private cloud technologies, standardization of architecture, and service management. Other activities in this category include supporting day-to-day operations of the mainframe, network, voice, and data communications, as well as backup and disaster recovery of mission critical applications. This investment provides an enterprise approach for managing information security and privacy, and supports the Large Scale Data Repository (LSDR), allowing for a robust, stable, and effective data repository environment.

- *Information Management and Analysis* – Supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards for over 820 databases. This investment also assures system performance, data availability, communication, and disaster recovery capabilities. Additionally, it supports coding changes and technical support for ongoing operations of legacy Cobol-based systems.

- *Systems Security* – Ensures that IT systems and data are adequately protected and meet IT security requirements. This investment includes required security control assessments and necessary employee security trainings, and also ensures that the Medicare Administrative Contractor (MACs) meet security requirements. Systems

security investments also provide a full-time, enterprise cyber risk management program to maintain situational awareness of cyber threats and enables leadership to make informed decisions.

- *Integrated Data Repository (IDR)* – Provides a multi-view data warehouse orientation that is capable of integrating data on beneficiaries, providers, health plans, claims, and prescriptions, without relying on voluminous raw data extracts. The IDR provides a scalable system to meet current and expanding data volumes.

- *Chronic Condition Warehouse (CCW)* – Provides a centralized research database that combines Medicare, Medicaid, and Part D Prescription Drug Event data for individuals with chronic conditions readily available to support research activities. The CCW contains data dating back to 1999 for Medicare FFS, eligibility and enrollment, and assessments. The data is linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze information across the continuum of care.

*Shared Services*: Provides CMS with cost-effective solutions that eliminate duplication by providing services that can be accessed across the various investments. These solutions provide standardized interfaces and reusable processes.

- *Enterprise Identity Management (EIDM)* – Ensures individuals have secure, authorized access to CMS business applications by providing a single point of entry and conducting remote identity proofing to confirm individual identities.

- *Master Data Management (MDM)* – This master directory provides a common identifier, which allows CMS to link and aggregate beneficiary, provider, program, and organization data from contrasting sources to create a trusted and authoritative data source. MDM is available to other investments, business processes, and applications, ensuring consistent display across CMS.

- *Enterprise Portal* – Provides a common portal for beneficiaries, providers, organizations, and States to access information and applications based on their roles and permissions. The portal combines and displays content and forms from multiple applications, and supports users with easy navigation, cross-enterprise search tools, simplified sign-on, and personalized, role-based access.

*Crosscutting Program Integrity*: Supports CMS-wide efforts to combat waste, fraud, and abuse by linking data across CMS programs via comprehensive and integrated investments that allow for better analysis and identification of bad actors.

- *Electronic Submission of Medical Documentation* (ESMD) – Allows providers to electronically submit medical documentation in support of medical review and audit efforts in Medicare.

- *Open Payments* – Collects information on payments from drug and device companies to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. This includes ownership interests of physicians or their

immediate family members in these companies. Applicable manufacturers and Group Purchasing Organizations are required to report an annual basis. The data is publically available in an easy to use, searchable, and downloadable format.

- *Healthcare Fraud Prevention Partnership (HFPP)* – Provides an opportunity for private and public payers to collaborate on health care fraud identification and prevention activities.

- *One Program Integrity (One PI)* – Provides an integrated data warehouse, which enables state Medicaid data to be combined with claims data from Medicare Parts A, B, and D. This allows for improved analytics to detect fraud, waste, and abuse activities across multiple Medicare programs.

- *The Unified Case Management System* – Serves as a central repository for contractor workload reporting, dashboards to monitor progress, and outcome measure calculations. This investment strategically positions CMS for a coordinated approach to Medicare and Medicaid audits and investigations.

# Federal Exchanges
(Dollars in Thousands)

| Treasury Account | FY 2018 Actual | FY 2019 Enacted | FY 2020 President's Budget | FY 2020 President's Budget +/- FY 2019 Enacted |
|---|---|---|---|---|
| Program Management | $1,944,190 | $1,772,999 | $1,273,605 | ($499,394) |
| Discretionary Appropriation | $618,164 | $280,552 | $0 | ($280,552) |
| *Program Operations (non-add)* | *$580,886* | *$247,865* | *$0* | *($247,865)* |
| *Federal Administration (non-add)* | *$37,278* | *$32,687* | *$0* | *($32,687)* |
| Offsetting Collections | $1,304,280 | $1,470,701 | $1,273,605 | ($197,096) |
| *Federally-facilitated Exchange User Fee (non-add)* | *$1,272,168* | *$1,422,107* | *$1,234,655* | *($187,452)* |
| *Risk Adjustment User Fee (non-add)* | *$32,112* | *$48,594* | *$38,950* | *($9,644)* |
| Other | $21,746 | $21,746 | $0 | ($21,746) |
| | | | | |
| Heath Care Fraud and Abuse Control | $4,629 | $5,000 | $6,000 | $1,000 |
| Discretionary Appropriation | $0 | $0 | $6,000 | $6,000 |
| Mandatory Appropriation[1] | $4,629 | $5,000 | $0 | $(5,000) |
| **Total, Program Level** | **$1,948,818** | **$1,777,999** | **$1,279,605** | **($498,394)** |

**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)

**Allocation Method** – Direct, Contracts, and Competitive Grants

**Program Descriptions and Accomplishments**

The Federal Exchanges allow individuals to compare health plan options, check eligibility for financial assistance with premiums, and purchase coverage. The FY 2020 Budget builds on actions the Administration has already taken to return management of health care to the States, increase options for consumers, and build financial stability and responsibility in major benefits programs.

States currently have the option to operate a State-based Exchange (SBE) or elect to use the Federally-facilitated Exchange (FFE). SBEs can partner with CMS to use portions of the federal platform, such as enrollment, and are referred to as State-based Exchanges on the Federal Platform (SBE-FPs).

[1] HCFAC mandatory Wedge funding is subject to an annual allocation process by the Attorney General and Secretary of Health and Human Services.

In FY 2020, CMS continues to conduct the following core responsibilities on behalf of all individual market Exchanges:

- Verify consumers' eligibility data for financial assistance through the Exchange or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP);
- Ensure proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) to issuers where a consumer is determined eligible;
- Operate a quality rating system for display on Exchange websites; and
- Conduct certification and oversight of SBEs.

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

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing consumers the ability to apply for coverage, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating consumers about the Exchange, including the open enrollment period (OEP), coverage options, and providing assistance to consumers.

In 2019, CMS continues to work with issuers to build a streamlined and simplified enrollment process where consumers can sign up for health plans offered on the Exchanges through direct enrollment partners, including agents and brokers. CMS will continue to accommodate further innovations for consumers to purchase QHPs outside of Healthcare.gov.

Recognizing that States are better positioned to address the unique needs of their populations, this Budget proposes returning substantial control over health care back to the States. States will be able to assume more control of their markets and expand enrollment options to include private partners to promote innovation and provide a better consumer experience. This aligns with the proposal to Empower States and Consumers to Reform Healthcare and supports an orderly wind down of the Federal Exchange in FY 2021.

**Funding History**

| Fiscal Year | Program Level |
|---|---|
| FY 2016 | $2,150,297,000 |
| FY 2017 | $2,075,714,000 |
| FY 2018 | $1,948,818,000 |
| FY 2019 Enacted | $1,777,999,000 |
| FY 2020 President's Budget | $1,279,605,000 |

**Budget Request**

The FY 2020 Budget request for Federal Exchange activities is $1,279.6 million at the program level of which $1,273.6 is proposed to be paid from anticipated user fee collections and $6 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation.

- *Health Plan Bid Review, Management, and Oversight:* $16.5 million. CMS oversees the annual certification process for QHPs and SADPs offered on the individual and small group markets. CMS supports the process by developing operational guidance, creating tools, and providing technical assistance to issuers on certification requirements and certifies agents and brokers to participate in the Federal Exchanges.

  In FY 2020, CMS will reduce issuer oversight efforts consistent with efforts to provide greater flexibility to stakeholders while transitioning these activities to States for plan year 2021.

  - *Payment and Financial Management:* $41.6 million. States and issuers supply a range of enrollment, premium, and claims data for calculating financial payments across multiple Exchange activities using the Health Insurance Oversight System (HIOS). Exchange-related payments leverage the Healthcare Integrated General Ledger Accounting System and financial management processes such as reporting and debt management.

  Each month, CMS receives enrollment information from the issuers or Exchanges, calculates the amount of aggregate APTC owed to issuers, and distributes payments. APTC is reconciled by the IRS when the consumer files a tax return.

  The Risk Adjustment Program balances the risk pool of compliant plans in the individual and small group markets by transferring premium revenue from plans with below-average actuarial risk to plans with above-average actuarial risk within a market within a state. The High-Cost Risk Pool under the Risk Adjustment Program partially reimburses issuers' for enrollee costs above a certain threshold. For the High-Cost Risk Pool, all issuers contribute while only certain issuers receive payments. The inclusion of the High-Cost Risk Pool starting in 2018, in addition to the existing risk adjustment methodology, allows CMS to better assess total actuarial risk for each risk adjustment eligible plan, and ensure that the program is appropriately compensating issuers. CMS accesses issuers' dedicated data environments to check program integrity and perform calculations for program implementation. The risk adjustment data validation (RADV) program conducts reviews and audits of data that was used to calculate risk adjustment transfers.

  States have the option to run their own risk adjustment programs, however in FY 2020, CMS will continue to administer financial assistance payments on behalf of all States and operate the risk adjustment program. CMS is working to strengthen financial oversight through increased external audits of issuers including claims based reviews. Funding supports strengthening the RADV program through a stronger audit process by incorporating a second audit to ensure that prior reviews were correctly done.

- *Eligibility and Enrollment:* $310.1 million. This activity allows consumers to submit applications for coverage during the open enrollment period or special enrollment periods (SEPs). Electronic applications are processed through HealthCare.gov where eligibility for financial assistance, Medicaid, and CHIP are verified through the Data Services Hub.

  When consumer-provided information does not match electronic data sources, data match inconsistencies will be generated. CMS reviews consumer-submitted supporting documentation to resolve the issue. Consumers have the opportunity to appeal

determinations for financial assistance, and SEP eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, and general case management.

CMS works with issuers to reconcile enrollment, resolving discrepancies identified through analytics or by issuers themselves. This process ensures only consumers who pay their monthly premium remain enrolled in coverage and that issuers receive the appropriate amount of financial assistance payments.

In FY 2020, CMS will continue to operate eligibility verification services for all states and conduct state-delegated and original jurisdiction appeals as consumer are supported in transitioning to other forms of coverage for plan year 2021.

- *Consumer Information and Outreach:* $306.6 million. CMS ensures consumers are fully supported not only during open enrollment, but throughout the plan year using mail, phone, and the website.

  The consumer call center is the primary means for consumers to ask questions, get help with online tools, complete an application, and report life event changes and inconsistencies. The call center offers support in over 200 languages and is open 24 hours a day, 7 days a week.

  Through the Government Printing Office, CMS prints and mails pertinent consumer notices including application status, data matching issues, and appeals.

  CMS provides educational publications on a wide variety of topics. Year-round on the ground community-based support is available through Navigators that supply impartial information to consumers on eligibility applications and selecting a plan.

  In FY 2020, CMS will focus on supporting consumers to transition to other forms of health coverage in plan year 2021.

- *Information Technology (IT):* $520.8 million. The Exchange IT environment uses a cloud-based approach to support consumer facing websites, issuer facing electronic data exchanges, and back end systems. The IT infrastructure is designed to support peak volumes, while ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end–to-end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Exchanges also leverage existing CMS Enterprise Shared Services. Major applications that support Exchanges include:

  - *Data Services Hub* – Provides a query-based verification service for information supplied by the consumer during the application process with Federal entities and private data sources. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veterans', or federal employee benefits.

- *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information. The system collects issuer data on claims for risk adjustment, rate review justifications, and medical loss ratio reporting for oversight activities.

- *Federal Health Care Exchanges (HIX)* – Provides the back end functionality of the Federal Exchanges including plan management, eligibility, and enrollment.

- *HealthCare.gov Web Portal* – Is the consumer facing online resource that allows consumers to search and compare health insurance plans, enroll in coverage, receive financial assistance determinations, upload documents, and submit appeals.

- *Exchange Quality:* $5.0 million. CMS uses a star rating system based on clinical quality measures and an enrollee satisfaction survey to give consumers easy to compare quality metrics on QHPs.

- *Small Business Health Option Program (SHOP):* $2.0 million. SHOPs provide small businesses, defined as those with fewer than 50 employees, with options for providing health insurance to their employees.

  In FY 2020, CMS will continue to conduct oversight, provide technical assistance and analytic support to states, as well as web and phone support to small businesses.

- *Other Activities:* $27.1 million. In coordination with efforts funded by the Health Care Fraud and Abuse Control account, this section includes work necessary to ensure program integrity in the Exchanges and other related planning and performance activities. CMS is also developing a methodology to measure and report estimated improper payments for APTC and will continue work on developing a Basic Health Program methodology. CMS will continue to strengthen oversight of State Exchange operations. CMS will also continue to operate a consumer complaint call center and to investigate complaints. CMS operates focused fraud prevention efforts in areas that have high risk factors for enrollment fraud and targets agents and brokers to ensure they are in good standing with the state.

- *Administration:* $50.0 million. This funding supports staffing and administration.

**Proposed Legislation**

CMS is proposing to allow user fees collected for FFE operations to be used on any Federal administrative Exchange-related activities – see General Provisoin below. Currently activities that CMS conducts on behalf of all Exchanges are not eligible to be paid for by user fees, these activities include eligibility verification, issuer payment activities, quality, and associated IT. This proposal would allow activities such as these to be paid from collected user fees.

General Provision:
SEC. ___. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program,

in addition to any other purposes authorized by law: Provided, That such collections shall be credited to the "Centers for Medicare and Medicaid Services—Program Management" account and shall remain available until expended for the purposes described in this section.

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# Centers for Medicare & Medicaid Services
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# Department of Health and Human Services
# Centers for Medicare & Medicaid Services
# Office of National Drug Control Policy

## Resource Summary

| | FY 2018 Estimate (millions) | FY 2019 Estimate (millions) | FY 2020 Estimate (millions) |
|---|---|---|---|
| Drug Resources by Budget Decision Unit and Function: | | | |
| Medicaid Treatment | $5,010 | $5,250 | $5,550 |
| Medicare Treatment | $2,490 | $2,660 | $2,870 |
| Total Funding | **$7,500** | **$7,910** | **$8,420** |
| Drug Resources Personnel Summary | | | |
| Total FTEs (direct only) | 0 | 0 | 0 |
| Drug Resources as a Percent of Budget | | | |
| Total Agency Budget (in Billions)[1] | $1,073.7 | $1,168.9 | $1,248.2 |
| Drug Resources Percentage | 0.7% | 0.7% | 0.7% |

### Program Summary

### Mission

As an effective steward of public funds, the Centers for Medicare & 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 a 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 providing substance use disorder treatment to eligible beneficiaries.

### Methodology

Medicaid

These projections were based on data from the Medicaid Analytic eXtract (MAX) for 2007 through 2012, based on expenditures for claims with substance use disorders as a primary diagnosis. Managed care expenditures were estimated based on the ratio of substance use disorder expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to FY 2017 using the growth rate of expenditures by state and eligibility category from the CMS-64, MAX data, and estimates consistent with the

[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 reflects 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.

President's Budget. The annual growth rates were adjusted by comparing the rate of substance use disorder expenditure growth from 2007-2011 to all service expenditure growth and adjusting the growth rate proportionately.

CMS notes that the baseline estimates are lower than those for the FY 2019 President's Budget, largely because actual FY 2018 Medicaid expenditures were lower than anticipated.

Medicare

The estimates of Medicare spending for the treatment of substance use disorder are based on the FY 2020 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 2017, using the primary diagnosis code[2] included on the claims. The historical trend was used to make projections into the future. These projections are higher than those for the FY 2019 President's Budget, primarily due to the incorporation of ICD-10 diagnosis codes that went into effect in October of 2015. The prior estimates reflected fee-for-service claims for the period just preceding the implementation of the ICD-10 diagnosis codes.

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 use disorder 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 Medicare Part D 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 use disorder are often also used to treat other conditions.

**Budget Summary**

The total FY 2020 drug control outlay estimate for the CMS is $8,420.0 million. This estimate reflects Medicaid and Medicare (excluding Part D) benefit outlays for substance use disorder treatment. Overall, year-to-year projected growth in substance use disorder spending is a function of estimated overall growth in Medicare and Medicaid spending. The remaining growth in Medicare and Medicaid substance use disorder spending compared to FY 2019 is attributable to the use of updated actual data, which was higher than anticipated, and the incorporation of additional ICD-10 diagnosis codes for substance use disorder.

Medicaid

FY 2020 outlay estimate: $5,550.0 million
(Reflects $300.0 million increase from FY 2019)

Medicaid is a means-tested health care entitlement program financed by states and the federal government. Medicaid mandatory services include substance use disorder services for detoxification and treatment for substance use disorder needs identified as part of early

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 category of codes, and also ICD-9 code 7903. The applicable ICD-10 codes for substance abuse include a subset of the F10, F11, F12, F13, F14, F15, F16, F17, F18, and F19, and R78 ICD-10 category of codes.

and periodic screening, and diagnostic and treatment services for individuals under age 21 years of age. Additional Medicaid substance use disorder treatment services may be provided as optional services. The recently enacted *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* also requires states to cover medication-assisted treatments from FY 2020 – FY 2025.

Medicare
FY 2020 outlay estimate: $2,870.0 million
(Reflects $210.0 million increase from FY 2019)

Medicare provides coverage of hospital, physician, skilled nursing facility, home health care, and other medical care services, as well as prescription drug coverage, to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance use disorder treatment benefit payments are made by Medicare Part A and Medicare Part B. This benefit outlays total includes the estimated impact for services provided to beneficiaries enrolled in Medicare Advantage. As noted above, Medicare Part D prescription drug spending is not counted in these estimates.

**Performance**

Performance measures are used across the health care delivery system and across federal payers, including Medicare and Medicaid, to improve outcomes, experience of care, population health, and health care affordability. In clinical and behavioral health care, measurement has been associated with improvements in providers' use of evidence-based strategies and health outcomes. CMS uses quality measures in its various programs that include quality improvement, pay for reporting, and public reporting. In 2017, the National Quality Forum (NQF) endorsed three new measures to help identify use of opioids at high doses or from multiple providers to persons without cancer.

CMS has a number of mechanisms to help discourage prescribing practices that place beneficiaries at risk of harm. These are employed judiciously to prevent problematic providers who fail to meet Medicare requirements from harming beneficiaries. CMS has continued to monitor Medicare prescribing patterns for potential misuse or abuse. Going forward into 2019, CMS will implement the many Medicare and Medicaid-related provisions of the *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*. Key provisions include: Medicare coverage of opioid use disorder treatment services in Opioid Treatment Programs (OTPs) through a new bundled payment for such services beginning in CY 2020; requiring all state Medicaid programs to cover medication assisted treatment (MAT) beginning in FY 2020; eliminating barriers to telehealth for the provision of substance use disorder (SUD) services to Medicare beneficiaries; and requiring a new Medicare demonstration to test bundled payments for comprehensive opioid use disorder treatment, among others. These and other efforts have helped CMS protect its beneficiaries from the harms associated with opioid misuse, while maintaining the ability of beneficiaries with pain to access necessary treatment.

CMS released the CMS Roadmap to Address the Opioid Crisis in 2018, focusing on three primary strategies to address this national challenge. These strategies include:

(1) Prevention - Managing pain using a safe and effective range of treatment options that rely less on prescription opioids;

(2) Treatment - Expanding access to treatment for opioid use disorders; and
(3) Data - Utilizing data to target prevention and treatment efforts and to identify fraud and abuse.

In addition, the Department of Health and Human Services established a FY 2018-2019 HHS-wide Agency Priority Goal to *Reduce Opioid Misuse,* and CMS is a supporting partner in that effort. Additional information can be found on Performance.gov.

Medicaid

In FY 2019, states will continue voluntary reporting on a core set of health care quality measures for adults and children enrolled in Medicaid and CHIP. The 2019 Adult Core Set includes 12 measures focused on behavioral health; these along with 5 measures from the Child Core Set have been identified as a Behavioral Health Core Set. CMS publicly reports state-specific data in its Annual Reporting from the Adult Core Set on Medicaid.gov and in the Medicaid and CHIP Scorecard, released June 2018. As of FY 2018, 42 CFR 438.3(s)(4) and (5) requires that each Medicaid managed care organization's (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the *Social Security Act* (the Act) and submit an annual report on the operation of its DUR program activities.

CMS allows states to utilize the section 1115 demonstration authority, as needed, to receive federal financial participation (FFP) for the continuum of services to treat substance use disorders (SUD), including services provided to Medicaid enrollees residing in residential treatment facilities that meet the definition of an institution for mental diseases (IMDs). Ordinarily such residential treatment services are not eligible for federal Medicaid reimbursement due to the exclusion in the Medicaid statute of services provided to beneficiaries in IMDs. A State Medicaid Directors Letter (SMDL # 17-003) issued November 1, 2017 describes this policy and a number of milestones or actions states are expected to meet to ensure Medicaid beneficiaries receive good quality of care in these residential facilities and have access to community-based care as well. Participating states report on relevant Adult Core Measures as well as a number of other measures to help monitor program performance. As of January 31, 2019, 21 states have been approved to implement the 1115 SUD demonstrations.

In addition, the Medicaid Innovation Accelerator Program (IAP) supports states' ongoing payment and delivery system reforms with the end goal of improving the health and health care of Medicaid beneficiaries. IAP's Substance Use Disorder (SUD) program area offers states a variety of technical assistance opportunities as they seek to improve care for individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD practices delivered to beneficiaries. Additional information is available here: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html

Medicare

In 2017, Medicare's Physician Quality Reporting System transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The program encourages reporting of quality measures by "eligible professionals" by tying payment adjustments to reporting criteria. The QPP has two tracks: 1) MIPS and 2)

Advanced Alternative Payment Models (APMs). Clinicians can choose how they want to participate based on their practice size, specialty, location, or Medicare patient population. There are four MIPS categories: Quality, Promoting Interoperability (formerly Advancing Care Information), Improvement Activities, and Cost. The current program portfolio includes two Improvement Activities, and four Quality measures that address opioid use. The Promoting Interoperability performance category includes two new opioid measures from the 2019 MIPS Notice of Proposed Rule Making and two new opioid measures finalized as part of the Promoting Interoperability Program in the FY 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) final rule. CMS continues to modify the measures, as needed, based on Office of the National Coordinator for Health Information Technology (ONC) and stakeholder feedback to promote interoperability and to reduce burden and implementation challenges.

The CMS Quality Innovation Network Quality Improvement Organization Program (QIN-QIO) is working with over 5,000 outpatient settings including pharmacies, nursing homes, and clinical practices and with community coalitions and state-based efforts across the nation to improve safe management of opioid medications while addressing appropriate treatment of pain. The program is currently working toward 2019 goals to achieve a hospital utilization reduction of over 77,000 opioid admissions, observation stays and emergency department visits for the “high risk” opioid Medicare population, and a reduction in over 6,000 readmissions for the “high risk” opioid Medicare population. To reach these goals, QIN-QIOs implement interventions in partnership with clinicians, use data analytics to support local innovation and change, and support local efforts such as improving communication across settings and communities. CMS QIN-QIOs have established a methodology using CMS data to identify adverse events for high risk Medicare beneficiaries using opioid medications. QIN-QIOs provide aggregated reports to recruited providers and community coalitions to support local and national efforts to address the opioid epidemic and increase surveillance of adverse events. QIN-QIOs also use advance analytics to support clinicians in prescribing and understanding how they compare to their state or community. Additional information about these initiatives can be found at the following links:
http://qioprogram.org/campaign-meds-management
http://qioprogram.org/qionews/topics/adverse-drug-events.

CMS updated its 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. The tool allows the user to see both the number and percentage of opioid claims at the local level, and allows a better understanding of variability in provider prescribing behaviors within and across regions, and how this critical issue impacts communities nationwide. The updated tool includes the addition of extended-release opioid prescribing rates and county-level hot spots.

Medicare Part D Drug Management Program

CMS published a final rule, “Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program,” on April 16, 2018 (final rule) in the Federal Register which contained provisions to implement certain provision of the Comprehensive Addiction and Recovery Act of 2016 (CARA). Specifically, in the final rule, CMS established the framework under which sponsors of Medicare Part D prescription drug benefit plans may voluntarily establish a drug management program for "at-risk

beneficiaries" (ARBs). The majority of Part D sponsors have established drug management programs for 2019. Under such a program, sponsors may restrict ARBs' access to coverage for opioids and benzodiazepines to a selected prescriber(s) and/or network pharmacy(ies) (more commonly known as a "lock-in" approach in Medicaid and some commercial plans) after case management with the prescribers and notice to the ARBs.

The final rule incorporated many aspects of the pre-2019 Part D Opioid Drug Utilization Review (DUR) Policy/Overutilization Monitoring System (OMS), which was based on retrospective DUR and case management by Part D sponsors to reduce opioid utilization in Part D. Through the Final CY 2019 Medicare Advantage and Part D Rate Notice and Call Letter, CMS also finalized a number of updates to Part D policies that address opioid overutilization prospectively for 2019. These prospective policies work in conjunction with Part D drug management programs, so that Part D sponsors take a comprehensive approach to continuing to prevent and address prescription opioid misuse and abuse and reduce high-risk opioid overutilization in the Medicare Part D program.

The *SUPPORT for Patients and Communities Act* requires all Part D sponsors to have a Drug Management Program (DMP) for plan years beginning on or after January 1, 2022. CMS is currently evaluating the Act's provisions and planning the steps necessary to implement it.

Clinical Quality Measure Reporting

CMS has included opioid use disorders as a meaningful measure area in the Meaningful Measures framework and also incorporated opioid-related measures and clinical improvement activities for clinicians to select as they participate in Medicare's QPP. For the QPP, CMS has updated the definition of high priority measures to include opioid-related measures in the CY 2019 Physician Fee Schedule final rule. CMS is also working in partnership with ONC to incorporate clinical quality measures (CQMs) into electronic health records (EHRs) to assist in implementing healthcare delivery and payment. Finally, CMS included opioid-related quality measure concepts in the "Measures Under Consideration (MUC) List" published each year to inform the public about measures being considered for use in Medicare. The 2017 MUC list included "Continuity of Pharmacotherapy for Opioid Use Disorder" which was approved by the MUC technical expert panel and proposed and finalized for the 2019 MIPS. CMS continues to consider additional opioid related measures for use in the Medicare quality programs through its annual rulemaking processes.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Centers for Medicare & Medicaid Services
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**Object Classification - Direct Budget Authority**
**CMS Program Management**
(Dollars in Thousands)

| Object Class | FY 2018 Enacted | FY 2019 Enacted | FY 2020 Request |
|---|---|---|---|
| **Direct Budget Authority** | | | |
| Personnel compensation: | | | |
| Full-time permanent (11.1) | $ 479,813 | $ 484,361 | $ 492,493 |
| Other than full-time permanent (11.3) | $ 14,032 | $ 11,124 | $ 13,909 |
| Other personnel compensation (11.5) | $ 7,836 | $ 7,806 | $ 7,892 |
| Military personnel (11.7) | $ 14,678 | $ 14,930 | $ 15,254 |
| Special personnel services payments (11.8) | $ - | $ - | $ - |
| **Subtotal personnel compensation** | **$ 516,359** | **$ 518,221** | **$ 529,548** |
| Civilian benefits (12.1) | $ 149,930 | $ 152,938 | $ 156,444 |
| Military benefits (12.2) | $ 7,561 | $ 7,691 | $ 7,858 |
| Benefits to former personnel (13.0) | $ - | $ - | $ - |
| **Subtotal Pay Costs** | **$ 673,850** | **$ 678,850** | **$ 693,850** |
| Travel and transportation of persons (21.0) | $ 1,048 | $ 5,464 | $ 5,464 |
| Transportation of things (22.0) | $ - | $ - | $ - |
| Rental payments to GSA (23.1) | $ 5,100 | $ 5,100 | $ 5,100 |
| Communication, utilities, and misc. charges (23.3) | $ - | $ - | $ - |
| Printing and reproduction (24.0) | $ 1,671 | $ 2,453 | $ 2,453 |
| **Other Contractual Services:** | | | |
| Advisory and assistance services (25.1) | $ - | $ - | $ - |
| Other services (25.2) | $ 1,976,752 | $ 1,996,737 | $ 1,540,892 |
| Purchase of goods and services from government accounts (25.3) | $ 3,187 | $ 2,778 | $ 2,778 |
| Operation and maintenance of facilities (25.4) | $ - | $ - | $ - |
| Research and Development Contracts (25.5) | $ 20,054 | $ 20,054 | $ 20,054 |
| Medical care (25.6) | $ 1,282,215 | $ 1,262,339 | $ 1,307,867 |
| Operation and maintenance of equipment (25.7) | $ - | $ - | $ - |
| Subsistence and support of persons (25.8) | $ - | $ - | $ - |
| **Subtotal Other Contractual Services** | **$ 3,282,208** | **$ 3,281,908** | **$ 2,871,591** |
| Supplies and materials (26.0) | $ 1,003 | $ 969 | $ 969 |
| Equipment (31.0) | $ - | $ - | $ - |
| Land and Structures (32.0) | $ - | $ - | $ - |
| Investments and Loans (33.0) | $ - | $ - | $ - |
| Grants, subsidies, and contributions (41.0) | $ - | $ - | $ - |
| Interest and dividends (43.0) | $ - | $ - | $ - |
| Refunds (44.0) | $ - | $ - | $ - |
| **Subtotal Non-Pay Costs** | **$ 3,291,030** | **$ 3,295,894** | **$ 2,885,577** |
| **Total Direct Budget Authority** | **$ 3,964,880** | **$ 3,974,744** | **$ 3,579,427** |
| | | | |
| **Average Cost per FTE** | | | |
| Civilian FTEs | 4,206 | 4,167 | 4,195 |
| Civilian Average Salary | $ 155 | $ 157 | $ 160 |
| Percent change | 0% | 2% | 2% |
| Military FTEs | 135 | 135 | 135 |
| Military Average Salary | $ 165 | $ 168 | $ 171 |
| Percent change | 0% | 2% | 2% |
| Total OPDIV FTEs | 4,341 | 4,302 | 4,330 |
| Total OPDIV Average Salary | $ 155 | $ 158 | $ 160 |
| Percent change | 0% | 2% | 2% |

**CMS Program Management**
**Salaries and Expenses**
**(Dollars in Thousands)**

| | FY 2018 Final | FY 2019 Enacted | FY 2020 Request |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent (11.1) | $ 479,813 | $ 484,361 | $ 492,493 |
| Other than full-time permanent (11.3) | $ 14,032 | $ 11,124 | $ 13,909 |
| Other personnel compensation (11.5) | $ 7,836 | $ 7,806 | $ 7,892 |
| Military personnel (11.7) | $ 14,678 | $ 14,930 | $ 15,254 |
| Special personnel services payments (11.8) | $ - | $ - | $ - |
| **Subtotal personnel compensation** | **$ 516,359** | **$ 518,221** | **$ 529,548** |
| Civilian benefits (12.1) | $ 149,930 | $ 152,938 | $ 156,444 |
| Military benefits (12.2) | $ 7,561 | $ 7,691 | $ 7,858 |
| Benefits to former personnel (13.0) | $ - | $ - | $ - |
| **Total Pay Costs** | **$ 673,850** | **$ 678,850** | **$ 693,850** |
| Travel and transportation of persons (21.0) | $ 1,048 | $ 5,464 | $ 5,464 |
| Transportation of things (22.0) | $ - | $ - | $ - |
| Rental payments to GSA (23.1) | $ 5,100 | $ 5,100 | $ 5,100 |
| Rental payments to Others (23.2) | $ - | $ - | $ - |
| Communication, utilities, and misc. charges (23.3) | $ - | $ - | $ - |
| Printing and reproduction (24.0) | $ 1,671 | $ 2,453 | $ 2,453 |
| Other Contractual Services: | | | |
| Advisory and assistance services (25.1) | $ - | $ - | $ - |
| Other services (25.2) | $ 1,976,752 | $ 1,996,737 | $ 1,540,892 |
| Purchase of goods and services from government accounts (25.3) | $ 3,187 | $ 2,778 | $ 2,778 |
| Operation and maintenance of facilities (25.4) | $ - | $ - | $ - |
| Research and Development Contracts (25.5) | $ 20,054 | $ 20,054 | $ 20,054 |
| Medical care (25.6) | $ 1,282,215 | $ 1,262,339 | $ 1,307,867 |
| Operation and maintenance of equipment (25.7) | $ - | $ - | $ - |
| Subsistence and support of persons (25.8) | $ - | $ - | $ - |
| **Subtotal Other Contractual Services** | **$ 3,282,208** | **$ 3,281,908** | **$ 2,871,591** |
| Supplies and materials (26.0) | $ 1,003 | $ 969 | $ 969 |
| **Total Non-Pay Costs** | **$ 3,291,030** | **$ 3,295,894** | **$ 2,885,577** |
| **Total Salary and Expense** | **$ 3,964,880** | **$ 3,974,744** | **$ 3,579,427** |
| **Direct FTE** | 4,341 | 4,302 | 4,330 |

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2018 Actual Total | 2019 Est. Total | 2020 Est. Total |
|---|---|---|---|
| **Office of the Administrator** | | | |
| Direct FTEs | 33 | 33 | 37 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 33 | 33 | 37 |
| **Center for Clinical Standards and Quality** | | | |
| Direct FTEs | 180 | 181 | 246 |
| Reimbursable FTEs | 41 | 42 | 42 |
| Subtotal | 221 | 223 | 288 |
| **Center for Consumer Information and Insurance Oversight** | | | |
| Direct FTEs | 212 | 213 | 211 |
| Reimbursable FTEs | 140 | 176 | 256 |
| Subtotal | 352 | 389 | 467 |
| **Center for Medicaid and CHIP Services** | | | |
| Direct FTEs | 305 | 301 | 304 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 305 | 301 | 304 |
| **Center for Medicare** | | | |
| Direct FTEs | 632 | 635 | 630 |
| Reimbursable FTEs | 6 | 6 | 6 |
| Subtotal | 638 | 641 | 636 |
| **Center for Medicare and Medicaid Innovation** | | | |
| Direct FTEs | 0 | 0 | 0 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 0 | 0 | 0 |
| **Center for Program Integrity** | | | |
| Direct FTEs | 8 | 8 | 8 |
| Reimbursable FTEs | 33 | 33 | 33 |
| Subtotal | 41 | 41 | 41 |
| **Office of Acquisition & Grants Management** | | | |
| Direct FTEs | 151 | 145 | 151 |
| Reimbursable FTEs | 2 | 2 | 2 |
| Subtotal | 153 | 147 | 153 |
| **Office of the Actuary** | | | |
| Direct FTEs | 81 | 80 | 81 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 81 | 80 | 81 |
| **Office of Communications** | | | |
| Direct FTEs | 214 | 215 | 214 |
| Reimbursable FTEs | 1 | 1 | 1 |
| Subtotal | 215 | 216 | 215 |
| **Office of Information Technology** | | | |
| Direct FTEs | 400 | 392 | 399 |
| Reimbursable FTEs | 1 | 3 | 3 |
| Subtotal | 401 | 395 | 402 |
| **Office of Equal Opportunity and Civil Rights** | | | |
| Direct FTEs | 31 | 32 | 31 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 31 | 32 | 31 |

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2018 Actual Total | 2019 Est. Total | 2020 Est. Total |
|---|---|---|---|
| **Federal Coordinated Health Care Office** | | | |
| Direct FTEs | 26 | 26 | 26 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 26 | 26 | 26 |
| **Office of Financial Management** | | | |
| Direct FTEs | 233 | 229 | 233 |
| Reimbursable FTEs | 6 | 8 | 8 |
| Subtotal | 239 | 237 | 241 |
| **Office of Hearings and Inquiries** | | | |
| Direct FTEs | 120 | 118 | 120 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 120 | 118 | 120 |
| **Office of Legislation** | | | |
| Direct FTEs | 49 | 53 | 49 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 49 | 53 | 49 |
| **Continuous Improvement and Strategic Planning** | | | |
| Direct FTEs | 12 | 12 | 12 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 12 | 12 | 12 |
| **Digital Service at CMS** | | | |
| Direct FTEs | 3 | 4 | 3 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 3 | 4 | 3 |
| **Office of Minority Health** | | | |
| Direct FTEs | 16 | 17 | 16 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 16 | 17 | 16 |
| **Office of Human Capital** | | | |
| Direct FTEs | 178 | 180 | 177 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 178 | 180 | 177 |
| **Office of Support Services and Operations** | | | |
| Direct FTEs | 94 | 95 | 94 |
| Reimbursable FTEs | 1 | 1 | 1 |
| Subtotal | 95 | 96 | 95 |
| **Office of Strategic Operations and Regulatory Affairs** | | | |
| Direct FTEs | 146 | 143 | 146 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 146 | 143 | 146 |
| **Office of Enterprise Data and Analytics** | | | |
| Direct FTEs | 66 | 66 | 66 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 66 | 66 | 66 |
| **Consortia** | | | |
| Direct FTEs | 1,151 | 1,125 | 1,078 |
| Reimbursable FTEs | 21 | 28 | 28 |
| Subtotal | 1,171 | 1,152 | 1,106 |
| **Total, CMS Program Management FTE 1/** | **4,593** | **4,602** | **4,710** |
| *Total, CMS Military Staffing (Non-Add) 1/* | *135* | *135* | *135* |

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2018 Actual Total | 2019 Est. Total | 2020 Est. Total |
|---|---|---|---|
| **American Recovery and Reinvestment Act (ARRA):** | | | |
| **Total, CMS Program Management ARRA FTE 1/** | **69** | **61** | **61** |

1/ FY 2018 reflects actual FTE consumption. Excludes directly-appropriated ACA provisions.

**Average GS Grade**

| | |
|---|---|
| FY 2016 | **13.4** |
| FY 2017 | **13.4** |
| FY 2018 | **13.4** |
| FY 2019 | **13.4** |
| FY 2020 | **13.4** |

**CMS Program Management**
**Detail of Positions**
(Dollars in Thousands)

| | FY 2018 Final | FY 2019 Enacted | FY 2020 President's Budget |
|---|---|---|---|
| Subtotal, EX | 1 | 1 | 1 |
| Total - Exec. Level Salary | $165 | $165 | $165 |
| Subtotal | 78 | 78 | 78 |
| Total - ES Salaries | $14,257 | $14,584 | $14,777 |
| GS-15 | 571 | 566 | 570 |
| GS-14 | 580 | 575 | 579 |
| GS-13 | 2,046 | 2,026 | 2,040 |
| GS-12 | 624 | 618 | 622 |
| GS-11 | 128 | 127 | 128 |
| GS-10 | 1 | 1 | 1 |
| GS-9 | 121 | 120 | 121 |
| GS-8 | 1 | 1 | 1 |
| GS-7 | 37 | 37 | 37 |
| GS-6 | 4 | 4 | 4 |
| GS-5 | 5 | 5 | 5 |
| GS-4 | 9 | 9 | 9 |
| GS-3 | 0 | 0 | 0 |
| GS-2 | 0 | 0 | 0 |
| GS-1 | 0 | 0 | 0 |
| Subtotal 1/ | 4,127 | 4,088 | 4,116 |
| Total - GS Salary 1/ | $479,422 | $480,732 | $491,454 |
| Average GS grade 1/ | 13.4 | 13.4 | 13.4 |
| Average GS salary 1/ | $116.167 | $117.596 | $119.401 |

1/ Reflects direct discretionary staffing within the Program Management account.

# CMS Program Management
# Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2010 | | | FY 2011 | | | FY 2012 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | $30,000 | 0 | | | 2 | | | 0 | |
| Rate Review Grants | 1003 | $250,000 | 0 | | | 0 | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | $5,000,000 | 0 | | | 13 | | | 18 | |
| Reinsurance for Early Retirees | 1102 | $5,000,000 | 0 | | | 2 | | | 4 | |
| Affordable Choices of Health Benefit Plans | 1311 | $49,322 | 0 | | $478,374 | 28 | | $1,654,596 | 44 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program | 1322 | $ 6,000,000 | 0 | | $ (2,200,000) | 1 | | $ (400,000) | 6 | |
| CO-OP Contingency Fund | 1322/644 | | 0 | | | 0 | | | 0 | |
| Adult Health Quality Measures 2/ | 2701 | $ 60,000 | 0 | | $ 60,000 | 2 | | $ 60,000 | 5 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | 0 | | $ 75,000 | 0 | | | | |
| Quality Measurement 2/ | 3014 | $ 20,000 | 0 | | $ 20,000 | 2 | | $ 20,000 | 4 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | $ 5,000 | 4 | | $ 10,000,000 | 68 | | | 163 | |
| Independence At Home Demonstration 2/ | 3024 | $ 5,000 | 0 | | $ 5,000 | 0 | | $ 5,000 | 3 | |
| Community Based Care Transitions | 3026 | | 0 | | $ 500,000 | 0 | | | 2 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | $ 5,000 | 0 | | | 0 | | | 2 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 0 | | $ 100,000 | 0 | | | 1 | |
| Community Prevention and Wellness | 4202 | $ 50,000 | 0 | | | 0 | | | 1 | |
| Graduate Nurse Education 2/ | 5509 | | 0 | | | 0 | | $ 50,000 | 1 | |
| Sunshine Act | 6002 | | 0 | | | 0 | | | 0 | |
| Long Term Care (LTC) National Background Checks | 6201 | $ 160,000 | 3 | | | 2 | | | 3 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | | 0 | | | 5 | | | 8 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | | 0 | | $ 10,000 | 2 | | $ 10,000 | 2 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | | 0 | | | 2 | | | 2 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | Such Sums | 0 | | Such Sums | 0 | | $302,000 | 2 | |
| **Total ACA Direct Appropriated FTEs** | | | **7** | | | **129** | | | **271** | |

1/ From FY 2014 through FY 2018, 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 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%) and FY 2018 (-6.6%)

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2013 | | | FY 2014 | | | FY 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | | 0 | | | 0 | | | 0 | |
| Rate Review Grants | 1003 | | 0 | | | 0 | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | | 12 | | | 7 | | | 5 | |
| Reinsurance for Early Retirees | 1102 | | 11 | | | 4 | | | 4 | |
| Affordable Choices of Health Benefit Plans | 1311 | $2,147,000 | 56 | | $784,000 | 51 | | $469,624 | 49 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program | 1322 | $ (2,278,544) | 18 | | | 15 | | | 0 | |
| CO-OP Contingency Fund | 1322/644 | $ 240,259 | | | | | | | 15 | |
| Adult Health Quality Measures 2/ | 2701 | $ 56,940 | 10 | | $ 55,680 | 9 | | | 11 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | | | | 0 | | | 1 | |
| Quality Measurement 2/ | 3014 | $ 18,980 | 6 | | $ 18,560 | 9 | | | 9 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | | 258 | | | 355 | | | 479 | |
| Independence At Home Demonstration 2/ | 3024 | $ 4,745 | 2 | | $ 4,640 | 1 | | $ 4,635 | 1 | |
| Community Based Care Transitions | 3026 | | 1 | | | 0 | | | 0 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | | 1 | | | 0 | | | 0 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 1 | | | 1 | | | 1 | |
| Community Prevention and Wellness | 4202 | | 1 | | | 0 | | | 0 | |
| Graduate Nurse Education 2/ | 5509 | $ 47,450 | 0 | | $ 46,400 | 0 | | $ 46,350 | 1 | |
| Sunshine Act | 6002 | $ 16,050 | 11 | | $ 1,024 | 14 | | $ 21,399 | 16 | |
| LTC National Background Checks | 6201 | | 4 | | | 5 | | | 5 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | $ 5,000 | 10 | | | 12 | | $ 18,035 | 13 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | $ 13,000 | 1 | | $ 3,000 | 1 | | $ 27,377 | 2 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | $ 3,300 | 1 | | $ 3,783 | 2 | | $ 3,975 | 2 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | $418 | 1 | | $316 | 1 | | $ 549 | 1 | |
| **Total ACA Direct Appropriated FTEs** | | | **405** | | | **487** | | | **615** | |

1/ From FY 2014 through FY 2018, 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 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%) and FY 2018 (-6.6%).

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2016 | | | FY 2017 | | | FY 2018 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | | 0 | | | 0 | | | 0 | |
| Rate Review Grants | 1003 | | | | | | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | | 0 | | | 0 | | | 0 | |
| Reinsurance for Early Retirees | 1102 | | 0 | | | 0 | | | 0 | |
| Affordable Choices of Health Benefit Plans | 1311 | $ 20,163 | 34 | | $ 18,221 | 25 | | $ 12,655 | 24 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program | 1322 | | 0 | | | 0 | | | 0 | |
| CO-OP Contingency Fund | 1322/644 | | 18 | | | 0 | | | 0 | |
| Adult Health Quality Measures 2/ | 2701 | | 11 | | | 8 | | | 6 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | 0 | | | 0 | | | 0 | |
| Quality Measurement 2/ | 3014 | | 0 | | | 0 | | | 0 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | | 521 | | | 551 | | | 540 | |
| Independence At Home Demonstration 2/ | 3024 | | 1 | | | 1 | | | 1 | |
| Community Based Care Transitions | 3026 | | 1 | | | 0 | | | 0 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | | 0 | | | 0 | | | 0 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 0 | | | 0 | | | 0 | |
| Community Prevention and Wellness | 4202 | | 0 | | | 0 | | | 0 | |
| Graduate Nurse Education 2/ | 5509 | | 1 | | | 2 | | | 2 | |
| Sunshine Act | 6002 | $ 4,211 | 17 | | $ 5,615 | 22 | | | 0 | |
| LTC National Background Checks | 6201 | | 6 | | | 6 | | | 4 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | $ 3,509 | 14 | | $ 3,509 | 9 | | | 0 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | $ 468 | 2 | | $ 468 | 1 | | | 0 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | $ 468 | 2 | | | 0 | | | 0 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | $329 | 1 | | | 0 | | | 0 | |
| **Total ACA Direct Appropriated FTEs** | | | **629** | | | **625** | | | **577** | |

1/ From FY 2014 through FY 2018, 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 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), and FY 2018 (-6.6%).

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2019 | | | FY 2020 | | |
|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | |
| Health Insurance Consumer Information | 1002 | | 0 | | | 0 | |
| Rate Review Grants | 1003 | | 0 | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | | 0 | | | 0 | |
| Reinsurance for Early Retirees | 1102 | | 0 | | | 0 | |
| Affordable Choices of Health Benefit Plans | 1311 | | 0 | | | 0 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program | 1322 | | 0 | | | 0 | |
| CO-OP Contingency Fund | 1322/644 | | 0 | | | 0 | |
| Adult Health Quality Measures 2/ | 2701 | $ 1,200 | 9 | | | 0 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | 0 | | | 0 | |
| Quality Measurement 2/ | 3014 | | 0 | | | 0 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | $ 92,000 | 600 | | $ 92,000 | 600 | |
| Independence At Home Demonstration 2/ | 3024 | | 0 | | | 0 | |
| Community Based Care Transitions | 3026 | | 0 | | | 0 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | | 0 | | | 0 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 0 | | | 0 | |
| Community Prevention and Wellness | 4202 | | 0 | | | 0 | |
| Graduate Nurse Education 2/ | 5509 | | 0 | | | 0 | |
| Sunshine Act | 6002 | | 0 | | | 0 | |
| LTC National Background Checks | 6201 | $ 857 | 6 | | $ 857 | 6 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | | 0 | | | 0 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | | 0 | | | 0 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | | 0 | | | 0 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | | 0 | | | 0 | |
| **Total ACA Direct Appropriated FTEs** | | | **615** | | | **606** | |

1/ From FY 2014 through FY 2018, 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 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), and FY 2019 (-6.2%)

# Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

**DHHS: Centers for Medicare and Medicaid Services (CMS)**

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
In order to attract and retain highly skilled and qualified Medical Officers, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) and the Physician's and Dental Pay (PDP). Details of the PDP are not included in this report. The majority of CMS Medical Officers receive PCA. CMS Medical Officers are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Generally speaking, physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

3 and 4) Please complete the table below with details of the PCA agreement for the following years:

| | FY 2018** (Final) | FY 2019*** (Estimates) | FY 2020 President's Budget (Estimates) |
|---|---|---|---|
| 3a) Number of Physicians Receiving PCAs* | 37 | 45 | 50 |
| 3b) Number of Physicians with One-Year PCA Agreements | 2 | 2 | 2 |
| 3c) Number of Physicians with Multi-Year PCA Agreements | 35 | 43 | 48 |
| 4a) Average Annual PCA Physician Pay (without PCA payment) | $160,599 | $160,599 | $160,599 |
| 4b) Average Annual PCA Payment | $25,474 | $25,474 | $25,474 |

* All Physicians are in Category IV-B Health and Medical Admin as additional physician categories have not been designated by CMS.
** Actual count as of 12/11/2018.
*** FY 2019 data will be approved during the FY 2020 Budget cycle.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
Recent legislation over the past several years required CMS to implement new programs. Some of these mandates require establishing additional new Medical Officer positions or quickly filling vacated Medical Officer positions to fill very specific needs. Many of these positions were also supervisory positions. Even though CMS has experienced many hurdles trying to recruit medical officers, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable to give us the opportunity to attract and hire exceptional physicians. Without this recruitment and retention allowance, CMS would not be able to attract and retain highly qualified physicians.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The average annual PCA Physician Pay (without PCA payment) will increase in FY 2019 resultant of 9 Medical Officers that are eligible for step increases during that timeframe. The average annual PCA amounts will increase in FY 2019 as 3 Medical Officers will have completed their 24 months as a government physician. Once they have more than 24 months, the maximum PCA limit is $30,000. Currently of the 37 Medical Officers, CMS has 14 at the maximum PCA amount of $30,000.

During FY 2018 and FY 2019, as of January 14, 2019, CMS has experienced a large decrease in our medical officer positions. In FY 2018, 8 physicians resigned, 2 retired and 3 were reassigned with CMS, with 1 of the 3 being reassigned to a Title 38 position. During FY 2018, only 1 medical officer was hired. During FY 2019, as of January 14, 2019, 1 physician retired and 2 have been reassigned to a Title 38 positions, with only 1 new physician planned to start in March 2019.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Centers for Medicare & Medicaid Services
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**SIGNIFICANT ITEMS**
Significant Items in Appropriation Committee Reports 211

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## SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2020 CONGRESSIONAL JUSTIFICATION

*ACA Notifications* - The Committee continues 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 enrollment figures from the Exchanges during the open enrollment period. The Department will continue to notify the Committees two business days in advance of any upcoming release of detailed enrollment figures.

*Health Insurance Exchange Transparency* - The Committee continues bill language 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 2020.

**Health Insurance Exchanges Transparency Table**

Dollars in Thousands

| Activity | FY 2010 Actual | FY 2011 Actual | FY 2012 Actual | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Actual | FY 2018 Actual | FY 2019 Enacted | FY 2020 President's Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Health Plan Bid Review, Management and Oversight** | $ - | $ 300 | $ 21,936 | $ 40,595 | $ 33,497 | $ 43,960 | $ 40,520 | $ 39,846 | $ 37,910 | $ 40,914 | $ 16,500 |
| **Payment and Financial Management** | $ - | $ 1,698 | $ 24,998 | $ 25,832 | $ 49,615 | $ 43,733 | $ 51,325 | $ 47,640 | $ 45,141 | $ 51,463 | $ 41,567 |
| **Eligibility and Enrollment 1/** | $ - | $ 2,218 | $ 3,433 | $ 275,501 | $ 339,754 | $ 363,768 | $ 445,249 | $ 484,144 | $ 392,660 | $ 369,682 | $ 310,053 |
| **Consumer Information and Outreach** | $ - | $ 2,427 | $ 32,610 | $ 701,075 | $ 704,136 | $ 753,238 | $ 805,833 | $ 640,232 | $ 591,948 | $ 572,319 | $ 306,550 |
| *Call Center (non-add)* | *$ -* | *$ -* | *$ 22,000* | *$ 505,446* | *$ 545,600* | *$ 566,178* | *$ 563,638* | *$ 540,197* | *$ 525,326* | *$ 496,525* | *$ 240,400* |
| *Navigators Grants & Enrollment Assisters (non-add)* | *$ -* | *$ -* | *$ -* | *$ 107,513* | *$ 97,152* | *$ 75,996* | *$ 99,677* | *$ 51,166* | *$ 12,720* | *$ 10,000* | *$ 10,000* |
| *Consumer Education and Outreach (non-add)* | *$ -* | *$ -* | *$ 7,043* | *$ 77,436* | *$ 49,334* | *$ 54,897* | *$ 101,048* | *$ 16,599* | *$ 10,744* | *$ 10,000* | *$ 10,000* |
| **Information Technology** | $ 2,346 | $ 92,672 | $ 166,455 | $ 402,553 | $ 770,957 | $ 798,648 | $ 664,083 | $ 710,867 | $ 767,413 | $ 603,084 | $ 520,819 |
| **Quality** | $ - | $ - | $ - | $ - | $ 17,189 | $ 15,634 | $ 11,736 | $ 7,301 | $ 7,240 | $ 7,338 | $ 5,000 |
| **SHOP and Employer Activities** | $ - | $ 366 | $ 18,479 | $ 25,076 | $ 30,541 | $ 42,717 | $ 34,520 | $ 16,500 | $ 4,418 | $ 2,500 | $ 2,000 |
| **Other Exchange** | $ 1,879 | $ 14,906 | $ 13,738 | $ 4,400 | $ 6,728 | $ 3,614 | $ 12,032 | $ 49,584 | $ 31,196 | $ 52,948 | $ 27,117 |
| **Federal Payroll and Other Administrative Activities** | $ 429 | $ 10,805 | $ 43,493 | $ 68,429 | $ 80,000 | $ 80,000 | $ 85,000 | $ 79,602 | $ 70,892 | $ 77,750 | $ 50,000 |
| **Total** | $ 4,654 | $ 125,392 | $ 325,142 | $ 1,543,461 | $ 2,032,418 | $ 2,145,312 | $ 2,150,297 | $ 2,075,714 | $ 1,948,818 | $ 1,777,999 | $ 1,279,605 |

1/ Funding for Enrollment Assisters ended in FY 2017.

NOTE: Fiscal years 2010 through 2018 include obligations as of September 30 of each year.

NOTE: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

NOTE: The FY 2019 Enacted level is an estimate as of February 2019.

*Access to Mental Health Care* - The Committee **strongly urges** CMS to pursue initiatives that expand access to quality care and increase parity for mental health services.

CMS takes robust actions across our programs to support access to mental health services. Each year, CMS issues a report to increase transparency with respect to enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). CMS has taken action to ensure compliance with MHPAEA since its enactment in 2008. The most recent report is available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf

CMS has also taken a number of actions in recent years to enhance access to mental health services for Medicare beneficiaries:

- Medicare covers annual depression screening for beneficiaries starting in late 2011. These screenings do not have a beneficiary copayment.
- As required by law, CMS expanded the use of telehealth services under Medicare for services furnished on or after July 1, 2019 by removing the originating site geographic restrictions for the purpose of treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder. It also adds the home of an individual as a permissible originating site for these telehealth services.
- As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for behavioral health integration (BHI) services they furnish to beneficiaries over a calendar month service period. Monthly BHI services are furnished using the Psychiatric Collaborative Care Model (CoCM), a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving. Medicare also pays for monthly BHI services furnished using other models. See MLN Fact Sheet for more details.
- CMS is actively exploring potential models focused on behavioral health, including focus areas such as opioids, substance use disorder, dementia, and improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or utilize episode payment. CMS recently announced the Integrated Care for Kids Model, which is a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and the Children's Health Insurance Program through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. The model will offer states and local providers support to address these priorities through a framework of child-centered care integration across behavioral, physical, and other child providers.

Additionally, Medicare Advantage (MA) Organizations offering an MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services, including mental health care services covered under original Medicare. MA plans may also choose to offer supplemental benefits, which are benefits not covered under original Medicare, and which may include mental health care services. For example, counseling services not covered by original Medicare may be offered as a supplemental benefit to plan enrollees.

*Agents Used for Cosmetic Purposes or Hair Growth* - Section 5008 of the 21st Century Cures Act (PL 114–255) eliminated Federal Medicaid matching funds for prescription drugs used for

cosmetic purposes or hair growth unless they are determined to be ''medically necessary''. The Committee appreciates the important role of the physician in deciding medical necessity for prescription drugs used for hair growth, particularly in regards to patients within State Medicaid programs. The Committee encourages CMS to provide further guidance to States on this issue, including whether medical conditions that cause hair loss, such as the autoimmune disease alopecia areata and thyroid disease, are medically necessary and allow Medicaid coverage for hair loss products for Medicaid patients suffering from these diseases. The Committee requests an update on this effort in the fiscal year 2020 Congressional Justification.

Action Taken or To Be Taken
CMS is committed to increasing state flexibility within the Medicaid program while reducing burdens for states in order to serve the health and wellness needs of our most vulnerable populations. While we believe states are in the best position to determine medical necessity criteria in their own state, we will continue to provide technical assistance to states in identifying existing coverage authorities to ensure that states can serve the health and wellness needs of their state.

*Burden Reduction and Improved Coordination of the Medicare Program* - The Committee is concerned about the lack of coordination between the Center for Medicare and the Center for Clinical Standards and Quality (CCSQ) within CMS. CCSQ is responsible for activities, functions, and duties that create administrative burden on providers who serve Medicare beneficiaries. In order to ensure there is sufficient coordination across components in CMS that impact Medicare, the Committee urges the Director of Medicare to oversee all activities, functions, and duties of the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services that relate to activities, functions, and duties of the Center for Medicare and the Medicare program under title XVIII of the Social Security Act, including but not limited to activities, functions, and duties relating to Medicare coverage, conditions of participation, and quality measures applied under the Medicare program. The Committee requests an update on these activities in the fiscal year 2020 Congressional Justification.

Action Taken or To Be Taken
At CMS, our top priority is putting patients first. CMS launched the "Patients over Paperwork" initiative, which is in accord with President Trump's Executive Order that directs federal agencies to "cut the red tape" to reduce burdensome regulations. Through "Patients over Paperwork," CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients. All CMS components, including the Center for Medicare and the Center for Clinical Standards and Quality, continue to coordinate closely on CMS programs and burden reduction activities. Through 2018, CMS eliminated 105 burdensome measures, saving the U.S. health care system $5.2 billion over the next 4 years.

*Cardiac Quality Measures* - The Committee requests CMS provide an update in the fiscal year 2020 Congressional Justification on the inclusion of quality measures to assign accountability of the prevention of conditions and complications that are commonly associated with cardiac procedures, such as perioperative hemorrhage.

Action Taken or To Be Taken
CMS continuously evaluates measures for its programs to ensure that the measures identify the highest priorities for quality measurement and improvement. Currently, there is a quality

measure called the Patient Safety Indicator 90 (PSI-90) measure, which is a patient safety and adverse events composite measure consisting of 10 separate components. One of the components is a measure of perioperative hemorrhage or hematoma (PSI-9). The PSI-90 composite measure is calculated based on hospital claims and is reported on Hospital Compare. It is also part of the Hospital Acquired Conditions Reduction Program and will be included in the Hospital Value-Based Purchasing Program beginning with FY 2023.

In addition, the following two measures related to Coronary Artery Bypass Graft (CABG) surgery are calculated by CMS and publicly displayed on Hospital Compare: the 30-day Hospital Readmission Rate following CABG surgery and the 30-day All-Cause Mortality Rate following CABG surgery. The CABG readmission measure is also in the Medicare Hospital Readmissions Reduction Program, and the CABG mortality measure will be included as a measure in the Hospital Value-Based Purchasing Program beginning in FY 2022.

*Congressional Justification* - The Committee directs CMS to include in the fiscal year 2020 Congressional Justification a table for current law estimates for all CMS administered programs listed in the table at the back of this report.

Action Taken or To Be Taken

FY 2020 CONGRESSIONAL JUSTIFICATION
ANNUALLY - APPROPRIATED ACCOUNTS
(Amounts in thousands)

| | | FY 2019 Enacted | FY 2020 Request |
|---|---|---|---|
| **Grants to States for Medicaid** | | | |
| Medicaid Current Law Benefits | M | $384,882,625 | $383,836,264 |
| State and Local Administration | M | $21,474,885 | $22,522,603 |
| Vaccines for Children | M | $4,726,461 | $4,761,408 |
| Subtotal, Medicaid Program Level | | $411,083,971 | $411,120,275 |
| Less funds advanced in prior year | M | ($134,847,759) | ($137,931,797) |
| Total, Grants to States for Medicaid | | $276,236,212 | $273,188,478 |
| New advance, 1st Quarter, FY 2021 | M | $137,931,797 | $139,903,075 |
| **Payments to Health Care Trust Funds** | | | |
| Supplemental Medical Insurance | M | $284,288,300 | $304,044,600 |
| Federal Uninsured Payment | M | $127,000 | $109,000 |
| Program Management | M | $898,000 | $913,000 |
| General Revenue for Part D Benefit | M | $92,070,000 | $104,539,500 |
| General Revenue for Part D Administration | M | $642,000 | $861,000 |
| HCFAC Reimbursement | M | $315,000 | $324,000 |
| State Low-Income Determination for Part D | M | $3,500 | $5,000 |
| Total, Payments to Trust Funds, Program Level | | $378,343,800 | $410,796,100 |
| **Program Management** | | | |
| Research, Demonstration, Evaluation | TF | $20,054 | $0 |
| Program Operations | TF | $2,519,823 | $2,389,702 |
| State Survey and Certification | TF | $397,334 | $442,192 |
| Federal Administration | TF | $732,533 | $747,533 |
| Total, Program Management | | $3,669,744 | $3,579,427 |
| **Health Care Fraud and Abuse Control Account** | | | |
| Centers for Medicare and Medicaid Services | TF | $599,389 | $614,000 |
| HHS Office of Inspector General | TF | $87,230 | $98,000 |
| Department of Justice | TF | $78,381 | $80,000 |
| Total, Health Care Fraud and Abuse Control | | $765,000 | $792,000 |
| Total, Centers for Medicare and Medicaid Services | | $796,946,553 | $828,259,080 |
| Federal Funds | | $792,511,809 | $823,887,653 |
| Current Year | | ($654,580,012) | ($683,984,578) |
| New advance, FY 2021 | | ($137,931,797) | ($139,903,075) |
| Trust Funds | | $4,434,744 | $4,371,427 |

*Direct and Indirect Remuneration* - The Committee is aware that CMS has put forth a Request for Information as part of the 2019 proposed Part D rule. The Committee understands any specific policy changes must occur through a future notice and comment rulemaking and urges the Secretary to consider the impact this proposal will have on seniors' premiums and the taxpayer, as well as its potential to reveal competitively sensitive information. The Committee requests an update on this topic in the fiscal year 2020 Congressional Justification.

Action Taken or To Be Taken

In the 2019 Part D proposed rule published on November 28, 2017, CMS included a Request for Information (RFI) regarding the application of manufacturer rebates and pharmacy price concessions to drug prices at the point of sale. In the 2019 Part D final rule published on April 14, 2018, CMS stated that the agency would carefully review all input received from stakeholders as it continues its efforts to meaningfully address rising prescription drug costs for beneficiaries.

On November 30, 2018, CMS published the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses Proposed Rule. In the proposed rule, CMS stated that the data Part D sponsors submit to CMS as part of the annual required reporting of direct or indirect remuneration (DIR) show that pharmacy price concessions, net of all pharmacy incentive payments, have grown faster than any other category of DIR received by sponsors and PBMs. Taking into consideration the responses to the 2019 RFI, CMS announced in the proposed rule that the agency is considering for a future year, which could be as soon as 2020, eliminating the exception for contingent pharmacy price concessions. Specifically, CMS is considering deleting the existing definition of "negotiated prices" at §423.100, which currently provides that the "negotiated prices" of drugs must include all pharmacy payment adjustments except those contingent amounts that cannot "reasonably be determined" at the point-of-sale. As a result of the current regulatory exception, negotiated prices typically do not reflect any performance-based pharmacy price concessions that lower the price a sponsor ultimately pays for a drug (because those price concessions arguably cannot "reasonably be determined" at the point-of-sale).

In the proposed rule, in addition to considering deleting the existing definition of "negotiated prices", CMS is also considering adopting a new definition for the term "negotiated price" at §423.100. The new definition of "negotiated price" would define the lowest amount a pharmacy could receive as reimbursement for a covered Part D drug under its contract with the Part D plan sponsor or the sponsor's intermediary (that is, the amount the pharmacy would receive net of the maximum negative adjustment that could result from any contingent pharmacy payment arrangement and before any additional contingent payment amounts, such as incentive fees).

By requiring sponsors to assume the lowest possible pharmacy performance when reporting the negotiated price, under the proposed rule, CMS would be prescribing a standardized way for Part D sponsors to treat the unknown (final pharmacy performance) at the point of sale under a performance-based payment arrangement, which many Part D sponsors and PBMs have identified as the most substantial operational barrier to including such concessions at the point of sale.

*Hospital Discharges with Pressure Ulcers* - The Committee understands data released in October 2017 by the CMS Office of Enterprise Data and Analytics identified that hospital discharges of patients with pressure ulcers have increased by over 58 percent between the first quarter of 2016 and 2017. In addition, HHS research shows that hospital-acquired pressure ulcers and their associated complications have led to roughly 60,000 patient deaths per year. These statistics are deeply concerning. The Hospital-Acquired Condition (HAC) Reduction

Program requires CMS to reduce payments for hospitals that rank among the lowest-performing 25 percent of hospitals with regard to HACs, but it also allows the Administration to adjust the Domain 1 and Domain 2 formulas used for that calculation. Given this adjustment ability, the Committee requests CMS provide information in the fiscal year 2020 Congressional Justification on steps CMS is taking to review the formulas and any other actions they are taking to reverse the trend of increased hospital-acquired pressure ulcers. (H.R 115-862; PG 94)

Action Taken or To Be Taken

We agree that pressure ulcers are a critical area to address. We now have pressure ulcer quality measures for all of the post-acute care providers (long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies). In the acute care hospital setting, there is not such an individual pressure ulcer measure; however, the Patient Safety 90 measure (PSI-90) is a patient safety and adverse events composite measure. It consists of 10 separate components, and one of the components (PSI-3) is pressure ulcer rates.

In FY 2019, in the Hospital Acquired Condition (HAC) Reduction Program, this composite measure is the only measure in Domain 1 and will comprise 15 percent of a hospital's score, while five healthcare-associated infection measures comprise Domain 2 with a weight of 85 percent. However, in the FY 2019 Medicare Inpatient Prospective Payment System final rule (https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf) (83 FR 41485-41489), CMS finalized a new scoring methodology for the HAC Reduction Program. Beginning in FY 2020, we will remove the domains from the program, and instead, an equal weight will be assigned to each measure for which a hospital has a measure score. This methodology will address concerns about the disproportionately large weight applied to Domain 2 measures for certain hospitals with less than five measure scores in this domain.

Patient safety is a priority measurement area at CMS, and as we move forward with the HAC Reduction Program, we will continue to consider other potential measures that could be added to the program in order to help address the important concerns relating to pressure ulcers.

*Hospital Based Nursing* - The Committee encourages CMS to address the ability of hospital-based nursing programs to maintain their pass-through payments in light of conflicting eligibility requirements established by national and regional higher education accrediting bodies. The CMS pass-through payments are essential for hospital-based nursing programs to continue to produce well educated nurses and address areas of national need and underserved populations. The Committee requests that CMS provide an update in the fiscal year 2020 Congressional Justification on efforts to remedy this policy discrepancy.

Action Taken or To Be Taken

The Inpatient Prospective Payment System (IPPS) for acute hospital inpatient care is a per-discharge payment system. The per-discharge payment is based on two national base payment rates: one that provides for operating expenses and another for capital expenses. These base payment rates are adjust to account for the costs associated with the patient's clinical condition and related treatment relative to the costs of the average Medicare case, as well as for market conditions in the hospital's location relative to national conditions.

In addition to the adjusted base payment rates, inpatient hospitals may qualify for additional payments and adjustments, including direct graduate medical education and indirect graduate medical education payments for teaching hospitals or hospitals that train residents in approved medical residency training programs. Separate from the IPPS, Medicare makes pass-through payments to hospitals for the costs of nursing and allied health education activities. The

regulations at 42 CFR 413.85 set forth the rules for determining these payments. The accreditation standards for the approved educational activities for which Medicare payments will be made are at 42 CFR 413.85(e), which states that CMS will consider an activity an approved nursing and allied health education program if the program is a planned program of study that is licensed by State law, or if licensing is not required, is accredited by the recognized national professional organization for the particular activity. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs, the National League of Nursing Accrediting Commission, the Association for Clinical Pastoral Education Inc., and the American Dietetic Association.

*Impact of Tobacco Cessation on Medicaid* - The Committee notes that Medicaid coverage of tobacco cessation nonprescription drugs may assist individuals in efforts to limit tobacco usage, which could result in savings to the Medicaid program. The Committee requests an update in the fiscal year 2020 Congressional Justification on the possible impact of such a coverage change, including any associated savings.

Action Taken or To Be Taken

Section 4107 of the Patient Protection and Affordable Care Act requires coverage of counseling and pharmacotherapy for cessation of tobacco use by pregnant women. Section 1905(bb)(2) of the Social Security Act defines the new tobacco cessation coverage for pregnant women as services recommended in the "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 (PHS Guideline), or any subsequent modification of this Guideline, and such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women. The PHS Guideline is intended to inform clinicians' decisions regarding tobacco cessation treatment as well as to provide insurers, purchasers, and health care administrators with strategies to support effective tobacco dependence treatment. The PHS Guideline identifies effective approaches and treatments for the population as a whole, and contains specific recommendations for some subpopulations, such as pregnant women.

Medicaid regulations at 42 CFR 440.230(b) offer States flexibility in designing their benefits, as long as each covered benefit is "sufficient in amount, duration, and scope to reasonably achieve its purpose." The PHS Guideline's emphasis on the effectiveness of counseling and the need to accommodate multiple attempts to quit should inform States' decisions as they design their smoking cessation benefit. The guidelines suggest that benefit packages ought to include coverage of at least four face-to-face counseling sessions per quit attempt, with a minimum of two quit attempts per year.

In addition to this new benefit requirement for pregnant women described above, States are required to cover tobacco cessation services for children when medically necessary and may rely on optional Medicaid benefit categories to provide coverage of tobacco cessation services to other Medicaid beneficiaries.

- Coverage of medically-necessary tobacco cessation services, including both counseling and pharmacotherapy, for children and adolescents, is mandatory under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when medically necessary for individuals under age 21.

- States may cover counseling for all other Medicaid beneficiaries through the benefits categories discussed in more detail below. While tobacco cessation drugs for non-pregnant individuals are currently covered outpatient drugs under section 1927(d) of the Act and may be excluded or restricted, States could elect such coverage. Moreover, section 2502 of the Affordable Care Act amended section 1927(d) of the Act so that, effective January 1, 2014, tobacco cessation drugs will no longer be excludable.

States may cover counseling for all other Medicaid beneficiaries through the benefits categories discussed in more detail below. Medicare and Federal Employees Health Benefits Plan benefit packages include both tobacco cessation counseling, as described above, and pharmacotherapy for non-pregnant individuals. These programs can be possible models for States. Below are various ways States are able to deliver and receive Federal Financial Participation for tobacco cessation services for individuals who are not pregnant, including counseling and drug therapy.

- Pharmacotherapy: States may currently choose to cover prescription and/or nonprescription tobacco cessation drugs for Medicaid beneficiaries who are not pregnant. According to the PHS Guideline, clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (pregnant women, adolescents, light smokers, and smokeless tobacco users).

- Counseling: Tobacco cessation counseling services may be covered under a variety of Medicaid benefit categories such as physician services (42 CFR 440.50(a)), other licensed practitioner services (42 CFR 440.60(a)) such as pharmacists, dietitians, mental health counselors, preventive services (42 CFR 440.130(c)) or rehabilitative services (42 CFR 440.130(d)), depending on how States structure their Medicaid programs.

*Lymphedema Compression Garments* - Nearly two million Medicare beneficiaries lack equal access to Lymphedema Compression Garments. The Department of Veterans Affairs and the TRICARE program provide coverage for compression garments used to treat lymphedema, as do 42 states and the District of Columbia as part of their Medicaid programs, yet the Medicare program does not provide access to these garments for Medicare beneficiaries. The Committee notes CMS decision memorandum (CAG–00016N) encourages patients to use compression garments to prevent re-accumulation of fluid. In order to ensure equal access to care and adherence to CMS' recommendations, the Committee strongly encourages CMS to take necessary steps to ensure Medicare beneficiaries have access to Lymphedema Compression Garments. The Committee requests an update on this effort in the fiscal year 2020 Congressional Justification.

Action Taken or To Be Taken

We understand the important role that compression garments and supplies play in the treatment of lymphedema. In order for items such as compression garments to be covered by Medicare, they would have to meet the definition of a Medicare-covered benefit category. CMS has carefully considered Part B coverage of compression garments and found that these items do not qualify.

Currently, MA plans may choose to offer compression garments as a supplemental benefit, including through the Over the Counter (OTC) benefit. Plans may elect to offer supplemental benefits in addition to the basic Medicare Part A and B benefits they are required to cover. We

understand that some MA plans are offering compression garments as OTC supplemental benefits in 2019.

Beginning in 2020, MA plans will have a new opportunity to provide targeted supplemental benefits, including compression garments, to subsets of certain MA plan enrollees. Beginning in January 2017, the Center for Medicare and Medicaid Innovation's Medicare Advantage Value-Based Insurance Design (VBID) model began testing the impact of providing MA plans the flexibility to offer reduced cost sharing or additional supplemental benefits to enrollees with select chronic conditions, focusing on the services that are of highest clinical value to them. Under a recently-announced change to the VBID model for 2020 and subsequent years, MA organizations participating in the model may offer supplemental benefits including compression garments to a subset of enrollees based on chronic condition alone, socioeconomic status alone (as determined by qualifying for the low-income subsidy and/or having dual-eligible status), or both chronic condition and socioeconomic status.

We will continue to explore how MA plans can further innovate on payment and care delivery redesign to increase access to medical items and supplies for Medicare beneficiaries that can reduce costs and improve quality of care.

*Medication Diversion* - The Committee understands the important role of medication-assisted treatment for beneficiaries with opioid use disorder. At the same time, several State and Federal authorities report rising rates of diversion of these FDA-approved medications. The Committee requests CMS evaluate diversion data from the Drug Enforcement Administration and State sources to determine the scope of this problem and submit an update in the fiscal year 2020 Congressional Justification. CMS should discuss specifically efforts to reduce division of prescriptions.

Action Taken or To Be Taken

In general, medication diversion is a law enforcement issue and not an activity CMS has primary responsibility for or authority to address. However, CMS has taken a number of actions within it authorities to combat the opioid crisis. For example, on April 2, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that implemented the requirements of the Comprehensive Addiction and Recovery Act of 2016 (CARA) to provide an important additional tool to combat the growing opioid epidemic that is devastating families and communities across the nation. CARA requires CMS to establish through regulation a framework that allows Part D sponsors to voluntarily implement a drug management program that limits "at risk" beneficiaries' access to controlled substances that CMS determines are "frequently abused drugs" beginning with the 2019 plan year. Under the final rule, the clinical guidelines used to determine if a beneficiary is potentially at-risk are based on using opioids from multiple prescribers and/or multiple pharmacies. Sponsors will be allowed to limit an at-risk beneficiary's access to frequently abused drugs (opioids and benzodiazepines) to a selected prescriber(s) and/or pharmacy(ies) ("lock-in") and through the use of beneficiary-specific point-of-sale claim edits. Part D sponsors may not implement such limitations unless they have engaged in case management with the prescribers of these drugs, and beneficiaries may submit prescriber and pharmacy preferences. CMS will also exempt beneficiaries who are being treated for active cancer-related pain, are receiving palliative or end-of-life care, or are in hospice or long term care from drug management programs.

*Naloxone* - Naloxone is a community-use overdose reversal agent that can be ingested through the nose. Some have recommended co-prescription of naloxone and opioids as a tool in mitigating the risk of overdose death. Studies within the Department of Veterans Affairs have

determined co-prescriptions can reduce long-term opioid use by 39 percent. The Committee requests an update in the fiscal year 2020 Congressional Justification on efforts by CMS to address access to naloxone for identified at-risk populations.

Action Taken or To Be Taken
CMS is promoting improved access to the opioid overdose reversal drug naloxone by requiring that it appear on all Medicare Part D formularies. CMS recognizes that it is very important for Medicare beneficiaries and those who care for them to understand that these options are available to them under Medicare, so CMS is also working to educate clinicians, health plans, pharmacy benefit managers, and other providers and suppliers on services covered by Medicare to treat beneficiaries with opioid use disorders (OUD).

In addition, Medicaid programs in 45 states include at least one buprenorphine/naloxone combination product available on their Preferred Drug Lists. CMS has also issued guidance[1] to states on improving access to naloxone. States can offer training in overdose prevention and response for providers and members of the community, including family members and friends of opioid users.

Regarding health insurance plans under the Marketplace, plans that are required to provide essential health benefits are required to cover Naloxone as a prescription drug benefit. Naloxone is the only drug that HHS has ever publicly clarified must be covered by all plans required to provide essential health benefits.

*National Health Expenditures* - The Committee requests that CMS include a detailed explanation in its fiscal year 2020 Congressional Justification of CMS' methodology for including data in the National Health Expenditure (NHE) database, and an analysis of how CMS-published data compares to other comparable information on health expenditures. The Committee remains concerned there are discrepancies between CMS estimates and industry surveys suggesting that CMS' method may understate the actual growth of private health insurance and total health spending at the household level. If private health spending is underreported in NHE, estimates of total health US spending may be too low as well.

Action Taken or To Be Taken
The National Health Expenditures (NHE) include both historical and projected NHE estimates.

NHE Historical:
The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, sources of funding, and type of sponsor.
The NHEA are generally compatible with a production-based accounting structure such as the National Income and Product Accounts, but include a more complete picture of the health care sector. Using an expenditures approach to national economic accounting, the NHEA identifies all final consumption of health care goods and services as well as investment in a given year that is purchased or provided by direct or third party payments and programs. Three primary characteristics of the NHEA flow from this framework. First, the NHEA are comprehensive because they contain all of the main components of the health care system within a unified

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf

mutually exclusive and exhaustive structure. Second, the NHEA are multidimensional, encompassing not only expenditures for medical goods and services, but also the payers that finance these expenditures. Third, the NHEA are consistent because they apply a common set of definitions that allow comparisons among categories and over time.

The information contained in the NHEA can be used to study numerous topics related to the health care sector including, but not limited to, changes in the amount and cost of health services purchased and the payers or programs that provide or purchase these services, the economic causal factors at work in the health sector, the impact of policy changes, and comparisons at the international level.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-16.pdf.

NHE Projections:
The Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) produces short-term (10-year) projections of health care spending for categories in the National Health Expenditure Accounts (NHEA) on an annual basis. The NHE projections consist of time series for all of the major spending categories in the NHEA. These categories include trends in aggregate medical spending, medical services consumed, sources of payment, and sources of financing.

For the current spending projections, CMS primarily utilizes the standard NHE Econometric Model, with adjustments to model projections for specific effects as needed. The NHE Econometric Model is based on a multi-equation structural econometric model that reflects relationships in historical time-series data and encompasses the health system as a whole. The primary focus of the NHE Econometric Model is to produce projections of future health care spending by private health insurers, by consumers on an out-of-pocket basis, and by other private payers that are consistent with exogenous projections for Medicare, Medicaid, CHIP, and key macroeconomic variables. Key exogenous inputs to the model include the most recent available macroeconomic and demographic assumptions from the Social Security Administration (SSA), as well as actuarial projections for Medicare, Medicaid, and CHIP spending and enrollment. CMS also projects residual spending for other government programs (excluding the programs mentioned above) to provide a comprehensive projection of all spending within the NHEA.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf.

*Qualified Clinical Data Registries* - The Committee supports the development and utilization of Qualified Clinical Data Registries as part of the Center for Medicare and Medication Innovation's purpose of testing innovative payment and service delivery models. The Committee requests an update in the fiscal year 2020 Congressional Justification regarding compliance with section 105(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (PL 114– 10) and how CMS will support data that is real-time.

Action Taken or To Be Taken
CMS is committed to opening up access to CMS data to increase transparency, improve healthcare quality, and reduce costs. CMS has issued a toolkit, available at:

https://www.qemedicaredata.org/QECP_Docs/2017%2001%2010%20QCDR%20-%20quasi-QE%20Toolkit_CMS_FINAL.pdf) to provide more information for Qualified Clinical Data Registries that are interested in accessing CMS data under the Qualified Entity Program. The Innovation Center works closely with participants in Innovation Center models to appropriately share information.

The Innovation Center leverages claims data, patient surveys, and other data to deliver actionable feedback to health care providers about their performance, while encouraging participants to use their own performance data to drive continuous improvement in outcomes. Every Innovation Center 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 public programs and the health care system at large.

*Quality Payment Program* - The Committee understands numerous physicians were ineligible to receive reimbursement from the Quality Payment Program (QPP) due to changes to their tax identification number (TIN) made between August 31st and December 31st, 2017. Claims changes to the TIN that took place in this time frame were ineligible and could not be retroactively reimbursed due to technological shortcomings. The Committee encourages CMS to review the QPP's procedures and report back to the Committee in the fiscal year 2020 Congressional Justification on proposals for necessary improvements to ensure qualified physicians are not denied reimbursement regardless of their employment start date.

Action Taken or To Be Taken

For clinicians who join a new practice with a new TIN at the end of the year (between September 1 and December 31), the applicability of the QPP's Merit-Based Incentive Payment System (MIPS) during that time period and of a payment adjustment under MIPS will depend on whether a clinician is participating in MIPS as an individual clinician or as part of that new group. For example, in 2018, if a clinician is participating as an individual (and not as part of the group), the clinician does not need to submit any data during that time period on or after 9/1/2018 through 12/31/2018 and will receive a neutral payment adjustment (neither a positive or a negative payment adjustment) under MIPS. If, however, the group associated with the TIN is participating at the group level (submitting aggregated data on behalf of all MIPS eligible clinicians in the group), then the data of a clinician who started billing under the TIN on or after 9/1/2018 through 12/31/2018 will be included as part of the group's data submission under MIPS. The group, inclusive of the new clinician, will receive a final score and payment adjustment based on the group's submission.

It is important to note, though, that a clinician who joins a new practice at the end of 2018 may have been associated with a different practice earlier in the year and may receive a MIPS payment adjustment in 2020 based on their participation and MIPS eligibility in that other practice. To determine whether it is necessary to submit data under MIPS, CMS encourages clinicians to check their 2018 MIPS eligibility status for each practice they participated in during 2018 on the QPP website (qpp.cms.gov) using the QPP Participation Status Look-up Tool (qpp.cms.gov/participation-lookup).

*Use of Social Security Numbers on Medicare Beneficiaries' Cards* - The Committee is pleased with CMS efforts to replace Social Security Numbers on Medicare Beneficiary's cards and directs CMS to provide an update on the progress of this initiative in their fiscal year 2020 CJ.

Action Taken or To Be Taken
The Centers for Medicare & Medicaid Services (CMS) recently completed a large-scale effort to provide new Medicare cards without Social Security numbers to people with Medicare. Over the past nine months, CMS sent new cards to more than 61 million people with Medicare across all U.S. states and territories. The mailing was completed three months before the April 2019 deadline set by Congress under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Throughout the process of implementing the new cards, we actively engaged with beneficiaries, partners, providers, and caregivers on a local and national level to make sure stakeholders are a part of the process and informed about the transition to new cards. We are processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

*Rural Nursing Homes* - Long-term services and supports are critical for the care and wellbeing of our senior population. Skilled nursing facilities play an instrumental role in providing this care for some of the most vulnerable Americans. Particularly in rural areas, ensuring continued access to high-quality nursing facility care in an individual's home community is an ever-increasing challenge. Similar to Medicaid's prioritization of funding for Critical Access Hospitals, adequate reimbursement helps preserve access to skilled nursing facility care in our country's rural and frontier regions. The Committee **requests an update in the fiscal year 2020 Congressional Justification on CMS' efforts to support rural nursing facilities.**

Action Taken or To Be Taken
Access to nursing facility care is important for Medicare and Medicaid beneficiaries. In 2018, CMS issued a Rural Health Strategy intended to provide a proactive approach on healthcare issues to ensure that the nearly one in five individuals who live in rural America have access to high quality, affordable healthcare. The agency-wide Rural Health Strategy, built on input from rural providers and beneficiaries, focuses on five objectives to achieve the agency's vision for rural health:

- Apply a rural lens to CMS programs and policies
- Improve access to care through provider engagement and support
- Advance telehealth and telemedicine
- Empower patients in rural communities to make decisions about their healthcare
- Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

This new strategy focuses on ways in which the agency can better serve individuals in rural areas and avoid unintended consequences of policy and program implementation. Work on the strategy is already underway. For example, to strengthen access to care, especially for those living in rural communities, CMS is transforming access to telehealth by paying for additional services and making it easier for providers to bill Medicare. We look forward to continuing to hear from stakeholders how we can improve access to care in rural areas.

*Sepsis Testing* - In the United States, more than 1.5 million people are diagnosed with sepsis resulting in approximately 250,000 deaths each year. CMS current SEP–1 guidelines for

treating septic patients are controversial and need to take into account evolving practices including the use of FDA approved tests for biomarkers like procalcitonin. SEP–1 is highly prescriptive, replaces physician's discretion over care, and could lead to excessive antibiotic use. The Committee urges CMS to reevaluate their SEP–1 policy taking into account expanded FDA approvals for biomarker tests like procalcitonin in conjunction with its impact on antibiotic stewardship. CMS is also to identify the direct and indirect cost of treating sepsis patients on its Medicaid and Medicare programs. The Committee **requests an update on these activities in the fiscal year 2020 Congressional Justification.**

Action Taken or To Be Taken
CMS works closely with the sepsis (SEP-1) quality measure stewards on measure updates. Since the measure was first used in 2015, the stewards have made many updates to the measure to improve abstraction, reduce burden, and address concerns that have been raised by clinicians and abstractors. Measure updates have taken into account evolving clinical practice (for example, updates to fluid infusion requirements for obese patients) and current measure specifications align with Surviving Sepsis Campaign guidelines. (The Surviving Sepsis Campaign is a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine committed to reducing mortality and morbidity from sepsis and septic shock worldwide.)

The measure stewards are aware of FDA-approved biomarker tests but have not incorporated their specific use into the measure specifications. The Surviving Sepsis Campaign guidelines support the use of biomarkers, such as procalcitonin, as supplementary information that the clinician can use to ascertain presence of infection as well as for discontinuing antibiotic therapy, which supports antibiotic stewardship. The measure stewards will continue to consider the use of biomarkers as part of measure specification updates in the future as clinical evidence evolves.

*Direct and Indirect Remuneration Fees* - The Committee is concerned about the dramatic increase of pharmacy direct and indirect remuneration [DIR] fees in Medicare Part D, especially the impact of ''pharmacy DIR fees'' on Medicare Part D beneficiaries who incur high drug costs. The Committee is aware that CMS has put forth a Request for Information included in the 2019 proposed Part D rule about this issue and others and encourages the agency to finalize their proposal without delay. The Committee looks forward to the **report requested in fiscal year 2018** on how to best address this issue, including consideration of options to require that all DIR fees be accounted for a point of sale; as part of negotiated price; and that any incentive fees be paid separately.

Action Taken or To Be Taken
In the 2019 Part D proposed rule published on November 28, 2017, CMS included a Request for Information (RFI) regarding the application of manufacturer rebates and pharmacy price concessions to drug prices at the point of sale. In the 2019 Part D final rule published on April 14, 2018, CMS stated that the agency would carefully review all input received from stakeholders as it continues its efforts to meaningfully address rising prescription drug costs for beneficiaries.

On November 30, 2018, CMS published the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses Proposed Rule. In the proposed rule, CMS stated that the data Part D sponsors submit to CMS as part of the annual required reporting of direct or indirect remuneration (DIR) show that pharmacy price concessions, net of all pharmacy incentive payments, have grown faster than any other category of DIR received by

sponsors and PBMs. Taking into consideration the responses to the RFI, CMS announced in the proposed rule that the agency is considering for a future year, which could be as soon as 2020, eliminating the exception for contingent pharmacy price concessions. Specifically, CMS is considering deleting the existing definition of "negotiated prices" at § 423.100, which currently provides that the "negotiated prices" of drugs must include all pharmacy payment adjustments except those contingent amounts that cannot "reasonably be determined" at the point-of-sale. As a result of the current regulatory exception, negotiated prices typically do not reflect any performance-based pharmacy price concessions that lower the price a sponsor ultimately pays for a drug (because those price concessions arguably cannot "reasonably be determined" at the point-of-sale).

In the proposed rule, in addition to considering deleting the existing definition of "negotiated prices", CMS is also considering adopting a new definition for the term "negotiated price" at § 423.100. The new definition of "negotiated price" would be "the lowest amount a pharmacy could receive as reimbursement for a covered Part D drug under its contract with the Part D plan sponsor or the sponsor's intermediary" (that is, the amount the pharmacy would receive net of the maximum negative adjustment that could result from any contingent pharmacy payment arrangement and before any additional contingent payment amounts, such as incentive fees).

By requiring sponsors to assume the lowest possible pharmacy performance when reporting the negotiated price, under the proposed rule, CMS would be prescribing a standardized way for Part D sponsors to treat the unknown (final pharmacy performance) at the point of sale under a performance-based payment arrangement, which many Part D sponsors and PBMs have identified as the most substantial operational barrier to including such concessions at the point of sale. Because CMS has taken robust action to discuss and address the issue of DIR through rulemaking, CMS believes drafting an additional report to Congress on this issue is unnecessary at this time.

*Hospital-Acquired Pressure Ulcers* - The Committee is aware of recent data from CMS identifying that pressure ulcer discharges have significantly increased between the first quarter of 2016 and the first quarter of 2017. The Committee requests the Secretary and CMS Administrator **provide an update and timeline in the fiscal year 2020 CJ** on steps HHS and CMS are taking to reverse this trend.

Action Taken or To Be Taken

We agree that pressure ulcers are a critical area to address. We now have pressure ulcer quality measures for all of the post-acute care providers (long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities and home health agencies). In the acute care hospital setting, there is not such an individual pressure ulcer measure; however, the Patient Safety 90 measure (PSI-90) is a patient safety and adverse events composite measure. It consists of 10 separate components, and one of the components (PSI-3) is pressure ulcer rates. The PSI-90 composite measure is calculated based on hospital claims and is reported on Hospital Compare. It is also part of the Hospital Acquired Conditions Reduction Program and will be included in the Hospital Value-Based Purchasing Program beginning with FY 2023.

The data being referenced above are found in a formative evaluation report done by the Hospital Improvement Innovation Networks (HIINs), which uses the Agency for Healthcare Research and Quality (AHRQ) metric, Patient Safety Indicator 3 (PSI-3). This data is based on Medicare claims data and is captured quarterly. Note that there are two recent changes in measurement that are contributing to the PSI-3 measure results – changes in definitions for the PSI-3 measure itself and the ICD-10 conversion. Documentation, coding, and measurement

factors are felt to be one of the strongest drivers of this apparent increase in pressure injury rates. Recent data from AHRQ, which are based on chart abstracted data and therefore less sensitive to coding issues, show that pressure injuries are likely increasing in short stay acute care hospitals, but not nearly as fast as the PSI-3 data seem to indicate.

*Hospital Surveys* - The Committee commends CMS for ensuring standards for safety and quality are maintained for the health of Medicare beneficiaries. The Committee is concerned with revisions to the State Operation Manual described in S&C Memo: 17–44–All Hospitals. In this Memorandum, CMS mandates a new standard for a hospital survey, and retroactively applies this standard to facilities for the prior 12 months. The Committee believes such a change is rulemaking and subject to a notice and comment period. The Committee notes CMS had to issue two additional memorandums to clarify the new policy. Such revisions serve as evidence that the change in policy warrants time for stakeholders to prepare. The Committee has concerns that hospitals did not receive notice and requests that CMS provide justification for why notice was not provided for hospitals through notice and comment rulemaking.

Action Taken or To Be Taken
In order to be a Medicare certified hospital, the Medicare statute at Section 1861 requires that these hospitals should be "primarily engaged" in providing inpatient services. In September 2017, CMS released guidance to clarify the statutory definition of a hospital, which states that a hospital must be primarily engaged in providing inpatient services to inpatients. Surveyors are required to check that these requirements are being met at each recertification survey. This did not go out for notice and comment rulemaking, because there is no change in Medicare policy—hospitals have always been required to provide inpatient services to patients.

*Initial Preventive Physical Examination/Annual Wellness Visit* - The Committee recognizes the importance of vaccines in preventing diseases, particularly among the Medicare population. The Initial Preventive Physical Examination [IPPE] under Medicare and Annual Wellness Visits [AWV] provide an important opportunity for improving immunization rates among Medicare beneficiaries. The National Vaccine Advisory Committee [NVAC] Standards for Adult Immunization Practice call on all healthcare professionals who provide care to adults to take steps to assess the immunization status of all patients in every clinical encounter, share a strong recommendation for vaccines that patients need, administer vaccines, or refer to a provider who can immunize and document administered vaccines. The goal of the standards is to reduce the number 142 of missed immunization opportunities by integrating these simple steps into clinical care. In following with the recommendations of NVAC, the **Committee directs CMS** to incorporate the Standards for Adult Immunization Practice in provider outreach and educational materials pertaining to the IPPE and AWV.

Action Taken or To Be Taken
Medicare covers a full range of preventive services, including immunizations as appropriate, to help keep beneficiaries healthy and help find problems early, when treatment is most effective. The Medicare website includes helpful information for physicians and beneficiaries regarding coverage of immunizations, including a preventive services checklist (available at: https://www.medicare.gov/Pubs/pdf/11420-Preventive-Services-Card.pdf). Beneficiaries should ask their doctor which of these preventive services, including immunizations, is right for them.

*Muscular Dystrophy* - The Committee is aware of the addition of the new ICD–10 code for Duchenne/Becker to the fiscal year 2019 CMS Addenda. The Committee requests a **report be submitted to the Committees on Appropriations 180 days after enactment of the Act** on

utilization for the newly established ICD–10 code, as compared to the former broader ICD–10 code.

Action Taken or To Be Taken
As this new code was added for the current fiscal year, utilization data is not available at this time.

*Risk Corridor Program* - The Committee continues bill language to prevent the CMS Program Management appropriation account from being used to support risk corridor payments. The agreement directs CMS to provide a report starting with plan year 2014 and continuing through the duration of the program to the Committees on Appropriations of the House of Representatives and the Senate detailing the receipts and transfer of payments for the Risk Corridor Program.

Action Taken or To Be Taken
The risk corridors program concluded in the 2016 Benefit Year. The requested information is available on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/

*Sepsis* - The Committee is concerned that the current SEP–1 guidelines for treating septic patients do not take into account evolving practices. The Committee encourages CMS to ask the SEP–1 measure stewards to reevaluate their SEP–1 quality measure taking into account expanded FDA approvals for biomarker tests like procalcitonin in conjunction with its impact on antibiotic stewardship. CMS is also encouraged to identify the Medicare and Medicaid expenditures for individuals with sepsis. The Committee **requests an update on these activities in the fiscal year 2020 CJ**.

Action Taken or To Be Taken
CMS works closely with the sepsis (SEP-1) quality measure stewards on measure updates. Since the measure was first used in 2015, the stewards have made many updates to the measure to improve abstraction, reduce burden, and address concerns that have been raised by clinicians and abstractors. Measure updates have taken into account evolving clinical practice (for example, updates to fluid infusion requirements for obese patients) and current measure specifications align with Surviving Sepsis Campaign guidelines. (The Surviving Sepsis Campaign is a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine committed to reducing mortality and morbidity from sepsis and septic shock worldwide.)

The measure stewards are aware of FDA-approved biomarker tests but have not incorporated their specific use into the measure specifications. The Surviving Sepsis Campaign guidelines support the use of biomarkers, such as procalcitonin, as supplementary information that the clinician can use to ascertain presence of infection as well as for discontinuing antibiotic therapy, which supports antibiotic stewardship. The measure stewards will continue to consider the use of biomarkers as part of measure specification updates in the future as clinical evidence evolves.

*Therapeutic Foster Care* - The Committee remains concerned about the lack of a uniform definition within the Medicaid program for therapeutic foster care services. A uniform definition would improve the ability for more consistent care and treatment. The Committee requests an update in the fiscal year 2020 CJ on the study requested in fiscal year House Report 114–699.

Action Taken or To Be Taken
CMS is committed to increasing state flexibility within the Medicaid program while reducing burdens for states in order to serve the health and wellness needs of our most vulnerable populations. We are currently examining the impact of a uniform definition of therapeutic foster care services under these objectives, while remaining cognizant of the fact that states may be best-positioned to define these services.

*Vaccine Utilization* - The Committee is concerned about the underutilization of vaccinations, particularly pneumococcal vaccines and encourages CMS to support development and implementation of electronic health records and other technologies, such as reminder recall programs, to identify Medicare beneficiaries who have not received the full course of pneumococcal vaccinations and remind those beneficiaries and their providers to adhere to the recommendations. The Committee encourages CMS to work with National Vaccine Advisory Committee to determine the vaccine adherence rate in the Medicaid and CHIP populations compared to the national average pediatric vaccine adherence rate. The Committee **asks for this to be included in the Department's CJ for fiscal year 2020**.

Action Taken or To Be Taken
CMS appreciates the Committees' interest in this important issue and will continue to look for opportunities to work with our HHS partners such as NVAC and CDC on the issue of vaccine utilization.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Centers for Medicare & Medicaid Services
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# Program Management Proposed Law Summary

CMS' FY 2020 Budget includes six proposals. Each of the proposals will require legislative changes and are described in more detail below:

- **Rebase National Medicare Education Program User Fee**

  The Budget includes a proposal that allows CMS to assess an increased amount of user fees from Medicare Advantage and Part D plans to more equitably support outreach and enrollment assistance activities provided by the National Medicare Education Program.

- **Change Medicare Beneficiary Education Requirements**

  The Budget includes a proposal that provides the Secretary with increased flexibility to determine how to most efficiently and effectively communicate Medicare benefits information included in the Medicare & You Handbook with beneficiaries, including providing information through electronic means as opposed to paper copies in some cases.

- **Tailor the Frequency of Skilled Nursing Facility Surveys to More Efficiently Use Resources and Alleviate Burden for Top Performing Nursing Homes**

  The Budget includes a proposal that gives the Secretary authority to adjust statutorily required survey frequencies for top-performing skilled nursing facilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities.

- **Survey and Certification Re-Visit and Complaint Investigation Fee**

  CMS proposes a discretionary fee for revisits that occur as a result of deficiencies found during initial certification, recertification, or substantiated complaints surveys. In addition, this proposal would allow CMS to charge facilities a fee for substantiated complaint surveys resulting in findings cited at the level of immediate jeopardy or actual harm. The collections would supplement the Program Management funding for the Survey and Certification program. The Budget assumes collections will begin in FY 2021.

- **Two Year Budget Authority for Survey and Certification**

  The Budget includes two-year budget authority for the Survey and Certification Program. This proposal will enable states to more effectively plan, staff, and fund their survey agency to accomplish federally mandated survey workloads.

- **Availability of CMS Exchange User Fee**

  The Budget proposes to allow user fees collected for Federal Exchange operations to be used on all federal administrative Exchange-related activities. This includes activities that CMS conducts on behalf of all Exchanges that are currently not eligible to be paid for by user fees, such as eligibility verification, issuer payment activities, Exchange quality, and associated IT.

# Program Management Appropriation Summary
**Proposed Law**
**(Dollars in Thousands)**

| Activity | FY 2018 Final | FY 2019 Enacted | FY 2020 Budget Request |
|---|---|---|---|
| **Program Operations** | $2,814,959 | $2,824,823 | $2,389,702 |
| Discretionary Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $2,814,959 | $2,824,823 | $2,389,702 |
| **Federal Administration** | $732,533 | $732,533 | $747,533 |
| Discretionary Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $732,533 | $732,533 | $747,533 |
| **State Survey & Certification** | $397,334 | $397,334 | $442,192 |
| Discretionary Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $397,334 | $397,334 | $442,192 |
| **Research, Demonstration & Evaluation /1** | $20,054 | $20,054 | $0 |
| Discretionary Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $20,054 | $20,054 | $0 |
| **Discretionary Appropriation, Net** | **$3,964,880** | **$3,974,744** | **$3,579,427** |
| **Discretionary Appropriation, Proposed Law** | **$0** | **$0** | **$0** |
| **Total Appropriation, Proposed Law** | **$3,964,880** | **$3,974,744** | **$3,579,427** |

/1 In FY 2020, the funding request is included within Program Operations.

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

## MCR9: Ensure Beneficiary Telephone Customer Service

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act* | 2020 | 90% | October 31, 2020 |
| | 2019 | 90% | October 31, 2019 |
| | 2018 | 90% | 98% (Target Exceeded) |
| | 2017 | 90% | 98% (Target Exceeded) |
| | 2016 | 90% | 98% (Target Exceeded) |
| | 2015 | 90% | 97% (Target Exceeded) |
| | 2014 | 90% | 97% (Target Exceeded) |
| | 2013 | 90% | 98% (Target Exceeded) |
| MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment* | 2020 | 90% | October 31, 2020 |
| | 2019 | 90% | October 31, 2019 |
| | 2018 | 90% | 97% (Target Exceeded) |
| | 2017 | 90% | 97% (Target Exceeded) |
| | 2016 | 90% | 96% (Target Exceeded) |
| | 2015 | 90% | 94% (Target Exceeded) |
| | 2014 | 90% | 98% (Target Exceeded) |
| | 2013 | 90% | 98% (Target Exceeded) |
| MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment* | 2020 | 90% | October 31, 2020 |
| | 2019 | 90% | October 31, 2019 |
| | 2018 | 90% | 97% (Target Exceeded) |
| | 2017 | 90% | 97% (Target Exceeded) |
| | 2016 | 90% | 95% (Target Exceeded) |
| | 2015 | 90% | 94% (Target Exceeded) |
| | 2014 | 90% | 95% (Target Exceeded) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2013 | 90% | 93% (Target Exceeded) |
| MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey* | 2020 | 90% | October 31, 2020 |
| | 2019 | 90% | October 31, 2019 |
| | 2018 | 90% | 94% (Target Exceeded) |
| | 2017 | 90% | 93% (Target Exceeded) |
| | 2016 | 90% | 92% (Target Exceeded) |
| | 2015 | 90% | 88% (Target Not Met) |
| | 2014 | 90% | 90% (Target Met) |
| | 2013 | 90% | 93% (Target Exceeded) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

The Beneficiary Contact Center (BCC) has expanded to handle calls and inquiries related to the Federal Exchanges. As a result, the contact center is now named Contact Center Operations (CCO), to reflect the handling of both beneficiary (Medicare) and consumer (Exchange) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate each Customer Service Representative's (CSR's) performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance each month in handling telephone inquiries using the quality standards of privacy act, knowledge skills, and customer skills.

For each fiscal year, the CCO has met or exceeded the target of 90 percent for each standard. Despite exceeding targets in previous reporting years, CMS will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching. This would mean additional costs for the contractors supporting the contact center. The resources required to ensure a higher quality metric would be better allocated to the increased contacts associated with the incoming baby-boomer population.

Beginning in FY 2009, the CCO (formerly BCC) has been assessed annually by an Independent Quality Assurance (IQA) contractor. The intent of this assessment is to gather more detail on where improvements can be made in handling telephone inquiries, to better serve the calling population. There is currently a parallel effort between the CCO and the IQA contractor to assess quality through quality monitoring tools – but for separate purposes. The CCO contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective, as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses

quality oversight of English and Spanish inbound and outbound telephone and written correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and for identifying areas of improvement for training and content materials as well as any other tools currently available to CSRs.

Since 2009, this performance measure has been based on survey methods designed by CMS, with questions approved by the Office of Management and Budget (OMB). The survey measures a variety
of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution, capturing an aggregated score of these dimensions.

## MCR12: Maintain CMS' Improved Rating on Financial Statements

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR12: Maintain an unmodified opinion* | 2020 | Maintain an unmodified opinion | November 30, 2020 |
| | 2019 | Maintain an unmodified opinion | November 30, 2019 |
| | 2018 | Maintain an unmodified opinion | Target Met |
| | 2017 | Maintain an unmodified opinion | Target Met |
| | 2016 | Maintain an unmodified opinion | Target Met |
| | 2015 | Maintain an unqualified opinion | Target Met |
| | 2014 | Maintain an unqualified opinion | Target Met |
| | 2013 | Maintain an unqualified opinion | Target Met |

* Prior years' targets and results for this goal can be found in previous CMS Budgets

The Chief Financial Officers (CFO) Act of 1990 creates a framework for the federal government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the federal government.

CMS' annual goal is to maintain an unmodified opinion, which indicates that its 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 2018 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2018, the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA) since FY 2010. CMS considers its financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems.* The Healthcare Integrated General Ledger Accounting System (HIGLAS) is CMS's official financial system of record used to produce its financial statements. 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. In addition, CMS provided a FY 2018 Federal Managers' Financial Integrity Act (FMFIA) statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30.

## MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Actual Rate

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR26: Reduce all-cause hospital readmission rate by 1% per year from the prior year's actual rate[1] | 2020 | 17.2%[2] | March 1, 2020 (based on CY 2018 data) |
| | 2019 | 17.4% | March 1, 2019 (based on CY 2017 data) |
| | 2018 | 17.8% | 17.6% (Target Exceeded) (based on CY 2016 data) |
| | 2017 | 17.4% | 18.0% (Target Not Met) (based on CY 2015 data) |
| | 2016 | 17.4% | 17.6 % (Target Not Met) (based on CY 2014 data) |
| | 2015 | 17.9% | 17.6% (Target Exceeded) (based on CY 2013 data) |
| | 2014 | 18.3% | 18.1% (Target Exceeded) (based on CY 2012 data) |
| | 2013 | 18.5% | 18.6% (Target Not Met) (based on CY 2011 data) |
| | 2012 | Baseline | 18.7% (Baseline – based on CY 2010 data) |

One way that the Medicare statute incentivizes hospitals to reduce preventable readmissions is through the Hospital Readmissions Reduction Program (HRRP). Established by Congress beginning in FY 2013, the HRRP reduces a statutorily defined 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 beyond, two additional readmission measures were added to the program: (1) Chronic Obstructive Pulmonary Disease and (2) Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and beyond, CMS established an additional measure for patients readmitted following Coronary Artery Bypass Graft Surgery, and CMS refined the Pneumonia readmission measure cohort.

[1] CMS targets reduction of all-cause Medicare hospital readmissions by one percent (not to be confused with one percentage point) per year from the prior year's actual rate (if available) or the prior year's target for the time period when the prior year's actual rate is not yet known. To meet or exceed the Target, the Result must be less than or equal to the calculated Target.

[2] The CY 2020 target may be adjusted based on CY 2019 result.

In addition to the HRRP, CMS leverages efforts of other programs to reduce hospital readmissions. Among these are the Hospital Improvement Innovation Networks that work 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, which must report on and meet targets for quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program.

CMS met its target for CY 2018 following two years, CY 2016 and CY 2017, where its targets were not met. The reduction in the readmission rates appears to have remained relatively constant following a historical pattern of slight reductions (the slight increase in CY 2017 appears to be a short term anomaly), and it is unclear whether this will continue or whether rates will decline further. In light of these results, CMS has set slightly less aggressive targets for FY 2019 and FY 2020. We have set the 2019 target at 17.4 percent and the 2020 target at 17.2 percent based on the CY 2018 result, but the CY 2020 target may be adjusted based on CY 2019 result. CMS will continue to monitor the data and will report on the CY 2019 target in the first half of 2019.

## MCR31: Improve Patient and Family Engagement by Improving Shared Decision-Making

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR31: Improve Clinician and Group- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Shared Decision Making Survey Score<br><br>Baseline:<br>CY 2014: Medicare Shared Savings Program (MSSP) ACO CAHPS: 74.6%<br><br>*ACOs Mean Score | 2020 | TBD | July 31 2021 |
| | 2019 | TBD | July 31 2020 |
| | 2018 | Establish new Baseline Developmental | July 31 2019 |
| | 2017 | 76% | 75.85% (Target Not Met) |
| | 2016 | Historical Actual | 75.40% |
| | 2015 | Historical Actual | 75.17%* |

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 reducing unnecessary costs. Similarly, Congress designed the Merit-based Incentive Payment System (MIPS) to tie Medicare payments to clinician performance in quality and cost-efficient care, improvements in care processes and health outcomes, and to increase the use of healthcare information. The purpose of this performance goal is to help assess an important component of a patient's experience of care with their provider. Shared decision-making between patient, caregiver, and provider is considered to be a fundamental component of a patient-centered healthcare system, leading to improved health outcomes for patients.

CMS can measure shared decision-making between the patient, caregiver, and provider through the Shared Decision-Making Summary Survey Measure (SSM), which is collected and reported through the CAHPS survey for the Physician Quality Reporting System (PQRS) program, the Merit-based Incentive Payment System (MIPS) (beginning in 2017), and the CAHPS for ACOs Survey, administered by Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (Shared Savings Program). The SSM is the percentage of patients who gave positive responses on experience in sharing decision making with providers on topics related to medications, procedures, and information sharing. A higher score indicates a better experience with shared decision making.

The performance target set for this measure was established using data limited to the Shared Savings Program's quality measure performance benchmark distribution, because these were the most recently available data. The 76 percent target for this goal in CY 2017 was set between the 80$^{th}$ and 90$^{th}$ percentiles for all Shared Savings Program ACOs, using the CY 2015 Shared Savings Program quality measure benchmarks. While we did not meet the target, we saw improvement from year to year. The mean performance on this measure was 75.40 in CY 2016 and was 75.85 in CY 2017, showing improvement in the overall SSM performance between CY 2015 and CY 2017. The target was ambitious, considering CAHPS scores do not change drastically from year to year, and considering that shared decision-making reflects a complex set of behaviors that may be difficult to change.

To ensure that ACOs attain and improve high measure performance, CMS provides training webinars and dedicated resource webpages and materials, including CAHPS guidance documents, to support ACOs and group practices in improving their CAHPS scores. The program will continue to provide these resources and will work to develop additional supports.

The CY 2018 performance period will be a developmental year because we are implementing a revised, shortened version of the survey in CY 2018 for both ACOs and MIPS. The revised, shortened version of the survey reflects substantive changes to the Shared Decision-Making SSM, as the number of questions contained in this SSM is reduced from eight to two.

The revised Shared Decision-Making section of the SSM will contain the below two questions:

1. When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?

2. In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?

CMS plans to re-establish the baseline for this goal (based on the results from the new survey for CY 2018), which is expected to be available to CMS in April 2019. In addition, CMS intends to provide targets for CY 2019, CY 2020, and CY 2021 when the new survey scores are available. As data from the CY 2018 CAHPS for MIPS becomes available, CMS intends to explore ways to broaden this goal and the respective target to encompass CAHPS for MIPS data, in addition to CAHPS for ACOs data.

## MCR35: 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 Arteriovenous Fistula (AVF) or Graft

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR35: Decrease the rate of long-term central venous catheter (CVC) use among prevalent patients, by increasing the patients that are no longer dialyzing with a long term catheter for greater than 120 days*<br><br>Baseline: FY 2017: 29.4% | 2020 | 30.9% | November 30, 2021 |
| | 2019 | 30.4% | November 30, 2020 |
| | 2018 | 29.9% | November 30, 2019 |
| | 2017 | Baseline | 29.4% |

* Prevalent patients are those on renal replacement therapy, excluding patients with acute renal failure, those with chronic renal failure who die before receiving treatment for ESRD, and those whose ESRD treatments are not reported to CMS.

In-center hemodialysis is the most common life-sustaining treatment for patients with End Stage Renal Disease (ESRD). The intent of this measure is to encourage and support the safest hemodialysis, to reduce harm in dialyzing patients, and reduce costs associated with infections. Individuals are diagnosed with ESRD when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD patients who have not received a transplant rely on dialysis to perform the life-sustaining filtering function that their kidneys can no longer perform. As of September 2018, there were over 730,000 ESRD patients, with about 550,000 dialyzing at one of the nation's 7,100 dialysis facilities. The estimated number of prevalent Medicare ESRD patients grows by about 3 percent annually.

The Medicare program funds dialysis at about $33 billion annually. Hemodialysis requires repeated vascular access to large blood vessels capable of effectively removing wastes from the blood. Hemodialysis vascular access-related complications, infection being the most common, remain one of the greatest sources of morbidity and cost. The United States Renal Data System reports that these total annual costs exceed $1 billion. As a result, CMS encourages and supports the use of safer vascular access of dialyzing patients.
Safer vascular access, specifically the reduction of long term catheter (LTC) use, will reduce hospitalizations and deaths associated with bloodstream infections and other vascular access complications.

The three forms of vascular access are arteriovenous fistula (AVF), arteriovenous graft (AVG), and central venous catheter (CVC). CMS, in collaboration with ESRD stakeholders that included dialysis organizations and patient advocacy organizations, established industry- wide goals for vascular access management.

Specifically, CMS set a national goal of reducing the rate of patients dialyzing with a LTC of greater than 90 days, to less than 10 percent. The 2018 ESRD Network Statement of Work calls for ESRD Networks to continue their efforts, interventions, and strategies to encourage and support the reduction of the use of LTCs and to convert those using LTCs to AVFs and AVGs.

Unlike the previous methodology (QIO10- see discontinued measure section), the current methodology (utilizing greater than 120 days to calculate LTC) mitigates some of the complications, with the eligibility of Medicare benefits and the time required for AVG or AVF to mature. Patients generally start dialysis urgently. The lack of preparation and/or early intervention requires initial dialysis with catheter. 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. LTC use refers to having a catheter in place for 90 days or longer. Compared with patients who receive an AVF, patients with a CVC may experience poorer clearance of blood toxins secondary to unreliable blood flow, central vein scarring with subsequent vein occlusion, and antibiotic resistance. This is exacerbated with a LTC, where patients may have higher rates of anemia and require greater doses of intravenous iron and recombinant human erythropoietin, compared with patients with AVFs or AVGs. In addition, the LTC is associated with the greatest risk of infection-related and all-cause mortality, compared with the AVF and AVG. Due to the risks associated with catheter use, where possible, those dialyzing with LTC should be converted to a different form of vascular access. The baseline figure of 29.4% represents a positive impact to 11,456 patients. The proposed target of 0.5% increase per year will positively impact an additional 834 patients each year, resulting in 15,182 patients no longer dialyzing with an LTC by 2020.

As a result of the ongoing work of the ESRD Network Program and efforts within the dialysis community, in 2017 the national level of dialyzing patients with an AVF placement is approximately 63-68 percent. CMS continues to promote the placement of AVFs and AVGs through quality improvement of the ESRD Networks, reducing the use of LTCs.

**NOTE:** This goal was publicly reported in the FY 2019 Congressional Justification with a goal identifier of QIO10.

## MCR36: Shift Medicare Health Care Payments from Volume to Value

| Measure | FY | Target | Result |
|---|---|---|---|
| Increase the percentage of Medicare health care dollars tied to Alternate Payment Models (APMs) incorporating downside risk | 2020 | TBD | December 15, 2020 |
| Baseline: Developmental | 2019 | TBD | December 15, 2019 |

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. These innovative payment and service delivery models can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of Alternative Payment Models (APMs) that create new incentives for clinicians to deliver better care at a lower cost. In addition, CMS is implementing payment reforms that reward quality and efficiency of care.

To achieve the goals of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality health outcomes, and value, over volume. APMs and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction. In order to continue the advancement of value-based care, CMS aims to increase the adoption of APMs where participants take on downside risk – that is, direct financial accountability for beneficiaries' costs and quality of care. Medicare is leading the way by publicly tracking and reporting payments tied to APMs that are taking on downside risk. CMS will use FY 2019 as a developmental year to establish a baseline and set future targets for FY 2020 and FY 2021.

## MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees

| Measure | CY | Target | Result |
|---|---|---|---|
| MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees<br><br>Baseline 2012: 92.7[1] readmissions per 1,000 Beneficiaries | 2020 | 0.5% Reduction From 2019 Actual | April 30, 2022 |
| | 2019 | 1% Reduction From 2018 Actual | April 30, 2021 |
| | 2018 | 1% Reduction From 2017 Actual | April 30, 2020 |
| | 2017 | Historical Actual | April 30, 2019 |
| | 2016 | Historical Actual | 83.7 per 1,000 (0.4% below 2015 actual) |
| | 2015 | Historical Actual | 84.0 per 1,000 (0.8% above 2014 actual) |
| | 2014 | Historical Actual | 83.4 per 1,000 (2.7% below 2013 actual) |
| | 2013 | Historical Actual | 85.7 per 1,000 (7.5% below 2012 baseline) |

[1] The methodology for this goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital 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 readmissions. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care, and may 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 2017, an estimated 12 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 and higher rates of institutionalization, in addition to challenges posed by socioeconomic issues. As a result, CMS seeks to assess the impact of interventions on this sub-population.

Numerous CMS initiatives help promote safer care transitions and reduce readmissions. Data regarding a sharp decline in potentially avoidable hospitalizations (including readmissions) in the NFI can be found in the CMS blog post: http://wayback.archive-it.org/2744/20170118123821/https://blog.cms.gov/2017/01/17/data-brief-sharp-reduction-in-avoidable-hospitalizations-among-long-term-care-facility-residents/; and the Year Four Evaluation of NFI can be found here: https://innovation.cms.gov/Files/reports/irahnfr-finalyrfourevalrpt.pdf. CMS focuses exclusively on Medicare-Medicaid enrollees in the *Financial Alignment Initiative*, through which CMS partners with state Medicaid agencies to test models for integrated, coordinated

care for this population, and the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*. This work is in addition to the many other efforts and initiatives, including the Hospital Readmission Reduction Program, and systemic efforts to reduce readmissions through the Partnership for Patients, as well as the efforts to align care with quality through Accountable Care Organizations, bundled payment models, and other delivery system reforms.

This measure is calculated using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

Based on national trends reflecting a slowing in readmissions reductions for all Medicare beneficiaries (after a number of years of larger declines), CMS has selected a more modest target reduction rate for CY 2020 of 0.5 percent.

# MEDICARE SURVEY & CERTIFICATION PROGRAM

## MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

| Measure | CY | Target | Result |
|---|---|---|---|
| MSC5: Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication | 2020 | 15.4% | April 30, 2021 |
| | 2019 | 15.5% | April 30, 2020 |
| | 2018 | 16.0% | April 30, 2019 |
| | 2017 | 16.0% | 15.4% (Target Exceeded) |
| | 2016 | 16.7% | 16.7% (Target Met) |
| | 2015 | 17.9% | 17.1% (Target Exceeded) |
| | 2014 | 19.1% | 19.1% (Target Met) |
| | 2013 | 20.3% | 20.3% (Target Met) |
| | 2012 | Historical Actual | 19.8% |
| | 2011 | Baseline – 23.87% (4th Q) | Last Quarter of Pre-Intervention Period |

The purpose of this performance measure is to decrease the use of antipsychotic medications in nursing homes with an emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the *Partnership to Improve Dementia Care in Nursing Homes* – to improve dementia care and reduce the use of antipsychotic medications. CMS staff have been working with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders, to decrease the use of these drugs. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; conducting focused dementia care surveys in selected states; and public reporting, to increase transparency. CMS hopes to enhance person-centered care for all nursing home residents, particularly those with dementia-related behaviors.

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. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the Advancing Excellence website (in the public domain) at www.nhqualitycampaign.org. State Coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with

dementia that may be distressing to residents or families.[1]

Person-centered care is an approach that focuses on residents as individuals, and supports caregivers, working most closely with them. It utilizes a continual process of listening, testing new approaches, and changing routines and organizational strategies in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012, CMS began posting on the Nursing Home Compare website, quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, CMS added the quality measures to the Five-Star Quality Rating System on the website.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long-stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of the calendar year 2011. It was selected because it was the last quarter in the pre-intervention period.

In 2011, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 36.6 percent to a national prevalence of 15.1 percent in 2017. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 40 percent. CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as-needed basis.

[1] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. JAMA, November 21, 2012; 308(19): 2020-2029.

## MSC6: Percentage of Hospice Facilities that Have Been Surveyed within 36 Months

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC6.2: Percentage of facilities that are surveyed within the required 36 month timeframe | 2020 | 98% of hospice facilities are surveyed within the required 36 month timeframe | May 31, 2021 |
| | 2019 | 98% of hospice facilities are surveyed within the required 36 month timeframe | May 31, 2020 |
| | 2018 | 95% of hospice facilities are surveyed within the required 36 month timeframe | May 31, 2019 |
| MSC6.1: Percentage of States that complete required hospice surveys within 36 months<br><br>Baseline: N/A | 2017 | 95% of States complete 98% of required hospice surveys | 88%<br>(Target Not Met) |
| | 2016 | 90% of States complete 95% of required hospice surveys | 71%<br>(Target Not Met) |

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/caregivers. 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 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. CMS is working on including the data for nursing homes and home health agencies.

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 that a hospice agency must meet in order to participate in Medicare. State Survey Agencies (SAs), 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 and had been every 72 months. In addition 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 requirement for the hospice survey interval is met nationally. 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. The data to confirm compliance with the requirements of the Act was not available until September 30, 2018. This data delay is a result of necessary follow up survey activity and data entry into the Automated Survey Processing Environment system. A post-September 30, 2018 review of the data indicates that as of April 18, 2018, 96.5% of all certified hospice agencies were surveyed in compliance with the requirements of the Impact Act.

To comply with the IMPACT Act and to ensure that states have plans in place to maintain compliance going forward, CMS worked through the CMS Regional Offices (ROs) to identify all hospice providers that required surveys by April 6, 2018.

CMS is revising the calculation and targets for the goal in order to make them more meaningful and understandable. It was discovered that simultaneously setting a percentage both of states, as well as facilities, was confusing. The previous methodology used for the calculation of this goal presents an inaccurate picture of the nationwide compliance with the hospice survey interval requirement. For example, an entire SSA may be found out of compliance based upon one survey when there are acceptable extenuating circumstances.

The new targets set beginning in FY 2018 are concise and clearly indicative of whether or not the work, as required by the Act, is being accomplished. CMS believes that the goal is more responsive to the IMPACT Act requirement that all hospice agencies nationwide be surveyed every 36 months.

## MSC7: Improve Staffing Reports to Support Better Outcomes for Residents of Long Term Care (LTC) facilities

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC7: Percentage of LTC facilities submitting complete staffing data through the Payroll-Based Journal (PBJ)<br><br>Baseline: 95.2% % (2018) | 2020 | 93.6% | December 31, 2020 |
| | 2019 | 93.6% | December 31, 2019 |

This measure aims to improve CMS' ability to publically report information about the staffing in long-term care (LTC) facilities, and ultimately improve care. Staffing levels, turnover, and tenure can have a significant impact on the quality of care provided by LTC facilities. This information is also very important to consumers when selecting or evaluating a LTC facility.

To publish accurate information, it is critical for CMS to obtain complete data from providers, which this measure seeks to address. In April 2018, CMS began using this data to calculate staffing measures and star ratings as part of the *Five Star Quality Rating System*. Stakeholders and LTC facilities use the published information to identify targets for staffing that lead to better outcomes for residents.

Baseline data for FY 2017 indicated 90.3 percent (14,162) of facilities submitted staffing data. For FY 2019, CMS aims for 93.6 percent of facilities to submit staffing data**.** This would be an improvement of 3.3 percentage points, or a 33 percent decrease in the number of facilities that did not meet this measure. CMS notes that this is a new program, and therefore difficult to predict the trajectory of performance. CMS will adjust the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results will be calculated by the end of the first quarter for each fiscal year, and the results for fiscal year 2018 are now available (95.2%).

As of July 1, 2016, LTC providers are required to electronically submit staffing data that is auditable back to payrolls and other verifiable information in accordance with 42 Code of Federal Regulations (CFR) §483.70(q) under current law. Receiving complete staffing data from providers is essential in order to calculate and publically report accurate staffing measures, which is the primary intent of the new program. For example, CMS believes that providers utilize nurse aides (certified nurse aides and medication aides) every day in their facilities. Therefore, if the data from a facility does not include hours for nurse aides on a particular day, CMS believes that indicates they have not submitted complete data. CMS does not expect data to be perfect, and facilities may miss a few days in a quarter. However, CMS believes that a reasonable threshold is for providers to submit data for nurse aides for each day in a quarter or miss no more than 14 days.

To incentivize improvement, CMS adjusts how a provider is reported on Nursing Home Compare and in the Nursing Home Five Star Quality Rating System (e.g., negative icon, suppress or reduce ratings). This has proven to be an effective method to improve reporting in the past. Also, CMS is conducting audits of the data submitted by providers, and will use the results of those audits to evaluate other actions that may be needed to improve the data submitted.

# MEDICAID

## MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality initiatives

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives | 2020 | Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures | March 31, 2021 |
| | 2019 | 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 | March 31, 2020 |
| | 2018 | 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 | March 31, 2019 |
| | 2017 | 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 | 88.2% of States reported on at least eleven quality measures<br>(Target Not Met) |
| | 2016 | 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 | 86% of States reported on at least ten quality measure<br>(Target Not Met) |
| | 2015 | Work with States to ensure that 90% of States report on at least nine quality measures in the CHIPRA children's core set of quality measures | 88% of States reported on at least nine quality measure<br>(Target Not Met) |
| | 2014 | Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA children's cores set of quality measures | 88% of States reported on at least eight quality measure<br>(Target Not Met) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2013 | Work with States to ensure that 85% of States report on at least seven quality measures in the CHIPRA children's core set of quality measures. | 88% of States reported on at least seven quality measure (Target Exceeded) |
| | 2012 | Work with States to ensure that 80% of States report on at least five quality measures in the CHIPRA children's core set of quality measures. | 92% of States reported on at least five quality measure (Target Exceeded) |
| | 2011 | Work with States to ensure that 70% of States report on at least one quality measures in the CHIPRA children's core set of quality measures. | 84% of States reported on at least one quality measure (Target Exceeded) |

The purpose of this measure is to improve the quality of children's health care across Medicaid and CHIP. Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of an initial core set (Child Core Set) of 24 children's quality measures. The 2018 Child Core Set contains 26 measures. While the use of the Child Core Set is voluntary for states until FY 2024, CMS encourages all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the pediatric quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for children in Medicaid and CHIP.

A State Health Official Letter (SHO) (#11-001) was released on February 14, 2011 to provide additional guidance on the Child Core Set and the process for voluntary reporting to CMS. The SHO also describes the initial CMS and AHRQ Pediatric Quality Measures Program (PQMP) developed measures that can be used to improve the Child Core Set. Thus far, the PQMP Centers of Excellence (COE) have developed 22 measures that have received National Quality Forum (NQF) measure endorsement. The current PQMP program (begun in 2016) is funding six grantees to further develop work on the feasibility and usability of PQMP measures by testing different measurement levels and quality improvement approaches to support adoption and use of these measures. Grantees are working closely with key stakeholders including state Medicaid agencies to build evidence and address the obstacles to state reporting.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas included in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team 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 (TA), CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/Analytic Support program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

The CHIPRA Quality Demonstration initiative concluded in 2016, and funding to improve state efforts in core measure data collection and reporting under that grant is no longer available. Additionally, as measures are retired from the CMS Child Core Set (which states have become accustomed to reporting), and new measures are added requiring new data collection and reporting efforts, CMS recognizes that states may choose to report on a lower number of measures without continued grant funding.

CMS also anticipates that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures. With this in mind, CMS anticipated a leveling and potential decline in the number of quality measures that states would report in future years. However, the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires that state reporting on Child Core Set measures be mandatory, starting in FY 2024. This new requirement will result in an uptick in reporting by states as it gets closer to FY 2024. CMS will continue to work with states to ensure that 90 percent of states report on at least eleven quality measures through FY 2019, with a new target in FY 2020 for 90 percent of states reporting on at least twelve quality measures.

Findings from state reporting on the Child Core Set are published annually and available on the Children's Health Care Quality Measures webpage (www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html) of Medicaid.gov and on https://data.medicaid.gov.

CMS continues to partner with the Office of the National Coordinator and other stakeholders to address opportunities for use of electronic quality measures for potential inclusion in future annual updates to child core measures collected through EHRs.

## MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid and Medicaid expansion Children's Health Insurance Programs (CHIP), who receive any preventive dental service*<br><br>National Baseline (2011) is 43%. | 2020 | +7 percentage points over 2011 baseline | October 15, 2021 |
| | 2019 | +6 percentage points over 2011 baseline | October 15, 2020 |
| | 2018 | +5 percentage points over 2011 baseline | October 15, 2019 |
| | 2017 | +4 percentage points over 2011 baseline | 51% (Target Exceeded) |
| | 2016 | +3 percentage points over 2011 baseline | 48% (Target Exceeded) |
| | 2015 | +5 percentage points over 2011 baseline | 47% (Target Not Met) |
| | 2014 | +6 percentage points over 2011 baseline | 45% (Target Not Met) |
| | 2013 | +4 percentage points over 2011 baseline | 44% (Target Not Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and Medicaid expansion CHIP programs. Between FY 2007 and FY 2017, 37 states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year. Despite this improvement, only 51 percent of all enrolled children nationally received a preventive dental or oral health service in FY 2017. CMS engaged in a vigorous fact-finding process in the late 2000s to understand the issues related to state performance on children's access to dental care. To help improve performance, from 2010 to 2015 CMS implemented the Oral Health Initiative 1.0. This initiative worked with federal and state partners, the dental and medical provider communities, children's advocates, and other stakeholders to expand the number of dental professionals participating in Medicaid and to increase the awareness of the need for dental care among beneficiaries in order to continue to improve children's access to dental care, with an emphasis on prevention.

In 2016, CMS reassessed its approach to the Oral Health Initiative (OHI) and developed a new strategy, which CMS called Oral Health Initiative 2.0. It comprises six steps and has at its core a stance of integration, both vertical and horizontal, within CMS and at the state level:

(1) Identifying elements that comprise a strong state Medicaid dental program

(2) Using performance data to prioritize which states to focus on, then conducting assessments of those states to understand which elements of a strong program are in place and which are missing

(3) Communicating the results of the assessments to state agency leaders and inviting engagement for improvement

(4) Identifying opportunities across CMCS to engage with states through existing levers such as Section 1115 demonstration renewals and State Plan Amendment reviews and approvals, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives (beyond dental program staff)

(5) Documenting improvement targets and strategies where appropriate, such as special terms and conditions, approval letters, etc., and,

(6) Having states take action based on those agreements

Through this new approach, CMS has brought more explicit leadership support and broader resources to the effort to increase use of dental services among children enrolled in Medicaid and CHIP. For example, CMS has been deeply engaged with California's Dental Transformation Initiative, which has dedicated $740 million to test several strategies to improve oral health in the state's 1115 demonstration. The State reports that the proportion of children ages 1-20 who have received preventive dental services has risen from 37 percent in FY 2015 to 45 percent in FY 2017. In addition, CMS adjusted its annual goals to better reflect states' current environments and their ability to drive improvement. In the coming year, we will be determining whether to adjust our Oral Health Initiative strategies in light of progress to date, and opportunities to engage with states for further improvement.

CMS continues to work closely with other stakeholders who engage in improvement efforts with states. For example, CMS provides technical support to the Dental Quality Alliance to support states in developing and implementing performance improvement projects, which deliver dental services through managed care contracts. CMS continues to host regular Oral Health Technical Advisory Group (OTAG) calls with state Medicaid and CHIP programs to share information on core measure data collection, reporting, and related quality improvement efforts. Recent OTAG topics have included managed care quality improvement regulations that will impact dental plans, implementing teledentistry in Medicaid, and aligning Medicaid payment policies with states' dental periodicity schedules.

## MCD8: Improve Adult Health Care Quality across Medicaid

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD8: Improve Adult Health Care Quality Across Medicaid | 2020 | Work with States to ensure that 75% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures | March 31, 2021 |
| | 2019 | Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures | March 31, 2020 |
| | 2018 | Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures | March 31, 2019 |
| | 2017 | Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures | 75% (Target Met) |
| | 2016 | Work with States to ensure that 70% of States report on at least nine quality measures in the Adult Medicaid core set of quality measures | 70% (Target Met) |
| | 2015 | Work with States to ensure that 70% of States report on at least seven quality measures in the Adult Medicaid core set of quality measures | 73% (Target Exceeded) |
| | 2014 | Work with States to ensure that 65% of States report on at least five quality measures in the Adult Medicaid core set of quality measures | 67% (Target Exceeded) |
| | 2013 | Work with States to ensure that 60% of States report on at least three quality measures in the Adult Medicaid core set of quality measures | 59% (Target Not Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets

The purpose of this measure is to improve health care quality for adults across Medicaid. The target for the adult core set has been met or exceeded since 2014. CMS will continue to work with states to ensure that 75 percent of states report on at least eleven quality measures through FY 2019, with a new target in FY 2020 for 75 percent of states reporting on at least twelve quality measures.

Similar to the children's quality goal (MCD6), which measures development and implementation of a core set of children's quality measures, this goal focuses on creating a core set of adult quality measures for voluntary use by states (all 50 states, including the District of Columbia) to assess the care received by adults in the Medicaid program. By encouraging states to report the core measures in a standardized manner, CMS is creating a

foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas includ in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars and 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. Findings from State reporting on the Adult Core Set are published annually on the Adult Health Care Quality Measures webpage at medicaid.gov and on https://data.medicaid.gov and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

This initiative aligns with the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program under the Recovery Act of 2009. Providers in Medicaid can qualify to receive incentive payments for adopting, implementing, and demonstrating meaningful use of certified electronic health record technology. To comply with meaningful use requirements, providers report data on clinical quality measures. Eight of the measures in the 2018 Medicaid Adult Core Set are identified as meeting the meaningful use criteria for quality measures under the EHR Medicaid Incentive Program.

It is important to highlight that the Adult Quality Measure Grant initiative has now concluded and funding toward state efforts in core measure data collection and reporting under that grant is no longer available. Additionally, as some measures are retired from the CMS adult core set (which states have become familiar with reporting) and new measures are added requiring new data collection and reporting efforts, CMS recognizes that states may choose to report a limited number of measures without continued grant funding.

CMS has also anticipated that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 requires that state reporting on Child Core Set measures be mandatory, starting in 2024. This new requirement may potentially result in an uptick in child core set reporting by states, as CMS get closer to 2024. It does not require mandatory reporting of the adult core set but may positively influence improved adult core set reporting. Additionally, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018, requires that state reporting on measures in the Behavioral Health Core Set (a subset of behavioral health measures from the Adult and Child Core Sets) be mandatory, starting in 2024. CMS is assessing the potential impact of these recent statutory changes as their actual impact cannot be determined until implementation.

Findings from state reporting on the Adult Core Set are published annually and available on the Adult Health Care Quality Measures webpage of Medicaid.gov (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html) and on https://data.medicaid.gov.

## MCD9: Improve Capacity to Collect Quality and Other Performance Data for Monitoring 1115 Demonstration Programs

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD9.1: Improve Capacity to Collect Quality and Other Performance Data for Monitoring Payment and Service Delivery Reform 1115 Demonstration Programs. | 2020 | Discontinued | N/A |
| | 2019 | Requirement for states to submit the data in the reporting platform from a minimum of 10 states. | September 30, 2019 |
| | 2018 | Requirement for states to submit the data in the reporting platform from a minimum of 5 states. | Reports from 10 states submitted.<br>(Target exceeded) |
| | 2017 | Testing 1 core metric data set with a minimum of 5 states. | CMS has tested 3 core metric sets with a total of 10 states<br>(Target Exceeded) |
| | 2016 | Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission. | (Target Met) |
| **Measure** | **FY** | **Target** | **Result** |
| MCD9.2 Improve Capacity to Collect Quality and Other Performance Data for Monitoring and Substance Use Disorder (SUD) 1115 Demonstrations | 2020 | CMS produce SUD performance trends across time and states for at least 10 states | September 30, 2020 |
| | 2019 | Require states to submit the SUD metric data in the reporting platform from a minimum of 10 states | September 30, 2019 |

| Measure | FY | Target | Result |
| --- | --- | --- | --- |
| Baseline: 0 states | 2018 | | Built new SUD-specific data collection instrument and trained states with approved 1115 SUD demonstrations on use of the instrument and system |

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant demonstrations to states for testing innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). These measures track the development of an automated infrastructure to support section 1115 Medicaid demonstrations, including payment and/or service delivery innovations (MCD9.1) and those focusing on comprehensive treatment for substance use disorders (SUDs) (MCD9.2).

States are using 1115 demonstration authority to achieve Medicaid reform through alternative models of service delivery and/or financing. These reforms aim at improving the quality of their Medicaid programs and their capacity to serve more people and to find alternatives to eligibility, enrollment, and coverage, to promote health improvement and independence. CMS is making significant investments in these types of demonstrations in order to study the results on a state-based and national level. However, to accomplish these goals, CMS needed an automated system for data collection and analysis of demonstration performance metrics, analytics, or reporting to assess quality performance of demonstrations. CMS developed several sets of performance metrics for high priority 1115 demonstrations. These sets have been reviewed by a Medicaid State Technical Advisory Group (TAG), and are being rolled-out to states working with CMS to implement applicable demonstrations. Additional improvements include the development of a monitoring report template, as well as templates for reporting these metrics. CMS is focused on improving the quality and structure of data, both quantitative and qualitative, for section 1115 demonstrations, through a more automated process that will improve federal monitoring of demonstration progress and performance. This initiative aligns with the Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP-related data from states to support better program oversight, administration, and program integrity.

CMS's 2019 target reflects the increasing scope of the work to incorporate the standard metric sets into more Medicaid section 1115 demonstrations, to improve CMS' capability to monitor outcomes for demonstrations that are testing similar innovative approaches. As new demonstrations are approved and existing demonstrations are renewed, CMS will work with states to incorporate the appropriate metrics into state reporting to CMS. While CMS will continue to collect and analyze quality and other performance data to monitor alternative service delivery and/or financing models in Medicaid, CMS is discontinuing the measurment of this aspect of 1115 demonstrations after FY 2019. This is due to the fact that CMS is in the process of considering its expectations for approval of such demonstrations, which will likely affect the metric set and reporting requirements.

CMS achieved its 2017 MCD9.1 target by exceeding the number of metric sets that were tested by at least ten states. CMS tested three sets, including metrics for Delivery System Reform Incentive Program demonstrations. In 2018, CMS also exceeded the number of states that were required to submit data via the Performance Metrics Database and Analytics (PMDA) system, with 10 states using the reporting platform.

CMS is shifting its focus to the opioid crisis and toward state performance in improving access to, and health outcomes related to, comprehensive treatment for people with Substance Use Disorders (SUDs) under Medicaid. CMS is proposing a new measure, MCD9.2, to reflect these efforts. In 2018, CMS focused on developing a metric set for the SUD demonstrations, including drafting a metric data collection template and a quarterly reporting template for qualitative information. CMS shared these templates with the 1115 Monitoring State Advisory Group, as well as with states, as their SUD demonstrations were being approved. The PMDA is adjusted regularly to collect these data and monitoring reports, assuring internal controls. CMS was delayed in finalizing the SUD metric specifications until September 2018. Since that time, 10 states have been trained on the SUD metric specifications and are expected to start submitting data in the next two quarters of FY 2019.

## 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

| Measure | FY | Target | Result |
|---|---|---|---|
| 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. Actual-Baseline: 49.50% (FY 2012) | 2020 | 65% | April 1, 2022 |
| | 2019 | 63% | April 1, 2021 |
| | 2018 | 61% | April 1, 2020 |
| | 2017 | 59% | April 1, 2019 |
| | 2016 | 57% | 57% (Target Met) |
| | 2015 | 55% | 55% (Target Met) |
| | 2014 | 53% | 53% (Target Met) |
| | 2013 | 51% | 51% (Target Met) |
| 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 (HCBS) by 2020.*<br><br>Actual Baseline is 47.1%* or 23 States and District of Columbia (FY 2012) | 2020 | 38 States and District of Columbia (76.5%)* | April 30, 2022 |
| | 2019 | 37 States and District of Columbia (74.5%)* | April 30, 2021 |
| | 2018 | 36 States and District of Columbia (72.5%)* | April 30, 2020 |
| | 2017 | 35 States and District of Columbia (70.6%)* | April 30, 2019 |
| | 2016 | 38 States and District of Columbia (76.5%)* | 30 States and District of Columbia 60.8% (Target Not Met) |
| | 2015 | 35 States and District of Columbia (70.6%)* | 28 States and District of Columbia<br><br>56.7%* (Target Not Met) |
| | 2014 | 31 States and District of Columbia (62.7%)* | 25 States and District of Columbia<br><br>51.0%* (Target Not Met) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2013 | 27 States and District of Columbia (54.9%)* | 25 States and District of Columbia<br><br>51.0%* |

* The target and result percentages for MCD10.2 have been corrected from previous versions appearing in past versions of the CMS budget.

Home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf). While services can be provided under many different authorities, most are provided under §1915(c) HCBS waiver programs, which are required to limit aggregate HCBS costs to less than or equal to the average institutional service cost that the individual would otherwise receive.

Several statutory programs, in addition to §1915(c) HCBS waiver programs, provide options for people to receive long-term services and supports in the community. These include the Community First Choice state plan option, flexibilities in §1915(i) state plan HCBS, the extension of and improvements to the Money Follows the Person (MFP) Rebalancing Demonstration, and an extension of spousal impoverishment protections to people who receive HCBS.

In FY 2016, Medicaid spent $167 billion on long term services and supports (LTSS), representing a nearly five percent increase in overall LTSS attributable to HCBS expenditures. The LTSS spending (institutional and HCBS) represented 30 percent of all Medicaid spending. The HCBS expenditures in FY 2016 represented all of the 4.5 percent growth in LTSS spending.

Due to the timing of available information through the Medicaid Budget and Expenditure System (MBES), CMS updates progress towards meeting targets annually with data that is available 15 to 18 months after the end of the fiscal year. Managed long term services and supports (MLTSS) expenditures continue to be estimated based on state reporting through the CMS contractor's survey since expenditures for the HCBS portion of MLTSS expenditures were not available through MBES in FY 2016.

In MCD 10.1, the FY 2020 target projects the HCBS expenditure to grow to 65 percent. CMS expects to meet or exceed targets by supporting the continued development of the previously mentioned programs and activities. CMS continues efforts to expand HCBS quality initiatives by introducing the Consumer Assessment of Health Care Providers and System (CAHPS) Home and Community-Based Services (HCBS) survey™. This CAHPS-trademarked tool allows states to determine the beneficiaries' experience of care in HCBS programs. Additionally, use of National Quality Forum (NQF)-approved HCBS measures contribute to states' efforts to continuously improve their HCBS services. Finally, new discrete individual level claims data, collected through the Transformed Medicaid Statistical Information System (T-MSIS), will provide promising opportunities to expand the development of quality metrics in the future.

Building off the information and reporting in MCD10.1, CMS believes that it is important to create a balance of expenditures on a state-by-state basis. There are currently 31 states, including the District of Columbia, that have reached the balancing benchmark with 50 percent or more of the LTSS expenditures supporting home and community based service options as reported under measure MCD 10.2.

During the next period, CMS will continue to focus efforts on providing technical assistance to states through the Innovation Accelerator Program (IAP) Community Integration track. Further, CMS will work with MFP demonstration grantees to implement their post-grant sustainability plans through expanding existing HCBS options or developing new waiver programs or state plan amendments (MFP grant funding ends in 2020).

# HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

## MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for- Service (FFS) Program* | 2020 | TBD | November 15, 2020 |
| | 2019 | 8.00% | November 15, 2019 |
| | 2018 | 9.40% | 8.12% (Target Exceeded) |
| | 2017 | 10.40% | 9.51% (Target Exceeded) |
| | 2016 | 11.50% | 11.00% (Target Exceeded) |
| | 2015 | 12.5% | 12.09% (Target Exceeded) |
| | 2014 | 9.9% | 12.7% (Target Not Met) |
| | 2013 | 8.3% | 10.1% (Target Not Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.

The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The CERT program was initiated in Fiscal Year (FY) 2003, and has produced a national Medicare FFS improper payment rate for each year since its inception. Information on the Medicare FFS improper payment methodology can be found in the 2018 HHS AFR.

CMS exceeded its FY 2018 target. The Medicare FFS improper payment estimate for FY 2018 is 8.12 percent or $31.62 billion. The decrease from the prior year's reported improper payment estimate of 9.51 percent or $36.21 billion was driven by a reduction in improper payments for Home Health and Skilled Nursing Facility (SNF) claims. Although the improper payment rate for these services and the overall Medicare FFS improper payment rate decreased, improper payments for Home Health, SNF, Inpatient Rehabilitation Facility (IRF), and Hospital Outpatient claims were the major contributing factors to the FY 2018 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

Per OMB, starting in FY 2017, CMS now establishes a target for only the next fiscal year. The FY 2019 target is 8.00 percent and the FY 2020 target will be established in the FY 2019 HHS AFR.

**Home Health Claims:** Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 32.28 percent in FY 2017 to 17.61 percent in FY 2018. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).

**SNF Claims:** Insufficient documentation was the major error reason for SNF claims. The improper payment rate for SNF claims decreased from 9.33 percent in FY 2017 to 6.55 percent in FY 2018. The primary reason for these errors was that the certification/recertification statement was missing or insufficient (e.g., one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).

**IRF Claims:** Medical necessity (i.e., services billed were not medically necessary) continues to be the major reason for error in IRF claims. The improper payment rate increased from 39.74 percent in FY 2017 to 41.55 percent in FY 2018. The primary reason for these errors was that IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires that there must be a reasonable expectation that the patient meets all of the coverage criteria at the time of admission to the IRF (42 CFR 412.622(a) (3)).

**Hospital Outpatient Claims:** Insufficient documentation is the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims decreased from 4.38 percent in FY 2017 to 3.25 percent in FY 2018. The primary reasons for these errors was either that the order (or intent to order for certain services) or the medical necessity documentation was missing or insufficient (42 U.S.C 1395y, 42 CFR 410.32).

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions. CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates, such as home health, SNF, and IRF claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the 2018 HHS AFR.

## MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program* | 2020 | TBD | November 15, 2020 |
| | 2019 | 7.90% (target in FY 2018 AFR) | November 15, 2019 |
| | 2018 | 8.08% (target in FY 2017 AFR) | 8.10%** (Target Met) |
| | 2017 | 9.50% (target in FY 2016 AFR) | 8.31% (Target Exceeded) |
| | 2016 | 9.14% (target in FY 2015 AFR) | 9.99% (Target Not Met) |
| | 2015 | 8.5% (target in FY 2013 AFR) | 9.5% (Target Not Met) |
| | 2014 | 9.0% (target in FY 2013 AFR) | 9.0% (Target Met) |
| | 2013 | 10.9% (target in FY 2012 AFR) | 9.5% (Target Exceeded) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.
** CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2018, CMS met its Part C Medicare Advantage (MA) error rate target of 8.08 percent, reporting an actual improper payment estimate of 8.10 percent**, or $15.55 billion. The decrease from the prior year's estimate of 8.31 percent was driven primarily by submission of more accurate diagnoses by MA organizations for payment.

The FY 2019 target is 7.90 percent. The FY 2020 target will be established in the FY 2019 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year. The FY 2018 target was met.

The Part C program payment error estimate reflects the extent to which MAO-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 between the diagnoses submitted to CMS and the medical record. To calculate the Part C program's error estimate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part C program:

**Contract-Level Audits:** Contract-level Risk Adjustment Data Validation (RADV) audits are CMS's primary corrective action to recoup overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. CMS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment, as contract-level RADV audits increase the incentive for MA organizations to submit valid and accurate diagnosis information. It also encourages MA organizations to return overpayments they have received. Payment recovery for the pilot audits has been completed, totaling $13.7 million recovered in FY 2012 through FY 2014. CMS expects to conduct recoveries for the 2011, 2012 and 2013 contract-level RADV audits (which began in FY 2014 and FY 2015, respectively).

**Regulatory Provision (Overpayment Recoveries):** As required by the Social Security Act, MA organizations must report and return overpayments that they identify. In FY 2018, MA organizations reported and returned approximately $64.93 million in self-reported overpayments. CMS believes that this requirement will reduce improper payments by encouraging MA organizations to submit accurate payment information.

**Training:** CMS has conducted training sessions on fraud, waste, and abuse, both in-person and via webinar, for Parts C and D sponsors. Training covers program integrity initiatives, investigations, data analysis, and potential fraud schemes. In the spring and fall of FY 2017, CMS conducted two in person missions. In late FY 2017, CMS procured a new contractor to support this initiative, and in FY 2018, conducted two in person missions and a fraud, waste, and abuse training conference.

## MIP6: Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program* | 2020 | TBD | November 15, 2020 |
| | 2019 | 1.65% (target in FY 2018 AFR) | November 15, 2019 |
| | 2018 | 1.66% (target in FY 2017 AFR) | 1.66% (Target Met) |
| | 2017 | 3.30% (target in FY 2015 AFR) | 1.67% (Target Exceeded) |
| | 2016 | 3.40% (target in FY 2013 AFR) | 3.41%** (Target Met) |
| | 2015 | 3.5% (target in FY 2013 AFR) | 3.6% (Target Not Met) |
| | 2014 | 3.6% (target in FY 2013 AFR) | 3.3% (Target Exceeded) |
| | 2013 | 3.1% (target in FY 2011 AFR) | 3.7% (Target Not Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.
** CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2018, CMS met its target of 1.66 percent, reporting an actual improper payment estimate of 1.66 percent, or $1.32 billion. The decrease from the prior year's estimate of 1.67 percent was driven primarily by submission of more accurate payment data by Part D sponsors.

The FY 2019 target is 1.65 percent. The FY 2020 target will be established in the FY 2019 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

The Part D program payment error estimate reflects the extent to which Prescription Drug Event (PDE) records submitted by Part D sponsors for a national sample of PDEs, are substantiated by supporting documentation such as prescription record hardcopies, long-term care medication orders, and claims information from Part D sponsors. Validation of PDEs is performed during CMS's annual Payment Error Related to Prescription Drug Event Data Validation (PEPV) process, where supporting documentation is reviewed by two separate clinicians. To calculate the Part D program's error estimate, the dollars in error are divided by the overall Part D payments for the year being measured.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part D program:

**Training:** Historically, HHS conducted fraud, waste, and abuse in-person and webinar training sessions for Part D sponsors on program integrity initiatives, investigations, data analysis, and potential fraud schemes. In FY 2017, HHS conducted a small mission (i.e. in-person event), May 2017. In late FY 2017, HHS procured a new contractor to support this initiative, and in FY 2018, HHS conducted three missions (one in October 2017 and two in April 2018), as well as an in-person fraud, waste, and abuse training conference (July 2018).

**Outreach:** CMS continued formal outreach to plan sponsors for invalid/incomplete documentation. CMS distributed Final Findings Reports to all Part D sponsors participating in the PDE review process. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.

**Regulatory Provision (Overpayment Recoveries):** As required by the Social Security Act, HHS requires that Part D sponsors report and return all identified overpayments. HHS believes that the overpayment statute and regulation contribute to increased attention paid by Part D sponsors to data accuracy. In FY 2018, Part D sponsors reported and returned approximately $2.1 million in self-reported overpayments.

## MIP9: Reduce the Improper Payment Rates in the Medicaid Program and the Children's Health Insurance Program (CHIP)

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP9.1: Reduce the Improper Payment Rate in the Medicaid Program* | 2020 | N/A | N/A |
| | 2019 | N/A | N/A |
| | 2018 | 7.93% | 9.79% (Target Not Met) |
| | 2017 | 9.57% | 10.10% (Target Not Met) |
| | 2016 | 11.53% | 10.48% (Target Exceeded) |
| | 2015 | 6.7% | 9.78% (Target Not Met) |
| | 2014 | 5.6% | 6.70% (Target Not Met) |
| | 2013 | 6.4% | 5.8% (Target Exceeded) |
| MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)* | 2020 | N/A | N/A |
| | 2019 | N/A | N/A |
| | 2018 | 8.20% | 8.57% (Target Not Met) |
| | 2017 | 7.38% | 8.64% (Target Not Met) |
| | 2016 | 6.81% | 7.99% (Target Not Met) |
| | 2015 | 6.5% | 6.80% (Target Not Met) |
| | 2014 | Report rolling improper payment rate in the 2014 AFR. | 6.50% (Target Met) |
| | 2013 | Report rolling improper payment rate in the 2013 AFR. | 7.1% (Target Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.

The Payment Error Rate Measurement (PERM) program measures improper payments in the Fee-For-Service (FFS), 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 reviews and CMS can complete the measurement on time for the Department of Health and Human Services (HHS) and Agency Financial Report (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 2015 HHS AFR were

also measured again in the 2018 HHS AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2018 HHS AFR.

The national Medicaid improper payment rate (MIP9.1) reported in the 2018 HHS AFR is based on measurements that were conducted in FYs 2016, 2017, and 2018. As described in Sections 11.4: Medicaid and 11.5: CHIP of the FY 2018 HHS AFR, HHS also used the Eligibility Review Pilots to test updated PERM eligibility processes and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, HHS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017) to update the methodology for the PERM eligibility component. HHS resumed the eligibility component measurement under this final rule and will report an updated national eligibility improper payment estimate in FY 2019. Since HHS uses a 17 state, three-year rotation for measuring Medicaid and CHIP improper payments, reduction targets will be published once a full baseline, including eligibility, has been established and reported in FY 2021.

The current national Medicaid improper payment rate is 9.79 percent. The national Medicaid component rates are 14.31 percent for Medicaid FFS and 0.22 percent for Medicaid managed care. The Medicaid eligibility component is held constant at the FY 2014 reported rate of 3.11 percent.

For FY 2015 through FY 2018, CMS did not conduct the eligibility measurement component of PERM. In place of these, all states were required to conduct eligibility review pilots that provided more targeted, detailed information on the accuracy of eligibility determinations. The pilots used 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. During this time, for the purpose of computing the overall national improper payment rates, the Medicaid and CHIP eligibility component improper payment rates were held constant at the FY 2014 national rate of 3.11 percent and 4.22 percent, respectively.

CMS used the eligibility review pilots to test updated PERM eligibility processes, and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, CMS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017) to update the methodology for the PERM eligibility component. CMS will resume the eligibility component measurement under this final rule and report an updated national eligibility improper payment estimate in FY 2019.

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. The majority of improper payments have been cited on claims where a newly enrolled provider had not been appropriately screened by the state, a provider did not have the required NPI on the claim, or a provider was not enrolled. Although these errors remain a driver of the Medicaid rate, state compliance has improved, as the Medicaid FFS improper payment rate for these errors decreased from 9.27 in FY 2017 to 7.21 in FY 2018. While the screening errors described above are for newly enrolled providers, states are also required to screen providers upon revalidation of enrollment. States are required to revalidate the enrollment of all providers at least every five years and must have completed the revalidation process of all existing providers by September 25, 2016. In FY 2018, HHS measured the first cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major source of error in the Medicaid improper payment rate. HHS will complete the measurement of all states for compliance with provider revalidation requirements in FY 2020. Non-compliance with the provider screening,

enrollment, and NPI requirements is still a major contributor to the Medicaid improper payment rate.

The national CHIP improper payment rate (MIP 9.2) reported in the 2018 HHS AFR is based on measurements conducted in FYs 2016, 2017, and 2018. The current national CHIP improper payment rate is 8.57 percent. The national CHIP component rates are 12.55 percent for CHIP FFS and 1.24 percent for CHIP managed care. The CHIP eligibility component is held constant at the FY 2014 reported rate of 4.22 percent. Additional detail about Medicaid and CHIP improper payment rates and underlying components is available in the 2018 HHS AFR.

The majority of CHIP improper payments have been cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately screened by the state or a provider did not have the required NPI on the claim (see Section 11.4 for further description of HHS's review of these errors). State compliance with screening requirements have not improved for CHIP. A higher percentage of CHIP providers are not enrolled in Medicare, and therefore, there are more CHIP providers where states cannot rely on Medicare's screening in lieu of conducting state screening.

The factors contributing to improper payments are complex and vary from year to year. In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit Corrective Action Plans (CAPs) to CMS. Each year CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. Detailed information on corrective actions can be found in the 2018 HHS AFR.

## MIP11: Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online

| Measure | CY | Target* | Result |
|---|---|---|---|
| MIP11: Increase the proportion of providers performing initial enrollment in the Medicare Program online.<br><br>Calendar Year (CY) 2015<br><br>Baseline: 30.1%<br><br>This is a CY goal. | 2020 | 46% | April 30, 2021 |
| | 2019 | 44% | April 30, 2020 |
| | 2018 | 38.7% | April 30, 2019 |
| | 2017 | 36.7% | 42.51%<br>(Target Exceeded) |
| | 2016 | 34% | 34.7%<br>(Target Exceeded) |
| | 2015 | Baseline | 30.1% |

* The baseline was established in CY 2015 when the result was measured at 30.1%. The CY 2016 target was established at 34%, based on the expectation of a modest increase over the baseline result. Consistent with this concept, the CY 2017 target was based on an increase of 2% above the CY 2016 result, a target of 36.7%.

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. Providers and suppliers are required to enroll in the Medicare program in order to bill and receive payment 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 provide savings.

The purpose of the measure is to increase online submission of enrollment applications and reduce the number of paper applications, thereby increasing operational efficiency. Further information or explanation for paper applications necessitates the return of an estimated 50 to 70 percent of applications. This process unnecessarily lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications. This added time and expense negatively impacts CMS' operational efficiency and can affect program beneficiaries' access to services. The average time to process an electronic enrollment application is 45 days. This compares favorably to the 60 days average time for processing a paper enrollment. The annual average of more than a million enrollment applications processed by CMS further amplifies this difference.

This measure will improve operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, resulting in reduced operating costs and improved access to care through timelier provider certification. Increased usability of online enrollment submissions by providers will also result in more complete applications and faster screening results through real time data verification to the Medicare contractors, reducing overall processing time. The online enrollment application supplies information needed by the provider with quick and easy access to update the

information. The electronic enrollment process will also enhance CMS' capacity to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). The QPP relies on PECOS data for Merit-Based Incentive Payment System (MIPS) eligibility. States leverage PECOS data for screening and enrollment of Medicaid fee-for-service providers. Faster processing and timely updates of enrollment information in PECOS will facilitate data sharing and the identification and determination of the eligibility of providers and groups in MACRA programs such as MIPS, Alternative Payment Models, and State Medicaid Agencies.

CMS is measuring the increase in the proportion of providers enrolling online. The baseline measurement was established in CY 2015 and goal implementation occurred in the calendar year (CY) 2016.

The CY 2016 result was 34.7 percent, which exceeded the target of 34 percent. The CY 2017 result was 42.51 percent, which exceeded the target of 36.7 percent. The CY 2018 result will be available by the end of April 2019, and subsequent measurements will be available by April of the year following the calendar year measured. Targets have been provided for CY 2019 (44%) and CY 2020 (46%).

## MIP12: Savings from the Prevention of Improper Medicare Payments by Successful Implementation of Fraud Prevention System (FPS) Edits

| Measure | FY | Target* | Result |
|---|---|---|---|
| MIP12: Maintain or increase dollar savings through the prevention of improper payments in Medicare Fee For Service (FFS) claims through innovative edit techniques employed by Fraud Prevention System (FPS) Edits. | 2020 | $33.5 million | April 30, 2021 |
| | 2019 | $33.5 million | April 30, 2020 |
| | 2018 | $33.0 million | April 30, 2019 |
| | 2017 | Baseline: Developmental | $32.1 million |

*The FY 2017 baseline for this goal is $32.1 million. The targets for FY 2018 through FY 2020 are based on previous years' results, coupled with expected changes in the program. These targets are expressed as dollar savings achieved through prevention, and represent a percentage change from the previous year. CMS calculates the savings metric three months after the end of the fiscal year. This three-month run out time is due to the fact that CMS' methodology captures denials/rejections that were resubmitted or overturned on appeal within the three months after the end of the fiscal year. The FPS edits methodology was certified by the Office of the Inspector General in the FPS 3rd Implementation Year Report to Congress.

To protect the integrity of the Medicare Trust Funds, CMS must ensure Medicare payments are correct and made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. This goal targets CMS's ability to prevent improper payments by measuring the dollar savings resulting from claims rejected or denied based on FPS edits. For the purpose of this measure, savings measured by this goal will only include rejected claims that are not resubmitted, and denied claims not overturned on appeal within three months after the end of the reporting period.

FPS edits screen Medicare fee-for-service claims on a pre-payment basis for improper billing, which could result from miscoding, or could indicate intentional fraud, waste, or abuse. The FPS has the capability to prevent payment of certain improper claims by communicating a denial or rejection message to the claims payment systems. CMS tested FPS's ability to successfully integrate with several legacy claims processing systems in early 2014. This test validated the capabilities of the FPS system to prevent improper payments in an automated fashion, without the need for human intervention.

CMS has also identified ways that FPS edits could address vulnerabilities in other systematic edits. CMS found that the FPS is more capable of doing a sophisticated data analysis on claims than other systems where edits occur (e.g. the Fiscal Intermediary Standard System (FISS)). The FPS is coded in a way that looks for these types of patterns and still catches the outliers. The FPS also is the only editing system that is built in a manner to allow for the coding of "families" of edits, which are edits that are designed based on similar Medicare policy. Edits that come from edit families are easier to implement, which is an advantage that FPS has over other systems.

CMS continues to develop new edits for implementation on Part A, Part B, and Durable Medical Equipment (DME). An example of a DME edit is one where the patient needs to have a corresponding Part A claim to receive payment for a DME claim. The edit checks a patient's claims history in one system (e.g. the FISS, which processes Medicare Part A and some Medicare Part B claims) to determine eligibility in the ViPs Medicare System (VMS), which processes DME payments.

CMS is also working on FPS edits that measure accumulated services over a rolling time period (for example, five services allowed in a rolling one-year timeframe), such as facet joint injections, or one service is allowed every month (such as intravitreal injections), and deny

payment for services exceeding those limits. Other CMS systems can neither examine one claim at a time nor scrutinize services provided on a single day of service, and successfully prevent improper payments. The FPS system is able to accomplish this data analysis, across time and across Medicare Administrative Contractor (MAC) jurisdictions.

Through collaboration with many stakeholders, CMS has developed a process to identify opportunities for the FPS to standardize editing across all MACs for certain billing scenarios. For example, if multiple MACs have similar Local Coverage Determinations, the FPS can implement a single edit on a nationwide basis, in lieu of having each MAC implement a local edit. The first such edit was launched in 2015.

CMS has launched FPS 2.0 as part of ongoing efforts to improve FPS system capabilities. FPS 2.0, using lessons learned and innovations achieved in predictive analytics and information technology, represents an updated version of the current FPS. A high priority of the improved system will be to reduce the “time to market” for models and edits. Moving from development to production more quickly accelerates the preventative benefits of the FPS edits. CMS will continue the ongoing edit evaluation process and will work toward adding new edits that support the prevention of improper payments through either automatic denial or rejection.

Due to a desire to reflect Small Business Jobs Act (SBJA) statutorily mandated changes in CMS fraud prevention work, and due to difficulties and anomalies in the reporting systems and data collection used to measure goal performance, the design of this goal has considered the changes made to FPS (1.0) during its existence, and those implemented in FPS 2.0. Those changes promoted alignment with CMS initiatives in targeting high risk providers, through a risk-based supplier and provider screening process and the SBJA, which added new requirements to use advanced predictive analytics to identify high risk providers for Medicare fee-for-service claims. With funding authorized in the SBJA, CMS developed the FPS. It is the provisions in these Acts, and the improved tracking system using FPS, that forms the basis for this goal. It is also important to note that while the FPS has enhanced CMS’ capacity to target improper payments, CMS continues to implement policy changes and other initiatives that may have an impact on Medicare improper payments year to year. The methodology of this measure strives to capture only the effects of the FPS edits; larger changes to payment systems may impact the annual measure as well, and should be considered when assessing the outcomes of this measure.

# MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

## QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaboration (NNHQCC)

| Measure | FY | Target | Result |
|---|---|---|---|
| QIO7.1: Making Care Safer: Improve nursing home safety by recruiting under-performing (one star) nursing homes via collaboratives to provide peer-to-peer improvement of Medicare beneficiary health care by end of FY.<br><br>Baseline: Zero (0) | 2018 | Discontinued | N/A |
| | 2017 | 75% | 111% (Target Exceeded) |
| | 2016 | N/A* | N/A* |
| | 2015 | 50% | 72% (Target Exceeded) |
| QIO7.2: Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes | 2020 | TBD | October 31, 2021 |
| | 2019 | 5% | October 31, 2020 |
| | 2018 | 6% | October 31, 2019 |
| | 2017 | Historical Actual | 4.6% |
| | 2016 | Baseline | 8% |

* There are two collaborative time periods. 2016 is a recruitment period with targets in 2017.

More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the nation's 15,600 nursing homes on any given day. Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable, high quality care. Current law requires CMS to develop a strategy that will guide local, state, and national efforts to improve the quality of care in nursing homes. The most effective approach to ensure quality is one that mobilizes and integrates all available tools and resources -- aligning them in a comprehensive, actionable strategy.

In December 2008, CMS added a star rating system to the Nursing Home Compare website. This rating system serves three purposes: 1) to provide residents and their

families with an assessment of nursing home quality; 2) to make a distinction between high and low performing nursing homes; and 3) to provide incentives for nursing homes to improve their performance. A one-star rating is the lowest rating and a five-star rating is the highest. CMS tracks nursing home care quality using this rating system.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of nursing homes and other activities, supported the creation of a National Nursing Home Quality Care Collaborative (NNHQCC). The purpose of the NNHQCC is to ensure, along with its partners, that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO supports the Collaborative's objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction". Although the QIN-QIO recruited nursing homes with an existing star status, all nursing homes or facilities providing long-term care services to Medicare beneficiaries are eligible and encouraged to participate in the Collaborative.

One-star nursing homes face specific challenges, including: lack of understanding of quality improvement processes, lack of resources to implement the processes, poor understanding of the data for use in improvement, lack of consistent leadership, and perhaps lower resident and family engagement. Participation in the NNHQCC involves peer-to-peer learning activities in an "all teach/all learn" environment. This involves both virtual and face-to-face meetings and other quality improvement activities, which help guide the nursing home to engage in the use of facility-specific data for rapid-cycle quality improvement activities. These activities include Plan-Do-Study-Act (PDSA) cycles, to instill systems-level improvement in the individual nursing home. There were two collaborative time periods, and recruitment goals were measured at the start of each collaborative. Continued engagement in collaborative activities is monitored throughout the life of each collaborative, via the facility's individual quality and outcome measures, such as the decreased use of antipsychotic medication in residents with dementia.

The one-star recruitment measure assessed the ability of the QIN-QIO to gain participation in peer-to-peer quality improvement activities, measured by the percentage increase of one-star nursing homes participating in the NNHQCCs, through 2018. Participation ensures safer care received by Medicare beneficiaries residing in the lowest performing nursing homes.

The QIN-QIOs exceeded the recruitment goal of 50 percent by recruiting 72 percent of the total One-Star Category Target Number (SCTN) in the Collaborative I time period. With the re-balancing of the Medicare.gov 5-Star Rating System, effective February 20, 2015, one star homes continued to be recruited by QIN-QIOs as part of Collaborative II in the NNHQCC. For both Collaborative I and II combined, the QIN-QIOs recruited more than 100 percent of the SCTN for the 11$^{th}$ Statement of Work (SOW).

The measure "quality improvement in one star nursing homes" (7.2) tracks the change in the percentage of nursing homes with a one-star quality rating, over time. CMS monitors quality improvement progress generated at the national, QIN-QIO, and nursing home levels

using the quality domain of the Five Star Rating System. The total quality score is one of three domains within CMS' Five Star Rating system, which also rates facilities based on inspections and staffing ratios. As of January 2017, the total quality score is based on data for 13 quality measures for short and long-stay residents, derived from the Minimum Data Set, and 3 claims-based measures for short-stay residents Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide . The QIN-QIO program is focusing on the quality domain of the star rating only, because of its capacity to influence this specific domain most effectively. The target for FY 2020 will be determined when the specific goals and aims of the 12th Statement of Work are finalized. These are still being developed at the time of publication of the FY 2020 Budget.

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 PDSA improvement cycle results, clinical outcomes measures such as falls with major trauma, and measures of quality improvement. Nursing homes participating in the NNHQCC are encouraged to improve quality as a whole rather than focus on any one measure. Therefore, the sixteen measure total quality score appropriately reflects general quality improvement. A reduction in the percentage of homes that receive the lowest quality score would indicate progress in the hardest to reach nursing homes.

## QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Compliant Resolution

| Measure | FY | Target | Result |
|---|---|---|---|
| QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints. | 2020 | TBD | January 15, 2021 |
| | 2019 | 75% QIO Satisfaction | January 15, 2020 |
| | 2018 | 75% QIO Satisfaction | 83.3% (Target Exceeded) |
| | 2017 | 70% QIO satisfaction | 67.8% (Target Not Met) |
| | 2016 | 62% - Baseline | 65.7% (Target Met) |

The primary focus of the Beneficiary and Family Centered Care (BFCC) is to improve healthcare services for Medicare beneficiaries, through the Quality Improvement Organization (QIO) performance of statutory review functions. This includes, but is not limited to: quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment and Labor Act (EMTALA) reviews. Beneficiary satisfaction with the QIO review process has been mixed over the course of the past several years, with concerns raised by patients and families regarding the quality of the reviews and the impartiality of the reviewers.

The BFCC QIOs develop activities that engage patients and families, with the goal of increasing patient knowledge, skill, and confidence in taking an active role in managing patient health care. Engagement in these activities is captured on the Beneficiary Satisfaction surveys. The current survey measures satisfaction for Quality of Care Reviews and Appeals Reviews. The BFCC Oversight and Review Center (ORC) began administering the satisfaction survey in April 2016, beginning with cases closed in November 2015 and continuing to the present. CMS began receiving QIO performance data for satisfaction, beginning in July 2016. The 11$^{th}$ Scope of Work (SOW) survey scoring is used to develop the targets for this goal.

The survey is mailed monthly to randomly-chosen Medicare beneficiaries, who file a Quality of Care Complaint or Appeal, and agree to participate in the survey. Beneficiaries share their views about their experience with the BFCC-QIO and the Medicare Complaint or Appeal process. The survey assesses beneficiary satisfaction in three domains which include:

(1) Effectiveness of the QIO review process; (2) Courtesy & Respect of BFCC-QIO staff in handling a beneficiary's complaint; and (3) Responsiveness of BFCC QIO staff.

For FY 2017, the measure demonstrated improvement, but the target was not met. Survey results revealed that beneficiary satisfaction is approximately 10 percentage points higher for QIO advocacy-based services such as Immediate Advocacy (an alternative dispute resolution process) and Complex Care Management (a health care navigation program), which are designed to assist beneficiaries overcome health care barriers. The FY 2018 measure was met.

## QIO11: Improve Hospital Patient Safety by Reducing Preventable Patient Harms

| Measure | CY | Target | Result |
|---|---|---|---|
| QIO11: Hospital Patient Safety Harm Reduction**<br><br>Baseline: CY 2014: 98 harms per 1,000 discharges based on revised baseline | 2020 | TBD | TBD |
| | 2019 | 78 harms per 1,000 discharges | December 31, 2020 |
| | 2018 | 82 harms per 1,000 discharges | December 31, 2019 |
| | 2017 | 86 harms per 1,000 discharges | 86*<br>(Target Met) |
| | 2016 | Historical Actual | 88 |
| | 2015 | Historical Actual | 92 |

*Data are preliminary based on partial data from this calendar year. The estimates are subject to change after all data from this calendar year are available and all quality control procedures have been completed.

** Targets and Results for this GPRA goal have been revised since the release of the FY 2019 President's Budget due to significant revisions in methodology that impacted the calculation. (See below)

The purpose of this measure is to track national progress on harm reduction in acute care hospitals and assess the impact of patient safety efforts by using a national chart abstracted sample and counting the number of patient harms that take place per 1,000 discharges. Examples of some of the preventable patient harms included in this measure are:

- Adverse Drug Events (ADEs)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Falls
- Pressure Ulcers (PrU), also known as Pressure Injuries
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia/Events (VAP/VAE)
- Venous Thromboembolism (VTE) and
- Hospital Readmissions

These harms can result in additional pain, stress, and even death while increasing treatment costs to both the patient and the Medicare Trust Fund. The Hospital Acquired Condition rate utilizes the Agency for Healthcare Research and Quality's (AHRQ) National Scorecard, which is derived from hospital charts abstracted from a nationally representative sample of charts annually. The sampling methodology includes abstracting clinically relevant, highly standardized national hospital safety metrics. This system is in active operation and was originally put into place to measure national patient safety efforts led by CMS' Hospital Improvement Innovation Network (HIIN). By itself, however, it represents an enormous contribution to the government's ability to measure, monitor, and improve patient

safety at a national scale. As a composite of many different harms, the AHRQ National Score Card also includes data from the Centers for Disease Control (CDC's) National Healthcare Safety Network (NHSN) and AHRQ's Healthcare Cost and Utilization Project (HCUP) databases. Historically, this dataset has allowed the government to demonstrate a reduction in harm from 145 harms per 1,000 discharges in the original baseline year of 2010, to 92 harms per 1,000 discharges in CY 2015. These data demonstrate a reduction in harm to patients of approximately 21 percent over five years (https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html).

Beginning in 2016, the all cause harm metric is being calculated differently due to two significant events that impacted the calculation: Hospital Inpatient Quality Reporting (IQR) Program changes and the ICD-9 to ICD-10 conversion. As a result, the previously reported targets and results for this GPRA goal were adjusted. Specifically, in 2015 and 2016, the IQR Program removed requirements for reporting on care related to four principal clinical conditions; the IQR reported data for these conditions were previously used to sample charts for abstraction. Samples in 2015 and later could only approximate this earlier sample. More significantly, the ICD-10 conversion, which is the International Classification of Diseases, Tenth Revision, Clinical Modification is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States, impacted identification of these four clinical conditions raising uncertainty regarding comparability of data before and after October 2015. Our best solution to this technical problem was to approximate the four condition sample and add a fifth group of charts that reflected the broader set of clinical conditions treated in acute care settings.

CMS anticipates that other changes to the sampling methodology will need to be made after 2019 based on improved definitions and sampling methodology, requiring another realignment of targets for 2020 and beyond.

The newly measured declines in hospital-acquired conditions parallel the earlier gains achieved between 2010 and 2014 where hospital-acquired conditions overall dropped 17 percent, saving $19.9 billion in health care costs and preventing 87,000 deaths. Between the revised 2014 baseline and 2016, we achieved an 11% decline resulting in an estimated 530,000 fewer hospital acquired conditions - 13,100 lives saved from harms avoided and $4.7 billion in costs saved. To review the full HAC report please see: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf

CMS has committed to a 20% reduction in all cause harm by 2019. The proposed 2019 target is a 20 percent reduction in patient harms, compared to the 2014 baseline (annualized reduction [-4.4%] applied for 5 years). Given the progress to date and the active intervention of HIINs, CMS and AHRQ believe that this is a challenging yet achievable goal. CMS will leverage the momentum and lessons learned from the prior harm reductions made to continue to drive down harm and support the Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO) improvement efforts. CMS has made patient safety an essential component of its work in protecting beneficiaries through the QIN-QIO Program and alignment across multiple networks will permit the systematic use of innovative patient safety practices at a national scale. Integration presents unique opportunities to leverage scope and scale in achieving patient safety goals and multiple

programs contribute to this effort such as the Hospital Acquired Condition (HAC) Reduction Program and the Inpatient Prospective Payment System (IPPS).

Final data for 2017 are expected at the end of 2019 to determine if the reductions achieved between 2014-2016 have continued. The data that will be used to confirm CMS' achievement of the 20% decrease by 2019 is expected to be available in preliminary form in December 2020, and final in CY 2021.

# MEDICARE BENEFITS

## MCR1: Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (FFS) who report access to care*<br><br>Baseline: 91%<br><br>(FY 2007) | 2020 | Contextual Indicator | December 31, 2020 |
| | 2019 | Contextual Indicator | December 31, 2019 |
| | 2018 | Contextual Indicator | 91% |
| | 2017 | Contextual Indicator | 91% |
| | 2016 | Contextual Indicator | 90% |
| | 2015 | 90% | 91%<br>(Target Exceeded) |
| | 2014 | 90% | 91%<br>(Target Exceeded) |
| | 2013 | 90% | 91%<br>(Target Exceeded) |
| MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care *<br><br>Baseline: 90%<br><br>(FY 2007) | 2020 | Contextual Indicator | December 31, 2020 |
| | 2019 | Contextual Indicator | December 31, 2019 |
| | 2018 | Contextual Indicator | 91% |
| | 2017 | Contextual Indicator | 91% |
| | 2016 | Contextual Indicator | 90% |
| | 2015 | 90% | 90%<br>(Target Met) |
| | 2014 | 90% | 90%<br>(Target Met) |
| | 2013 | 90% | 91%<br>(Target Exceeded) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

CMS has monitored Medicare FFS and MA access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS is continuing to monitor FFS and MA access to care in order to maintain the same high rates for its 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) that report they usually or always get needed care right away, as soon as they thought they needed it." CMS has met or exceeded its targets for this goal since the inception of the goal. Since FY 2016, CMS has reported the data trend annually as a contextual measure. High rates have continued for this 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

| Measure | FY | Target | Result |
|---|---|---|---|
| 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 | 2020 | 25% | April 30, 2022 |
| | 2019 | 28% | April 30 2021 |
| | 2018 | 37% | April 30, 2020 |
| | 2017 | 43% | April 30, 2019 |
| | 2016 | 48% | 48% (Target Met) |
| | 2015 | 50% | 49% (Target Exceeded) |
| | 2014 | 53% | 53% (Target Met) |
| | 2013 | 55% | 52% (Target Exceeded) |
| | 2012 | 58% | 57% (Target Exceeded) |
| | 2011 | 60% | 57% (Historical Actual) |
| | 2010 | N/A | Baseline = 100% |

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). For 2019, this "gap" in coverage is above $3,820 in total drug costs, and up until a beneficiary spends $5,100 out-of-pocket.

Since 2011, brand-name (applicable) pharmaceutical manufacturers have been required to provide a 50 percent discount on the negotiated price of their drugs while a beneficiary is in the coverage gap. Public Law No. 115-123, also known as the Bipartisan Budget Act of 2018 (BBA), enacted on February 9, 2018, increased the manufacturer discount for beneficiaries in the gap from 50 to 70 percent and reduced beneficiary cost sharing to 25 percent in 2019 for applicable drugs. The BBA's change to the Coverage Gap Discount Program was such that the gap for brand drugs closed a year earlier than had been established in the MMA. The discount is applied at the point of sale, and both the beneficiary cost sharing and the manufacturer discounts counts toward the annual out-of-

pocket threshold (known as True Out-of-Pocket Costs or TrOOP). Since 2013, Part D Plans have been required to cover a portion of the costs of applicable drugs in the coverage gap as well, with this coverage increasing over time from 2.5 percent in 2013 to 25 percent for 2018. However, because of changes made in the BBA that shift more liability to manufacturers, plans will now be responsible for just 5 percent of applicable drugs costs in the gap for 2019 and beyond. Since 2011, Part D Plans have also been required to cover a portion of the costs for generic drugs in the coverage gap, starting with 7 percent in 2011 and increasing to 75 percent for 2020 and beyond. Notably, the BBA did not change the existing schedule for beneficiary cost sharing for non-applicable drugs (generics). This performance measure reflects CMS' effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy (LIS) Medicare beneficiaries while in the coverage gap. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap, making this coverage equivalent to coverage prior to reaching the gap.

CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (57% compared to 58% in 2012, 52% compared to 55% in 2013), and 49% compared to 50% in 2015). The statute which established the Coverage Gap Discount Program gave CMS the authority to authorize exceptions to requiring that drugs be covered under the agreement (Section 1860D-43 (C) in extenuating circumstances. However, CMS has successfully encouraged all manufacturers of applicable drug products to participate in the program, which has resulted in the consistent application of discounts for all branded products. Furthermore, the infrastructure which has been put in place treats manufacturers fairly, which has resulted in manufacturers choosing to stay in the program. Specifically it has: 1) allowed public access to information about which manufacturers are participating in the program, and 2) offered an equitable process for manufacturers to dispute invoiced amounts. This has occurred without any meaningful decreases in plan participation in the Part D market. As generic utilization in the Part D program has remained static, and very high (over 75% since 2012), that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the coverage gap discount program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

# CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

## CHIP3: Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid

| Measure | FY | Target | Result |
|---|---|---|---|
| CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid*<br><br>2008 Baseline: 37,311,641 children | 2020 | 46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579) | March 31, 2021 |
| | 2019 | 46,556,502 children (Medicaid - 37,245,202/CHIP - 9,311,300) | March 31, 2020 |
| | 2018 | 46,440,401 children (Medicaid – 37,152,321/CHIP – 9,288,080) | March 31, 2019 |
| | 2017 | 46,062,581 children (Medicaid – 36,850,065/CHIP – 9,212,516 | 46,322,217 children (Medicaid – 36,862,057/CHIP – 9,460,160)<br>(Target Exceeded) |
| | 2016 | 45,271,662 children (Medicaid – 36,217,330/CHIP – 9,054,332) | 45,980,595 children (Medicaid - 37,080,521/ CHIP - 8,900,074)<br>(Target Met) |
| | 2015 | 47,642,385 children (Medicaid – 38,920,959/CHIP – 8,721,426) | 45,201,455 children (Medicaid – 36,834,253/CHIP – 8,367,202)<br>(Target Not Met) |
| | 2014 | 46,617,385 children (Medicaid – 38,083,596/CHIP – 8,533,789) | 43,689,824** children<br>(Target Not Met) |
| | 2013 | 45,592,385 children (Medicaid – 37,246,233/CHIP – 8,346,152) | 45,292,410 children (Medicaid – 37,198,483/CHIP – 8,093,927)<br>(Target Not Met) |

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

** CMS is unable to provide the Medicaid/CHIP enrollment totals for 2014 due to state data limitations.

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 46,672,893 children by the end of FY 2020. Under the CHIP and Medicaid programs, States submit quarterly and annual statistical forms, which report the number of children who are 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.

This measure should be considered in the context of a recent Urban Institute analysis (*Health Affairs*) highlighting 2016 data that show that nationally, 93.7 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 45 states. In contrast, in 2008, only five States had participation rates of at least 90 percent. With such gains in increasing children's participation in Medicaid and CHIP, it is important to note that the remaining eligible uninsured children will be the hardest to reach. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with its State and Federal partners, continuing to implement statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering its data collection activities.

Many factors affect enrollment figures in CHIP and Medicaid, including states' economic situations, programmatic changes, efficiency of state eligibility and enrollment processes, and the accuracy and timeliness of state reporting.

Considerable investments have been made to modernize eligibility verification procedures to rely primarily on electronic data sources, while providing states flexibility to determine the usefulness of available data before requesting additional information from applicants, and simplifying verification procedures for states through the operation of a federal data services "Hub" that links states with federal data sources. Retention in Medicaid and CHIP is strengthened by the new renewal policies which require that eligibility is renewed by first evaluating the information available through existing data sources, and then limiting renewals for the beneficiaries to once every 12 months, unless a beneficiary reports a change, or the agency has information to prompt a reassessment of eligibility.

Recent legislation extended CHIP for ten years. The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through September 30, 2023, and the ACCESS Act, as included in P.L. 115-123, provides CHIP funding for an additional four years, for FY 2024 through FY 2027. The HEALTHY KIDS Act and the ACCESS Act also included provisions related to the extension and reduction of federal financial participation for CHIP and maintenance of effort for children's Medicaid and CHIP coverage, and the extension of express lane eligibility and the Connecting Kids to Coverage Outreach and Enrollment Program.[2] Through the HEALTHY KIDS Act and the ACCESS Act, the Connecting Kids to Coverage Outreach and Enrollment grants and National Campaign, received $120 million in funding for outreach and enrollment activities through FY 2023, and $48 million for FY 2024 to FY 2027. The Connecting Kids to Coverage grants and National Campaign fund activities are aimed at reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled, and improving retention of eligible children who are currently enrolled.[3] On November 30, 2018, CMS issued the Connecting Kids to Coverage HEALTHY KIDS 2019 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which will make available $48 million in cooperative agreements to states, local governments, Indian tribes, tribal consortium, urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act, federal health safety net organizations, community-based organizations, faith-based organizations, and

[2] Key provisions of the HEALTHY KIDS Act and the ACCESS Act are described in State Health Official Letter# 18-010.

[3]Enrollment grants have been awarded to a variety of community organizations—such as health care providers, schools, tribal organizations, and other types of nonprofits—through four, two-year funding cycles since 2009. Thus far, over 230 entities have received Connecting Kids to Coverage grants. The National Campaign conducts training webinars and works with partners on outreach, creates and updates existing outreach print materials, produces new social media graphics, and publishes a newsletter that has over 30,000 subscribers.

schools. The estimated award amount per grant is $500,000 to $1.5 million over a performance period of three years. CMS anticipates announcing the award recipients in June 2019, with the grant performance period beginning in July 2019.

Prior to these recent extenders, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), extended CHIP funding for two years, through September 30, 2017. MACRA also provided $40 million for the Connecting Kids to Coverage Outreach and Enrollment grants and National Campaign. The ACA extended federal CHIP funding for two years through September 30, 2015.

With 93.7 percent of eligible children enrolled in Medicaid and CHIP in 2016, effective and targeted strategies are needed to enroll the remaining 6.3 percent of eligible uninsured children. As noted above, the remaining eligible but uninsured children are the hardest to reach.

# CENTER OF MEDICARE AND MEDICAID INNOVATION (CMMI)

## CMMI2: Identify, Test, and Improve Payment and Service Delivery Models

| Measure | FY | Target | Result |
|---|---|---|---|
| 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.<br><br>Baseline: 1.0<br><br>FY 2014 | 2020 | 8.0 | November 30, 2020 |
| | 2019 | 7.0 | November 30, 2019 |
| | 2018 | 6.0 | 6<br>(Target Met) |
| | 2017 | 5.0 | 5<br>(Target Met) |
| | 2016 | 4.0 | 4<br>(Target Met) |
| | 2015 | 3.0 | 3<br>(Target Met) |

CMS 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 that 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 CMS is making toward sustainable success of its models. As of September 30, 2018, six Section 1115A model tests, [Pioneer Accountable Care Organization (ACO), Diabetes Prevention Program (DPP), Comprehensive Care for Joint Replacement (CJR), Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT), Maryland All-Payer, and Next Generation ACO (NGACO)], have met this goal, according to data received to date. The Pioneer ACO model was certified by the CMS Office of the Actuary (OACT), 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. The DPP model also has been certified by OACT 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. Performance year 1 evaluation results for CJR (Q2-Q4 2016) show that the total Medicare payments for Lower Extremity Joint Replacement (LEJR) episodes decreased by $910 per episode (3.3%), while maintaining quality. The RSNAT first interim evaluation shows average quarterly per beneficiary spending on Medicare ambulance services for beneficiaries with End-Stage Renal Disease (ESRD), declined by $523, for a 72% decrease. Average quarterly spending on total Medicare Part A and B

services for this group declined by $530, or almost 4%. For the Maryland All-Payer model, evaluation data show $679 million in total cost of care savings over the first three years of the model, amounting to almost a 3% reduction in Medicare spending. Finally, the first-year evaluation report for the Next Generation ACO (NGACO) model shows Medicare savings of approximately $100 million (1.7% of Medicare spending). For other 1115A models, CMS continues to assemble and assess the evidence as it becomes available. Note that results can fluctuate based on new and updated evaluation results and policy decisions. CMS targets are intended to increase the number of models indicating positive results to seven in FY 2019 and eight in FY 2020, consistent with the evidence available to date.

## CMMI3: Accelerate the Spread of Successful Practices and Models

| Measure | FY | Target | Result |
|---|---|---|---|
| CMMI3.1: Percentage of Medicare Beneficiaries Participating in Innovation Center models<br><br>Baseline: 2014 5% | 2020 | Contextual Indicator | November 30, 2020 |
| | 2019 | Contextual Indicator | November 30, 2019 |
| | 2018 | Contextual Indicator | 17% |
| | 2017 | Contextual Indicator | 13% |
| | 2016 | Contextual Indicator | 9% |
| | 2015 | Contextual Indicator | 9% |
| CMMI3.2: Number of States Developing and Implementing a Health System Transformation and Payment Reform Plan<br><br>Baseline: 2014 25 | 2020 | 11 | November 30, 2020 |
| | 2019 | 15 | November 30, 2019 |
| | 2018 | 16 | 16<br>(Target Met) |
| | 2017 | 17 | 20<br>(Target Exceeded) |
| | 2016 | 38 | 38<br>(Target Met) |
| | 2015 | 38 | 38<br>(Target Met) |
| CMMI3.3: Number of Providers Participating in Innovation Center Models<br><br>Baseline: 2014 < 60,000 | 2020 | Contextual Indicator | November 30, 2020 |
| | 2019 | Contextual Indicator | November 30, 2019 |
| | 2018 | Contextual Indicator | 574,467 |
| | 2017 | Contextual Indicator | 219,719 |
| | 2016 | Contextual Indicator | 103,291 |
| | 2015 | Contextual Indicator | 61,000 |

| | | | |
|---|---|---|---|
| CMMI3.4: Increase the Percentage of Active Model Participants who are Highly Engaged in Innovation Center or Related Learning Activities<br><br>Baseline: 2014 56% | 2018 | Discontinued | N/A |
| | 2017 | 59.7% | 47.6%<br>(Target Not Met) |
| | 2016 | 64.5% | 56.9%<br>(Target Not Met) |
| | 2015 | 61.0% | 58.6%<br>(Target Not Met) |
| CMMI3.5: Percentage of Model Awardees Participating in Learning Activities<br><br>Baseline: 2018 TBD | 2020 | TBD | November 30, 2021 |
| | 2019 | TBD | November 30, 2020 |
| | 2018 | Baseline TBD | November 30, 2019 |

Through its mission, CMMI aims to "test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished" to Medicare, Medicaid, and CHIP beneficiaries. Every CMMI 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. CMMI also strives to understand the level of participation from beneficiaries, providers, states, payers, and other stakeholders to effectively design, test, and evaluate its portfolio of models.

To date, CMMI has introduced a wide range of Medicare initiatives – involving a broad array of Medicare Fee-for-Service (FFS) beneficiaries, health care providers, states, payers, and other stakeholders. In FY 2014, nearly 2.7 million Medicare FFS beneficiaries participated in CMS model tests compared to FY 2018, where more than 7.3 million Medicare FFS beneficiaries participated in CMS models, representing approximately 17 percent of Medicare FFS beneficiaries. As a contextual indicator, CMMI3.1 provides a snapshot of Medicare beneficiary model participation at a given point in time (not cumulative participation), in models that have been operational for more than 6 months. The methodology for the numerator includes Part A and B FFS beneficiaries and the denominator reflects total Medicare Part A FFS beneficiaries.

States play a critical role in determining the effectiveness of the health care system and the health of their populations. In addition to being health care payers for 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, and convening ability. CMS provides funding and technical assistance to states to test states' ability to utilize these levers in the design or testing of new payment and service delivery models that have the potential to

reduce health care costs and increase the quality of care delivery in Medicare, Medicaid, Children's Health Insurance Program, and in collaboration with commercial healthcare systems. In FY 2014, 25 participating State Innovation Model (SIM) states designed or implemented a health system transformation and multi-payer payment reform strategy. In FY 2015, CMS reported an additional 9 states, 3 territories, and the District of Columbia (38 in total), were committed to designing or testing new SIM payment and service delivery models in exchange for financial and technical support. By FY 2016, these 38 states continued designing and testing new payment and service delivery models. In FY 2017, the state count was 20, which included three All-Payer models with formal Medicare Alternative Payment Models (APM) participation, and 17 SIM states that continued testing and improving their health system transformation and payment reform plans. CMS saw a reduction in the number of SIM states in FY 2017, due to the design award project period ending, as intended by the program. In FY 2018, the CMMI3.2 target of 16 states to test their delivery system and payment transformation plans, which included the All-Payer models, was met.

To accelerate the development and testing of new payment and service delivery models, CMS recognizes that many robust ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. CMMI3.3 seeks to understand the level of interest and participation among providers in CMS' model portfolio. CMS estimated that the number of participating providers in its payment and service delivery models was more than 60,000 in FY 2014, approximately 61,000 in FY 2015, 103,291 in FY 2016, 219,719 in FY 2017, and 574,467 in FY 2018.

CMS has created learning collaboratives for providers and other model participants to promote the broad and rapid dissemination of lessons learned and of promising practices that have the potential to deliver higher quality and lower cost of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Every 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 engaged in learning activities, including Pioneer Accountable Care Organizations (Pioneer ACO), the Comprehensive Primary Care (CPC) initiative, and Health Care Innovation Awards Round 1 (HCIA1), as measured by CMMI3.4

By FY 2017, 47.6 percent of model participants were participating in learning systems through eight models, including the ACO Investment Model (AIM), the Comprehensive End-stage Renal Disease (ESRD) Care Initiative (CEC), Next Generation ACO, the Bundled Payments for Care Improvement (BPCI) Models, the Comprehensive Care for Joint Replacement (CJR) Model, HCIA2, the Oncology Care Model (OCM), and the Strong Start Model. These models were included because they had been operational for more than 6 months as of September 30, 2016, were currently receiving learning system support, and had learning system data to report. Pioneer ACO and CPC have been dropped, since the testing period for those models has ended. Embedded within CMMI3.4 report totals are wide range of learning events, including: all awardee events, regional webinars, action groups, affinity groups, in-person learning events, and office hours.

While the methodology for calculating the FY 2017 result stayed the same, one reporting change was made in 2017. For multiple model events, the FY 2017 report captures the hosting model (the model leading the event) participant attendance only. Non-host model attendees tend not to show up as predictably as host model attendees and for this reason,

targets and attendee counts for non-host model participants were not included in the count for multiple model events in 2017.

The 2017 participation rate of 47.6 percent fell short of the 59.7 percent target. As learning systems have matured, CMS has learned the importance of having more learning event options, to support model participants' wide range of needs. The result is a slightly lower participation rate for each event. In addition, CMS determined that the target for some of the learning events included participants for whom the event was not intended. For this reason, CMS improved the calculation methodology in a new measure (CMMI3.5) effective FY 2018. As we move into future model support, CMS continues to optimize measurement of the content and delivery of learning events, to deliver best practices in a participant-centered format.

# CMS DISCONTINUED PERFORMANCE MEASURES

## Program Operations Discontinued Measures

### MSC2: Percentage of States that Survey All Nursing Homes at Least Every 15 Months

This measure evaluates CMS' and survey partners' success in meeting core statuary obligations for carrying out surveys with routine frequency, to assure quality of care to residents of the nation's nursing homes. CMS has in place a monitoring system that requires the CMS Regional Offices to review compliance with the nursing home survey interval requirement in each of their States annually, and State Survey Agencies follow up with Corrective Actions, as necessary. These safeguards ensure continued focus in this important area, so this goal is being discontinued.

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC2: Percentage of States that survey nursing homes at least every 15 months | 2018 | Discontinued | NA |
| | 2017 | 97% | 81% (Target Not Met) |
| | 2016 | 97% | 86% (Target Not Met) |
| | 2015 | 97% | 94% (Target Not Met) |
| | 2014 | 97% | 84% (Target Not Met) |
| | 2013 | 97% | 87% (Target Not Met) |
| | 2012 | 97% | 83% (Target Not Met) |
| | 2011 | 97% | 86% (Target Not Met) |
| | 2010 | 95% | 87% (Target Not Met) |
| | 2009 | 85% | 96% (Target Exceeded) |
| | 2008 | 80% | 96% (Target Exceeded) |

## MSC3: Percentage of States That Survey All Home Health Agencies at Least Every 36 Months

Federal statute requires that every Home Health Agency (HHA) be surveyed at least once every 36 months. States that do not complete all required surveys have the dollar value of "non-delivered surveys" deducted from their subsequent budget allocation. This measure quantifies CMS' and its survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency. Routine surveys are used to assure quality care to beneficiaries who receive care from the nation's HHAs. However, state Survey Agencies (SA) continue to experience issues with hiring limitations, due to individual state government budgets, issues with frequent surveyor turnover, which then impedes the ability of some SAs to complete their HHA workload. CMS has in place a monitoring system that requires the CMS Regional Offices to review compliance with the HHA interval requirement in each of their states annually and any discrepancies are reported to SAs to make adjustments to comply. Given ongoing challenges and the safeguards in place by CMS, this goal is being discontinued.

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC3: Percentage of States that survey Home Health Agencies at least every 36 months | 2018 | Discontinued | N/A |
| | 2017 | 96% | 73% (Target Not Met) |
| | 2016 | 96% | 81% (Target Not Met) |
| | 2015 | 96% | 96% (Target Met) |
| | 2014 | 96% | 86% (Target Not Met) |
| | 2013 | 96% | 90% (Target Not Met) |
| | 2012 | 96% | 83% (Target Not Met) |
| | 2011 | 95% | 85% (Target Not Met) |
| | 2010 | 90% | 81% (Target Not Met) |
| | 2009 | 75% | 94% (Target Exceeded) |
| | 2008 | 70% | 94% (Target Exceeded) |

## MCR25: Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit

The Medicare Annual Wellness Visits (AWVs) benefit is available to Medicare beneficiaries with no copayments or other cost-sharing, if the doctor or other health care provider accepts assignment. This measure, tracked as a contextual indicator since 2015, reflected beneficiary awareness and utilization of this benefit. Originally, the main intervention for increasing awareness of this new benefit to Medicare beneficiaries, was funded outreach and publicity, and CMS tracked modest increases in the measure. There are no significant interventions that CMS currently has planned that will influence whether Medicare beneficiaries avail themselves of the AWV, and since there are no levers to move the number, CMS has discontinued the goal. Additional information about preventive services provided to Medicare beneficiaries is available at Medicare.gov.

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR25: Increase the number of Medicare Part B beneficiaries who receive an annual wellness visit<br><br>Baseline: 2.3 million<br><br>CY 2011 | 2018 | Discontinued | N/A |
| | 2017 | Contextual Indicator | 8.31 million |
| | 2016 | Contextual Indicator | 7.16 million |
| | 2015 | Contextual Indicator | 6.02 million |
| | 2014 | 3.2 million | 4.9 million (Target Exceeded) |
| | 2013 | 2.8 million | 4.1 million (Target Exceeded) |
| | 2012 | Baseline set with CY 2011 data | 3.2 million (Target Met) |
| | 2011 | N/A | N/A |

## MCR28: Reduce Healthcare-Associated Infections

CMS has been successful in its intra-Agency partnership goal to reduce Catheter-Associated Urinary Tract Infections (CAUTI) in hospitals. CMS introduced a new goal to improve Hospital Safety by Reducing Preventable Patient Harms (QIO11). This composite goal is to reduce overall hospital harms using a constellation of measures, including CAUTI. As a result, the CAUTI goal is being discontinued as of FY 2018.

| Measure ID | FY | Target | Result |
|---|---|---|---|
| MCR28.2: Reduce by 10%[1] hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2017 | 2018 | Discontinued | N/A |
| | 2017 | 10% | 13% decrease (Target Met) |
| | 2016 | 5% | 5% decrease (Target Met) |
| | 2015 | 10%[2] | 10% decrease (Target Met) |
| | 2014 | 5% | 4.9% decrease (Target Not Met) |
| | 2013 | 20% | +12% increase (Target Not Met) |
| | 2012 | 10% | +17% increase (Target Not Met) |

[1] The FY2017 target is a 10% reduction, equating to a national CAUTI SIR of 0.90 (from 1.0 to 0.90). CDC reset the national CAUTI SIR baseline to 1.0 in FY 2015.

[2] The final CAUTI target will be a 10% reduction in the national CAUTI SIR from baseline or a target SIR of 0.93. (Note: the October 31, 2014 report noted an end CAUTI SIR of 1.02.)

## MCR30: Shift Medicare Health Care Payments from Volume to Value

Health care costs consume a significant amount of the 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.

This measure identifies, tests, evaluates, and expands innovative payment and service delivery models. These innovative payment models can reduce program expenditures, while improving or preserving beneficiary health and quality of care. These alternative payment models (APMs) create new incentives for clinicians to deliver better care at a lower cost. While CMS made progress in 2017, it fell short of its target of 40 percent.

To reflect Administration priorities and focus, CMS is discontinuing the MCR30 goal after 2018, and is developing a new goal (MCR36), measuring the development and launch of new models that will increase the percentage of Medicare health care dollars to APMs that take into account the downside risk (see *MCR36: Increase the percentage of Medicare health care dollars tied to Alternate Payment Models (APMs) incorporating downside risk).

| Measures | CY | Target | Result Available |
|---|---|---|---|
| MCR30.1: Alternative payment models<br><br>Baseline: Calendar Year (CY) 2014: 22%<br><br>Increase the percentage of Medicare Fee-for-Service (FFS) Payments Tied to Alternative Payment Models | 2019 | *Discontinued | N/A |
| | 2018 | 50% | November 30, 2019 |
| | 2017 | 40% | 38%<br>(Target Not Met) |
| | 2016 | 30% | 31%<br>(Target Met) |
| | 2015 | 26% | 26%<br>(Target Met) |

## PHI2: Increase the Number of Young Adults Ages 19-25 who are Covered as a Dependent on Their Parent's Employer-Sponsored Insurance Policy

This goal focused on the number of young adults under age 26 that were newly-allowed to continue health insurance coverage under their parent's employer-sponsored insurance policy. The estimated number of adult children covered as dependents on a parent's insurance policy increased from 11.0 million in FY 2015 to 11.1 million in FY 2016. The underlying data on the number of potentially-affected individuals were derived from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). While CMS will continue to monitor compliance with the requirement that issuers offer coverage for young adults ages 19 to 25, CMS will discontinue reporting on this goal as of FY 2018.

| Measure | CY | Target | 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 | 2018 | Discontinued | N/A |
| | 2017 | Contextual indicator | 10.9 million |
| | 2016 | Contextual indicator | 11.1 million |
| | 2015 | Contextual indicator | 11.0 million |
| | 2014 | 9.7 million | 10.8 million (Target Exceeded) |
| | 2013 | 9.7 million | 10.5 million (Target Exceeded) |
| | 2012 | 8.7 million | 10.2 million (Target Exceeded) |
| | 2011 | 8.4 million | 9.5 million (Target Exceeded) |
| | 2010 | Historical Actual | 8.3 million |
| | 2009 | Baseline | 7.3 million |

## PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Exchanges

This goal focused on the number of individuals with confirmed enrollment through the Exchanges. The CY 2016 target was 10 million individuals enrolled and the CY 2017 target was 11.4 million enrollees. The December 2017 effectuated enrollment was 8,916,244, and can be found in the 2018 Effectuated Enrollment Snapshot. CMS will discontinue reporting on this goal as of FY 2018.

| Measure | CY | Target | Result |
|---|---|---|---|
| PHI5: Track the number of individuals who have confirmed enrollment through the Affordable Insurance Exchanges | 2018 | Discontinued | N/A |
| | 2017 | 11.4 million | 8,916,244 |
| | 2016 | 10 million | 9,115,154 |
| | 2015 | 9.0 million | 8,780,545 |
| | 2014 | Baseline | 6,337,860 |

## PHI7: Maintain or Reduce Percent of Population Who are Uninsured by Providing Increased Access to Health Care through Private Insurance, Medicaid, and CHIP

This contextual indicator tracked the percentage of the United States civilian non-elderly, non-institutionalized population who were uninsured. The indicator tracked the impact of various legislative and administrative policies on health insurance coverage and served as a baseline while the Administration considered additional health care reforms to expand choice, increase access, and lower premiums. The Administration remains committed to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improve the risk pool, and bring stability and certainty to the individual and small group markets, while increasing the options for patients and providers. CMS will discontinue reporting on this contextual measure as of FY 2018.

| Measure | CY | Target | Result |
|---|---|---|---|
| PHI7: Percentage of the Non-elderly United States Population Who are Uninsured (Civilian, Non-institutionalized)<br><br>Baseline: 18.20%<br><br>CY 2010 | 2018 | Discontinued | N/A |
| | 2017 | Contextual Indicator | 10.7% |
| | 2016 | Contextual Indicator | 10.4% |
| | 2015 | Historical Actual | 10.5% |
| | 2014 | Historical Actual | 13.3% |
| | 2013 | Historical Actual | 16.6% |
| | 2012 | Historical Actual | 16.9% |
| | 2011 | Historical Actual | 17.3% |

## Medicare Quality Improvement Organizations Discontinued Measures

### QIO9: Improve Health Outcomes for Medicare Beneficiaries by Providing Technical Assistance (TA) Support Related to Value-Based Payment and Quality Improvement Programs to the Eligible Clinician Population Working in Ambulatory Care Settings

The purpose of this measure was to ensure broad-reaching national access to technical assistance (TA) for clinicians in clinical practices, in order to support successful participation in value-based payment and quality improvement programs. Programs provided TA through Learning and Action Network (LAN) events and/or direct TA. These LAN events included topics related to improving health outcomes for beneficiaries and improving care coordination and costs, related to care. Measuring the reach of TA across programs ensured these programs achieved successful outcomes. CMS Administrator Seema Verma publicly communicated the successful results in a May 2018 blog post: https://blog.cms.gov/2018/05/31/quality-payment-program- exceeds-year-1-participation-goal/. CMS will discontinue reporting on this goal as of FY 2020.

| Measure | FY | Target | Result |
|---|---|---|---|
| QIO9: Increase Clinician Practice Technical Support | 2020 | Discontinued | N/A |
| | 2019 | 90% | April 30, 2020 |
| | 2018 | *540,000 (90% of 600,000 eligible clinicians) | April 30, 2019 |
| | 2017 | *510,000 (85% of 600,000 eligible clinicians) | 77% (Target Not Met) |

* The FY 2017 and FY 2018 actual and confirmed data, for FY 2017, using the validated denominator (eligible clinician count), was 511,590 and 254,635 respectively. The FY 2018 target of 540,000 will not be met as the denominator is less than half of the target. The target numbers for FY 2017 and FY 2018 were generated using early estimates of MIPS-eligible clinicians.

## 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 Arteriovenous Fistula (AVF) or Graft

The intent of this measure is to encourage and support the safest hemodialysis, to reduce harm in dialyzing patients and reduce costs associated with infections.

In 2016 the results of this measure to reduce the rate of patients dialyzing with a long term catheter (LTC) did not meet the projected target of one percent relative improvement. CMS learned that the former methodology used to measure the rate of improvement was flawed and did not accurately reflect the rate of LTC use and improvement. The former methodology for measurement and reporting utilized any vascular access type (AVF, AVG CVC, and LTC) as the denominator, and the current rate of LTC as the numerator. Using a snapshot of LTC rate for the numerator does not take into consideration patients constantly being added and removed from the current numerator, based on multiple factors. These factors include new patients not yet on a more permanent access type added to the pool of patients, patients with AVF and AVG who are waiting for access maturity, deaths, and other factors. Patients ineligible for a more permanent access due to co-morbidities, age-related and/or heart-related issues, and patients with weakened or compromised vascularity were not removed from the denominator. As a result, CMS was unable to utilize its former numerator and denominator to accurately capture and measure the rate of improvement. An additional factor is that the time frame of "long term" for LTC catheters, is defined as greater than or equal to 90 days. New ESRD patients may receive dialysis immediately, however, their Medicare benefits (which would pay for converting a catheter to AVG or AVF) require a 90 day waiting period. Both AVG and AVF must mature (30-90 days or beyond) before they can be utilized for dialysis.

CMS learned that the methodology used to measure the rate of improvement did not accurately reflect the rate of LTC use and improvement, and is being revised. The results of the FY 2016 QIO10 measure to reduce the rate of patients dialyzing with a LTC, did not meet the projected target of 1 percent relative improvement. The flaws in the current methodology meant that CMS would never meet its intended targets. As a result, this goal is being discontinued as of FY 2018. Refer to MCR 35 for the new performance goal.

| Measure | FY | Target | Result |
|---|---|---|---|
| QIO10: Decrease the rate of long-term central venous catheter (CVC) use among prevalent patients*<br><br>Baseline: FY 2015: 10.8% | 2018 | 1% Relative Improvement over 2017 baseline | Discontinued |
| | 2017 | 1% Relative Improvement over 2016 baseline | Discontinued |
| | 2016 | 1% Relative Improvement over 2015 baseline | 10.9 (Target Not Met) |

* Prevalent patients are those on renal replacement therapy, excluding patients with acute renal failure, those with chronic renal failure who die before receiving treatment for ESRD, and those whose ESRD treatments are not reported to CMS.

## Center for Medicare and Medicaid Innovation Discontinued Measures

### ACO1: Reduce the Growth of Health Care Costs while Promoting Better Health and Health Care Quality through Delivery System Reform

This measure focuses on Accountable Care Organizations (ACOs), which are groups of physicians, providers and suppliers that work together to coordinate care for beneficiaries with original Medicare fee-for-service health coverage. These ACOs enter into agreements with CMS, taking responsibility for the quality care they provide to Medicare beneficiaries, in return for the opportunity to share in savings realized through care improvement. CMS is no longer singling out a particular class of model in these revised goals. ACOs are one of several areas that CMS focuses on. Instead, CMS is focusing on measures that cut across the portfolio of models. As a result, CMS is discontinuing this goal as of FY 2018.

| Measure | CY | Target | Result |
|---|---|---|---|
| ACO1.1: Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations<br><br>Baseline: 4,002,532 | 2018 | Discontinued | N/A |
| | 2017 | Total Estimate= 9,920,000 | Total Actual = 10,253,676 (Target Exceeded) |
| | 2016 | Total Estimate= 8,710,000 | Total Actual = 8,669,462 (Target Not Met) |
| | 2015 | Total Estimate= 7,090,000 | Total Actual = 7,731,655 (Target Exceeded) |
| | 2014 | Total Estimate= 5,425,000 | Total Actual= 5,954,342 (Target Exceeded) |
| | 2013 | Baseline | Total Actual= 4,002,532 |
| ACO1.2: Increase the number of physicians participating in an Accountable Care Organization<br><br>Baseline: 102,717 | 2018 | Discontinued | N/A |
| | 2017 | Total Estimate= 275,200 | Total Actual = 305,337 (Target Exceed) |
| | 2016 | Total Estimate= 266,600 | Total Actual = 274,075 (Target Exceeded) |
| | 2015 | Total Estimate= 178,000 | Total Actual = 195,212 (Target Exceeded) |
| | 2014 | Total Estimate= 150,000 | Total Actual = 132,148 (Target Not Met) |
| | 2013 | Baseline | Total Actual = 102,717 |
| ACO1.3: Increase the percentage of Accountable Care Organizations that share in savings<br><br>Baseline: 34% | 2018 | Discontinued | N/A |
| | 2017 | Total Estimate = 37% | 41.59% (Target Exceeded) |
| | 2016 | Total Estimate = 36% | 39.35% (Target Exceeded) |
| | 2015 | Total Estimate = 37% | 34% (Target Not Met) |
| | 2014 | Total Estimate = 35% | 34% (Target Not Met) |
| | 2013 | Baseline | CMS Baseline Result = 34% |