DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2016

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) 2016 performance budget. Our programs will touch the lives of over 126 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2016. In addition, we expect millions of consumers to be enrolled in coverage through the Health Insurance Marketplaces in FY 2016. We take our role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow dramatically. This performance budget proposes improvements in our programs that directly contribute to significant savings and deficit reduction.

CMS remains committed to strengthening and modernizing the nation's health care system through better care for individuals, better health for the population, and lower cost through improvements. This budget request reflects our commitment to the Medicare, Medicaid and CHIP programs, while highlighting progress toward the continued implementation of the Health Insurance Marketplaces. We also help millions of Americans access affordable, quality healthcare and administer important consumer protections including preventing insurers from denying anyone coverage for pre-existing conditions or charging them more for coverage based on their health condition. Continuing to build on our success in transforming America's health care system and making quality, affordable health insurance available to millions of Americans continues to be our priority in FY 2016.

Our resource needs are principally driven by workloads that grow annually and by our role in leading national efforts to improve efficiency, health care quality and access to care for all Americans. Our FY 2016 Program Management request reflects a level of funding that is consistent with the magnitude and complexity of the programs and provisions CMS is tasked with administering. Wherever possible, CMS will leverage its experience and existing systems and programs to achieve efficiencies and avoid duplication of effort.

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

On behalf of our beneficiaries and consumers, I thank you for your continued support of CMS and its FY 2016 performance budget.

Marilyn Tavenner

Marilyn Tavenner

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Centers for Medicare & Medicaid Services

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

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As of February 2, 2015
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****Reports to Deputy Admin. for Innovation and Quality**

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (DHHS). The creation of CMS (previously the Health Care Financing Administration) in 1977 brought together, under unified leadership, the two largest Federal health care programs at that time—Medicare and Medicaid. In 1997, Congress established the Children's Health Insurance Program (CHIP) to address the health care needs of uninsured children. In FY 2014, CMS began to connect the uninsured with health coverage through the first open enrollment period for the private insurance Marketplace. Our programs will touch the lives of almost 126 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2016. We take our role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow.

In the past decade, legislation has significantly expanded CMS' responsibilities. The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act") provided investment funding for technological advances including health information technology and the use of electronic health records, along with prevention and wellness activities. In March 2010, the President signed into law the Affordable Care Act. The law contains numerous provisions that impact CMS' traditional role as the overseer of Medicare, Medicaid, and CHIP including: a major expansion of the Medicaid program; a two-year extension of CHIP; the establishment of a new Federal Coordinated Health Care Office in CMS to improve care for beneficiaries who are eligible for both Medicare and Medicaid; the gradual elimination of the Medicare prescription drug "donut hole"; and the creation of a CMS Innovation Center to explore different care delivery and payment models in Medicare, Medicaid, and CHIP. In January 2011, CMS became responsible for the implementation of the Affordable Care Act's consumer protections and private health insurance market regulations. These provisions include new requirements regarding the market conduct of private health care insurers and new consumer outreach and education efforts to help consumers assess their options and determine their eligibility for public health programs. In 2014, CMS worked with States to create new competitive health insurance markets that will operate through Health Insurance Marketplaces and provide millions of Americans with access to affordable health coverage.

More recently, the Protecting Access to Medicare Act of 2014 provided a 0.5 percent update for Medicare physician payments through the rest of CY 2014 and imposed a 0.0 percent update for the first three months of CY 2015. It also included numerous Medicare reforms and temporarily extends some Medicare and Medicaid policies. Finally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires post-acute care providers to report and share standardized assessment data.

Our FY 2016 performance budget proposes improvements in our programs that directly contribute to significant savings and deficit reduction. CMS also uses performance measures to track our progress toward meeting statutory requirements and internal goals.

CMS remains the largest purchaser of health care in the United States. Our programs currently pay almost one-third of the Nation's health expenditures. For nearly 50 years, these programs have helped pay the medical bills of millions of older and low-income Americans in Medicare and Medicaid. CMS outlays more benefits than any other Federal agency and we are committed to administering our programs as efficiently and effectively as possible. In FY 2016, benefit outlays for our programs are expected to total more than $1 trillion. Non-benefit costs,

which include administrative costs such as Program Management, the Federal share of Medicaid State and local administration, the Health Care Fraud and Abuse Control account (HCFAC), the Quality Improvement Organizations (QIO), and the new insurance market reforms, among others, are estimated to total $52.3 billion. CMS' non-benefit costs are relatively small when compared to Medicare benefits and the Federal share of Medicaid and CHIP benefits. Remarkably, Program Management costs are less than one-half of one percent of these benefits.

Through better care for individuals, better health for the population, and lower costs through care improvements, CMS remains committed to strengthening and modernizing the nation's health care system. This budget request reflects our commitment to the Medicare, Medicaid, and CHIP programs, while continuing administration and improvements to the Health Insurance Marketplace and consumer protection programs. Implementing the Marketplace and making affordable health insurance available to millions of Americans continues to be our priority in FY 2016.

Mission

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

Overview of Budget Request

CMS requests funding for four annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid and Payments to the Health Care Trust Funds (PTF). The table on the next page displays our FY 2014 Final, FY 2015 Enacted, and FY 2016 President's Budget request for these accounts.

CMS Annual Appropriated Funds in Accounts
(Dollars in Millions)

Accounts	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Program Management	$4,091.7	$3,974.7	$4,245.2	$270.4
HCFAC – Discretionary	$293.6	$672.0	$706.0	$34.0
Grants to States for Medicaid 1/	$284,208.6	$338,081.2	$356,817.6	$18,736.4
Payments to Health Care Trust Funds	$255,185.0	$259,644.0	$283,171.8	$23,527.8
Grand Total 1/	**$543,778.9**	**$602,371.9**	**$644,940.6**	**$42,568.7**

1/ Totals may not add, due to rounding. In FY 2014, the Medicaid appropriation does not include $21.6 billion in indefinite authority.

Key Initiatives

- **Health Insurance Marketplace**

  CMS is responsible for operating the Federal Health Insurance Marketplace in States that elect not to set up their own Marketplace, as well as for operating many other functions that support Marketplaces in all States. These Marketplaces give tens of millions of Americans and small businesses access to affordable coverage. Implementation and administration of the Federal Health Insurance- Marketplace continues to be an unprecedented effort for CMS. CMS' FY 2016 Program Management request includes $629.0 million in appropriated funding for the Marketplaces, along with $1.6 billion in projected user fee collections from all sources to fund the Marketplaces at a program level totaling $2.2 billion.

- **Program Integrity**

  CMS' FY 2016 request includes a proposal to modify the HCFAC appropriations language to request discretionary CMS funding for "CMS program integrity activities" rather than Medicare and Medicaid program integrity only. This budget request assumes $25 million for private insurance program integrity, including the Health Insurance Marketplaces.

- **Proposed Law**

1. Implementation Funding for Administration Proposals

CMS' request includes $1.0 billion in proposed law funding to implement the Agency's mandatory legislative proposals, including $600 million for Physician Payment Reform. CMS will utilize this funding to implement systems changes and process improvements needed to generate additional savings, improve efficiencies and enhance program integrity in a timely manner. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our traditional Program Management request.

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

This proposal would institute a filing fee for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, to pay a per-claim filing fee at each level of appeal. This filing fee would allow HHS to invest in the appeals system to improve responsiveness and efficiency. This proposal additionally returns all filing fees to an appellant who receives a fully favorable appeal determination. Collections are estimated at $4 million in FY 2016.

3. Invest in CMS Quality Measurement

The Budget proposes to extend funding for a consensus-based entity focused on performance measurement through 2018. The duties for a consensus-based entity are divided between those originally authorized by the Medicare Improvements for Patients and Providers Act of 2008 and those that were added by the Affordable Care Act and amended by the American Taxpayer Relief Act of 2012. Under current law, no additional funding will be provided after 2015. The Budget includes $30 million each year for 3 years for both activities, which is available until expended. Continued funding for endorsing and maintaining performance measures and other performance measurement review functions are essential as CMS continues to implement valued-based purchasing initiatives and other models which focus on performance-based payments. (+$90 million over 3 years).

4. Federal Payment Levy Program Fees

The Federal Payment Levy Program authorizes CMS to impose a levy on Medicare providers for debt owed to the Federal Government. The FY 2016 request includes a proposal that authorizes CMS to assess a fee that would offset the administrative costs incurred in carrying out this program. Under this proposal, the Department of the Treasury would continue to receive the full amount of the levy and the Medicare provider would pay fees directly to CMS to cover administrative costs. Collections are estimated at $2.0 million in FY 2016.

5. Reinvesting Home Health Civil Monetary Penalties (CMPs)

Under current law, States conduct initial, recertification, and complaint surveys of Home Health Agencies (HHAs) under their purview; should the surveyors find an HHA to be deficient in meeting required quality and safety standards, they can levy a variety of penalties, including CMPs, which are then returned in full to the Treasury. Under this proposal, CMS would be authorized to retain and invest a portion of the CMPs recovered

from HHAs to help improve beneficiary quality of care and to assist HHAs in meeting Medicare's Conditions of Participation. Collections are estimated at $1.0 million in FY 2016.

6. Allow Collection of Application Fees from Individual Providers

This proposal would allow CMS to collect a fee from individual providers to cover the costs of conducting necessary provider screening and program integrity efforts associated with enrolling providers in Medicare and keeping bad actors out of the program. Hardship exemptions would be available for providers based on needs, as determined by CMS. Collections are estimated at $9.0 million in FY 2016.

7. Establish Registration Process for Clearinghouses and Billing Agents

This proposal expands the provider screening authorities included in the Affordable Care Act by establishing a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers. This proposal would provide CMS the authority to charge application fees to screen billing agents and clearinghouses. Collections are estimated at $14.0 million in FY 2016.

FY 2016 Budget Request

Program Management

In FY 2016, CMS requests $4,245.2 million in appropriated funding, a $270.4 million increase over the FY 2015 enacted level. CMS' request reflects funding needed to support Marketplace operations in FY 2016, and to maintain unprecedented growth in our traditional programs, particularly Medicaid. Effective implementation of the Affordable Care Act (ACA) remains a top Administration priority. CMS' requested investment in FY 2016 for ACA implementation is critical to expanding health care coverage to millions of Americans and to control the growth in health care costs.

- <u>Program Operations</u>:

  CMS' FY 2016 budget request for Program Operations totals $3,024.4 million, a $199.6 million increase over the FY 2015 enacted level. Most of the funding within the Program Operations line supports CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, maintain our 1-800 MEDICARE call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2016 request includes funding for Medicaid and CHIP operations and for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

  Program Operations also includes funds for many provisions enacted in the Affordable Care Act. These provisions enhance all three existing health care programs—Medicare, Medicaid, and CHIP—and include the establishment of new consumer protections and private insurance market reforms. Our discretionary request includes $544 million to partially fund operations for the Marketplaces in 2016, including enrollment, outreach and education for a new and diverse cohort of consumers. In addition, CMS anticipates collecting $1.6 billion in user fee revenue from all sources to support Marketplace operations for a total program level of $2.2 billion.

- Federal Administration:

  CMS requests $783.6 million in FY 2016, a $51.1 million increase over the FY 2015 enacted level. The FY 2016 request includes $686.0 million to support 4,671 direct FTEs, an increase of 201 FTEs over the FY 2015 level. This amount includes $85.0 million to support the Health Insurance Marketplace. Our payroll estimate assumes a 1.3 percent civilian and military cost of living allowance (COLA) in 2016.

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

- Survey and Certification:

  CMS' FY 2016 request includes $437.2 million for State survey and certification activities, a $39.9 million increase over the FY 2015 enacted level. Of this amount, $358.0 million will support direct survey costs, $24.7 million will support additional costs related to direct surveys, and $54.5 million will be used for surveyor training, Federally-directed surveys and information technology. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and supports policy level survey frequencies at other facility types. The budget also supports contracts to strengthen quality improvement and national program consistency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

  Approximately 87 percent of the requested funding will go to State survey agencies for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, organ transplant facilities and ESRD facilities. This request supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers and ambulatory surgery centers.

Health Care Fraud and Abuse Control

CMS requests $706.0 million in discretionary HCFAC funding in FY 2016, a $34.0 million increase over the FY 2015 enacted level. This funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, and CHIP. This includes ongoing investments in the oversight of Medicare Parts C and D; state-of-the-art analytic technology to detect and prevent improper payments; staffing to implement corrective actions; support for Medicare Strike Forces, used to identify and prosecute fraudulent providers; and pre-enrollment provider screening. To help ensure the prudent use of Federal funds, the funding request assumes at least $25.0 million for program integrity activities in private insurance, including the Health Insurance Marketplaces.

Grants to States for Medicaid

The FY 2016 Medicaid request is $356.8 billion, an increase of $18.7 billion above the FY 2015 enacted level. The majority of this increase is attributed to increased enrollment resulting from the ACA Medicaid expansion. This appropriation consists of $243.5 billion for FY 2016 and

$113.3 billion in an advance appropriation from FY 2015. These funds will finance $357.0 billion in estimated obligations in FY 2016. These obligations consist of:

- $322.6 billion in Medicaid medical assistance benefits;
- $12.5 billion for benefit obligations incurred but not yet reported;
- $17.8 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.1 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2016 President's budget for Payments to the Health Care Trust Funds account totals $283.2 billion, an increase of $23.5 billion above the FY 2015 enacted level. Our FY 2016 request reflects increases for the prescription drug benefit and the rise in beneficiary population. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds, including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC and other administrative costs that are properly chargeable to the General Fund.

Conclusion

CMS' FY 2016 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 $644.9 billion in FY 2016, an increase of $42.6 billion above the FY 2015 enacted level.

CMS' FY 2016 program level request for Program Management totals $4.2 billion, a $270.4 million increase over the FY 2015 enacted level. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs and to also fund many provisions enacted in FY 2010 as part of the Affordable Care Act, including the Federal Marketplace.

CMS requests $706.0 million in discretionary HCFAC funds, a $34.0 million increase over the FY 2015 enacted level. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

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

OVERVIEW OF PERFORMANCE

Consistent with the Government Performance and Results Act of 1993 (GPRA), CMS has focused on identifying a set of meaningful, outcome-oriented performance measures that highlight fundamental program purposes and focus on the Agency's role as a steward of taxpayer dollars. The CMS FY 2016 performance budget includes a proposal of 39 goals (67 performance measures). We continue to track many of the measures included in the FY 2015 plan, with new FY 2016 targets consistent with the President's goals and priorities.

Our plan is also structured to reflect the CMS mission: *As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.* Our measures are also linked to the DHHS Strategic goals to Strengthen Health Care and Increase Efficiency, Transparency, and Accountability of its programs.

Consistent with the GPRA Modernization Act of 2010 (GPRA-MA), CMS is developing a rigorous, integrated, data-driven performance management process that includes regular progress reviews of its priorities by CMS leadership. CMS also continues to be an active participant in the HHS Agency Priority Goals for FY 2015 – 2016. CMS leads a collaborative effort with its HHS partners in the Office of the Assistant Secretary for Health (ASH), the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare Research and Quality (AHRQ), "To improve patient safety: To reduce the national rate of healthcare-associated infections (HAIs) by September 30, 2015 by demonstrating a 10 percent reduction in national hospital-acquired catheter associated urinary tract infections (CAUTI)" CMS is also a partner on the HHS Health Information Technology Priority Goal to increase the number of eligible providers receiving CMS Medicare and Medicaid incentive payments for the successful adoption or meaningful use of certified Electronic Health Record (EHR) technology, and is a contributor to the tobacco cessation priority goal led by the ASH.

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

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

	FY 2014 Final 1/	FY 2015 Enacted 1/	FY 2016 President's Budget	FY 2016 +/- FY 2015
Program Operations	$2,943,405	$2,824,823	$3,024,386	$199,563
Federal Administration	$732,533	$732,533	$783,600	$51,067
State Survey & Certification	$375,330	$397,334	$437,200	$39,866
Research 2/	$20,054	$20,054	$0	($20,054)
High-Risk Pool Grants 3/	$0	$0	$0	$0
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$4,071,322**	**$3,974,744**	**$4,245,186**	**$270,442**
High-Risk Pool Grants 3/	$20,420	$0	$0	$0
Subtotal, Appropriation/BA Current Law (Mandatory; 0511)	**$4,091,742**	**$3,974,744**	**$4,245,186**	**$270,442**
MIPPA (Mandatory; P.L. 110-275)	$2,784	$2,781	$3,000	$219
Affordable Care Act (ACA; Mandatory; P.L. 111-148/111-152)	$69,600	$50,985	$0	($50,985)
PAMA (Mandatory; P.L. 113-93)	$48,500	$24,750	$6,000	($18,750)
IMPACT Act (Mandatory; P.L. 113-185)	$0	$107,333	$21,333	($86,000)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$120,884**	**$185,849**	**$30,333**	**($155,516)**
Total, Appropriation/BA Current Law (0511)	**$4,212,626**	**$4,160,593**	**$4,275,519**	**$114,926**
Proposed Law Appropriation (Mandatory) 4/	$0	$0	$1,030,000	$1,030,000
Total, Appropriation/BA Proposed Law (0511)	**$4,212,626**	**$4,160,593**	**$5,305,519**	**$1,144,926**
Est. Offsetting Collections from Non-Federal Sources:				
User Fees and Reimbursements, C.L. 5/	$367,069	$202,892	$225,917	$23,025
Marketplace User Fees, C.L. 5/	$252,306	$850,000	$1,514,000	$664,000
Risk Corridors, C.L.	$0	$5,450,382	$6,389,995	$939,613
Recovery Audit Contracts, C.L. 5/	$762,811	$437,000	$750,000	$313,000
Subtotal, New BA, Current Law	**$5,594,812**	**$11,100,867**	**$13,155,431**	**$2,054,564**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2011) 6/	$180,303	$189,843	$0	($189,843)
Program Level, Current Law (0511)	**$5,775,115**	**$11,290,710**	**$13,155,431**	**$1,864,721**
Proposed Law Offsetting Collections 7/	$0	$0	$207,000	$207,000
Program Level, Proposed Law (0511)	**$5,775,115**	**$11,290,710**	**$14,392,431**	**$3,101,721**
Affordable Care Act (ACA; P.L. 111-148/111-152):				
Section 2701 Adult Health Quality Measures	$55,680	$0	$0	$0
Section 10323 Medicare Coverage/Environmental Health Hazards	$316	$549	$600	$51
Total, ACA Appropriation/BA C.L. (Mandatory; 0509) 8/	**$55,996**	**$549**	**$600**	**$51**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):				
Section 4103 Medicare Incentives	$92,800	$92,700	$45,000	($47,700)
Section 4201 Medicaid Incentives	$37,120	$37,080	$20,000	($17,080)
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 8/	**$129,920**	**$129,780**	**$65,000**	**($64,780)**
Total, Program Management Appropriation/BA, P.L. (All Sources)	**$4,398,542**	**$4,290,922**	**$5,371,119**	**$1,080,197**
Total Prog. Mgt. Program Level, Proposed Law (All Sources)	**$5,961,031**	**$11,421,039**	**$14,458,031**	**$3,036,992**
HCFAC Discretionary	**$293,588**	**$672,000**	**$706,000**	**$34,000**
Non-CMS Administration 9/	**$1,953,000**	**$1,906,681**	**$2,063,100**	**$156,419**
CMS FTEs:				
Direct (Federal Administration) 10/	4,495	4,470	4,671	201
Reimbursable (CLIA, CoB, RAC)	103	122	125	3
Subtotal, Program Management FTEs	**4,598**	**4,592**	**4,796**	**204**
Affordable Care Act (Mandatory)	25	10	8	-2
ARRA Implementation (Mandatory)	102	87	0	-87
Total, Program Management FTEs, Current Law	**4,725**	**4,689**	**4,804**	**115**
Program Management, Proposed Law		0	20	20
Total, Program Management FTEs	**4,725**	**4,689**	**4,824**	**135**
Affordable Care Act (Mandatory)	462	650	753	103
HCFAC Mandatory	214	247	248	1
HCFAC Discretionary	144	180	181	1
Medicaid Integrity (State Grants; Mandatory)	79	90	96	6
QIO	196	224	225	1
Total, CMS FTEs 10/	**5,820**	**6,080**	**6,327**	**247**

1/ The FY 2014 and FY 2015 columns are shown as enacted, net of rescissions, transfers, reprogrammings and the sequester, where applicable.
2/ In FY 2016, CMS proposes to fund activities previously funded through the Research line in the Program Operations line.
3/ In FY 2014, the High-Risk Pool grants are considered a CHIMP and rebased as mandatory once an appropriations bill is enacted.
4/ CMS' FY 2016 request includes $400.0 million in administrative funding to implement the Administration's health care proposals, $600.0 million for physician payment reform and $30.0 million for quality improvement investments.
5/ Includes user fees and reimbursables supporting CMS program management. The FY 2014 amounts reflect enacted collections, except for the Marketplace user fees. The FY 2014 Marketplace user fee amount reflects actual obligations.
6/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.
7/ CMS' FY 2016 request includes proposals for seven new offsetting collections: a Survey and Certification Revisit Fee, administrative fees to offset costs incurred for the Federal Payment Levy Program, the retention of a portion of HHA Civil Monetary Penalties for quality improvements, appeals filing fees, provider application fees, fees to offset the cost of a registration process for clearinghouses and billing agents, and RAC recoveries for preventative action.
8/ Includes ACA, PAMA and ARRA mandatory funds included within the CMS Program Management account. Excludes transfers of discretionary budget authority (BA). BA amounts are scored in the first year of availability.
9/ Includes funds for the SSA, DHHS/OS, the Medicare Payment Advisory Commission (MedPAC), and SHIPs (ACL).
10/ Excludes staffing funded from indirect cost allocations. The FY 2014 column reflects actual FTE consumption. In FY 2015 and FY 2016, 13 FTE included in the direct Program Management line will be funded from other sources.

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

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CMS PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare **[**and**]** *&* Medicaid Services, not to exceed **[**$3,669,744,000**]** *$4,245,186,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section **[**302 of the Tax Relief and Health Care Act of 2006;**]** *1893(h) of the Social Security Act,* and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until **[**September 30, 2020**]** *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 **[**2015**]** *2016* 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. *(Department of Health and Human Services Appropriations Act, 2015.)*

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare **[**and**]***&* Medicaid Services, not to exceed **[**$3,669,744,000**]***$4,245,186,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;*	Provides a one-year appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section **[**302 of the Tax Relief and Health Care Act of 2006;**]** *1893(h) of the Social Security Act,* and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until **[**September 30, 2020**]***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 **[**2015**]** *2016* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.

General Provision

Language Provision	**Explanation**
Section 1864 of the Social Security Act (42 U.S.C. 1395aa) is amended to read as follows: "(e) FEES FOR CONDUCTING REVISIT SURVEYS.—The Secretary may, for fiscal year 2016 and each subsequent fiscal year, impose fees upon facilities or entities referred to in this section for conducting revisit surveys in cases where such facilities or entities have been cited for deficiencies during initial certification, recertification, or substantiated complaint surveys. Such fees shall be established and collected in accordance with regulations prescribed by the Secretary that provide for a gradual phase-in of the fee amounts, and collected funds shall be available to supplement funding appropriated for such surveys. Fee amounts assessed upon an entity in an entity class shall not exceed the estimated average cost of performing such surveys for an entity in such class. Such fees shall be collected and available only to the extent [and in such amounts as] provided in advance in appropriations acts."	Authorizes the collection of user fees from providers who had previously been cited for deficiencies in care, and required a revisit. Since this is proposed as an amendment to the Social Security Act, the authority to collect fees is contingent on their appropriation, so that collections will be classified as discretionary.

Sec. 221

CMS Program Management
Amounts Available for Obligation

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,952,740,000	$3,974,744,000	$4,245,186,000
Secretary's 1-percent transfer	$118,582,000	$0	$0
Subtotal, Appropriation (L/HHS)	$4,071,322,000	$3,974,744,000	$4,245,186,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$22,004,000	$0	$0
Sequester	-$1,584,000	$0	$0
Subtotal, appropriation (L/HHS)	$20,420,000	$0	$0
ACA (PL 111-148/152)	$25,341,000	$5,592,000	$600,000
PAMA/SGR (PL 113-93)	$48,500,000	$24,750,000	$6,000,000
IMPACT Act (PL 113-185)	$0	$107,333,000	$21,333,000
Sequester	-$1,825,000	-$409,000	$0
Subtotal, trust fund mand. appropriation	$72,016,000	$137,266,000	$27,933,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$3,000,000	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$110,000,000	$50,000,000	$0
Sequester	-$8,136,000	-$3,869,000	$0
Subtotal, trust fund mand. appropriation	$104,864,000	$49,131,000	$3,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$52,821,000	$50,000,000	$50,000,000
Coordination of benefits user fees	$0	$30,000,000	$30,000,000
MA/PDP user fees	$73,600,000	$71,100,000	$76,400,000
Sale of data user fees	$11,908,000	$7,378,000	$7,526,000
Provider enrollment user fees	$28,108,000	$27,735,000	$30,000,000
Marketplace user fees	$377,221,000	$887,638,000	$1,449,202,000
Risk adjustment administration	$0	$20,400,000	$19,511,000
Recovery audit contracts	$821,995,000	$471,413,000	$750,000,000
Risk corridors	$0	$5,450,382,000	$6,389,995,000
Nursing home cmp/other	$2,502,000	$3,776,000	$3,776,000
Sequester 2/	-$97,470,000	-$114,031,000	$0
Sequester pop-up	$5,089,000	$34,483,000	$73,502,000
Subtotal, offsetting collections 1/	$1,275,774,000	$6,940,274,000	$8,879,912,000
Unobligated balance, start of year	$655,400,000	$722,051,000	$539,317,000
Unobligated balance, end of year 1/, 2/	-$722,051,000	-$538,008,000	-$398,648,000
Prior year recoveries	$24,674,000	$0	$0
Unobligated balance, lapsing	-$323,093,000	$0	$0
Total obligations 1/, 2/	**$5,179,326,000**	**$11,285,458,000**	**$13,296,700,000**

American Recovery and Reinvestment Act (ARRA)

Mandatory Appropriation:			
ARRA (PL 111-5)	$140,000,000	$140,000,000	$65,000,000
Sequester	-$10,080,000	-$10,220,000	$0
Unobligated balance, start of year	$171,346,000	$193,790,000	$184,683,000
Unobligated balance, end of year	-$193,790,000	-$184,683,000	-$149,553,000
Prior year recoveries	$0	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$107,476,000**	**$138,887,000**	**$100,130,000**

1/ Current law display. Excludes the following amounts for reimbursable activities carried out by this account: FY 2014: $221,710,000. Reflects actual budget authority enacted in FY 2014.

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

Summary of Changes

2015	
Total estimated budget authority 1/	$3,974,744,000
(Obligations) 1/	($3,976,957,000)
2016	
Total estimated budget authority 1/	$4,245,186,000
(Obligations) 1/	($4,245,186,000)
Net Change	**$270,442,000**

	2015 Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Pay Raise				$4,750,000
2. Annualization of Pay Raise				$1,583,000
3. Additional Day of Pay				$2,425,000
Subtotal, Built-in Increases 1/				**$8,758,000**
B. Program:				
1. Program Operations		$2,824,823,000		$429,972,000
2. Federal Administration	4,470	$732,533,000	201	$43,483,000
3. State Survey & Certification		$397,334,000		$40,567,000
Subtotal, Program Increases 1/				**$514,022,000**
Total Increases 1/				**$522,780,000**
Decreases:				
A. Program:				
1. Program Operations		$2,824,823,000		($230,409,000)
2. Federal Administration		$732,533,000		($1,174,000)
3. State Survey & Certification		$397,334,000		($701,000)
4. Research 2/		$20,054,000		($20,054,000)
Subtotal, Program Decreases 1/				**($252,338,000)**
Total Decreases 1/				**($252,338,000)**
Net Change 1/				**$270,442,000**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.
2/ In FY 2016, ongoing research activities will be funded from the Program Operations line.

American Recovery and Reinvestment Act (ARRA):

2015				
Total estimated budget authority 1/				$129,780,000
(Obligations)				($138,887,000)
2016				
Total estimated budget authority				$65,000,000
(Obligations)				($100,130,000)
Net Change 1/				**($64,780,000)**
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT	87	$129,780,000	(87)	($64,780,000)
Net Change 1/				**($64,780,000)**

1/ Displayed net of sequester in FY 2015.

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

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
1. Program Operations	$2,519,823	$2,519,823	$3,024,386
Additional Medicare Operations Funding	$305,000	$305,000	$0
Secretary's 1-Percent Transfer	$118,582	$0	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
ACA (PL 111-148/152)	$20,000	$0	$0
PAMA/SGR (PL 113-93)	$48,500	$24,750	$6,000
IMPACT Act (PL 113-185)	$0	$88,000	$13,000
Sequester	-$1,656	-$219	$0
Subtotal, Program Operations	**$3,013,249**	**$2,940,354**	**$3,046,386**
(Obligations)	($2,975,523)	($3,006,450)	($3,046,386)
2. Federal Administration	$732,533	$732,533	$783,600
ACA (PL 111-148/152)	$60,000	$0	$0
Sequester	-$4,320	$0	$0
Subtotal, Federal Administration	**$788,213**	**$732,533**	**$783,600**
(Obligations)	($788,719)	($803,772)	($837,459)
3. State Survey & Certification	$375,330	$397,334	$437,200
IMPACT Act (PL 113-185)	$0	$19,333	$8,333
Subtotal, State Survey & Certification	**$375,330**	**$416,667**	**$445,533**
(Obligations)	($381,172)	($440,037)	($468,903)
4. Research, Demonstration & Evaluation	$20,054	$20,054	$0
ACA (PL 111-148/152)	$55,341	$55,592	$600
Sequester	-$3,985	-$4,059	$0
Subtotal, Research, Demonstration & Evaluation	**$71,410**	**$71,587**	**$600**
(Obligations)	($87,940)	($94,649)	($64,040)
5. High-Risk Pool Grants	$22,004	$0	$0
Sequester	-$1,584	$0	$0
Subtotal, High-Risk Pool Grants	**$20,420**	**$0**	**$0**
(Obligations)	($20,420)	$0	$0
6. User Fees	**$546,160**	**$1,098,027**	**$1,666,415**
Sequester	-$38,286	-$79,618	$0
Sequester Pop-Up	$5,089	$34,483	$73,502
Subtotal, User Fees	**$512,963**	**$1,052,892**	**$1,739,917**
(Obligations)	($457,200)	($1,053,168)	($1,739,917)
7. Recovery Audit Contracts	**$821,995**	**$471,413**	**$750,000**
Sequester	-$59,184	-$34,413	$0
Subtotal, Recovery Audit Contracts	**$762,811**	**$437,000**	**$750,000**
(Obligations)	($468,352)	($437,000)	($750,000)
8. Risk Corridors	**$0**	**$5,450,382**	**$6,389,995**
Sequester	$0	$0	$0
Subtotal, Risk Corridors	**$0**	**$5,450,382**	**$6,389,995**
(Obligations)		($5,450,382)	($6,389,995)
Total, Budget Authority 1/, 2/	**$5,544,396**	**$11,101,415**	**$13,156,031**
(Obligations) 1/, 2/	**($5,179,326)**	**($11,285,458)**	**($13,296,700)**
FTE 2/	**4,623**	**4,602**	**4,804**

1/ Excludes $221,710,000 in collections for other reimbursable activities carried out by the Program Management account. Of the amount collected, $219,908,000 was obligated in FY 2014.

2/ Reflects CMS' current law request.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$140,000**	**$140,000**	**$65,000**
Sequester	-$10,080	-$10,220	$0
Subtotal, ARRA	**$129,920**	**$129,780**	**$65,000**
(Obligations)	($107,476)	($138,887)	($100,130)
FTE	**102**	**87**	**0**

CMS Program Management
Authorizing Legislation

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite		
- Section 1115 1/	$2,000,000	$2,000,000		
b) P.L. 92-603, Section 222	Indefinite	Indefinite		
c) P.L. 90-248, Section 402	Indefinite	Indefinite		
d) Social Security Act, Title XVIII	Indefinite	Indefinite		
2. Program Operations:				
Social Security Act, Titles XI, XVIII, XIX and XXI	Indefinite	Indefinite	Indefinite	Indefinite
a) Social Security Act, Title XI				
- Section 1110			Indefinite	Indefinite
- Section 1115 1/			$2,000,000	$2,000,000
b) P.L. 92-603, Section 222			Indefinite	Indefinite
c) P.L. 90-248, Section 402			Indefinite	Indefinite
d) Social Security Act, Title XVIII			Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003	2/	2/	2/	2/
7. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
8. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
9. Marketplace:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
10. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2016.
2/ Limits authorized user fees to an amount computed by formula.

American Recovery and Reinvestment Act (ARRA)

1. ARRA Implementation:				
American Recovery and Reinvestment Act of 2009 (PL 111-5)	$140,000,000	$140,000,000	$65,000,000	$65,000,000

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2007				
Trust Fund Appropriation:				
Base	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,141,108,000
TRHCA (PL 109-432)	$0	$0	$0	$105,000,000
Subtotal	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,246,108,000
2008				
General Fund Appropriation:				
MMSEA (PL 110-173)	$0	$0	$0	$60,000,000
Supplemental (PL 110-252)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,207,690,000
Rescissions (P.L. 110-161)	$0	$0	$0	($56,038,000)
MMSEA (PL 110-173)	$0	$0	$0	$55,000,000
MIPPA (PL 110-275)	$0	$0	$0	$20,000,000
Subtotal	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,226,652,000
2009				
General Fund Appropriation:				
CHIPRA (PL 111-3)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,305,386,000
MIPPA (PL 110-275)	$0	$0	$0	$182,500,000
Subtotal	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,487,886,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Trust Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$2,000,000
2010				
General Fund Appropriation:				
ACA (PL 111-148/152)	$0	$0	$0	$251,600,000
Trust Fund Appropriation:				
Base **1/**	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,470,242,000
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$95,300,000
Subtotal	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,600,542,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2011				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$60,000,000
MMEA (PL 111-309)	$0	$0	$0	$200,000,000
Trust Fund Appropriation:				
Base **1/**	$3,646,147,000	$3,470,242,000	$3,470,242,000	$3,470,242,000
Rescissions (P.L. 112-10)	$0	$0	$0	($6,940,000)
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$527,750,000
Subtotal	$3,646,147,000	$3,470,242,000	$3,470,242,000	$4,026,052,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2012				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Trust Fund Appropriation:				
Base **1/**	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,879,476,000
Rescissions (P.L. 112-74)	$0	$0	$0	($7,249,000)
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$25,302,000
Subtotal	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,932,529,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2013				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Transfers	$0	$0	$0	$453,803,000
Sequestration	$0	$0	$0	($5,763,000)
Trust Fund Appropriation:				
Base **1/**	$4,820,808,000	$0	$4,370,112,000	$3,872,227,000
Transfers (P.L. 113-6)	$0	$0	$0	$113,588,000
Rescissions (P.L. 113-6)	$0	$0	$0	($7,656,000)
Sequestration	$0	$0	$0	($194,827,000)
ATRA (PL 112-240)	$0	$0	$0	$17,500,000
ACA (PL 111-148/152)	$0	$0	$0	$25,440,000
Sequestration	$0	$0	$0	($2,190,000)
Subtotal	$4,820,808,000	$0	$4,370,112,000	$3,824,082,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($7,140,000)
2014				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Sequestration	$0	$0	$0	($8,136,000)
Trust Fund Appropriation:				
Base **1/**	$5,217,357,000	$0	$5,217,357,000	$3,669,744,000
Additional Medicare Ops. (PL 113-76)	$0	$0	$0	$305,000,000
Transfers (P.L. 113-76)	$0	$0	$0	$118,582,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$25,341,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$48,500,000
Sequestration	$0	$0	$0	($1,825,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,163,758,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)
2015				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Sequestration	$0	$0	$0	($3,869,000)
Trust Fund Appropriation:				
Base	$4,199,744,000	$0	$0	$3,669,744,000
Additional Medicare Ops. (PL 113-235)	$0	$0	$0	$305,000,000
ACA (PL 111-148/152)	$0	$0	$0	$5,592,000
Sequestration	$0	$0	$0	($408,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$24,750,000
IMPACT Act (PL 113-185)	$0	$0	$0	$107,333,000
Subtotal	$4,199,744,000	$0	$0	$4,112,011,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,220,000)
2016 2/				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Trust Fund Appropriation:				
Base	$4,245,186,000	$0	$0	$0
ACA (PL 111-148/152)	$0	$0	$0	$600,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,245,186,000	$0	$0	$27,933,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$65,000,000

1/ High-Risk Pools are considered a CHIMP and rebased as mandatory once an appropriations bill is enacted.
2/ Reflects the FY 2016 current law request.

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	Appropriations in FY 2015

CMS Program Management has no appropriations not authorized by law.

Program Management
Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' traditional programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Clinical Laboratory Improvement Amendments (CLIA), the Quality Improvement Organizations (QIO), State Grants and Demonstrations, and the Health Care Fraud and Abuse Control (HCFAC) account as well as the Federal Marketplaces and private health insurance provisions and consumer protections enacted by the Affordable Care Act. The FY 2016 request includes funding for CMS' Program Management line items--Program Operations, Federal Administration, and State Survey and Certification.

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

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

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

CMS' FY 2016 Program Management request is $4,245.2 million, a $270.4 million increase from the FY 2015 Enacted level. The table below, and the following language, provides additional detail on each of these levels for the FY 2016 request.

Program Management Summary Table
($ in millions)

Line Item	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Program Operations	$2,824.8	$3,024.4	+$199.6
Federal Administration	$732.5	$783.6	+$51.1
Survey & Certification	$397.3	$437.2	+$39.9
Research	$20.1	$0.0	-$20.1
Program Management 1/	**$3,974.7**	**$4,245.2**	**+$270.4**
Direct FTEs – Federal Administration	4,470	4,671	+201

1/ Numbers may not add, due to rounding.

FY 2016 Request

Program Management: In FY 2016, CMS requests $4,245.2 million in appropriated funding, a $270.4 million increase over the FY 2015 enacted level. CMS' request reflects funding needed to support Marketplace operations in FY 2016, and to maintain unprecedented growth in our traditional programs, particularly Medicaid. Effective operational management of ACA programs, managing Medicare appeals workload growth, and Medicare claim administration all remain top Administration priorities.

- Program Operations:

  CMS' FY 2016 budget request for Program Operations totals $3,024.4 million, a $199.6 million increase over the FY 2015 enacted level. This request includes $544.0 million for the Marketplaces, excluding user fees. This request will allow CMS to continue to effectively administer Medicare, Medicaid, CHIP, and to operate and oversee private health insurance reforms such as the Marketplaces.

  Most of the funding within the Program Operations line supports CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, maintain our 1-800 MEDICARE call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2016 request includes funding for Medicaid and CHIP operations and for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

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

- Federal Administration:

  CMS requests $783.6 million in FY 2016, a $51.1 million increase over the FY 2015 enacted level. The FY 2016 request includes $686.0 million to support 4,671 direct FTEs, an increase of 201 FTEs over the FY 2015 level. Our FY 2016 request also funds other objects of expense for ongoing activities and ACA implementation

efforts. This amount includes $85 million to support the Health Insurance Marketplace.

- Survey and Certification:

  CMS' FY 2016 request includes $437.2 million for State survey and certification activities, a $39.9 million increase over the FY 2015 enacted level. Of this amount, $358 million will support direct survey costs, $24.7 million will support additional costs related to direct surveys, and $54.5 million will be used for surveyor training, Federally-directed surveys and information technology. This request maintains statutory survey frequencies at long-term care facilities and home health agencies, and supports policy level survey frequencies at other facility types.

Program Management Proposed Law Summary

The CMS budget request includes proposed appropriations totaling $1,030.0 million in FY 2016. Of this amount, $400.0 million would be requested through a General Fund appropriation to implement the Administration's health care proposals. CMS will utilize this funding to implement systems changes and process improvements needed to generate additional savings, improve efficiencies and enhance program integrity in a timely manner. Funded through trust fund appropriations, $600.0 million of the proposed request will be used for Physician Payment Reform and the remaining $30.0 million will be used for quality investments. Scored mandatory, this funding will be subject to PAYGO rules, and is in addition to our discretionary request.
CMS' FY 2016 request also includes proposals for offsetting collections. The authority to implement the new collections will be requested through authorizing language proposals, not appropriations language. Some of these proposals are described in more detail below:

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

This proposal would institute a filing fee for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, to pay a per-claim filing fee at each level of appeal. This filing fee would allow CMS to invest in the appeals system to improve responsiveness and efficiency. This proposal additionally returns all filing fees to an appellant who receives a fully favorable appeal determination. Collections are estimated at $4 million in FY 2016.

2. Federal Payment Levy Program Fees ($2,000,000)

The Federal Payment Levy Program authorizes CMS to impose a levy on Medicare providers for debt owed to the Federal Government. The FY 2016 request includes a proposal that authorizes CMS to assess a fee that would offset the administrative costs incurred in carrying out this program. Under this proposal, the Department of the Treasury would continue to receive the full amount of the levy and the Medicare provider would pay fees directly to CMS to cover administrative costs. Collections are estimated at $2.0 million in FY 2016.

3. Reinvesting Home Health Civil Monetary Penalties (CMPs) ($1,000,000)

Under current law, States conduct initial, recertification, and complaint surveys of Home Health Agencies (HHAs) under their purview; should the surveyors find an HHA to be deficient in meeting required quality and safety standards, they can levy a variety of penalties, including CMPs, which are then returned in full to the Treasury. Under this proposal, CMS would be authorized to retain and invest a portion of the CMPs recovered from HHAs to help improve beneficiary quality of care and to assist HHAs in meeting Medicare's Conditions of Participation. Collections are estimated at $1.0 million in FY 2016.

4. Allow Collection of Application Fees from Individual Providers ($9,000,000)

This proposal would allow CMS to collect a fee from individual providers to cover the costs of conducting necessary provider screening and program integrity efforts associated with enrolling providers in Medicare and keeping bad actors out of the program. Hardship exemptions would be available for providers based on needs, as determined by CMS. Collections are estimated at $9.0 million in FY 2016.

5. Establish Registration Process for Clearinghouses and Billing Agents ($14,000,000)

This proposal expands the provider screening authorities included in the Affordable Care Act by establishing a registration process for clearinghouses and billing agents that act on behalf of Medicare providers and suppliers. This proposal would provide CMS the authority to charge application fees to screen billing agents and clearinghouses. Collections are estimated at $14.0 million in FY 2016.

Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Budget Request
Program Operations	$2,943,405	$2,824,823	$3,024,386
Mandatory Appropriation, Proposed Law 1/	$0	$0	$1,025,000
Appropriation, Net, Proposed Law	$2,943,405	$2,824,823	$4,049,386
Federal Administration	$732,533	$732,533	$783,600
Mandatory Appropriation, Proposed Law 1/	$0	$0	$5,000
Appropriation, Net, Proposed Law	$732,533	$732,533	$788,600
State Survey & Certification	$375,330	$397,334	$437,200
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$375,330	$397,334	$437,200
Research, Demonstration & Evaluation	$20,054	$20,054	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,054	$20,054	$0
State High-Risk Pool Grants 2/	$22,004	$0	$0
Sequester	($1,584)	$0	$0
Mandatory Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,420	$0	$0
Discretionary Appropriation, Net	**$4,071,322**	**$3,974,744**	**$4,245,186**
Mandatory Appropriation, Net 2/	**$20,420**	**$0**	**$0**
Mandatory Appropriation, Proposed Law	**$0**	**$0**	**$1,030,000**
Total Appropriation, Proposed Law 3/	**$4,091,742**	**$3,974,744**	**$5,275,186**

1/ Reflects a separate $400.0 million general fund appropriation needed to implement the proposals contained in the President's Budget, along with $600.0 million for physician payment reform and $30.0 million in funding for quality investments.

2/ In FY 2014, the High-Risk Pool grants are a CHIMP and rebased as mandatory once an appropriations bill has been enacted.

3/ In addition, CMS is proposing $207.0 million in offsetting collections for facility revisit surveys, the Federal Payment Levy Program, reinvesting home health civil monetary penalties, appeals filing fees, provider application fees, a registration process for clearinghouses and billing agents, and RAC recoveries for preventative action.

Program Operations

	FY 2014 Operating	FY 2015 Enacted	FY 2016 Request	FY 2016 +/- FY 2015
BA 1/	$2,943,405,000	$2,824,823,000	$3,024,386,000	+$199,563,000

1/ The FY 2014 and FY 2015 Operating Level for Program Operations does not include $20.054 million for Research, Demonstrations, and Evaluation - FY 2014 funding is provided under a separate PPA. In FY 2016 the Research budget request is included in the Program Operations account.

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

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

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

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

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

FY 2016 Authorization – One Year/Multi-Year

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

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

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

CMS is also responsible for administering and overseeing private insurance oversight included in the Affordable Care Act (ACA). Among the major oversight market reforms CMS will continue to support in 2016 are:

- Prohibition of most health insurance issuers from denying coverage to people because of a pre-existing condition or any other health factor.
- Prohibition of most health insurance issuers in the individual and small group markets from using factors -- such as pre-existing conditions, health status, claims history, duration of coverage, gender, occupation, and small employer size and industry - to charge consumers greater premiums.
- Prohibition of most issuers from refusing to renew coverage because an individual or employee becomes sick or has a pre-existing condition.

Program Description and Accomplishments

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 19 million in 1966 to 57 million beneficiaries expected in FY 2016. Medicare benefits, that is, the payments made to providers for their services, are permanently authorized and are discussed in a separate chapter. The Medicare administrative expenses discussed in this chapter are funded annually through the Program Management appropriation. CMS uses these funds primarily to pay contractors to process providers' claims, to fund beneficiary outreach and education, to maintain the information technology (IT) infrastructure needed to support various claims processing systems, and to continue programmatic improvements such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS), the administrative simplification provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the tenth revision of the International Classification of Diseases (ICD-10), and others.

Medicare Parts A and B

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

Medicare Parts C and D

Part C, also known as Medicare Advantage (MA), offers comprehensive Part A and B medical benefits in a managed care setting through private health care companies. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits. In FY 2016, CMS estimates over 18 million beneficiaries will enroll in MA plans.

Medicare Part D provides voluntary prescription drug coverage. Most Medicare beneficiaries, including over 12 million low-income beneficiaries in 2016, receive comprehensive prescription drug coverage, either through a standalone prescription drug plan (PDP), a joint MA-prescription drug plan (MA-PDP), an employer-sponsored drug plan, or other creditable coverage. In FY 2016, approximately 43.3 million beneficiaries will receive Part D benefits, including approximately 41.6 million enrolled in a Part D private plan and 1.7 million who receive benefits through the Retiree Drug Subsidy.

Medicaid and CHIP

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

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

[1] Seven states implemented an “early option” to expand Medicaid coverage to adults with incomes up to 133 percent of the FPL between April 1, 2010 and January 1, 2014.

Health Insurance Market Reform

The Affordable Care Act has made health care more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers. This includes previously uninsured Americans, and Americans who had insurance that didn't provide them adequate coverage and security. Some notable impacts that health care reform has had to date:

- Millions of previously uninsured Americans have signed up for Marketplace plans, paid their premiums, and accessed quality, affordable coverage, reducing the number of uninsured adults by 26%.
- Employer premiums for family coverage grew just 3.0 percent in 2014, tied with 2010 for the lowest on record back to 1999.
- The Affordable Care Act is making prescriptions more affordable for seniors by phasing out the Medicare donut hole.
- Americans no longer face limited lifetime coverage based on a fixed dollar amount. The ACA eliminated this limit on essential health benefits for 105 million Americans.

CMS is responsible for operating the Federally-Facilitated Marketplace in States that elect not to set up their own Marketplaces. The Marketplace gives millions of Americans and small businesses access to affordable coverage. Implementation of the Federally-Facilitated Marketplace is an unprecedented effort for CMS. CMS' FY 2016 Program Management request includes $629.0 million in appropriated funding for the Marketplaces (including $544.0 million in Program Operations and $85.0 million in Federal Administration), which combined with $1.6 billion in projected user fee collections would fully fund the operation of the Marketplaces at a program level totaling $2.2 billion.

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

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RDE) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 126 million beneficiaries in FY 2016.

Funding History

FY 2010	$2,335,862,000
FY 2011	$2,325,801,000
FY 2012	$2,658,900,000
FY 2013	$2,633,412,000
FY 2014	$2,943,405,000
FY 2015	$2,824,823,000

Budget Request: $3,024.4 Million

CMS' FY 2016 budget request for Program Operations is $3,024.4 million, an increase of $199.6 million above the FY 2015 Enacted level. This request will allow CMS to continue to operating Medicare, Medicaid, and CHIP, and to administer health insurance reforms, such as the Federally-facilitated Marketplace.

Program Operations
(Dollars in Millions)

Activity	FY 2014 Operating	FY 2015 Enacted	FY 2016 Request	FY 2016 +/- FY 2015
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$781.599	$842.193	$899.008	+56.815
FFS Operations Support	$40.410	$55.029	$98.895	+43.866
Claims Processing Systems	$71.237	$74.089	$78.962	+4.873
DME/Part B Competitive Bidding	$60.000	$19.000	$36.600	+17.600
Contracting Reform	$16.194	$13.978	$22.475	+8.497
II. Other Medicare Operational Costs				
Accounting & Audits	$104.059	$104.059	$118.750	+14.691
QIC Appeals (BIPA 521/522)	$88.800	$107.720	$158.736	+51.016
HIPAA Administrative Simplification	$28.492	$29.417	$46.220	+16.803
ICD-10/5010	$27.998	$45.000	$30.000	-15.000
Research, Demonstration, & Evaluation	$20.054[2]	$20.054[2]	$18.908	-1.146
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	$15.248	$24.401	$41.468	+17.067
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$60.154	$52.655	$57.595	+4.940
Oversight & Management	$367.944	$368.947	$317.114	-51.833
V. Health Care Quality				
Health Care Improvement Initiatives	$43.183	$59.408	$72.827	+13.419
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$258.184	$265.333	$355.131	+89.798
Provider Outreach	$23.904	$22.454	$25.140	+2.686
Consumer Outreach	$333.594	$83.405	$6.578	-76.827
VII. Information Technology				
IT Investments	$622.403	$657.733	$639.979	-17.755
TOTAL	**$2,943.405**	**$2,824.823**	**$3,024.386**	**+199.563**

[2] The FY 2014 Operating level and FY 2015 Enacted level for Research, Demonstration, and Evaluation is only shown for comparable purposes – FYs 2014 and 2015 funding is provided under a separate PPA.

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

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

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

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

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

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

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

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

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

In FY 2014 the MACs processed 3.8 million redeterminations and are expected to process 4.0 million in FY 2015. In FY 2016, CMS estimates the MACs will process over 4.2 million redeterminations reflecting steady growth in the number of redeterminations as seen in prior fiscal years.

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

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

In FY 2014, contractors responded to approximately 34 million telephone inquiries and 600,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. The contractors utilized Interactive Voice Response (IVR) systems to automate approximately 64 percent of their telephone inquiries. CMS estimates receiving 35 million telephone inquiries in FY 2016 and a slight increase in the IVR utilization rate. Utilization of the IVR frees up customer service representatives to handle the more complex questions. CMS has made a number of efforts that have contributed to decreased volume in FFS provider calls to MAC contractors' toll free lines. These efforts include:

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

The following table displays provider toll-free line call volumes from FY 2010 through FY 2016 (estimated):

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

	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate
Completed Calls	44.4	41.1	38.8	35.6	34.4	34.4	34.4

CMS believes the FFS related call volume will slightly decline in FY 2014 and remain stable through FY 2016, allowing CMS to absorb inquiries related to the implementation of Medicare related ACA provisions and other initiatives, such as ICD-10, and allowing CMS to provide better service for more complex calls.

Participating Physician/Supplier Program (PARDOC) – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who "participate" in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows. Every year, the MACs are instructed to furnish participation enrollment materials to providers. The open enrollment period runs from November 15 through December 31 of each year. CMS has made more information available at http://www.medicare.gov about physicians participating in Medicare. The National Participating Physician Directory includes the providers' medical school and year of graduation, any board certification in a specialty, gender, hospitals at which they have admitting privileges, and any foreign language capabilities. In 2014, 749,510 physicians "participated" out of 769,063 enrolled physicians (97.5%), and out of a total of 1,301,002 physicians, LLPs, and NPPs, 1,256,879 participated (96.6%).

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

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

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

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

Budget Request: $899.0 Million

The FY 2016 budget request for Ongoing Operations is $899.0 million, an increase of $56.8 million above the FY 2015 Enacted level. CMS' FY 2016 request supports a projected 1.5 percent increase in claims volume from the current FY 2015 projections.

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

In FY 2016, CMS' contractors expect to:

- Process nearly 1.3 billion claims
- Handle 4.2 million redeterminations (does not assume efficiencies from Medicare appeals proposals)
- Answer 34.4 million toll-free inquiries

The following table displays claims volumes and unit costs for the period FY 2010 to FY 2016. The unit costs reflect the total funds provided to our contractors in the Ongoing Operations line for claims processing, data centers, appeals, inquiries, enrollment, outreach and education, provider reimbursement, and PARDOC workloads. CMS' unit cost has declined sharply over the last several years as the MACs have replaced the fiscal intermediaries and carriers. We remain committed to achieving greater efficiencies in our fee-for-service operations.

Claims Volume and Unit Costs
(FYs 2010 – 2016)

Volume (in millions)	**FY 2010 Actual**	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**	**FY 2014 Actual**	**FY 2015 Estimate**	**FY 2016 Estimate**
Part A	195.2	199.1	207.3	207.6	210.0	213.9	217.1
Part B	979.5	989.8	1,011.9	1,006.3	1,003.0	1,036.7	1,052.2
Total	**1,174.7**	**1,188.9**	**1,219.2**	**1,213.9**	**1,213.0**	**1,250.6**	**1,269.3**
Unit Cost (in dollars)							
Total	**$0.89**	**$0.87**	**$0.83**	**$0.78**	**$0.76***	**$0.78***	**$0.71**

* Represents estimated costs per claim.

Fee-for-Service Operations and Systems Support

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

Social Security Number Removal from Medicare Card – Since the inception of the Medicare program, beneficiaries are identified using the Health Insurance Claim Number (HICN) that is comprised of the primary beneficiary's SSN and a beneficiary identification code (BIC). The HICN is used for communications between the beneficiary and CMS, for providers who bill CMS, and for enrollment transactions with Medicare Advantage and prescription drug plans. Additionally, the eleven Medicare Administrative Contractors (MACs) use the HICN for provider or supplier claims processing, remittance, and payment. With the rise of identity theft and the potential impact on beneficiaries, CMS conducted and transmitted to Congress an analysis for replacing the HICN with a randomly generated Medicare Beneficiary Identifier (MBI) and the Budget request supports the FY 2016 investment needed for implementation. The MBI will be issued on new Medicare cards and used by beneficiaries, providers, contractors, and private health plans when communicating with CMS. CMS is developing a reference service that will support operational flexibility with our partners and reduce costs by leveraging existing systems and process. This reference service will provide a platform to cross-reference various beneficiary identifiers. SSA will continue to generate the SSN and BIC for use as the HICN. The HICN will continue to be used by our federal partners and for internal CMS processes.

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

Cost Contract Audits – CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit effort to comply with the Federal Acquisition Regulations (FAR) and Departmental Supplemental Regulations (HHSAR). The OIG is currently conducting investigations on CMS' contract closeout processes to evaluate whether CMS is making necessary contract audit efforts. This activity supports the identification and addresses the steady state and backlogged audit requirement of a multitude of pre and post award audits.

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

Ongoing ACA Reform and Support Cost – This activity supports ongoing operations for Hospice Payment Reform, Mis-valued Physician Fee Schedule Codes, Consumer Research/Social Marketing to Support ACA, Self-Referral Disclose Protocol, Data Analytics by Physician-owned Hospitals Requesting ACA-mandated Exceptions, and Improvements to Medicare DSH Implementation.

Claims Surveillance DME Competitive Bidding & Bundled ESRD PPS – This activity supports the following activities and initiatives: End Stage Renal Disease Prospective Payment System (ESRD PPS) Refinement, Partial Hospitalization Program (PHP) Analytic Support, Claims Surveillance of ESRD PPS, the DMEPOS Competitive Bidding Program, SNF PPS, IRF PPS, and other General Program Monitoring Activities. CMS has developed the capacity to monitor claims and assessment data to examine key aspects of our payment programs. This payment monitoring capacity allows for program officials to analyze the effects of changes to the payment system on beneficiary utilization, health outcomes and care delivery. CMS will continue with our work to expand and update these claims surveillance programs as well as develop a broader monitoring framework to address spending variation across the Medicare program.

A-123 Internal Controls Assessment – The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations.

Medicare Beneficiary Ombudsman – The legislative mandate for the creation of a Medicare Ombudsman (MMA Section 923) requires the Medicare Beneficiary Ombudsman to provide assistance to Medicare beneficiaries with handling their inquiries, complaints, grievances, and appeals. To this end, CMS works internally and with partners to identify underlying systemic issues in the administration of the Medicare program, make recommendations for short and long term resolution, and serve as a facilitator for resolutions to these issues that affect people with Medicare.

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

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

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

MAC Provider Internet Transaction Pilots – Medicare Administrative Contractors (MACs) have been in the process of establishing internet based services for providers. Using these portals to eliminate paper has great savings potential through decreasing the provider inquiries workload by obtaining more information via the Internet as opposed to strictly provider telephone Interactive Voice Response (IVR) or CSRs, decreasing the number of paper claims, and decreasing the number of people required to process clerical re-openings and redeterminations.

CMS must support the existing portals, and ensure continued contractor compliance with Agency standards.

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

Budget Request: $98.9 Million

The FY 2016 budget request for fee-for-service operations support is $98.9 million, an increase of $43.9 million above the FY 2015 Enacted level. This increase is due to a single new activity request to remove social security numbers from Medicare cards. The activities that make up this request are as follows:

- *SSN Removal:* $50 million, an increase of $50 million over the FY 2015 Enacted level. This invests in the FY 2016 related program needs and will support continuation of implementation activities. CMS is developing the Enterprise Reference Service and will begin to conduct outreach activities to address beneficiary and provider concerns.

- *Printing and Postage*: $8.0 million, a decrease of $0.4 million below the FY 2015 Enacted level. This funds CMS' ongoing FFS printing and postage needs. CMS estimates the direct billing of Medicare Part A, Part B and Part D IRMAA premiums for beneficiaries in FY 2016 will increase by approximately 10 percent

- *Cost Contract Audits*: $4.9 million, an increase of $2.7 million above the FY 2015 Enacted level. This funding will be used to enter into agreements with the Defense Contract Audit Agency, as well as other contractors, to handle steady state and backlogged cost audit efforts.

- *Prototypic Shared Services*: $4.2 million, an increase of $4.2 million above the FY 2015 Enacted level. Funding is requested for contractor support assisting with multiple initiatives, including continued development and expansion of SharePoint, EPPE, and Non-Claims Based Payment. Increasing the availability and adoption of SharePoint across businesses is expected to save costs associated with redundant collaboration software. The EPPE system will allow CMS to more efficiently track and adjudicate requests for PII data, while reducing security and privacy risks. CMS will outgrow its capacity for storing non-claims based payment data by late 2015, which threatens the viability of current Shared Savings Programs and impedes our ability to change our payment paradigm to encourage better care at lower costs.

- *Ongoing ACA Reform and Support Cost*: $3.9 million, an increase of $0.6 million above the FY 2015 Enacted level. This request supports contract costs for ongoing ACA FFS activities. The increase funds the expansion of new consumer research and social marketing efforts to help consumers better understand ACA programs. CMS has recently begun using more engaging electronic media to reach our target audiences. These include social media, text, and broader consumer based email.

- *Bundled ESRD PPS*: $3.0 million, an increase of $0.7 million above the FY 2015 Enacted level. CMS requests an increase in funding to complete the analysis required by section 632 of the American Taxpayer Relief Act (ATRA) and 217 of the Protecting Access to Medicare Act (PAMA) for bundled ESRD PPS refinements, and thus, be able to realize the associated savings to the Medicare program. Additionally, CMS will be able to procure the analytic support needed to explore potential refinements to the Partial Hospitalization Program (PHP) payment system or update sub regulatory guidance on reasonable cost reimbursement issues impacting ESRD, PHP, and other post-acute programs.

- *A-123 Internal Controls Assessment*: $2.0 million, the same as the FY 2015 Enacted level. Funding supports a Certified Public Accountant (CPA) firm to conduct a rigorous assessment of the CMS internal controls over financial reporting, which is required by the Office of Management and Budget (OMB) Circular A-123 (Management's Responsibility for Internal Control). This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors.

- *Medicare Beneficiary Ombudsman*: $1.8 million, the same as the FY 2015 Enacted level. This request provides continued support in developing the Medicare Beneficiary Ombudsman Report to Congress and the Competitive Acquisition Ombudsman (CAO) Report to Congress, support and identifying, tracking, and analyzing systemic Medicare program issues and support for Ombudsman-focused outreach mechanisms.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $1.8 million, a decrease of $0.4 million below the FY 2015 Enacted level. Contractor support is needed to operate the program and process payments quarterly. Further, the program is to remain operational until the appropriated funds are expended. It is anticipated that appropriated funds will still be available in FY 2016 therefore CMS is required to meet the statutory obligations under Section 1011 of the MMA.

- *Actuarial Services*: $1.2 million, an increase of $0.2 million above the FY 2015 Enacted level. Funding is requested for contractor support to produce financial estimates for all CMS demonstrations, regulations, and legislative proposals.

- *Medicare HEDIS Quality of Care Performance Measures*: $1.2 million, a decrease of $0.3 million below the FY 2015 Enacted level. Funding supports a contractor that coordinates and provides research support to the Geriatric Advisory Panel (GMAP) to assist in the development, evaluation, and refinement of quality of care performance measures relevant to MA organizations. This activity is critical for CMS to be able to evaluate SNPs' ability to effectively coordinate care for older and/or disabled adults and to develop tangible SNP models of care outcome measures.

- *MAC Provider Internet Transaction Portals*: $0.7 million, the same as the the FY 2015 Enacted level. The FY 2015 request included funding needed for both ongoing costs and the expansion/integration of the MAC portals into the Agencies shared services, hence the additional need in the FY 2015 Enacted level. FY 2016 funding will support the existing portals, and ensure continued contractor compliance with Agency standards for security, privacy, systems architecture, and data exchange as well as bring all portals up to consistent minimum levels of self-service functionality.

- *Home Health PPS Refinement:* $0.6 million, a decrease of $0.9 million below the FY 2015 Enacted level. In FY 2015, CMS expects to implement structural changes to the payment system which increase one year operational costs. In FY 2016, the funding will be used for a new monitoring contract to understand the effects of the structural changes on patient access, quality of care, and provider behavior.

- *Other Operational Costs:* $15.6 million, a decrease of $13.3 million below the FY 2015 Enacted level. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

Claims Processing Systems

CMS' claims processing systems currently process nearly 1.3 billion Part A and B claims each year, and these systems are a major component of our overall information technology costs. The claims processing systems receive, verify, and log claims and adjustments, perform internal claims edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The request covers ongoing systems maintenance and operations. The main systems include:

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

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

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

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

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

Budget Request: $79.0 Million

The FY 2016 budget request for claims processing systems is $79.0 million, an increase of $4.9 million above the FY 2015 Enacted level. This request reflects the ongoing costs associated with maintaining claims processing systems. Maintaining these systems will provide integration and regression testing for claims adjudication, payments, and remittance advices that support various system interfaces, which is essential in ensuring accurate payments. Additionally, CMS must make software changes to the claims processing systems including four quarterly releases that control, implement, and update software changes due to legislative mandates that dictate the amount of payment for services or coverage levels. These system changes needed aid in supporting the Medicare Administrative Contractor (MAC) functionality for the Medicare Fee for Service Program.

Competitive Bidding

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

Budget Request: $36.6 Million

The FY 2016 budget request for competitive bidding is $36.6 million, an increase of $17.6 million above the FY 2015 Enacted level.

The increase in funding over the FY 2015 Enacted level will be used to fund the oversight and maintenance for the Round 2 Re-compete and the National Mail Order Re-compete competitions which are comprised of significantly more Competitive Bidding areas than the Round 1 Re-compete.

In addition to conducting the bidding phases of the various competitions, CMS must continue to also perform the oversight and maintenance periods for the competitions once they are implemented.

The DMEPOS competitive bidding program saved the Medicare fee-for-service program approximately $400 million over the first two years of operation, and according to current actuarial estimates, the program is projected to save the Medicare program approximately $30 billion between 2016 and 2025, with an additional $20 billion in savings for beneficiaries during that same period.

Contracting Reform

Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B contracting under a single contract authority, known as a Medicare Administrative Contractor or MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR), and enabling a re-engineering of business processes. Following are the major funding requirements for this effort:

IT Systems – Contractor Management Information System (CMIS), maintenance and enhancements to the electronic change management portal (eChimp) system, and the Common Electronic Data Interchange (CEDI) system. The CMIS is an application that allows CMS to effectively manage, monitor, and report on the performance of its Medicare fee-for-service contractors. CMIS is a web-based analytical application that has been deployed on the CMS net. The eChimp system is used by CMS, Medicare FFS Contractors, and MACs to support the Fee for Service Change Management Process. This support includes online forms for the MACs to report the functions involved in reviewing and implementing the requirements in the change requests and an electronic approval process. The CEDI front-end system provides a single front-end solution for the submission of electronic claims-related transactions for Medicare durable medical equipment suppliers. This standardization allows greater efficiencies in inbound and outbound EDI exchange. The need for standardization, modernization, and consolidation in both front-end and post-claims adjudication functions and processes is imperative for efficiencies. The Standard Front End (SFE) is a system that is cost effective, extensible, and sufficiently flexible to meet current needs and support future enterprise EDI and electronic commerce requirements.

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

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

On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of procurements. CMS' original plan was to reduce the number of A/B MACs from fifteen to ten by 2017. As of February 2014, CMS has consolidated the number of A/B MAC's to twelve. CMS has decided to indefinitely suspend plans to reduce the number of MACs to ten.

Below is the general status of MAC procurements.

Medicare Administrative Contractors (MACs)			
As of February 14, 2014			
MAC Jurisdiction	**Previous MAC Jurisdiction**	**Processes Part A & Part B Claims for the following states:**	**MAC**
DME A	DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	NHIC, Inc.
DME B	DME B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	National Government Services, Inc.
DME C	DME C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands	CGS Administrators, LLC
DME D	DME D	Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
E	1	California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
F	2 & 3	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian Healthcare Solutions, LLC
5	5	Iowa, Kansas, Missouri, Nebraska	Wisconsin Physicians Service Insurance Corporation
6	6	Illinois, Minnesota, Wisconsin **HH + H for the following states: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, US Virgin Islands, Wisconsin and Washington	National Government Services, Inc.
H	4 & 7	Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi	Novitas Solutions, Inc.
8	8	Indiana, Michigan	Wisconsin Physicians Service Insurance Corporation
N	9	Florida, Puerto Rico, U.S. Virgin Islands	First Coast Service Options, Inc.
10	10	Alabama, Georgia, Tennessee	Cahaba Government Benefit Administrators, LLC
11	11	North Carolina, South Carolina, Virginia, West Virginia (excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia) **HH + H for the following states: Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas	Palmetto GBA, LLC
L	12	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (includes Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)	Novitas Solutions, Inc.
K	13 & 14	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont **HH + H for the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	National Government Services, Inc.
15	15	Kentucky, Ohio **HH + H for the following states: Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming	CGS Administrators, LLC
**Also Processes Home Health and Hospice claims			

Budget Request: $22.5 Million

The FY 2016 budget request for contracting reform is $22.5 million, an increase of $8.5 million above the FY 2015 Enacted level. This request includes funding for MAC implementation and transition costs as a result of re-competes, implementation and audit expertise, and three IT systems.

- *IT Systems:* $6.1 million, an increase of $0.2 million above the FY 2015 Enacted level. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), eChimp system and Common Electronic Interchange System (CEDI).

- *MAC Transition Costs*: $16.4 million, an increase of $8.3 million above the FY 2015 Enacted level. CMS' request supports contract termination claims/settlements that will come due in FY 2016 for several large legacy contracts that ended during FY 2013 and will need to be settled out in FY 2016. CMS anticipates several contract awards in FY 2016, including the very largest MAC contract (Jurisdiction H).

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

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

II. OTHER MEDICARE OPERATIONAL COSTS

Program Description and Accomplishments

Accounting and Audits

Healthcare Integrated General Ledger and Accounting System (HIGLAS) – HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting and replaces the existing separate accounting/payment systems for Medicare and Medicaid. The main objective of this effort is to leverage the use of commercial off the shelf (COTS) software in the Federal government to increase automation, increase efficiency, and maximize economies of effort to centralize management. 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 DHHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of DHHS.

HIGLAS implementation has yielded significant improvements and benefits to the Nation's Medicare program which has strengthened the Federal government's fiscal management and program operations/management of the Medicare program. HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement

Act (FFMIA) of 1996. HIGLAS is a critical success factor in ensuring DHHS meets FFMIA compliance requirements. Through the implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the implementation of administrative program accounting functions at CMS central office, 100 percent of CMS core program dollars (Medicare, Medicaid and Children's Health Insurance Program (CHIP)) are accounted for in HIGLAS. In addition, the transition of Medicare contractors to HIGLAS enables CMS to resolve material weaknesses identified in the CFO audits related to the accounting of Federal dollars. The MAC transition schedule was completed in FY12.

The HIGLAS effort has significantly improved the ability of CMS to perform Medicare accounting transactions. These improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare contractor overpayments. Moreover, HIGLAS implementation has resulted in better internal financial controls across Medicare contractor operations. Implementation of HIGLAS has had a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. From the beginning of HIGLAS implementation in May 2005 through FY 2013, CMS estimates that more than $620 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes. In addition, new financial functionality for the Affordable Care Act related legislation has been implemented in HIGLAS. In early FY 2014, CMS implemented the initial capability to account for the Health Insurance Marketplace payments in HIGLAS. Additional programs and financial functionality as required by the Affordable Care Act is planned for implementation in HIGLAS during FY 2016.

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

Budget Request: $118.8 Million

The FY 2016 budget request for HIGLAS and the CFO audit is $118.8 million, an increase of $14.7 million above the FY 2015 Enacted level. In FY 2016, CMS will support the production and application maintenance of HIGLAS. There is no request for funding in FY 2016 for additional development, modernization and enhancements to HIGLAS.

- *HIGLAS*: $108.9 million. This request supports operations and maintenance costs including payment to the entity that performs data processing and hosts the HIGLAS application (including hardware and software maintenance), payment for the disaster recovery hot site and continuity of operations support, development and implementation of quarterly software releases to update HIGLAS for changes in two Medicare claims processing and payment

rules systems, shared system maintainer costs related to changes made to enable HIGLAS interfaces, HIGLAS production help desk, and HIGLAS technical and analytical services.

HIGLAS Costs - FY 2012 through FY 2016
(Dollars in Millions)

	FY 2012 Final	FY 2013 Final	FY 2014 Operating	FY 2015 Operating	FY 2016 Request
Development, Modernization & Enhancement	$33.9	$32.2	$8.5	$0.0	$0.0
Operations & Maintenance	$118.2	$118.2	$85.7	$94.2	$108.9
Total	$152.1	$151.4	$94.2	$94.2	$108.9

- *CFO/Financial Statement Audits:* $9.9 million. The cost of the audit is funded through an interagency agreement (IAA) between CMS and DHHS, and is based upon the General Services Administration (GSA) rate schedules and federal audit requirements.

Qualified Independent Contractor Appeals (QIC)

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

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

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

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

Budget Request: $158.7 Million

The FY 2016 budget request for QIC appeals (BIPA section 521) is $158.7 million, an increase of $51.0 million above the FY 2015 Enacted level. CMS requests:

- *QIC Operations*: $144.3 million, an increase of $43.6 million above the FY 2015 Enacted level. Of the $144.3 million request, CMS requests $107.1 million for ongoing QIC operations to manage the increase in workloads and to complete appeals within the required 60-day timeframe. Additional contractor funding is required to handle an estimated 10% increase in claims workload in FY 2016 as compared to FY 2015.

  CMS also requests $36.2 million allowing CMS to engage in discussions with providers to resolve disputes at the earliest stage in the appeals process and additional funding for greater CMS participation in Administrative Law Judge hearings at Office of Medicare Hearing and Appeals (OMHA). This investment will improve the efficiency of the Medicare appeals process at the third and fourth level, enabling OMHA to more quickly and efficiently adjudicate its current backlog by reducing the number of claims appealed beyond the CMS levels.

- *Medicare Appeals System*: $14.4 million, an increase of $7.4 million above the FY 2015 Enacted level. The additional funding will aid in bringing the five remaining MACs on board the MAS system.

The number of appeals has consistently increased over the last several years. In FY 2013, the largest appeals increases involved Part A Durable Medical Equipment (DME) claims. CMS is anticipating continued increases in overall appeal receipts through FY 2016. The workload chart below contains actual receipts by fiscal year and current projections of appeals for FY 2015 through FY 2016.

QIC Appeals Workload

	FY 2010 Actual	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**	**FY 2014 Actual**	**FY 2015 Estimate**	**FY 2016 Estimate[3]**
QIC Appeals	494,077	520,221	758,921	1,000,013	1,112,192	1,223,411	1,345,752
% Increase from Previous Year	8.1%	5.3%	45.9%	31.8%	11.2%	10.0%	10.0%

[3] This estimate does not include efficiencies gained by implementing the Medicare appeals legislative package.

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

Reconsiderations (2nd Level of Appeal)		
FY	**Part A**	**Part B**
2007	99.90%	72.28%
2008	99.89%	99.69%
2009	99.82%	99.01%
2010	99.96%	99.87%
2011	99.96%	92.76%
2012	82.23%	88.99%
2013	21.47%	99.75%
2014	92.51%	99.89%

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

- Continued growth in the beneficiary population.

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

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

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

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

HIPAA Administrative Simplification

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

- *National Provider Identifier (NPI) & National Plan and Provider Enumeration System (NPPES)* – HIPAA requires the assignment of a unique national provider identifier (NPI) to

all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. CMS was delegated the responsibility to build a system, known as the NPPES, which assigns NPIs and processes NPI applications. It also makes subsequent changes to the data of enumerated providers. Providers are required to keep their NPPES data current by submitting timely updates. In addition, approximately 12.6 percent of the covered health care providers need to furnish updates in a given year. 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 is intended to continue indefinitely. Currently, over 4.3 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers.

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

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

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

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

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

- *ACA Initiatives Sections 1104 and 10109* – Section 1104 establishes a series of new operating rules and standards for administrative transactions that will improve the utility of

the existing HIPAA transactions. The law mandates additional requirements for all HIPAA covered entities such as industry health plans, providers, and clearinghouses. Additionally, all CMS health care programs such as Medicare, Medicaid, and health plans participating in the Marketplaces are required to comply with the requirements or face hefty penalties.

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

- *Section 1104* requires the Secretary to adopt two new standards and eight new sets of operating rules for administrative transactions by December 31, 2015. It also establishes a Review Committee to recommend amendments to standards and operating rules. The law requires that CMS and all health private and commercial health plans adopt and implement an ongoing certification of compliance process triggered with every new or modified standard or operating rule. This requires CMS to build the infrastructure and systems to certify health plans, establish a new enforcement and appeals process that ensures certification compliance, and design the internal systems and processes to assess federally mandated penalties and to comply with Treasury reporting requirements.

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

Budget Request: $46.2 Million

The FY 2016 budget request for HIPAA Administrative Simplification is $46.2 million, an increase of $16.8 million above the FY 2015 Enacted level. The increase supports CMS' HIPAA administrative simplification efforts as mandated by the ACA. Funding is requested for the following activities:

- *NPI & NPPES*: $9.0 million, an increase of $0.5 million above the FY 2015 Enacted level. At this level, CMS can comply with current NPI requirements, continue its current enumeration workload, and conduct the following ongoing activities:

  - Resolution and correction of data inconsistencies between NPPES and the IRS. The NPI Enumerator works with providers whose data do not match IRS' records in order to resolve issues. This work is an ongoing part of CMS' responsibility for ensuring the inclusion of accurate, correct data in NPPES.
  - Dissemination of the monthly NPPES file. CMS is required by Federal Notice to make this file available via the Internet each month.
  - Utilization of SSA's Death Master File by the NPI Enumerator to verify the death of providers who have been assigned NPIs, deactivate those NPIs, and pass this information on to the Medicare provider/supplier enrollment system.

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $13.3 million, a decrease of $0.4 million below the FY 2015 Enacted level. CMS provides institutions and

other health care providers with beneficiary eligibility information. This systems application is considered mission critical as it provides eligibility information on a real-time basis as well as assists in determining how Medicare should be billed for the services rendered. The FY 2016 request will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA EDI standard.

- *HIPAA Outreach, Enforcement, Compliance Reviews, Pilot*: $9.3 million, an increase of $2.1 million above the FY 2015 Enacted level. Contractor support will be needed to complete IT system requirements, develop regulations, and conduct training, outreach and education. CMS's goal is to reduce the clerical burden on patients, providers, and health plans by reducing the amount and complexity of forms and data entry required prior to or at the point of care. The industry has requested that CMS conduct more outreach to assist in understanding the new policies that are being published, and the Regional Offices require greater support from Central Office. The gap analysis pilot will help in the adoption of an updated version of the standard when the Review Committee is established to make its recommendations to the Secretary.

- *ACA Initiatives Sections 1104 and 10109*: $14.6 million, an increase of $14.6 million above the FY 2015 Enacted level. Section 1104 establishes a series of new operating rules and standards for administrative transactions that will improve the utility of the existing HIPAA transactions. The law mandates substantial additional requirements for all HIPAA covered entities such as industry health plans, providers, and clearinghouses. Additionally, all CMS health care programs such as Medicare and Medicaid will be impacted as covered entities and are also required to comply with the requirements or face hefty penalties. CMS requests funding for Medicare/Medicaid implementation of Section 1104, certification compliance implementation and audit, project management, and outreach and education which will continue to be necessary after plans are required to certify by December 31, 2015.

  If funding is not received, CMS programs will be delayed in implementing new standards and operating rules, while other covered entities move forward with their implementations. Additionally, all covered entities including all CMS health care programs like Medicare, Medicaid, and health plans participating in the Marketplaces are susceptible to non-compliance sanctions and therefore face penalties.

ICD-10 and Version 5010 Regulations

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

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted. Under section 212 of PAMA, the Secretary may not, prior to October 1, 2015, adopt ICD-10 code sets as standard codes under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, the U.S. Department of Health and Human Services released an interim final rule on July 31, 2014 that established a new compliance date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS). This interim final rule required the use of ICD-10-CM and ICD-10-PCS by all entities covered under HIPAA, including CMS, for services provided beginning October 1, 2015. The rule also required HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

CMS has prepared its systems to continue to process ICD-9 coded claims after October 1, 2014. CMS is continuing to manage the transition back to ICD-9 coded claims while simultaneously preparing for the new ICD-10 compliance date on October 1, 2015.

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

As the largest payer of healthcare in the U.S., CMS must be equipped to handle increased volume of provider payment issues, including payment rejections and denials, coordination of benefit issues, appeals, and call center inquiries. While systems will be ready to accept ICD-10 on October 1, 2015, the volume of claims with later dates of service are expected to increase through January to March 2016. CMS also anticipates the need for increased call center support through most of FY2016 for the Medicare Administrative Contractor, 1-800-Medicare and Medicaid programs for providers requiring additional instruction and for beneficiaries who are incorrectly billed for services due to invalid coding.

- *Current ICD-10 Status:* CMS is on track to implement ICD-10 on October 1, 2015. In support of CMS' implementation targets, key activities include:

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

    - Conversion of groupers, pricers, code editors, and National Coverage Determinations (NCD). CMS Medicare FFS claims processing systems were updated with ICD-10 as of October 1, 2013. Due to the PAMA delay, additional legislative requirements have been added to the program that requires CMS to extend the usage of ICD-9 for another year for dates of service beyond October 1, 2014. Therefore, significant ICD-9 system edits were required to limit disruptions to payments on October 1, 2014 (for ICD-9 coded claims). Furthermore, all ICD-10 coded manuals and payment policies like groupers, pricers, code editors, and NCDs have been redesigned to include the usage of ICD-9 for a longer period of time.

    - CMS' ICD-10 Steering Committee is working to resolve outstanding policy issues, and identifying risk mitigation strategies to ensure that the agency's primary goal of making payments to providers will be met in response to industry-wide concerns, outreach and education efforts have been ramped up/targeted based on the survey results.

    - State Medicaid agencies are reporting progress toward ICD-10 compliance on periodic self-assessments conducted by CMS, while others have continued to need additional assistance. CMS has provided ICD-10 training and technical assistance to States as requested and based on progress reported on assessments. CMS has visited over 44 states and is working with each of the U.S. Territories. In addition to the technical assistance program, CMS conducted 5 comprehensive 2-day State Medicaid ICD-10 workshops encompassing all 10 HHS/CMS regions, during February and March 2014.

All 56 State Medicaid Agencies were invited to their respective Regional Offices for ICD-10 training focused on risk mitigation and testing.

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

Budget Request: $30.0 Million

The FY 2016 budget request for ICD-10/Version 5010 is $30.0 million, a decrease of $15.0 million below the FY 2015 Enacted level. The majority of the agency's ICD-10 implementation work and contractor requirements should be accounted for in FY 2015, with allowances for finalization of system and business process modifications and allowances for workarounds to address possible unexpected claims adjudication issues taking place post-implementation. These actions should bring ICD-10 into a steady state in FY 2016.

The costs associated with ICD-10 implementation affected by the PAMA mandate can be broken into three cost categories: 1) the cost to disengage IT systems, processes, manuals, regulatory requirements, and other agency functions that had been built around an October 1, 2014 ICD-10 compliance date; 2) the cost to re-implement use of ICD-9 in systems, processes, manuals, regulatory requirements, and other agency functions to be in effect from October 1, 2014 through September 30, 2015; 3) the cost to implement ICD-10 into systems, processes, manuals, regulatory requirements, and other agency functions around an October 1, 2015 ICD-10 compliance date. Remaining transition costs for FY 2016 include:

- *Post-implementation Risk Planning IT System Costs:* $15.5 million. This request supports CMS' Risk Mitigation and Post-implementation strategy to establish a process that would manage and mitigate any potential or unforeseen systems issues related to ICD-10 claims processing. Through this action, CMS' post implementation planning will be flexible, adaptable, and responsive to potential policy changes that would require a corresponding action to CMS systems. Any potential changes would require quick remediation and turnaround times to minimize disruptions.

- *Post-Implementation Code Policy Analysis and Evaluation:* $2.8 million. This request supports all activities associated with conducting additional analysis and evaluation of code policies for national and local coverage determinations, and quality measures once the updated measures and coverage decisions are launched into production. National coverage determinations are evaluated and updated on an annual basis. Additionally, code policy changes will be needed to analyze and evaluate ICD-10 data for purposes of developing risk adjustment models for Medicare Advantage plans. Quality measures will utilize ICD-10 policy changes to determine payment.

- *Training, Outreach & Education:* $5.7 million. This request supports CMS transparency and communication with providers and the health care industry. This action supports the development of industry-wide training, messaging, and outreach and education. CMS will

develop targeted messaging, frequently asked questions, and training to clarify operational policy guidance and increased responsiveness to the provider community.

- *Post-Implementation Project and Risk Management Requirements:* $6.0 million. This request supports CMS' Risk Mitigation and Post-implementation strategy to establish a post-implementation project plan and risk mitigation strategy to manage potential post-implementation issues. Many large-scale implementations undergo a transition period after the compliance date before a sense of industry-wide equilibrium is achieved. Project management, risk mitigation, special daily reporting, monitoring, and evaluation of industry adoption as well as increased industry-wide guidance and coordination between CMS the healthcare industry will be required.

Research, Demonstration, and Evaluation

The Research, Demonstration and Evaluation (RDE) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 126 million beneficiaries in FY 2016. This request leverages other funding sources, such as ACA section 3021, to support RDE projects wherever possible.

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

Medicare Current Beneficiary Survey – The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose, in-person survey of a representative sample of the Medicare population. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete information on health care costs, utilization, access to and quality of care. MCBS is a unique and valued data source, having been continuously fielded for more than 20 years (encompassing over 1 million interviews) and evolving as the agency's needs have progressed.

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

MCBS continues to be used by CMS to track trends in out-of-pocket spending and monitor Medicare supplemental insurance (Medigap), and is a major basis for the annual Trustees' Report. MCBS data have also been used to track beneficiary's knowledge and sources of

information about Medicare, especially following the implementation of a new program or services (e.g. Part D, “Welcome to Medicare” benefits, etc.). Self-reported MCBS’ data on immunizations is currently used to track whether CMS is meeting population health objectives.

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

Given the multi-purpose nature of the MCBS and its significant use and applicability to ACA section 3021 research and evaluation, CMS will jointly fund the MCBS in FY 2016 from both the Program Management and ACA Section 3021 appropriations. CMS is estimating an equal cost allocation in FY 2016 between these two appropriations, but will reassess the allocation on an annual basis based on user data statistics.

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

CMS continues to develop, enhance and administer multiple initiatives aimed at providing important data products and information key to research efforts. One such tool is the chronic conditions warehouse (CCW). The CCW houses CMS data that are easily linked, at the individual patient level, for all Medicare and Medicaid claims data, eligibility data, nursing home and home health assessments, and CMS beneficiary survey data. This data warehouse transforms and summarizes this administrative health insurance information into research data files, thus providing researchers all the information they need to conduct studies focused on improving the quality and cost of care provided to chronically ill beneficiaries. To further facilitate research and assure the security of CMS’ administrative data, the CMS Virtual Research Data Center (VRDC) was constructed within the current CCW infrastructure. The VRDC provides approved researchers with access to more timely CMS data in a secure and more cost effective manner. In addition, the CCW project supports the CCW Website (www.ccwdata.org) which includes documentation on the various data sets available via the CCW and provides a number of static data tables related to the Medicare and Medicaid population as well as an interactive Chronic Conditions Dashboard. Finally, the CCW project also includes help desk and training (both classroom and virtual) to better acclimate researchers to the complexity of working with Medicare and Medicaid data.

Another CMS tool that supports external and internal researchers is the Research Data Assistance Center (ResDAC), comprised of a help desk and website. The ResDAC provides technical assistance to researchers on CMS data and data systems. The goal is to increase the number of researchers skilled in accessing and using CMS data for research studies, which may lead to improvements in the Medicare and Medicaid programs. The ResDAC receives approximately 6,800 inquiries a year.

Historically Black Colleges University and Hispanic Serving Institutions Research Grant Programs – Consistent with the HBCU Executive Order 13532 and HSI Executive Order 13555, CMS awards grants to HBCU and HSI investigators to research topics of relevance to CMS African American and Hispanic American Medicare, Medicaid, and CHIP beneficiaries. The Research program meets the crosscutting research needs of the wider health research community through grant programs that establish partnerships with Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs) researchers. These grants assist researchers in conducting health services research that supports the CMS mission and our diverse beneficiary population by presenting new paradigms, strategies, and tactics to reduce health care disparities and better the health of African American and Hispanic American populations. The HBCU grant program was established in 1995 and the HSI grant program was established in 1999. HBCU and HSI provide funding amounts to three research projects totaling $600,000 ($200,000 per project).

Budget Request: $18.9 Million

The FY 2016 budget request for Research, Demonstration, and Evaluation is $18.9 million, a decrease of $1.1 million below the FY 2015 Enacted level. CMS will continue funding ongoing research data analytic activities supporting the Agency and split funding the MCBS with the Innovation Center (ACA Section 3021).

- *MCBS*: $12.0 million, the same as the FY 2015 Enacted level. CMS requests funding to maintain the survey's content and utility, and support provisions in the ACA. In FY 2016, CMS is expecting an equal split of the MCBS' total operational cost of $24.0 million between RDE and ACA Section 3021 at $12.0 million each. This operational sum will allow CMS to continue the modernization and redesign of the MCBS per the recommendations and findings of the most recent Federally Funded Research and Development Center (FFRDC) report.

- *Other Research*: $6.9 million, a decrease of $1.1 million below the FY 2015 Enacted level. This funding supports efforts that build and improve CMS' health service research, data and analytical capacity, as well as program evaluations. These activities include, for example, the Chronic Condition Warehouse (CCW), Research Data Assistance Center (ResDAC) and CER Public Use Data Files and Medicaid Analytic Data. Additional programmatic requests include Demonstration Operations, Design and Analysis, and the HBCU/Hispanic Research Grants Program.

III. MEDICAID & CHIP INITIATIVES

Program Description and Accomplishments

Medicaid and CHIP Operations

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

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance.

At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a larger population of medically vulnerable Americans, including low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services and supports, who all should receive coordinated, quality care. The enrollment for Medicaid and CHIP is expected to be 78.8 million in FY 2016 with more than 1 in 5 Americans participating in Medicaid or CHIP.

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

CHIP was created through the Balanced Budget Act of 1997 to address the fact that nearly 11 million American children - one in seven - were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but earned too much to be eligible for Medicaid. On February 4, 2009, CHIPRA was enacted reauthorizing CHIP and extending funding through FY 2013. The ACA provided additional funding for CHIP through 2015.

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

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

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

- *Basic Health Program* – Section 1331 directs the Secretary to establish a Basic Health Program (BHP) in which states may choose to enroll eligible individuals, with income between 133% and 200% the Federal Poverty Level (FPL), in lieu of offering such individuals coverage through the Marketplace. States electing the BHP option will provide coverage to eligible individuals and receive 95% of the federal funding that would have been provided to the individual as premium tax credits and cost-sharing reductions if they had been covered through the Exchange. As States consider the BHP, CMS will be required to provide technical assistance, review and certify state plans for implementation (known as BHP Blueprints), and provide ongoing oversight of state BHPs. CMS must also conduct an annual review of each state program to ensure compliance with federal requirements.

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

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

- *CHIPRA Initiatives* – CMS continues to champion efforts to enroll and retain more children in Medicaid and CHIP by providing technical assistance to States, grantees, and other critical stakeholder groups. The CHIPRA grants allow CMS to successfully target and implement

outreach strategies in geographical areas with high rates of eligible but un-enrolled children, including children who are racial and ethnic minorities or who reside in rural areas. This funding also allows CMS to address the Agency's focus to improve access to pediatric dental services for Medicaid and CHIP children, which has traditionally been underutilized. Additionally, continued funding will support outreach activities designed to help families understand new application procedures and health coverage opportunities, including Medicaid, CHIP and insurance affordability programs under the ACA.

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

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

- *Certification of Pediatric Coverage* – Section 2101 of the ACA requires the Secretary to review the benefits offered and the cost sharing imposed for such benefits by qualified health plans (QHPs) offered through a Marketplace, and certify those QHPs that have benefits and cost sharing that are at least comparable to the benefits offered and cost-sharing protections provided in CHIP. This certification process must be completed by April 1, 2015.

- *Survey of Retail Prices* – The Survey of Retail Prices is divided into two parts. Part I consists of a nationwide retail survey for collecting information about consumer prices. Part II of the survey helps determine pharmacies' acquisition costs of covered outpatient drugs to serve as a source of information for States to set reasonable payment rates to pharmacies. Due to budgetary limitations, we determined that collecting the actual invoice prices from retail community pharmacies in Part II was more critical. Part I was suspended in July 2013. The FY 2016 request includes a proposal to fully fund both parts of this survey through mandatory funding.

Budget Request: $41.5 Million

The FY 2016 request for Medicaid and CHIP operations is $41.5 million, an increase of $17.1 million above the FY 2015 Enacted level. Funding in this section includes support for administrative activities necessary to operate Medicaid and CHIP.

- *Medicaid Systems Support:* $16.1 million, an increase of $3.2 million above FY 2015 Enacted level. This request will aid in funding the operation and maintenance for the Medicaid & Child Health Budget & Expenditure System (MBES), Medicaid Drug Rebate/Federal Upper Limit System, Medicaid IT Architecture (MITA), and the Medicaid Statistical Information System (MSIS) among others. Operation and maintenance includes maintaining (upgrading hardware, operating systems, etc.) the system infrastructure to support the systems. In addition, enhancements are applied to applications as changes to statutory requirements change. All of these systems are mission critical to administering the Medicaid and CHIP program.

- *The National Home and Community Based Services (HCBS) Quality Enterprise*: $4.3 million, an increase of $2.8 million above the FY 2015 Enacted level. Contract support is required to provide practical expertise to support States' efforts to improve quality and compliance with policy, regulations and system goals, to adopt a strategic approach to improving quality outcomes across home and community-based services programs as States design and implement their reform initiatives, and practical expertise in achieving goals of corrective action plans, oversight and program integrity, and assisting States to implement new HCBS regulations, effective March 17, 2014. CMS plans to expand the scope of work after the base year of the contract to include other regulatory requirements including but not limited to person centered planning, conflict of interest and targeting population. As a result, CMS estimated waiver submissions and the volume of education and training will increase as states work to come into compliance with new regulations and begin to move into other areas of concentration regarding the new regulations.

- *Basic Health Program*: $2.5 million, an increase of $2.5 million above the FY 2015 Enacted level. Given that States began implementation of BHP on January 1, 2015, CMS requests funding in FY 2016 to begin evaluating state data collection and perform analysis so that meaningful evaluation and subsequent programmatic refinements can be initiated. It is also anticipated that some additional states may elect the BHP option as the year progresses, and CMS will need funding in FY 2016 for new State implementation.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $1.8 million, the same as the FY 2015 Enacted level. Funding is requested to assist with program oversight and evaluation of State demonstration programs, as well as to maintain the website used to support the public commenting capability. CMS needs to build infrastructure to improve tracking of post-approval State deliverables required to ensure sufficient program performance as well as to evaluate the innovations being tested to ascertain best practices for program design and administration.

- *Managed Care Review and Oversight*: $2.6 million, an increase of $1.4 million above the FY 2015 Enacted level. This project supports CMS' attempt to correct deficiencies raised by the GAO related to the quality and extent of CMS oversight of Medicaid managed care programs. It will provide critical and essential tools that do not exist currently for our staff to

more effectively exercise their oversight and financial stewardship role minimizing Agency vulnerability to future audits.

- *CHIPRA Initiatives*: $1.2 million, the same as the FY 2015 Enacted level. Funding is requested to continue functionality and quality oversight of the Provider Locater Tool on the Insure Kids Now website. Additionally, CMS is requesting funding to perform oversight, monitoring, data collection, and analysis of all awarded outreach grants for the final Report to Congress. As mentioned above, these initiatives support the Agency's initiative to enroll and retain children in coverage and to improve access to pediatric dental services for Medicaid and CHIP children.

- *Learning Collaborative:* $1.0 million, a decrease of $0.2 million below the FY 2015 Enacted level. The LC will continue to work on issues related to monitoring performance and revising procedures based on initial ACA experience. In addition, the LCs work related to Value-Based Purchasing and Data Analytics ensure high-performing Medicaid and CHIP programs will be continued in 2016.

- *Medicaid Expansion:* $1.0 million, the same as the FY 2015 Enacted level. Funds are requested to continue the direct assistance and oversight of States' progress with outreaching, educating, and enrolling millions of newly eligible adults. Funding is also needed for expected refinement of the tools developed for States to train on the new program rules.

- *State Readiness, Enrollment and Eligibility*: $7 million, an increase of $7 million above the FY 2015 Enacted level. Under the Affordable Care Act, states will be required to implement significant and substantial changes to their Medicaid programs, including eligibility determinations, plan management, financial management, customer service, and integration with new affordable insurance programs from health insurance exchanges. The Government Accountability Office (GAO) has identified Medicaid as a program at significant risk for overpayments. Eligibility is the major contributor to the payment error rate in Medicaid, as calculated by CMS. Implementation of the changes required by the Affordable Care Act presents an opportunity to address some of the long-standing problems identified in the Medicaid Payment Error Rate Measurement process through simplified business rules, automated verifications of submitted data, modernized systems, and associated changes in other areas of the Medicaid program.

  Additionally, the Act presents some significant challenges and opportunities in ensuring that changes in the Federal Medical Assistance Percentage (FMAP) for the newly eligible Medicaid population are implemented by states in accordance with the statute and regulations. In order to ensure proper implementation of these and other changes, CMS has developed a technical assistance model to work closely with states as they implement the new requirements. A contractor will support the teams in the model as well as provide necessary short-term resources who can work directly with states. This effort has previously been funded out of the Healthcare Fraud and Abuse Control Account.

- *Medicaid and CHIP Business Information Solutions (MACBIS):* $4 million, an increase of $4 million over the FY 2015 Enacted level. Begun in 2009, MACBIS is a CMS enterprise-wide initiative to ensure the data infrastructure and information technologies that support Medicaid and CHIP are commensurate to their role as the nation's largest health insurer. Described in greater detail in the State Grants and Demonstrations chapter of this

document, MACBIS has two parts. First, MACBIS includes efforts to modernize the work flows and business processes that support online submission, review and approval of State Plan Amendments (SPAs), waivers, and Advance Planning Documents (APDs). Second, MACBIS includes Transformed Medicaid Statistical Information System (T-MSIS), which modernizes and enhances systems and data analytics infrastructure for State-submitted operational data about beneficiaries, providers, claims, and encounters.

IV. HEALTH CARE PLANNING AND OVERSIGHT

Program Description and Accomplishments

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

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

<u>Part C and D Information Technology (IT) Systems Investments</u>

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

These systems include:

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

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

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

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

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

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

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

Budget Request: $57.6 Million

The FY 2016 budget request for Parts C and D IT Systems Investments is $57.6 million, an increase of $4.9 million above the FY 2015 Enacted level. This request supports ongoing systems maintenance and implementation. The request validates Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems. These activities include data center hosting, hardware/software maintenance, system technical support, database administration and system security testing.

Oversight and Management of Health Plans

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

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

CMS also performs eligibility and enrollment functions on behalf of State-Based Marketplaces (Oregon, Nevada and New Mexico specifically) on the FFM platform.

CMS operated a Marketplace in 34 States and the eligibility platform for 2 State-Based Marketplaces (SBMs) in plan year 2014, and will continue to operate the Marketplace in 34 States and the eligibility platform for 3 SBMs in plan year 2015. We estimate the same numbers for plan year 2016. In addition to operating the FFM in States that opt not to establish their own Marketplace, CMS has responsibilities on behalf of all Marketplaces, such as developing quality improvement and transparency standards, performing eligibility appeals, and conducting certification and oversight of State-Based Marketplaces.

CMS must also oversee Marketplace-related programs, including two transitional risk- sharing programs - reinsurance and risk corridors - as well as a permanent risk adjustment program. These programs are sometimes referred to in aggregate as premium stabilization programs, or

the “3Rs.” States that operate a State-based Marketplace (Individual and SHOP or SHOP-only) will have the opportunity to operate a risk adjustment program using a methodology certified by CMS or using the federal methodology. In States that do not operate a risk adjustment program, CMS will operate the program. In 2016, CMS will operate the risk adjustment program in 48 States and the District of Columbia. Massachusetts and Utah will operate their own risk adjustment programs.

States also have the opportunity to operate reinsurance. Beginning in FY 2015, CMS will collect reinsurance contributions in all States and distribute funding to State-operated programs in order to make reinsurance payments. In States that do not operate reinsurance, CMS will operate the program. In 2016, CMS expects to operate the program in 49 States and the District of Columbia. Connecticut operates its own reinsurance program.

Risk corridors are a temporary federal program that will be operated solely by CMS.

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

CMS will begin reporting information about Marketplace enrollment to the IRS and consumers (“IRS Reporting”) for the first time in January 2015 through the issuance of a 1095A form. In FY 2016, CMS will support consumer casework regarding the 1095A, including consumer inquiries, investigation and reconciliation of data discrepancies that may arise.

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

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

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

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

QIC Appeals Workload for Parts C/D – FY 2011 through FY 2016

	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate
Part C Appeals	64,843	98,464	122,948	72,190	76,000	80.000
Part D Benefit Appeals	13,872	14,879	21,780	23,530	28,000	33,000
Part D LEP appeals	31,332	36,456	38,468	40,639	44,000	46,000

Insurance Market Reform – The Affordable Care Act includes several provisions that reform the private health insurance market. Between FYs 2010 and 2013, CMS released several significant rules related to these reforms, including regulations on new market reforms that went into effect in 2014. These regulations implemented provisions relating to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, essential health benefits (EHB), and catastrophic plans. CMS continues to release technical sub-regulatory guidance related to these rules as well as the market rules that went into effect in 2010. Additional details on these regulations and related guidance can be found at: http://cciio.cms.gov/resources/regulations/index.html. In FY 2016, CMS will continue to focus on working with States to ensure that these rules are being enforced and that consumers are benefiting from the changes included in the Affordable Care Act.

Medical Loss Ratio (MLR) – The Affordable Care Act requires health insurance issuers offering group or individual coverage to submit an annual report to the Secretary on the proportion of premium revenue spent on clinical services and quality improvement activities, also known as the medical loss ratio (MLR). The MLR rules require insurance companies to spend at least 80 or 85 percent, depending on the market, of their premium dollars on reimbursement for clinical services to enrollees and on quality improvement activities or pay a rebate to their customers if they fail to meet these standards. Insurers submitted their first annual report detailing their spending on health care and quality improvement activities in 2012. The annual reports, including information on issuer's rebate payments, are available to the public on the HHS website.

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

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

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

Budget Request: $317.1 Million

The FY 2016 budget request for Oversight and Management is $317.1 million, a decrease of $51.8 million below the FY 2015 Enacted level.

- *Oversight and Management of Marketplaces*: The FY 2016 Program Operations budget request is $244.0 million. In addition, CMS expects to expend $394.8 million in user fees to fully fund Marketplace Oversight and Management activities at a program level of $638.8 million in FY 2016, an increase of $160.3 million above the FY 2015 Enacted level. Note that this level reflects $25 million in reinsurance administrative collections reflected in the Transitional Reinsurance account.

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

  This funding supports verification and accuracy of information attested to by applicants in order to determine eligibility for coverage and insurance affordability programs. CMS must verify this information through other agencies, and therefore needs to set up data sharing functionality with these agencies. This funding would provide federal agencies with the funding needed to develop their systems to provide verification services to CMS in order to accomplish important health care initiatives.

  Of the Marketplace applicants that CMS expects to support through the eligibility determination process, including those who are ultimately not eligible, CMS expects a significant number will require additional support to complete the application. To assist in this process, eligibility support staff will process incoming mail, including paper applications and verification documentation. Additionally, eligibility support staff associate applications with existing accounts, populate systems with information from such documentation, conduct research, analyze issues, and support complex issue resolution. In FY 2016, the FFM expects to continue handling large volumes of complex eligibility issues, mailing new notices types in addition to existing notices, and improving the consumer experience by enhancing access to information for both consumers and the CMS staff and contractors supporting the systems.

  CMS has established an appeals process for the individual and SHOP markets. CMS also adjudicates appeals for decisions made by the Marketplace regarding exemptions from the

shared responsibility payment. This work entails overall management of the eligibility appeals process, coordination of data collection with appellants, general case management, and federal hearing support.

In FY 2016, CMS will continue to administer the advance payments of the premium tax credits and cost-sharing reductions on behalf of all Marketplaces. This process involves receiving enrollment information from issuers and some Marketplaces, including the level of APTC selected, to calculate and distribute monthly, aggregate payments to issuers for APTC and CSR owed. At the end of the year, CMS must collect information from issuers to reconcile the advance CSR payments to actual cost-sharing experienced by the enrollees.

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

In addition, CMS must implement the three market stabilizing programs (reinsurance, risk corridors, and risk adjustment). Continuing in 2016, CMS will collect reinsurance contributions from all issuers, distribute reinsurance payments, calculate risk scores and make the risk adjustment transfers, and calculate and process risk corridors payments and charges.

In FY 2016, CMS will continue to certify health plans as members of Marketplaces across both the individual and small group markets. Although many QHPs will already have been certified for previous benefit years, CMS expects that new plans will seek certification for the 2017 benefit year. Maintaining a steady state of technical assistance and issuer support is important. For QHPs that have been certified, CMS will engage in an annual process of re-certifying and potentially de-certifying plans. CMS is continuing to request funding in FY2016 for post-certification monitoring of issuer plan, rate and benefits. CMS is tasked with QHP issuer oversight in the FFM. In conjunction with States, CMS will monitor the performance and compliance of FFM issuers, and work with issuers and their respective States to address any areas of concern.

The FY 2016 funding request continues FY 2015 activities around building functionality to implement quality provisions related to QHP-certification, and continue plan-related oversight including oversight of agents and brokers. The FY 2016 funding request includes further development of CMS's monitoring tools and strategies and the development of the compliance review standard operating procedures and strategies, so as to effectively coordinate CMS's oversight activities with the State Departments of Insurance. In 2016, CMS will continue to develop requirements for QHPs for future years. For example, based on review of QHP data and complaints, CMS plans to increase reviews on the prescription drug benefit offered in QHPs.

Additionally, in 2016, CMS will continue to support an industry-based option for its agent/broker training-an IT build (established in 2015) which would enable external vendors to train and register agents and brokers to enroll consumers in the FFM.

In FY 2016, a critical component of SHOP activities will be a managed services contract to provide premium aggregation services (PAS) (i.e., billing and payment functionality) in States where a Federally-Facilitated SHOP is operating. Integrated into the managed services contract will be a call center with the capacity to support small businesses, their

employees, agents and brokers, and SHOP issuers and the unique issues they will face involving small group coverage through the FF-SHOP. This assistance will include technical, customer support, as well as enrollment assistance and billing and payment inquiries for small employers, their employees, agents and brokers working with small employers, and issuers that participate in SHOP. SHOP employers need customer service when applying for SHOP coverage and assistance with benefit administration activities, such as changing employment status and setting up accounts for eligible employees. Employees enrolled in coverage through SHOP can also call the SHOP Call Center for account management services, enrollment assistance, as well as filing an appeal. In addition, the SHOP PAS contract supports two additional call centers-the ACA information line that supports large employers with business-related questions about the ACA, and the Plan Cancellation Hotline that assists consumers that experience cancelled policies.

SHOP support activities in FY 2016 will continue to focus on providing SHOP-specific technical assistance to States, analyzing small group markets in each State and conducting SHOP-specific issuer and broker training. The SHOP support contract also provides valuable market research to make continuous improvements to the SHOP Marketplace and develop strategies to increase the supply of issuers that participate and the demand of the consumer to want to participate in FF-SHOP. These activities support marketing activities that will help increase SHOP awareness and visibility in various SHOP communities-small employers, agents and brokers, and issuers.

CMS has a statutory responsibility for developing and implementing a robust quality rating system, developing an enrollee satisfaction survey for the Marketplace, providing valid, reliable and comparable information to Marketplace enrollees, prospective enrollees and small employers/employees on quality measures, and specifying the quality-related requirements for certification. FY 2016 funding will ensure that CMS fully implements the qualified health plan specific tools and displays this information for the first time in 2016 for the 2017 plan year.

The FY 2016 funding request will also support the development of a comprehensive, coordinated oversight and monitoring strategy of the SBMs that build on current grant oversight requirements. States must meet at least the minimum functions: ensure efficient and non-discriminatory administration, prevent fraud and abuse, streamline eligibility and enrollment, minimize acquisition expenses, promote financial integrity and public accountability, inform consumer choice, and prohibit conflicts of interest. To support this, SBMs will be required to submit reports for review to CMS and in selected cases, site visits will be conducted. CMS will be responsible for reviewing these materials and working with the SBMs as necessary to improve performance. CMS will also conduct similar, though more limited oversight, of the activities performed by Partnership States.

- *Medicare Parts C and D*: $62.7 million, an increase of $4.5 million above the FY 2015 Enacted level. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, and the on-going Medicare Part C and Part D reconsideration contracts. This function is critical to the Agency fulfilling its statutory obligation to provide Medicare Advantage enrollees with meaningful due process by contracting with an independent review entity (IRE) to review adverse decisions made by Medicare health plans.

  It also funds ongoing ACA initiatives such as closing the Medicare Part D coverage gap, reforming MA plan payments, and making improvements to Part D plan operations.

- *Insurance Market Reform*: $4.4 million, similar to the FY 2015 Enacted level. Funding will support the review of form filings, market conduct examinations, and complaint-driven investigations in States where CMS has assumed primary enforcement authority.

- *Medical Loss Ratio (MLR):* $4.0 million, the same as the FY 2015 Enacted level. Funding supports a contractor to conduct audits of the annual reports health insurance issuers submit to CMS on their allocation of premium dollars. This request also provides funding for analysis of the MLR data.

- *Rate Review:* $2.0 million, an increase of $0.2 million above the FY 2015 Enacted level. Funding will support the actuarial review of proposed rate increases in the States where CMS is the primary rate review regulator, and the actuarial monitoring of all rate increases.

V. HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality Improvement Initiatives

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value-based purchasing (VBP) programs and other CMS health care quality initiatives. In FY 2016, CMS plans to perform activities that achieve the development of a coordinated quality improvement strategy aimed at adjusting payments to providers and suppliers based on quality performance, increasing availability of information on performance, and sharing in savings with providers who meet efficiency targets while also providing high quality care.

Examples of these initiatives include:

- *Medicare Shared Savings Program* – The Shared Savings Program was implemented January 2012 to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). Focusing on the needs of patients and linking payment rewards to outcomes, this leading Affordable Care Act delivery system reform will help improve the health of individuals and communities while lowering the growth in Medicare expenditures. CMS continues to ramp up the program, which maintains strong industry interest. Currently, there are 405 ACOs participating in the Medicare Shared Savings.

- *Physician Feedback Improvements* – CMS is statutorily required to provide reports to physicians and groups of physicians that compare their resource use for Medicare fee-for-service patients with that of similar physicians or groups of physicians. These feedback reports also include indicators of clinical quality and they are the primary mechanism for informing physician groups of their performance under the value-based payment modifier. In 2014, CMS distributed reports that cover all Medicare-enrolled physicians furnishing services to fee for service beneficiaries. The reports build on lessons that were developed from reports produced in prior years and include refinements suggested by stakeholders.

- *Physician Value-Based Purchasing IT* – CMS must invest in data infrastructure necessary to support the value-based payment modifier and physician feedback programs. This investment enables CMS to provide reports to physicians and groups of physicians that compare their resource use among Medicare fee-for-service patients with that of similar physicians or groups of physicians.

- *Physician Value-Based Payment Modifier* – The value-based payment modifier measures cost and quality of care that will be used to adjust physician payments. The modifier will be used to adjust physician payments under the modifier. The modifier will be phased in starting in 2015 so that, by 2017, all participating physicians will be subject to the modifier. It will apply to each payment physicians receive under the Physician Fee Schedule. CMS established initial cost and quality measures, as well as the initial performance period in the CY 2012 Physician Fee Schedule Final Rule. The CY 2014 Physician Fee Schedule Final Rule established policies for the second year of the phase in (2016), continuing to expand the number of physicians and physician groups subject to the value-based payment modifier so as to apply the modifier to all physicians by 2017. Additionally, as specified in the CY 2015 Physician Fee Schedule Final Rule, the value-based payment modifier will be applied to all non-physician eligible practitioners by 2018.

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

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

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

- *Program Support Activities for the Competitive Acquisition Ombudsman (CAO) –T*he Competitive Acquisition Ombudsman Program (CAO) in order to respond to inquiries and complaints from suppliers and individuals regarding the DMEPOS Competitive Bidding

Program, calling for nationally directed Ombudsman services for suppliers and people with Medicare. The purpose of this contract is to support the operations of this national program to facilitate assistance to suppliers of durable medical equipment, beneficiaries that use durable medical equipment, and to provide substantive issues to enable the development of the CAO's mandated Annual Report to Congress from the Secretary of the Department of Health and Human Services (HHS).

- *Hospital Readmission Reduction Program* – In FY 2016, CMS will continue to administer payment adjustments for hospitals. CMS will calculate hospital specific readmission rates, calculate the hospital specific payment adjustment factor for excess readmissions, and engage in rulemaking to maintain the current measures.

Budget Request: $72.8 Million

The FY 2016 budget request for health care quality improvements is $72.8 million, an increase of $13.4 million above the FY 2015 Enacted level.

- *Medicare Shared Savings Program*: $42.6 million, an increase of $11.9 million above the FY 2015 Enacted level. In FY 2016, CMS must re-compete and fund the final option year for the existing ACO program analytics, program monitoring, quality measurement and application review and marketing support contracts as the program continues its rapid expansion. In order to avoid a lapse in the program analysis contract, it is necessary to fund the re-compete using FY2016 funds. CMS must also re-compete and exercise the final option year of the existing monitoring and application contract. This contract is tasked with supporting provider screening, data monitoring, audit protocols, compliance analysis, and application review.

- *Physician feedback reports and value-based payment adjustments:* $11.1 million, a decrease of $2.8 million below the FY 2015 Enacted level. CMS requests funding for methodology, infrastructure development and maintenance costs required to implement the program. Similar to FY 2015, in FY 2016, CMS will continue to increase the number, scope, and type of practitioners for whom we will produce and disseminate reports in order to meet statutory requirements and also programmatic goals to share accountability across provider types.

- *Physician Value-Based Purchasing IT:* $5.5 million, an increase of $0.1 million above the FY 2015 Enacted level. The reports will produce efficiencies from previous years while covering all Medicare-enrolled physicians that furnish services to fee for service beneficiaries. Specific information technology infrastructure support required to produce and disseminate the reports and calculate the payment modifier include Integrated Data Repository (IDR) capacity, IDR backup and tape infrastructure, IDR operations and maintenance, testing, IDR development support, IT program management, security control assessments and data storage.

- *Value-Based Payment Modifier*: $4.8 million, an increase of $2.8 million above the FY 2015 Enacted level. FY 2016 funding is required to exercise the third option year of the program analytics contract responsible for calculating and implementing the value-based payment modifier that will be applied to physician claim payments. The funding will provide technical support along with research and development support for the refinement of the value-based payment modifier methodology as it is expanded to all physicians. Specific activities include

constructing the value-based payment modifier for diverse physician specialties, establishing benchmarks for quality and cost of care and developing composite measures of quality and cost, and computing payment adjustments for each physician group.

- *Medicare Data for Performance Measurement:* $4.5 million, an increase of $0.3 million above the FY 2015 Enacted level. The funds will be used to continue operations, oversight, monitoring, and evaluation of the program. CMS will procure the services of contractor staff to support three major areas: program management, data preparation and distribution, and technical assistance.

- *DME Bidding Systems*: $1.8 million, the same as the FY 2015 Enacted level. The DME Bidding system was previously funded out of MIPPA. This system collects bids for certain types of Durable Medical Equipment within certain geographical areas. This request funds ongoing operations and maintenance support.

- *Hospital Value-Based Purchasing (VBP) Medicare Spending per Beneficiary (MSBP)*: $1.5 million, an increase of $0.6 million above the FY 2015 Enacted level. In FY 2016, funding is required to support procurement of a new contract to assist with efficiency measurement, consistent with the National Quality Strategy priority to provide affordable care. The work will include measure development, refinement, calculation, reporting, and potential submission for NQF endorsement and oversight of CMS standardization approach used by multiple components across the agency.

- *Program Support Activities for the Competitive Acquisition Ombudsman (CAO)*: $0.6 million, an increase of $0.6 million above the FY 2015 Enacted level. In 2016, CMS needs funding for continued efforts in program monitoring and development of outreach strategies to ensure access to program benefits for all citizens that use DMEPOS products.

- *Hospital Readmission Reduction Program*: $0.6 million, the same as the FY 2015 Enacted level. Funding is required to expand the methodologies used to identify hospitals with high rates of readmissions. CMS will make readmission rates for hospitals publicly available. Funding is also needed to expand the types of conditions considered under this policy in future years as required by the law. In FY 2016, CMS will continue to administer payment adjustments for hospitals pursuant to the ACA provision. CMS will calculate hospital specific readmission rates, calculate the hospital specific payment adjustment factor for excess readmissions and engage in rulemaking to maintain the current measures.

VI. OUTREACH AND EDUCATION

Program Description and Accomplishments

National Medicare Education Program (NMEP)

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

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

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

  The chart below displays the actual number of *Medicare & You* handbooks distributed for fiscal years 2010 through 2014 and the estimated distribution for fiscal years 2015 through 2016. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

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

	FY 2010 Actuals	**FY2011 Actuals**	**FY 2012 Actuals**	**FY 2013 Actuals**	**FY 2014 Actuals**	**FY 2015 Estimate**	**FY 2016 Estimate**
Number of Handbooks Distributed	43.6	39.3	40.8	42.3	43.3	44.6	45.9

  In addition, Section 1502(a) of the Affordable Care Act added new section 6055 (Reporting of Health Insurance Coverage) to the Internal Revenue Code that every provider of minimum essential coverage ensures beneficiaries have proof of insurance.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC)* – The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. This line provides beneficiaries with responses to both general and claim-specific Medicare questions. CSRs respond to inquiries including, but not limited to: authorizations, benefit periods, claims (including denials, filing or status), election periods, deductibles, coverage, eligibility and enrollment, complaints, plan compares, prescription drug benefit enrollment and disenrollment, appeal status, etc. Beneficiaries can also use 1-800 MEDICARE to report fraud allegations.

  1-800 MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families, and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800 MEDICARE

while seeking to preserve efficiencies and cost-effectiveness. Additionally, CMS uses a variety of quality assurance technologies and services to ensure that the responses provided are accurate and complete and continue to maintain excellent customer service. For example, in FY 2013, CMS enhanced the 1-800-Medicare language line services to include over 200 languages including several native Alaskan languages.

The following table displays call volume experienced from FYs 2010 through 2014 and the number of calls we expect to receive in FYs 2015 through 2016. In FY 2016, CMS expects to receive 25.8 million calls to the 1-800 MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system. Approximately 30 percent of the calls are handled completely by IVR.

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

	FY 2010 Actuals	**FY 2011 Actuals**	**FY 2012 Actuals**	**FY 2013 Actuals**	**FY 2014 Actuals**	**FY 2015 Estimate**	**FY 2016 Estimate**
Number of Calls	25.6	25.3	25.6	25.4	25.1	25.5	25.8

Internet – The Internet budget funds three websites:

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

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

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

In FY 2016, CMS estimates 323.0 million page views to http://www.medicare.gov, approximately a five-percent increase in traffic from the page views anticipated in FY 2015. CMS expects page views to grow as the Medicare beneficiary population

increases, beneficiaries and their caregivers become more internet savvy, and we continue to implement more self-service features for beneficiaries to use, maximizing their health and quality of care decisions.

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

	FY 2010 Actuals	FY 2011 Estimate	FY 2012 Actuals	FY 2013 Actuals	FY 2014 Actuals	FY 2015 Estimate	FY 2016 Estimate
Number of http://www.medicare.gov Page Views	231.4	241.0	270.0	266.9	294.0	308.0	323.0

- *Community-Based Outreach* – CMS conducts community-based outreach programs which include collaborative grassroots coalitions, and national, local, multi-media training and partnership building efforts that provide assistance at the local level.

  The administration of the SHIP program was transferred to the Administration for Community Living in FY 2014. Ongoing community outreach through partners and stakeholders will continue, as will a liaison role with the SHIP program housed at ACL.

- *Program Support Services* – This activity includes the multi-media Medicare education campaign, assessment activities, and consumer research addressing both general and Hispanic markets. In addition, it funds the *Medicare & You* handbook support activities such as electronic and composition support, production of the handbook, Medicare Summary Notice, and other NMEP materials in formats such as Braille, large print and audio.

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

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category	Funding Source	FY 2014 Operating	FY 2015 Enacted	FY 2016 Request	Description of Activity in FY 2016
Beneficiary Materials	**Total**	**$49.2**	**$50.9**	**$83.2**	National Handbook with comparative information in English and/or Spanish (national & monthly mailing); initial enrollment packages to new beneficiaries; targeted materials only to the extent that funding is available after payment of the Handbook. Provides annual notice to as many as 49 million beneficiaries whose minimum essential coverage is provided through Medicare.
	PM	$49.2	$50.9	$65.2	
	User Fees	$0.0	$0.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	**Total**	**$246.6**	**$250.8**	**$312.5**	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.
	PM	$175.5	$179.6	$248.9	
	User Fees	$71.1	$71.2	$63.6	
Internet	**Total**	**$17.9**	**$17.3**	**$19.3**	Maintenance and updates to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.
	PM	$14.8	$17.3	$19.3	
	QIO	$3.1	(TBD)	(TBD)	
Community-Based Outreach	**Total**	**$2.3**	**$2.4**	**$2.0**	Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to Medicare beneficiaries in their communities.
	PM	$2.3	$2.4	$2.0	
Program Support Services	**Total**	**$16.4**	**$15.1**	**$19.7**	A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as LIS.
	PM	$16.4	$15.1	$19.7	
	Total	**$332.4**	**$336.5**	**$436.7**	
	PM	**$258.2**	**$265.3**	**$355.1**	
	User Fees	**$71.1**	**$71.2**	**$81.6**	
	QIO	**$3.1**	(TBD)	(TBD)	

Budget Request: $355.1 Million

The FY 2016 Program Operations budget request for NMEP is $355.1 million, an increase of $89.8 million above the FY 2015 Enacted level. The following activities are funded under the Program Operations request:

- *Beneficiary Materials*: The FY 2016 budget request for Beneficiary Materials is $65.2 million, an increase of $14.3 million above the FY 2015 Enacted level. The majority of the budget request funds the cost of the Medicare & You handbook. This estimate is based on historical publication usage data and current market prices for printing and mailing.

  Of the $65.2 million request, CMS has built in $26 million to support mailings to provide proof of enrollment in Medicare for CY 2016. ACA section 1502 provides that every provider of minimum essential coverage will report coverage information, and CMS will report coverage under the program. CMS will also be responsible to ensure that beneficiaries have proof of insurance to show compliance with the IRS individual shared responsibility provision.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The FY 2016 budget request for 1-800-MEDICARE/BCC activities is $248.9 million, an increase of $69.3 million above the FY 2015 Enacted level. The estimated call volume for FY 2016 is 25.8 million, 0.3 million more calls than estimated for FY 2015. CMS expects to operate at no more than a 5-minute ASA in FY 2016, consistent with current policy.

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

- *Internet*: The FY 2016 budget request for Internet is $19.3 million, an increase of $2.0 million above the FY 2015 Enacted level. These funds will be used for ongoing maintenance costs, renewing software licenses, the continued redesigning of the http://www.cms.hhs.gov website to make it more user friendly, providing database support, as well as support for the Part D prescription drug plan and fall open enrollment period requirements. This includes expanded Agency programs, ongoing security and testing, and monitoring activities. This funding supports ongoing efforts to increase beneficiary self-service via online channels and provide beneficiaries with expanded, easy to understand Medicare information through interactive tools, including an interactive electronic tool for the *Medicare & You* handbook. This includes expanding MyMedicare.gov services to provide integrated health management capabilities. CMS believes it is especially important to provide sufficient funding to activities that increase beneficiary self-service online. Because services accessed online are generally much less resource intensive than services accessed in person or via telephone, providing funds now to increase beneficiaries' use of online tools will reduce costs in the future.

- *Community-Based Outreach:* The FY 2016 budget request for Community-Based Outreach is $2.0 million, a decrease of $0.4 million below the FY 2015 Enacted level. Decreased funding is due to the re-prioritization of project funds to support ACA and Health Insurance Marketplace outreach with partners and uninsured consumers, which will now be funded elsewhere in program management.

- *Program Support Services:* The FY 2016 budget request for Program Support Services is $19.7 million, an increase of $4.6 million above the FY 2015 Enacted level. This activity provides funding for accessible materials for low vision/blind and disabled beneficiaries (audio, Braille and large print and e-reader designs), electronic and composition support for the *Medicare &You* (M&Y) Handbook, mail file creation for the statutory September mailing of the M&Y Handbook, NMEP consumer research and assessment (including consumer testing of the M&Y handbook), a publication ordering web site for partners that support the Medicare education program, support for the Advisory Panel on Outreach and Education (APOE), and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

In addition to the Program Management request, the NMEP will receive approximately $81.6 million in user fees bringing the total funding level for NMEP to $436.7 million.

Provider Outreach

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

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

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

- In-depth presentations by CMS subject matter experts providing the latest information on topics specific to Medicare providers and suppliers.
- Slide presentations and other related materials posted to the CMS website prior to the call that participants can download and reference during the call.
- Opportunities to ask questions of CMS subject matter experts.
- 24/7 access to all National Provider Call training materials on the CMS website in various formats, e.g., written transcripts, audio recordings, and podcasts, as well as video slideshow presentations that are accessible on the CMS YouTube Channel.
- On-line registration for all calls.

- Opportunities to provide CMS with feedback by responding to polling questions during the registration process and completing an anonymous evaluation after the call.

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

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

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

Budget Request: $25.1 Million

The FY 2016 budget request for Provider Outreach is $25.1 million, an increase of $2.7 million above the FY 2015 Enacted level.

- *Provider Toll-Free Service*: $7.4 million, the same as the FY 2015 Enacted level. The minutes of telephone service, which drive costs, are projected to remain consistent in FY 2015 and FY 2016. Making sure that each caller receives an appropriate level of service requires that CMS be technologically current and work with a technical support contractor for network optimization. The goal is to make the best use of our human and technological resources to provide timely, accurate, and consistent responses to providers. This funding also covers modest ongoing costs of a provider toll-free number consolidation project to investigate approaches and technologies to simplify the provider's experience when calling Medicare.

- *National Provider Education, Outreach, and Training*: $8.5 million, an increase of $0.3 million above the FY 2015 Enacted level. Funding will support the development and dissemination of Medicare fee-for-service (FFS) educational information on Medicare policy and operations. This also supports fulfillment activities related to requests for hard copy products and national provider calls.

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

- *Federal Coverage and Payment Coordination:* $9.2 million, an increase of $2.4 million above the FY 2015 Enacted level. CMS requests funding to support the following contracts:

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

Consumer Outreach

Consumer Information & Outreach for the Health Insurance Marketplace - Funding supports the development and execution of a strategic communications and marketing plan to inform and educate the various segments of the consumer population about health insurance coverage options.

Outreach efforts target various segments of the population, including the uninsured and historically hard to reach populations. Funding requested will be used to conduct an open enrollment multi-media education campaign in both English and Spanish, including television, radio, digital and social media; outreach to engage states and stakeholders; as well as developing, disseminating, and translating consumer educational materials.

In 2016, CMS will focus on promoting knowledge of reenrollment process for those already enrolled in Marketplace plans; and signing up for those who are uninsured.

As the SHOP program matures, this funding will also provide a means to educate small businesses and their employees about their options in the Health Insurance Marketplace.

Marketplace Enrollment Assistance – In September 2014, CMS awarded a second round of Navigator grants to over 90 entities in FFM and Partnership States; supporting preparation and enrollment and outreach activities in year two of Marketplace enrollment and building on lessons learned from year one. In addition to the Navigator program, CMS continued to work with contractors to provide additional in-person assistance with filing applications. There are differences in the geographic and demographic communities that Navigators serve versus those served by the Enrollment Assistance Program, indicating the importance of maintaining a variety of consumer assistance options. In FY 2016, CMS will fund in-person assistance efforts to continue to serve these communities. Finally, CMS will continue certification of Certified Application Counselor Designated Organizations. These organizations enter into an agreement with CMS to certify individuals to provide outreach and enrollment assistance across the FFM and Partnership States.

HealthCare.gov – Consumers can use the site to enroll in the Health Insurance Marketplaces. The website supports new consumers as well as returning consumers who may be renewing or re-applying for coverage. The website provides the public with ways to search and compare private plans, learn more about coverage and benefits, and serves as a resource on the ACA and how it may affect different individuals. It also provides a wealth of helpful content via numerous articles on the site and various tools such as one which helps a consumer find help in his/her local area. Note that various IT systems that support HealthCare.gov functioning are reflected in the discussion of Information Technology later in this chapter.

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

Issuer Data Collection and Management – In FY 2016, the Health Insurance Oversight System (HIOS) will continue to be the system through which CMS collects and computes the rates and benefits of coverage options on the HealthCare.gov Plan Finder. This resource is used by consumers to research, find, and compare their health insurance options in the off-Marketplace private insurance market. The data submitted to HealthCare.gov informs the oversight efforts within the Center and serves as an important analytical resource for the Department. Internally, this data is used to identify firms authorized to sell insurance and to track those responsible for rate review and medical loss ratio filings as well as other oversight provisions of the Affordable Care Act (ACA).

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

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

Budget Request: $6.6 Million

The FY 2016 budget request for consumer outreach is $6.6 million, a decrease of $76.8 million below the FY 2015 Enacted level. This decrease is due to the use of additional funding sources such as user fees in the Consumer Outreach request.

- *Consumer Information & Outreach for Marketplaces:* The FY 2016 Budget includes a program level for Consumer Information & Outreach for Marketplaces of $808.3 million, all of which is anticipated to be funded through user fees. This funds consumer outreach efforts, the implementation of the Federal Marketplace consumer contact center, and Marketplace Navigators and Enrollment Assistance Program. Although the Program Management request for Marketplace activities in Consumer Outreach is increasing, CMS anticipates covering Marketplace outreach costs by collecting and expending more user fees in FY 2016 as compared to FY 2015, as described in more detail below.

  CMS anticipates new individuals will apply for Marketplace coverage in FY 2016 and these individuals will be harder to reach than the early adopters, as demonstrated in 2015. A broad base of enrollees entering the program is necessary to maintain a balanced risk pool within the Marketplaces and avoid adverse selection.

  Consumer outreach effort, such as the multi-media and education campaigns during open enrollment, cast a wide net. CMS also performs outreach activities that target specific segments of the population, including the uninsured and historically hard to reach populations.

  This funding supports all activities necessary for the operation of the Marketplace Consumer Call Center. Trained customer service representatives in English and Spanish are available to provide information about health insurance coverage options and to assist consumers with applying, selecting a plan and enrolling in coverage.

For FY 2016, we are assuming a projected call volume of 26 million calls. The $545.0 million level supports a 3-minute Average Speed of Answer (ASA) across the year. This projected volume to the call center assumes a significant increase in direct enrollment assuming that consumers, especially those that may have been in health plans in previous years choose to work directly with the health plan call center or website for the eligibility and enrollment process and therefore reduce the number phone calls to the Marketplace. Also with systems maturity and individuals becoming more familiar with Marketplace enrollment processes we are assuming a reduced average length of call.

The Marketplace Consumer Call Center is a critical mechanism to assist individuals with questions about the Marketplace program, for help comparing health plans, filling out an application to find out if they are eligible for tax credits or cost-sharing reductions, and enrolling in a health plan that meets their needs. The funding requested will allow us to purchase all the services necessary to manage the large-scale call center operation and provide quality customer service. The operation includes facilities, staffing, training, quality assurance, the language line and call center technologies.

CMS FY 2016 funding will allow ongoing in-person consumer enrollment assistance for the Marketplaces. CMS anticipates that there will continue to be the need for targeted education and awareness activities, as well as significant one-on-one in-person assistance for consumers who have not participated in an insurance market in the past and for those who may be transitioning in and out of public coverage programs. As people become more familiar with the Marketplace, more consumers will likely want to enroll in qualified health plans through the Marketplace. Additionally, consumers will have to reevaluate their eligibility for the Marketplace and for insurance affordability programs each year, as well as reevaluate their plan selection. Many will continue to seek assistance from Navigators and other in-person enrollment assisters as part of the reevaluation process. Navigators, as trusted resources in their communities, also play an important role by providing newly-insured consumers with information on how to use their coverage.

- *General Consumer Information on Private Insurance:* $2.0 million, the same as the FY 2015 Enacted level. Supports a multitude of activities to ensure the public has access to timely and accurate resources to assist with private insurance plan comparisons, understanding insurance and rate changes, comparing coverage providers, and learning how various parts of the ACA may impact their health care insurance benefits and coverage. This information is made publicly available at healthcare.gov. In addition to the above functions, the site has added and will continue to enhance functionality for returning enrollees.

- *Consumer Appeals:* $1.7 million, an increase of $1.2 million above the FY 2015 Enacted level request. Through an inter-agency agreement (IAA) with the Office of Personnel Management (OPM), CMS established and operated an interim federal external review program in FY 2011. Through a subsequent IAA with OPM, CMS engaged a contractor, an independent review organization, to operate the permanent FERP from FY 2012 through FY 2014. Beginning in FY2015, CCIIO will operate the FERP through a new contracting vehicle.

  Grandfathered plans and issuers are not subject to Section 2719 of the Public Health Service (PHS) Act; however, an increasing number of these entities lose their grandfathered status annually. CMS anticipates that many of these non-grandfathered issuers will elect to use the FERP. Thus, an increasing number of consumers will have access to external

review that complies with Section 2719 of the PHS Act through the FERP. On January 1, 2016, States must come into compliance with a stricter set of external review standards or fall into the FERP. CMS anticipates that more States will make changes to State processes, resulting in their compliance in preparation for the January 1, 2016 deadline, thus decreasing the number of States that fall into the FERP. However, as more consumers become insured, through coverage sold in the Marketplaces, and as they become more acquainted with using their coverage and more familiar with their rights to external review, consumers will increasingly take advantage of their right to file an independent review of their claims denials. Accordingly, CMS anticipates an increase in the number of consumers accessing the FERP through FY 2016.

- *Issuer Data Collection and Management*: $1.1 million, an increase of $0.6 million above the FY 2015 Enacted level. As market rules are put in place, CMS anticipates that changes in non-Marketplace plans will need to be tracked and evaluated. This includes not only the composition of non-Marketplace offerings, but also the impacts on consumer satisfaction and regulatory compliance. The evaluation of this data against external sources is critical to understanding the completeness of our collection and the accuracy of reports, and combining and comparing this data with other sources, including internal information on appeals and consumer assistance, provides a more nuanced understanding of the health insurance landscape. Funding also supports the continuation of the Health Plan Identifier (HPID) program, and given its importance to the Marketplaces, continued analysis is required and monitoring third parties who are affected by the data will require continued focus.

- *Summary of Benefits and Coverage (SBC)*: $1.2 million, an increase of $0.2 million above the FY 2015 Enacted level. The funds requested for FY 2016 will develop new coverage examples and we continue to anticipate the need for SBC translations into different languages and will continue to require the maintenance of existing coverage examples and translations of SBC documents.

- *Indian Health Care*: $0.6 million, the same as the FY 2015 Enacted level. Additional funding in outlying years is crucial to ensure continued AI/AN enrollment in State/Federal health exchange plans, Medicaid expansion programs, and new benefits and services under Medicare.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Health Insurance Marketplace IT

Several key information technology investments support the Marketplace, such as the Data Services Hub, Cloud Computing and Marketplace Infrastructure, the Federal Health Care Exchange, Marketplace Systems Integrator, and the Healthcare.gov web portal. In FY 2016, CMS will continue development on Marketplace IT systems for program requirements that are implemented on a longer timeline, such as quality reporting, and will also transition to general operations and maintenance of existing systems.

Enterprise IT Activities

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

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

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

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

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

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

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

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

Infrastructure Investments

Key IT infrastructure projects include:

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

- *Virtual Call Center* – This critical project has greatly increased the overall efficiency and effectiveness of the 1-800-MEDICARE call center. Through this project, CMS is able to standardize the management of the Medicare beneficiary call center operations with best practice technology and process improvements, allowing for greatly improved customer service. The funding level for the FY 2016 request supports current ongoing contract costs.

- *The Web Hosting project* – This project covers the transitions of MMA web-hosted applications to an Enterprise Data Center (EDC). These applications include the Medicare Advantage Prescription Drug Payment System, Premium Withhold System, the Medicare Beneficiary Suite of Systems, and the Risk Adjustment System. The EDCs are designed to support the increased security and reliability that are required in the long term.

CMS ACA Non-Marketplace IT

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

CMS Shared Services

This request will support CMS's continued development and operation of shared services, i.e. IT applications and infrastructure that will meet the programmatic needs of multiple

business units. Specific shared services include Master Data Management, Enterprise Identity Management, Enterprise Portal, and Business Rules Enterprise Services.

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

Budget Request: $640.0 Million

The FY 2016 budget request for information technology investments supporting all Program Operations is $640.0 million, a decrease of $17.7 million below the FY 2015 Enacted level. This category includes five major IT investment activities, as shown in the table below.

FY 2016 IT Investments Request
(Millions of Dollars)

Activity	FY 2014 Operating	FY 2015 Enacted	FY 2016 Request	FY 2016 +/- FY 2015
Marketplace IT	$320.4	$370.2	$300.0	-$70.2
Enterprise IT Activities	$242.2	$238.6	$259.0	+$20.4
Infrastructure Investments	$25.8	$24.1	$37.6	+$13.5
ACA Non-Marketplace IT	$6.1	$5.3	$6.1	+$0.8
Shared Services	$27.9	$19.6	$37.3	+$17.7
Total Program Ops Request	**$622.4**	**$657.8**	**$640.0**	**-$17.8**

- *Marketplace Information Technology (IT):* Program level of $657 million, of which $300.0 million is in budget authority and $356.8 million in user fees. In FY 2016, the key information technology investment projects are the Data Services Hub, Cloud Computing and Marketplace Infrastructure, the Federal Health Care Exchange, Marketplace Systems Integrator, and the Healthcare.gov web portal. This budget request will fund maintenance, operations, and IT development for automated policy-based payments, automated maintenance enrollment records, direct enrollment, and planned management.

    - Data Services Hub: The Data Services Hub provides information exchange and business functionality to support Marketplace operations. It interfaces with many federal entities and performs multiple tasks including verifying citizenship, immigration status, and advance payment of the premium tax credit (APTC) determinations. This project will also deliver information to the states for the Marketplace, Medicaid, and CHIP.

    - Cloud Computing & Marketplace Infrastructure: In FY 2016, these projects will enable maintenance and growth of the Marketplaces and other IT initiatives to support data transferring between multiple entities through the Virtual Data Center (VDC). These functions are critical to the hosting of Marketplaces and other consumer facing IT platforms. Furthermore, these projects will provide integration support services to coordinate the configuration, staging, and development of system components, in addition infrastructure monitoring and reporting.

- Federal Health Care Exchange (HIX): This project supports technical assistance and the core business functions of the FFMs including administration, health plan management, eligibility and enrollment, risk adjustment, premium tax credit administration, program integrity, and a portal for customers.

- Marketplace Systems Integrator: In FY 2016, this project supports new development work, current architecture codes for all Marketplace systems, monitoring environments, and establishing production paths and testing environments. This work is expected to increase the workload of the VDC for FY 2016.

- Healthcare.gov Web Portal: This funding supports all areas associated with the web portal user interface to include modifications/enhancements to address ongoing Marketplace policy changes. Consumers can use the site to enroll in the Health Insurance Marketplaces. The website supports new consumers as well as returning consumers who may be renewing or re-applying for coverage. The website provides the public with ways to search and compare private plans, learn more about coverage and benefits, and serves as a resource on the ACA and how it may affect different individuals. It also provides a wealth of helpful content via numerous articles on the site and various tools such as one which helps a consumer find help in his/her local area.

- Other Marketplace IT: The remaining Marketplace IT activities in FY 2016 includes the Health Insurance Oversight System project for data collection from health insurance companies, Quality Assurance Testing for support comprehensive testing strategies, Business Requirements for development and maintenance of the Marketplaces Test Database and project management, IT Security to support FFM and other ACA related IT Security needs, Enterprise Architecture Support, Enterprise Project Management Operations, Multidimensional Insurance Data Analytics Systems, SHOP IT, Marketplace Quality, Marketplace Shared Services, and the Federal Agency Verification IT development IAA.

- *Enterprise IT Activities*: $259.0 million, an increase of $20.4 million above the FY 2015 Enacted level. The increase in funding is necessary to continue ongoing IT operations, including making necessary investments to existing systems that were delayed in FY 2014. This funding is needed to support improvements in the effectiveness and efficiency of CMS program management operations. These activities provide the operational support to manage the Agency's data environment for mission critical and enterprise-wide CMS IT strategies. One such area is the Baltimore Data Center (BDC), which supports all facets of CMS business operations.

- *Infrastructure Investments*: $37.6 million, an increase of $13.5 million above the FY 2015 Enacted level. This increase can be attributed to funding for the CMS-wide Information Security Program (ISP), which meets Federal legislative mandates for information technology. Funding is needed to continue to support the activities of the virtual call center as well as the web hosting project. This funding will also include several crosscutting projects such as Enterprise Architecture, Data Services Management, Enterprise Services and Infrastructure to continue implementation of legislative mandates.

- *CMS ACA Non-Marketplace IT*: $6.1 million, an increase of $0.8 million above the FY 2015 Enacted level. This funding supports the CMS Information Security Program (ISP) related to ACA, which provides services to ensure systems and beneficiary data are protected and

meeting CMS' federal requirements. The majority of these requirements stem from the Federal Information Security Management Act of 2002 (FISMA), which requires that all agencies have a risk-based information security program that covers all systems and data, and includes contractors and business partners who operate systems on behalf of the agency. Other funding will support the Enterprise Architecture (EA) structure of business processes and align them with the core goals and strategic direction of the Affordable Care Act.

- *Shared Services*: $37.3 million, an increase of $17.7 million above the FY 2015 Enacted level. Funding is needed to cover the program management allocation for key shared services including Master Data Management, Enterprise Identity Management, Enterprise Portal, and Business Rules Enterprise Services. Shared services enable CMS programs to utilize common services, such as eligibility verification, identity proofing, authentication, and data services, reducing redundant development and leveraging efficiencies of scale.

Performance Measurement

CMS has a vast purview in its responsibility for administering and overseeing three of the Nation's largest ongoing health care programs: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS is also tasked with implementing ACA. Because we cannot measure every possible activity that CMS oversees, we have developed representative performance measures that focus on the larger outcomes that these programs seek to achieve.

MCR9 Ensure Beneficiary Telephone Customer Service: Beneficiary telephone customer service is a central part of CMS' customer service function. The Beneficiary Contact Center (BCC) was expanded to handle calls and inquiries related to the new Health Insurance Marketplace. As a result, the contact center is now being called the Contact Center Operations (CCO) to reflect the handling of both beneficiary (Medicare) and consumer (Marketplace) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate Customer Service Representatives' (CSRs') performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance in handling telephone inquiries using the quality standards of privacy act compliance, knowledge skills, and customer skills every month. The CCO has exceeded the FY 2014 target of 90 percent for each standard. Despite exceeding targets in previous reporting years, we will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching staff. The resources required to ensure a higher quality metric would be better allocated to the increased amount of contacts associated with the incoming baby-boomer population, as well as the inclusion of the new Health Insurance Marketplace inquiries. The FY 2016 targets are 90 percent.

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

CMS met its FY 2014 target of maintaining an unqualified opinion on four out of the six principal financial statements. During FY 2014 the auditors could not express an opinion on the financial condition of the CMS Statement of Social Insurance (SOSI) as of January 1, 2014 or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). CMS reflected in the projections of the social insurance program the direct impact, but not the secondary impacts, if any, of productivity adjustments and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act and current law. Due to these limitations, the auditors were unable to obtain sufficient evidential support for the amounts presented in the SOSI and consequently, the SCSIA.

Since FY 2010, CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA). CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems,* since, as of September 2013; CMS has all core program dollars accounted for in the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS is CMS' official financial system of record, as we produce our financial statements via HIGLAS. Overall, CMS continued to improve its financial management performance in many areas as evidenced by no material weaknesses being reported as a result of the agency's CFO audit and OMB Circular A-123 review. Our FY 2016 target is to maintain an unqualified opinion on the CMS financial statements.

MCR20 Implement the International Classification of Diseases (ICD)-10:
The Health Insurance Portability and Accountability Act requires Centers for Medicare & Medicaid Services (CMS), along with the entire U.S. health care industry, to transition to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9) code set. On January 16, 2009, a final rule was published in the Federal Register adopting the ICD-10-CM and ICD-10-PCS code sets. Subsequent regulation set the compliance date to October 1, 2014. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted. Under section 212 of PAMA, the Secretary may not, prior to October 1, 2015, adopt ICD-10 code sets as standard codes under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, the U.S. Department of Health and Human Services will release an interim final rule that will establish a new compliance date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS). This interim final rule will require the use of ICD-10-CM and ICD-10-PCS by all entities covered under HIPAA, including CMS, for services provided beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Our goal was to identify a delay timeframe that takes into consideration the timing of other initiatives, the investments already made by the industry, and the need for thorough testing and preparation on the part of all industry segments.

Currently, CMS is preparing its systems to continue to process ICD-9 coded claims on and after October 1, 2014. This requires significant ICD-9 system changes and re-testing to ensure no disruptions to payments occur on October 1, 2014 (for ICD-9). All ICD-10 coded manuals and payment policies are being revised to reflect ICD-9 codes in addition to other processes that are being revamped to process ICD-9 coded claims. Downstream systems are storing both ICD-9 and ICD-10 codes which requires additional capacity to maintain both code-sets. FY 2012, FY 2013, FY 2014, and FY 2015 targets represent efforts leading up to ICD-10 implementation recommendations that were vetted and approved through the agency's E-Health Steering Committee, CMS reports its ICD-10 progress through its agency-wide governance infrastructure, Executive Steering Committee Meetings, and its integrated ICD-10 project plans that include over 22 project areas, 168 systems, and numerous operational policy and processes impacted by the transition.

FY 2014 targets were met and we continued many FY 2013 activities which included continued external ICD-10 outreach and communications, updates to ICD-10 industry compliance level and State Medicaid program, and readiness baselines. In addition, we completed the transition back to ICD-9 and reviewed and monitored ICD-10 industry compliance levels for ICD-9.

FY 2015 targets will now see continued external ICD-10 outreach and communications for pre-implementation activities, review and monitoring of ICD-10 industry compliance levels, continued, pre-implementation monitoring and assessments as well as monitor, test, and remediate ICD-9 claims payment, policy and systems issues. In addition to monitoring, testing and assessment activities, FY 2016 targets will continue external ICD-10 outreach and communications for post-implementation, review and monitor ICD-10 industry compliance levels, continue pot-implementation monitoring and assessments as well as monitor and remediate ICD-10 claims payment, policy and systems issues.

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

making sure that CMS IT systems have a formal Authority to Operate (ATO) and are included in a vulnerability management program.

CMS met two of its FY 2012 targets. In FY 2012, 100 percent of the Federal Information System Management Act (FISMA) systems were scanned and monitored by a vulnerability management system. The FY 2015 target is set at 100 percent. In addition, 100 percent of IT projects have adapted to the XLC framework. Based on this result CMS set FY 20135 through FY 2016 targets at 95 percent. CMS exceeded the FY 2012 Post Implementation Review (PIR) target of 12 PIRs with an actual of 16 PIRs. Going forward, the PIR targets will be reflected in percentages. It is more realistic to base projections on the percentage of candidate PIRs completed rather than to strive to reach a numerical target because the number of systems moving through the life cycle during any given year is variable, making it impossible to accurately predict the number of systems that will be good candidates for the PIR. In FY 2013, 31 percent of the PIRs performed were completed. In FY 2014, the goal is to complete PIRs for 65 percent and in FY 2015, the goal is to complete PIRs for 70 percent of new IT implementation projects that have been in operations for up to 12 months. The FY 2016 target is to complete PIRs for 75 percent of new IT implementation projects that have been in operations for up to 12 months.

CMS did not meet the FY 2012 target of 90 percent of CMS FISMA systems ATO based on defining the number of CMS FISMA systems for the following reasons: 1) In the FISMA system inventory list, there are systems that did not fully follow the lifecycle; some either went into production prior to getting an ATO, and others still do not have an ATO. These systems may have followed parts of the lifecycle, but they did not fully complete it properly and 2) the influx of systems from ACA created a large backlog of current and future systems that needed Security Control Assessments (SCAs) at one time. CMS does not have the resources to test them all at once. For FY 2013, the target of 90 percent was also not met based on these same reasons. The FY 2014, FY 2015 and FY 2016 target is 90 percent.

MCR26 Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Target Rate: In order to improve quality of care and reduce Medicare expenditures, CMS is measuring preventable Medicare inpatient hospital readmissions. CMS established the Hospital Readmissions Reduction Program in FY 2013, which would reduce a portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: acute myocardial infarction, pneumonia, and congestive heart failure. We are proposing to expand to two additional readmissions measures for FY 2015: Chronic Obstructive Pulmonary Disease, and Total Hip Arthroplasty and Total Knee Arthroplasty.

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

CMS targets reduction of all-cause Medicare hospital readmissions by one percent per year, beginning with a baseline of 18.7 percent on CY 2010 data set in FY 2012. Based on CY 2011 fee-for-service inpatient claims data, the Medicare all-cause hospital readmission rate is estimated to be 18.6 percent, which falls slightly above the 2013 target of 18.5 percent. Much of

this slight short fall is due to rounding (the CY 2011 rate before rounding was 18.561 percent). We note that although hospital specific readmission data was publicly available in 2011 on the Hospital Compare website, many of CMS' endeavors aimed at reducing hospital readmissions (discussed above) were not fully developed or implemented until after CY 2011, which is the period for assessing the 2013 target for this goal. The 2014 target was set at 18.3 percent. Despite not successfully achieving the 2013 target, we met the 2014 target for this goal, resulting in 18.1 percent reduction. We have set the 2015 target at 17.9 percent and the 2016 target is 17.7 percent. The readmission rate will be monitored annually through FY 2016.

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

In FY2013, the target was exceeded as there were over 325,000 eligible providers who received an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology. CMS set FY 2014 targets based on previous performance and has now updated the FY 2014 target to 375,000. In FY 2014 the target was exceeded as there were over 414,000 eligible providers who received an incentive payment. The FY 2015 target is 450,000 and the FY2016 target is 455,000. For more information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs.

MCR28 Reduce Healthcare-Associated Infections: Healthcare-associated infections (HAIs) are a significant cause of morbidity and mortality in the United States. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death, and catheter-associated urinary tract infections (CAUTI) are among the most common. Research has shown that a significant portion of these infections can be prevented. As such; the FY2014-15 HAI Agency Priority Goal (APG) is to reduce the national CAUTI standardized infection ratio by 10 percent by September 2015 over the current 2012 baseline of 1.03. Of note, this SIR baseline was recently changed from 1.02 to 1.03 in this goal. This reflects the fact that the CDC released preliminary final numbers for 2012 in September 2013, the time at which this goal was written. We make this adjustment in the HAI.APG to reflect the finalized SIR and to maintain consistency with other HAI reports moving forward. This APG is led by CMS with the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and the Office of the Assistant Secretary for Health.

The March 2014 CLABSI Standardized Infection Ratio (SIR) (reflecting data through September 2013 in this goal), is 0.54 which reflects a final reduction of 19 percent from the CLABSI SIR baseline of 0.68. Despite the continual CLABSI reductions seen throughout the FY2011-2013 HAI APG period, it did fall short of the final target which was a 25 percent reduction in CLABSI

or a final SIR of 0.51. Although CLABSI was not retained in the FY2014-15 HAI APG, this data is closely monitored and will be reported as a part of the CDC GPRA goal(s).

We do have data for the first six (6) month period of the 2014-2015 APG (Oct 2013 – March 2014). The overall SIR for CAUTI was 1.056. The "good news" is that we ran a preliminary analysis of the CAUTI SIR for (Apr 2014 – Jun 2014) and the overall SIR will be down to 0.981. The reasons behind the initial increase in CAUTI are felt to be multifactorial:

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

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

- ICU-focused data: Continued analysis throughout the goal period shows higher CAUTI SIRs in ICUs than in non-ICUs. Data from both settings are reported into NHSN but ICU reporting of CAUTI is incentivized by CMS' Hospital Inpatient Quality Reporting (HIQR) program. This program requires reporting of CAUTI discharges in ICUs as a part of receiving participating hospitals' annual market update. We project a potential spike in the CAUTI SIR around January 2015 when hospitals begin reporting CAUTI data in non-ICUs as part of CMS' HIQR program.

- Need for continued widespread implementation of prevention strategies:

  - Despite measurement-related factors that could be contributing to increasing SIRs, data from large prevention projects are showing that CAUTIs can be significantly decreased in US hospitals using the current interventions and metrics.
  - Widespread and consistent application of CDC CAUTI prevention recommendations and proven interventions such as Comprehensive Unit-Based Safety Program (CUSP) should reduce these infections, just as they have been reduced in these prevention projects. In June of 2014, CDC and CMS completed a pilot with seven (7) QIOs geared toward targeting CAUTI prevention efforts in those facilities that have a high number of excess CAUTIs using the national SIR as a baseline. The Targeted Assessment for Prevention (TAP) pilot allowed QIOs to analyze NHSN data reports in additional formats to enhance feedback capabilities.
  - Therefore, it is key, not only to sustain the large-scale infection prevention programs currently in place, but to also spread these protocols in acute-care facilities identified as needing them through data-driven analysis.

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

- Collaboration among multiple stakeholders in the healthcare community;
- Tracking and monitoring data that drives improvement;
- Linking higher quality, safer and more efficient care to payment;
- Research and testing to refine evolving HAI prevention guidelines, optimize implementation strategies and tools and integrate health information technology;
- Applying new approaches in ICUs based on some of the potential barriers identified to CAUTI reduction;
- Release new national 5-year HAI targets, including those for CAUTI, as a part of the HHS HAI National Action Plan to Prevent HAIs: Roadmap to Elimination.

There is no FY 2016 target for this goal at this time. The FY 2014-15 Healthcare Associated Infections (HAI) Agency Priority Goal (APG) two year cycle ends September 30, 2015. The FY 2016 target will be dependent on whether this goal is renewed as an APG. Any future targets will be consistent with the Federal Steering Committee for the Prevention of HAIs "National Action Plan to Prevent HAIs: Roadmap to Elimination" 2020 targets that are projected for release in the spring 2015.

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

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

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

For future years of the program, CMS aims to strengthen the QIP by evaluating facilities on a wider range of measures covering more topic areas. For example, CMS is currently developing measures to assess fluid weight management, on transplantations, iron management, and transfusions, and additional measures on bone mineral metabolism. The proposed PY 2016 rule was published in the Federal Register in July 2013 and the Final Rule was published on December 2, 2013.

For FY 2014, CMS met all of its targets including publishing the PY 2016 rule, adjusting payments for facilities not meeting performance standards (based on 2012 claims data), and developing and completing the ESRD QIP Final Monitoring Report for PY 2013. CMS also met all of its targets for FY 2015 including publishing the PY 2017 rule, adjusting payments for facilities not meeting performance standards (based on 2013 claims data), and developing and completing the ESRD QIP Final Monitoring Report for PY 2014.. FY 2016 targets include publishing the PY 2019 rule, adjusting payments for facilities not meeting performance standards (based on 2014 claims data) and developing and completing the ESRD QIP Final Monitoring Report for PY 2015.

MCR30: Delivery System Reform: Provide Better Care at Lower Cost across the Health Care System by Improving the Way Providers are Incentivized: Health care costs consume a significant amount of our nation's resources. In the United States, one source of inefficiency is a payment system that rewards medical inputs rather than outcomes, has high administrative costs, and lacks focus on disease prevention. HHS, through the Innovation Center at CMS, established by the Affordable Care Act, identifies tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and CHIP, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of alternative payment models that create new incentives for clinicians to deliver better care at lower cost. In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care (such as the readmissions/hospital acquired condition reduction program).

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

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

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

To encourage alignment between public and private payers and to help move payment reform

along the continuum described above, HHS has set two targets for Medicare. The first is to have 30 percent of Medicare FFS payments tied to a payment model in categories 3 or 4 by the end of 2016 (MCR30.1). The second is to have 85 percent of Medicare FFS payments tied to a payment model that is in category 2 or higher (MCR30.2) by the end of 2016. Thus, the first target is a subset of the second target. By 2018, HHS and CMS have set goals to have 90 percent of payments tied to a model in category 2 or higher and 50 percent of payments tied to a model in categories 3 or 4.

	Payment Taxonomy Framework[4]			
	Category 1: *Fee for Service No Link to Quality*	**Category 2:** *Fee for Service Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee for Service Architecture*	**Category 4:** *Population Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Instead payment is tied to a provider's ability to effectively manage a patient population. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., >1 yr.)*
Medicare FFS	Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD	• Eligible Pioneer accountable care organizations in years 3-5 • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

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

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2013, an estimated 10.7 million beneficiaries were dually eligible for Medicare and Medicaid.

[4] Rajkumar R, Conway PH, Tavenner M. CMS--engaging multiple payers in payment reform. JAMA. 2014 May 21; 311(19):1967-8. eTable: http://jama.jamanetwork.com/data/Journals/JAMA/930209/JVP140049supp1_prod.pdf

Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees have higher rates of chronic and co-morbid conditions[5] and higher rates of institutionalization[6], as well as challenges posed by socioeconomic issues. As a result, we seek to assess the impact of interventions on this sub-population.

In calendar year (CY) 2013, CMS' Innovation Center implemented two demonstrations focused on improving care for Medicare-Medicaid enrollees. The first and larger is the "*Financial Alignment Initiative*", in which CMS partners with State Medicaid Agencies to test models for integrated, coordinated care for this population. The second is the "*Initiative to Reduce Avoidable Hospitalizations Among Nursing Home Residents*".
This measure will gauge the impact of interventions on reducing unnecessary all-cause hospital readmissions in order to ensure patient quality of care and to reduce unnecessary Medicare spending. The CY 2012 will serve as our baseline year. We will set our CY 2016 target in June 2015, when our CY 2012 baseline data is finalized.

PHI2 Increase the Number of Young Adults Ages 19 to 25 Who Are Covered as a Dependent on Their Parent's Employer-sponsored Insurance Policy: To extend health insurance coverage to a segment of the American population that is disproportionately uninsured, CMS is monitoring the implementation of a regulation that allows adult children to remain on their parents' employer-sponsored health insurance plans through age 26. In FY 2013, 10.5 million young adults were covered under this regulation, exceeding our target of 9.7 million. CMS and State regulatory authorities are performing audits to monitor compliance with the requirements that issuers offer coverage for young adults ages 19 to 25. After FY 2014, we will report this number as a contextual indicator.

PHI5 Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces (Exchanges): Health Insurance Marketplaces are designed to make buying health coverage easier and more affordable. Marketplaces will bring new transparency to the market and will allow individuals to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance, and enroll in a health plan that meets their needs. Baseline enrollment data for CY 2014 will be available in March 2015. We will set our CY 2015 and 2016 targets once baseline data is available.

PHI6 Protect Individuals and Small Businesses from Potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review Program The ACA brings an unprecedented level of scrutiny and transparency to health insurance rate increases in the individual and small group markets through the creation of an Effective Rate Review program. This measure will track how the Effective Rate Review program has deterred issuers from proposing high, potentially unjustified rate increases that would be subject to review for reasonableness. In every State, proposed rate increases of 10 percent or more are now evaluated by independent experts to assess whether the increases are based on reasonable cost assumptions and solid evidence. The review and scrutiny is expected to prevent unjustified premium hikes by insurance companies, cutting costs for individuals, families and small business owners. Since September 1, 2011, health insurers have been required to justify any rate increase of 10 percent or more before the increase takes effect. Additionally, the ACA

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[5] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf
[6] http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf

requires that all rates increases be monitored by the Secretary and the States after January 1, 2014, when the new federal rating rules took effect.

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

CMS has set standards for States by defining what makes a rate review effective, and most States have met those standards. We continue to monitor and assess the effectiveness of State rate review programs. Most States have also utilized grant money to help implement these new national standards to help assure consistency and enhanced competency throughout the country. In CY 2014, of the 4,792 product submissions received from issuers, 590 (12 percent) were subject to review; therefore, our FY 2014 baseline is 12 percent. The CY 2015 target is 11 percent and the CY 2016 target is 10 percent.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
MCR9.1a: Quality Standards: Minimum of 90% pass rate for Adherence to Privacy Act (Outcome)	FY 2014: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1b: Quality Standards: Minimum of 90% expectations for Customer Skills Assessment (Outcome)	FY 2014: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.1c: Quality Standards: Minimum of 90% meets expectations for Knowledge Skills Assessment (Outcome)	FY 2014: 95% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR9.3: Minimum of 90% pass rate for the Customer Satisfaction Survey (Outcome)	FY 2014: 90% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR12: Maintain an unqualified opinion	FY 2014: Maintain an unqualified opinion (Target Met)	Maintain an unqualified opinion	Maintain an unqualified opinion	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2014: External ICD-10 outreach and communications continued. (Target Met) FY 2014: ICD-10 Industry Compliance Level and State Medicaid program readiness baselines updated. (Target Met) FY 2013: ICD-10 industry compliance Level and State Medicaid program readiness baselines in May 2013 was completed (Target Met)	1) Continue external ICD-10 outreach and Communications for pre-implementation 2) Review and monitor industry compliance levels 3) Continue pre-implementation monitoring and assessment 4) Monitor and remediate ICD-9 claims payment policy, and systems issues.	1) Continue external ICD-10 outreach and Communications for post-implementation. 2) Review and monitor ICD-10 industry compliance level and State Medicaid program baselines 3) Continue post implementation monitoring and assessment 4)Monitor and remediate ICD-10 claims payment, policy, and systems issues	N/A
MCR21.1: Percent of CMS Federal Information Security Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. (Outcome).	FY 2014: 93% Target: 90% (Target Exceeded)	90%	90%	Maintain
MCR21.2: Percentage of CMS FISMA systems scanned and	FY 2014: 100% Target: 100%	100%	100%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
monitored by centralized vulnerability management solution (Outcome)	(Target Met)			
MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (EXL) framework (Outcome)	FY 2014: 100% Target: 95% (Target Exceeded)	95%	95%	Maintain
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) (Outcome)	FY 2014:8 PIRs (or 89%) Target: 6 PIRs (65%) (Target Exceeded)	70%	75%	+5%
MCR26: Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent over the previous year's target rate Baseline: 18.7% (CY 2010 data)	FY 2014: 18.1%[7] Percent Target: 18.3% (Target Exceeded)	17.9%	17.7%	-0.2%

[7] Based on CY 2011 data

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
MCR27.1: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use for Medicare	FY 2014: 279,000 Target: 240,000 (Target Exceeded)	290,000	290,000	0
MCR27.2: Increase number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicaid	FY 2014 63,650: Target : 28,000 (Target Exceeded)	65,000	75,000	+10,000
MCR27.3: Increase number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicare	FY 2014: 4,538 Target: 4,000 (Target Exceeded)	4,500	4,550	+50
MCR27.4: Increase number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use under Medicaid	FY 2014: 4,307 Target : 2,800 (Target Exceeded)	4,300	4,350	+50

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
MCR27.5: Increase number of Eligible Professionals receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program	FY 2014 : 128,451 Target: 110,000 (Target Exceeded)	150,000	175,000	+25,000
MCR27.6: Increase number of Eligible Hospitals receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program	FY 2014: 3679 Target : 3,550 (Target Exceeded)	3,700	3,725	+25
MCR28.2: Reduce by 10[8] percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2015.	FY 2013: 12% Increase Target: 10% (Target Not Met)	10%[9]	TBD	N/A
MCR29.1: Develop drafts and final ESRD QIP rules for payment years (PY) 2014 through 2016	FY 2015: PY 2016 Final Rule Published November 6, 2014 (Target Met)	Publish 2017/PY2018 final rule	Publish 2019 final rule	N/A
MCR29.2: Implementation of	FY 2015: Payments adjusted	Adjust payments for facilities not	Adjust payments for facilities not meeting	N/A

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

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
ESRD QIP payment reduction (to meet statutory requirement)	for facilities not meeting performance standards (based on 2013 claims data) (Target Met)	meeting performance standards (based on 2013 claims data)	performance standards (based on 2014 data)	
MCR29.3: Obtain monitoring and evaluation contractor and implement monitoring strategy	FY 2015: Developed and completed ESRD QIP Final Monitoring Report for PY 2014 (Target Met)	Develop and complete ESRD QIP Final Monitoring Report for PY 2014	Develop and complete ESRD QIP Final Monitoring Report for PY 2015	N/A
MCR30.1: Alternative Payment Models: Increase the Percentage of Medicare Fee-for-Service (FFS) Payments Tied to Alternative Payment Models	CY 2014 Baseline: Available October 2015	TBD	30%	TBD
MCR30.2: FFS Payments Linked to Quality: Increase the Percentage of Medicare FFS Payments Linked to Quality and Value	CY 2014 Baseline: Available October 2015	TBD	85%	TBD
MMB1: Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees	Baseline 2012: Available June 2015	N/A	TBD	N/A
PHI2 Increase the Number of Young Adults Ages 19 to 25 Who Are	FY 2013: 10.5 million Target:	Contextual Indicator	Contextual Indicator	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
Covered as a Dependent on Their Parent's Employer-sponsored Insurance Policy (contextual indicator)	9.7 million (Target Exceeded)			
PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces	New for 2015 CY 2014 Baseline Available March 2015	CY 2015 target will be set when CY 2014 baseline is available	TBD	N/A
PHI6: Decrease or Maintain the Percentage of product Submissions for Rate Increases Equal to or Greater than 10%	2014: Baseline = 12%	11%	10%	-1%

[i]The MMB indicator is "Medicare-Medicaid Beneficiaries"

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Federal Administration

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015 PB
BA	$732,533,000	$732,533,000	$783,600,000	+$51,067,000
FTE 1/	4,542	4,470	4,671	+201

1/Excludes staffing funded from indirect cost allocations. The FY 2014 column reflects actual FTE consumption. In FY 2015 and FY 2016, 13 FTEs will be funded from other sources.

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

Program Description and Accomplishments

CMS oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), the Nation's largest health insurance programs. CMS currently oversees benefits for consumers and employers through the Federal Marketplace (Marketplace), the Pre-existing Condition Insurance Program (PCIP), and the Early Retirement Reinsurance Program (ERRP). In addition, CMS is responsible for enforcing new rights and greater accountability for consumers and providers in the private health insurance market, and CMS disseminates an unprecedented level of consumer information regarding coverage options. As the largest purchaser of health care in the United States, CMS expects to serve almost 126 million beneficiaries in the traditional programs and millions of new consumers in the private insurance market in 2016.

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

Since 1988, CMS has utilized an indirect cost allocation methodology that enables the Agency to use these other fund sources to offset some costs that would otherwise be funded out of the Federal Administration account.

CMS currently employs Federal employees working in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; ten Regional Offices located throughout the country, and three anti-fraud field offices located in Miami, Los Angeles, and New York. Employees in Baltimore, Bethesda and Washington write health care policies and regulations; set payment rates; develop national operating systems for a variety of health care programs; provide funding for the Medicare contractors and monitor their performance; develop and implement customer service improvements; provide education and outreach to beneficiaries, consumers, employers and providers; implement guidelines to fight fraud,

waste and abuse; and assist law enforcement agencies in the prosecution of fraudulent activities. Regional Office employees provide services to Medicare contractors; accompany State surveyors to hospitals, nursing homes, labs, and other health care facilities to ensure compliance with CMS health and safety standards; assist States with Medicaid, CHIP and other health care programs; and conduct outreach and education activities for health care providers, beneficiaries, and the general public. CMS also has staff in the fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program.

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

Personnel Compensation and Benefits:

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

CMS' staffing level and related compensation and benefits expense is largely workload-driven. Since 2004, CMS' core workloads have increased dramatically due to major legislative and Secretarial initiatives. These include the completion of activities mandated by the Health Insurance Portability and Accountability Act (HIPAA); the Balanced Budget Act (BBA); the Medicare Modernization Act (MMA); the Medicare Improvements for Patients and Providers Act (MIPPA); the American Recovery and Reinvestment Act (ARRA); and, the Affordable Care Act (ACA). In addition, CMS is responsible for the concurrent implementation of a number of Secretarial priorities, including quality improvement, value-based purchasing, price transparency, consumer choice, e-health initiatives, and enhanced beneficiary outreach.

Other Objects:

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

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

CMS' FY 2016 request has been prepared in accordance with Executive Order 13589, Promoting Efficient Spending.

- Rent, Communication & Utilities

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

- Building Loans

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

- Service and Supply Fund

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

- Administrative Services

This category funds contracts for activities that support the daily operation of CMS' Central, Regional and anti-fraud field offices including building and machine maintenance and repairs, employee medical and health services, space enhancements and transportation costs for shipping and receiving Agency documents. This category also includes expenses needed to comply with the Americans with Disabilities Act, such as interpreting services, closed-captioning services, personal assistance fees, and adaptable furniture. In addition, the cost

of heating and cooling the Central Office data center 24 hours-a-day, 7 days a week, is included here. While the Rent, Communication and Utilities category covers most standard-level utility charges, the data center utility cost is over and above the GSA standard-level user charge for this activity and must be paid separately.

- Information Technology (IT)

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

- Inter-Agency Agreements

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

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

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

- Supplies and Equipment

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

- Administrative Contracts and Intra-Agency Agreements

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

  - Legal services with the Office of General Counsel (OGC): CMS reimburses the OGC for the legal services and guidance it provides on ethics activities and on legislative, programmatic, and policy issues related to CMS' programs. This intra-agency agreement allows CMS to implement policies and run its programs. In FY 2016, CMS will pay about $20.6 million for these services. OGC calculates the charge and informs CMS of the amount it must pay.

  - Tribal Training and Outreach: In support of HHS' priorities, CMS is committed to working with the Tribal governments to improve the health care of American Indians and Alaska Natives (AI/ANs). Several contracts enable CMS to continue its work with the Indian Health Service (IHS) to provide ongoing outreach and education to AI/ANs, facilitate AI/AN enrollment in CMS' programs, enhance our relationship with

the IHS and the Tribes, and conduct satellite training for providers in remote areas. The satellite activity is designed to break down cultural barriers and reach out to the tribal populations who are geographically isolated. Using satellite broadcasts, CMS can provide specialized interactive training to Indian health care providers, efficiently and cost-effectively. To date, CMS has provided support for satellite installation at 120 Tribes and Urban Indian health facilities.

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

- Training

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

- Travel

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

- Printing and Postage

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

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

Funding History

FY 2011	$685,806,000
FY 2012	$772,963,000
FY 2013	$732,533,000
FY 2014	$732,533,000
FY 2015 Enacted	$732,533,000

Non-comparable values.

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Budget Overview and Supported Activities

FY 2016 Request ($783.6 million):

Personnel Compensation and Benefits ($686.0 million): The FY2016 President's budget request for payroll is $686.0 million, a $45.1 million increase above the FY 2015 enacted level. This increase results mainly from a 1.3 percent Cost of Living Allowance included in the request. The FY 2016 request supports 4,671 direct FTEs, a 201 FTE increase above the FY 2015 enacted level. Staffing funded from the Federal Administration line is necessary in order to maintain and improve our traditional programs in light of significant beneficiary population growth.

Rent, Communication & Utilities ($5.1 million): The FY 2016 President's budget supports rent, communications and utilities at $5.1 million. This amount remains the same as FY2015 enacted level. Our FY 2016 request excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Service and Supply Fund ($3.8 million): The FY 2016 President's budget for the Service and Supply Fund totals $3.8 million in discretionary funds. This estimate remains the same as the FY 2015 enacted level. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Services ($7.7 million): The FY 2016 President's budget for Administrative Services is $7.7 million, a $947 thousand increase above the FY 2015 enacted level of $6.7million. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Administrative Information Technology ($37.6 million): The FY 2016 President's budget for Administrative IT is $37.6 million, a $1.2 million decrease below the FY 2015 enacted level of $38.8 million.

Inter-Agency Agreements ($3.9 million): The FY 2016 President's budget t for the Inter-Agency Agreement is $3.9 million, a $564 thousand increase above the FY 2015 enacted level of $3.3 million.

Supplies and Equipment ($1.3 million): The FY 2016 President's budget for supplies and equipment is $1.3 million, a $75 thousand increase above the FY2015 enacted level of $1.2 million.

Administrative Contracts and Intra-Agency Agreements ($24.7 million): The FY 2016 President's budget for Contracts and Intra-Agency Agreements totals $24.7 million, a $2.9 million increase above the FY 2015 enacted level of $21.8 million. This increase will allow us to continue funding a majority of our mandatory contracts within the Federal Administration line. This amount excludes the portion of the total cost that is being covered by CMS' other budget accounts.

Training ($2.9 million): The FY 2016 President's budget for Training totals $2.9 million in discretionary funds. This estimate remains the same as the FY 2015 enacted level.

Travel ($6.8 million): The FY 2016 President's Budget for Travel totals $6.8 million, a $1.1 million dollar increase above the FY 2015 enacted level of $5.6 million.

Printing and Postage ($3.9 million): The printing and postage President's budget for the FY 2016 request totals $3.9 million, a $1.5 million dollar increase above the FY2015 enacted level of $2.3 million.

Federal Administration Discretionary Summary
(Dollars in thousands)

Objects of Expense	FY 2015 President's Budget	FY 2016 Budget Request	FY 2016 +/- FY2015
Personnel Compensation	$640,941	$686,016	$45,075
Rent, Communications and Utilities	$5,100	$5,100	$0
Service and Supply Fund	$3,763	$3,763	$0
Administrative Services	$6,725	$7,672	$947
Administrative IT	$38,806	$37,632	-$1,174
Inter-Agency Agreements	$3,318	$3,882	$564
Supplies and Equipment	$1,178	$1,253	$75
Administrative Contracts and Intra-Agency Agreements	$21,797	$24,736	$2,939
Training	$2,938	$2,938	$0
Travel	$5,621	$6,753	$1,132
Printing and Postage	$2,346	$3,855	$1.509
Subtotal, Non-Pay Objects of Expense	$91,592	$97,584	$5,992
Total, Federal Administration 1/	**$732,533**	**$783,600**	**$51,067**

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

Medicare Survey and Certification

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Request	FY 2016 +/- FY 2015
BA	$375,330,000	$397,334,000	$437,200,000	+$39,866,000

Authorizing Legislation - Social Security Act, title XVIII, section 1864
FY 2016 Authorization - One Year
Allocation Method – Contract Agreements

Program Description and Accomplishments

In order to secure quality care for the elderly, one of the Nation's most vulnerable populations and for millions of other Americans who rely on the U.S. health care system, CMS requires that all facilities seeking participation in Medicare and Medicaid to undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico and two territories. Using about 7,000 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards. In FY 2013, 89.7 percent of Medicare participating nursing homes were cited for health care deficiencies (such as abuse, avoidable injury from falls or pressure ulcers, infection control lapses, and deaths from medication errors). The average number of health deficiencies per standard survey was approximately six. Similarly, 71 percent of dialysis facilities surveyed were cited for failing to meet regulatory requirements in FY 2013 (such as infections or hazards to life from poor equipment cleaning or water quality); 58 percent of hospitals surveyed were cited for deficiencies such as wrong site surgery, medication errors, poor outcomes, failure to maintain an effective quality improvement system; and 47 percent of home health agencies (HHAs) surveyed received deficiency citations. In FY 2013, approximately 67 percent of ambulatory surgical centers (ASCs) surveyed were cited for deficiencies. In FY 2013, the number of surveyed ASCs cited for infection control deficiencies was 50 percent, a slight improvement over the 57-59 percent range in prior years as CMS and Centers for Disease Control and Prevention continue efforts to address this serious issue. These examples illustrate the profound importance of regular, comprehensive inspections of health care facilities, as well as timely and effective investigation of complaints.

Thirty-three recent reports (2010-2013) from the Government Accountability Office (GAO) and the Office of Inspector General (OIG) highlight the need for Federal oversight to ensure quality of care. At various times, the GAO has placed areas of survey and certification oversight, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement. Recent reports from the OIG focused on adverse events in hospitals, nursing homes, and Ambulatory Surgery Centers. We are therefore implementing a variety of the OIG recommendations to strengthen survey and certification oversight, such

as improvements in infection control, adverse event reporting, and internal quality assessment and performance improvement systems. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to ensuring Federal dollars support only quality care.

Direct Survey Costs

Direct Survey costs represent the funding provided directly to States to perform surveys and complaint investigations and to support associated program costs. Three facility types have statutorily-mandated survey frequencies: each individual nursing home must be surveyed at least every 15 months and all nursing homes every 12 months on average; each home health agency must be surveyed at least every 3 years; and hospice facilities must be surveyed at least once every three years. Survey frequencies for all other facility types are determined by policy and funding levels. Direct survey costs are affected primarily by the number of Medicare-participating providers and the onsite survey time required. The number of providers continues to increase, with home health agencies, ambulatory surgical centers, and dialysis facilities growing the fastest in number (increasing by 16 percent, 3.3 percent, and 15 percent respectively from FY 2010 to FY 2014).

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

Survey frequencies and quality of oversight for non-statutorily mandated facilities have decreased in FY 2013 and FY 2014 compared to prior years due to a growing number of facilities, demands to survey more facility types, and the continuing gaps between the President's requested budget and the final enacted budget for survey and certification. The President's budget request for FY 2016 seeks to address these problems.

In recent years, CMS improved standards and survey processes for many types of providers, especially dialysis facilities for end stage renal disease (ESRD), ambulatory surgical centers (ASC), hospices, home health, and nursing homes. Since 2008, dialysis facilities have also been surveyed in accordance with the new ESRD regulations that substantially improved infection control, water quality safety, and internal quality assurance. CMS has increasingly used statistical information to review outcomes as well as focus more attention on facilities whose performance data indicate a higher risk of poor patient outcomes. For ASCs, CMS has, starting in 2010, surveyed 25% of non-accredited ASCs each year using a more rigorous survey process that included a significantly increased focus on infection control. By the end of FY 2014 all currently participating non-accredited ASCs had been surveyed using the new process, and a consistently high level of infection control problems was identified and facilities were required to correct their deficient practices or have their

Medicare participation terminated. Starting in FY 2015 CMS will be able to assess whether previously surveyed ASCs have been able to sustain their improved practices.

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

Nursing home survey processes have been improved through clarified surveyor guidance (such as guidance on surveying for the use of unnecessary medications), further development and deployment of the Quality Indicator Survey(QIS), and continued focus on the nursing homes judged to have the highest risk of poor quality of care (through the CMS *Special Focus Facility* (*SFF*) initiative). A 2012 analysis of nursing homes identified for special attention from 2005-2011 through the SFF initiative found that such nursing homes came into compliance with CMS requirements 50 percent more quickly compared the comparison of candidate facilities that were not surveyed with the same frequency.

CMS establishes survey priorities for States. Tier I priorities are comprised primarily of statutorily-required surveys, while Tier II includes targeted surveys of facilities judged to be of highest risk of poor quality of care. For example, for HHAs, in FY 2016 under the President's proposed budget, CMS and States will conduct 2,976 (92.6 percent of all HHA recertification surveys) Tier 1 HHA surveys and an additional 239 Tier II surveys (7.4 percent or all HHA recertification surveys). In addition, CMS and States will conduct approximately 1,500 complaint investigations in HHAs each year as Tier I and Tier II priorities. Tiers III and IV include surveys of HHAs that newly seek Medicare participation.

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

Support Contracts and Information Technology

Support Contracts

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

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

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

Support contracts permit CMS to use performance data to direct survey attention to higher risk areas, prepare for surveys, and track provider progress. For example, CMS uses performance information to assure that onsite surveys are conducted – every year – for at least the 10 percent of dialysis facilities that CMS and the States consider to be at highest risk for poor quality of care or safety. CMS also applies an algorithm to identify providers with the highest risk of poor care, in nursing homes, dialysis facilities, and home health agencies. CMS also plans to develop a similar survey targeting algorithm for higher risk hospices (pursuant to funding under the 2014 IMPACT Act). As a consumer service and market-oriented incentive for nursing homes to improve quality, CMS also maintains a Five Star Quality Rating System, with results updated monthly on the Nursing Home Compare website, one of CMS' most-visited websites. Objective, onsite surveys represent the primary source of verifiable information used for the Five-Star Quality Rating System. Beginning in 2012 and 2013, support contracts enabled CMS to begin publishing the reports of onsite surveys for nursing homes and for hospital complaint surveys in a searchable database accessible for public use. In addition to complaint investigations of acute care hospitals, complaint investigations for Critical Access Hospitals, Long Term Care Hospitals, and Psychiatric Hospitals are also now posted. Support contracts also permit CMS to test methods, to improve checks on the accuracy of the data reported by nursing homes. These checks are important because the data form the basis of quality measures that CMS uses as one dimension of the publicly-reported Five Star rating of nursing homes.

Information Technology

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

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

Evidence-Based Practices

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

The FY 2016 budget request expands the use of evidence-based approaches, particularly through pilot tests of potentially improved survey processes as part of the CMS Survey and Certification Efficiency and Effectiveness Initiative. For example, a targeted survey will assess nursing home systems to investigate adverse events and make system improvements based on the results of the investigations. Similarly, we expect to test methods that may better calibrate the intensity of home health agency surveys with the degree to which evidence suggests the need for surveyor attention.

Funding History

FY 2011	$361,276,000
FY 2012	$375,203,000
FY 2013	$355,578,000
FY 2014	$375,330,000
FY 2015	$397,334,000

Budget Request

CMS' FY 2016 budget request for Medicare Survey and Certification is $437.2 million, a $39.9 million increase over the FY 2015 Enacted level. Key cost drivers include the cumulative impact of more providers, the ending of furloughs and salary freezes on the part of States (including in some States, authorizing catch-up pay increases after many years of salary freezes or reductions), improved CMS standards for quality and safety, effects of inflation, and new survey processes and responsibilities (such as organ procurement organizations, advanced diagnostic imaging, and community mental health center surveys).

In addition, the FY 2016 budget also provides $5.0 million for CMS to proactively identify and address health care quality, safety, and level of care issues in Medicare eligible facilities, particularly in remote areas where access to care is a problem. The budget also invests $8.0 million for targeted surveys of Nursing Homes ($5.0 million over FY 2014 Enacted) to focus on facilities where there is high use of anti-psychotics for residents who have dementia, higher risk of adverse events or harm to residents (such as those identified in the OIG Adverse Events report in 2014), and higher risk that resident assessments and quality of care reporting may not be done properly and accurately. The results of resident assessments and data reporting are used in the Quality Measure dimension of CMS's *Five-Star Quality Rating System* upon which the public relies for important information about nursing homes. We believe there has been an increase in quality for the areas measured by the nursing home Quality Measures. However, in the past 2 years we have seen a consistent increase in the Quality Measure scores at a rate we believe exceeds the actual improvements made by certain nursing homes. A portion of the targeted surveys discussed here are designed to ensure both accuracy of reporting and effective resident assessments that form the basis for care plans.

CMS also uses information on nursing home staffing in the *Five-Star Quality Rating System,* and is in the process of designing and implementing a national system for electronic collection of staffing information on a quarterly basis that is auditable back to payroll, rather than the the once-per-year self-reporting of staffing data that has been the subject of much concern. Funding for the staffing data project was included in the 2014 IMPACT Act and is not part of this FY 2016 Medicare request.

Implementation of the GAO and OIG recommendations for improvements to oversight and survey processes also contributes to the cost increase. Another factor is continued expansion in the role that survey and certification plays in addressing issues of national importance such

as, reducing the use of anti-psychotics and improving dementia care in nursing homes, reducing infections, pressure ulcers and other healthcare-association conditions in a multiplicity of provider types, reducing hospital readmissions, and coordinating with the Department of Justice and other agencies to address fraud or poor quality of care.

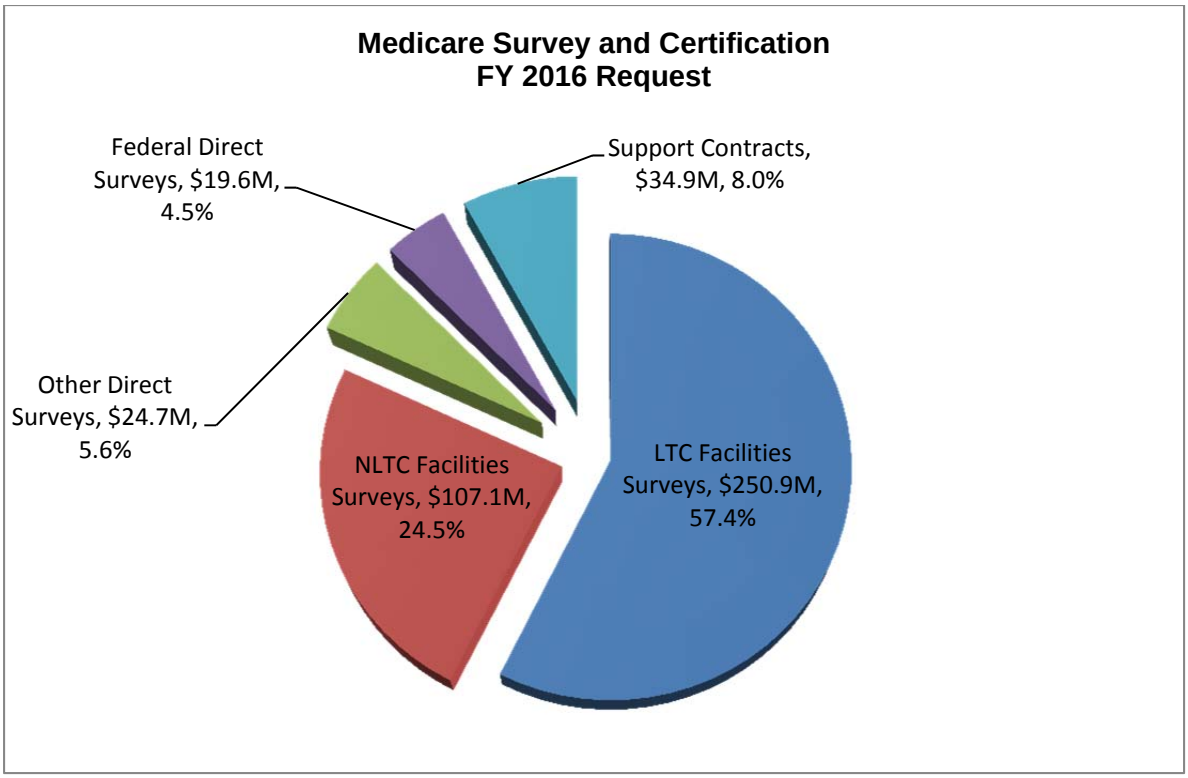
To contain costs in the face of a greater survey workload, CMS' request already assumes administrative efficiencies resulting from the Survey and Certification Efficiency and Effectiveness Initiative finalized in early 2013, with projected savings totaling over $50 million. Efficiency initiatives include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

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

As described below in more detail, approximately $358.0 million will support State direct survey costs, $24.7 million will support additional costs related to State direct surveys, and $54.5 million will be used for direct surveys by CMS National Contractors (non- State), support contracts, and information technology.

Approximately 87 percent of the requested funding will go to State survey agencies. This funding will be used for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, ESRD facilities, and others. It will mitigate the delay experienced by prospective providers that newly seek Medicare participation. The budget also includes funding for continued program support contracts to strengthen quality improvement and national program consistency, promote gains in efficiency, make oversight of accrediting organizations more effective, and implement key recommendations made by the GAO and OIG.

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

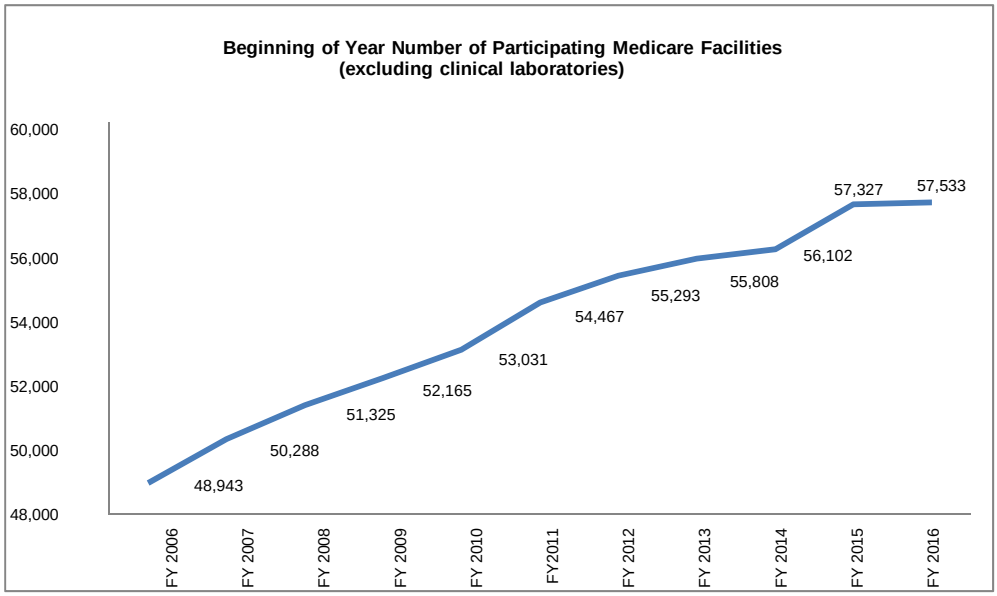


State Direct Survey Costs - $358.0 million

The FY 2016 request includes $358 million for State direct survey costs. This is an increase of $15.9 million above the FY 2015 Enacted level. This funding will enable CMS to continue to meet statutory survey frequencies as well as increase the survey frequencies for non-statutory facilities from the FY 2015 levels to near CMS policy levels. Hospice surveys are separately funded by the IMPACT Act.

Conditions of Participation (COPs) for Community Mental Health Centers (CMHCs) were published in final form in FY 2014. The budget provides funding for State surveys of CMHCs beginning in FY 2015 and continuing in FY 2016. The COPs will promote improvements in the quality of care at CMHCs by setting minimum quality and safety of care standards that CMHCs will have to meet in order to enter and maintain enrollment as a Medicare provider.

As shown in the pie chart above, the direct survey budget includes resources to survey most provider types, with the majority of the budget funding long-term care facility surveys (i.e., SNFs and dually-certified SNF/NFs). Between FY 2013 and the end of FY 2016, the number of Medicare-certified facilities to be surveyed is expected to have increased three percent, from 55,808 to 57,533 facilities in FY 2016, as shown in the following graph, excluding clinical laboratories. The projections do not include any impact that the expansion of health care coverage under the Affordable Care Act may have on the number of providers, as there is insufficient information currently available to make reliable projections.



State Direct Survey Costs (Dollars in Millions)

Provider Type	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Budget Request
Skilled Nursing Facility (SNF)	$14.1	$14.9	$16.8
SNF/NF (dually-certified)	$228.0	$232.2	$234.2
Home Health Agencies	$23.8	$19.4	$18.7
Non-Accredited Hospitals	$14.0	$15.8	$15.2
Accredited Hospitals	$18.8	$25.3	$27.7
Ambulatory Surgery Centers	$9.0	$9.1	$10.6
ESRD Facilities	$17.8	$20.6	$29.2
Hospices	$6.6	$0.0*	$0.0*
Outpatient Physical Therapy	$1.0	$1.3	$1.3
Outpatient Rehabilitation	$0.2	$0.2	$0.2
Portable X-Rays	$0.2	$0.3	$0.3
Rural Health Clinics	$1.8	$2.4	$2.0
Organ Transplant Centers	$0.3**	$0.0**	$0.0**
Community Mental Health Centers	$0.0	$0.6	$1.8
Subtotal, Direct Survey Costs	**$335.6**	**$342.1**	**$358.0**
Other Direct Survey Costs	$10.2	$13.2	$24.7
Total, Direct Surveys [1]/	**$345.8**	**$355.3**	**$382.7**

[1] Total may not add due to rounding.
* Hospice surveys are separately funded under the IMPACT Act PL 113-185 at $8.3 million in FYs 2015 and 2016.
** Excludes approximately $3 million for onsite surveys of organ transplant centers done by national contractor.

CMS' FY 2016 Budget request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. CMS continues to advance efforts to address healthcare associated infections (HAI) across all providers. The request continues the enhanced survey process in ASCs to target infection control deficiencies with an average survey frequency that meets the policy levels of every 3 - 4 years. Individuals in hospices are also highly vulnerable. Based on concerns regarding the quality of care in hospices (such as a 15% increase in complaints between FY 2010 and FY 2013), using the IMPACT Act funding, CMS will increase the frequency of hospice surveys in FY 2016 from an average of once every 6 years to once every 3 years. Also with IMPACT Act funds, CMS will conduct specialized surveys of a select number of hospices for which data indicates that there may be greater risk of substandard quality of care. Use of such targeted surveys, based upon performance indicators, will allow CMS to more promptly identify and address issues that ultimately impact beneficiary care, and do so in an effective and efficient manner.

The following chart includes updated frequency rates for FY 2014 through FY 2016.

Type of Facility	FY 2014 Enacted Budget	FY 2015 Enacted Budget	FY 2016 Budget Request
Long-Term Care Facilities	Every Year (100%)*	Every Year (100%)	Every Year (100%)
Home Health Agencies	Every 3 Years (33.3%)	Every 3 Years (33.3%)	Every 3 Years (33.3%)
Non-Accredited Hospitals	Every 4.8 Years (20.8%)	Every 3.3 Years (30.3%)	Every 3 Years (33.3%)
Accredited Hospitals - Validations	1.0% Year	1.6% Year Sample	2.5% Year Sample
Ambulatory Surgery Centers	Every 4 Years (25%)	Every 4 Years (25%)	Every 4 Years (25%)
ESRD Facilities	Every 5 Years (20%)	Every 3.5 Years (28.6%)	Every 3 Years (33.3%)
Hospices	Every 6 Years (16.7%)	Every 3 Years (33.3%)**	Every 3Years (33.3%)**
Outpatient Physical Therapy	Every 9 Years (11.1%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Outpatient Rehabilitation	Every 9 Years (11.1%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Portable X-Rays	Every 9 Years (11.1%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Rural Health Clinics	Every 9 Years (11.1%)	Every 6 Years (16.7%)	Every 6 Years (16.7%)
Organ Transplant Centers	Every 5 Years (20%)***	Every 5 Years (20%)***	Every 5 Years (20%)***
Community Mental Health Centers	Not Funded	Every 6 Years (16.7%)	Every 6 Years (16.7%)

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

In FY 2016, CMS expects to complete approximately 25,000 initial and recertification inspections, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates 52,200 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2016 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of pressure ulcers in nursing homes and to decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication. Additional information about Survey and Certification performance measures is included in the performance section of this chapter.

Survey and Complaint Visit Table

FY 2015 Enacted Budget					
Type of Facility	**Projected # Fac (Beg of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	805	805	28	808	1641
SNF/NF (dually-certified)	14330	14460	114	43450	58024
Home Health Agencies	12625	2790	92	1496	4378
Non-accredited Hospitals	1660	503	32	470	1005
Accredited Hospitals	4565	72	0	3685	3757
Ambulatory Surgery Centers	5590	818	45	117	980
ESRD Facilities	5910	1689	235	782	2706
Hospices	3835	857*	45*	594*	1496*
Outpatient Physical Therapy	2385	398	26	8	432
Outpatient Rehabilitation	305	51	5	7	63
Portable X-Rays	585	98	35	5	138
Rural Health Clinics	4025	671	210	37	918
Organ Transplant Centers	245	0**	0**	0**	0**
Community Mental Health Centers	612	0	64	7	71
Total	**57,477**	**23,212**	**931**	**51,466**	**75,609**

*Hospice surveys are separately funded under the IMPACT Act PL 113-185.
**Organ transplant centers surveys done by the CMS national contractor, do not appear in this chart.

FY 2016 Budget Request					
Type of Facility	**Projected # Fac (Beg of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	795	795	120	975	1890
SNF/NF (dually-certified)	14450	14580	127	44325	59032
Home Health Agencies	12640	2911	65	1545	4521
Non-accredited Hospitals	1572	524	18	455	997
Accredited Hospitals	4595	115	0	3285	3400
Ambulatory Surgery Centers	5570	954	25	137	1116
ESRD Facilities	6110	2037	255	790	3082
Hospices	3907	917*	40*	645*	1602*
Outpatient Physical Therapy	2225	371	25	8	404
Outpatient Rehabilitation	265	44	10	7	61
Portable X-Rays	574	96	32	5	133
Rural Health Clinics	4030	672	72	35	779
Organ Transplant Centers	245	0**	0**	0**	0**
Community Mental Health Centers	555	92	111	7	210
Total	**57,533**	**24,108**	**900**	**52,219**	**77,227**

** Hospice surveys are separately funded under the IMPACT Act PL 113-185.
** Organ transplant centers surveys done by the CMS national contractor, do not appear in this chart.

Other State Direct Survey Costs - $24.7 million

The FY 2016 direct survey cost estimate also includes $24.7 million in other direct survey costs for several continuing activities. This is an increase of $11.5 million above the FY 2015 Enacted level. There were some minor offsetting increases in cost, such as more targeted surveys in FY 2016, and additional funding for training manuals. Examples of such activities include:

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

Federal Direct Surveys and Support Contracts and Information Technology - $54.5 million

Federal Direct Surveys - $19.6 million

The FY 2016 request includes $19.6 million for Federal direct survey costs. This is an increase of $2.3 million above the FY 2015 Enacted level. The increase in funding can be attributed directly to the addition of $2.5 million for monitoring and oversight of territories and islands. There was also a small increase in targeted and performance surveys, psychiatric hospital surveys, and transplant center oversight support. CMS will be engaged with a small number of national contractors (in lieu of or with States) to conduct certain surveys on behalf of CMS in areas that are highly specialized or so small in number that States have difficulty maintaining infrequently-used expertise. For example, all organ transplant hospital surveys in FY 2016 will be conducted by a national contractor, as will be the psychiatric hospital special conditions. CMS contractors also assist States or federal surveyors in emergencies, addressing State performance lapses, or in responding to special challenges. Contractors are used to provide special support to States for ESRD facility and for nursing home surveys. In addition, prospective improvements in survey processes are often pre-tested with national contractors before enlisting State volunteers for pilot-testing. The FY 2016 budget would aid in restoration of the federal direct survey capability that was substantially reduced pursuant to the FY 2013 budget sequestration.

The FY 2016 budget request of $2.5 million for oversight of territories and islands is needed for national contractors to promote improved health care and continued access to health care in both U.S. Territories and among Indian tribes where there are often few providers. Numerous providers and suppliers in such areas face the prospect of Medicare and Medicaid termination due to unresolved safety or quality of care problems. Recent examples of providers CMS has been working with to improve care delivery include: an acute care hospital in the Commonwealth of the Northern Marianas, a hospital and nursing home on one of the Virgin Islands, a dialysis facility in one of the U. S Territories, and multiple Tribal and Indian Health Service hospitals.

Funds requested for this initiative would improve the ability of survey and certification to conduct the necessary surveys to assure health care quality, provide onsite education and training to the providers about CMS quality of care and safety standards, coordinate the work

of technical assistance resources that may be engaged (such as the Commission Corps and Quality Improvement Organizations) under terms of the plans of correction or performance improvement agreements between the provider and CMS, and defray the cost of the multiple on-site revisit surveys generally necessary to confirm that quality of care has been restored and Medicare termination may be avoided. We believe these actions in remote and underserved areas would greatly enhance the ability of providers in those areas to achieve and maintain the level of service necessary to uphold the Federal Government's obligation to meet the health care needs of those populations.

Support Contracts and Information Technology - $34.9 million

Support contracts and information technology, managed by CMS, constitute $34.9 million of the FY 2016 budget request.

Support Contracts

The FY 2016 request for support contracts totals $31.1 million. This is an increase of $7.9 million over the FY 2015 Enacted level. The increased funds will improve data analysis of ESRD performance, implement revisions to CMS regulations, and strengthen CMS training of surveyors (especially through web-based offerings). Surveyor training continues to be one of the largest categories in support contracts. These contracts enable CMS to fulfill statutorily-required training mandates of sections 1819, 1919, and 1891 of the Social Security Act. Implementing more efficient and effective training of surveyors is an area that has a high return on investment. Through web-based, in-person, and case-study training, surveyors gain the skills necessary to perform proficiently and promote quality care for beneficiaries. CMS is developing an increasing array of web-based trainings in order to reduce State travel expenses and gain efficiencies. Although CMS efforts to develop more online or web-based trainings results in greater CMS support contract costs, there is a net fiscal benefit as the reduction in State travel costs and travel time exceeds the increase in CMS expenses.

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

The FY 2016 request will also continue to provide funds for maintenance and continued improvement of the CMS *Nursing Home Compare* website and *Five Star Quality Rating System* for nursing homes, and continued publication of full survey reports in a searchable database on the web for all nursing home surveys and for hospital complaint investigations. CMS also plans to add more Quality Measures to the *Five-Star* system in FY2016, begin the transition to electronic quarterly reporting of each nursing home's staffing data, and expand the targeted surveys (discussed previously) that help ensure integrity and accuracy of resident assessments and reporting of data used in the Quality Measures.

Using IMPACT Act funding, CMS will also engage a support contractor to develop a risk-based algorithm to identify hospice agencies for which available data indicate a higher risk of substandard care. The support contractor will then assist CMS in developing the methodology for a focused survey process of such higher risk hospices that can address quality of care issues.

Information Technology

The IT funding request for FY 2016 is $3.9 million. This is an increase of $2.2 million over the FY 2015 Enacted level. This request includes $0.9 million for an IT training system and $0.5 million for the continued implementation of the IT portion of the Quality Indicator Survey (QIS). These funds support the ongoing system support and maintenance for current and future states implementation to the QIS process. Another $1.0 million is required to make changes to the national surveyor information system to accommodate statute and regulation changes. The remaining $1.5 million in IT funds upgrade system capabilities to address oversight of accrediting organizations, ESRD surveys, increases in survey efficiency, increases in transparency (such data integrity edits and safeguards for making survey reports publicly available while protecting privacy), and similar work requiring IT support.

Program Level Table

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Request**	**FY 2016 +/- FY 2015**
BA	$375,330,000	$397,334,000	$437,200,000	+$39,866,000
IMPACT P.L. 113-185. Hospice Surveys	N/A	$8,333,333	$8,333,333	-
Revisit User Fee	N/A	N/A	$0	-
Program Level	$375,330,000	$405,667,333	$445,533,333	+$39,866,000

Performance Measurement

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

MSC1 Decrease the Prevalence of Pressure Ulcers in Nursing Homes: CMS measures quality of care in nursing homes in a number of ways. The pressure ulcer measure is clinically significant and is closely tied to the care given to beneficiaries. CMS Regional Offices have taken the lead in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative. New survey guidance and follow-up with States has increased the focus on pressure ulcer reduction. The prevalence of pressure ulcers in nursing homes is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers. A decrease in the prevalence of pressure ulcers of even 0.1 percentage points represents more than 1,000 fewer nursing home residents with a pressure ulcer. The success of the efforts can be attributed to greater collaboration between State survey agencies and Quality Improvement Organizations and the national Advancing Excellence in America's Nursing Homes campaign.

In October 2010, all nursing homes began submitting nursing home clinical assessment data using the Minimum Data Set (MDS), Version 3.0; therefore, CMS rescaled and rebased the measure. Beginning with the FY 2012 reporting period, we are reporting the prevalence of pressure ulcers, Stage 2 and greater, in high-risk, long-stay residents. In FY 2013, the actual reported prevalence of Stage 2 and greater pressure ulcers among high risk residents was 6.1 percent, better than our target of 6.9 percent. The FY 2015 target was lowered to 5.7 percent and the FY 2016 target is set at 5.5 percent, reflecting our belief that a continued focus on this important measure is well warranted.

MSC2 Percentage of States that Survey Nursing Homes at Least Every 15 Months and MSC3 Percentage of States that Survey Home Health Agencies at Least Every 36 Months: CMS has performance measures to assess whether CMS and our survey partners are meeting the core statutory obligations for carrying out surveys with routine frequency. Although 99.1 percent of all nursing homes were surveyed within the statutory 15-month timeframe, CMS did not meet its FY 2013 target of 97 percent of States completing all surveys, as only 87 percent of States achieved 100 percent. In addition, only 90.4 percent of States surveyed all home health agencies at least every 36 months, missing the FY 2013 target of 96 percent. The primary factor affecting the ability to meet the FY 2013 targets was the continued effects of prior State employee furloughs, hiring freezes, salary freezes, and staff turnover. The FY 2016 targets are for 97 percent of States to survey nursing homes at least every 15 months and for States to survey at least 96 percent of home health agencies at least every 36 months. This methodology requires a State to comply with 100 percent of its surveys, and the metric is, therefore, sensitive to States achieving this absolute bar. In order to assist States, CMS must ensure that proper operational controls, such as training and regulations, are in place. CMS also issues annual instructions to States, which update the agency's policies, priorities, and the

statutory survey frequency requirements to meet these targets. The FY 2016 budget includes some funds for a national contractor to assist States when they are experiencing personnel shortages, one of the causes of State performance lapses.

MSC5 Improve Dementia Care in Nursing Homes and Decrease the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication:
Antipsychotic medications have common and dangerous side effects, including the risk of death, when used to treat the behavioral and psychological symptoms of dementia. CMS has been working with partners, including State coalitions, provider associations, nursing home resident advocates, and stakeholders to decrease the use of these drugs and improving dementia care. A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the national Partnership to Improve Dementia Care and have been incorporated into clinical practice guidelines and various tools and resources. In the three years immediately prior to CMS intervention in March 2012, the prevalence rates had consistently risen each quarter. In the last quarter of CY 2011, 23.87 percent of long stay nursing home residents received an anti-psychotic medication (excluding residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome). We use this CY 2011 rate as a baseline. By the end of the last quarter of FY 2013, the rate had dropped by 13.1 percent to 20.7 percent. Progress has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20 percent. Continuing results are posted to the Nursing Home Compare website at www.medicare.gov/nursinghomecompare. CMS's most recent target is for a further reduction to 17.9 percent of long stay residents by the last quarter of CY 2015 (a 25 percent reduction from the baseline) and a further reduction to 16.7 percent by the end of CY 2016, which will represent a 30 percent reduction from the baseline.

Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
MSC1: Decrease the Prevalence of Pressure Ulcers in Nursing Homes	FY 2013: 6.1% Target: 6.9% (Target Exceeded)	5.7%	5.5%	-.2 pp
MSC2: Percentage of States that Survey Nursing Homes at Least every 15 Months	FY 2013: 87% Target: 97% (Target Not Met)	97%	97%	Maintain
MSC3: Percentage of States that Survey Home Health Agencies at Least Every 36 Months	FY 2013: 90.4% Target: 96% (Target Not Met)	96%	96%	Maintain
MSC5: Improve Dementia Care in Nursing Homes by Decreasing the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication	FY 2013: 20.3% Historical Actual	17.9% CY[1]	16.7% CY	-1.2 pp

[1] *Targets were revised to be more ambitious based on recent results.

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

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Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$234,608,916,000] *$243,545,410,000,* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, 2016, [2015 payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] for the last quarter of fiscal year [2015] *2016* 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 [2016] *2017*, [$113,272,140,000] *$115,582,502,000,* to remain available until expended.

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

Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $243,545,410,000, to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2016. This appropriation is in addition to the advance appropriation of $113.3 billion provided by P.L. 113-235 for the first quarter of FY 2016. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
In addition, for carrying out such titles after May 31, 2016, for the last quarter of fiscal year 2016, 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 2016 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. "[F]or carrying out" is substituted for consistency throughout the appropriations language. "[T]o remain available until expended" is included for alignment with other Medicaid appropriations provided in this language.

Medicaid

Language Analysis

Language Provision	Explanation
In addition, for carrying out such titles for the first quarter of fiscal year 2017, $115,582,502,000, to remain available until expended.	This section provides an advanced appropriation for the first quarter of FY 2017 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 2017 is not enacted by October 1, 2016. "[F]or carrying out" is substituted for consistency throughout the appropriations language.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

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

	2014 Actual	2015 Current Law	2016 Estimate
Appropriation Annual	$284,208,616	$338,081,239	$356,817,550
Appropriation Indefinite	$21,634,851	$0	$0
Unobligated balance, start of year	$2,282,850	$1,407,328	$134,682
Unobligated balance, end of year	-$1,407,328	-$134,682	$0
Recoveries of Prior Year Obligations	$21,597,311	$0	$0
Collections/Refunds	$703,037	$360,000	$4,800
Total Gross Obligations	$329,019,337	$339,713,885	$356,957,032
Offsetting Collections Medicare Part B QI Program	-$687,552	-$360,000	$0
Offsetting Collections (Other)	-$15,485	$0	-$4,800
Obligations Incurred but not Reported	$0	-$10,759,000	-$12,505,000
Total Net Obligations	$328,316,300	$328,594,885	$344,447,232

Medicaid Program
Authorizing Legislation

	FY 2015 Amount Authorized	FY 2015 Current Law	FY 2016 Amount Authorized	FY 2016 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$334,099,989,000	Indefinite	$352,708,243,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,981,250,000		$4,109,307,000
Total Appropriations		$338,081,239,000		$356,817,550,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2006	$215,471,709,000	$215,471,709,000	$215,471,709,000	$215,471,709,000	
2007	$200,856,073,000	------	------	$168,254,782,000	1/
2008	$206,885,673,000	$206,887,673,000	$206,885,673,000	$206,885,673,000	
2009	$216,627,700,000	------	------	$254,890,065,000	2/
2010	$292,662,503,000	$292,662,511,000	$292,662,511,000	$292,662,511,000	
2011	$259,933,181,000	------	------	$258,365,747,000	3/
2012	$270,724,399,000	------	------	$270,724,399,000	
2013	$269,405,279,000	------	------	$269,405,279,000	4/
2014	$284,208,616,000	------	------	$305,843,467,000	5/
2015	$338,081,239,000	------	------	$338,081,239,000	
2016	$356,817,550,000				

1/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
2/ Includes $38,262.4 million under indefinite authority.
3/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
4/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
5/ Includes $21.6 billion under indefinite funding authority obligated during FY 2014.

Medicaid
(Dollars in Thousands)

	FY 2014 Actual	FY 2015 Current Law	FY 2016 Estimate	FY 2016 +/- FY 2015
Medical Assistance Payments (MAP)	$306,822,348	$305,752,074	$322,570,810	$16,818,736
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$0	$10,759,000	$12,505,000	$1,746,000
Vaccines for Children	$3,556,731	$3,981,250	$4,109,307	$128,057
State & Local Administration (SLA), Survey and Certification, Fraud Control Units, and ARRA Health IT provider and admin	$18,640,258	$19,221,561	$17,771,915	-$1,449,646
Obligations (gross)	$329,019,337	$339,713,885	$356,957,032	$17,243,147
Unobligated Balance, Start of Year	-$2,282,850	-$1,407,328	$0	$1,407,328
Unobligated Balance, End of Year	$1,407,328	$134,682	$0	$134,682
Recoveries of Prior Year Obligations	-$21,597,311	$0	$0	$0
Appropriation Budget Authority (gross)	$306,546,504	$338,441,239	$356,822,350	$18,381,111
Collections	-$703,037	-$360,000	-$4,800	$355,200
Total Budget Authority (net)	$305,843,467	$338,081,239	$356,817,550	$18,736,311
Indefinite Authority	$21,634,851	$0	$0	$0
Advanced Appropriation	-$106,335,631	-$103,472,323	-$113,272,140	-$9,799,817
Annual Appropriation	$177,872,985	$234,608,916	$243,545,410	$8,963,494

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

FY 2015 Authorization - Public Law 113-76, Public Law 113-235

Allocation Method - Formula Grants

Medicaid Program
Summary of Changes
(Dollars in Thousands)

2016 Estimated Budget Authority	$356,817,550
2015 Estimated Budget Authority from PB 2015	$338,081,239
Net Change	$18,736,311

Program Description and Accomplishments

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

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

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

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

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

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

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

Medicaid Integrity Program

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

Vaccines for Children Program

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

Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities, 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 6,500 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards.

Medicaid Fraud Control Units (MFCUs)

Medicaid Fraud Control Units (MFCUs) are required by law to be established for all States operating a Medicaid program, unless the State receives a waiver from the Secretary. The

MFCUs investigate State law violations of Medicaid fraud and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities. The MFCU must be part of or coordinate with an office with statewide prosecutorial authority, such as the State Attorney General's office.

Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Prior to 1982, 99 percent of Medicaid recipients received coverage through fee-for-service arrangements. The passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997 made it easier for States to develop managed care delivery systems thereby significantly increasing the number of Medicaid recipients enrolled in managed care organizations. As of July 1, 2012 over 75 percent of all Medicaid beneficiaries (over 44 million) in 47 States, the District of Columbia, and Puerto Rico were enrolled in some type of managed care plan. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization of services, contain costs, improve access to services, and achieve greater continuity of care. Increasingly, States are using managed care to provide acute, primary, and behavioral health services, as well as long-term services and supports, to older individuals, individuals with disabilities and individuals with chronic conditions.

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

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

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

Section 1115 Demonstrations

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

Since the enactment of the Affordable Care Act, States have used 1115 demonstrations to promote healthcare transformation in alignment with the law. Several states have recently used this authority to implement innovative new Medicaid financing and wellness programs linked to Medicaid expansion, such as incentive-based reform programs or premium assistance to wrap-around qualified health plans offered in the individual market. Several states have also used this authority to move their long-term services and supports into a managed care delivery system. To better monitor the program transformations that are being operationalized through these Medicaid demonstrations, CMS is implementing a strategy to build infrastructure for monitoring and evaluating state performance. The improved infrastructure will provide CMS with robust data to assess best practices that can provide value to the continued implementation of the expanded Medicaid program and the Marketplace. The most current fiscal data available indicates the Federal share of obligations for 1115 demonstrations in FY 2014 was $89.2 billion:

- 41 statewide health care reform demonstrations in 30 States (Arizona, Arkansas, California, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, Nevada, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia and Wisconsin) and the District of Columbia.

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

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

Recipients

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

Medicaid Enrollment (Person-Years in Millions) /1

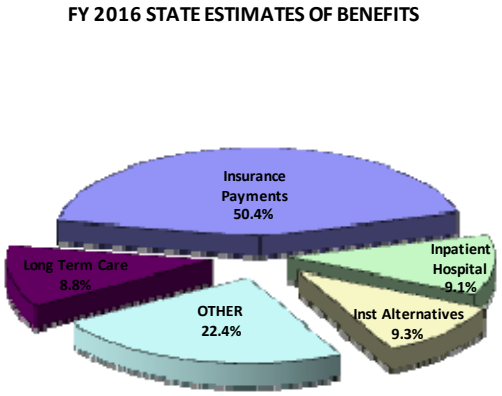
	FY 2014 Estimate	FY 2015 Estimate	FY 2016 Estimate	FY 2016 +/- FY 2015
Aged	5.4	5.6	5.8	0.2
Disabled	10.2	10.2	10.3	0.1
Adults	19.2	22.4	25.5	3.1
Children	28.9	29.6	30.3	0.7
Territories	1.0	1.0	1.0	0
Total/1	64.8	68.9	72.9	4.1

1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2016, 72.9 million of the projected 324.0 million in the total U.S. population will be enrolled in Medicaid for the equivalent of a full year during FY 2016. In FY 2016, Medicaid will provide coverage to more than one out of every five children in the nation.

CMS projects that in FY 2016, non-disabled children and adults under age 65 will represent 78 percent of the Medicaid population (compared to 74 percent in FY2012), but account for approximately 42 percent of the Medicaid benefit outlays, excluding Disproportionate Share Hospital (DSH) payments and Medicaid beneficiaries in the Territories. In contrast, older individuals and individuals with disabilities are estimated to make up over 22 percent of the Medicaid population, yet account for approximately 58 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services



As displayed in the table on the following page, the State estimates for medical assistance payments increased from $272.5 billion for FY 2015 to $287.3 billion for FY 2016.

Health insurance payments are the largest Medicaid benefit service category. These benefit payments are comprised primarily of premiums paid to Medicaid managed care plans. These services are estimated to require $178.6 billion in funding for FY 2016 representing 50.4 percent of the State-submitted benefit estimates for FY 2016. The second largest FY 2015 Medicaid category of service is institutional alternatives. It is composed of personal care, home health, and home and community-based services. The States have submitted FY 2016 estimates totaling $33.0 billion or 9.3 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2016 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($32.1 billion or 9.1 percent), followed by long-term care, such as nursing facilities, intermediate care for individuals with intellectual disabilities ($31.4 billion or 8.8 percent). Together these four benefit service categories for health insurance payments, institutional alternatives, inpatient hospital, and long-term care account for over 77 percent of the State-estimated cost of the Medicaid program for FY 2016.

Estimated Benefit Service Growth, FY 2015 to FY 2016
November 2014 State-Submitted Estimates and Actuarial Adjustments
(Dollars in Thousands)

Major Service Category	Est. FY 2015	Est. FY 2016	Dollar Growth	Annual Percent Growth	Percent Of State Estimate Growth
Health Insurance Payments (Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums)	$165,710,323	$178,636,550	$12,926,227	7.8%	109.4%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$32,401,888	$33,034,068	$632,180	2.0%	5.4%
Other (Targeted case management, hospice, all other services, and collections)	$27,810,847	$28,050,566	$239,719	0.9%	2.0%
Long-Term Care (Nursing facilities, intermediate care facilities for individuals with intellectual disabilities)	$32,134,226	$31,362,955	-$771,271	-2.4%	-6.5%
Outpatient Hospital	$9,369,553	$9,352,628	-$16,925	-0.2%	-0.1%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$5,997,586	$5,920,759	-$76,827	-1.3%	-0.7%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$33,837,889	$32,104,996	-$1,732,893	-5.1%	-14.7%
Physician/Practitioner/Dental	$15,058,365	$14,819,925	-$238,540	-1.6%	-2.0%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$11,052,490	$11,324,598	$272,108	2.5%	2.3%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$9,202,922	$9,784,495	$581,573	6.3%	4.9%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$342,576,089	$354,391,440	$11,815,351	3.4%	100.0%

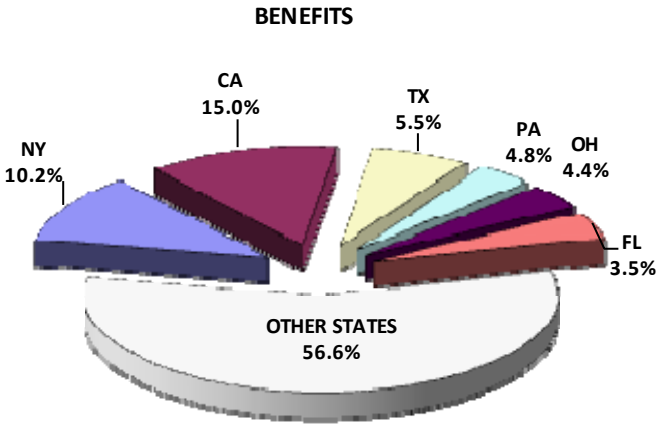
Note: This table reflects current law estimates.

Distribution of Medicaid Funding

The total FY 2016 State-submitted estimates for Medicaid are $369.5 billion, composed of $354.4 billion for Medicaid medical assistance payments and $15.1 billion for State and local administration.

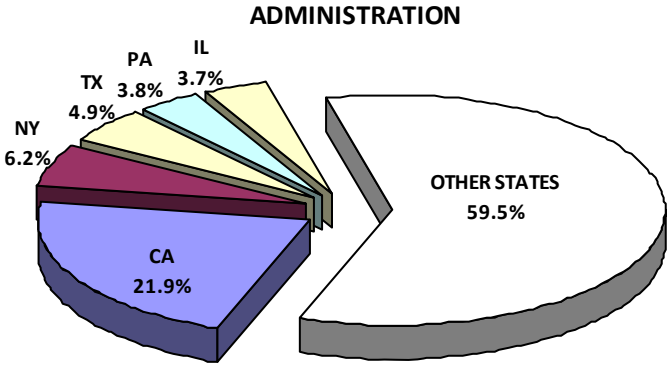
Distribution of Benefit Funding

As displayed, California, New York, Texas, Pennsylvania, Ohio and Florida account for $153.8 billion, or over 43 percent, of the State-submitted estimates for benefits for FY 2016. Ten States represent over 54 percent of these estimates.



Distribution of State and Local Administration Funding

The State-submitted estimates for FY 2016 State and local administration represents about 4.1 percent of the total State-submitted estimates for Medicaid costs for FY 2016. As displayed, California, New York, Texas, Pennsylvania, and Illinois account for $6.1billion or more than 41 percent of the FY 2016 estimates for State and local administration. Ten States represent over 55 percent of these estimates.



Funding History (Appropriation)

FY 2011	$259,933,181,000 [1/]
FY 2012	$270,724,399,000
FY 2013	$269,405,279,000
FY 2014	$305,843,467,000 [2/]
FY 2015	$338,081,239,000

[1/] Full year continuing resolution appropriation provided indefinite funding authority.
[2/] Includes $21.6 billion in indefinite funding authority.

Budget Request

CMS estimates its FY 2016 appropriation request for Grants to States for Medicaid is $356.8 billion, an increase of $18.7 billion relative to the FY 2015 level of $338.1 billion. This appropriation is composed of $113.3 billion in authorized advance appropriation for FY 2016 and a remaining appropriation of $243.5 billion for FY 2016.

Resources will fund $357.0 billion in anticipated FY 2016 Medicaid gross obligations. These obligations are composed of:

- $322.6 billion in Medicaid medical assistance benefits;
- $12.5 billion for benefit obligations incurred but not yet reported;
- $17.8 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $4.1 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

This submission is based on projections from State-submitted estimates and the CMS' Office of the Actuary (OACT) using Medicaid expenditure data as recent as the first quarter of FY 2015. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2016 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $344.4 billion in FY 2016. This represents an increase of 4.8 percent relative to the estimated net outlay level of $328.6 billion for FY 2015. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 5.8 percent during FY 2016, which includes the impact of Medicaid expansion enrollment.

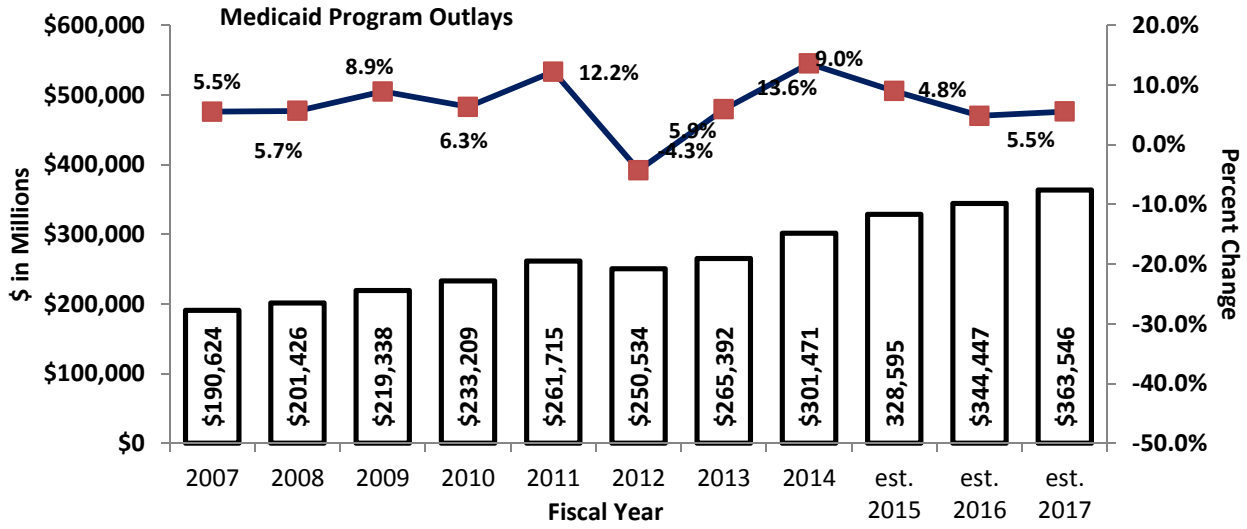
Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2014 State estimates. These adjustments reflect actuarial estimates, legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2014 State estimates for MAP in FY 2016 are the first State-submitted estimates for FY 2016. Typically, State estimation error is most likely to occur early in the budget cycle because States are most focused on their current year budget and have not yet focused on their projections for the Federal budget year.

OACT developed the MAP estimate for FY 2016. Using the last three quarters of FY 2014 State-reported expenditures as a base, expenditures for FY 2015 and FY 2016 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by the OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the November 2014 State-submitted estimates.



Factors Impacting Medicaid Expenditure Growth

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

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

In March 2010, President Obama signed the Affordable Care Act which ushered in major improvements to health care coverage, cost and quality for all Americans. The largest change occurred in 2014 which included the expansion of Medicaid eligibility at the State's option to persons under age 65 with incomes under 133 percent of the Federal Poverty Level (with a 5 percent income disregard). Federal Medicaid spending increased in FY 2014 due to large increases in enrollment among newly eligible individuals whose medical assistance expenditures were reimbursed at 100 percent Federal match. The newly eligible Federal match rate remains at 100 percent in calendar years 2015 and 2016 after which it gradually phases down to 90 percent for 2020 and beyond. As enrollment

increases associated with the eligibility expansion are anticipated to continue beyond FY 2014, expenditures are projected to continue to grow relatively faster in FY 2015. Growth in FY 2016 however will be tempered particularly due to the conclusion of the primary care payment increase.

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

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

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

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

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

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

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

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

Please refer to the Program Management chapter for more information.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Recent Legislation (Estimated FY 2016 costs are $411 million)

Protecting Access to Medicare Act of 2014
(P.L. 113-93)

- Extension of the Qualified Individual (QI) Program

  The Qualified Individual (QI) program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. In addition, QI beneficiaries are deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. This provision extended the QI program from April 1, 2014 through March 31, 2015.

- Extension of Transitional Medical Assistance (TMA)

  TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This provision extended the TMA program from April 1, 2014 through March 31, 2015.

- Delay of Rebasing of Reductions to Medicaid Disproportionate Share Hospital - Allotments (DSH)

  Section 2551 of the Affordable Care Act reduced Medicaid DSH funding over FY 2014-2020. The Bipartisan Budget Act of 2013 (P.L. 113-67) subsequently delayed DSH reductions until FY 2016. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) further delayed the DSH reductions until FY 2017, revised the aggregate reduction amounts scheduled for FY 2017-2020, and applied new aggregate reduction amounts to FY's 2021 through 2024. Under current law, DSH allotments revert to pre-Affordable Care Act levels starting in FY 2025.

- Delay of Effective Date for Medicaid Third Party Liability Provisions

  Section 202 of the Bipartisan Budget Act of 2013 (P.L. 113-67) affirmed Medicaid's position as the payer of last resort for medical treatment by strengthening third-party liability to improve states' and providers' abilities to receive payments for beneficiary services, as appropriate. Section 211 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) delays the effective date for these provisions until FY 2017.

- Demonstration to Improve Community Mental Health Services

  Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) requires the Secretary to publish criteria for a State-certified community behavioral health clinic to participate in a mental health services demonstration program participated in by a State. Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, is required to

issue guidance for the establishment of a prospective payment system that shall apply only to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program. It also requires the Secretary to award planning grants to States to develop proposals to participate in two-year demonstration programs not later than January 1, 2016. Participating states will receive an enhanced FMAP for mental health services provided in certified community behavioral health clinics to Medicaid enrollees.

Veterans Access, Choice, and Accountability Act of 2014
(P.L. 113-146)

- Establishes a new temporary program to provide hospital care and medical services to certain eligible veterans in non-VA facilities or through non-VA providers, including providers who participate in Medicare and Medicaid or Medicare-only. Extends the reduction in amount of pension furnished by the Department of Veterans Affairs for certain veterans covered by Medicaid plans for services furnished by nursing facilities.

Emergency Afghan Allies Extension Act of 2014
(P.L. 113-160)

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

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2016 savings are $155 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $155 million in FY 2016. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure State compliance with Federal regulations governing Medicaid and State financing. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific high-risk areas, and other ongoing oversight and enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2016 estimate of $12.5 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2015 to September 30, 2016. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Vaccines for Children (VFC) Program
The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. In addition to the

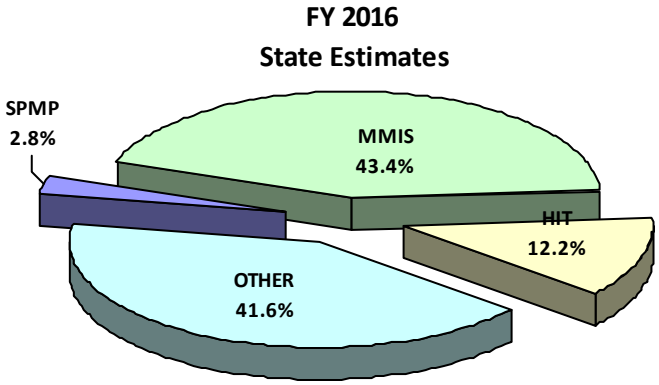
health benefits of vaccines, they also provide significant economic value. A 2011 economic evaluation found that for each birth cohort vaccinated against 13 childhood diseases (diphtheria, *haemophilus influenzae* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella) over 20 million cases of disease and over 42,000 deaths are prevented over the lifetime of children born in any given year, and result in an annual cost savings of $13.6 billion in direct medical costs. An estimated $10.20 is saved in direct medical costs for each $1 invested in vaccines for VPDs.

The current FY 2016 estimate for the VFC program is $4.1 billion, which is $128.0 million above the FY 2015 estimate. This estimate includes an increase for vaccine-purchase contract costs and additional quality assurance and quality improvement site visits to VFC-enrolled providers. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget is used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of States, immunization coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2016, based on recent actual data and the November 2014 State estimates, CMS estimated the Federal share of State and local administration costs to be $17.8 billion. This estimate is composed of $17.2 billion for Medicaid State and local administration and $.5 billion in additional funds for Medicaid State survey and certification and State Medicaid fraud control units.

State and Local Administration



In November 2014 the States estimated the Federal share of State and local administration outlays to be $17.2 billion for FY 2016. State and Local Administration monies provide funding for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing activities; ARRA authorized Health Information Technology Incentive program; skilled professional medical personnel (SPMP); salaries, fringe benefits, training; and other State and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

CMS adjusted the FY 2016 State-submitted estimates of $17.8 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when States submitted estimates. These estimates were adjusted to reflect the estimated costs of incentives to eligible providers and hospitals for the adoption and meaningful use of electronic health records (EHR), described further below. After these adjustments, the FY 2016 estimate for State and local administration is $17.8 billion.

- Health Information Technology Meaningful Use Incentive Program

  FY 2016 estimate is $2.1 billion for provider incentives payments

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

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for individuals with intellectual disabilities in FY 2016 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2016 estimate for Medicaid State survey and certification is $285 million. This represents an increase of $35.6 million above the current FY 2015 estimate of $249.4 million. This increased funding level includes monies to support increasing workload requirements (i.e. increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 29,000 Medicaid participating facilities with nearly 24,500 health and life safety code annual certifications, as well as over 50,500 complaint survey investigations; direct State survey costs associated with nursing home quality; and Home Health agencies.

State Medicaid Fraud Control Units (MFCUs)

In FY 2016, State Medicaid fraud control unit operations are currently estimated to require $243.7 million in Federal matching funds. This represents an increase of $10.0 million over the FY 2015 funding level of $233.7 million. Forty-nine States and the District of Columbia participate in the program. Estimated increases are due to increases in staff and related expenses as MFCUs invest resources into curtailing Medicaid fraud and patient abuse and neglect.

The MFCU's mission is to investigate and prosecute provider fraud in State Medicaid programs as well as patient abuse and neglect in health care facilities. In FY 2014, States reported $2.0 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

Medicaid Impact of Proposed Legislation

1. Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid

   The Budget would require coverage of preventive health services as defined in section 2713 of the Public Health Service Act without cost-sharing for all adults enrolled in the Medicaid program, and also expand section 4107 of the Affordable Care Act, which provides tobacco cessation services (including counseling) to pregnant women, to all Medicaid eligible populations. Such services are already required for most other populations without cost sharing, including individuals in private health plans, the Medicaid expansion population, and various other Medicaid beneficiaries.

   Ten-year budget cost: $754 million

2. Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults

   Currently, individuals enrolled in Medicaid are required to report changes in income, assets, or other life circumstances that may affect eligibility between regularly scheduled redeterminations. This proposal would create a state plan option to allow 12 months of continuous eligibility for individuals who would otherwise be at risk of moving between insurance coverage, often referred to as churning, that disrupts existing provider relationships or increasing the odds of becoming uninsured. States already have a state plan option for continuous eligibility for children in Medicaid and CHIP and that authority would be broadened to include all adults or, at state option, only adults determined eligible for Medicaid on the basis of Modified Adjusted Gross Income.

   Ten-year budget cost: $4.7 billion in net federal costs including $27.7 billion in Medicaid costs

3. Extend the Medicaid Primary Care Payment Increase through CY 2016 and Include Additional Providers

   Effective for dates of service provided on January 1, 2013 through December 31, 2014, states were required to reimburse qualified providers at the rate that would be paid for the primary care service under Medicare. The federal government covered 100 percent of the difference between the Medicaid and Medicare payment rate. This increased payment rate expired at the end of CY 2014. As part of the Administration's workforce initiative, this proposal would extend the enhanced rate through December 31, 2016, expand eligibility to obstetricians, gynecologists, and non-physician practitioners, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care

   Ten-year budget cost: $6.3 billion

4. Pilot Comprehensive Long-Term Care State Plan Option

   This eight-year pilot program would create a comprehensive long-term care state plan option for up to five states. Participating states would be authorized to provide

home and community-based care at the nursing facility level of care, creating equal access to home and community-based care and nursing facility care. The Secretary would have the discretion to make these pilots permanent at the end of the eight years. This proposal works to end the institutional bias in long-term care and simplify state administration.

Ten-year budget cost: $4.1 billion

5. Allow States to Develop Age-Specific Health Home Programs

   The Affordable Care Act includes a provision that allows states to create Health Homes for Medicaid enrollees with chronic conditions. Under a Health Home program, states can develop a comprehensive system of care coordination for the purpose of integrating and coordinating all primary, acute, behavioral health, and long term services and supports to treat the whole person. States receive an increased federal match for Health Home services for the first eight quarters of their program. This proposal would allow states to target their Health Home programs by age. Currently, states are required to cover Health Home services for all categorically needy individuals with the specified chronic condition(s), regardless of age. Many states have voiced support for allowing age-specific targeting of their Health Home model to better serve the needs of youth with chronic conditions.

   Ten-year budget cost: $1 billion

6. Permanently Extend Express Lane Eligibility Option for Children

   The Children's Health Insurance Program Reauthorization Act (P.L. 111-3) authorized Express Lane Eligibility through FY 2014 under which state Medicaid or CHIP agencies can use another public program's eligibility findings to streamline eligibility and enrollment into Medicaid or CHIP. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) extended the authorization to use Express Lane Eligibility through September 30, 2015. As of January 1, 2015, 14 states and 1 territory used this authority to partner with programs like the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families to identify, enroll, and retain children who are eligible for Medicaid or CHIP. The Budget supports a permanent extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP eligible children.

   Ten-year budget cost (Medicaid impact): $680 million

7. Expand Eligibility for the 1915(i) Home and Community-Based Services (HCBS) State Plan Option

   The Budget proposes to update eligibility requirements to increase states' flexibility in expanding access to home and community-based services under section 1915(i) of the Social Security Act. Under current law, certain non-categorically eligible individuals who meet the needs-based criteria can only qualify for home and community-based services through the 1915(i) state plan option if they are also eligible for home and community-based services through a waiver program. Removing this requirement would reduce administrative burden on states and

increase access to home and community-based services for the elderly and individuals with disabilities.

Ten-year budget cost: $1.3 billion

8. Allow Full Medicaid Benefits for Individuals in a Home and Community-Based Services State Plan Option

   This proposal would provide states with the option to offer full Medicaid eligibility to medically needy individuals who access home and community-based services through the state plan option under section 1915(i) of the Social Security Act. Under current law, when a state elects to not apply the community income and resource rules for the medically needy, these individuals can only receive 1915(i) services and no other Medicaid services. This option will provide states with more opportunities to support the comprehensive health care needs of individuals with disabilities and the elderly.

   Ten-year budget cost: $38 million

9. Allow Pregnant Women Choice of Medicaid Eligibility Category

   Pregnant women are categorically eligible for Medicaid if they have income under 133% of the Federal Poverty Level, so under current law they are excluded from the new adult Medicaid expansion group. Because the benefits and delivery system may differ between the pregnant women and the new adult groups in states that elect to expand, women enrolled in the new adult group who become pregnant as well as postpartum women may have to change providers which would disrupt continuity of care. This proposal addresses this concern by allowing pregnant women enrolled in Medicaid to choose the eligibility category most suited to their needs.

   Ten-year budget impact: $0

10. Require Coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit for Children in Inpatient Psychiatric Treatment Facilities

    While Medicaid coverage is available for children and young adults under age 21 receiving inpatient psychiatric services, they are excluded from coverage of comprehensive preventive and medically necessary items and services to which Medicaid enrolled children are otherwise entitled. This proposal would lift the federal Medicaid exclusion of comprehensive children's coverage to reduce the financial burden on states and Medicaid families and encourage the provision of critical mental health services to children in Medicaid.

    Ten-year budget cost: $425 million

11. Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities

    This proposal would provide states with additional tools to manage their children's mental health care service delivery systems by expanding the non-institutional

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

Ten-year budget cost: $1.6 billion

12. Expand State Flexibility to Provide Benchmark Benefit Packages

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

Ten-year budget impact: $0

13. Extend Transitional Medical Assistance through CY 2016

The Transitional Medical Assistance program extends Medicaid coverage for at least 6 months and up to 12 months for low income families who lose cash assistance due to an increase in earned income or hours of employment. This proposal extends the Transitional Medical Assistance program through December 31, 2016. This proposal would allow determination of eligibility for Transitional Medical Assistance to be calculated using Modified Adjusted Growth Income to be consistent with the Affordable Care Act. States that adopt the Medicaid expansion will be able to opt out of Transitional Medical Assistance, consistent with a related Medicaid and CHIP Payment and Access Commission recommendation. Current law extends this program through March 31, 2015.

Ten-year budget cost: $1.8 billion

14. Extend the Qualified Individual Program through CY 2016

The Qualified Individual program provides states 100 percent federal funding to pay the Medicare Part B premiums of low income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal Poverty Level. This proposal extends authorization and funding of the program through December 31, 2016. Current law extends this program through March 31, 2015.

Ten-year budget cost: $975 million

15. Expand Eligibility Under the Community First Choice Option

    This proposal would provide states with the option to make medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility. Under current law, any state interested in the Community First Choice Option must create or maintain a 1915(c) waiver with at least one waiver service to make the Community First Choice benefit available to the special income group, or provide eligibility for the benefit through another eligibility pathway. This approach is administratively burdensome for states. This proposal would provide equal access to services under the state plan option and provide states with additional tools to manage their long-term care home and community-based service delivery systems.

    Ten-year budget cost: $3.6 billion

16. Rebase Future Medicaid Disproportionate Share Hospital Allotments

    As the number of uninsured individuals decreases due to the coverage expansions in the Affordable Care Act, uncompensated care costs for hospitals will also decrease, reducing the level of Disproportionate Share Hospital funding needed. Legislation has extended and revised aggregate Disproportionate Share Hospital funding reductions through FY 2024, but in FY 2025, allotments revert to levels that had been in effect prior to the Affordable Care Act. This proposal would determine future allotments based on states' actual prior year allotments as reduced by the Affordable Care Act and subsequent legislation.

    Ten-year budget savings: $3.3 billion

17. Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates

    Through the Durable Medical Equipment Competitive Bidding Program, Medicare is in the process of implementing innovative ways to increase efficiency for durable medical equipment payments. These efforts are expected to save Medicare more than $30.2 billion over 10 years. This proposal extends some of these efficiencies to Medicaid by limiting federal reimbursement for a state's Medicaid spending on certain durable medical equipment to what Medicare would have paid in the same state for the same services.

    Ten-year budget savings: $4.3 billion

18. Clarify the Medicaid Definition of Brand Drugs

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

Ten-year budget savings: $160 million

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

    Current law requires that brand and authorized generic drugs are included in the calculation of the Federal Upper Limit (FUL) on payment for outpatient prescription drugs. This proposal removes brand name drugs (innovator multiple source drugs) from the weighted average used to calculate FULs.

    Ten-year budget savings: $780 million

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

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

    Ten-year budget savings: $200 million

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

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

    Ten-year budget savings: $4.0 billion

22. Apply Inflation-Associated Medicaid Rebate to Generic Drugs

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

    Ten-year budget savings: $1.2 billion

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

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

Ten-year budget impact: $0

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

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

    Ten-year budget impact: $0

25. Exempt Emergency Drug Supply Programs from Medicaid Drug Rebate Calculations

    Under the Medicaid drug rebate program, manufacturers are required to report a best price for covered outpatient drugs that are single source or innovator multiple source to the Federal government. Free drugs provided a manufacturer's emergency drug supply programs must be included in the manufacturer's best price. This proposal provides the Secretary discretion to exempt emergency drug supply programs from the Medicaid drug rebate calculation.

    Ten-year budget impact: $0

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

    This proposal would require manufacturers to pay states back for the drugs in cases where the manufacturer improperly reported non-drug products to CMS or reported drugs that the Food and Drug Administration has found to be less than effective. By requiring full reimbursement, this proposal eliminates the incentive for manufacturers to improperly report information about drugs in these situations.

    Ten-year budget savings: $10 million

27. Enforce Manufacturer Compliance with Drug Rebate Requirements

    This proposal would enhance existing enforcement of manufacturer compliance with drug rebate requirements. Under current law, CMS has authority to survey drug manufacturers, and OIG has authority to audit drug manufacturers. This proposal

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

Ten-year budget impact: $0

28. Increase Penalties for Fraudulent Noncompliance on Rebate Agreements

This proposal would increase penalties for fraudulent noncompliance on rebate agreements. Under Medicaid drug rebate agreements, drug manufacturers are required to report accurate information, such as the Average Manufacturer Price. This proposal would increase penalties collected from drug manufacturers that knowingly report false information under their drug rebate agreements for the calculation of Medicaid rebates.

Ten-year budget impact: $0

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

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

Ten-year budget impact: $0

30. Provide Continued Funding for Survey of Retail Pharmacy Prices

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

Ten-year budget costs: $30 million

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

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

currently being reported through these wholesalers or to set accurate Upper Payment Limits (UPL).

Ten-year budget impact: $0

32. Support Medicaid Fraud Control Units for the Territories

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

Ten-year budget impact: $10 million in costs and $2 million in non-PAYGO savings

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

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

Ten-year budget savings: $710 million

34. Expand Medicaid Fraud Control Unit Review to Additional Care Settings

The Budget proposes to allow Medicaid Fraud Control Units to receive federal matching funds for the investigation or prosecution of abuse and neglect in non-institutional settings, such as home-based care—in which a beneficiary may be harmed in the course of receiving health care services. The current limitation on federal matching was established in 1978, at a time when Medicaid services were typically provided in an institutional setting, but does not reflect the shift in delivery and payment for health services to in-home and community based settings.

Ten-year budget impact: No PAYGO budget impact, but $66 million in non-PAYGO savings

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

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

Ten-year budget impact: $0

36. Consolidate Redundant Error Rate Measurement Programs

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

    Ten-year budget impact: $0

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

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

    Ten-year budget impact: $0

38. Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers

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

    Ten-year budget impact: $0

39. Allow for Federal/State Coordinated Review of Dual Special Need Plan Marketing Materials

    This proposal would introduce flexibility to rules around the review of marketing materials provided by Dual Special Needs Plans to beneficiaries. Under existing statute, all marketing materials provided by the plans to beneficiaries must be reviewed by CMS staff for accuracy, content, and other stated requirements. Because the plans also market to Medicaid beneficiaries, many of the same marketing materials must also go through a separate review from a state Medicaid agency for compliance with a different set of rules and regulations. Providing CMS with the ability to perform coordinated reviews of these marketing materials for compatibility with a unified set of standards will reduce the burden on CMS and the states, while also potentially improving the quality of the products available to beneficiaries.

    Ten-year budget impact: $0

40. Create Pilot to Expand PACE Eligibility to Individuals Between Ages 21 and 55

    This program provides comprehensive long term services and supports to Medicaid and Medicare beneficiaries through an interdisciplinary team of health professionals who provide coordinated care to beneficiaries in the community. For most

participants, the comprehensive service package includes medical and social services and enables them to receive care in the community rather than to receive care in a nursing home or other facility. Under current law, the program is limited to individuals who are 55 years old or older and who meet, among other requirements, the state's nursing facility level of care. This proposal would create a pilot demonstration in selected states to expand eligibility to qualifying individuals between 21 years and 55 years of age. This effort would test whether the Program for All-Inclusive Care for the Elderly can effectively serve a younger population without increasing costs. The pilot would promote access to community services in line with the integration of the landmark Olmstead Supreme Court decision, supporting self-determination, and achieving better health outcomes. [1]

Ten-year budget impact: $0

41. Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries

This proposal would allow CMS to contract with a single plan to provide Part D coverage to low income beneficiaries while their eligibility is processed. This plan would serve as the single point of contact for beneficiaries seeking reimbursement for retroactive claims. These beneficiaries are assigned at random under current law to a qualifying Part D plan, which is reimbursed based on the standard Part D prospective payment, regardless of their utilization of Part D services during this period. Under this proposal, the plan would be paid using an alternative methodology whereby payments are closer to actual costs incurred by beneficiaries during this period. A current demonstration, which was recently extended through 2019, has shown the proposed approach to be more efficient and less disruptive to beneficiaries.

Ten-year budget impact: $0

42. Integrate the Appeals Process for Medicare-Medicaid Enrollees

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

Ten-year budget impact: $0

[1] The U.S. Supreme Court's 1999 landmark decision in Olmstead v. L.C. (Olmstead) found the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). Olmstead requires States to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

43. Extend CHIP Funding through FY 2019

The Budget proposes to extend funding for CHIP for four years through FY 2019, to ensure continued comprehensive and affordable coverage for CHIP children. This proposal would also extend the contingency fund and the performance bonus fund authorizations through 2019. The proposal is paid for through an increase in tobacco taxes that will help reduce youth smoking and save lives.

Ten-year budget savings (Medicaid Impact): $7.3 billion

44. Establish Hold Harmless for Federal Poverty Guidelines

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

Ten-year budget impact: $0

45. Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care

The Budget proposes a five-year CMS demonstration in partnership with the Administration for Children and Families beginning in FY 2016 to encourage states to implement evidence-based psychosocial interventions targeting children and youth in the foster care system, as an alternative to the current over-prescription of psychotropic medications in this population. States would receive performance-based Medicaid incentive payments to improve care coordination and delivery for children and youth in foster care through increased access to evidence based psychosocial interventions with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people.

Ten-year budget impact (Medicaid Impact): $552 million in non-PAYGO costs

46. Extend Special Immigrant Visa Program

This proposal extends the Special Immigrant Program for Afghans through the end of FY 2016. Please see the Department of State 2016 President's Budget request for more information.

Ten-year budget costs (Medicaid Impact): $121 million

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

Beginning in FY 2016, this proposal would extend the SSI for qualified refugees under the Elderly and Disabled Refugees Act for two years. Please see the Social Security Administration's 2016 President's Budget request for more information.

Ten-year budget costs (Medicaid Impact): $22 million

48. Modernize Child Support. The Budget includes two proposals that affect Medicaid:

    a. Provide States Option to Eliminate Medicaid Assignment of Cash Medical Support

    This proposal would allow states to eliminate Medicaid's requirement to assign the right to cash medical child support to the state as a condition of eligibility to reduce barriers to health care access and increase resources for families. Section 1912 of the Social Security Act requires, as a condition of eligibility for medical assistance, that an individual assign the right to any cash medical support they receive to the state to reimburse Medicaid costs. Sections 1413 and 2201 of the Affordable Care Act require eligibility and enrollment simplification and coordination between Medicaid, CHIP, and the Marketplaces. Only Medicaid requires the assignment of cash medical support. Therefore, it is the poorest parents, those who are eligible for Medicaid, that are forced to give up their cash medical support to the government. Allowing the child support program to require parents to use their limited resources in the best interest of their child, rather than to repay Medicaid, will make more cash support available to help meet the child's other needs—food, clothing, shelter, school supplies, and even out-of-pocket medical expenses.

    Ten-year budget cost: $130 million

    b. Eliminate Medicaid Recoupment of Birthing Costs from Child Support

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

    Ten-year budget impact: $0

49. Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics

This proposal would increase competition for biological products by reducing the number of years (from 12 to 7) that a drug company has exclusivity or monopoly pricing power and prohibits additional years of exclusivity due to minor formulation changes. The proposal also modifies how Part B pays for biosimilar and innovator biological products. For these products, reimbursement would be based on the weighted average sales price of the reference biological product and all of its biosimilars, plus 6 percent.

Ten-year budget savings (Medicaid Impact): $130 million

50. Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologics

Beginning in 2016, this proposal would prohibit anticompetitive pay-for delay agreements between branded and generic pharmaceutical companies. This proposal increases the availability of generic drugs and biologics by authorizing the Federal Trade Commission to stop companies from entering into anticompetitive agreements which block consumer access to safe and effective generics.

Ten-year budget savings (Medicaid Impact): $1.5 billion

51. Expand Funding and Authority for the Medicaid Integrity Program

This proposal increases the Medicaid Integrity Program by $580 million over ten years on top of the current funding level. The additional investment would start with an additional $25 million in FY 2016 and increase gradually to an additional $100 million in 2025. Thereafter, the total would be annually adjusted by the Consumer Price Index. This funding will give CMS the ability to address additional program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing; and other efforts to assist states to fight fraud, waste, and abuse. Over time, the inflation adjusted investment will support initiatives that respond to emerging vulnerabilities. This proposal also expands the statutory authority for the Medicaid Integrity Program to increase program flexibility in protecting state and federal resources ten-year budget impact (Medicaid impact): No PAYGO impact to Medicaid, but $850 million in non-PAYGO savings. $580 million in PAYGO costs are reflected in the State Grants and Demonstrations chapter.

Proposed Law Medicaid Impact

(Dollars in Millions)

Legislative Proposal	FY 2016 - FY 2025
Require Full Coverage of Preventive Health and Tobacco Cessation Services for Adults in Traditional Medicaid	$754
Create State Option to Provide 12-Month Continuous Medicaid Eligibility for Adults	$27,700
Extend the Medicaid Primary Care Payment Increase through CY 2016 and Include Additional Providers	$6,290
Pilot Comprehensive Long-Term Care State Plan Option	$4,085
Allow States to Develop Age-Specific Health Home Programs	$1,010
Permanently Extend Express Lane Eligibility Option for Children	$680
Expand Eligibility for the 1915(i) Home and Community-Based Services (HCBS) State Plan Option	$1,341
Allow Full Medicaid Benefits for Individuals in a Home and Community-Based Services State Plan Option	$38
Allow Pregnant Women Choice of Medicaid Eligibility Category	$0
Require Coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit for Children in Inpatient Psychiatric Treatment Facilities	$425
Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities	$1,625
Expand State Flexibility to Provide Benchmark Benefit Packages	$0
Extend Transitional Medical Assistance through CY 2016	$1,825
Extend the Qualified Individual Program through CY 2016	$975
Expand Eligibility Under the Community First Choice Option	$3,581
Rebase Future Medicaid Disproportionate Share Hospital Allotments	-$3,290
Limit Medicaid Reimbursement of Durable Medical Equipment Based on Medicare Rates	-$4,270
Clarify the Medicaid Definition of Brand Drugs	-$160
Exclude Brand and Authorized Generic Drug Prices from the Medicaid Federal Upper Limits	-$780
Exclude Authorized Generics from Medicaid Brand-Name Rebate Calculations	-$200
Correct the ACA Medicaid Rebate Formula for New Drug Formulations	-$4,020
Apply Inflation-Associated Medicaid Rebate to Generic Drugs	-$1,165
Require the Coverage of Prescribed Prenatal Vitamins and Fluorides under the Medicaid Drug Rebate Program	$0
Limit Dispute Resolution Timeframe in the Medicaid Drug Rebate Program to Twelve Quarters	$0
Exempt Emergency Drug Supply Programs from Medicaid Drug Rebate Calculations	$0
Require Manufacturers That Improperly Report Items for Medicaid Drug Coverage to Fully Repay States	-$10
Enforce Manufacturer Compliance with Drug Rebate Requirements	$0
Increase Penalties for Fraudulent Noncompliance on Rebate Agreements	$0
Require Drugs Be Electronically Listed with FDA to Receive Medicaid Coverage	$0
Provide Continued Funding for Survey of Retail Pharmacy Prices	$30
Require Drug Wholesalers to Report Wholesale Acquisition Costs to CMS	$0

Proposed Law Medicaid Impact

(Dollars in Millions)

Legislative Proposal	FY 2016 - FY 2025
Support Medicaid Fraud Control Units for the Territories (non-PAYGO)	-$66
Track High Prescribers and Utilizers of Prescription Drugs in Medicaid	-$710
Expand Medicaid Fraud Control Unit Review to Additional Care Settings (PAGYO and non-PAYGO impacts)	$8
Prevent Use of Federal Funds to Pay State Share of Medicaid of CHIP	$0
Consolidate Redundant Error Rate Measurement Programs	$0
Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities	$0
Strengthen Penalties for Illegal Distribution of Beneficiary Identification Numbers	$0
Allow for Federal/State Coordinated Review of Dual Special Need Plan Marketing Materials	$0
Create Pilot to Expand PACE Eligibility to Individuals Between Ages 21 and 55	$0
Ensure Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries	$0
Integrate the Appeals Process for Medicare-Medicaid Enrollees	$0
Extend CHIP Funding through FY 2019	-$7,300
Establish Hold Harmless for Federal Poverty Guidelines	$0
Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care	$552
Extend Special Immigrant Visa Program	$121
Extend Supplemental Security Income (SSI) Time Limits for Qualified Refugees	$22
Modernize Child Support	$130
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	-$130
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs and Biologicals	-$1,450
Expand Funding and Authority for the Medicaid Integrity Program (non-PAYGO)	-$850
SUBTOTAL	**$26,791**

FY 2016 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	Difference +/- 2015
Alabama	$3,746,154	$3,699,871	$4,099,689	$399,819
Alaska	$916,768	$909,524	$942,912	$33,388
Arizona	$6,759,752	$7,831,757	$8,223,475	$391,718
Arkansas	$3,826,062	$4,503,569	$4,886,948	$380,380
California	$38,479,655	$48,596,182	$52,757,883	$4,161,701
Colorado	$3,558,739	$4,042,497	$4,691,922	$649,425
Connecticut	$4,093,240	$3,951,810	$3,989,186	$37,376
Delaware	$1,083,615	$977,074	$1,044,147	$67,073
District of Columbia	$1,820,902	$1,764,590	$1,945,096	$180,506
Florida	$12,484,992	$12,237,990	$11,486,807	-$751,183
Georgia	$6,659,041	$6,201,521	$6,304,551	$103,030
Hawaii	$1,201,433	$1,151,806	$1,241,577	$89,774
Idaho	$1,214,119	$1,376,111	$1,426,631	$50,250
Illinois	$9,610,754	$9,896,000	$10,041,621	$145,622
Indiana	$6,468,932	$6,877,143	$8,139,566	$1,262,423
Iowa	$2,597,103	$2,714,805	$2,909,547	$194,742
Kansas	$1,699,112	$1,737,619	$1,765,110	$27,491
Kentucky	$6,093,211	$6,844,911	$7,035,305	$190,394
Louisiana	$4,585,835	$4,628,299	$4,806,487	$178,188
Maine	$1,587,429	$1,522,226	$1,530,667	$8,441
Maryland	$5,523,473	$5,299,468	$5,781,467	$481,999
Massachusetts	$7,743,410	$8,359,870	$8,305,184	-$54,686
Michigan	$9,708,521	$11,292,431	$11,838,127	$545,696
Minnesota	$5,729,924	$6,489,180	$6,947,569	$458,388
Mississippi	$3,686,577	$3,677,468	$3,833,253	$155,785
Missouri	$5,816,082	$5,930,395	$5,943,606	$13,212
Montana	$782,088	$845,084	$892,312	$47,228
Nebraska	$1,069,608	$1,028,311	$970,009	-$58,302
Nevada	$1,697,724	$2,107,921	$2,136,260	$28,339
New Hampshire	$743,764	$1,102,630	$1,165,738	$63,108
New Jersey	$7,507,258	$8,601,781	$8,950,029	$348,248
New Mexico	$3,261,381	$3,762,421	$4,261,056	$498,636
New York	$28,463,986	$32,722,891	$34,277,286	$1,554,395

FY 2016 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	Difference +/- 2015
North Carolina	$8,385,785	$7,811,327	$7,997,363	$186,035
North Dakota	$238,925	$750,065	$762,191	$12,127
Ohio	$13,570,233	$13,760,834	$14,571,640	$810,806
Oklahoma	$3,215,206	$3,079,950	$3,379,710	$299,761
Oregon	$5,233,077	$6,384,387	$6,787,364	$402,978
Pennsylvania	$13,306,235	$14,766,348	$16,101,448	$1,335,100
Rhode Island	$1,497,731	$1,727,721	$1,823,782	$96,060
South Carolina	$3,956,175	$3,880,367	$4,078,643	$198,276
South Dakota	$496,884	$451,923	$468,793	$16,870
Tennessee	$6,345,844	$6,444,928	$6,854,431	$409,504
Texas	$19,673,852	$19,317,387	$18,344,146	-$973,241
Utah	$1,582,803	$1,515,183	$1,650,193	$135,009
Vermont	$939,783	$917,354	$994,765	$77,411
Virginia	$4,141,855	$4,000,127	$4,217,478	$217,351
Washington	$4,482,261	$7,851,142	$8,097,608	$246,466
West Virginia	$2,559,075	$2,576,228	$2,644,525	$68,297
Wisconsin	$4,688,924	$4,338,625	$4,697,684	$359,059
Wyoming	$313,048	$308,404	$304,579	-$3,825
Subtotal	**$294,848,340**	**$322,567,454**	**$338,344,101**	**$15,776,647**
American Samoa	$14,724	$16,170	$16,170	$0
Guam	$45,113	$39,254	$39,936	$682
Northern Mariana Islands	$19,650	$16,891	$17,188	$297
Puerto Rico	$1,200,800	$1,455,663	$1,378,486	-$77,177
Virgin Islands	$47,434	$35,142	$26,329	-$8,813
Subtotal	**$1,327,721**	**$1,563,120**	**$1,478,109**	**-$85,011**
Total States/Territories	**296,176,061**	**324,130,574**	**339,822,210**	**$15,691,636**
Survey & Certification	$219,811	$249,400	$285,000	$35,600
Fraud Control Units	$213,923	$233,661	$243,715	$10,054
Vaccines For Children	$3,556,731	$3,981,250	$4,109,307	$128,057
Medicare Part B Transfer	$687,552	$730,000	$779,800	$49,800

FY 2016 MANDATORY STATE/FORMULA GRANTS[1]
(Dollars in Thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	Difference +/- 2015
Incurred But Not Reported	$0	$10,759,000	$12,505,000	$1,746,000
Undistributed	$28,165,259	$4,485,000	$6,545,000	$2,060,000
TOTAL RESOURCES	**$329,019,337**	**$344,568,885**	**$364,290,032**	**$19,721,147**

[1] Represents current law baseline projections of obligations.

Medicaid Program
Budget Authority by Object
(Dollars in Thousands)

	2015 Estimate	2016 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$334,099,989	$352,708,243	$18,608,254
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,981,250	$4,109,307	$128,057
Total Budget Authority	$338,081,239	$356,817,550	$18,736,311

Performance Measurement

Medicaid covers a wide range of health services for eligible beneficiaries, including low-income families with dependent children, pregnant women, children and aged, blind and disabled individuals. The Affordable Care Act (ACA) extends, at the State's option, Medicaid eligibility to non-elderly individuals with family incomes up to 133 percent of the Federal poverty level (FPL), with the Federal government paying most of the costs of coverage for newly eligible adults. To measure performance in the Medicaid program and to reflect recent legislation, CMS has goals to represent the populations who receive Medicaid coverage. We have several measures to track quality of and access to care for children and we measure children's enrollment in Medicaid. We have also identified a measure set to track the quality of care provided to adults.

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

This measure should be considered in the context of 2012 data that show that in 21 States,[2] at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[3] In contrast, in 2008, five States had rates at or above 90 percent.[4] Many

[2] For the purposes of reporting, "States" refers to the 50 States and the District of Columbia.
[3] http://www.insurekidsnow.gov/professionals/reports/index.html

factors will affect enrollment in CHIP and Medicaid, including States' economic situations, and programmatic changes, and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In previous years, CMS set separate targets for Medicaid and CHIP. Beginning in FY 2013, we began to track combined Medicaid and CHIP enrollment. In 2013, 45,292,410 children were enrolled in Medicaid (37,198,483) and CHIP (8,093,927), falling short of our target of 45,592,385 children (Medicaid 37,246,233/CHIP 8,346,152). The FY 2016 target is to increase CHIP and Medicaid enrollment to 48,667,385 children[5], (Medicaid: 39,758,322/CHIP: 8,909,063), about 30 percent more children than were covered in FY 2008.

MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary State collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and States, CMS identified and published an initial core set (Child Core Set) of twenty-four children's quality measures. Section 1139A9b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the initial Child Core Set. In 2013, based on stakeholder feedback, CMS added three measures (HPV vaccinations for female adolescents; medication management for people with asthma, and behavioral risk assessment for pregnant women) and retired one measure (otitis media with effusion). In January 2014, CMS retired three measures: appropriate testing for children with pharyngitis (two to 18 years); annual pediatric hemoglobin A1C testing (five to 17 years); and annual percentage of asthma patients who are two to 20 years old with one or more asthma-related emergency department visits.[6] The 2015 Child Core Set was released through a December 2014 Informational Bulletin.

While the use of the Child Core Set is voluntary for States, CMS encourages all States to use the Child Core Set to collect and report data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2013, 88 percent of States reported on at least seven quality measures, exceeding the CMS target to work with States to ensure that 85 percent of States report on at least seven quality measures in the Children's Core Set. The FY 2016 target is to work with States to ensure that 90 percent of States report on at least ten measures in the Child Core Set.

CMS will continue to work with our Technical Assistance and Analytic Support (TA/AS) Program to provide States with specific clarifications on measurement collection questions; hold all-State webinars, as well as one-on-one calls with States, around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance, CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. Further, as the TA/AS program continues to mature, CMS is expanding the scope of the technical assistance to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

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[4] http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf
[5] Subject to CHIP reauthorization.
[6] http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

MCD7 Increase the National Rate of Low Income Children and Adolescents, who are Enrolled in Medicaid, who Receive Any Preventive Dental Service: This measure seeks to improve access to and utilization of oral health care services for children enrolled in Medicaid. Preventive dental services are those procedures, performed by a dentist or under the supervision of a dentist, that are primarily conducted to keep dental disease from occurring. Services can include prophylaxis, placement of dental sealants and application of topical fluoride. States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid. From FFY 2000 to FFY 2012, the number of Medicaid-enrolled children, ages 1-20, accessing dental services nationally increased 166% from 6.3 million to 16.9 million. [7]. Between FFY 2007 and FFY 2011, almost half of all States achieved at least a 10 percentage point increase in the proportion of enrolled children, ages one through twenty, who received a preventive dental service during the reporting year. [8] Despite this improvement, fewer than half of enrolled children nationally are receiving at least one preventive dental service in a year, and there remains a wide variation across States.

CMS is committed to providing technical assistance to States as they work to reach this goal. The FY 2011 national baseline for Medicaid is 43 percent. We fell short of our FY 2013 target of 47 percent, with an actual result of 44 percent. Many factors likely contributed to the failure to meet the targets, including staff and resource capacity deficits in States and the inherent complexity of the task. The FY 2016 target is to increase the national rates of preventive dental service to 50 percent, 7 percentage points over the FY 2011 baseline.

MCD8 Improve Adult Health Care Quality Across Medicaid: The Affordable Care Act called for the establishment of an adult quality measures program in Medicaid. Similar to the children's quality goal, this goal focuses on creating a core set of adult quality measures for voluntary use by States to report in a standardized manner. Through a partnership with the Agency for Healthcare Research and Quality and States, CMS identified an initial set of core measures (Medicaid Adult Core Set) that were published in the *Federal Register*. The Medicaid Adult Core Set, includes measures like "Controlling High Blood Pressure" and "Flu Shots for Adults Ages 50 to 64". CMS has also been working with States over the past year to help them prepare to report data on the measures by January 2014. Beginning in 2014, the Secretary began to publish annual updates to the Medicaid Adult Core Set. In FY 2013, the first year of reporting on the Medicaid Adult Core Set, 59 percent of States reported on at least three quality measures, falling short of our target to have 60 percent of States reporting on at least three quality measures. The FY 2016 target is to work with States to ensure that 70 percent of States report on at least nine quality measures from the Medicaid Adult Core Set. CMS will continue to provide technical assistance and analytic support to States collecting and reporting the measures. The 2015 Adult Core Set was released in a December 2014 Informational Bulletin. As with the Child Core Set, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

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[7] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/dental-trends-2000-to-2012.pdf

[8] The definition of "preventive dental service" differs in this cited analysis from that used in the GPRA goal. The cited analysis includes only preventive dental services performed by, or under the supervision of, a dentist. The GPRA goal includes all preventive dental and oral health services, including those performed by dental professionals not under the supervision of a dentist as well as primary care medical professionals. http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf

MCD9 Improve Capacity to Evaluate 1115 Demonstration Programs: Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant waivers of the Act to states to test innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). CMS previously reported on a goal established in FY 2006 that measured state compliance with the Administrations' policy of budget neutrality. CMS will complete reporting on this goal in FY 2015, and is proposing a new goal for FY 2016 and future years that will reflect a current area of important focus in the Medicaid program.

States are using 1115 demonstration authority to achieve Medicaid reform through alternative models of service delivery and/or financing aimed at improving the quality of their Medicaid programs and the capacity to serve more people. CMS is making significant investments in these types of demonstrations in order to study results on State based and national levels. However, there is no automated system for data collection of performance metrics, analytics, or reporting to assess quality performance of demonstrations. Additionally, demonstration information provided by states is not captured in a manner that easily permits data collection or manipulation to support program management, oversight, monitoring or evaluation. CMS is focused on improving the quality of evaluations of section 1115 demonstrations through a more automated process that will improve federal monitoring of section 1115 demonstration progress and performance. This initiative aligns with the Agency's Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP related data from states in support of better program oversight, administration, and program integrity; and will be designed for eventual incorporation into MACPro. The FY 2016 target is to release the automated collection and reporting platform for 1115 performance metrics and related requirements for State data submission.

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

The Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in the community, including a new option for States to provide HCBS; improvements to an existing State plan option to provide HCBS; additional financial incentives for States to rebalance the provision of long-term care to include HCBS; an extension of and improvements to the "Money Follows the Person Rebalancing Demonstration"; and an extension of the "spousal impoverishment" protections to people who receive HCBS. We believe that the new opportunities made available through the Affordable Care Act will further enhance State offerings in HCBS. These programs are driving HCBS expenditures which account for many of the cost effective alternatives to care for individuals. In federal fiscal year (FFY) 2012, Medicaid spent $140 billion on LTSS, which represented 34.1 percent of all Medicaid spending.[9]

[9] Mathematica Policy Research, Inc. and the Centers for Medicare & Medicaid Services (CMS), *Medicaid Expenditures for Long-Term Services and Supports in FFY 2012*, April 28, 2014, pg. 5,

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

The HCBS expenditures have increased by one to three percent over the past decade. The Medicaid Budget and Expenditure System (MBES) is used by CMS to capture state expenditures as reported on a quarterly basis. In recent years expenditures have slowed due in large part to the presence of State budget deficits that have reduced the capacity of State governments to appropriate additional funds to serve new waiver participants. The FY 2015 target is to increase growth in total to 55%.

The expenditure growth reflects the percentage of state and Federal funds that will be targeted to beneficiaries who received home and community-based services in the out years. Managed long-term care services and supports expenditures will be estimated in total based on state reporting though a CMS contractor initially. CMS expects to meet or exceed targets by supporting the development of the new programs available under the Affordable Care Act. The 65 percent long-term target represents a base outcome, which will be further refined over the coming years to ensure that the growth represents quality outcomes for individuals receiving HCBS.

CMS believes that it is important to create a balance of expenditures on a state by state basis. There are currently twenty-eight states as well as 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. The FY 2016 target is to increase the percentage of Medicaid spending on long-term services and supports for HCBS to 57 percent. In addition, the FY 2016 target is for 38 states to utilize at least to 50 percent of Medicaid spending on LTSS for HCBS.

Key Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY2015
CHIP3.3[10] Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid and CHIP FY 2008: 37,311,641 children (baseline)	FY 2013: 45,292,410 children (CHIP: 8,093,927/ Medicaid: 37,198,483) Target: 45,592,385 (CHIP 8,346,152/ Medicaid 37,246,233) (Target Not Met)	+28% over baseline 47,642,385 children (CHIP 8,721,426/ Medicaid 38,920,959)	+30% over baseline 48,667,385 children (CHIP 8,909,063 Medicaid 39,758,322)	+1,025,000 children
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2013: 88% of States reported on at least seven quality measures Target: 85% of States report on at least seven quality measures in the CHIPRA core set of quality measures (Target exceeded)	Work with States to ensure that 90% of States report on at least nine quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90% of States report on at least ten quality measures in the CHIPRA core set of quality measures	+1 quality measure
MCD7 Increase the national rate of low income children and adolescents, who are enrolled in Medicaid, who receive any preventive dental service. Baseline: 43% (FY 2011)	FY 2013: 44%/ +1 percentage point over FY 2011 baseline/ Target 47% +4 percentage points over FY 2011 baseline (Target Not met)	+5 percentage points over FY 2011 baseline 48%	+7 percentage points over FY 2011 baseline 50%	+ 2 pp

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

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY2015
MCD8: Improve Adult Health Care Quality Across Medicaid	FY 2013: 59% of States reported on at least three quality measures. Target: Work with States to ensure that 60% of States report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures (Target Not Met)	Work with States to ensure that 70% of States report on at least seven quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 70% of States report on at least nine quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	+2 quality measures
MCD9: Improve Capacity to Evaluate 1115 Demonstration Programs	New for FY 2016	N/A	Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission.	N/A
MCD10.1: Increase the Percentage of Medicaid Spending on Long-Term Services and Supports for Home and Community-Based Services (HCBS) to 65 percent by 2020	FY 2012 Baseline: 49.5%	55%	57%	+2 pp
MCD10.2: Increase the Number of States that Utilize at Least 50 Percent of Medicaid Spending on Long-Term Services and Supports for Home and Community-Based Services	FY 2012 Baseline: 23 States and the District of Columbia (45.1%)	35 States and the District of Columbia (68.6%)	38 States and the District of Columbia (74.5%)	+5.9 pp

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, ***[****$259,212,000,000****]*** *$283,171,800,000.*

In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

Payments to the Health Care Trust Funds
Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $283,171,800,000.	Provides a one-year appropriation from general revenues to make the HI and SMI Trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match, and provides resources for the Part D prescription drug benefit program in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds
Amounts Available for Obligation

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Appropriation: Annual	$255,185,000,000	$259,212,000,000	$283,171,800,000	$23,959,800,000
Indefinite Annual Appropriation, for SMI Premium Match	---	$432,000,000	---	($432,000,000)
Indefinite Annual Appropriation, for Part D Benefits	---	---	---	---
Lapse in Supplemental Medical Insurance	($8,836,179,000)	---	---	---
Lapse in General Revenue Part D: Benefits	($5,397,000,000)	($1,281,000,000)	---	$1,281,000,000
Lapse in General Revenue Part D: Federal Administration	---	---	---	---
Lapse in Program Management	($579,000,000)	---	---	---
Lapse in Transfer for HCFAC Reimbursement	---	---	---	---
Lapse in State Low Income Determination	---	($6,000,000)	---	$6,000,000
Adjustment from Expired Accounts *(FY09-11 HCFAC, FY11 PM – non-add)*	---	---	---	---
Total Obligations	$245,422,301,000	$258,357,000,000	$283,171,800,000	$24,814,800,000

Payments to the Health Care Trust Funds
Summary of Changes

2015 Enacted
Total Budget Authority $259,644,000,000
(Includes projected $432,000,000 in indefinite authority)

2016 President's Budget
Total Budget Authority - $283,171,800,000

Net Change, Total Appropriation - $23,527,800,000

Changes	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Federal Payment for Supplementary Medical Insurance (SMI)	$194,565,000,000	$194,343,000,000	$198,530,000,000	$4,187,000,000
Indefinite Annual Appropriation, SMI	---	$432,000,000	---	($432,000,000)
Hospital Insurance for Uninsured Federal Annuitants	$204,000,000	$187,000,000	$158,000,000	($29,000,000)
Program Management Administrative Expenses	$1,319,000,000	$763,000,000	$1,044,000,000	$281,000,000
General Revenue for Part D (Drug) Benefit	$58,596,000,000	$63,342,000,000	$82,453,000,000	$19,111,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---	---
General Revenue for Part D Federal Administration	$373,000,000	$418,000,000	$691,000,000	$273,000,000
Part D: State Low-Income Determination	$0	$6,000,000	$4,800,000	($1,200,000)
Reimbursement for HCFAC	$128,000,000	$153,000,000	$291,000,000	$138,000,000
Net Change	$255,185,000,000	$259,644,000,000	$283,171,800,000	$23,527,800,000

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

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Supplementary Medical Insurance (SMI)	$194,565,000	$194,343,000	$198,530,000	$4,187,000
Indefinite Annual Appropriation, SMI	---	$432,000	---	($432,000)
Hospital Insurance for Uninsured Federal Annuitants	$204,000	$187,000	$158,000	($29,000)
Program Management Administrative Expenses	$1,319,000	$763,000	$1,044,000	$281,000
General Revenue for Part D Benefit	$58,596,000	$63,342,000	$82,453,000	$19,111,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---	---
General Revenue for Part D Federal Administration	$373,000	$418,000	$691,000	$273,000
Part D: State Low-Income Determination	---	$6,000	$4,800	($1,200)
Reimbursement for HCFAC	$128,000	$153,000	$291,000	$138,000
Total Budget Authority	$255,185,000	$259,644,000	$283,171,800	$23,527,800

Payments to the Health Care Trust Funds
Authorizing Legislation

	FY 2014 Final	FY 2015 Enact	FY 2016 President's Budget	FY 2016 +/- FY 2015
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)	$255,185,000,000	$259,644,000,000	$283,171,800,000	$23,527,800,000
Total Budget Authority	$255,185,000,000	$259,644,000,000	$283,171,800,000	$23,527,800,000

Annual Budget Authority by Activity

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$255,185,000,000	$259,644,000,000	$283,171,800,000	$23,527,800,000

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.
Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. This account has no sources of funds - rather, it is a source of funds to the HI and SMI trust funds. These payments make the Medicare trust funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to general funds under current law, including amounts due the SMI Trust Fund with the general fund contribution for the cost of the Part B and Part D programs.

Through this appropriation, the trust funds are made whole for:

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

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

The Health Care Fraud and Abuse Control (HCFAC) account, including program integrity activities for Medicare, Medicare Advantage, Medicare Part D, Medicaid, and the Children's Health Insurance Program. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance trust funds, which are properly chargeable to the general funds.

Federal Contribution for SMI, consisting of a Federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is currently set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

Finally, as a result of enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this account includes General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these new Medicare Prescription Drug Account costs. Most of these activities started in FY 2006.

Funding History

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

FY 2011	$229,464,000,000
FY 2012	$230,741,378,000
FY 2013	$234,228,577,491
FY2014	$255,185,000,000
FY2015	$259,212,000,000

Does not include the Indefinite Annual Appropriation, for SMI Premium Match

Budget Request

Hospital Insurance for the Uninsured Federal Annuitants:

The FY 2016 President's Budget of $158 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $29 million under the FY 2015 enacted of $187 million.

Program Management Administrative Expenses:

The FY 2016 President's Budget of $1,044 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare Trust Fund activities, is a net increase of $281 million over the FY 2015 enacted level of $763 billion. CCIIO administrative increases primarily represent the implementation costs of the marketplaces.

Federal Contribution for SMI:

The President's Budget of $198.5 billion for the FY 2016 Federal Contribution for SMI is a net increase of $4.2 billion over the FY 2015 enacted level of $194.3 billion. The cost of the Federal match continues to rise from year to year because of beneficiary population and program cost growth.

General Revenue for Part D (Benefits):

The FY 2016 President's Budget of $82 billion for General Revenue for Part D (Benefits) is a net increase of $19 billion over the FY 2015 enacted amount of $63 billion. Much like the SMI Federal Contribution, this benefit contribution rises with Part D Prescription Drug program population and cost growth.

General Revenue for Part D Federal Administration:

The FY 2016 President's Budget of $691 million for General Revenue for Part D Federal Administration is a net increase of $273 million over the FY 2015 enacted amount of $418 million.

General Revenue for Part D State Eligibility Determinations:

The FY 2016 President's Budget of $5 million is a net decrease of $1 million below the FY 2015 enacted amount of $6 million.

Reimbursement for HCFAC:

The FY 2016 President's Budget of $291 million for Reimbursement of HCFAC is a net increase of $138 million over the FY2015 enacted amount of $153 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI trust funds, but which are properly chargeable to the general funds. The FY 2016 increase reflects the estimated Medicare non-trust fund burdens only.

Permanent Budget Authority
(Dollars in thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Tax on OASDI Benefits	$18,066,000	$20,225,000	$23,480,000	$3,255,000
SECA Tax Credits	---	---	---	---
HCFAC, FBI	$127,319	$129,217	$141,204	$11,987
HCFAC, Asset Forfeitures	$24,676	$28,000	$29,000	$1,000
HCFAC, Criminal Fines	$344,379	$950,000	$990,000	$40,000
HCFAC, Civil Penalties and Damages: Administration	$24,294	$31,000	$31,500	$500
Total BA	$18,586,668	$21,363,217	$24,671,704	$3,308,487

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. In addition, the following permanent indefinite appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: FBI funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D). FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and again are permanent indefinite appropriations from the general funds, transferred to the HI Trust Fund.

Payments to the Health Care Trust Funds
Budget Authority by Object

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Grants, subsidies and contributions: Non-Drug	$194,565,000,000	$194,343,000,000	$198,530,000,000	$4,187,000,000
Indefinite Annual Appropriation	---	$432,000,000	---	($432,000,000)
Grants, subsidies and contributions: Drug	$58,596,000,000	$63,342,000,000	$82,453,000,000	$19,111,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---	---
Insurance claims and indemnities	$204,000,000	$187,000,000	$158,000,000	($29,000,000)
Administrative costs-General Fund Share	$1,820,000,000	$1,334,000,000	$2,026,000,000	$97,000,000
General Revenue Part D: State Eligibility Determinations	---	$6,000,000	$4,800,000	($1,200,000)
Total Budget Authority	$255,185,000,000	$259,644,000,000	$283,171,800,000	$23,527,800,000

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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, [$672,000,000] $706,000,000, to remain available through September 30, [2016] 2017, 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 [$477,120,000] $474,175,000 shall be for the [Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in Section 1893(b) of such Act,] Centers for Medicare and Medicaid Services program integrity activities; of which [$67,200,000] $118,631,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act[, of which $67,200,000 shall be for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities,]; and of which [$60,480,000] $113,194,000 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 [2015] 2016 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 [$361,000,000] $395,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act. (Department of Health and Human Services Appropriations Act, 2015.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$672,000,000] $706,000,000, to remain available through September 30, [2016] 2017, 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 [$477,120,000] $474,175,000 shall be for Centers for Medicare and Medicaid Services program integrity activities;	Provides funding for Centers for Medicare and Medicaid Services for program integrity activities.
of which [$67,200,000] $118,631,000 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 [$60,480,000] $113,194,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Discretionary				
CMS Program Integrity	$237,344	$544,320	$474,175	($70,145)
OIG	$28,122	$67,200	$118,631	$51,431
DOJ	$28,122	$60,480	$113,194	$52,714
Subtotal, Discretionary	$293,588	$672,000	$706,000	$34,000
Mandatory				
CMS Program Integrity	$858,346	$863,773	$894,696	$30,923
FBI	$127,319	$129,217	$141,204	$11,987
OIG	$184,979	$186,066	$203,262	$17,196
DOJ Wedge	$57,756	$58,095	$63,464	$5,369
HHS Wedge	$35,379	$35,587	$38,876	$3,289
Subtotal, Mandatory	$1,263,779	$1,272,738	$1,341,502	$68,764
Total Funding	**$1,557,367**	**$1,944,738**	**$2,047,502**	**$102,764**

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817K

FY 2016 Authorization – Public Law 104-191

Allocation Method – Other

OVERVIEW

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse.

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides a stable stream of mandatory funds. In FY 2009, discretionary funding was appropriated to increase program integrity efforts and the discretionary appropriation was authorized to be available for obligation over two fiscal years beginning in FY 2010. In FY 2011, in a show of bipartisan support for combating health care fraud, waste, and abuse, and in recognition that program integrity efforts are paying off, the Budget Control Act of 2011 (BCA) created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. The passage of the Consolidated and Further Continuing Appropriations Act of FY 2015 was the first time the HCFAC cap adjustment has been appropriated.

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

Fighting health care fraud is a top priority for the Administration. Through the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a Cabinet-level commitment to combat health care fraud, waste, and abuse, CMS, HHS-OIG and DOJ carry out a coordinated program to reduce fraud and recover taxpayer dollars. Each HEAT partner plays a critical role in this effort to reduce Medicare and Medicaid fraud, waste and abuse, including the Medicare Fraud Strike Force, CMS's enhanced provider screening and fraud prevention endeavors, the OIG's investigative, audit, evaluation, and data analytic work, and DOJ's investigative and prosecutorial activities and tougher sentencing guidelines. Together, these efforts root out existing fraud and abuse and act as a deterrent for potential future bad actors. This collaboration continues to demonstrate positive results, yielding an $8.1 to $1 return on investment for law enforcement and detection efforts in FY 2013.

The HCFAC cap adjustment provided in the Consolidated and Further Continuing Appropriations Act of 2015 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. Continuing to fund these efforts in FY 2016 up to the cap adjustment, as requested in this Budget, will support enhancements in interagency HEAT efforts, strike a proper balance between prevention and enforcement, and return billions of dollars to the federal government

CMS HCFAC

CMS' approach to program integrity is guided by four major principles:

- Prevention - Increase CMS' capability to stop fraudulent claims before they are paid by enhancing existing processes and increasing predictive analytic capabilities.

- Detection - Foster collaboration with HEAT, of HHS/OIG, various components of HHS, DOJ, states, and other stakeholders with a shared interest in the integrity of the national health care system.

- Recovery - Identify and recover overpayments to reduce improper payments. CMS will continue to work with its contractors and partners, including the HHS/OIG, DOJ, state agencies for survey and certification, and state Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

- Transparency and Accountability - Develop and deploy a comprehensive program integrity communication plan to share key messages and information with internal and external stakeholders. Performance measures are also being developed to evaluate operations and outcomes against other CMS reporting activities.

Discretionary funding has allowed HCFAC to expand its activities to include strengthened program integrity activities in Medicare Advantage (MA) and Medicare Part D; program integrity staffing and support; funding for program integrity initiatives; preventing excessive payments; and program integrity oversight efforts. Discretionary funds allow CMS to make traditional HCFAC actions such as Medical Review and Provider Audits more robust and all encompassing.

Additionally, CMS is committed to fighting fraud, waste and abuse in the Medicaid program. HCFAC activities associated with Medicaid program integrity work in tandem with the activities of the Medicaid Integrity Program, which is detailed in the State Grants and Demonstrations chapter of this document, to protect Medicaid by improving both Federal oversight and support for the program integrity efforts of state Medicaid programs. These activities enhance the Federal-State partnership.

Since its inception in 1997, HCFAC has grown steadily and has returned over $25.9 billion to the Medicare Trust Funds. The return on investment (ROI) from various HCFAC activities ranges from nearly $8 to $1 expended for audit, investigative, and prosecutorial work performed by the Department of Health and Human Services Office of Inspector General (HHS/OIG) and DOJ to $14 to $1 for the Medicare Integrity Program's activities. The ROI for the HCFAC program (2011-2013) is $8.10 for every $1.00 expended. Since the annual ROI can vary depending on the number of cases that are settled or adjudicated during a given year, DOJ and HHS use a three-year rolling average.

CMS is committed to working with law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Medicare Fraud Strike Force teams, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. In 2009, the Strike Force teams were reorganized under the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

Strike Forces are located in nine areas: Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; and Dallas TX. Since their inception in March 2007, Strike Force operations have charged more than 1,700 defendants who collectively have falsely billed the Medicare program for more than $5.5 billion. CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

In addition, CMS has been working with its private and public partners to build better relationships and increase coordination. CMS has co-hosted a series of regional fraud prevention summits on health care fraud in Miami, FL; Los Angeles, CA; Brooklyn, NY; Boston, MA; Detroit, MI and Philadelphia, PA bringing together federal and state officials, law enforcement experts, private insurers, health care providers, and beneficiaries. CMS also participates in the Healthcare Fraud Prevention Partnership, launched in July 2012 by HHS and DOJ, which is a collaboration of the Federal government, private health insurers, and other health care and anti-fraud groups and associations to combine the best health care fraud prevention and detection efforts in the public and private arena.

In 2010, the passage of the Affordable Care Act (ACA) provided an additional $350 million over ten years and an inflationary adjustment to the mandatory HCFAC base. In addition, the ACA provided a comprehensive set of tools to strengthen CMS' program integrity efforts.

This funding has allowed CMS to develop and implement activities to prevent and find fraud such as the following:

- Enhanced Provider Screening – Risk-based screening of categories of providers for Parts A and B before enrolling in Medicare.
- National Site Visit Contractor– Established a contractor focused on conducting site visits (except for durable medical equipment suppliers) to increase efficiency and standardization of site visits performed in support of various program integrity initiatives.
- Enrollment Revalidation Project – CMS is on target to revalidate the enrollments of all 1.5 million existing Medicare suppliers and providers in FY 2015 and transition provider/supplier revalidation to an ongoing operational activity in FY 2016.
- Sharing of Information about Terminated Providers – Implementation of a process to support the exchange of information between Medicare, State Medicaid programs, or Children's Health Insurance Program (CHIP) about providers and suppliers terminated for cause from those programs – allowing other programs to also revoke, if appropriate.
- Law Enforcement Access to Data – CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. The IDR is populated with historical Medicare Parts A, B, and Durable Medical Equipment (DME) paid claims beginning with FY 2006, along with Part D drug events since Part D's inception. Additionally, Medicare Advantage claims processed is now available in the IDR. In addition, the IDR contains pre-payment claims data for Medicare Parts A, B and DME beginning with FY 2012.

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

Funding History

FY 2012	$	1,599,611,000
FY 2013	$	1,553,327,000
FY 2014	$	1,557,367,000
FY 2015	$	1,944,738,000

Budget Request

The FY 2016 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2016 budget request is $2.05 billion, $102.8 million above the FY 2015 Enacted Level. The FY 2016 discretionary budget request is $706.0 million, $34.0 million above the FY 2015 Enacted level, and in line with the incremental increase included in the BCA.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include both traditional methods such as Medical Review (MR), Benefits Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education. CMS is also using innovative approaches to prevent fraud, such as predictive analytics in both claims processing and provider enrollment. These new approaches require the use of in-house personnel, contractor, law enforcement, and auditors to identify, investigate, and prosecute individuals committing fraud, waste, and abuse. Importantly, these initiatives move CMS beyond "pay and chase" toward preventing fraud before it happens.

Specific steps CMS is taking with the current authorities and resources available include: more stringent scrutiny of applicants seeking to bill the Medicare program, increased collaboration with law enforcement in the application of payment suspensions, enhanced oversight of MA and Part D Prescription Drug Plans (PDPs), and testing new methods to detect and deter potential fraudulent behaviors before and after providers and suppliers are enrolled in the Medicare program.

In FY 2016, the major initiatives CMS will fund under MIP include Provider Audit, Medicare Secondary Payer, Medical Review, Data Matching, Provider Education & Outreach, and Error Rate Measurement. These activities will be discussed in more detail throughout this section.

CMS Program Integrity Budget Request

The FY 2016 CMS base discretionary request level of $474.2 million will fund the activities listed in the table at the end of this chapter.

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

Medicare Drug Integrity Contractors (MEDICs): CMS has a fiduciary responsibility to safeguard the Medicare Part C and Part D programs and the Medicare Trust Funds from fraud, waste and abuse. In FY 2014, CMS plans to have the National Benefit Integrity (NBI) MEDIC focus on the continual development and improvement of their data analysis capabilities to proactively fight fraud, waste and abuse. In order for the NBI MEDIC to improve their ability to perform data analysis by building potential fraud detecting profiles and algorithms, the NBI MEDICs must have the resources to increase their ability to store, mine and manipulate data. In addition, CMS intends to enhance the MEDICs effectiveness by increasing program; oversight, vulnerability detection, audits of Part C & D plan sponsors and outreach and education. This effort will continue into FY 2016.

Part C & D Contract/Plan Oversight: Oversight efforts assess whether an entity is qualified to contract with Medicare. CMS determines the qualifications of an entity through the Health Plan Management System (HPMS). HPMS is a web-enabled information system that supports the ongoing business operations of the MA and Part D programs. HPMS software modules collect data for and manage a number of MA and Part D plan enrollment and compliance processes.

CMS will continue to use a support contract to provide technical and analytic assistance with bid review for more than 3,600 plans with 16 million enrollees. In an effort to maximize beneficiary protection, this contract includes bid review tools to analyze changes in benefit cost.

In FY 2015 and 2016, CMS will continue implementation of an audit redesign initiative in HPMS to integrate the MA and Part D audit functions and establish new workflows for audit scheduling, recording of audit findings, uploading of supporting documentation in a centralized repository, automated letters, and corrective action plan submission and monitoring.

CMS will also develop a new Network Management Module to further integrate health service delivery and retail pharmacy automated reviews and perform additional network reviews for renewing networks, plan benefit package-specific networks and other specialized networks, such as provider-specific networks.

Monitoring, Performance Assessment, and Surveillance: This category emphasizes the day-to- day use of plan-reported data, CMS data, and data received from outside sources to ensure accurate payment and compliance with program requirements. Technical, clinical, compliance and enforcement audit support is provided to assist CMS in conducting MA and Part D audits. More specifically, clinical experts conduct program and compliance audits, ensure a sponsor's readiness to participate in the MA and Part D programs, and conduct compliance program effectiveness audits and core performance audits for parent organizations.

In FY 2014, CMS conducted 28 program audits of plan sponsors. CMS conducts program audits that test a variety of core MA and Part D program functions to determine whether sponsors provided beneficiaries with the services and medication as required under their contract with CMS. The goal of CMS' audit program is not just to ensure that our beneficiaries are receiving the services and medications they need and are entitled to receive under the program, but also to drive the industry towards improvements in the delivery of health services in the MA and Part D programs.

In an effort to ensure accurate payment, CMS has enlisted the help of a Reconciliation Support contractor to analyze Part D reconciliation calculations, which helps CMS to understand plan impacts and support decision-making about potential major adjustments to Part D payments. Through this contractor, CMS receives, tracks, and analyzes any issues raised by plans with respect to reconciliation after its completion, including appeals. The contractor will also support our effort to collect Part D overpayments in accordance with section 6402 of the Affordable Care Act, which established new section 1128J(d) of the Social Security Act entitled "Reporting and Returning of Overpayments". This will be a significant undertaking requiring that the contractor run multiple iterations of reconciliation simulations to verify each overpayment reported by each of the Part D sponsors. In addition, this project analyzes Prescription Drug Event (PDE) data and other relevant payment information to support correct Part D payment.

Under Part D reconciliation, CMS must calculate the overall profit or loss of each Part D plan for risk sharing purposes, as well as each of the Part D plan's actual costs for low-income cost sharing and reinsurance. These calculations are dependent on the accuracy of numerous variables that affect payment (e.g., enrollment information, up-to-date risk scores, plan

submitted cost information). The final reconciliation amounts and how these amounts are determined are of significant interest to Part D sponsors, CMS' auditors and other interested stakeholders.

In FY 2016, the work of the Reconciliation Support contractor will continue. CMS is anticipating an increase in the volume of data analysis, require overpayment analysis and analyses associated with direct and indirect renumeration, a factor in the Part D reconciliations. CMS is also projecting increases in the number of PDE's, PDE's with coverage gap discount amounts, and PDE's that need to be identified to be withheld from the Medicare Coverage Gap Discount Program (CGDP) quarterly invoice processor and additional validation and analysis. This translates into an increase in the number of correctable rejected PDEs and more time assisting with disputes.

Significant efforts to review the Part C & D Medical Loss Ratio and quality assurance of Part C Encounter Data will be increased. In January 2012, the agency launched the Encounter Data Processing System (EDPS) to collect encounter data that detail each item and service provided to enrollees of MA organizations. This information is comparable to the data collected on a Fee For Service (FFS) claim. With encounter data, CMS will have a much more detailed and comprehensive profile of the health care services provided to MA enrollees and CMS will be able to more accurately make risk adjusted capitated payments. 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. This encounter data will also inform MA oversight, program integrity and compliance. This will allow CMS to analyze, compare and better manage the health care being provided to beneficiaries in both MA and FFS.

Program Audit: Sections 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of the Medicare Advantage Organizations (MAOs) and PDPs offering plans. These audits enable CMS to review and assess previously submitted information to ensure compliance with program requirements. During the audits, auditors review costs associated with the MA and PDPs, identify internal control deficiencies, and make recommendations for compliance with Medicare regulations and accurate reporting to CMS. Some of the specific areas of review include plans' solvency; related party transactions; administrative costs; direct medical costs; and Part D costs and payments, including direct and indirect remuneration and true out-of-pocket costs. To meet the one-third audit requirement, CMS conducts approximately 250 audits of MAOs and Part D sponsors per year.

In response to the Improper Payments Information Act (IPIA) of 2002, as amended by Improper Payments Elimination and Recovery Act (IPERA) of 2010, and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), CMS enhanced its efforts to address improper payments with the implementation of both pre and post-payment validation activities. Pre-payment validation activities include evaluating diagnoses submitted by MAOs for risk adjusted payment for correctness for the likelihood of being supported by medical record documentation. Post-payment activity includes risk adjustment data validation (RADV), a process which measures the payment error estimates at the national and contract level. Diagnosis data submitted by plans is validated to check for incorrect reporting of diagnoses, which can lead to overpayments and underpayments. An overpayment recovery and appeals process has been implemented for contract level payment error. Error rate targets for the MA program are described in more detail in the Performance Measurement

section near the end of this chapter. RADV intends to conduct 60 audits in FY 2016, which is twice the amount of audits it plans to conduct in FY 2015.

Compliance and Enforcement: CMS provides audit compliance training, technical assistance, education, and outreach to the managed care industry, MAOs, PDPs, and audit assistance contractors. These training, education, and outreach models extend to internal and external stakeholders via webinars, compliance conferences, and on-line training sessions.

In addition, IT infrastructure plays a large role in supporting CMS' efforts of compliance and enforcement to safeguard the Trust Funds. For example, the Risk Adjustment System produces the risk adjustment factors to calculate beneficiary level payments. The factors are created by analyzing the history of diagnoses for each beneficiary and executing statistical models to adjust the risk experienced by each plan with regard to each individual beneficiary. Multiple risk adjustment factors are generated for each Medicare beneficiary that supports both the payments to MA and Part D plans.

The Medicare Advantage Prescription Drug (MARx) application is the enterprise system of record supporting daily nationwide operations of the Medicare MA and Part D programs. MARx primary system functions include processing transactions for enrollment/disenrollment of Medicare beneficiaries into/from MA and Part D health plans, and calculating monthly capitated payments to MA and Part D plans. Under CMS' current Enterprise Systems Development (ESD) model, MARx requires three separate IT support service contracts which include the following: (1) systems development and maintenance, (2) testing services, and (3) business operations services.

The implementation of the Managed Care Payment Validation Contractor is another measure CMS instituted to ensure the accuracy of payments to MAOs and PDPs. The contractor processes retroactive requests in accordance with CMS guidelines that reinforce the requirement for MAOs and Part D plans to adhere to CMS policies and procedures and improves payment accuracy. The data analysis conducted by the contractor allows CMS to take proactive measures to address vulnerabilities affecting payment accuracy and the implementation of other Parts C and D programmatic requirements. Furthermore, the information provided by the contractor assists the Regional Office Account Managers with their monitoring and oversight responsibilities.

II. Program Integrity Staffing & Support:

Field Offices/ Rapid Response/ and Oversight Staffing: This funding includes staffing for CMS' Central Office and three field offices in areas of the country that are highly vulnerable to fraud, waste, and abuse in Medicare and Medicaid (New York City, Los Angeles, and Miami). The staff possesses the required skills to perform detailed analytic and investigative work, fraud prevention and detection outreach, and policy development relating to all of CMS' program integrity activities. In addition, this funding provides support services for IT infrastructure, data communications, security, and administrative services.

III. Program Integrity Initiatives:

Automated Provider Screening (APS): In FY 2013, CMS made significant advancements to automate program integrity and screening checks performed during the enrollment process. In FY 2014, CMS performed data analysis, expanded monitoring of licensure information, and

expanded efforts to do additional screening assessments such as criminal background checks. CMS also expanded the use of the APS monitoring to all Medicare Administrative Contractors (MACs). In FY 2015 and FY 2016, CMS will add new functions and data sources available to screen providers. CMS will widen the scope of APS by updating provider profiles such that they may be used enterprise wide by other CMS programs. This transition increases overall process volume and data expansion needs. APS will return from semi-annual releases to quarterly releases to better support ongoing maintenance. In addition, APS will work with Zone Program Integrity Contractors (ZPICs) and obtain the Medicaid provider information captured in their data warehouses. This information will be entered into APS, and the state-specific outcomes will be communicated back to the ZPICs and states. This will allow for immediate action to recoup inappropriate payments and prevent fraudulent activities. This project is split-funded between mandatory funding associated with the Medicare Integrity Program and HCFAC discretionary funding associated with Medicaid program integrity.

Case Management System: CMS plans to provide a centralized case management capability for the Unified Program Integrity Contractors (UPICs) to use, allowing for a centralized data (via OnePI and the IDR) and analytic capability. This will help ensure that appropriate case management and analytic capability is in place when the new UPIC contracts are established.

In FY 2016, CMS will continue to enhance its case management and analytical capabilities for health care fraud detection and prevention as well as improve integration across the Medicare and Medicaid programs with CMS contractors (UPIC's and ZPICs). This will allow CMS to provide more comprehensive, timely and accurate health care fraud prevention modeling and reporting.

1-800-MEDICARE Integration: In an effort to fight fraud, waste, and abuse in the Medicare and Medicaid programs, suspected fraud can be reported to both the HHS/OIG Hotline and 1- 800- MEDICARE. In FY 2014 and FY 2015 the consolidation of the HHS/OIG Hotline and 1-800- MEDICARE complaints into the Next Generation Desktop (NGD) will be completed. The NGD allows a 1-800-MEDICARE customer service representative to escalate a reported instance of Medicare fraud when reported by a beneficiary. Once this instance is escalated, only investigators are able to access the report. NGD uses the National Data Warehouse to track and compile the reported Medicare instances by providers, and the original complaint, providing a useful investigative tool to law enforcement.

CMS is exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE. These updated processes will help CMS to more quickly and efficiently examine and address waste, fraud, and abuse issues. The FY 2016 request reflects the cost of issuing more licenses and gaining valuable law enforcement specific upgrades to enable near real-time retrieval of data.

IV. Prevent Excessive Payments:

Fraud Prevention System (FPS): In FY 2014, FPS continued to add and refine existing models to better detect and prevent fraud. The FPS applies predictive analytic technology to Medicare claims prior to payment to identify aberrant and suspicious billing patterns. There are over 700 users of the FPS system including data analysts, law enforcement, policy experts and clinicians. Modifications were made to the FPS system to integrate the system into the Fee for Service claims processing stream. This ability allows CMS to identify fraud

and prevent improper payments. A proof of concept was established that immediately rejected claims prior to the claims finalizing, resulting in immediate savings. Other efforts were also focused on implementing a fraud data analytics framework to expand capabilities of identifying complex social network of fraudulent providers. Implementation will continue into FY 2015 and will allow for expanded access to the MACs to resolve and reduce improper payments.

To meet goals related to reducing fraud, FPS developed a new anti-fraud tool using predictive and real-time data to spot abnormalities for fee-for-service claims. This functional requirement integrates fully with the Medicare FFS claims flow. Upon completion of a transition to FPS 2.0, the system will be more user friendly and have an increased number of valid data elements that increases search capabilities, therefore enabling more robust identification of potentially fraudulent cases. Transition costs have been built into the FY 2016 request. By 2016, CMS is projecting that the FPS will support 1,250 users with potential to increase to approximately 2,000 users. FPS will focus on preventing payments prior to claims finalizing, creating complex algorithms, and identifying fraudulent social network activities. These efforts will increase return on investment and achieve efficiencies that will reduce costs in future years. HCFAC discretionary funding associated with Medicaid program integrity will be used to support Medicaid activities in this area, as reflected in the table at the end of this chapter.

Fraud System Enhancements: Fraud System Enhancements will continue to provide support for the FPS, the National Correct Coding Initiative (CCI) and analytic investigations to detect and prevent fraud, waste and abuse. In FY 2016, Fraud System Enhancements will continue to support the CMS program integrity strategic plan and CMS priorities for data analytics to improve detection and prevention.

Command Center: In FY 2012, CMS established the Command Center as the center for excellence for detection and investigation, driving program integrity innovation and improvement. The Command Center is a paradigm shift in the way CMS conducts its program integrity work by supporting multi-party working sessions among Federal program staff, contractors, and law enforcement to identify emerging fraud schemes, identify program vulnerabilities, prioritize and develop approaches to address high priority issues, and resolve leads from the Fraud Prevention System faster.

In FY 2014, the Command Center hosted collaborative sessions in which significant outcomes have been achieved. Using the collaborative tools of the Command Center, many CMS staff and law enforcement partners have been trained on the use of the FPS to conduct and enhance investigative work. CMS used the Command Center to develop additional models for the FPS and has held collaborative sessions with the Zone Program Integrity Contractors (ZPICs). In these sessions, the ZPICs shared best practices with the other zones to improve their ability to rule on Alert Summary Reports (ASR's) from the FPS. Since the opening of the Command Center in FY 2012 through the end of FY 2014, 191 collaborative sessions have been hosted. Ongoing funding in FY 2015 and FY 2016 supports this effort to effectively share and present findings, display data, and make determinations and decisions on a system-wide basis across various fraud detection and prevention efforts.

Benefits Integrity (BI): Benefit Integrity activities deter and detect Medicare fraud through concerted efforts with the CMS, HHS/OIG, DOJ, and other CMS partners. Nearly all of the BI funding is directed to the 10 ZPICs/PSCs that operate throughout the United States. In FY 2016, ZPICs/Program Safeguard Contractors (PSCs) will continue to conduct proactive

and reactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement, a major component of BI activities. ZPICs/PSCs also evaluate and investigate complaints that indicate potential fraud and support law enforcement during the development and prosecution of cases.

The ZPICs/PSCs are now using FPS as an additional source of leads to identify, prevent and investigate potential fraud. The FPS screens claims data before payment is made, allowing the ZPIC/PSCs to rapidly implement administrative actions, such as prepayment review, revocation, or payment suspension, as appropriate. The FPS generates a prioritized list of leads for ZPIC/PSCs to review and investigate potential Medicare fraud in their designated region. When suspect behavior or billing activity is identified, the ZPICs/PSCs investigate to determine if appropriate administrative actions should be taken and/or if it should be referred to law enforcement.

The continuum from detection to prosecution of fraudulent activity requires complete coordination among CMS, its contractors, and law enforcement partners. The ZPICs/PSCs meet on a regular basis with the HHS/OIG and DOJ staff to share information on active cases and new leads. CMS participates in fraud task forces, educational sessions and formal meetings to review the status of cases, and discuss identified fraud schemes. The ZPICs/PSCs also frequently perform medical review or data analysis for cases initiated by HHS/OIG or the FBI.

The ZPICs/PSCs currently support many of the antifraud initiatives in the Field Offices, including HEAT activities. In FY 2015, funding continues to be used for ZPICs/PSCs to perform data analysis projects and to support immediate and real-time requests for information from the field offices special projects. The Field Offices have notably strengthened the revocation process by improving the manner in which substantiating documentation is obtained. Moving forward into FY 2016, there will be an increased need for rapid response activities to quickly investigate new leads to further identify and prevent potential fraud.

In addition to using the FPS system, ZPICs/PSCs will continue to participate in Command Center Missions, to work on model development, investigative techniques, resolving specific leads, and training opportunities.

In FY 2015, CMS plans to begin transitioning from the ZPICs to the UPICs. The transition is consistent with the CMS agency-wide strategic plan for program integrity and combines the audit and investigation work currently conducted by the ZPICs, including the Medicare-Medicaid Data Matching Contractors (Medi-Medi) and their responsibilities, and the Audit Medicaid Integrity Contractors (Audit MICs) funded by the Medicaid Integrity Program described in the State Grants and Demonstrations chapter of this document to form the UPIC. CMS expects contracts with ZPICs/PSCs and MICs to end as the UPIC is implemented in specific geographic regions. CMS anticipates implementation of the UPICs over a multi-year period in order to complete the entire transition. In FY 2016, CMS will continue the implementation of the UPIC initiative by transitioning two additional geographic regions.

Streamlining to the UPIC initiative will provide benefits that will ultimately enhance CMS ability to aggressively combat fraud, waste, and abuse by consolidating the separate funding sources into a single contract. Benefits to the UPIC strategy can include reduced state and provider burden, increased contractor accountability, reduced overhead and administrative costs over time, enhanced data and reporting capabilities, and improved program oversight. The UPIC

initiative is the next logical step in the transition to an integrated program integrity strategy and is a key milestone supporting the CMS' strategic goal of improving contractor accountability.

Medical Review (MR): MR activities can be conducted either pre-payment or post-payment and serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the appropriate conditions. Complex medical review is conducted on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements. CMS also conducts pre-payment medical reviews to prevent improper payments from being made. Both types of medical reviews help reduce the Medicare fee-for-service error rate.

CMS requires the MACs to focus their medical review efforts on areas identified at risk for high improper payments in their jurisdictions. CMS has contracted with a Supplemental Medical Review Contractor to evaluate medical records and related documents to determine whether claims were billed in compliance with Medical coverage, coding, payment and billing rules.

CMS continues closely monitoring the decisions made by these contractors. The MACs' medical review resulted in contractor reported savings of $5.6 billion in FY 2013.

In 2014, CMS also issued a proposed rule to require prior authorization of certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies to provide a provisional payment determination before the item is delivered. CMS believes a prior authorization process will ensure beneficiaries receive medically necessary care while minimizing the risk of improper payments therefore, protecting the Medicare Trust Fund.

CMS will continue to conduct Medical Review activities in FY 2016.

Provider Audit: Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report.

In FY 2014, approximately 47,000 Medicare cost reports were accepted by the MACs, and tentative settlements were completed for 23,000 cost reports. In addition, approximately 20,000 desk reviews and 1,900 audits were completed. CMS completed contractor monitoring activities on all MACs during the year and plans to maintain similar levels of effort for FY 2015 and FY 2016.

Medicare Secondary Payer (MSP): MSP efforts ensure that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on the proper order of payers, and makes sure that Medicare only pays for those claims where it has primary responsibility for payment of health care services. When mistaken Medicare primary payments are identified, recovery actions are undertaken.

On February 1, 2014, CMS completed the transition of its MSP contracting strategy to fully integrate pre-payment coordination of benefits activities with MSP debt recovery activities. During Fiscal Years 2015 and 2016, significant enhancements will be implemented to take advantage of combined MSP operations. Once complete, the public will have one primary point of contact for all MSP coordination of benefits and recovery activities.

Medicare-Medicaid Data Match Project (Medi-Medi): Medi-Medi, authorized by the Deficit Reduction Act (DRA) of 2005, is a voluntary partnership between CMS and participating states where data is collected and analyzed from both programs with the intent of detecting potential fraud, waste and abuse that may otherwise go undetected in each program. The Medicare and Medicaid programs share many common beneficiaries and providers. Matching claims helps identify billing patterns that might be indicative of potential fraud, waste, and abuse and could otherwise go undetected if viewed in isolation. Analysis performed in the Medi-Medi program can reveal trends that are not evident in claims data from each program alone, making the Medi-Medi program an important tool in identifying and preventing fraud. The Medi-Medi program has grown to 20 states.

CMS will continue to expand this program in FY 2016. CMS is in the process of developing an updated comprehensive strategy for the Medi-Medi program with a focus on encouraging state participation. Through this strategy, CMS plans to reduce provider and state audit burden, provide better access to improved data, and establish better collaboration between the Medicare and Medicaid investigations and audits. The Medi-Medi program will become increasingly more effective as more states participate. Program participation is optional for the states; however, the ZPICs/PSCs work diligently to encourage each individual state's participation. The Medi-Medi program will be able to further Federal- State collaboration in analyzing trends to identify potential fraud, waste, and abuse in the Medicare and Medicaid programs throughout the country. CMS has partnered with some of the larger states in the country as it relates to expenditures; the 20 states that are in the Medi-Medi program account for a majority of total Medicaid expenditures. At least 12 additional states have expressed an interest in participating. CMS is also working to identify ways the program can be improved and be more beneficial to states.

V. Program Integrity Oversight Efforts:

Overpayments and Payment Suspension: In FY 2013, CMS began developing instructions and implementing a standardized process for Medicare contractors to deny Medicare billing privileges if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing overpayment that has not been repaid in full at the time an enrollment application is filed. This includes denying new enrollments or change of ownership applications from a current owner of an enrolling provider or supplier or a physician or non-physician practitioner.

CMS anticipates this standardized process to be fully implemented and operational in FY 2015. Also in FY 2015, CMS will develop further instructions and implement a process to deny Medicare billing privileges if the current owner of an enrolling provider or supplier or the enrolling physician or non-physician practitioner has been placed under a Medicare payment suspension. Funding in FY 2016 will allow CMS to continue these efforts.

Compromised Numbers Checklist (CNC): CMS continues to refine the national CNC of Medicare provider and beneficiary identification numbers known or suspected to be compromised. In FY 2016, CMS will continue the ongoing process of redefining the entries in the CNC database to facilitate its incorporation into the FPS and other program integrity predictive analytics. In addition to assigning risk levels (high, medium, low) to each beneficiary Health Insurance Claim Number (HICN) and provider National Provider Identifier/Provider Transaction Access Number (NPI/PTAN), the ZPICs/PSCs are designating the specific reason code indicating why the number was determined to be compromised and eligible to be entered into the database. CMS and the CNC contractor

will continue to operate, maintain, and upgrade the web-based system, allowing PSCs, ZPICs, the MEDIC and law enforcement real-time access and updating capability. The CNC is used to identify investigative leads, provide background information to justify implementation of claims processing edits, and share corrective actions taken against providers and individuals. The CNC has helped CMS identify and track false front providers and other providers submitting claims for stolen or compromised beneficiary numbers and stolen or compromised rendering or ordering provider numbers, and implement timely corrective actions such as revoking Medicare billing privileges, resulting in significant savings to the Medicare Trust Fund.

CMS will continue to focus on developing and refining a more robust process to provide comprehensive data quality validation and to include additional information on the providers and beneficiaries included in the database. The expectation is that the database will continue to grow as new compromised numbers are identified and added. Additional funding will support continued refinement and ongoing maintenance.

National Supplier Clearinghouse (NSC): The NSC activity is a continuing contractual arrangement for the receipt, review and processing of applications from organizations and individuals seeking to become suppliers of DMEPOS in the Medicare program. The NSC is responsible for conducting on-site visits, enrolling the DMEPOS supplier and implementing safeguards to ensure only legitimate suppliers enter and/or remain in the Medicare program. In FY 2015, CMS plans to modify the fraud and abuse index of risk (FAIR) and to transition to a new contractor, if applicable. The efforts of the NSC will continue in FY 2016, with the added ability of being able to assist with enrollment backlogs at the A/B MAC as needed.

OnePI Data Analysis: In order to fight fraud, waste and abuse in Medicare and Medicaid, CMS has built the OnePI portal to provide Program Integrity contractors, Law Enforcement and HHS/OIG with centralized access to multiple analytical tools and data sources. Through this investment, CMS will continue to train and support a multitude of contractors and law enforcement on the use of these tools and the IDR to fight fraud, waste, and abuse.

CMS will continue to implement the loading and matching of Medicaid data with the historical Medicare Parts A, B, and D and provider enrollment data in the IDR. CMS will continue to integrate the receipt and loading of Medicaid and CHIP state data through the T-MSIS data exchange. The investment will continue to promote the efficient expansion of the agency's Medi-Medi data match project and data sharing requirements as required in the DRA and Section 6402a of the ACA. CMS will continue to transition ZPIC, PSC, and MEDIC data analytic access through the OnePI to the IDR allowing the discontinuance on separate regional contractor data repositories.

OnePI provides access to current and historical Medicare data that is used to develop and refine predictive analytic models prior to integration into the FPS. Program Integrity analysts and investigators rely on the data available via OnePI to further develop the leads identified by FPS.

Health Care Fraud Prevention & Enforcement Action Team (HEAT) Support / Strike Force Teams: The first Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse in South Florida. The Strike Force teams use advanced data analysis techniques to identify aberrant billing levels in health care fraud hot spots so that

interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of these efforts and funding for the HCFAC program, DOJ and HHS expanded the Strike Force to include teams of investigators and prosecutors in a total of nine areas – Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; and Dallas, TX.

Since their inception, Strike Force operations have charged more than 1,700 defendants who collectively have falsely billed the Medicare program for more than $5.5 billion. In addition, CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers. In FY 2013, CMS awarded a contract for the HEAT Strike Force Data Compendium Project. This contract is a multifaceted approach to build investigative guides and templates for CMS, CMS contractors and Law Enforcement partners as well as a library compendium of training materials for the same audience. The funding request for FY 2016 will allow CMS to continue its joint efforts with law enforcement to support the HEAT initiatives such as the HEAT Strike Force Data Compendium Project as well as investigations in Strike Force cities.

Appeals Initiatives: CMS's Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) for Medicare fee-for-service (FFS) Parts A and B claims. CMS currently contracts with two QICs to perform Medicare Part A reconsideration activities, and three QICs to perform Medicare Part B reconsideration activities. The QICs are currently required to participate as "non-party participants" in 10 percent of Administrative Law Judge (ALJ) hearings. CMS anticipates that by invoking party status in more hearings, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Funds expenditures. In the past, funding had been provided to the QICs to participate in ALJ hearings as a party. FY 2016 funds will support continued activities and efforts in QIC participation. This project is supplemented with program management funds that support the QICs.

Healthcare Fraud Prevention Partnership (HFPP): This project is split- funded between mandatory funding associated with the Medicare Integrity Program and HCFAC discretionary funding associated with Medicaid program integrity. The funding table at the end of this chapter displays the estimated share covered by Medicaid.

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care system. As part of this initiative, CMS launched the Healthcare Fraud Prevention Partnership with HHS/OIG, DOJ, FBI, private health insurance companies, and other health care and anti-fraud groups and associations. The mission of the HFPP is to exchange data and information between partners to help improve capabilities to detect and combat fraud, waste and abuse. These exchanges of data and information take the form of targeted data exchange studies.

In FY 2014, CMS obtained a Trusted Third Party (TTP) contractor to perform duties associated with standing up and running joint public-private data analytics in a secure environment. CMS also launched a public website (hfpp.cms.gov) to share various information and lessons learned from the partnership as well as a secure partner portal for sharing of sensitive partnership information. Products and communications materials will continue to be added to this site in FY 2015. Additionally, CMS will continue to invest in analytic capabilities specific to HFPP data, ensuring that CMS both contributes effectively to the partnership and can act on HFPP data to realize cost savings. The FY 2016 funding request represents the estimated

cost of maintaining and expanding the partnership, maintaining systems in place to support the partnership, and continuing to expand fraud prevention and detection capabilities through public and private sector data exchanges.

Provider Outreach and Education (POE): POE funding is used by the Medicare FFS claims processing contractors (MACs, fiscal intermediaries and carriers) to educate Medicare providers and their staffs about the fundamentals of the Medicare program, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such mechanisms as provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing (CERT) data and Recovery Audit Contractor data. The primary goal of the POE program is to reduce the CERT error rate by giving Medicare providers the timely and accurate information they need to understand the Medicare program, be informed about changes and correctly bill Medicare claims. Medicare contractors utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms such as educational events and webinars.

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

In FY 2014, essential PECOS updates focused on improved customer service, increased connectivity within CMS, and allowed for greater data integrity. The system was also moved to a Virtual Data Center (VDC) and changes were implemented to allow the enterprise Master Data Management system (MDM) to be used for analytical reporting and data extracts. Finally, CMS began transitioning the National Provider Identifier Crosswalk System (NPICS) to PECOS. For FY 2015 and FY 2016, funding will be needed to continue enrollment data collection and management, integrate NPICS into PECOS, and integrate provider enrollment data in the enterprise MDM system and other systems within CMS. Based on current trends, CMS is expecting an increase of online enrollment from the current level of 35 percent to a level of 50-55 percent by the end of FY 2016. This is being accomplished by dramatically improving the PECOS provider enrollment interface to a more user centric platform focused on the users that maintain the information, and not just the providers. It will also be accompanied by reducing redundancy in data entry, and improving administrative processing of online applications to ensure online enrollment is significantly faster than submitting standard paper applications. The projected completion date for the PECOS redesign is FY 2017.

Comprehensive Error Rate Testing (CERT): CMS developed the CERT program to produce a Medicare FFS improper payment rate to comply with the requirements of the Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). The IPIA, as amended, requires Federal agencies to

annually identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments in those programs, and report the estimates and actions the Agency is taking to reduce improper payment review and measure for the programs they oversee that are at risk for high levels of improper payments.

During FY 2016, CMS expects to accomplish the following:

- Measure and report improper payments in the Medicare FFS program; develop corrective actions; and report this information in the HHS Agency Financial Report as required by IPERIA;
- Conduct accuracy reviews for the MAC Medical Review Accuracy Award Fee Metric;
- Develop a CERT Live Data Dashboard to provide MACs with their current CERT data to focus their actions to reduce improper payments;
- Participate in the Electronic Submission of Medical Documentation (esMD) for CERT to allow CERT contractors to accept documents electronically; and
- Conduct a Security Control Assessment (SCA) on each of the CERT contractors' systems as required and providing contractors with additional funding to meet the information technology security requirements, if necessary.

VI. Medicaid Program Integrity Initiatives:

Payment Error Rate Measurement (PERM) in Medicaid and CHIP: CMS developed the PERM program to produce a Medicaid and CHIP improper payment rate to comply with the requirements of IPIA of 2002, as amended IPERA of 2010 and IPERIA of 2012. The IPIA requires Federal agencies to annually identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments in those programs, and report the estimates and actions the Agency is taking to reduce improper payment review and measure for the programs they oversee that are at risk for high levels of improper payments.

FY 2015 and FY 2016 Goals:

- Measure and estimate the improper payments in the Medicaid and CHIP programs; develop corrective actions; and report this information in the HHS Agency Financial Report as required by IPERIA;
- Provide support to states, as needed, to conduct targeted reviews on areas at risk for improper payments (i.e., Mini-PERMs, which are voluntary smaller scale measurements of state improper payments during years when a state is not being measured under PERM);
- Participate in the Electronic Submission of Medical Documentation (esMD) for PERM to allow PERM contractors to accept documents electronically;
- Conduct a Security Control Assessment (SCA) on each of the PERM contractors' systems as required and provide contractors with additional funding to meet the information technology security requirements, if necessary;
- Develop a state policy database to collect states' policies for PERM; and
- In August 2013, HHS released guidance announcing temporary changes to future PERM eligibility reviews, starting in 2014, in light of changes to the way States adjudicate eligibility for Medicaid and CHIP. CMS implemented an interim methodology to conduct PERM eligibility reviews for FYs 2014 - 2016. Given the changes required by the Affordable Care Act, all states are participating in Medicaid and CHIP eligibility review pilots to provide targeted, detailed information on the accuracy of eligibility

determinations. The pilots will provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors. The pilots will also help inform CMS' approach to rulemaking prior to the resumption of the PERM eligibility measurement component in FY 2017.
- Undergo a significant effort, including additional work with states and utilizing new federal contracting strategies, to roll out a new PERM eligibility methodology and implement new processes and procedures to recommence the PERM eligibility component.

In addition, CMS conducts annual site visits to select states involved in the current cycle measurement for the PERM program. During the site visits, CMS educates the states regarding PERM requirements and identifies any state-specific issues that may hinder an accuracy of the measurement. This proactive measure helps CMS achieve a more accurate improper payment rate measure for the Medicaid and CHIP programs. In FY 2016, PERM will resume the eligibility component of the program which will require additional funding.

National Correct Coding Initiative (NCCI): The goal of this statutory program is to protect Medicaid funds by reducing the number of improperly paid Medicaid claims through the use of standard methodologies, which include edits for state Medicaid claims. This initiative was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payments of Medicaid claims. Procedure-to-Procedure (PTP) edits are automated prepayment edits that prevent improper payments when certain codes are submitted together. In addition to the PTP edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a single date of service for a single beneficiary. MUEs specify the number of times a procedure can be performed on the same beneficiary on the same date of service by the same provider without denying payment of all UOS on the claim line. New edits are continually developed in the NCCI program for states to use to screen Medicaid claims for codes that should not be submitted together and for UOS that should not exceed a certain limit on one claim line for that code.

FY 2014 ACCOMPLISHMENTS

- Worked closely with the HHS OIG to develop and implement a detailed study of each state's implementation of the Medicaid NCCI methodologies.
- Developed and implemented 34,740 new Medicaid NCCI PTP edits and MUEs.

FY 2015 AND FY 2016 GOALS

- Develop and implement new Medicaid NCCI PTP edits and MUEs to further strengthen the correct coding of Medicaid claims by providers and to further reduce inappropriate payment of Medicaid claims by states due to improper coding of Medicaid claims by providers.
- Provide technical assistance to states individually and in groups based on the findings and recommendations in the 2015 report of the national study of each state's implementation of the Medicaid NCCI methodologies conducted by the HHS OIG in 2014.

Review of Medicaid Managed Care Rates, Upper Payment Limits, and Supplemental Payments: In FY 2014, CMS began a cross-component review of states' rate setting in managed care and home and community-based services as part of the Medicaid Integrity Program, including assessment of the accuracy and quality of data used by states to support rate setting. In FY 2016, CMS would use HCFAC discretionary funding to continue CMS oversight of states' rate setting to ensure that appropriate mitigation strategies are developed and to provide information for subsequent approvals of rates for Medicaid waivers. In addition, CMS will leverage these resources to improve state accountability for upper payment limit demonstrations and supplemental provider payments, including Medicaid disproportionate share hospital payments.

Physician Transparency: This project is split- funded between mandatory funding associated with the Medicare Integrity Program and HCFAC discretionary funding associated with Medicaid program integrity. The funding table at the end of this chapter displays the estimated share covered by Medicaid. In February 2013, CMS published a final rule that requires manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests. On September 30, 2014, CMS refreshed those public data with additional records and corrections made by the industry.

Covered recipient physicians and teaching hospitals were afforded a 45-day period to review and dispute records which they felt were incorrect. Data identified as containing incongruent information about covered recipients was published in an anonymous manner while applicable manufacturers and GPOs were afforded additional time to correct submitted information. As of the December 2014 data refresh, the Open Payments website published approximately $3.7 billion representing over 4.4 million payments or other transfers of value. The data was collected through an electronic system developed by CMS to facilitate the reporting process. This process of reporting and public posting will be an annual process. This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers. During FY 2014, CMS developed the technical capabilities for registration, data submission, data review and dispute and reporting capabilities for public posting. In order to verify the accuracy of the data and that it is matched to the correct covered recipient (physician or teaching hospital), CMS hired a technical contractor to monitor and validate the data prior to public posting.

During FY 2015, additional core functions will be implemented such as data validation, a verification function and an audit function. Additionally, there will be a greater need for engagement and education to align with the first submission of program data.

During FY 2016, the program will shift from implementation to an operational mode. The ongoing operations of the program will require funding for system operations, expanding the reporting capabilities on the Open Payments website, ongoing data validation, auditing strategy and some education and analytics support. Communications, outreach and education are also vital to this program as there are millions of potential users of the system who must be educated about the program and rules of participation.

VII. Program Integrity Private Insurance:

In FY 2016, the budget includes $25.0 million in discretionary funding for CMS to invest in activities related to program integrity in the private insurance market. These activities will include CMS program integrity responsibilities within the Health Insurance Marketplaces.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. Each of the 56 FBI field offices has personnel assigned specifically to investigate health care fraud matters. With national health care expenditures projected to exceed $3.2 trillion dollars by 2015, representing a 58 percent increase from $2.0 trillion expenditures in 2005, it is especially important to coordinate all investigative efforts to combat the significant fraud and abuse within the health care system. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as HHS/OIG, the FDA, the DEA, the Defense Criminal Investigative Service, the Office of Personnel Management-OIG, the Internal Revenue Service-CI, State Medicaid Fraud Control Units, and other state and local agencies. On the private side, the FBI is actively involved in the Healthcare Fraud Prevention Partnership, an effort to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. These efforts will enable members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud. In addition, the FBI maintains significant liaison with private insurance national groups, such as the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, private insurance investigative units, and other professional associations.

In FY 2014, the FBI initiated 602 new health care fraud investigations and had 2,771 pending investigations. Investigative efforts produced 730 criminal health care fraud convictions and 849 indictments and informations. In addition, investigative efforts resulted in over 605 operational disruptions of criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 140 health care fraud criminal enterprises.

FBI Budget Request

The FY 2016 FBI budget includes mandatory funding in the amount of $141.2 million, an increase of $12.0 million above the FY 2015 Enacted level. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year Consumer Price Index-Urban (CPI-U) Annual Averages and Percent Change.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS/OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in health-care-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. In

FY 2013, OIG's Medicare and Medicaid oversight efforts resulted in 849 criminal actions and 458 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS/OIG excluded a total of 3,214 individuals and entities. For FY 2013, potential savings from legislative and administrative actions that were supported by HHS/OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $19.4 billion in Medicare savings and $834 million in savings to the Federal share of Medicaid.

OIG Budget Request

The FY 2016 OIG budget includes $203.3 million in base mandatory funding. The FY 2016 discretionary request is $118.6 million which represents an increase of $51.4 million above the FY 2015 Enacted level. This request will support the joint HHS and DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and related program integrity efforts.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The DOJ's litigating components (United States Attorneys, Criminal Division, Civil Division, and Civil Rights Division) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

DOJ Budget Request

The FY 2016 DOJ budget estimate includes $63.5 million in base mandatory funding, which is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations. The DOJ discretionary request for FY 2016 is $113.2 million, which represents an increase of $52.7 million above the FY 2015 Enacted level.

HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING

PROJECTS

Program Description and Accomplishments

In addition to MIP, CMS also uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2014, negotiated amounts were $35.4 million for distribution among HHS components and $57.8 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding.

CMS Medicaid Financial FTEs: Funding Specialists work in the field to review proposed Medicaid State Plan reimbursement amendments, develop financial management reviews, research state Medicaid financing policy and practices, and promote proper state Medicaid financing methods prior to implementation. States report an estimated $188 million in questionable reimbursement was averted in FY 2013 due to the funding specialists' preventive work with states to promote proper state Medicaid financing. Additionally, states report that CMS assistance contributed to removing an estimated $2.7 billion (with approximately $375 million recovered and $2.4 billion resolved) of approximately $9.7 billion identified in questionable Medicaid costs.

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds in support of litigation and enforcement activities that assist in the recovery of program funds. In FY 2013, OGC participated in FCA and related matters that recovered over $1 billion for the Government. The types of FCA cases that OGC participated included drug pricing manipulation; illegal marketing activity by pharmaceutical manufacturers that resulted in Medicare and Medicaid paying for drugs for indications not covered; underpayment of rebates to state Medicaid programs; physician self- referral violations; and provider coding cases.

Administration for Community Living (ACL) Senior Medicare Patrol (SMP) Grants & Support: This funding supports infrastructure, technical assistance, and the other SMP program support and capacity-building activities designed to enhance the effectiveness of statewide SMP programs. In FY 2013, the Secretary has provided this funding to enable the provision of grants to help more than 54 SMP programs fight Medicare fraud in high fraud states.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): This PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. In FY 2013, FDA initiated 23 criminal investigations, actively pursued several criminal prosecutions, and conducted a three day training seminar for criminal investigators and supervisors covering PFP related topics.

HHS Wedge Budget Request

The FY 2016 HHS Wedge request includes mandatory funding of $38.9 million, which is an increase of $3.3 million above FY 2015 Enacted level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General; therefore, decisions on how this funding will be allocated will not be determined until after HHS and DOJ complete negotiations.

Congressional Request

*Please see the Significant Items Section for a description of CMS' prevention efforts impact to Medicare and Medicaid improper payments.

Performance Measurement

Please note: For more information about the Medicare Fee-for-Service, Parts C and D, and Medicaid/CHIP payment error rates, please see the 2014 HHS AFR.

MIP1 Reduce the Percentage of Improper Payments Made under the Medicare Fee-for-Service (FFS) Program: We have made progress on our efforts to reduce the Medicare FFS error rate over the years; however, at a rate of 12.7 percent, we did not meet our FY 2014 target of 9.9 percent. The primary causes of improper payments were insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 17.3 percent in FY 2013 to 51.4 percent in FY 2014, due to the implementation of documentation requirements to support the medical necessity of the services. The increase was also attributed to medical necessity errors for inpatient hospital claims, particularly short stays determined to not be medically necessary in an inpatient setting (i.e., services should have been billed as outpatient).

The factors contributing to improper payments are complex and vary from year to year. CMS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources is used to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

CMS believes that three corrective actions will have a considerable effect in preventing and reducing improper payments. First, CMS issued a final rule to update Medicare's Home Health Prospective Payment System payment rates and wage index for CY 2015 to clarify face-to-face requirements that caused confusion in the provider community and increased the improper payment rate. Second, CMS implemented two major policies pertaining to impatient hospital claims that allow hospital participants to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient and clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A. Third, in FY 2015, CMS will test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care through demonstration projects to test prior authorization for certain non-emergent services. Our FY 2015 target is 12.5 percent and our FY 2016 target is 11.5 percent.

MIP5 Reduce the Percentage of Improper Payments Made under the Part C Medicare Advantage Program: In FY 2014, CMS met its Part C Medicare Advantage (MA) error rate target of 9.0 percent. The Part C program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS' annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error rate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions that required that MA organizations must

report and return overpayments that they identify and payment recover and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by an MA organization. The FY 2016 target is to reduce the Part C error rate to 8.1 percent.

MIP6 Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program: In FY 2014, CMS reported a result for Part D of 3.3 percent, exceeding our target of 3.6 percent. The FY 2014 Part D composite payment error rate amount is the sum of the payment error amounts for four component measures, divided by the overall Part D payments for the year being measured. The four components are: Payment Error related to Prescription Drug Event Data Validation (PEPV), Payment Error related to Low-income Subsidy, (PELS), Payment Error related to incorrect Medicaid Status (PEMS) and Payment Error related to Direct and Indirect Remuneration (PEDIR). The root cause of all improper payments in the Part D program reported in FY 2014 is administrative and documentation errors. CMS continues to pursue enhancement of program integrity through national training sessions for Part D plan sponsors on Part D sponsors to update beneficiary Low Income Subsidy statuses prior to reconciliation, and establish formal outreach to plans on invalid/incomplete PDE data submission for PEPV. The FY 2016 target for the Part D error rate is 3.4 percent.

MIP7 Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data: In their efforts to fight fraud, waste, and abuse in the Medicare program, the HEAT Strike Forces have utilized near real-time, CMS systems data to examine claims payment data for aberrancies, to identify suspicious billing patterns/trends, and to conduct surveillance on target providers and suppliers under investigation for potentially fraudulent practices. The purpose of this measure is for CMS to increase the number of law enforcement personnel with training and access to CMS program integrity data systems and applications. CMS met its FY 2011, 2012, 2013, and 2014 targets of training 100 percent of Law Enforcement referred for training and access, and will continue to offer and expand training for additional strike force law enforcement personnel. The FY 2015 result will be available in September 2015, at which time the FY 2017 target will be determined. We will maintain our 2015 target in 2016.

MIP8 Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment and Payment Safeguard Actions: In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate, and reasonable services for beneficiaries. This goal is aimed at measuring CMS' ability to target high risk providers and suppliers effectively. To reflect statutorily mandated changes in CMS fraud prevention work and because of difficulties and anomalies in the reporting systems and data systems, CMS redesigned this goal in FY 2012 to reflect our direct fraud identification and prevention work —the National Fraud Prevention Program (NFPP). This goal aligns with provisions of the ACA and the Small Business Jobs Act (SBJA) which added new requirements to use advanced predictive analytics to identify high risk providers. With funding authorized in the SBJA, CMS developed the Fraud Prevention System (FPS) which allows for better tracking of administrative actions against high risk providers and suppliers.

Our predictive analytics work using FPS will focus on activities in areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. Our goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

Our FY 2012 baseline is from the first year of the FPS (July 2012). We reported that 27 percent of Medicare providers and suppliers, identified as high risk through predictive analytics, received an administrative action. In FY 2014, the 36 percent target rate was again exceeded by an actual rate of 41.15 percent. We set our FY 2015 targets at a rate 42 percent. The FY 2015 result will be available in November 2015, at which time the FY 2016 and FY 2017 targets will be determined. CMS partners with the HHS' Office of General Counsel and the Office of Inspector General, the Department of Justice, and the Federal Bureau of Investigation to implement the full spectrum of administrative actions, including those that result from referrals to law enforcement. Instances of potential fraud identified through predictive analytics are referred to law enforcement for additional civil and criminal remedies, which are powerful tools to assist CMS to protect the integrity of the Medicare Trust Fund and ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries.

MIP9.1 Estimate the Payment Error Rate in the Medicaid Program and MIP9.2 Estimate the Payment Error Rate in the Children's Health Insurance (CHIP): The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 States each year as a means to contain cost, reduce the burden on States, and make measurement manageable. In this way, States can plan for the reviews and CMS can complete the measurement on time for the Department of Health and Human Services (HHS) 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 2011 AFR were also measured again in the 2014 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2014 HHS AFR.

The national Medicaid error rate (MIP9.1) reported in the 2014 AFR is based on measurements that were conducted in FYs 2012, 2013 and 2014. We fell short of our FY 2014 target of 5.6 percent, as the current national Medicaid error rate is 6.7 percent. The national Medicaid error component rates are: Medicaid FFS: 5.1 percent; Medicaid managed care: 0.2 percent; and Medicaid eligibility: 3.1 percent. This rate increased from prior years due to an increase in the FFS component, driven primarily by state systems having difficulty complying with new requirements. Both the eligibility and managed care components of the rate decrease from the prior year estimate. Our FY 2015 and 2016 targets are 6.7 percent and 6.4 percent, respectively.

Due to Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and Section 205(c) of the Medicare and Medicaid Extenders Act of 2010, CMS temporarily suspended CHIP PERM reviews and did not report a national improper payment rate for CHIP in the 2009 through 2011 AFRs. CMS resumed CHIP measurement in 2012 and reported the first CHIP improper payment baseline error rate encompassing all three cycles of States in the 2014 AFR.

The national CHIP error rate (MIP9.2) reported in the FY 2014 AFR is based on measurements conducted in FYs 2012, 2013, and 2014. We met our FY 2014 target to report a CHIP rolling error rate in the 2014 AFR. The current national CHIP error rate is 6.5 percent. The national FY 2014 CHIP error component rates are as follows: CHIP FFS: 6.2 percent; CHIP managed

care: 0.2 percent; and CHIP eligibility: 4.2 percent. CMS also reported CHIP's first reduction targets for the program in the 2014 AFR. Our FY 2015 and FY 2016 targets for CHIP are 6.5 percent and 6.4 percent, respectively.

Additional detail about Medicaid and CHIP error rates and underlying components is available in the 2014 HHS AFR.

In order to reduce the national Medicaid and CHIP error rates, States are required to develop and submit corrective action plans (CAPs) to CMS. CAPs will focus on helping States comply with new system requirements, provider communication and education to reduce errors related to missing or insufficient documentation and also target eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPs CMS has implemented additional efforts to lower improper payments rates including provider outreach, mini-PERM audits, best practice calls, and various other methods of state outreach. For more information on corrective actions see the 2014 HHS AFR.

MIP10 Ensure Accuracy of the Medicare Fee-for-Service Recovery Audit Program: As mandated by Section 302 of the Tax Relief and Health Care Act of 2006, CMS implemented the MFFS Recovery Audit Program in all 50 States to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The ACA expanded the Recovery Audit Contractor Program to Medicaid, Medicare Advantage, and Medicare Part D. The National Recovery audit program is the outgrowth of a successful demonstration program that used Recovery Auditors to identify FFS Medicare overpayments and underpayments.

Ongoing monitoring of review activity is a key part of the Recovery Audit program as it serves as an important gauge on the impact to the provider community. CMS publishes an annual identification rate, which is the percent of times an improper payment is identified when additional documentation is requested and can be an indicator of the burden of the review process on providers. In FY 2014, the Recovery Auditor identification rate was 35.7 percent, lower than the target. The main contributing factor to the low rate is a requirement introduced in the Protecting Access to Medicare Act of 2014 (PAMA), which specifies that all outpatient therapy claims above $3,700 must be reviewed. Prior to the PAMA requirement, Recovery Auditors focused reviews on targeted claims most likely to be associated with improper payments.

CMS and Recovery Auditors use complex algorithms, the Comprehensive Error Rate Testing program results and Office of Inspector General, General Accountability Office and Medicare Administrative Contractor results to determine review areas. These review areas should be tailored to each audit situation. The more tailored and specific the audit is, the higher the identification of improper payments and the lower the unnecessary burden on providers. CMS is working with the Recovery Auditors to reduce burden and fine tune their audit strategies. Our FY 2016 target is to increase the Recovery Auditor identification rate by 5 percent over FY 2015.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY2015 Target
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Outcome)	FY 2014: 12.7% Target: 9.9% (Target Not Met)	12.5%	11.5%	-1 pp
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program	FY 2014: 9.0% Target: 9.0% (Target Met)	8.5%	8.1%	-.4 pp
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program	FY 2014: 3.3 Target: 3.6% (Target Exceeded)	3.5%	3.4%	-.1 pp
MIP7: Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data at 100% of the LE personnel referred up to approximately 200 LE personnel annually.	FY 2014: 100% Target:100%[1] (Target Met)	100% Sep 2015	100% Sep 2016	TBD
MIP8: Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Outcome)	FY 2014: 41.15% Target: 36% (Target Exceeded)	42% Nov 2015	TBD	TBD
MIP9.1: Estimate the Payment Error Rate in the Medicaid Program (Outcome)	FY 2014: 6.7% Target: 5.6% (Target Not Met)	6.7%	6.4%	-.3 pp

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY2015 Target
MIP9.2: Estimate the Payment Error Rate in the Children's Health Insurance Program (CHIP)	FY 2014: 6.5% Target: Report rolling average error rate in the 2014 AFR (Target met)	6.5%	6.4%	-.1pp
MIP10: Reduce provider burden by increasing the Identification Rate of an improper payment by the Medicare FFS Recovery Auditors when additional documentation is requested from providers	FY 2014: 35.7% Target: Increase the Recovery Auditor Identification Rate over the FY 2012 baseline by 5% over FY 2013 (41.4%) (Target not met)	Increase the Recovery Auditor Identification Rate by 5% over FY 2014 (37.5%)	Increase the Recovery Auditor Identification Rate by 5% over FY 2015	+5% over previous year

[1] CMS trained 200 new LE personnel

Project or Activity	FY 2016 Discretionary Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D	
Medicare Drug Integrity Contractors (MEDICs)	$25,391
Part C & D Contract/Plan Oversight	$22,930
Monitoring, Performance Assessment, and Surveillance	$62,619
Program Audit	$56,400
Compliance and Enforcement	$17,600
Total	**$184,940**
II. Program Integrity Staffing & Support	
Field Offices/Rapid Response/and Oversight Staffing	$35,887
Total	**$35,887**
III. Program Integrity Special Initiatives	
Automated Provider Screening	$19,005
Case Management System	$10,100
1-800 Medicare Integration	$2,000
Total	**$31,105**
IV. Prevent Excessive Payments	
Fraud Prevention System	$26,425
Fraud System Enhancements	$2,000
Command Center	$1,130
Benefits Integrity	$59,627
Total	**$89,182**
V. Program Integrity Oversight Efforts	
Overpayment/Payment Suspension	$5,000
Compromised Numbers Checklist	$1,479
National Supplier Clearinghouse	$23,322
One PI Data Analysis	$12,348
HEAT Support / Strike Force	$1,000
Appeals Initiatives	$1,162
Healthcare Fraud Prevention Partnership	$9,461
Total	**$53,772**
VI. Medicaid Program Integrity Initiatives	
Payment Error Rate Measurement (PERM)	$28,000
National Correct Coding Initiative	$1,521
Review of Medicaid Managed Care Rates, Upper Payment Limits and Supplemental Payments.	$8,133
Physician Transparency	$8,635
Healthcare Fraud Prevention Partnership	$4,500
Automated Provider Screening	$2,000
Fraud Prevention System	$1,500
Total	**$54,289**
VII. Other Program Integrity	
Program Integrity Private Insurance	$25,000
Total	**$25,000**
HCFAC Summary	
Total CMS Discretionary	**$474,175**

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Clinical Laboratory Improvement Amendments of 1988

	FY 2014 Operating	FY 2015 President's Budget	FY 2016 Request	FY 2016 +/- FY 2015
BA	$46,400,000	$50,000,000	$50,000,000	-
FTEs	75	81	81	-

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

Allocation Method – Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA strengthens quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens to diagnose, prevent, or treat illness or impairment. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 19,099 laboratories during the FY 2014-2015 survey cycle.

Laboratories exempt from routine Federal inspections include those performing waived tests only, laboratories in which specified practitioners perform only certain microscopic tests, laboratories accredited by approved independent accrediting organizations, and laboratories in States that approve or license clinical laboratories under their own Standards, waived laboratories perform only simple and routine testing following the manufacturers' instructions. Waived laboratories are required to pay applicable certification fees. Laboratories which are accredited, or which operate in exempt States, are inspected by an accrediting organization or the State at the same frequency as CMS-certified laboratories, namely every 2 years. The accrediting organizations and exempt States have standards considered equal to or more stringent than those required under the CLIA statute. Laboratories that are subject to Federal surveys can choose to be surveyed either by CMS or by one of the six CMS- approved private accrediting organizations. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Currently, 247,228 laboratories are registered with the CLIA program. Approximately 209,947 or 84.9 percent, of these laboratories are classified as waived or provider-performed microscopy laboratories and are not subject to routine onsite inspection. The largest number of laboratories, physician office laboratories (POLs), account for approximately 122,099 or 49.4 percent, of the laboratories registered under the CLIA program. Approximately 102,755 or 84.2

percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will remain steady for the FY 2015-2016 survey cycle.

Effective October 31, 2003, the authority for CLIA test categorization was transferred to the Food and Drug Administration (FDA), which enables laboratory device manufacturers to submit applications to only one agency for both device approval and categorization. CMS, the Centers for Disease Control (CDC), the FDA, and the States remain focused on the mission to improve the accuracy of tests administered in our Nation's laboratories, thereby improving health care for all. CMS, the CDC, and the FDA have reevaluated the program, procedures, responsibilities, and time lines to continually achieve greater efficiencies, while ensuring that requirements reflect the current standard of practice in laboratory medicine. By being flexible and results-oriented, the CLIA program has remained successful in the dynamic health care environment.

Budget Request

The FY 2016 budget request for CLIA is a program level of $50.0 million of which $50 million is user fee. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories. CMS then sets the national survey workload at 100 percent of the laboratories to be inspected in a two-year cycle. Workloads projected for the FY 2015-2016 cycle include surveys of 18,684 non- accredited laboratories, State validation surveys of 806 accredited laboratories, and approximately 1,364 follow-up surveys and complaint investigations.

Performance Measurement

CLIA2: Improve Laboratory Safety by Measuring the Outcome of Delivering Educational Materials Prior to an Educational Survey -The Clinical Laboratory Improvement Amendments (CLIA) ensure the quality of laboratory testing by requiring that all laboratories are certified by HHS and meet the CLIA provisions. The CLIA provisions are based on the complexity of tests performed by laboratories. CLIA imparts an exemption or a Certificate of Waiver (CW) of quality provisions to laboratories that perform only simple tests. "Simple" in this context refers to simple laboratory examinations and procedures that have an insignificant risk of an erroneous result, including those that employ methodologies that are so simple and accurate as to render the likelihood of erroneous results by the user negligible, or the Secretary of HHS has determined the test poses no unreasonable risk of harm to the patient if performed incorrectly.

Because of the significant growth of waived tests and laboratories, CMS developed a survey of the nations' waived laboratories. These surveys measure whether a lab is in full compliance with CLIA regulations as they pertain to waived testing laboratories.

Survey data has continually substantiated that a significant percentage of waived laboratories have pre- and post-testing issues, are not performing Quality Control as instructed by the manufacturer, and that testing personnel are not familiar with and are less trained in good laboratory practice compared to personnel in non-waived labs. Additionally, these surveys have brought to light that some laboratories are performing testing beyond the scope of their certificate (i.e. non-waived testing), which can lead to potential patient harm.

The FY 2015 target is to increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA by 2 percent over the FY 2014 actual. We remain cautious in our expectations to achieve greater than a 2 percent increase because of the variability state that exists with CW laboratories, high staff turnover, the limitations of human resources to train personnel and monetary considerations. At this time we are continuing to use the same States selected during fiscal year 2012 because another CLIA project was taking place in 2014. During 2015 we will expand this measure to additional States during the FY2015 survey cycle. The FY 2016 target is to increase the number of States that are in full compliance with CLIA by 2 percent over the FY 2015 actual

Key Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target+/- FY 2015 Target
CLIA2: Increase the percentage of certificate of waiver laboratories that are in full compliance with CLIA provisions.	FY 2013: 45% Target: +2% over 2012 % of certificate of waiver laboratories qualifying for a Letter of Congratulations (Target Exceeded)	+2% over FY 2014 % of the certificate of waiver laboratories qualifying for a Letter of Congratulations	+2% over 2015 % of the certificate of waiver laboratories qualifying for a Letter of Congratulations	+2% over FY 2015

*[*1] Data updated to reflect results from corrected algorithm for Letter type assignments and additional FY 2012 survey updates between January 2012 and May 2013. Originally reported as 44% on 4/29/2013.

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Quality Improvement Organizations

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Obligations	$1,412,000,000	$770,124,706	$549,200,000	($220,924,706)

Authorizing Legislation – Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended
Allocation Method – Contracts

The 11th Statement of Work (SOW) began August 1, 2014 and will end July 31, 2019. The focus of the 11th SOW will expand on work started in the 10th SOW with emphasis on priorities set forth in the Patient Protection and Affordable Care Act of 2010 (ACA).

The 11th SOW will specifically support the goals set forth in the following titles of the Affordable Care Act:

- Title III: Improving the Quality and Efficiency of Health Care requires that the quality of care for seniors drives all of our decisions;
- Title IV: Prevention of Chronic Disease and Improving Public Health requires improved data collection and analysis, facilitates better data sharing, and requires the development of standards for the collection of data regarding the nation's health and the performance of the nation's health care, including health disparities; and,
- Title X: Strengthening Quality and Affordable Health Care for All Americans.

Program Description and Accomplishments

Under the Quality Improvement Organization (QIO) program, CMS maintains contracts with independent community-based organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of care, and is provided in the most economical setting. In addition, through the QIOs and other State and local partners, CMS collaborates with healthcare providers and suppliers to promote improved health status, including quality improvement in nursing homes.

- The 11th SOW will expand on work started in the 10th SOW with focus on Clinical Quality Improvement and Value Based Purchasing;
- The 11th SOW seeks to achieve better health care, better health, and lower healthcare costs;
- QIO funding comes directly from the Medicare Trust Funds and is permanently appropriated. Spending levels are controlled by an apportionment negotiated between HHS and OMB;
- The 11th SOW has significant programmatic and structural improvements.

The 11th SOW will implement several changes to the program as enacted in the Trade Adjustment Assistance Extension Act of 2011 (the "Trade Law"), which provides the Secretary authority to:

- Determine the geographic scope of QIO contracts such that QIO activity is no longer restricted to a single entity in each state or territory;
- Extend the length of QIO contracts from three years to five years;
- Contract with a broader range of entities to perform QIO functions;
- Award certain QIO tasks to specialty contractors; and
- More easily terminate QIO contracts for poor performance in line with other Federal contracting rules and regulations.

CMS will align the 11th SOW with the Secretary's National Strategy for Quality Improvement in Health Care (the National Quality Strategy).

Funding History

FY 2012	$372,800,000
FY 2013	$458,600,000
FY 2014	$1,648,900,000
FY 2015	$770,124,706

Budget Request

Estimated QIO Funding 11th Statement of Work (2014-2019)
(dollars in millions)

Estimated QIO Funding 11th Statement of Work (2014-2018) *(dollars in millions)*	
QIO Clinical Quality Improvement	
Subtotal, Clinical Quality Improvement	**$839.9**
Value Based Purchasing Support Contracts and Quality Measures	**$1,129.4**
Infrastructure, Coordinating Centers, and Special Initiatives.....	**$568.0**
Beneficiary and Family Centered Care	**$402.5**
Other Support Contracts and Staff	**$1,100.6**
Subtotal Funding	**$4,040.4**

Performance Measurement

CMS uses performance measures to support its mission and to inform the decision-making process. The following performance measures touch on the themes of the 10th SOW, as well as CMS efforts to improve oversight of the QIOs. As CMS transitions from the 10th SOW to the 11th SOW, we have developed additional performance measures to evaluate the employment of proven quality improvement techniques and beneficiary satisfaction.

QIO1 - Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those who Receive an Annual Vaccination for Influenza: For all persons age 65 or older, the Advisory Committee on Immunization Practices and other leading authorities recommend annual vaccination against influenza. The FY 2012 influenza result of 83.6 percent for beneficiaries residing in a long term care facility did not exceed the FY 2012 target of 84 percent. Development of a new Quality Improvement contract for the 11th SOW has caused a delay in FY 2013 results, which will now be determined in spring of 2015.

Through the use of the Physician Quality Reporting System, electronic health records, this Aim will engage the participating professionals by implementing care management and tracking, and improve their patients' receipt of the influenza vaccine. Participating eligible professionals will utilize their electronic health records to facilitate immunization practices, document vaccination recommendations, and improve compliance with recommendations, allowing them to use decision support tools to improve quality of care, care coordination and better engagement of patients and families in making health care decisions.

It is expected that rates will improve over time, resulting in an 85.4 percent target for 2015 and 2016. The goals were set with the consideration of the national decline of influenza immunization rates seen from 2008 to 2010 reported among the Medicare Current Beneficiary Survey (MCBS) Facility, MCBS Community, and the CDC's Behavior Risk Factor Surveillance System Community data. The goals will be linked to the CMS Quality Strategy Goal: Promoting Effective Prevention and Treatment of Chronic Disease through satisfying the objective to increase appropriate use of screening and prevention services. We will adjust targets as appropriate in consultation with CDC as data becomes available.

QIO3 - Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol Testing: CMS is committed to improving care for its diabetic beneficiaries by increasing the rate of hemoglobin A1c (HbA1c) and cholesterol (LDL) testing. Multiple studies have demonstrated a relationship between well-controlled blood sugars as measured by HbA1c and protection against the development and/or progression of the devastating complications of diabetes. Cardiovascular complications of diabetes are common and cause heart attacks, strokes and lower extremity amputations. Cardiovascular disease is the number one cause of death for diabetic patients. CMS improved over the previous year; however, the agency fell just short of its CY 2012 target of 89.5 percent (HbA1c) at a rate of 88.29 percent. The CY 2012 rate of 82.05 percent (LDL) did not change from the previous year and the 84.1 percent target was not met. We set the FY 2014 targets for HbA1c at 90.5 percent and (LDL) cholesterol testing at 86 percent.

Recent evidence suggests that HbA1c is not as powerful a target as is effective blood pressure and lipid management in averting macro-vascular events and disease. CMS will continue to track this measure and consider it for modification as evidence emerges. CMS improved over

the previous year; however, the agency fell just short of its CY 2013 target of 90.0 percent (HbA1c) at a rate of 88.69 percent. The CY 2013 rate of 82.45 percent (LDL) has improved from previous year but the 85.0 percent target was not met.. We will determine the new targets in the spring of 2015 as the redesigned program becomes fully operational. In the 11th SOW, QIOs will recruit a subset of practitioner-owned/operated clinics or offices who will report on hypertension and other cardiovascular measures via the Physician Quality Reporting System (PQRS) measures via the CEHRT. Additionally, in the 11th SOW, the QIOs focus on recruitment shall be on those providers who manage patients with the greatest cardiovascular health needs and those most challenged to succeed in implementing evidence-based practices to improve cardiovascular health and support the Million Hearts® initiative.

MCR28 - Reduce Healthcare-Associated Infections: The QIOs play an important role in the Agency Priority Goal to reduce Catheter-Acquired Urinary Tract Infections. For more information, please see measure MCR28 in the Performance Measurement Section of the Program Operations chapter.

QIO6 - Improve Oversight of Quality Improvement Organizations: The purpose of this goal is to ensure that CMS' efforts in overseeing the QIOs are aligned with the performance targets in the QIO 10th SOW. The targets are important as they are designed to measure improvements in the quality of care for Medicare beneficiaries at a national level. QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The 9th SOW ended July 31, 2011, and represented a change from previous QIO contracts, since it held all QIOs accountable for meeting specific, predefined performance targets under four major themes. CMS was successful in improving QIO 9th SOW oversight by conducting routine quarterly monitoring of the metrics, and requesting immediate correction of identified problems.

Under the 10th SOW, which ended July 31, 2014, QIOs were evaluated on achievement associated with meeting the "Drivers" performance expectations and contract monitoring evaluation targets. For FY 2013, CMS has achieved all four of its targets. The "Drivers" for performance are: a) Supporting and Convening Learning and Action Networks, b) Providing Technical Assistance, and c) Care Reinvention through Innovation Spread Model. Please note that as CMS transitions from the 10th SOW to the 11th SOW; this goal will be used to evaluate the transition of the new QIOs to the new contracts. CMS is utilizing a transition measure for the projects and work performed by 53 QIOs in the 10th SOW to new contractors in the 11th SOW. The narrative will apply to all of the measures equally, as every measure will be reviewed at the 18th and 27th month, and every measure will use the described specifications to determine whether the QIOs have passed the goal. CMS currently has preliminary 2014 Data and Deliverable Submission Tool data. The data has not yet been finalized nor validated as of this date. We will have the data for an update in March 2015. The FY 2016 targets are to be determined (TBD). We will determine new targets in the spring of 2015 as the redesigned program becomes fully operational.

QIO7- Make Care Safer via Recruitment of Low Performing Nursing Homes (NH) (One-Star NH) through the National Nursing Home Quality Care Collaborative (NNHQCC): More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the Nation's over 15,600 nursing homes on any given day. The Affordable Care Act called for CMS to develop a strategy that will guide local, state and national efforts to improve the quality of care in nursing homes. In December 2008, CMS added a star rating system to the Nursing Home Compare website. This rating system serves three purposes: to provide residents and their families with an assessment of nursing home quality, to make a

distinction between high and low performing nursing homes, and to provide incentives for nursing homes to improve their performance. The one-star rating is the lowest rating and the five-star rating is the highest.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of Nursing Homes and other activities, shall support the creation of a National Nursing Home Quality Care Collaborative (NNHQCC). The purpose of the NNHQCC is for it, along with its partners, to ensure that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO shall support the Collaborative objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction." Although the QIN-QIO will recruit one-star nursing homes, all nursing homes or facilities providing long term care services to Medicare beneficiaries are eligible to participate in the Collaboratives and the QIN-QIO will encourage them to participate.

One-star nursing homes face specific challenges including lack of understanding of quality improvement processes; lack of resources to implement the processes; poor understanding of the data for use in improvement; lack of leadership; and patient and family engagement. Participation in the NNHQCC will entail peer-to-peer learning activities in an "all teach/all learn" environment involving virtual, face-to-face meetings, and quality improvement activities which help guide the nursing home to engage in the use of facility specific data for rapid-cycle-Plan Do Study Act activities to improve systems-level improvement in the individual nursing home. Recruitment goals are measured at the start of each collaborative and continued engagement in collaborative activities is monitored throughout the life of each collaborative via the facilities' individual Composite Scores and outcome measures, such as the decreased use of antipsychotic medication in residents with dementia. The one-star recruitment measure will assess the ability of the QIN-QIO to gain participation, in peer to peer quality improvement activities as measured by the percentage increase of one-star nursing homes participating in the NNHQCCs through 2018 and therefore ensure safer care received by Medicare beneficiaries. While we plan to begin with measuring participation in the early years of the project, the goal is to move toward measuring improvement utilizing the NNHQCC Quality Composite score of each participating nursing home as the project matures. The first recruitment measurement period ended November 5, 2014. Data are being calculated, but are not available at this time.

QIO8 - Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Complaint Resolution: The primary focus of the Beneficiary and Family Centered Care (BFCC) QIO work is to improve healthcare services for Medicare beneficiaries, through the QIO-performance of statutory review functions. This includes, but is not limited to, quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment & Labor Act reviews. Beneficiary satisfaction with the review process has been mixed with concerns regarding the quality of the reviews and the impartiality of the reviewers. CMS has implemented several process improvements that began in 2014.

As a result of the flexibilities provided by the Trade Bill, CMS has restructured the program to address these concerns. The BFCC QIOs will develop activities that engage patients and families, with the goal to increase patient knowledge, skill, and confidence in taking an active role in managing patient health and health care. Patient and family engagement in these activities will be captured on the Beneficiary Satisfaction surveys.

This measure evaluates beneficiary satisfaction with the QIO's resolution of quality of care complaints. The measure also holds QIOs accountable for engaging patients and families to

ensure that the review process is continuously improved. CMS has begun to measure beneficiary satisfaction with the quality of care complaints process.

In the 9th SOW, the Beneficiary Satisfaction survey was performed using quality of care cases via a telephone survey. The 10th SOW survey was redesigned to increase efficiency by using a paper based model. We anticipated that the paper (mail) based model may significantly reduce our response rate. To account for a reduction in the response rate, we added an additional high volume case review type, appeal reviews, to the denominator of cases to be surveyed. In addition to the change in survey delivery method, we were also asked by OMB to score all neutral responses as negative satisfaction responses. These two changes (mail based surveys and neutral responses scored as negative) dramatically changed and reduced the baseline satisfaction rate. We observed significant drops in the median satisfaction rate which we believe are directly related to these changes in the survey delivery method and scoring methodology.

For these reasons, we did not use the Beneficiary Satisfaction Survey scores for contract measurement at the end of the 10th SOW. In addition, we intend to use the 11th SOW survey scoring methodology for the 2015 goal. The Beneficiary Satisfaction survey is part of the Oversight and Review Center contract and has not yet been awarded. We expect contract award in early 2015 with a survey start date in the fall 2015. The FY 2015 and FY 2016 targets are to be determined (TBD). The FY 2015 and FY 2016 targets will be set once baseline data are available.

Key Outputs and Outcomes

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
QIO1 Increase influenza immunization (nursing home subpopulation) (Outcome)	FY 2012: 83.6% Target: 84% (Target Not Met but Improved)	85.4%	85.4%	N/A
QIO3.1 Increase hemoglobin A1c (HbA1c) testing rate (Outcome)	FY 2013: 88.69% Target: 90% (Target Not Met but Improved)	Spring 2015	Spring 2015	N/A
QIO3.2 Increase cholesterol (LDL) testing rate (Outcome)	FY2013: 82.45% Target: 85% (Target Not Met)	Spring 2015	Spring 2015	N/A

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
QIO6.5a Improve Health for Populations and Communities (Outcome)	FY 2013: 100% of pertinent QIOs populated the DDST Quality Data Reporting system with data that demonstrated provider assistance on EHR implementation. Target: 100% of the QIOs will populate the DDST Quality Data Reporting system with data that demonstrates provider assistance on EHR implementation (Target Met)	100% of new QIOs will have completed a successful transition to the 11th SOW (March 31, 2015)	Spring 2015	N/A
QIO6.5b Improve Individual Patient Care (Outcome)	FY 2013: 83% of the QIOs met the expectations towards the 18th month targets for HAIs. Target: 80% of the QIOs will meet expectations towards the 18th month targets for Urinary Catheter Utilization Rates, CLABSI (Central Line-Associated Bloodstream Infection), CAUTI (Catheter-Associated Urinary Tract Infection), CDI (Clostridium difficile Infection), pressure ulcer prevention treatment practices and reduction of adverse drug events (Target Exceeded)	100% of new QIOs will have completed a successful transition to the 11th SOW March 31, 2015	Spring 2015	N/A

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
QIO6.5c Integrate Care for Populations and Communities (Outcome)	FY 2014: Greater than 80% of the QIOs met the overall performance expectations for the 10th SOW. Target: 80% of the QIOs will have met the overall performance expectations for the 10th SOW. (Target Exceeded)	100% of new QIOs will have completed a successful transition to the 11th SOW March 31, 2015	Spring 2015	N/A
QIO6.5d Beneficiary and Family Centered Care (Outcome)	FY 2013: 87% of the QIOs met performance expectations. Target: 80% of the QIOs will meet the 18th month (quarter 6) performance expectations (Target Exceeded)	100% of new QIOs will have completed a successful transition to the 11th SOW March 31, 2015	Spring 2015	NA
QIO7 Making Care Better and Safer - Improve nursing home safety by recruiting under-performing nursing homes via collaboratives to provide peer-to-peer improvement of Medicare beneficiary healthcare. Baseline: Zero (0)	N/A	N/A	**FY 2017 Target:** Recruit-ment of 50% of One-Star category target count by the end of FY 2017.	N/A
QIO8 Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints. Baseline (2014) - TBD	N/A	TBD—FY 2015 Target set when FY 2014 baseline is available	TBD	N/A

Medicare Benefits
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Outlays	$ 597,132,000	$ 618,928,000	$ 676,490,000	$ 57,562,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process. The estimates are based on the FY 2016 President's Budget, and include the effects of the sequester orders for FY 2014 and FY 2015. They do not include expected savings from Program Integrity initiatives, nor do they include the SMI transfer to Medicaid.

Authorizing Legislation - Title XVIII of the Social Security Act
FY 2016 Authorization - Indefinite
Allocation Method - Direct Federal

Program Description and Accomplishments

Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Enacted in December 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), P.L. 108-173, was designed to improve and modernize the Medicare program, including the addition of a prescription drug benefit. Based on current efforts to implement the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5, Medicare added significant new funding and incentives for physician and hospital expansion in electronic health records and quality information in FY 2011. Implementation of these ARRA provisions builds on Medicare's ongoing transformation into an active purchaser of high quality services. In addition, the Affordable Care Act of 2010 (P.L.111-148) created a number of changes that will improve the Medicare program. While full implementation is expected to take several years, many beneficial aspects of the law have already been implemented.

Medicare processes over one billion fee-for-service (FFS) claims every year and is the Nation's largest purchaser of health care (and within that, of managed care). Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and the Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to an estimated 57.03 million beneficiaries in FY 2016.

The Medicare Hospital Insurance program, also known as HI or Medicare Part A, is normally provided automatically to people aged 65 and over who qualify for Social Security benefits. This program is also extended to most disabled people who are entitled to Social Security or Railroad Retirement benefits. The Hospital Insurance program pays for inpatient hospital care, as well as skilled nursing, home health and hospice care. Medicare Part A is financed primarily through payroll taxes paid by workers and employers. While these taxes are primarily used to pay benefits for current beneficiaries, funds not currently needed to pay benefits and related expenses are held in the Hospital Insurance trust fund and invested in U.S. Treasury securities.

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. Beneficiaries who choose the optional Part B coverage are subject to monthly premium payments. About 91 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI Trust Fund, and invested in U.S. Treasury securities.

The Medicare Advantage (MA) program, also known as Medicare Part C, created in 2003 by the MMA, is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join an MA plan, if they are entitled to Part A and enrolled in Part B, and if there is a plan available in their area. Those who are eligible for Medicare because of ESRD may join an MA plan only under special circumstances. All MA plans are currently paid a per capita payment, and must provide all Medicare covered services. Further, MA plans assume financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services to beneficiaries, such as vision and dental benefits, which are not available under Part A or Part B; many also offer Part D coverage of prescription drugs in addition to medical benefits. MA plans have an estimated 18.08 million enrollees in FY 2016.

The Prescription Drug Benefit Program, also created by the MMA, is funded through the SMI Trust Fund, and provides an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A or Part B. Beneficiaries who qualify for both Medicare and Medicaid ("dual eligibles") automatically receive the Medicare drug benefit. The statute also provides for assistance with premiums and cost sharing to full-benefit dual-eligibles and qualified low-income beneficiaries.

In general, coverage for this benefit is provided under private prescription drug plans, which offer only prescription drug coverage, or through Medicare Advantage plans which integrate prescription drug coverage with the general health care coverage they provide to Medicare beneficiaries. In addition, plan sponsors of employer and union plans offering a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the retiree drug subsidy program to fund some of their costs. Part D benefits are funded through premiums paid by beneficiaries, general fund subsidies, and specified payments from states. Enrollment in Part D plans is estimated to be 43.3 million in FY 2016, including 41.6 million enrolled in Part D plans and 1.7 million who receive benefits through the retiree drug subsidy. The Affordable Care Act authorized a rebate program for those applicable beneficiaries who reached the coverage gap before the end of the 2010 calendar year. In addition, the Act offers a discount for prescription drugs in 2011 and beyond, to applicable beneficiaries who reach the coverage gap before the end of each calendar year after 2010.

Outlays History

FY 2010	$518,948,805,000
FY 2011	$557,732,000,000
FY 2012	$549,311,000,000
FY 2013	$586,877,000,000
FY 2014*	$597,132,000,000
FY 2015*	$618,928,000,000
FY 2016*	$676,490,000,000
*Estimate Under Current Law	

Budget Estimates

The budget estimates for Medicare benefit outlays for FY 2016, by trust fund account, are shown in the following table.

	FY 2016	+/- from FY 2015
HI	$294,551,000,000	$18,313,000,000
SMI – Part B	$284,175,000,000	$16,784,000,000
SMI – Part D	$97,764,000,000	$22,465,000,000
Total	$676,490,000,000	$57,562,000,000

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

The estimate for FY 2016 is an increase of $57,562,000,000 from FY 2015. This increase is due to higher enrollment and increasing medical service utilization/costs.

Performance Measurement

MCR1 Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive: CMS has monitored Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. As the ACA is implemented, we will continue to monitor FFS and MA access to care in order to maintain the same high rates for our beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: "Percent of persons with FFS (or MA Plans) report they usually or always get needed care right away as soon as they thought they needed it." CMS met or exceeded our FY 2014 targets reflecting beneficiary experience in FFS and MA access to care in 2013. For FY 2015, we want at least 90 percent of beneficiaries surveyed to report that they have access to care in the MFFS and MA programs. After FY 2015, we will no longer set targets for this measure, but will report the trend annually as a contextual measure.

MCR23 Reduce the Average Out-of-Pocket Share of Prescription Drug Costs While in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non Low- Income Subsidy (LIS) Medicare Beneficiaries Who Reach the Gap and Have No Supplemental Coverage in the Gap: This measure tracks the success of the ACA Coverage Gap Discount Program, which reduces the amount Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap, by measuring the average percent of drug costs beneficiaries must pay while in the coverage gap. Discounts are provided through a combination of rebate checks for 2010, and significant manufacturer discounts and increased Medicare coverage according to a predetermined scale for years 2011 through 2020. CMS exceeded its FY 2012 target of 58 percent with an actual result of 57 percent. In FY 2013, beneficiaries in the coverage gap saw their average out-of-pocket share of prescription drug costs reduced to 47.5 percent for brand drugs and 79 percent for generic drugs. Results are still pending for FY 2014. To reflect current analysis using baseline data and applying the discounts that will be available to beneficiaries through 2020, CMS set the FY 2015 target at 50 percent and FY 2016 target is 48 percent, respectively.

MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit: CMS measures the number of Medicare Annual Wellness Visits (AWVs) to demonstrate success in increasing beneficiary awareness and utilization of this benefit, which was first available January 2011. The ACA added this benefit with no copayments or other cost-sharing on the part of the beneficiary, if the doctor or other health care provider accepts assignment. The AWV includes elements that focus on assessing health risks, furnishing personalized health advice and referrals, as appropriate to health education and preventive counseling services, and creating a screening schedule for the next five to ten years. The elements also include a list of risk factors and conditions, as well as ongoing and/or recommended interventions. The CY 2011 baseline is 2.3 million beneficiaries. In CY 2013 about 4.1 million beneficiaries received AWVs, exceeding the target of 2.8 million. The CY 2014 target was set at 3.2 million. FY2014 results will be available in June 2015. After FY 2014, we no longer set targets for this measure, but report the trend annually as a contextual measure. Additional information about preventive services provided to Medicare beneficiaries is available at Medicare.gov.

Key Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/-FY 2015 Target
MCR1.1a Maintain or Exceed Percent of Beneficiaries in Medicare Fee-for-Service (FFS) Who Report Access to Care (Outcome)	FY 2014: 91% Target: 90% (Target Exceeded)	90%	Contextual Indicator	N/A
MCR1.1b Maintain or Exceed Percent of Beneficiaries in Medicare Advantage (MA) who Report Access to Care (Outcome)	FY 2014: 90% Target: 90% (Target Met)	90%	Contextual Indicator	N/A
MCR23 Reduce the Average Out-of-pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have No Supplemental Coverage in the Gap (Outcome)	FY 2012: Result 57% Target: 58% (Target Exceeded)	50%	48%	-2 pp
MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Outcome)	FY 2013: 4.1 million Target: 2.8 million (Target Exceeded)	Contextual Indicator	Contextual Indicator	N/A

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Children's Health Insurance Program

	FY 2014 Enacted	FY 2015 Estimate	FY 2016 President's Budget	FY 2016 +/- FY 2015
State allotments (CHIPRA of 2009, P.L. 111-3 ; ACA P.L 111-148)	$19,147,000,000	$16,512,000,000	$5,700,000,000	($10,812,000,000)
CHIP Performance Bonus Payments [1] (P.L. 111-3)	$8,447,799,000	$1,825,525,000	$67,525,000	($1,758,000,000)
Child Health Quality Improvement [1] (P.L. 111-3)	$76,108,000	$36,754,000	$28,481,000	($8,273,000)
Total Budgetary Resources /1	**$27,670,907,000**	**$18,374,279,000**	**$5,796,006,000**	**($12,578,273,000)**
CHIP State Allotment Outlays	$8,978,596,000	$10,400,000,000	$14,000,000,000[2]	$3,600,000,000
Performance Bonus Payments Outlays	$292,346,000	$170,000,000	$0	($170,000,000)
Child Health Quality Improvement Outlays	$48,671,000	$8,273,000	$9,900,000	$1,627,000
Total Outlays /2	**$9,319,613,000**	**$10,578,273,000**	**$14,009,900,000**	**$3,431,627,000**

[1] Funding levels reflect carry-forward balances from prior years along with enacted rescissions and do not represent new appropriations. The FY 2016 level for CHIP Performance Bonus Payments is subject to change due to adjustments throughout the year.
[2] Estimate includes spending from prior year allotments, redistribution funds, and the baseline assumption that CHIP continues at $5.7 billion a year (discussed below). The increase in spending from FY 2015 to FY 2016 is primarily due to the 23 percentage point increase in matching rates, effective from FY 2016 to FY 2019.
[3] FY 2016 Authorization – In accordance with scoring rules, the CHIP baseline includes $5.7 billion for State allotments based on the last appropriated level under section 2104(a)(18) of the Social Security Act. This funding is not available for states unless additional funding is appropriated for CHIP.

Child Enrollment Contingency Fund

	FY 2014 Enacted	FY 2015 Estimate	FY 2016 President's Budget	FY 2016 +/- FY 2015
Child Enrollment Contingency Fund	$2,095,784,000	$2,098,437,000	$2,104,865,000	($6,428,000)
Interest Estimate	$2,653,000	$6,428,000	$0	($6,428,000
Total Budgetary Resources	$2,098,437,000	$2,104,865,000	$2,104,865,000	$0
Total Outlays	$0	$50,000,000	$0	($50,000,000)

[1] FY 2014 - FY 2016 figures reflect carry-forward balances from previous years and do not represent new appropriations.

Allocation Method – Formula Grants

Authorizing Legislation – The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113),
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148).

Program Description and Accomplishments

The Balanced Budget Act of 1997 authorized the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a Federal-State matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program has improved access to health care and the quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States have the option to expand Medicaid (Title XIX) coverage, create separate CHIP programs, or have a combination of the two.

Since September 1999, all States, Territories, Commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review States' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibilities to make innovative changes. As of July 2, 2014, CMS has approved a total of 691 amendments to CHIP plans.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44 billion through FY 2013 to maintain State programs and to cover more insured children. The Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $28.8 billion in budget authority over the baseline. In FY 2016, there is no new funding for CHIP appropriated under current law, although States can carry-over and spend against unused allotments from FY 2015. The FY 2016 President's Budget proposes to extend CHIP funding through 2019.

In addition to increased funding for States, CHIPRA created several new programmatic features of the CHIP program. A few of the major provisions include:

- *CHIP Performance Bonus Payments* – Created as an incentive for States to enact policies promoting the enrollment and retention of eligible children, States receive bonus payments for the enrollment increase on a per child basis equal to a portion of the State's annual per capita Medicaid expenditure on children. In order to receive a performance bonus payment, States must implement 5 of 8 enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation, and transfers of any unobligated FY 2013 national allotments and excess funds beyond the aggregate cap from the Child Enrollment Contingency Fund. The FY 2016 President's Budget proposes to extend this authority through FY 2019.

- *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 target average number of enrollees for the fiscal year.

The fund received an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2015, Section 2104(n) of the Social Security Act appropriates amounts necessary to make payments to eligible States, not to exceed 20 percent of the total annual allotment appropriation for CHIP. Any amounts in excess of the aggregate cap are made available for CHIP Performance Bonus Payments. In addition, the contingency fund is invested in interest bearing securities of the United States; Income derived from these investments constitutes a part of the fund. The fund accrued a total of $2,653,000 in interest in FY 2014 and is estimated to accrue an additional $6,428,000 in FY 2015. To date, only one state (Iowa) has received shortfall funds through the Contingency Fund. The FY 2016 President's Budget proposes to extend this authority through 2019.

- *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. In addition, per Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) ensures at least $15 million is transferred from Medicaid Adult Health Quality funding.

The current status of Child Health Quality Improvement activities in Medicaid and CHIP include:

CHIPRA Pediatric Quality Measures Program:

- A Beginning in February 2011, CMS and the Agency for Healthcare Research and Quality (AHRQ) have collaborated to identify and improved the core set of children's health care quality measures. During 2013, CMS and AHRQ began releasing improvements to the Core Set (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf) and updates to the 2014 the Core Set. In December 2014, CMS released the 2015 updates to the Core Set via an informational bulletin available at: http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf. For FY 2015, CMS retired one measure, added two measures, and introduced a pilot reporting process for the child version of the hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) in order to assess future inclusion of Child HCAHPS in the Core Set.

- To increase the number of States consistently collecting, reporting, and using the Child Core Set measures, CMS established a national "Technical Assistance and Analytic Support Program" FY 2011. Under this program CMS holds national and individual state technical assistance calls, webinars and has released issue briefs for states to provide clarification and guidance about collecting, reporting, and using the Child Core Set measures to drive quality improvements in health care. As part of these activities, CMS also releases an annual technical specification and resource manual for states. CMS has sponsored a quality improvement series to increase States' knowledge about how to design and implement quality improvement projects. CMS continues to

provide targeted QI 301 technical assistance program with Medicaid agencies to improve maternal and infant health with a focus on post-partum care quality improvement methodologies.

- State data derived from the voluntary Child Core Set measures are part of the annual Secretary's Report on the Quality of care for Children in Medicaid and CHIP published annually (link to 2014 report: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf. Over the next year, CMS with the support of its technical assistance contractors will continue to conduct additional analyses on data submitted by States.

- In FY 2011, CMS, in collaboration with the AHRQ, created seven Centers of Excellence to develop measures of healthcare quality for children. The Centers of Excellence receive prioritized measurement development assignments for maternal/infant, child and adolescent health measures. Measures are focused on care coordination, content and follow-up of well-care visits, sickle cell, pediatric readmissions, cost and efficiency. CMS continues collaborations with the Office of the National Coordinator of Health IT to develop and test a small set of measures for inclusion in electronic health records certification program.

CHIPRA Electronic Health Record Program:

- CMS and AHRQ jointly released development standards including data elements and standards for EHR developer to ensure relevant elements are captured in a consistent manner. The standards can be found at http://www.ahrq.gov/news/newsroom/press-releases/2013/childehrpr.html. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting. The format allows for interoperable exchange of data, is compatible with other EHR standards, and facilitates quality measurement and improvement through collection of clinical quality data.

- The format was transitioned to the United States Health Information Knowledgebase (USHIK) website in 2013, an on-line, publicly-accessible registry and repository of healthcare related data, metadata, and standards. USHIK is funded and directed by AHRQ with management support and partnership from CMS and CDC's National Center for Health Statistics. The format is currently available for viewing at: http://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf.

- Two CHIPRA Quality Demonstration Grantees, Pennsylvania and North Carolina, continue testing the impact of the Children's EHR format.

- In 2014, CMS in collaboration with AHRQ developed and implemented a second phase effort to improve format requirements by obtaining input from a multi-stakeholder workgroup that included state Medicaid program representatives, a diverse health care providers, and federal agencies. The effort discussed policy challenges related to information exchange across care settings, institutions, and programs. Efforts focused a case study review of the experiences reported by Pennsylvania and North Carolina testing the initial format released in 2013.

CHIPRA Quality Demonstration Grants:

- CMS awarded the first $20,000,000 in demonstration grants to ten States on February, 2010. The fifth year of the demonstrations is scheduled to end February 2015, however, 9 of the ten grantees noted intent to request a no-cost extension to complete grant activities and final reporting to CMS.

- CMS continues to host monthly all-grantee calls. CMS staff facilitates calls and grantees present early successes and challenges on topics identified by the grantees. The 2012-2013 call topics included asthma management best practices, integration of EHRs to support medical home transformation, improving access to oral health and methods for engaging patients in their care and self-management. The 2014 call topics included care coordination in rural areas, psychotropic medication prescribing practices for youth, and an update on the Children's EHR format. All grantees are required to submit semi-annual progress reports. The first report was submitted to CMS on August 1, 2011. Grantees will continue to submit semi-annual progress reports through the end of the grant program. The final report for each grantee is due to CMS 90 days after the grant ends.

- In December 2014, the CHIPRA Quality Demonstration Grantees attended the CMS Healthcare Quality Conference known as QualityNet. During the conference, grantees attended several sessions focused on sustaining grant activities beyond the grant period.

- The National Evaluation of the CHIPRA Quality Demonstrations conducted site visits to all 10 Grantee states in FY 2012 and launched The National Evaluation website, which is hosted by the AHRQ website. In early 2013, the National Evaluation team released its first evaluation highlight (http://www.ahrq.gov/policymakers/chipra/demoeval/highlights/highlight01.pdf). CMS has partnered with AHRQ and the National Evaluation team to complete nine evaluation focused on how grantees are implementing medical home models and strategies to improve adolescent health care, and to support the use of care coordinators. In addition, the National Evaluation team produced two implementation guides titled: Engaging Stakeholders to Improve the Quality of Children's Health care and Designing Care Management Entities for Youth with Complex Behavioral Health Needs. As the grant comes to a close. The National Evaluation team will work with AHRQ and CMS to develop updated grantee state profiles and a final evaluation report on lessons learned from the grantees.

State Allotment Funding History

FY 2011	$13,459,000,000
FY 2012	$14,982,000,000
FY 2013	$17,406,000,000
FY 2014	$19,147,000,000
FY 2015	$21,061,000,000

Budget Request

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) authorized and appropriated $40 billion for CHIP allotments to States, territories, commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113) authorized and appropriated additional funding for CHIP allotments to commonwealths and territories. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) authorized funding for States, commonwealths, and territories. Under this appropriation, funding to States increased by $44.0 billion above the baseline over five years. Additional provisions added through CHIPRA include Performance Bonus Payments, the Child Enrollment Contingency Fund and Child Health Quality Improvement in Medicaid and CHIP (discussed earlier in this chapter). Information regarding additional provisions provided by CHIPRA can be found in the State Grants and Demonstrations chapter. In addition to CHIPRA, the Affordable Care Act extends Federal funding for CHIP through FY 2015, appropriating $19,147,000,000 in FY 2014 and $21,061,000,000 in FY 2015.

CHIP Proposals

Permanently Extend Express Lane Eligibility Option for Children

The Children's Health Insurance Program Reauthorization Act (P.L. 111-3) authorized Express Lane Eligibility through FY 2014 under which state Medicaid or CHIP agencies can use another public program's eligibility findings to streamline eligibility and enrollment into Medicaid or CHIP. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) extended the authorization to use Express Lane Eligibility through September 30, 2015. As of January 1, 2015, 14 states and 1 territory used this authority to partner with programs like the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families to identify, enroll, and retain children who are eligible for Medicaid or CHIP. The Budget supports a permanent extension of this tool to aid states in furthering their efforts to enroll Medicaid and CHIP eligible children. [$1.2 billion including $490 million in CHIP costs over 10 years].

Extend CHIP Funding through FY 2019

The Budget proposes to extend funding for CHIP for four years through FY 2019, to ensure continued comprehensive and affordable coverage for CHIP children. This proposal would also extend the contingency fund and the performance bonus fund authorizations through 2019. The net federal cost of $11.9 billion[1] is paid for through an increase in tobacco taxes that will help reduce youth smoking and save lives.

[1] Includes $34.6 billion in costs to CHIP, $7.3 billion in savings to Medicaid, and $15.4 billion in savings to Marketplace subsidies and related impacts in U.S. Department of Treasury accounts.

FY 2016 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	Difference +/-
Alabama	$173,058,845	$149,456,860	$201,080,761	$51,623,901
Alaska	$21,847,065	$20,669,786	$30,552,861	$9,883,075
Arizona	$145,439,368	$69,733,343	$135,675,428	$65,942,085
Arkansas	$109,672,923	$81,241,605	$58,184,197	-$23,057,408
California	$1,377,293,364	$1,507,720,328	$2,636,385,684	$1,128,665,356
Colorado	$140,521,788	$136,161,881	$236,049,588	$99,887,707
Connecticut	$43,920,250	$41,550,520	$33,149,248	-$8,401,272
Delaware	$16,740,286	$17,514,392	$34,991,442	$17,477,050
District of Columbia	$16,307,193	$17,904,183	$18,889,418	$985,235
Florida	$382,280,490	$489,322,259	$750,913,650	$261,591,391
Georgia	$300,850,804	$354,914,592	$628,868,857	$273,954,265
Hawaii	$27,464,952	$40,038,478	$51,488,395	$11,449,917
Idaho	$38,212,225	$57,240,485	$51,863,984	-$5,376,501
Illinois	$292,847,277	$312,423,005	$521,922,669	$209,499,664
Indiana	$153,942,939	$140,794,618	$159,990,777	$19,196,159
Iowa	$98,296,803	$108,931,489	$152,809,628	$43,878,139
Kansas	$58,873,322	$73,604,658	$106,445,288	$32,840,630
Kentucky	$157,160,156	$148,612,022	$193,218,404	$44,606,382
Louisiana	$182,927,060	$155,720,915	$212,651,088	$56,930,173
Maine	$33,452,936	$23,652,206	$35,066,940	$11,414,734
Maryland	$170,538,555	$202,519,369	$269,218,886	$66,699,517
Massachusetts	$351,626,832	$357,692,389	$485,137,920	$127,445,531
Michigan	$58,233,410	$102,502,647	$148,537,189	$46,034,542
Minnesota	$34,093,646	$35,559,394	$24,596,212	-$10,963,182
Mississippi	$187,969,703	$195,520,375	$218,737,956	$23,217,581
Missouri	$130,658,477	$141,067,801	$216,240,478	$75,172,677
Montana	$68,222,552	$79,301,129	$129,608,492	$50,307,363
Nebraska	$64,379,146	$60,243,533	$112,763,020	$52,519,487
Nevada	$33,497,360	$37,262,373	$51,312,601	$14,050,228
New Hampshire	$19,336,448	$17,290,459	$22,837,599	$5,547,140
New Jersey	$680,332,783	$298,058,132	$447,111,616	$149,053,484
New Mexico	$132,016,200	$63,653,882	$109,380,102	$45,726,220
New York	$677,321,405	$840,932,139	$863,043,080	$22,110,941
North Carolina	$323,738,478	$341,474,350	$692,570,352	$351,096,002
North Dakota	$18,787,251	$18,151,422	$22,774,392	$4,622,970

FY 2016 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	**FY 2014 Actual**	**FY 2015 Estimate**	**FY 2016 Estimate**	**Difference +/-**
North Dakota	$18,787,251	$18,151,422	$22,774,392	$4,622,970
Ohio	$357,126,170	$296,310,345	$420,630,458	$124,320,113
Oklahoma	$121,936,988	$149,607,291	$199,652,683	$50,045,392
Oregon	$152,919,671	$167,301,124	$220,604,888	$53,303,764
Pennsylvania	$324,890,388	$320,818,103	$430,362,068	$109,543,965
Rhode Island	$41,984,303	$39,753,498	$75,262,919	$35,509,421
South Carolina	$104,749,415	$123,511,758	$165,895,208	$42,383,450
South Dakota	$20,761,872	$16,310,304	$23,493,402	$7,183,098
Tennessee	$212,945,074	$171,238,506	$311,164,545	$139,926,039
Texas	$955,760,207	$923,867,708	$1,536,929,338	$613,061,630
Utah	$66,844,336	$51,097,483	$90,424,002	$39,326,519
Vermont	$13,854,432	$13,471,924	$9,745,106	-$3,726,818
Virginia	$198,337,665	$214,026,900	$329,966,985	$115,940,085
Washington	$103,282,871	$111,473,692	$184,297,134	$72,823,442
West Virginia	$51,303,242	$47,760,648	$71,869,423	$24,108,775
Wisconsin	$109,462,826	$191,253,393	$220,982,669	$29,729,276
Wyoming	$11,522,755	$9,848,921	$11,610,858	$1,761,937
Subtotal	**9,569,544,507**	**9,586,088,617**	**14,366,959,890**	**$4,780,871,273**
Commonwealths and Territories				
American Samoa	$1,383,737	$1,466,033	$1,947,812	$481,779
Guam	$4,816,092	$5,102,525	$6,777,912	$1,675,387
Northern Mariana Islands	$992,712	$999,756	$1,403,241	$403,485
Puerto Rico	$140,979,029	$158,403,646	$191,856,496	$33,452,850
Virgin Islands	$0	$4,288,061	$0	-$4,288,061
Subtotal	**148,171,570**	**170,260,021**	**201,985,460**	**$31,725,439**
TOTAL RESOURCES	**$9,717,716,077**	**$9,756,348,638**	**$14,568,945,350**	**$4,812,596,712**

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

Performance Measurement

CMS is committed to improving quality of care and to increasing enrollment of eligible children in the CHIP program, as illustrated by our efforts to track and improve performance in those areas. Our past efforts have resulted in dramatic improvement in States' reporting of CHIP health quality performance information.

MCD6 Improve Children's Health Quality Across Medicaid and CHIP through Implementation of the CHIPRA Quality Initiatives: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary State collection, submission and reporting on child health quality measures. In collaboration with the Agency for Healthcare Research and Quality and States, CMS identified and published an initial core set (Child Core Set) of twenty-four children's quality measures. Section 1139A9b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the initial Child Core Set. In 2013, based on stakeholder feedback, CMS added three measures (HPV vaccinations for female adolescents; medication management for people with asthma, and behavioral risk assessment for pregnant women) and retired one measure (otitis media with effusion). In January 2014, CMS retired three measures: appropriate testing for children with pharyngitis (two to 18 years); annual pediatric hemoglobin A1C testing (five to 17 years); and annual percentage of asthma patients, who are two to 20 years old, with one or more asthma-related emergency department visits.[2] The 2015 Child Core Set was released through a December 2014 Informational Bulletin.

While the use of the Child Core Set is voluntary for States, CMS encourages all States to use the Child Core Set to collect and report data that will lead to improved health outcomes and to enhance the accuracy of data reported. In FY 2013, 88 percent of States reported on at least seven quality measures, exceeding the CMS target to work with States to ensure that 85 percent of States report on at least seven quality measures in the Child Core Set of measures. The FY 2016 target is to work with States to ensure that 90 percent of States report on at least ten measures in the Child Core Set.

CMS will continue to work with our Technical Assistance and Analytic Support (TA/AS) Program to provide States with specific clarifications on measurement collection questions; hold all-State webinars, as well as one-on-one calls with States, around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance, CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. Further, as the TA/AS program continues to mature, CMS is expanding the scope of the technical assistance to help States understand how to use the data they collect to drive quality improvement at the State and programmatic levels.

CHIP3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid: States submit quarterly and annual statistical forms, which report the number of children enrolled in Medicaid, separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year. CHIPRA, which provided CHIP funding through September 30, 2013, provides options to facilitate enrollment and retention of children in health coverage. The Affordable Care Act (ACA) provided CHIP funding through FY

[2] http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

2015 and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

This measure should be considered in the context of 2012 data that show that in 21 states[3] at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[4] In contrast, in 2008 five States had rates at or above 90 percent.[5] Many factors will affect enrollment in CHIP and Medicaid, including States' economic situations, and programmatic changes, and the reported enrollment results can be affected by the accuracy and timeliness of State reporting. In previous years, CMS set separate targets for Medicaid and CHIP. Beginning in FY 2013, we began to track combined Medicaid and CHIP enrollment. In 2013, 45,292,410 children were enrolled in Medicaid (37,198,483) and CHIP (8,093,927), falling short of our target of 45,592,385 children (Medicaid 37,246,233/CHIP 8,346,152). The FY 2016 target is to increase CHIP and Medicaid enrollment to 48,667,385[6] children, (Medicaid: 39,758,322/CHIP: 8,909,063), about 30 percent more children than were covered in FY 2008.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
MCD6 Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program	FY 2013: 88% of States reported on at least seven quality measures Target: Work with States to ensure that 85% of States report on at least seven quality measures in the CHIPRA core set of quality measures (Target exceeded)	Work with States to ensure that 90% of States report on at least nine quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90% of States report on at least ten quality measures in the CHIPRA core set of quality measures	+1 quality measure

[3] For the purposes of reporting, “States” refers to the 50 states and District of Columbia.
[4] http://www.insurekidsnow.gov/professionals/reports/index.html
[5] http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf
[6] Subject to CHIP reauthorization.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
CHIP3 Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid[7] FY 2008: 37,311,641 children (baseline)	FY 2013: 45,292,410 children (CHIP: 8,093,927/ Medicaid: 37,198,483) Target: 45,592,385 (CHIP 8,346,152/ Medicaid 37,246,233) (Target Not Met)	+28% over baseline 47,642,385 children (CHIP: 8,721,426/ Medicaid 38,920,959)	+30% over baseline 48,667,385 children (CHIP 8,909,063 Medicaid 39,758,322)	+1,025,000 children

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

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State Grants and Demonstrations

(Budget Authority Dollars in Thousands)

Program	FY 2014 Actual	FY 2015 President's Budget	FY 2016 Estimate	FY 2016 +/- FY 2015
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$0	$0	$0	$0
Subtotal – TWWIIA	**$0**	**$0**	**$0**	**$0**
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Alternatives to Psychiatric Residential Treatment Facilities for Children	$0	$0	$0	$0
Money Follows the Person (MFP) Demonstration[1]	$416,579	$416,130	$448,900	$32,770
MFP Research & Evaluations[2]	$1,021	$1,020	$1,100	$80
Medicaid Integrity Program[3]	$75,630	$76,757	$83,878	$7,121
Medicaid Integrity Program-Proposed	$0	$0	$25,000	$25,000
Subtotal – DRA	**$493,230**	**$493,907**	**$558,878**	**$64,971**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment[4]	$0	$0	$0	$0
Application of Prospective Payment System	$0	$0	$0	$0
Subtotal – CHIPRA	**$0**	**$0**	**$0**	**$0**
Affordable Care Act				
Medicaid Emergency Psychiatric Demonstration Project	$0	$0	$0	$0
Medicaid Incentives for Prevention of Chronic Diseases	$0	$0	$0	$0
Subtotal – Affordable Care Act	**$0**	**$0**	**$0**	**$0**
SGR Extender Bill				
Programs to Improve Mental Health Services	$2,000	$0	$25,000	$25,000
Appropriations/BA	**$495,230**	**$493,907**	**$583,878**	**$89,971**

[1] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2014 and FY 2015 columns reflect post-sequestration amounts.
[2] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2014 and FY 2015 columns reflect post-sequestration amounts.
[3] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2014 and FY 2015 columns reflect post-sequestration amounts.
[4] P.L. 111-148 extended the availability of these funds through FY 2015.

Authorizing Legislation - Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170; Medicare Modernization Act of 2003, Public Law 108-173; Deficit Reduction Act of 2005, Public Law 109-171; Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3; Affordable Care Act, Public Law 111-148 together with Public Law 111-152; Protecting Access to Medicare Act of 2014, Public Law 113-93

Allocation Method - Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The grants assist in providing State infrastructure support and services to targeted populations. Targeted populations include working individuals with disabilities, undocumented aliens, and other eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight and resources to combat fraud, waste and abuse; improving the effectiveness and efficiency in providing Medicaid; establishing alternate non-emergency service providers; and modernizing Medicaid programs to be more sustainable while helping individuals achieve independence. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two programs: an outreach grant program to increase children's enrollment and retention in Medicaid and the Children's Health Insurance Program (CHIP), and transition grants for the application of the Medicaid prospective payment system for services provided by Federally-qualified health centers and rural health clinics. The Affordable Care Act established two programs, the Medicaid Emergency Psychiatric Demonstration Project and Incentives for Prevention of Chronic Diseases in Medicaid and extended several existing programs.

Funding History

FY 2011	$807,816,000
FY 2012	$528,334,000
FY 2013	$503,173,000
FY 2014	$495,230,000
FY 2015	$493,907,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration programs, determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT GRANT PROGRAMS

Program Description and Accomplishments

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA - P.L. 106-170) established two grant programs starting in FY 2001: the Medicaid Infrastructure Grants and the Demonstration to Maintain Independence and Employment (DMIE). By statute, funding for new grant awards for the DMIE program ended on September 30, 2009.

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants (MIG), section 203 of the TWWIIA, provides funding to States to build the infrastructure necessary to support working individuals with disabilities. This infrastructure includes:

- Increased outreach on Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs on Medicaid and other work incentives.

A major goal of the program is to support the expansion of Medicaid coverage for workers with disabilities (also known as “Medicaid buy-in”). With this infrastructure funding, States make systemic changes to help individuals with disabilities gain employment and retain their health care coverage. These changes include, but are not limited to, creating Medicaid buy-in programs and enhancing State personal assistance service programs.

Through FY 2010, a total of 50 entities (49 States and the District of Columbia) had been approved for Medicaid Infrastructure Grants. Thirty-eight of these States had created Medicaid buy-in programs for working adults with disabilities. As of December 2010, there were approximately 177,000 workers receiving Medicaid benefits under the buy-in options. A total of 18 States applied for and received 2011 MIG continuation grant awards. Twenty-five States and the District of Columbia received new 2011 MIG competitive grant awards. FY 2011 marked the final year for this program.

Budget Overview

The Medicaid Infrastructure Grant Program (section 203) was authorized for 11 years beginning in fiscal year 2001 with an appropriation of $150,000,000 for the first 5 years. Beginning in FY 2006, the funding level is tied to the consumer price index for all urban consumers (CPI-U). Of the $42.8 million appropriated for FY 2007, $35.6 million had been granted to the States as of July 30, 2007. Of the $44 million appropriated for FY 2008, $40.3 million had been granted to States. Of the $45 million appropriated in FY 2009, $64.5 million had been granted to States (which included $19.5 million in carryover funding from previous years). In FY 2010, section 203 of TWWIIA authorized and appropriated $46 million, $74.6 million was granted to States (which includes 28.6 million in carryover funding from previous years). In FY 2011, section 203 of TWWIIA authorized and appropriated $46.5 million for 100 percent Federally-funded Medicaid Infrastructure Grants to States.

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Grant Awards*
Alabama	$3,625,000	$500,000	$500,000	$750,000
Alaska	$3,675,000	$750,000	$700,000	$750,000
Arizona	$500,000	$750,000	$750,000	$750,000
Arkansas	$1,544,950	$682,000	$745,116	$633,556
California	$10,099,274	$2,640,006	$4,028,900	$3,166,715
Colorado	$500,000	$0	$750,000	$743,328
Connecticut	$14,510,205	$4,631,665	$7,260,844	$5,666,161
DC	$3,400,860	$750,000	$750,000	$750,000
Delaware	$1,000,000	$0	$0	$0
Florida	$1,650,000	$750,000	$750,000	$750,000
Georgia	$1,125,000	$0	$0	$500,000
Hawaii	$2,000,000	$750,000	$750,000	$750,000
Idaho	$1,625,000	$500,000	$750,000	$750,000
Illinois	$3,725,001	$500,000	$500,000	$500,000
Indiana	$2,450,000	$750,000	$1,443,000	$1,443,000
Iowa	$5,533,450	$744,000	$750,000	$750,000
Kansas	$4,815,277	$750,000	$959,627	$1,139,136
Kentucky	$500,000	$0	$0	$0
Louisiana	$3,600,000	$750,000	$1,700,000	$900,000
Maine	$4,702,003	$750,000	$870,000	$750,000
Maryland	$2,525,440	$600,000	$750,000	$750,000
Massachusetts	$14,236,084	$5,600,409	$6,353,521	$4,993,868
Michigan	$2,262,000	$750,000	$1,320,000	$1,320,000
Minnesota	$14,256,400	$5,434,648	$6,089,210	$4,605,603
Mississippi	$500,000	$0	$0	$0
Missouri	$3,125,000	$0	$0	$0
Montana	$1,000,000	$750,000	$750,000	$750,000
Nebraska	$4,175,000	No-cost extension	$750,000	$750,000
Nevada	$4,175,000	$500,000	$750,000	$750,000
New Hampshire	$7,033,998	$1,480,863	$2,357,893	$2,033,304
New Jersey	$3,775,000	$500,000	$1,754,890	$1,482,451
New Mexico	$5,356,068	$1,592,000	$1,540,000	$1,500,000
New York	$1,811,689	$5,992,413	$5,992,413	$4,710,037
North Carolina	$2,349,339	$600,000	$600,000	$750,000
North Dakota	$359,177	$750,000	$750,000	$750,000
Ohio	$2,786,416	$500,000	$500,000	$653,500
Oklahoma	$1,045,053	$0	$0	$0
Oregon	$4,373,563	$750,000	$935,000	$1,500,000
Pennsylvania	$2,946,470	$5,327,141	$5,327,000	$4,187,133
Rhode Island	$3,625,000	$750,000	$750,000	$750,000
South Carolina	$1,799,647	$0	$0	$0
South Dakota	$3,500,000	$500,000	$581,289	$520,600
Texas	$1,500,000	$750,000	$750,000	$750,000
Utah	$4,225,000	$750,000	$750,000	$750,000
Vermont	$4,505,000	$750,000	$750,000	$750,000
Virginia	$3,500,000	$750,000	$750,000	$750,000
Washington	$3,100,000	$750,000	$750,000	$750,000
West Virginia	$3,625,000	$750,000	$750,000	$750,000
Wisconsin	$22,253,336	$9,881,187	$12,846,137	$7,635,582
Wyoming	$2,050,000	$750,000	$750,000	$750,000
TOTAL	**$202,355,700**	**$64,456,332**	**$79,904,840**	**$67,083,974**

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Program Description and Accomplishments

Authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA), Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, provides funding to hospitals, physicians, and ambulance suppliers for their un-reimbursed costs of furnishing emergency health services to undocumented and certain other aliens. Payment of Section 1011 funds is limited to services required by section 1867 of the Social Security Act (Emergency Medical Treatment and Labor Act (EMTALA))[5] and related services. Section 1011 provided $250 million per year during each of Federal fiscal years 2005 through 2008.

As of November 2014, Section 1011 provided funding to a total of 2,274 hospitals, 49,340 physicians, and 538 ambulance providers. Since inception of the program in May 2005 through November 2014, Section 1011 has disbursed $974 million in provider payments, in response to 1,479,595 payment requests.

Providers may seek reimbursement for emergency services provided to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa. Eligible hospitals include hospitals with EMTALA obligations (generally, Medicare-participating hospitals that have emergency departments), including critical access hospitals and Indian Health Service facilities, whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as described in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Eligible physicians include doctors of medicine, doctors of osteopathy, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, doctors of optometry, chiropractors or doctors of dental surgery. Eligible ambulance suppliers include State-licensed providers of ambulance services.

Budget Overview

Section 1011 of the MMA appropriated $250 million per year during each of fiscal years 2005 through 2008. Individual State allocations, for each year of appropriation, are based on data provided by the Department of Homeland Security (DHS). Two-thirds of total funds ($167 million) were allocated to all 50 States and the District of Columbia, based on their relative percentages of the estimated total number of undocumented aliens nationwide. The remaining one-third ($83 million) was allocated to the six States with the largest number of DHS undocumented alien apprehensions. Funds appropriated shall remain available until expended.

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[5] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals participating in Medicare to medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those having an emergency condition, regardless of an individual's method of payment or insurance status.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVE TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Program Description and Accomplishments

Over the last decade, psychiatric residential treatment facilities (PRTFs) have become the primary provider for children and youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities, States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to institutional care which would provide services that would enable children and youth to be diverted from institutionalization or transition out of PRTFs back to their homes and with their families.

Section 6063 of the DRA addressed this issue by authorizing up to ten States to develop demonstration programs that provide home and community-based waiver services to youth as alternatives to institutionalization in PRTFs. To participate in this demonstration, Medicaid eligible individuals must be 21 years of age or younger and require the need for a PRTF level of care as defined in the State's Medicaid State plan.

This demonstration program has been evaluated and has improved or maintained functional outcomes for children and youth participating in the demonstration. The common theme across all State grantees is that children and youth with the highest level of needs at baseline benefited the most from participating in the demonstration waiver. These children showed the most improvement, across the most domains, and over the most follow-up periods. The demonstration was also cost effective. The savings have been consistent across all State grantees and through all waiver years. In July 2013, CMS issued a Report to Congress highlighting the evaluation results, including an average savings of 68 percent with waiver services costing only 32 percent of comparable services provided in PRTFs. These findings are quite positive and reflect the need for a more permanent format for home and community-based services (HCBS) mental health programs for children and youth.

The ten participating States submitted a 5-year, web-based 1915(c) demonstration waiver application as the grant implementation plan. Nine States have approved 1915(c) demonstration waivers. While Florida was awarded a grant, due to budget cuts in the State, Florida rescinded their grant and their grant award was returned to the demonstration grant appropriation. All nine States with approved waivers have provided waiver services 5,314 children and youth as of September 30, 2012. The demonstration services ended as of September 30, 2012.

The table below shows the total five year commitment for the grant awards funded in FY 2007-2011 by State.

Budget Overview

The DRA provided ten States with up to $218 million for a period of five years (appropriations through FY 2011) to develop demonstration programs. One million dollars of the project funding is made available for required interim and final evaluation reports.

CMS has made awards totaling $191 million to participating States for the demonstration project period, less the rescission by Florida of $2.1 million, leaving a total awarded to States of over $191.9 million. CMS also awarded a contract for the national evaluation in April 2007 for $904,422 and a modification in the amount of $93,690 in FY 2008 totaling $998,112.

The DRA authorized and appropriated $37 million for FY 2008, $49 million in FY 2009, $53 million in FY 2010, and $57 million in FY 2011. CMS also provided grant funding matching the increased FMAP provided for in the American Reinvestment and Recovery Act (ARRA) of 2009 during the recovery period. States received their final supplemental funding award in September 2011 that covered the period October 1, 2011 through September 30, 2014. Funding provided in FY 2011 is available to serve children and youth in FY 2012 and claims for services provided in FY 2012 will require funding from the FY 2011 appropriation through FY 2014 (federal assistance is available for up to two years from the date of service for claims).

State	Total PRTF Appropriation	Original Program Funding Commitment	FY 07-11 Supplemental Awards
AK		$8,927,571	$7,165,217
IN		$25,139,967	$41,652,061
MT		$5,184,455	$8,848,070
MS		$56,603,183	$63,396,017
VA		$18,705,337	$5,580,920
KS		$17,978,247	$5,940,574
MD		$10,410,333	$30,441,069
SC		$22,808,864	$9,226,436
GA		$22,614,239	$19,708,997
Totals	**$218,000,000**	**$188,372,196**	**$191,959,361**

Some States received larger supplemental awards to serve additional children and youth as they amended their 1915(c) demonstration waiver unduplicated counts. This grant is in the close out period and final reports are due 90 days after September 30,2014.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of Section 6071 of the DRA, as amended by Section 2403 of the Affordable Care Act, States have options to rebalance their long-term support

programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve independence. Specifically, the MFP demonstration supports State efforts to:

- Rebalance their long-term services and supports system so that individuals have a choice of where they live and receive services;
- Transition individuals from institutions who want to live in the community; and,
- Implement a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

The demonstration provides for enhanced Federal Medical Assistance Percentage (FMAP) for 365 days for qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. Eligibility for participation in the demonstration was modified by the Affordable Care Act. Individuals must reside in a qualified institution for at least 90 days before they transition to the community, with the exception that any days an individual resides in an institution solely for the purpose of short-term rehabilitative services for which payment is limited under Medicare are excluded. In addition, States must continue to provide community-based services after the 365 day demonstration period for as long as the individual needs community services and is Medicaid eligible.

The table on the following page shows grant awards that were made in FY 2007-FY 2014. The Affordable Care Act amended the Deficit Reduction Act by extending MFP grant demonstration through FY 2016 and included $2.25 billion additional funding to allow continuation of existing demonstrations and participation by new States.

The CMS Money Follows the Person (MFP) Tribal Initiative (TI) offers existing MFP State grantees and tribal partners the resources to build sustainable community-based long term services and supports (CB-LTSS) specifically for Indian Tribes. The TI may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives (AI/AN) using a single, or a variety of applicable Medicaid authorities. In April 2014, CMS awarded a total of $1.48 million to five MFP grantees for the first phase of the program development. The amounts in the chart on the following page are inclusive of these supplemental awards.

According to the December 2013 Overview of State Grantee Progress Report, program transitions for the period from January 1, 2013 through December 31, 2013 represents just under 35 percent of all transitions since the beginning of the program. To serve a participant in the program costs half as much as the cost of care in an institution. The rebalancing funds that are generated by the program have helped states expand and improve their home and community based service programs.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.75 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. The provision appropriated $250 million for FY 2007, $300 million in FY 2008 and $350 million in FY 2009, $400 million in FY 2010, $450 million in FY 2011. Section 2403 of the Affordable Care Act of 2010 amended the Deficit Reduction Act providing $450 million in each fiscal year from 2012-2016, totaling an additional $2.25 billion. In accordance with the

sequestration report dated March 1, 2013, the funding for the MFP demonstrations and evaluation was reduced by 5.1 percent in FY 2013 and 7.2 percent in FY 2014. The adjusted FY 2013 appropriation is $427 million and the FY 2014 appropriation is $418 million. The FY 2015 appropriation is $450 million. The FY 2016 appropriation is $450 million. States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50 percent of the State share, capped at 90 percent. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and four additional fiscal years. This allows States to expend MFP funding awarded in FY 2016 through FY 2020 through no cost extensions.

CMS has also provided grantees grant funding matching the increased FMAP provided for in the Recovery Act of 2009 for service claims for the allowable nine fiscal quarters and is reflected in the chart below.

Of the original DRA appropriation of $1.75 billion, a total of $2.4 million was made available in fiscal years 2007 and 2008 to carry out technical assistance for, and oversight of, States efforts to improve quality under HCBS waivers and $1.1 million per year for evaluation and reporting to Congress. In addition, Section 2403 of the Affordable Care Act authorizes $1.1 million from each year's appropriation in FY 2012 through FY 2016 that may be used to carry out evaluation and a required Report to Congress.

As of November 2014, CMS obligated $1,733,474,120 in grants to 44 States and the District of Columbia (DC). Grantees have transitioned over 40,693 individuals as of December 2013. The 44 participating States and DC have proposed to transition an additional 25,816 individuals out of institutional settings through 2016.

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION			
State Name	***Cumulative Award Total 2007-2014***	***Budget Projections 2014-2020***	***Total Project Funds*** ***(cumulative award plus budget projections)***
Alabama	**$3,955,677**	**$21,819,996**	**$25,775,673**
Arkansas	**$30,421,039**	**$38,367,116**	**$68,788,155**
California	**$82,782,164**	**$211,901,289**	**$294,683,453**
Colorado	**$4,805,393**	**$28,533,162**	**$33,338,555**
Connecticut	**$75,553,386**	**$113,269,270**	**$188,822,656**
District of Columbia	**$21,593,213**	**$10,937,868**	**$32,531,081**
Delaware	**$7,709,652**	**$3,092,871**	**$10,802,523**
Georgia	**$93,064,243**	**$369,308,730**	**$462,372,973**
Hawaii	**$5,916,710**	**$10,517,542**	**$16,434,252**
Idaho	**$8,344,718**	**$7,387,132**	**$15,731,850**
Iowa	**$31,623,965**	**$18,136,740**	**$49,760,705**

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION			
State Name	***Cumulative Award Total 2007-2014***	***Budget Projections 2014-2020***	***Total Project Funds*** ***(cumulative award plus budget projections)***
Illinois	**$20,649,151**	**$64,548,507**	**$85,197,658**
Indiana	**$34,975,945**	**$82,350,030**	**$117,325,975**
Kansas	**$47,581,582**	**$20,620,395**	**$68,201,977**
Kentucky	**$47,438,477**	**$178,207,958**	**$225,646,435**
Louisiana	**$26,235,286**	**$63,720,631**	**$89,955,917**
Maine	**$4,499,925**	**$4,807,762**	**$9,307,687**
Maryland	**$92,378,196**	**$83,535,371**	**$175,913,567**
Massachusetts	**$36,716,171**	**$160,123,797**	**$196,839,968**
Michigan	**$51,507,308**	**$35,488,125**	**$86,995,433**
Minnesota	**$20,559,703**	**$200,429,367**	**$220,989,070**
Mississippi	**$10,208,385**	**$29,114,578**	**$39,322,963**
Missouri	**$44,586,559**	**$34,686,962**	**$79,273,521**
Montana	**$2,684,302**	**$9,812,318**	**$12,496,620**
North Carolina	**$18,835,966**	**$26,985,618**	**$45,821,584**
North Dakota	**$18,473,232**	**$44,101,319**	**$62,574,551**
Nebraska	**$12,196,402**	**$19,061,977**	**$31,258,379**
Nevada	**$4,989,657**	**$5,402,999**	**$10,392,656**
New Hampshire	**$10,753,380**	**$8,860,468**	**$19,613,848**
New Jersey	**$51,907,060**	**$82,986,721**	**$134,893,781**
New York	**$85,226,579**	**$156,000,749**	**$241,227,328**
Ohio	**$131,008,152**	**$131,217,974**	**$262,226,126**
Oklahoma	**$33,816,220**	**$11,651,163**	**$45,467,383**
Oregon	**$31,269,191**	**$52,554,896**	**$83,824,087**
Pennsylvania	**$60,549,496**	**$159,503,649**	**$220,053,145**
Rhode Island	**$4,536,368**	**$21,329,677**	**$25,866,045**
South Carolina	**$2,270,084**	**$15,023,324**	**$17,293,408**
South Dakota	**$1,323,044**	**$2,828,328**	**$4,151,372**
Tennessee	**$39,820,667**	**$142,368,312**	**$182,188,979**
Texas	**$267,201,174**	**$119,385,630**	**$386,586,804**
Vermont	**$5,765,811**	**$11,906,656**	**$17,672,467**
Virginia	**$40,653,136**	**$27,967,993**	**$68,621,129**
Washington	**$99,521,725**	**$136,090,794**	**$235,612,519**
West Virginia	**$6,114,959**	**$32,779,491**	**$38,894,450**
Wisconsin	**$27,757,903**	**$22,124,801**	**$49,882,704**
Totals	**$1,733,474,120**	**$3,030,850,056**	**$4,790,631,412**

NOTE: States may exceed their original request for funding by surpassing their benchmarks and transitioning additional participants into home and community-based services.

New Mexico rescinded the grant in January 2012; Florida rescinded the grant in August 2013.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171) established the Medicaid Integrity Program in Section 1936 of the Social Security Act (the Act). With the passage of this legislation, Congress provided the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program. While the Medicaid Integrity Program represents CMS' first national strategy to detect and prevent Medicaid fraud, waste, and abuse, other Medicaid program integrity activities are funded through the Health Care Fraud and Abuse Control Program (HCFAC) and are discussed in the HCFAC chapter.

CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste, and abuse beginning in Fiscal Year (FY) 2006. The first CMIP was published in July 2006, and covered FYs 2006 through 2018. The most recent CMIP was released in July 2014 and covers FYs 2014 through 2018. The FY 2014-2018 CMIP is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf.

The Medicaid Integrity Program has achieved a number of clear successes since the start of the program in 2006.

The National Medicaid Audit Program (NMAP)

Congress mandated that CMS enter into contractual agreements with eligible entities to do the following:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and,
- Conduct education of State or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

The contractors that perform these functions have historically been known as Medicaid Integrity Contractors (MICs). In December 2007, CMS awarded umbrella contracts, and contractors began conducting provider reviews and audits in September 2008 as part of the NMAP.

In the last few years, CMS has redesigned the NMAP and significantly increased identified overpayments by focusing on collaborative audit projects with the States. This approach replaced an earlier type of federal audit, and instead uses more timely claims data residing with each State's Medicaid Management Information System (MMIS). Collaborative audits using State-level data have proven to be an effective way to coordinate Federal and State audit efforts and resources to better meet States' needs, resulting in more timely and accurate audits. By the end of FY 2014, CMS had assigned a cumulative total of 703 collaborative audits with 40 States that represent approximately 87 percent of Medicaid program expenditures. As a result of continued improvements in the audit program, CMS identified $24.6 million in overpayments in FY 2014, of which $19.9 million were overpayments identified by collaborative audits..

CMS is reconfiguring its approach to the review and audit of Medicaid providers by developing a Unified Program Integrity Contractor (UPIC) strategy that restructures and consolidates the current Medicare and Medicaid program integrity audit and investigation work. This reconfiguration focuses on efficient contractor structure and improved coordination between Medicare and Medicaid contractors and States. The UPIC concept consolidates the work of the MICs and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data Match activities. The overarching goal of the UPIC is to integrate these program integrity functions by implementing a contracting strategy that rationalizes our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners, including States.

Medicaid Integrity Institute (MII)

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

The MII has been cited repeatedly by States, the Government Accountability Office (GAO), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association for Medicaid Program Integrity (NAMPI), and the National Association of Medicaid Directors (NAMD) as making a substantial contribution to State efforts to combat fraud and improper payments. From its inception in 2008 through the end of FY 2014, the MII has trained State employees from all 50 States, the District of Columbia, and Puerto Rico through more than 5,100 enrollments in 114 courses and 8 workgroups. In FY 2014 alone, the MII conducted 19 courses and two workgroup meetings with 909 enrollments. The MII developed a distance learning program in addition to its classroom activities, and sponsored 11 webinars in FY 2013 and 9 webinars in FY 2014 to extend its training capacity to even more State program integrity staff. The MII also began offering a credentialing program for State Medicaid program integrity employees to certify their professional qualifications. By the end of FY 2014, 153 State employees in 41 States had received the credential of Certified Program Integrity Professional. In addition, the MII supports a secure, web-based information sharing system called the Regional Information Sharing System (RISS) that all States may use to exchange documents, questions and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance within the DOJ. In the coming years, CMS plans to enhance the educational opportunities provided through the MII by expanding course offerings and other training opportunities.

State Program Integrity Reviews

Since 2007, CMS has conducted triennial comprehensive State program integrity reviews, which assess each State's Medicaid program integrity vulnerabilities and best practices. By the end of FY 2013, CMS completed 110 comprehensive program integrity reviews, including each State, Puerto Rico and the District of Columbia at least twice. In FY 2013, comprehensive reviews were conducted for 14 States. FY 2014 represents a transition period in the assessment of State program integrity activities. During FY 2014 CMS will conduct focused reviews of high-risk program integrity areas rather than comprehensive State reviews. Focused reviews will examine areas such as managed care in Medicaid expansion States, enhanced provider screening and enrollment activities required by the Affordable Care Act, and personal care services. CMS plans to assess the comprehensive State program integrity review process and possibly implement a new process beginning in FY 2015. CMS has hosted conference calls with States to discuss program integrity issues and best practices, issued guidance on policy and regulatory issues, and published annual reports of program integrity best practices that have been of considerable value to States.

Technical Assistance to States

The Medicaid Integrity Program provides additional support to States through technical assistance from CMS staff and through contracted educational activities. For example, CMS has provided personnel and other resources to augment State Medicaid staff during field investigations designed to target identified and documented high-risk fraud and abuse situations with saturated enforcement actions. CMS also assists in the education of Medicaid providers, beneficiaries and Managed Care Organizations (MCOs) on program integrity efforts by employing an Education MIC to develop materials, conduct training, provide educational resources to educate providers, beneficiaries, MCOs and stakeholders, promote best practices and fraud and compliance awareness, and encourage Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. In September 2013, CMS launched a new online resource for Medicaid program integrity education (http://www.cms.gov/Medicare-Medicaid- Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html). The website includes a wide array of resources using a variety of media including print and electronic formats, toolkits, train-the-trainer guides, webinars, YouTube videos, email blast, social media post and other innovative strategies. The current 14 educational toolkits cover topics such as managed care compliance, pharmacy education, drug diversion, off-label pharmaceutical marketing, dental professional compliance, personal care services, nursing home compliance, safeguarding your medical identity, documentation matter, beneficiary card sharing, and fraud awareness and reporting. In addition to these online resources, the CMS education contractor has conducted webinars on these topics which have been attended by program integrity staff from Medicaid programs from all 50 States, Puerto Rico and the District of Columbia. State staff are trained to use the above train-the-trainer resources to conduct ongoing education for their co-workers' providers, beneficiaries and MCOs in their States.

In the last few years, CMS has continued to expand support for provider enrollment and screening by State Medicaid programs. The Affordable Care Act and Social Security Act § 1902 allows States to rely on Medicare Fee For Service provider enrollment screening and coordination between State programs for terminated providers. CMS continues to facilitate the exchange of information between Medicare and all States about providers who have been terminated for cause – allowing Medicare and other State agencies to take action on those providers. To reduce provider burden and avoid duplication of efforts, CMS

provides States access to the Medicare Enrollment System (PECOS), and data files with key data about providers to support State screening and enrollment efforts. The data sharing files have been downloaded 1,174 times by participating States from January - June 2014, and at the most recent PECOS training offered by CMS, 143 participants from States were in attendance. CMS is also continually providing States educational support through MII.

Medicaid and CHIP Business Information Solutions (MACBIS)

Begun in 2009, MACBIS is a CMS enterprise-wide initiative to ensure the data infrastructure and information technologies that support Medicaid and CHIP are commensurate to their role as the nation's largest health insurer. Today, the data that is available at the Federal level for the Medicaid and CHIP programs is incomplete, not timely, and of questionable quality. To address the well-documented issues with Federal Medicaid and CHIP data, the CMS MACBIS Council implemented several short- and medium-term efforts to incrementally improve both the data and access to the data, as well as to explore long term opportunities for making radical improvements. The MACBIS Council identified two key transformational efforts:

- The Medicaid and CHIP Program (MACPro) System modernizes the work flows and business processes that support online submission, review and approval of State Plan Amendments (SPAs), waivers, and Advance Planning Documents (APDs). Once in place, the system will provide up-to-date data on programmatic features of Medicaid and CHIP as implemented by States.

- Transformed Medicaid Statistical Information System (T-MSIS) modernizes and enhances the way States submit operational data about beneficiaries, providers, claims, and encounters and will build a robust State and national analytic data infrastructure. Future releases of T-MSIS will incorporate calculation of quality measures and performance indicators.

Robust and timely data of this nature is crucial to identifying potential fraud, waste and abuse in the Medicaid and CHIP programs. In addition, the transformed infrastructure will offer States, CMS and others the ability to do the following at the national level:

- Study encounters, claims, and enrollment data by claim and beneficiary attributes;
- Analyze expenditures by medical assistance and administration categories;
- Monitor and track review processes for state submissions such as SPAs and waivers;
- Monitor expenditures within delivery systems and assess the impact of different types of delivery system on beneficiary outcomes;
- Examine the enrollment, service provision, and expenditure experience of providers who participate in our programs (as well as in Medicare);
- Observe trends or patterns indicating potential fraud, waste, and abuse in the program so we can prevent or mitigate the impact of these activities; and,
- Use informatics to improve program oversight and inform future policy and operational decisions.

The following milestones have been achieved in 2014:

- Refined the requirements, worked with stakeholders, developed the T-MSIS

application, tested state data files, and worked on data quality received from the states.

- As part of the development process, built File Receipt and Control, Business Rules Management, and Business Intelligence/Data Analytics modules. Engaged a contractor to provide technical assistance to the states in creating the state data files, defect/error triage and data quality improvement.
- Begun refining the T-MSIS data warehouse to store data received from the states. This data warehouse is the source of business intelligence and data analytic activities by both internal and external CMS stakeholders.
- Forty-one states are in the process of testing with CMS. This testing involves the states submitting data files that encompass Claims, Eligibility, Third-party, and Managed Care information. The state data files are processed through receipt and control and then through 3-levels of business rules. The states receive Acknowledgement, Error Summary, and Error Report Files.
- Using these error reports, the states work with CMS and the technical assistance contractor in reducing errors and improving the quality of the data submitted.

Budget Overview

The DRA appropriated $5 million in FY 2006, $50 million in fiscal years 2007 and 2008 respectively, and $75 million in FY 2009 and each year thereafter for the Medicaid Integrity Program. Beginning in FY 2011, Section 1303(b)(3) of P.L. 111-152 adjusts this funding by the percentage increase in the CPI-U annually. The FY 2011 appropriation was $76.3 million, and the appropriation for FY 2012 is $78.3 million. The FY 2013 enacted appropriation was $78.3 million with a CPI-U adjustment of 2.4 percent, bringing the total to $80.2 million. Sequestration reduced the FY 2013 total by 5.1 percent, bringing the new budget authority to $76.1 million. Consequently, the FY 2014 enacted appropriation was $80.2 million with a CPI-U adjustment of 1.6 percent, bringing the total new budget authority to $81.5 million. The FY 2014 budget authority was reduced by 7.2 percent due to sequestration, bringing the final budget authority to $75.6 million. The FY 2015 appropriation is $81.5 million with a CPI-U adjustment of 1.6 percent, bringing the total budget authority to $82.8 million. The FY 2015 budget authority was reduced by 7.3 percent due to sequestration, bringing the final budget authority to $76.7 million. The FY 2016 budget authority will be $82.8 million with an estimated CPI-U adjustment of 1.3 percent, bringing the total budget request to $83.9 million. The CPI-U adjustments are based on the current FY 2016 President's Budget economic assumptions. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

Section 201 of CHIPRA provided $100 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Affordable Care Act (ACA) provided an additional $40 million. These programs will conduct

outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid or CHIP.

Outreach and Enrollment Grants

The grants provided outreach and application assistance to enroll eligible, uninsured in CHIP and Medicaid, with a particular focus on children who are the most difficult to reach and enroll. Recognizing that traditional methods of outreach had not been effective with these children and families, CHIPRA funding was provided to develop specialized strategies to target these children by organizations that would have access to and credibility with families in the communities in which these eligible but uncovered children resided.

Of the $100 million provided by section 201 of CHIPRA, $90 million was appropriated for the Outreach and Enrollment Grants (with $10 million of the $90 million specifically dedicated to outreach and enrollment of American Indian/Alaska Native children (AI/AN). The first $40 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40 million in Federal funds across 41 States and the District of Columbia. On August 18, 2011 CMS awarded an additional $40 million in grant funds to 39 grantees across 23 States. These grants, entitled CHIPRA Outreach and Enrollment Grants (Cycle II) encouraged applicants to take a more systematic approach to outreach, enrollment and retention. Grantees focused on five specific areas that have been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

CMS awarded a third round of outreach and enrollment grants (a total of $32 million) entitled Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) in July 2013 from the $36 million, dedicated to grant funding, appropriated through the ACA Grantees focus on five specific areas. These areas support outreach strategies similar to those conducted in Cycles I and II and also fund activities designed to help families understand new application procedures and health coverage opportunities, including Medicaid, CHIP and insurance affordability programs under the ACA.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Outreach to Indian Children

The authorizing statute for this program sets aside ten percent of appropriations to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible AI/AN children in Medicaid and CHIP. On April 15, 2010, CMS awarded 41 grants for a total of $9,902,105. CMS awarded a second round of Outreach and Enrollment Grants, totaling $3.9 million, from the $4 million appropriated through the ACA, to organizations serving Indian children on November,12 2014.

National Enrollment Campaign

The statute sets aside 10 percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. Through the Connecting Kids to Coverage National Campaign, CMS has developed materials, such as posters, palmcards and public service announcements, which include a call to action to

enroll and retain children in Medicaid and CHIP, as well as their parents in Medicaid. Campaign efforts have enhanced communications in target markets and with states, grantees, and other groups working on outreach and enrollment efforts through educational webinars and by distributing free tools that can be easily adapted to support these efforts.

A suite of general campaign materials were developed in 2013 around three waves of outreach to engage national, state and local partners to reach out to families with eligible children and teens: Winter Wave (February to March, 2013), Allergies and Asthma (April to May, 2013) and Back-to-School (July to August, 2013). The waves were designed to focus on enrollment and retention of coverage. A Spring Wave, launched in May 2014 once Marketplace Open Enrollment ended, promoted year round enrollment in Medicaid and CHIP and featured a web video, radio public service announcements in English and Spanish, flyer and social media graphics. CMS launched an Oral Health Initiative and set goals for improvement by FY 2015. Materials, including an oral health tear pad for pregnant women and a flyer for parents of infants and toddlers, were developed. Additional materials developed in FY 2014, include a flyer featuring teens and a oral health tear pad for school-aged children.

CMS launched Connecting Kids to Coverage National Campaign in English and Spanish television and radio public service announcements in May 2013. Messaging was framed around giving parents the peace of mind and security that comes from knowing they can find quality, affordable health coverage for their children. Core messages are aimed at educating families about the availability and affordability of health coverage, the valuable benefits offered (e.g., check-ups, hospital visits, emergency services, prescriptions, etc.) and how to get enrolled. The PSAs were distributed nationally and aired more than 90,000 times in187 markets out of 210 during the first year. These pro-bono airings generated more than $8 million in advertising equivalent dollar value. The PSAs were re-distributed in June 2014 to include the year round enrollment messaging.

Remaining FY 2015 funds will be used to extend the Connecting Kids to Coverage National Campaign through August 2015. CMS will use outreach and enrollment tactics that have worked well throughout the National Campaign. Those tactics include conducting a paid radio media buy in targeted markets and releasing the spot as a public service announcement in the markets not included in the media buy; distribution of electronic newsletters; increasing the number of training webinars and continuation of technical assistance provided to grantees and States; and continuing to refresh content on InsureKidsNow.gov, the National Campaign's home for tools and resources.

Budget Overview

CHIPRA appropriated a total of $100 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the ACA provided an additional $40 million in fiscal year 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, ten percent is set aside for the national enrollment campaign and another ten percent is for AI/AN outreach. CMS awarded $40 million in FY 2009 for outreach grants and approximately $10 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40 million of the remaining grants funds, under CHIPRA, on August 18, 2011. Under the ACA, in July 2013, CMS awarded a third round of outreach and enrollment grants (totally $32 million) entitled "Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III)" and then in November 2014 awarded a second

round of Outreach and Enrollment Grants, totalling $3.9 million, from the $4 million appropriated through the ACA, to organizations serving AI/AN children.

The $10 million appropriated through CHIPRA in combination with the $4 million appropriated through the ACA have been used to fund national campaign efforts, as required under the statutes. Two national enrollment campaign contracts have been in place over the last six years. The first contract had a period of performance of June 2009 to July 2012 with a total contract value of $6.575 million. A second contract was awarded in August 2012 and will end in August 2015 with a total contract value of $6.114 million.

APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Program Description and Accomplishments

Section 503 of CHIPRA establishes transition grants to states to apply in their CHIP programs the prospective payment system (PPS) established under section 1902(bb) of the Social Security Act to services provided by federally-qualified health centers (FQHCs) and rural health clinics (RHCs). State CHIP programs that contract with FQHCs are required to develop a prospective payment system or an alternative payment methodology (APM) agreed to by the FQHCs and RHCs to pay for these services provided to CHIP beneficiaries.

The CHIPRA transition grants provided funding to states that operated either a separate CHIP or combination CHIP (i.e., had both a separate CHIP and a Medicaid expansion) to assist them in transitioning to a PPS for the FQHC/RHC payments. The goals of this grant appropriation was to assist states in applying the PPS requirements for this purpose as required by CHIPRA.

Budget Overview

The statute appropriated $5 million for FY 2009. In June 2010, a total of five grants were awarded. However, one grantee declined the award. The four grantees in 2010 to 2011 were: California, Michigan, Colorado, and Pennsylvania, representing $1,934,345 of the appropriated funds. CMS released a second solicitation on January 11, 2012 for another round of these transition grants. On July 1, 2012, CMS awarded the second round of grants to three States: Montana ($500,000), Iowa ($200,000), and Pennsylvania ($426,170), for a combined total of $1,126,170 in grant funding. After all awards, a total of $1,939,485 remains unawarded from the appropriation; however, CMS does not intend to release another round of grants. Currently, all grant projects have been closed-out, and CMS is actively working to finalize the required Report to Congress on the effect these grants may have had on access to benefits, provider payment rates, or scope of benefits offered by states.

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Section 2707 of the Affordable Care Act authorizes a demonstration project where selected States may provide payment under the State Medicaid plan under Title XIX of the Social Security Act (SSA) to an institution for mental disease that is not publicly owned or operated

and is subject to the requirements of section 1867 of the SSA for Medicaid beneficiaries aged 21 to 64 who require medical assistance to stabilize psychiatric emergency medical condition, defined as expressions of suicidal or homicidal thoughts or gestures or is determined to be dangerous to themselves or others. The demonstration project shall be conducted for a period of three consecutive years (July 1, 2012 – June 30, 2015). Each eligible State shall be paid an amount each quarter equal to the FMAP of expenditures in the quarter. An evaluation of the demonstration shall be conducted to determine the impact on Medicaid beneficiaries and the health and mental health service system.

On August 9, 2011, a solicitation to participate in the demonstration was distributed to all State Medicaid Directors. Application proposals from the States were received by October 14, 2011. CMS announced the final selection of eleven States and the District of Columbia on March 12, 2012. Participants in the Demonstration are: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, West Virginia and the District of Columbia. All of the participants began implementing their programs during 2012.

The ACA required that the Secretary of the Department of Health and Human Services (DHHS) submit a Report to Congress on the demonstration, which was submitted on January 8, 2014. The report indicated there were 2,791 participants in the program constituting 10,485 admissions to Institutions for Mental Disease through June 30, 2014. Data continue to be collected on outcomes for the enrolled participants and impacts on Medicaid costs; the Department will conclude an updated evaluation of the demonstration in 2016.

Budget Overview

Section 2707 authorized and appropriated $75 million in fiscal year 2011 to carry out this section. The funds appropriated for this demonstration are available until December 31, 2015.

MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES

Section 4108 of the Affordable Care Act (ACA) authorizes CMS to provide grants to States to provide incentives to Medicaid beneficiaries who successfully participate, complete, and maintain healthy behaviors by meeting the specific targets of a comprehensive, evidence based, widely available, and easily accessible program designed to help individuals achieve one or more of the following:

1. Ceasing the use of tobacco products
2. Controlling or reducing their weight
3. Lowering their cholesterol
4. Lowering their blood pressure
5. Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

The Funding Opportunity Announcement (FOA) was released to States on February 23, 2011 and grants were awarded to New York, Texas, Hawaii, Minnesota, New Hampshire, California, Montana, Nevada, Wisconsin, and Connecticut on September 13, 2011. All ten MIPCD State grantees are operational and currently enrolling beneficiaries.

CMS awarded an evaluation contract in May 2012. This evaluation focuses on: the effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program; the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and the administrative costs incurred by State agencies that are responsible for administration of the program.

The ACA requires that the Secretary of the Department of Health and Human Services (DHHS) submit an initial Report to Congress on the progress of the initiatives established under this program, based on information provided by States, which was submitted to Congress on December 16, 2013. According to this initial report, there were 7,936 participants across the 10 States as of August 31, 2013.

Data continue to be collected on satisfaction and outcomes for the enrolled participants and impacts on State agency administrative costs. A final Report to Congress, including results of the independent evaluation described above and any recommendations for administrative action or legislation determined appropriate by the Secretary, is due not later than July 1, 2016.

Budget Overview

Section 4108 authorized and appropriated $100 million over a five-year period beginning calendar year 2011 to carry out this section. Amounts appropriated for this program shall remain available until expended.

DEMONSTRATION PROGRAMS TO IMPROVE MENTAL HEALTH SERVICES

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) requires the Secretary to publish criteria for a State-certified community behavioral health clinic to participate in a mental health services demonstration program participated in by a State. Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, is required to issue guidance for the establishment of a prospective payment system that shall apply only to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program. It also requires the Secretary to award planning grants to States to develop proposals to participate in two-year demonstration programs not later than January 1, 2016.

Key responsibilities have been identified for the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Assistant Secretary for Planning & Evaluation (ASPE). $1.2 million of the $2 million will be utilized by CMS to procure consultant support for the development of guidance on Prospective Payment Systems for testing under demonstration programs, and CMS will reimburse the remaining $800K to SAMHSA under an interagency agreement for the development of eligibility criteria for certified behavioral health centers to participate in the Demonstration. Beginning one year after the first State has been selected for the

Demonstration programs, the Secretary will submit an annual report to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

Budget Overview

Section 223 authorized and appropriated $2 million in FY 2014 and $25 million for the planning grants in FY 2016 to carry out this section. Amounts appropriated for this program shall remain available until expended.

FY 2016 Legislative Proposals

Expand Funding and Authority for the Medicaid Integrity Program: This proposal increases the Medicaid Integrity Program by $580 million over ten years on top of the current funding level. The additional investment would start with an additional $25 million in FY 2016 and increase gradually to an additional $100 million in 2025. Thereafter, the total would be annually adjusted by the Consumer Price Index. This funding will give CMS the ability to address a number of program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing; and other efforts to assist states to fight fraud, waste, and abuse. Over time, the inflation adjusted investment will support initiatives that respond to emerging vulnerabilities. This proposal also expands the statutory authority for the Medicaid Integrity Program to increase program flexibility in protecting state and federal resources. [$580 million in costs over 10 years, with $850 million in savings to Medicaid not scored under PAYGO]

Extend and Improve the Money Follows the Person Demonstration: This proposal would extend the demonstration period through FY 2020 to enable states to continue to rebalance their long-term care systems and transition individuals to home and community-based services within the existing appropriation. Currently, individuals must enter institutions to qualify for covered home and community based services in the Money Follows the Person Demonstration. To support individuals remaining in the community, this proposal would modify the demonstration to allow funds to be used to prevent individuals from entering an institution in the first place, as well as transition services. This proposal would also reduce the institutional requirement from 90 to 60 days and allow skilled nursing facility days to be counted towards the institutional requirement. Lastly, this proposal would allow individuals in certain mental health facilities to transition to home and community-based services under the demonstration. [No budget impact]

Create Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care: The Budget proposes to authorize a five-year joint Medicaid demonstration in partnership with the Administration for Children and Families beginning in FY 2016 to address the over-prescription of psychotropic medications for children in foster care. States would receive performance-based Medicaid incentive payments to improve care coordination and delivery for foster care children with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people. This investment is paired with $250 million in the Administration for Children and Families (ACF) to support state efforts to build provider and systems capacity.

Ten year budget costs: $500 million (State Grants and Demonstrations), $199 million (mandatory ACF child welfare), and $608 million (costs to Medicaid not scored under PAYGO)

Affordable Insurance Exchange Grants
(dollars in thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Obligations	$784,491	$495,619	$51,521	($444,098)
Outlays	$1,803,000	$2,144,000	$380,000	($1,764,000)

Authorizing Legislation – Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

Allocation Method – Direct Federal, Competitive Grant, and Co-operative Agreements

Program Description and Accomplishments

The Affordable Care Act (ACA) gives States the option of establishing a Health Insurance Marketplace. The Marketplace must facilitate the purchase of qualified health plans (QHPs), provide for the establishment of a Small Business Health Options Program (SHOP) designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered through the SHOP, and meet other requirements specified in 1311(d) of the ACA and in the Marketplace final rule [77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, and 157)]. A Federally-facilitated Marketplace (FFM) or State-Partnership Marketplace (SPM) will operate in those States that elect not to pursue a State-based Marketplace (SBM).

Marketplaces provide millions of Americans and small businesses access to affordable health insurance coverage. Since January 1, 2014, Marketplaces have helped individuals and small employers better understand their insurance options, and assist them in shopping for, selecting, and enrolling in high-quality, competitively-priced private health insurance plans. The Marketplaces also facilitate receipt of tax credits to offset premium costs for insurance, provide cost-sharing assistance to individuals, and help eligible individuals enroll in other Federal or State insurance affordability programs. By providing one-stop shopping, Marketplaces will make purchasing health insurance easy and understandable, giving individuals and small businesses access to increased options for, and control over, their health insurance purchases. During the first open enrollment period, millions of individuals selected Qualified Health Plans through the Marketplaces.

Section 1311 of the ACA provides such sums as necessary to enable the Secretary to award grants to States to support their roles in establishing Marketplaces. Grant funds are available for permissible and approved Marketplace establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment and start-up year. Funding can also be used to support States that wish to transition from an SPM or FFM to an SBM. The final found of grants was awarded in December 2014 for all Marketplace models States may continue to spend grant funding in 2015 and beyond.

The Centers for Medicare & Medicaid Services (CMS) used a phased approach to provide States with funding for implementing Marketplaces. In 2010 and 2011, CMS awarded

Exchange Planning Grants to 49 States and the District of Columbia. These grants assisted States with initial planning activities related to the implementation of the Marketplaces in key areas, including background research, stakeholder involvement, governance, program integration, technical infrastructure and business operations.

In February 2011, CMS awarded Early Innovator funding to six States and one consortium of States to develop Exchange Information Technology (IT) systems that would serve as models for other States. This approach reduced the need for each State to “reinvent the wheel” and aided States in Marketplace establishment by accelerating the development of Exchange IT systems.

Since 2011, CMS has awarded Exchange Establishment Grants to 37 States and the District of Columbia, totaling over $5.5 billion. These grants provided States with support for establishment of Exchange IT systems, outreach and education, necessary testing and improvement, as well as other activities (e.g., development of business processes such as plan management, eligibility and enrollment, and financial management) related to the establishment of the Marketplaces. States used these funds to make demonstrable progress toward Marketplace establishment. Currently, 16 states and the District of Columbia operate State-based Marketplaces, and 7 states partner with HHS to operate some functions in State Partnership Marketplaces.

Grant Table
Size of Awards

(Whole dollars)	FY 2014 Final	FY2015 Enacted
Number of Awards	17	17
Average Award	$43,701,414	$26,389,350
Range of Awards	$4,407,987 - $155,076,686	$977,813 - $99,889,291
Total Obligations:	$742,924,033	$448,618,949

Funding History

The fiscal year obligations for each year are listed below. Section 1311(a) of the ACA appropriated such sums as are necessary for the Secretary to award grants under this account.

FY 2011	$478,373,712
FY 2012	$1,655,000,000
FY 2013	$2,306,598,000
FY 2014	$784,491,000
FY 2015	$495,619,000
FY 2016	$51,521,000

Budget Overview

This account funds CMS activities to support State work to establish Marketplaces. Administrative costs include an estimated 66 full-time equivalent staff to serve as project officers, grants management staff, technical assistance teams and managers to oversee State progress toward achieving their milestones under their cooperative agreements. Funding will also be used for contracts to provide States with instruction on establishment of Marketplace business functions (e.g., eligibility, plan management) and to help States use their grant funding to implement programmatic components that are in line with Federal policy.

Although grants will not be awarded after December 31, 2014, CMS requires administrative resources for continued activities in FY 2016. CMS considers maintaining the same amount of funding for administrative costs necessary to perform our continued oversight and monitoring duties.

In FY 2016, some states will still be in the development phase of establishment and will need continued technical assistance. In addition, states will be enhancing functions related to renewals, privacy and security, and calculating and reporting advance payments for the premium tax credits.

CMS currently has over 150 Grants that will close out and will require support, and states may request no cost extensions of their funding, which will require continued monitoring.CMS will continue to support transitions that may occur over the next year and the support needed thereafter (SPM to SBM, FFM to SPM).

Grant Table - Total Award by State

	FY10	FY11	FY12	FY13	FY14	FY15	Total
Alabama	1,000,000		8,772,451				9,772,451
American Samoa		1,000,000					1,000,000
Arizona	999,670		29,877,427				30,877,097
Arkansas	1,000,000		26,461,483	16,470,852	14,217,496	99,889,291	158,039,122
California	1,000,000	39,421,383	196,479,629	673,705,358	155,076,686		1,065,683,056
Colorado	999,987		61,685,359	116,245,677		6,055,673	184,986,696
Connecticut	996,848	6,687,933	108,880,176	27,599,500	20,302,003	11,403,961	175,870,421
Delaware	999,999		3,400,096	8,536,543	8,321,608	977,813	22,236,059
District of Columbia	999,999	8,200,716	72,985,333	16,969,089	68,235,908	27,750,106	195,141,151
Florida	1,000,000						1,000,000
Georgia	1,000,000						1,000,000
Guam		1,000,000					1,000,000
Hawaii	1,000,000		76,255,636	128,086,634			205,342,270
Idaho	998,220		20,376,556		48,019,031	35,896,938	105,290,745
Illinois	1,000,000	5,128,454	32,861,161	115,823,521		10,089,170	164,902,306
Indiana	1,000,000	6,895,126					7,895,126
Iowa	1,000,000		34,376,665	6,844,913	17,462,311		59,683,889
Kansas	1,000,000	31,537,465					32,537,465
Kentucky	1,000,000	7,670,803	62,319,810	182,707,738		35,605,175	289,303,526
Louisiana	998,416						998,416
Maine	1,000,000		5,877,676				6,877,676
Maryland	999,226	33,464,203	123,048,693	24,670,310		7,947,711	190,130,143
Massachusetts	1,000,000	35,591,333	62,219,472	80,225,650	27,841,050	26,926,282	233,803,787
Michigan	999,772		9,849,305	30,667,944			41,517,021
Minnesota		5,168,071	68,674,821	39,326,115	41,851,458	34,343,062	189,363,527
Mississippi	1,000,000	20,143,618			21,569,043		42,712,661
Missouri	1,000,000	20,865,716					21,865,716
Montana	1,000,000						1,000,000
Nebraska	1,000,000		5,481,838				6,481,838

	FY10	FY11	FY12	FY13	FY14	FY15	Total
Nevada	1,000,000	4,045,076	69,709,209	9,020,798	17,225,985		101,001,068
New Hampshire	1,000,000			6,267,088	5,266,990	3,385,882	15,919,960
New Jersey	1,000,000		7,897,316				8,897,316
New Mexico	1,000,000		34,279,483	18,600,000	69,402,117		123,281,600
New York	1,000,000	38,206,330	143,971,309	245,887,768	82,188,253	63,826,144	575,079,804
North Carolina	999,999	12,396,019		73,961,296			87,357,314
North Dakota	1,000,000						1,000,000
Ohio	1,000,000						1,000,000
Oklahoma	1,000,000	54,608,456					55,608,456
Oregon	1,000,000	57,065,907	8,877,701	238,262,979			305,206,587
Pennsylvania	1,000,000		33,832,212				34,832,212
Puerto Rico		917,205					917,205
Rhode Island	1,000,000	5,240,668	58,515,871	19,073,635	56,902,346	11,841,974	152,574,494
South Carolina	1,000,000						1,000,000
South Dakota	1,000,000		5,879,569				6,879,569
Tennessee	1,000,000		8,110,165				9,110,165
Texas	1,000,000						1,000,000
US Virgin Islands		1,000,000					1,000,000
Utah	1,000,000			1,000,000	4,407,987		6,407,987
Vermont	1,000,000		122,269,334	49,371,747		27,077,461	199,718,542
Virginia	1,000,000			5,567,803		9,295,086	15,862,889
Washington	996,285	22,942,671	127,852,056	37,369,035	84,633,761	36,307,220	310,101,028
West Virginia	1,000,000	9,667,694		10,165,134			20,832,828
Wisconsin	999,873	38,058,074					39,057,947
Wyoming	800,000						800,000
TOTAL:	**48,788,294**	**466,922,921**	**1,631,077,812**	**2,182,427,127**	**742,924,033**	**448,618,949**	**5,520,759,136**

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Early Retiree Reinsurance Program

(dollars in thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	-	-	-	-
Outlays	$13,259	$2,212	$374	($1,838)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), Section 1102

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Contract

Program Description and Accomplishments

The Early Retiree Reinsurance Program (ERRP) was created to address the gradual erosion over the last 20 years in the number of employers and other employment related health plan sponsors providing health coverage to early retirees. Early retirees often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable and inaccessible. Additionally, rising health care costs have made it difficult for employers to provide high quality, affordable health coverage for workers and retirees while also remaining competitive in the global marketplace. The proportion of large employers offering retiree coverage declined by half in just 20 years, dropping from 66 percent in 1988 to 25 percent in 2012. Health insurance premiums in the individual market for older Americans are over four times more expensive than they are for young adults and the deductible these enrollees pay is, on average, almost four times that for a typical employer-sponsored insurance plan.

ERRP was designed as a temporary program that provided needed financial help for employer-based plans to continue to provide valuable coverage and financial relief to plan participants, before health insurance programs created in the Affordable Care Act, such as Health Insurance Marketplaces are available in 2014. ERRP provided reimbursement to approved sponsors of certified plans providing health benefits to early retirees, their spouses, and surviving spouses and dependents equal to 80 percent of the actual cost of health expenses paid for an individual between a cost threshold (originally $15,000) and cost limit (originally $90,000). The cost threshold and cost limit were adjusted each year by linkage to the Medical Care Component of the Consumer Price Index. ERRP reimbursement was used to reduce employer health care costs, provide premium or other out-of-pocket relief to workers and families, or both. Analysis of data, as of February 2012, from a voluntary survey of plan sponsors that had received ERRP funds indicated that over 19.1 million plan participants have already, or will have, benefitted from the ERRP (either

directly or indirectly) as their plan sponsors apply the ERRP funds to offset the plan's increased costs, plan participants' costs, or both.

The Affordable Care Act appropriated $5 billion for this program. It became effective on June 1, 2010, pursuant to the interim final rule published on May 5, 2010. The ERRP ended on January 1, 2014.

Funding History

FY 2010	$5,000,000,000
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0
FY 2016	$0

Budget Overview

In FY 2016, CMS will complete the final program closeout. The majority of the program is being closed out in FY 2015. Such activities include archiving data and records, responding to any inquires about the program, and responding to any appeals that come up as a result of debt collection activities and program integrity audits. ERRP funds recovered from debt collection activities are expected to eventually be returned to the Treasury once all contract closeout and other program termination activities are completed.

Consumer Operated and Oriented Plan Program and Contingency Fund
(dollars in thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Appropriation (rescission)	-	-	-	-
CO-OP Account (10% Transferred to the Contingency Fund)				
Net Outlays	$284,000	$188,000	$116,000	($72,000)
CO-OP Account Contingency Fund				
Net Outlays	$27,000	$132,000	$52,000	($80,000)
Total Outlays	$311,000	$320,000	$168,000	($152,000)

Authorizing Legislation - Patient Protection and Affordable Care Act (ACA), Public Law 111-148, Title I, section 1322, and Public Law 111-152.

Allocation Method - Direct Loans and Contracts

Appropriating Legislation: Patient Protection and Affordable Care Act, Public Law 111-148, Title I, section 1322, and Public Law 111-152. Amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10, Title VIII, section 1857, the Consolidated Appropriations Act, 2012, Public Law 112-74, Division F, Title V, section 524, the American Taxpayer Relief Act of 2012, Public Law 112-240, Title VI, Subtitle C, section 644, and a sequester pursuant to the Balanced Budget Act and Emergency Deficit Control Act, as amended, section 251A.

Program Description and Accomplishments

The Affordable Care Act required HHS to establish the Consumer-Operated and Oriented Plan (CO-OP) Program to foster the creation of CO-OPs that will offer non-profit qualified health plans in the individual and small group health insurance markets. The program provided start-up Loans (repayable in 5 years) for start-up costs and Solvency Loans (repayable in 15 years) to meet State reserve and solvency requirements to support the development of CO-OPs. Priority for the award of loans was given to applicants that will offer Qualified Health Plans (QHPs) on a State-wide basis, use an integrated care model, and have significant private support.

CO-OPs therefore will provide much needed choice to customers and improve competition both inside and outside the Marketplaces, help constrain the growth of healthcare costs, and keep

premiums down. The program helps foster competition in states like Maine, where the CO-OP is one of only two issuers offering plans on the Marketplace, and offers the lowest cost plans in almost all metal categories. For 2015, many CO-OPs are offering the lowest-cost silver plans in several states.

Award of CO-OP Loans

Currently, 23 CO-OP loan recipients are licensed and have enrolled members in 25 states. CO-OPs offer coverage both inside and outside of the new Marketplaces. CMS has approved four CO-OP loan recipients to expand operations into additional states. Loan awards as of December 31, 2014 total $2.5 billion. Of the $2.5 billion in total loans awards, approximately $1.09 billion is from the direct appropriation loan subsidy and the remaining $1.4 billion is from Treasury borrowing

States with enrolled members as of January 2015 are AZ, CO, CT, IA, ID, IL, KY, LA, MA, MD, ME, MI, MT,NE, NH, NJ, NM, NY, NV, OH, OR, SC, TN, UT, and WI). Four CO-OP loan recipients are expanding operations into additional states. Starting in 2015: Montana expanded into Idaho; Massachusetts into New Hampshire; and Maine into New Hampshire. Kentucky will expand into West Virginia in 2016.

The CO-OP Program contracted externally for expert objective reviews of the loan applications. The expert reviewers provided recommendations on awarding loans to a CMS Selection Committee, which made the final awards. CMS made initial loan awards in February 2012 and continued to accept applications and award loans into FY 2015.

Loan Servicing and CO-OP Monitoring

CMS began disbursing Start-up and Solvency loan funds and established an infrastructure to support the awarding and monitoring of CO-OP funding. Start-up loan funds are disbursed in installments based on loan disbursement schedules that reflect the specific business plan of each CO-OP. Disbursements are contingent upon documented completion of key milestones in the business plan. Solvency loan funds are disbursed as needed to meet State licensing and solvency reserve requirements. One CO-OP (VT) failed to become licensed, and was subsequently terminated from the program.

Funding History

FY 2010	$6,000,000,000
FY 2011	-$2,200,000,000
FY 2012	-$400,000,000
FY 2013	-$2,278,544,136
FY 2014	$0
FY 2015	$0
FY 2016	$0

The Affordable Care Act appropriated $6 billion for the program in FY 2010. In FY 2011 Congress rescinded $2.2 billion; in FY 2012 Congress rescinded an additional $400 million; and the American Taxpayer Relief Act rescinded $2.3 billion, and required that any unobligated balances be transferred to a contingency fund. In 2013, CMS transferred $253 million to a contingency fund for oversight and assistance to existing loan entities.

Budget Overview

During FY 2016 CMS will continue to actively monitor the loan portfolio and support the continued growth of the CO-OPs as operating insurance providers. CO-OP monitoring includes regular financial reporting, coordination with the State Department of Insurance, calls with an Account Manager, audits and site visits, and increased oversight as required. The CO-OP Program contracted with a vendor for the provision of technical assistance to CO-OPs. In addition, an independent auditor has been retained to perform compliance audits.

The program will continue to require contract-funded technical assistance to program staff and CO-OPs as the CO-OPs build up enrollment in their health plans. Program efforts will also continue the development and maintenance of internal IT systems for loan servicing and monitoring borrower performance and compliance. The program staff will provide program management, oversight of contractors, and ensure program integrity. Funding for program integrity allows CMS to adequately identify, prevent, and prosecute fraud, abuse and/or misuse of CO-OP funds. CMS will continue to support program integrity by monitoring activities of recipient organizations, collecting documentation, conducting site visits, and engaging vendors for audits. Based on the scale of loans for this program, CMS must ensure that loan recipients meet quality and performance standards, engage in proper use of Federal funds, and reinvest profits to the benefit of the members. The CO-OP loan program requires account management, program controls, and program integrity activities.

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Health Insurance Rate Review Grants
(dollars in thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	-	-	-	-
Outlays	$26,696	$53,520	$40,192	($13,328)

Authorizing Legislation - PPACA, Section 1003, Section 2794 of the Public Health Service Act

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Application for Grants

Program Description and Accomplishments

In 2010, HHS established a program of grants to States, the District of Columbia, and the U.S. territories to enhance the health insurance rate review process. The five-year grants program of $250 million began in fiscal year 2010. In accordance with the Affordable Care Act (ACA), no State qualifying for a grant shall receive less than $1 million in overall grant funding or more than $5 million in a single grant year. Grants assist States in improving their rate review processes and/or establishing Data Centers that enhance the transparency of medical services. Each grant recipient is required to provide the Secretary with information about trends in premium increases in health insurance coverage. States that receive grants for the purpose of improving their rate review activities and/or for required rate reporting are required to establish a process for the review of "unreasonable" rate increases. The final rate review regulations promulgated in the Spring of 2011, Fall of 2011, Spring of 2013, and Spring of 2014 provide Federal guidance on the definition of "unreasonable" rate increases, as well as guidance on the justifications for such unreasonable rates that grantees must employ in their annual rate review processes under the grants.

There have been four cycles of grants that have been awarded. Each cycle had a difference emphasis on use of funds. Cycle I funding was used to:

- Enhance the current rate review process in the States;
- Increase consumer transparency and outreach efforts in the States;
- Report data to the Secretary on premium trends; and,
- Implement the optional provision to provide funding to Data Centers to assist collecting, analyzing, and sharing fee schedule data with the public and other partners.

The Cycle II grant funding opportunity was designed to provide States with multiple opportunities to apply for funding, depending on the status of their progress toward meeting the criteria for an Effective Rate Review process. Cycle III differed from Cycle II by providing greater support to Data Centers to ensure greater public access to health care pricing data, and

permitted agencies other than state departments of insurance to submit applications. The Cycle IV funding opportunity continued to broaden the eligibility criteria for States to receive funding for Data Center work.

Funding History

FY 2010	$250,000,000
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0
FY 2016	$0

Budget Overview

The Public Health Service (PHS) Act section 2794(c) appropriated $250 million for the Rate Review Grant Program for grants awarded during the five-year period beginning with FY 2010. Section 2794(c)(2)(B) provides that any amounts not fully obligated under the $250 million will remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under Part A of the ACA (i.e., the market reform rules). As the Rate Review program is now over, CMS will issue grants to States in support of planning and implementing the health insurance market reforms under Part A of the ACA, pursuant to section 2794(c)(2)(B).

Transitional Reinsurance Program

(Dollars in Millions)

	FY 2014 Final	FY 2015 Estimate	FY 2016 President's Budget	FY 2016 +/- FY 2015
Receipts	-	$10,020	$6,025	-$ 3,995
Outlays	-	$9,289	$6,756	-$ 2,533

Outlays in FY 2016 reflect amounts previously unavailable from FY 2015 due to sequestration.

Appropriations – Funding Available for Obligation

Authorizing Legislation – Affordable Care Act (P.L. 111-148 & 111-152)

Allocation Method - Direct Federal

Program Description and Accomplishments

Section 1341 of the Affordable Care Act establishes a transitional reinsurance program in effect for expenditures incurred during calendar years 2014 through 2016 in which contributions are collected from health insurance issuers and group health plans to fund payments to issuers of non-grandfathered individual market plans that enroll high-cost individuals. In addition to contributions, the statute authorizes collection of an administrative fee to support program operations. HHS will collect all reinsurance contributions nationwide. In the event a State does not operate its own transitional reinsurance program, the Federal government will make reinsurance payments directly to issuers in that State.

Funding History (Outlays)

FY 2015	$9,289,000,000
FY 2016	$6,756,000,000

Budget Overview

In FY 2016, CMS expects to collect $6 billion to provide reinsurance payments for the 2015 plan year. These contributions are collected under the authority established in 1341(b)(3)(B) for reinsurance payments to issuers that enroll high-cost individuals, and under the payment parameters described in the applicable Annual Notice of Benefit and Payment Parameters. Additionally, the appropriation would be used to disburse reinsurance collections to State reinsurance entities to make reinsurance payments as required by Section 1341(b)(1)(B) and 45 CFR 153.235. CMS also expects to collect $25 million to support CMS reinsurance program operations and to disburse to States to support their program operations, as described in 78 FR 15461. FY 2016 outlays reflect budget authority previously unavailable in FY 2015 due to sequestration.

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Risk Adjustment Program Payments

(Dollars in Millions)

	FY 2014 Final	FY 2015 Estimate	FY 2016 President's Budget	FY 2016 +/- FY 2015
Receipts	-	$3,679	$5,641	$1,962
Outlays	-	$3,410	$5,910	$2,500

Outlays in FY 2016 reflect amounts previously unavailable from FY 2015 due to sequestration.

Appropriations – Funding Available for Obligation

Authorizing Legislation – Affordable Care Act of 2010 (P.L. 111-148 & 111-

152) Allocation Method – Direct Federal

Program Description and Accomplishments

Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program in which CMS collects charges from health insurance issuers that enroll healthier than average enrollees and redistributes those funds to health insurance issuers that enroll sicker than average enrollees. These provisions apply to non-grandfathered individual and small group market plans inside and outside of the Marketplace. The program is designed to reduce premium differences resulting from risk selection. Risk adjustment will be operated by a State or by the Federal government in the event the State does not establish a Marketplace or chooses not to operate a risk adjustment program. When the Federal government operates the risk adjustment program, charges will be collected and payments made for the 2014 benefit year in mid-2015.

Funding History (Outlays)

FY 2015	$3,410,000,000
FY 2016	$5,910,000,000

Budget Overview

In FY 2016, CMS projects $5.6 billion will be collected from plans in the individual and small group markets with healthier than average enrollees in order to make risk adjustment payments, as determined by the risk adjustment methodology described at 78 FR 15417, to plans with higher than average risk. Projected payments of $5.9 billion in FY 2016 reflect amounts previously unavailable from FY 2015 due to sequestration.

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Center for Medicare and Medicaid Innovation (CMMI)

(Dollars in Thousands)

	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	FY 2016 +/- FY 2015
BA	$0	$0	$0	$0
Obligations	$1,180,700	$1,841,600	$1,646,300	($195,300)

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010, Section 3021

Allocation Method - Contracts, Cooperative Agreements, Grants

Program Description and Accomplishments

The Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by Section 3021 of the Affordable Care Act (ACA) “to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals under” Medicare, Medicaid, and Children’s Health Insurance Program (CHIP).

The CMS Innovation Center is an integral part of CMS’s efforts to transform itself from a claims payer in a fragmented care system into a health care partner in a more integrated health care environment. CMS supports the development of a health care system that is integrated, accountable, and equitable; that monitors and promotes health; that continuously improves care; and that reduces unnecessary costs through adoption of new payment and service delivery models. Since its launch in November 2010, the CMS Innovation Center has sought to identify, test, evaluate and expand, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and CHIP while improving or preserving beneficiary health and quality of care.

As required by statute, the CMS Innovation Center consults with stakeholders and representatives of relevant Federal agencies, drawing on ideas received from members of the health care community, including health care providers, analysts, and clinical researchers.

To serve as a good steward of health care dollars, CMS rapidly and rigorously evaluates each new payment and service delivery model being tested to assess the quality of care furnished, patient outcomes, and patient-centeredness, and to determine both the return on investment and the model’s overall impact on total cost of care. The emphasis in evaluations is to identify best practices and successful programs as quickly as possible to determine which new models of health care service delivery and payment are worth pursuing further.

In addition to the rigorous evaluation of the impact of each model on outcomes of interest, CMS maximizes the likelihood of model success through continuous quality improvement. Promising model tests are refined through rapid cycle evaluation and feedback to achieve better value and facilitate greater improvements in health and access to quality care. Insights into best practices identified during the test are spread as quickly, widely, and effectively as possible.

In order to ensure the success of each model, the CMS Innovation Center provides operational oversight and planning that includes model specifics and Center-wide activities. Within each model, a process has been established that requires:

- data sharing
- implementation assistance
- learning & diffusion activities, including Advanced Development Learning Sessions, associated with the model;
- payment administration and/or reconciliation; and
- performance monitoring and evaluation

Center-wide activities include:

- establishing and evaluating the effectiveness of Center-wide learning systems that facilitate the testing of models and the rapid and widespread diffusion of best practices and validated service delivery and payment models;
- harvesting best practice models and identifying need gaps for designing new innovations in care delivery improvement and sustainability;
- assessment of planning, design, and business process requirements for an information systems environment;
- data management activities;
- project management support; and
- operations management and oversight including routine administrative costs at the CMS Innovation Center including personnel and benefits.

In partnership with a broad array of stakeholders including health care providers, states, payers, and others, CMS has developed an extensive portfolio of promising initiatives that are serving Medicare, Medicaid, and CHIP beneficiaries in all fifty states and the District of Columbia. Furthermore, to better coordinate initiatives, demonstrations, and research projects at CMS – and to prevent duplication of effort and expense – the CMS Innovation Center also manages activities under other provisions of the Affordable Care Act and other laws, and certain projects authorized under section 402 of the Social Security Act of 1967 as amended.

Initiatives launched by CMS under the authority of Section 3021 of the ACA include:

Partnership for Patients: CMS has dedicated up to $500 million in CMS Innovation Center funding to test Partnership for Patients (PfP), a model to reduce preventable Hospital-Acquired Conditions (HACs) by 40% and to reduce preventable thirty-day readmissions by 20%. PfP combines the efforts of multiple partners, including federal and non-federal programs, in an aligned effort to support rapid action and progress in these hospitals and communities. In addressing preventable HACs, the PfP initiative has prioritized reducing inpatient adverse events, such as adverse drug events, central line-associated blood stream infections, catheter-associated urinary tract infections, falls, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

In its first phase, the PfP involves more than 3,700 participating hospitals nationwide committed to improve care by teaming in their quality improvement work together with one of twenty-six Hospital Engagement Networks (HENs). These HENs have established infrastructure and

organized technical assistance programs to support these hospitals in improvement and measurement, engaged with patient and families, and helped hospitals with learning, reporting and generating results. Beginning in September 2013, six of the twenty-six HENs also participated in the Leading Edge Advanced Practice Topic (LEAPT) initiative to rapidly test and develop practices to reduce harm in eleven advanced practice areas including, severe sepsis and septic shock, clostridium difficile, hospital acquired acute renal failure, airway safety, iatrogenic delirium, procedural harm, undue exposure to radiation, and others. This robust program is aimed squarely at improving the level of patient safety in hospitals across the nation.

The work being done at these hospitals is complemented by an investment in over one hundred community coalitions supported via the Community Based Care Transitions Program (CCTP). CCTP provides financial assistance to community-based organizations that work closely with hospitals and other health care providers to assist high risk Medicare patients by improving transitions in care and reducing preventable re-hospitalizations. In addition, PfP has supported Strong Start for Mothers and Newborns (see below) in its efforts to reduce early elective deliveries.

The Partnership for Patients contracts came to a natural end in December 2014. CMS has planned to extend the program.

Health Care Innovation Awards: CMS is committed to providing stakeholders and other providers with up to $1.4billion in funding to implement the most compelling new ideas for delivering better health and better care at a lower cost to people enrolled in Medicare, Medicaid, and CHIP, particularly to enrollees with the greatest health care needs. These funds were distributed in two rounds of cooperative agreements. The Round One cooperative agreement period began July 1, 2012 and included 107 awardees. Round One includes a broad range of models with a focus on health care workforce development and deployment, as well as developing enhanced infrastructure to support effective and efficient system-wide function and diffusion of best practices. The Round Two cooperative agreement period began September 1, 2014 and included 39 awards. This latter funding opportunity supports a diverse portfolio of new and innovative payment and service delivery models focused on four categories: rapidly reducing costs for patients in outpatient hospital and post-acute settings; improving care for populations with specialized needs; testing improved financial and clinical models for specific types of providers; and linking clinical care delivery to preventive and population health.

Pioneer Accountable Care Organizations (ACOs): The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. The model tests payment arrangements that hold providers accountable for cost, quality, and patient experience outcomes for a defined population of beneficiaries. It uses a shared savings payment methodology with generally higher levels of shared savings and risk than levels currently used in the Medicare Shared Savings Program and is assessing the ability of hospital and physician organizations experienced in care and risk management to achieve savings for Medicare while sustaining or improving quality of care for beneficiaries. Pioneer ACOs that demonstrated savings during the first 2 performance years and met other criteria were able to transition to a monthly population-based payment starting in performance year 3.

The Pioneer ACO Model was launched in 2012 with 32 ACOs. Organizations agree to an initial 3-year performance period with the option to extend for 2 additional option years. At present, 19 Pioneer ACOs are participating and plan to enter their fourth performance year in 2015. Of

those Pioneer ACOs that made the decision to exit the model, each organization did so based on its particular business priorities and concerns. Three of the withdrawing organizations generated shared losses. Other Pioneer ACOs that generated losses made the decision to remain in the model and a number of others transitioned into the Medicare Shared Savings Program to continue healthcare transformation with a slower transition to downside risk. More than 625,000 Medicare beneficiaries are aligned to Pioneer ACOs. The model has reported favorable results on both cost and quality measures for its first 2 performance years.

Advance Payment ACO Model: The Advance Payment Model has provided support to certain ACOs — such as physician-based and rural ACOs — that have the potential to deliver better care at lower costs but need access to seed capital in order to invest in care coordination infrastructure. Designed for organizations participating in the Medicare Shared Savings Program, the Advance Payment Model has tested whether providing up-front and monthly payments to providers increased participation in the Medicare Shared Savings Program, allowed ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and increased the amount of Medicare savings. The payments are being repaid through the shared savings that participating ACOs earn. The last payments were made in June 2014. Thirty-six ACOs participating in MSSP selected for this model received payments between 2012 and 2014. Currently, 35 of 36 ACOs that started in the Advance Payment Model are set to complete the model on December 31, 2015.

ACO Investment Model: The ACO Investment Model is an initiative developed by the Center for Medicare & Medicaid Innovation designed for organizations participating as ACOs in the Medicare Shared Savings Program. The ACO Investment Model is a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model. The ACO Investment Model will test whether providing up-front and monthly payments to providers will encourage new ACOs to form in rural and underserved areas and current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. The pre-payment of shared savings will allow ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and increase the amount of Medicare savings. The pre-paid shared savings are to be repaid through the shared savings that participating ACOs earn. The model is expected to accept up to 75 ACOs across the country.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: This model tested: (1) the impact that additional financial support has on FQHCs' ability to transform their practices into Patient-Centered Medical Homes (PCMHs), and (2) the effect of this transformation on quality of care, health outcomes, and expenditures. More specifically, the goal of the demonstration was for its participants to achieve NCQA Level 3 recognition as Patient Centered Medical Homes (PCMH). This entailed a practice transformation process that was designed to strengthen infrastructure, including information technology systems, and improve health and quality of care for Medicare beneficiaries, while reducing costs.

A total of 466 FQHCs participated in this Demonstration between 2011 and 2014, serving approximately 214,000 fee-for-service beneficiaries across forty-four states. A formal evaluation is ongoing, but NCQA Level 3 recognition increased at a rapid rate in the final year of the demonstration due to the targeted technical assistance that is provided to assist participating FQHCs with their practice transformation.

Medicare-Medicaid Financial Alignment Initiative: The Financial Alignment Initiative builds upon and, for some states, incorporates funding from its precursor, the State Demonstrations, to Integrate Care for Dual Eligible Individuals (see below). Under this initiative and through related

work, CMS is partnering with states to test both a capitated model and a managed fee-for-service (MFFS) model. Under the capitated model, the state and CMS enter into a three-way contract with a health plan, which receives a prospective blended payment to provide comprehensive, coordinated care. Under the MFFS model, the state and CMS enter into an agreement by which the state may benefit from a portion of savings from initiatives that improve quality and reduce costs in the FFS delivery system. Although the approaches differ in each state demonstration, beneficiaries are eligible to receive all the standard Medicare and Medicaid services and benefits that they are entitled to, as well as additional care coordination, beneficiary protections, and access to enhanced services.

As of September 2014, under the Financial Alignment Initiative, CMS has entered into MOUs with a total of 11 states: seven states that received awards from the State Demonstrations (California, Colorado, Massachusetts, Michigan, New York, South Carolina, and Washington) and four additional states (Illinois, Ohio, Texas, and Virginia) to integrate care for Medicare-Medicaid enrollees. Nine of these states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) are implementing capitated model demonstrations. Colorado is implementing a MFFS model demonstration and Washington is implementing both a MFFS model and a capitated model demonstration in separate regions of the state. Each model is scheduled to serve beneficiaries for approximately 3 years. As of October 2014, approximately 200,000 beneficiaries were enrolled in the combined Financial Alignment Initiative & State Demonstrations to Integrate Care for Dual Eligible Individuals.

State Demonstrations to Integrate Care for Dual Eligible Individuals: Through this initiative, CMS awarded design contracts to 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) in April 2011 to design new approaches to better coordinate care for beneficiaries enrolled in both the Medicare and Medicaid programs.

Eight of these states are now part of the Financial Alignment Initiative, but continue to receive implementation funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals. Seven of these eight states have signed Memoranda of Understanding (MOUs) to test new models under the Financial Alignment Initiative. In Minnesota, the eighth state from the State Demonstrations, CMS has signed an MOU to test an alternative model, building on the longstanding Minnesota Senior Health Options program.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: The CMS Innovation Center, in collaboration with the Medicare-Medicaid Coordination Office, has launched a demonstration focused on reducing preventable inpatient hospitalizations among dual eligible residents of nursing facilities. CMS competitively selected seven independent organizations that are providing enhanced clinical services to people in approximately 146 nursing facilities. Participants were announced in fall of 2012, and the first sites began serving beneficiaries in February 2013.

Bundled Payments for Care Improvement: CMS is testing four models of episode-based (bundled) Medicare payments in partnership with hospitals, physician groups and post-acute care providers. Under the current fee-for-service (FFS) system, separate FFS payments to numerous providers for a single episode of care may result in fragmentation of care and duplication of services. Payment models that provide a single bundled payment to providers for an entire episode of care — and that hold the same group of providers accountable for the

cost, quality, and patient outcomes of that episode — may spur hospitals, physicians, and other providers to better coordinate care, improve quality of care, and reduce costs. CMS has developed four distinct models of bundling payments, varying by the types of health care providers involved and the services included in the bundle. Participation in Model One, which tests bundled payments for acute care hospital stays, began between April 2013 and January 2014. For Models 2-4, the initial application period was in 2012, with additional open periods for new providers to join in late 2013 and early 2014. Subsequent submissions expanded to 6,691 the number of participating hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long term care hospitals, physician group practices and convening organizations. Models two through four participations began a preparatory data and shared learning phase in January 2013. All entities remaining in Models 2-4 in October 2015 are expected by then to have transitioned all episodes of care into a risk-bearing phase by that time.

Comprehensive Primary Care (CPC) initiative: This CMS Innovation Center-led, multi-payer initiative fosters collaboration between public and private payers to strengthen primary care. Health plans that cover only a small segment of a primary care practice's total patient population have historically struggled to provide enough resources to support the transformation of primary care practices to provide higher-quality, coordinated care. The CPC initiative attempts to break through this historical impasse by inviting payers to join together with Medicare to invest in primary care. CMS chose seven regions for the CPC intervention. As of October 2014, 481 practices are participating in the CPC initiative representing 2,528 providers who serve an estimated 396,000 Medicare fee-for-service beneficiaries and over 66,000 Medicaid beneficiaries.

Strong Start for Mothers and Newborns: CMS is pursuing two complementary strategies as part of a national initiative to improve birth outcomes. First, CMS partnered with providers and hospitals to improve perinatal safety by reducing early, elective deliveries prior to thirty-nine weeks. Second, CMS is testing three models of enhanced prenatal care services for women enrolled in Medicaid or CHIP who are at high risk for having a preterm birth. Awards were announced in February 2013. CMS is partnering with the Administration for Children and Families (ACF) and the Health Resources and Services Administration (HRSA) on a fourth model that aims to test the effectiveness of two evidence-based home visiting models to improve birth and health outcomes. CMS is providing funding to evaluate the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), which is being implemented by the Nurse Family Partnership and Healthy Families America.

State Innovation Models: The State Innovation Models (SIM) initiative is testing the ability of State governments to accelerate health transformation using policy and regulatory levers to improve health, improve health care delivery, and decrease costs. Round One SIM Awards, announced in February 2013, supported both the design and implementation of State transformation plans. Round Two SIM awards were announced in December 2014.

CMS launched a related initiative, the Medicaid Innovation Accelerator Program (IAP), in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting states' efforts to accelerate new payment and service delivery reforms.

Comprehensive End-Stage Renal Disease (ESRD) Care: The Comprehensive ESRD Care model will test the effectiveness of a new payment and service delivery model for Medicare beneficiaries with ESRD beginning in July 2015. Through this initiative, CMS will enter into agreements with groups of health care providers and suppliers called ESRD Seamless Care Organizations who will work together to provide beneficiaries with a more patient-centered,

coordinated care experience. These participating organizations will assume clinical and financial responsibility for a group of beneficiaries with ESRD, and those organizations that are successful in improving beneficiary health outcomes and lowering the per capita cost will have an opportunity to share in Medicare savings with CMS.

Maryland All-Payer Model: Maryland's all-payer rate setting system for hospital services presents an opportunity for Maryland and CMS to test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for achieving better health and access to quality care at lower cost. Under an agreement signed between CMS and Maryland in January 2014, Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate and will limits its all payer total per capita hospital expenditure growth to 3.58% per year; and its Medicare total per capita hospital expenditure growth to 0.5% less than the national growth rate over 5 years.

Prior Authorization Model- Non-Emergent Hyperbaric Oxygen Therapy: On March 2, 2015 CMS is implementing a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey. CMS will test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

Prior Authorization Model- Repetitive Scheduled Non-Emergent Ambulance Transport: CMS implemented a prior authorization demonstration program for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina on December 1, 2014. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. CMS believes that using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

Medicare Care Choices Model: Despite ample evidence showing that hospice patients receive higher quality care and experience a higher quality of life at the end of life as compared to terminally ill patients in the hospital setting, CMS data show that utilization of Medicare's hospice benefit stands at 44% among eligible Medicare patients. Currently, in order for an eligible beneficiary to utilize Medicare's hospice benefit, he or she must forgo curative care before receiving access to hospice benefits that provide palliative care services. In partnership with Medicare certified and enrolled hospices, the Medicare Care Choices Model will test whether this policy is a barrier to hospice access among Medicare patients by allowing beneficiaries who participate in the Model to elect to receive palliative and supportive hospice care without discontinuing curative care. In doing so, CMS hopes to determine whether allowing simultaneous access to curative and hospice services will affect the use of curative services and Medicare hospice benefits, and whether the policy will result in improved quality of care and patient and family satisfaction. Participation in the Model will be limited to Medicare beneficiaries with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and HIV/AIDS who both qualify for the Medicare hospice benefit and meet the eligibility requirements of the benefit.

Transforming Clinical Practice Initiative: In October 2014, the Secretary announced the Transforming Clinical Care Practice Initiative, which is designed to help clinicians achieve large-scale health transformation. The Initiative will support 150,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. CMS will award cooperative agreement funding for two network systems under this initiative: Practice Transformation Networks and Support and Alignment Networks. The Practice Transformation Networks are peer-based learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to practice transformation. The Support and Alignment Networks will provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts.

Funding History (Budget Authority)

FY 2010	$5,000,000
FY 2011	$10,000,000,000
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0

Section 3021, which created Section 1115A of the Social Security Act, provides $10 billion in budget authority for activities initiated in fiscal years 2011 through 2019, with not less than $25 million to be made available each year for the design, implementation, and evaluation of innovative payment and service delivery models, and enhanced evaluation and research activities.

Performance Measurement

ACO1[1]: Reduce the Growth of Health Care Costs while Promoting Better Health and Health care Quality through Delivery System Reform: Delivery system reform will potentially include a very broad array of interventions, but this measure focuses on Accountable Care Organizations (ACOs), which are groups of physicians, providers and suppliers that work together to coordinate care for beneficiaries with original Medicare fee-for-service health coverage. These ACOs enter into agreements with CMS, taking responsibility for the quality of care they provide to Medicare beneficiaries in return for the opportunity to share in savings realized through care improvement. Data for this measure will be collected and aggregated across the following initiatives: Medicare Shared Savings Program (SSP) including advance payment and non-advance payment ACOs, the Pioneer ACO model, and the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative. This measure represents efforts across CMS, not just CMMI, to promote better health and health care quality through delivery system reform.

[1] In FY 2014 budget/performance documents, these goals were numbered CMMI1.1, CMMI1.2, and CMMI1.3. They were renamed ACO1.1, ACO1.2, and ACO1.3

As part of the delivery system reform process, we aim to increase the number of Medicare beneficiaries who have been aligned with ACOs, the number of physicians participating in ACOs, and the percentage of ACOs that share in savings (ACO measures 1.1-1.3). In 2013, more than 4 million beneficiaries were aligned to ACOs (3,394,587 Medicare SSP and 607,945 Pioneer), with the expectation of increasing alignment to more than 7 million beneficiaries during the 2015 performance year. Just over 100,000 physicians participated in an ACO in 2013 (83,877 Medicare SSP and 18,840 Pioneer). In the 2015 performance year, CMS expects physician participation to increase by almost 80% to 178,000 physicians. CMS also established a baseline for the percentage of ACOs that share in savings of 34%. Given this percentage will be limited in its second year ACO performance, and the fact that the Shared Savings Program expects ACO second year participation to nearly triple by the end of 2015 to 335 ACOs, we anticipate modest growth in the total number of ACOs that will share in savings at 35% in performance year 2014 and 37% in performance year 2015 respectively. The CY 2016 targets for ACO measures 1.1-1.3 are to be determined (TBD). We will determine new targets by September 30, 2015.

CMMI2: Identify, test, and improve payment and service delivery models: At the core of the Innovation Center's work is a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

CMMI2.1 Increase the number of model tests that currently indicate 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.

Demonstrating that model tests improve quality of care, while reducing costs using rigorous evaluation and assessment methodologies, goes to the heart of the Innovation Center's daily work—the goal of measure CMMI2.1. The Innovation Center assesses routinely and rigorously the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies to assess the performance of models and generate value-based payments. As of September 30, 2014, one out of twenty-two 3021 model tests (Pioneer ACOs) has met this cost and quality goal. Positive results are also associated with two additional models (Partnership for Patients and Comprehensive Primary Care), but the available results on these models are still too preliminary. For these and the remaining 3021 models, we are assembling and assessing the evidence as it becomes available. The Innovation Center's FY 2015 target is to increase the number of models demonstrating positive results to three.

CMMI3: Accelerate the Spread of Successful Practices and Models

Every Innovation Center test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both CMS and the health care system at large. The Innovation Center also strives to understand the level of participation from beneficiaries, providers, States, payers, and other stakeholders in order to effectively design, test, and evaluate its portfolio of models.

CMMI3.1: Percentage of Medicare beneficiaries participating in Innovation Center models:

To date, the Innovation Center has introduced a wide range of Medicare initiatives – involving a broad array of Medicare beneficiaries, health care providers, states, payers and other

stakeholders. In FY 2014, over 2.5 million Medicare beneficiaries were participating in Innovation Center models. As a contextual indicator, this measure provides a snapshot of Medicare beneficiary model participation at a given point in time (not cumulative participation) in 3021 models that have been operational for more than 6 months.[2] Models that do not have mature data or are national in scope were excluded.

CMMI3.2: Number of states with health system transformation and payment reform plans: States play a critical role in determining the effectiveness of the health care system and the health of their population. In addition to being health care payers for the Medicaid, CHIP and state employee populations, states impact the delivery of care through their licensing and public health activities. The Innovation Center offers grant support to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP. In FY 2014, 25 participating states were designing or implementing a health system transformation and multi-payer payment reform strategy. An additional 9 states, 3 territories, and the District of Columbia (38 in total) are expected to design or test new payment and service delivery models in exchange for financial and technical support in FY 2015.

CMMI3.3: Number of providers participating in Innovation Center models: To accelerate the development and testing of new payment and service delivery models, the Innovation Center recognizes that many of the best ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. This contextual indicator seeks to understand the level of interest and participation among providers in the Innovation Center's model portfolio. In FY 2014, we estimate that more than 60,000 providers participated in Innovation Center payment and service delivery models. This number is expected to increase as the Innovation Center improves its ability to collect provider information and more Innovation Center models mature in FY 2015 and FY 2016.

CMMI3.4: Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities: The Innovation Center has created learning collaboratives for providers and other model participants in its models to promote broad and rapid dissemination of lessons learned and best practices that have the potential to deliver higher quality and lower cost of care for Medicare, Medicaid and CHIP beneficiaries. Every Innovation Center test of a new service delivery or payment model includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible. However, data were available only for mature models that had an established learning system in place prior to 2014 and that had convened multiple learning events during 2014. In FY 2014, 56% of 609 participating organizations in three mature models (Pioneer ACOs, the Comprehensive Primary Care initiative practice sites, and Health Care Innovation Awards Round 1grantee participants) engaged in learning activities intended to disseminate best practices. A target of 61% and 67% has been set for FY 2015 and FY 2016 respectively.

[2] Beneficiaries may be participating in more than one model.

Key Outcomes and Outputs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	CY 2015 Target	CY 2016 Target
ACO1.1 Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations: *Calendar Year Measure* CY 2013 Baseline: 4,002,532	CY 2014: September 2015 Target: 5,425,000	7,090,000 (MSSP 6,480,000 + 610,000 Pioneer)	TBD September 2015
ACO1.2 Increase the number of physicians participating in an Accountable Care Organizations: *Calendar Year Measure* CY 2013 Baseline: 102,717	CY 2014: September 2015 Target: 150,000	178,000	TBD September 2015
ACO1.3 Increase the percentage of Accountable Care Organizations that share in savings: *Calendar Year Measure* CY 2013 Baseline: 34%	CY 2014 September 2015 Target: 35%	37%	TBD September 2015

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target
CMMI2.1 Increase the number of model tests that demonstrate: 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	FY 2014 Baseline 1	3	5

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target
CMMI3.1 Percentage of Medicare beneficiaries participating in Innovation Center models	FY 2014 Baseline 5%	Contextual Indicator	Contextual Indicator
CMMI3.2 Increase the total number of States developing and implementing a health system transformation and payment reform plan	FY 2014 Baseline 25	38	38
CMMI3.3 Number of providers participating in Innovation Center models	FY 2014 Baseline < 60,000	Contextual Indicator	Contextual Indicator
CMMI3.4 Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities	FY 2014 Baseline 56%	61%	67%

Information Technology

(Dollars)

Information Technology Portfolio	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 16 PB +/- FY 15 Enacted
Medicare Parts A & B	$ 344,401,053	$ 373,739,847	$ 379,570,747	$ 5,830,900
Other Medicare Operational Costs	175,538,262	172,552,493	203,946,627	31,394,134
Medicaid & CHIP	19,965,478	37,058,681	44,658,788	7,600,107
Health Care Planning & Oversight	121,513,808	109,525,831	116,663,170	7,137,339
Health Care Quality	301,349,657	300,942,360	303,764,752	2,822,392
Outreach & Education	17,933,426	20,163,000	22,163,000	2,000,000
Enterprise Activities	801,262,576	832,274,745	817,196,263	(15,078,482)
Total Information Technology Portfolio	**$ 1,781,964,260**	**$ 1,846,256,957**	**$ 1,887,963,347**	**$ 41,706,390**

Program Description and Accomplishments

CMS' information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, HCFAC, and QIO programs. IT activities support most programs that CMS oversees, including Medicare, Medicaid, CHIP, the Affordable Care Act provisions, Private Market Insurance and associated quality-assurance and program safeguards. CMS' IT investments support a broad range of business operational needs, as well as implement provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. Further information on specific IT projects can be found within the IT Portfolio Summary (formerly known as the Exhibit 53) and the IT Business Cases (formerly known as the Exhibit 300s), which can be viewed at the investment tab located at the following address http://www.itdashboard.gov/portfolios/agency=009,bureau=38

Information Technology Portfolio:

Medicare Parts A & B investments – This investment reflects the Medicare contractors' ongoing fee-for-service (FFS) workloads, which include processing claims, enrolling providers in the Medicare program, handling provider reimbursement services, processing appeals, responding to provider inquiries, educating providers about the program, and administering the participating physicians/supplier program (PARDOC). These funds also support HITECH activities and Fraud Prevention. Major systems within this category include:

- The Enterprise Data Centers (EDC) provide hosting and support for CMS systems and services.

- CMS Common Working File (CWF) is a single data source for Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs) and Carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the FFS claims processing system where full individual beneficiary information is housed.

- Fiscal Intermediary Shared System (FISS) is a critical component of the FFS program, processing millions of Medicare claims a year. FISS is the shared system used to process 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 Medicare Administrative Contractor (MAC) authority for the Medicare FFS Program.

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

- The Single Testing Contractor (STC) provides integration and regression testing for the Shared Systems functionality pertaining to claims adjudication, payments, remittance advices, and Medicare Summary Notices (MSN). It also provides testing for various system interfaces outside of the FISS, Medicare Claims System (MCS), ViPS Medicare System (VMS), and the CWF.

- ViPS Medicare System (VMS) is a shared system used to process durable medical equipment (DME) claims for physician services, diagnostic tests, ambulance services and other services/supplies that are not covered by Part A. It interfaces directly with the CWF for verification, validation, and payment authorization.

- HITECH (Health Information Technology for Economic & Clinical Health) - The American Recovery and Reinvestment Act of 2009 (Recovery Act) provided the Health Information Technology for Economic and Clinical Health (HITECH) Act, which invests in the use of incentive payments to promote the meaningful use of electronic health records (EHRs) by eligible professionals and hospitals. This investment includes all information technology required to implement the program, including development of the National Level Repository (NLR). The NLR will serve as the central system hub for the HITECH EHR Incentive Program. This investment supports the incentive payment program production operations and supports data quality initiatives including data validation, analysis, and investigation.

Other Medicare Operation Costs – This IT investment includes the Healthcare Integrated General Ledger Accounting System (HIGLAS) Operations, ICD-10, Medicare-Medicaid Financial Alignment Models, Pioneer ACO Models and numerous CMMI activities including the new ACO capitation Model.

- HIGLAS is a national standardized financial program that began operation in 2005. HIGLAS is a component of the department-wide effort of the Health and Human Services Unified Financial Management System (UFMS). HIGLAS is a single, integrated dual-entry accounting system that is compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA) that processes the mission critical payment calculation for Medicare benefits to Part A and Part B, Medicaid Grants, and Children's Health Insurance Program (CHIP) for the entire nation. HIGLAS also incorporates internal CMS administrative program accounting transactions.

- The International Classification of Diseases (ICD-10) code sets provide more detailed information concerning diagnoses and procedures for fraud and abuse detection, increased accuracy of claims payment, and supports the Secretary's quality and transparency initiatives such as the Value-Based Purchasing initiative and the CMS' quality and transparency initiatives.

- The Medicare-Medicaid Financial Alignment Models project supports CMS work to implement the financial alignment initiative. CMS will need to enhance its systems to support both the capitated and fee-for-service financial alignment models. The capitated model will test new payment, enrollment, oversight, appeals, benefit, network adequacy, marketing, quality, and encounter data mechanisms. In the fee-for-service model, changes are needed to correctly align beneficiaries with the demonstration delivery model as well as track payments and/or shared savings.

- The Pioneer ACO Model will test alternative payment models that (1) include escalating levels of financial accountability (2) provide a transition from fee-for-service to population-based payment and (3) generate Medicare savings.

Medicaid & CHIP – CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). The Medicaid data investments establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims for Medicaid beneficiaries. This data is used for the administration of Medicaid at the Federal level, to produce statistical reports, support Medicaid related research, and assist in the detection of fraud and abuse in the Medicaid and CHIP programs.

- The Medicaid Statistical Information System (MSIS) supports much of the Medicaid research and analysis performed by the Congressional Budget Office and the Congressional Research Service. MSIS also captures claims data reported by the States, which allows for the audit of financial payments within the Medicaid and CHIP programs.

- Data storage (flat files, data warehouse, and data marts).

- The Medicaid and Child Health Budget and Expenditure (MBES) system enables CMS to support fiscal integrity for both State and Federal components of the Medicaid and CHIP programs by projecting anticipated budget expenditures, managing and supporting tracking of financial operations and actual expenditures related to program operations.

- Unified Case Management system serves as a central repository for tracking leads that contain all contractor workload reporting, dashboards to monitor progress, and outcome measure calculations.

Health Care Planning and Oversight - CMS maintains several major systems needed to run the Parts C and D programs. These systems support Beneficiary Enrollment and Plan Payment for Part C and D, Encounter Data Processing.

- Medicare Advantage Prescription Drug (MARx) and Premium Withhold Systems (PWS) deliver Enrollment and Healthplan Payment for Part C and Part D benefits. The systems process transactions for approximately 40 million enrollees from over 800 Part C and D plans.

- Retiree Drug Subsidy (RDS) creates a financial incentive to sponsors of retiree drug plans to continue offering high quality drug coverage to retirees. This IT system gives plan sponsors the flexibility to leverage existing business arrangements with consulting companies to electronically submit required data to CMS. All transactions in the RDS program are performed electronically through the use of the Internet and electronic business technology.

- The Virtual Call Center supports the national system for handling beneficiary inquiries.

- The Encounter Data System collects health care utilization (encounter) data for the purpose of editing, pricing, and storage of MA claims data for more than 16 million beneficiaries. CMS would be able to evaluate coverage, profile and analyze service utilization, and assess quality of care, with the goal of reducing fraud, waste and abuse and improving Medicare programs and healthcare in general.

Health Care Quality - CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value based purchasing (VBP) programs and other CMS health care quality initiatives, including Quality Improvement Organizations (QIO).

- Accountable Care Organizations provide technical assistance and support for CMS to implement financial and quality performance determinations. The IT systems associated with ACOs support the functions required to operate and evaluate effectiveness of care coordination for Fee-For-Service Medicare beneficiaries. These investments also assist in data sharing, ACO eligibility verification, beneficiary assignment, calculating annual expenditures, calculating and applying performance and quality scores, calculating shared savings, and program reporting. IT systems will support the activities associated with business intelligence development, database development, data dissemination, web portal application development and data analytics to support ACOs current and future program needs. This investment is dependent on shared services data environments within the CMS framework including, Integrated Data Repository (IDR), National Claims History (NCH), Master Data Management, Baltimore Data Center Hosting, and Business Intelligence Software.

- The Standard Data Processing System (SDPS) funds the hospital reporting system and is established for the user community to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

- The Health Care Quality Improvement System (QIES) is a national system that fully supports the Survey and Certification program, fulfills CMS' quality initiatives for select provider settings, aids in managing payment for services to beneficiaries, and assists in the battle against fraud and abuse. QIES supports major initiatives, such as Nursing Home Compare, Home Health Compare, and Hospital Compare. QIES supports over 111,000 users and is used by State Survey agencies, Federal Agencies, QIOs, beneficiaries, consumers and researchers.

- The Physician Quality Reporting System (PQRS) supports the combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

- Healthcare Quality End Stage Renal Disease (ESRD) Systems are the systems and network technology required to facilitate the collection and maintenance of information of the Medicare End Stage Renal Disease (ESRD) program, its beneficiaries, and the services provided to beneficiaries. They include the network infrastructure to facilitate the collection, calculation, transmission, and maintenance of data necessary to initiate performance-based payments for ESRD facilities under MIPPA Section153 C.

Outreach and Education - IT systems within this category support National Medicare Education Program (NMEP), Non-Marketplace Healthcare.gov and ACA provider Outreach.

- Beneficiary e-Services create a virtual enterprise-wide multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support www.medicare.gov and www.cms.gov websites.

Enterprise Activities - Enterprise IT activities include CMS' critical systems that support ongoing operations, primarily the Consolidated Information Technology Infrastructure Contract (CITIC). The CITIC data center contract supports the day-to-day operations and maintenance activities of CMS' enterprise-wide infrastructure, including managing the mainframe, network, voice and data communications, as well as backing up CMS' mission critical applications and managing CMS' hardware and software.

- Infrastructure Investments support the cost savings and operational efficiencies of data center consolidation, reliable backup of data through enhanced disaster recovery and maximizes the value of software license costs by transitioning to usage-based enterprise license agreements. Major IT systems within this investment include:

  -Consolidated Information Technology Infrastructure Contract (CITIC)
  -Baltimore Data Center Operations
  -Enterprise Software Licenses
  -Medicare DataComm Network (MDCN)
  -Integrated Data Repository
  -Enterprise Identify and Access Management Service

- CMS Plan Enrollment - The Health Plan Management System (HPMS) is a secure extranet web application that serves as the primary plan-based information system supporting the Medicare Advantage (MA) and Prescription Drug (Part D) programs. HPMS manages the plan enrollment and compliance business processes for all private health and drug plans participating in the MA and Part D programs.

- IT systems that support voice and data telecommunication costs, web-hosting and satellite services, ongoing systems security activities and systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

- Marketplace IT investments support the systems that implement the Health Insurance Marketplace. It includes the CMS Health Insurance Exchange (HIX) investment. HIX provides a platform for organizing the Health Insurance Marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. Marketplace IT activities are organized around two key systems: the HIX and Data Services Hub. The HIX supports the core business functions of a Marketplace, including administration, health plan management, eligibility and enrollment, risk adjustment, premium tax credit administration, program integrity, and web portal for customers. The Data Services Hub acts as a broker of information and facilitates accessing and management of a complex set of data from a variety of sources, including multiple Federal agencies and Medicaid systems. IT investments include activities aimed at coordinating integration with state Marketplaces.

- Enterprise Shared Services include:

Enterprise Identity Management (EIDM) **-** EIDM provides remote identity proofing by confirming persons are who they say they are and secure systems access via a single sign-on, while meeting federal security requirements.

Master Data Management (MDM) **-** MDM comprises processes, policies, and tools that consistently define master data. MDM links and aggregates beneficiary, provider, program, and organization data from multiple disparate sources across the agency creating a trusted authoritative data source.

Enterprise Portal **–** The Enterprise Portal provides a framework for integrating information and processes onto a single platform and entry point for beneficiaries, providers, organizations, and States to receive CMS information, products, and services.

Business Rules Enterprise Service (BRES) **–** BRES enables policies and other operational decisions to be defined, tested, executed and maintained separately from application code, which facilitates enterprise consistency and efficiency.

Enterprise Eligibility Services – The Enterprise Eligibility Service is a consistent and re-usable way for business applications to access beneficiary eligibility data for a variety of uses (e.g., claims processing, providers and plans, and external programs).

Budget Request

The FY 2016 President's Budget request for Information Technology is $1.9 billion, a $41.7 million increase from the FY 2015 Enacted level. The majority of this increase is related to Marketplace funding as the demand on the CMS IT portfolio continues to grow with the enactment and implementation of the Affordable Care Act. CMS continues to address areas within the IT portfolio to maximize efficiencies while working through tight budgetary constraints.

The FY 2016 request continues to support CMS' IT shared services strategy. The shared services strategy will reduce costs associated with development and maintenance of enterprise functions. It increases reliability and promotes better government practices that will be measured rigorously through performance and earned value management. CMS will continue to use multiple funding sources to support the Shared Services environment. Using a cost allocation methodology, CMS utilizes funds from the Program Management, HCFAC, CMMI, and QIO accounts. These funds support critical Agency priorities, including Affordable Care Act implementation.

The chart below shows the IT portfolio by funding sources.

Information Technology Portfolio	FY 2014 Operating	FY 2015 Enacted	FY 2016 President's Budget
CLIA	$ 5,100,000	$ 5,100,000	$ 5,100,000
CMMI (ACA §3021)	125,217,984	100,803,939	124,161,759
Federal Admin	38,800,000	38,806,000	37,632,000
HITECH ARRA	56,795,212	52,112,942	64,000,742
Program Integrity (MIP/HCFAC)	212,875,143	239,410,609	244,248,258
Program Ops	1,017,988,001	1,065,866,850	1,091,978,630
Quality Improvement Organizations	273,580,914	282,666,839	280,134,434
RAC Collections	18,126,792	15,894,490	18,251,086
Small Business Jobs Act of 2010	11,588,214	24,000,000	-
Survey and Certification	1,926,000	1,625,000	3,853,000
User Fee	19,966,000	19,970,288	18,603,438
Total Information Technology Portfolio	**$ 1,781,964,260**	**$ 1,846,256,957**	**$ 1,887,963,347**

Medicare Parts A & B investments

The FY 2016 President's Budget request for Medicare Parts A and B Investments is $379.6 million, which is an increase of approximately $5.8 million from the FY 2015 Enacted Level. This increase can be attributed to the Agency's priority to support fraud prevention and the One PI initiative.

Other Medicare Operation Costs

The FY 2016 President's Budget Request for Other Medicare Operation Costs is $203.9 million, a $31.3 million increase over the FY 2015 Enacted Level. In FY 2016, we expect to increase CMMI funding to support the new ACO capitation Model and the Pioneer ACO Model. This increase also supports the growing workload of the Medicare Appeals System (MAS).

Medicaid and CHIP

The FY 2016 President's Budget request for Medicaid and CHIP is $44.7 million, which is a $7.6 million increase from the FY 2015 Enacted Level. This increase in funding is to support the growing workload of the Medicaid Statistical Information System (MSIS), which is the National Medicaid Information System.

Health Care Planning and Oversight

The 2016 President's Budget Request for Health Care Planning and Oversight is $116.7 million, a $7.1 million increase over the FY 2015 Enacted level. This increase in funding supports the Medicare Advantage Prescription Drug (MARx) system and enhancements needed for the management of benefit data.

Health Care Quality

The FY 2016 President's Budget request for Health Care Quality is $303.8 million, a $2.8 million increase from the FY 2015 Enacted Level and continues to fund Health Care Quality initiatives. Funding for the FY 2016 request will continue to support the Medicare Shared Savings program, Physician Feedback, Value-Based Purchasing and ESRD initiatives. Systems supporting these initiatives such as the Consolidated Renal Operations in a Web-Enabled Environment, will continue to have periodic releases consisting of new features and fixes for defects detected in the production environment. The development and maintenance of this particular system will support the ability for End-Stage Renal Disease (ESRD) facilities to submit administrative and clinical data electronically.

Outreach and Education

The FY 2016 President's Budget request for Outreach and Education is $22.2 million, which is a $2.0 million increase from the FY 2015 Enacted Level. This increase will provide enhancements for the modernization of website functionality for the National Medicare Education Program (NMEP).

Enterprise Activities

The FY 2016 President's Budget request for Enterprise Activities is $817.2 million, which is a $15.1 million decrease over the FY 2015 Enacted Level. This funding is needed to continue IT activities which support improvements in the effectiveness and efficiency of CMS program management operations. These activities provide the operational support to manage the Agency's data environment for mission critical and enterprise-wide CMS IT strategies. One such area is the Baltimore Data Center (BDC), which supports all facets of CMS business operations. The increase in funding also continues to support CMS's Shared Service strategy to maximize cost efficiencies and productivity.

In FY 2016, the key information technology investment projects are the Data Services Hub, Cloud Computing and Marketplace Infrastructure, the Federal Health Care Exchange, Marketplace Systems Integrator, and the Healthcare.gov web portal. This budget request will fund maintenance, operations, and IT development for automated policy-based payments, automated maintenance enrollment records, direct enrollment, and planned management.

For further detail on the FY 2016 Program Operations IT budget request, the chart on the following page crosswalks IT funding according to the breakout in the Program Operations Chapter.

Program Operations - Information Technology	FY 2014 Operating	FY 2015 Enacted	FY 2016 President's Budget
Ongoing Operations - MAC & Legacy	$ 80,528,516	$ 80,260,399	$ 79,456,841
Claims Processing Investments	$ 71,236,923	$ 74,089,345	$ 78,962,123
Contracting Reform	$ 5,693,791	$ 5,947,483	$ 6,124,777
I. Medicare Parts A&B	$ 157,459,230	$ 160,297,227	$ 164,543,741
HIGLAS Operations	$ 85,659,000	$ 94,159,000	$ 108,850,000
QICs	$ 5,300,000	$ 7,000,000	$ 14,400,000
HIPAA plus NPI	$ 16,305,911	$ 17,231,011	$ 16,805,911
ICD-10 (and Version 5010)	$ 12,200,000	$ 19,608,543	$ 17,500,000
HIGLAS Development	$ 8,500,000	$ -	$ -
II. Other Medicare Operational Costs	$ 127,964,911	$ 137,998,554	$ 157,555,911
Medicaid & CHIP	$ 5,475,832	$ 11,196,489	$ 25,108,788
ACA Medicaid & CHIP	$ 1,764,646	$ 1,764,646	$ 2,000,000
III. Medicaid & CHIP	$ 7,240,478	$ 12,961,135	$ 27,108,788
Part C/D IT Systems Investments	$ 58,197,180	$ 50,305,288	$ 55,245,431
ACA Part C/D IT Systems Investments	$ 1,956,447	$ 2,350,000	$ 2,350,000
IV. Health Care Planning & Oversight	$ 60,153,627	$ 52,655,288	$ 57,595,431
ACA Health Care Quality IT	$ 19,541,739	$ 18,665,350	$ 17,491,259
ACA Physician Value	$ 5,291,520	$ 5,393,000	$ 5,542,000
V. Health Care Quality	$ 24,833,259	$ 24,058,350	$ 23,033,259
National Medicare Education Program	$ 15,079,426	$ 17,309,000	$ 19,309,000
Non-Marketplace Healthcare.gov	$ 2,000,000	$ 2,000,000	$ 2,000,000
ACA Provider Outreach	$ 854,000	$ 854,000	$ 854,000
VI. Outreach & Education	$ 17,933,426	$ 20,163,000	$ 22,163,000
Health Insurance IT	$ 320,448,283	$ 370,197,043	$ 300,000,000
Enterprise Activities	$ 242,090,895	$ 238,557,193	$ 259,007,003
Infrastructure Investments	$ 23,917,939	$ 23,105,943	$ 34,974,299
Other MMA Mandates	$ 1,916,570	$ 1,037,300	$ 2,589,210
General ACA IT	$ 6,120,895	$ 5,271,192	$ 6,109,295
Enterprise Shared Services	$ 27,908,488	$ 19,564,625	$ 37,298,693
VII. Enterprise IT	$ 622,403,070	$ 657,733,296	$ 639,978,500
Total	**$ 1,017,988,001**	**$ 1,065,866,850**	**$ 1,091,978,630**

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

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Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of National Drug Control Policy

Resource Summary
(Dollars in Millions)

	Budget Outlay Estimates			
	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	FY 2016 +/- FY 2015
Drug Resources by Decision Unit and Function:				
Medicaid Treatment	$4,000	$4,700	$5,200	+$500
Medicare Treatment	$1,100	$1,130	$1,180	+$50
Total	$5,100	$5,830	$6,380	+$550
Drug Resources by Decision Unit:				
Centers for Medicare & Medicaid Services				
Total	$5,100	$5,830	$6,380	$550
Drug Resources Personnel Summary				
Total FTEs (direct only)	0	0	0	0
Drug Resources as a Percent of Budget				
Total Agency Budget (in Billions)[1]	$883.6	$948.5	$999.8	+$51.3
Drug Resources Percentage	0.6%	0.6%	0.6%	0

Program Summary

Mission

As an effective steward of public funds, the Centers for Medicare and Medicaid Services (CMS) is committed to strengthening and modernizing the Nation's health care system to provide access to high quality care and improved health at lower cost. Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by continuing to meet the challenges of providing drug abuse treatment care benefit payments to eligible beneficiaries.

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflect the federal share of net benefit outlays and includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

Methodology

Medicaid Estimate

These projections were based on the estimates in the report "Medicaid Substance Abuse Treatment Spending: Findings Report"[2], which was written at the request of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health & Human Services (HHS) and the Office of National Drug Control Policy (ONDCP). The projections relied on the estimates of substance abuse treatment expenditures within core services (inpatient and outpatient hospital services, residential care services, prescription drugs, and substance abuse treatment services provided through managed care plans) for calendar year 2008 by state, service, and eligibility category. Those estimates were trended forward to fiscal year 2013 using the growth rate of expenditures by state, service, and eligibility category from the CMS-64, the Annual Person Summary files from the Medicaid Statistical Information System, and the estimates of enrollment growth consistent with the President's FY 2016 Budget. The annual growth rates were multiplied by 98 percent, consistent with the findings of Bouchery et al. (2012) that substance abuse treatment expenditures grew on average at the 98 percent of the rate of all Medicaid services in the same service categories. For residential care services, because neither the CMS-64 nor the Annual Person Summary files provides detail on this service, the growth rate in total Medicaid benefits (by state and eligibility category) was used.

The projections for fiscal years 2014 through 2016 were then developed from the fiscal year 2013 estimates multiplied the 98 percent of the growth rate in expenditures by service and eligibility category from the President's FY 2016 Budget (the Budget does not include projections of expenditures by state). The projections include the impacts of the Affordable Care Act, most notably the Medicaid eligibility expansion in 2014. For the service categories, because of changes to CMS-64 in 2010 and 2011, some adjustments were made in calculating the growth rates for 2008 through 2013. For inpatient hospital services, expenditures for critical access hospitals, emergency hospital services, inpatient hospital supplemental payments, and inpatient hospital graduate medical education payments were included to calculate the growth rate in inpatient hospital services. For outpatient hospital services, outpatient hospital supplemental payments were included. Additionally, consistent with the estimates in Bouchery et al. (2012), these projections do not include any prescription drug rebates collected by Medicaid; the prescription drug rebates substantially reduce net Medicaid expenditures on prescription drugs.

[2] Bouchery E, Harwood R, Malsberger R, Caffery E, Nysenbaum J, and Hourihan K, "Medicaid Substance Abuse Treatment Spending: Findings Report," Mathematica Policy Research, September 28, 2012.

Medicare Estimate

The estimates of Medicare spending for the treatment of substance abuse are based on the FY 2016 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 2014, using the primary diagnosis code[3] included on the claims. These projections are higher than those for the 2015 President's Budget, due to the incorporation of three more years of actual experience, which was higher than anticipated. The historical trend was used to make projections into the future. An adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage plans, since their actual claims are not available. It was assumed that the proportion in costs related to substance abuse treatment was similar for beneficiaries enrolled in Medicare Advantage plans as for those enrolled in fee-for-service Medicare. These estimates do not include spending under Part D of Medicare because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat substance abuse are also used to treat other conditions.

Budget Summary

The total FY 2016 drug control outlay estimate for the CMS is $6,380 million. This estimate reflects Medicaid and Medicare benefit outlays for substance abuse treatment. Overall year to year growth in substance abuse spending is a function of estimated overall growth in Medicare and Medicaid. Some of the FY 2015 to FY 2016 growth is attributable to impacts of the Affordable Care Act in Medicaid, and the actual data in Medicare was higher than anticipated.

Medicaid
FY 2016 outlay estimate: $5,200 million
(Reflects $500 million increase from FY 2015)

Medicaid is a means-tested health care entitlement program financed by States and the Federal government. States have considerable flexibility in structuring their Medicaid programs. Medicaid mandatory services include substance abuse services for detoxification and treatment for substance abuse needs identified as part of early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21 years of age. Additional Medicaid substance abuse treatment services may be provided as optional services.

Medicare
FY 2016 outlay estimate: $1,180 million
(Reflects $50 million increase from FY 2015)

Medicare provides hospital, supplemental medical and prescription drug insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance abuse treatment benefits payments are made for Medicare Part A inpatient hospital care, Medicare Part B outpatient treatment, Medicare Part B preventative substance abuse treatment, and Medicare Part D prescription drugs for substance abuse.

[3]Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 disease categories.

Performance

Both Medicaid and Medicare contain quality measurement programs that relate to substance abuse screening and treatment. However, none of the programs require reporting of specific measures, nor do they set specific performance targets for the measures. Given that these programs are in various stages of development, CMS is still working to improve data quality and data reporting timeliness. CMS is working in partnership with the Office of the National Coordinator for Health Information Technology to incorporate Clinical Quality Measures with relevant information into Electronic Health Records (EHRs) to assist in implementing the health care delivery and payment reform provisions of the Affordable Care Act. The data collected will provide insight on a wide spectrum of health care quality issues, including screening and treatment for substance use. Currently, eligible professionals may elect to report on measures related to tobacco cessation and substance abuse screening and treatment as part of a program to increase use of EHRs. As part of the requirement to qualify for EHR meaningful use incentive payments in the Medicare and Medicaid programs, professionals must report on 9 of 64 identified quality measures.

Medicaid
In FY 2015, states will continue voluntary reporting on the initial core set of health care quality measures for adults enrolled in Medicaid. One of the measures in the core set, as finalized in a January 2012 Federal Register Notice, relates to initiation and engagement of alcohol and other drug dependence treatment.

Medicare
The Physician Quality Reporting System (PQRS) is a Medicare quality reporting program that provides eligible professionals incentives for reporting on a set of quality measures. Eligible professionals may select from a set of over 200 performance measures to receive an incentive payment. The number of measures they are required to report in order to receive an incentive varies depending on the reporting method selected. In 2015, eligible professionals will stop receiving incentives for reporting and start receiving payment adjustments when they fail to successfully report.

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

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CMS Program Management
Budget Authority by Object

	2015 Enacted	2016 Budget	FY 2016 +/- FY 2015
Personnel compensation:			
Full-time permanent (11.1)	$460,672,000	$490,110,000	$29,438,000
Other than full-time permanent (11.3)	$11,915,000	$12,105,000	$190,000
Other personnel compensation (11.5)	$7,680,000	$7,982,000	$302,000
Military personnel (11.7)	$15,891,000	$16,111,000	$220,000
Subtotal personnel compenstion	**$496,158,000**	**$526,308,000**	**$30,150,000**
Civilian benefits (12.1)	$136,597,000	$151,409,000	$14,812,000
Military benefits (12.2)	$8,186,000	$8,299,000	$113,000
Total Pay Costs	**$640,941,000**	**$686,016,000**	**$45,075,000**
Travel and transportation of persons (21.0)	$5,621,000	$6,753,000	$1,132,000
Rental payments to GSA (23.1)	$5,100,000	$5,100,000	$0
Communication, utilities, and misc. charges (23.3)	$310,000	$310,000	$0
Printing and reproduction (24.0)	$2,036,000	$3,545,000	$1,509,000
Other Contractual Services:			
Other services (25.2)	$2,000,269,000	$2,216,974,000	$216,705,000
Purchase of goods and services from government accounts (25.3)	$3,318,000	$3,882,000	$564,000
Research and Development Contracts (25.5)	$20,054,000	$18,908,000	($1,146,000)
Medical care (25.6)	$1,264,748,000	$1,301,276,000	$36,528,000
Subtotal Other Contractual Services	**$3,288,389,000**	**$3,541,040,000**	**$252,651,000**
Supplies and materials (26.0)	$1,078,000	$1,153,000	$75,000
Equipment (31.0)	$100,000	$100,000	$0
Grants, subsidies, and contributions (41.0)	$31,169,000	$1,169,000	($30,000,000)
Total Non-Pay Costs	**$3,333,803,000**	**$3,559,170,000**	**$225,367,000**
Total Budget Authority by Object Class	**$3,974,744,000**	**$4,245,186,000**	**$270,442,000**

American Recovery and Reinvestment Act (ARRA)

Personnel compensation:			
Full-time permanent (11.1)	$9,535,000	$0	($9,535,000)
Other personnel compensation (11.5)	$150,000	$0	($150,000)
Civilian benefits (12.1)	$2,826,000	$0	($2,826,000)
Other Contractual Services:			
Other services (25.2)	$117,269,000	$65,000,000	($52,269,000)
Total Budget Authority by Object Class	**$129,780,000**	**$65,000,000**	**($64,780,000)**

CMS Program Management
Salaries and Expenses

	2015 Enacted	2016 Budget	FY 2016 +/- FY 2015
Personnel compensation:			
Full-time permanent (11.1)	$460,672,000	$490,110,000	$29,438,000
Other than full-time permanent (11.3)	$11,915,000	$12,105,000	$190,000
Other personnel compensation (11.5)	$7,680,000	$7,982,000	$302,000
Military personnel (11.7)	$15,891,000	$16,111,000	$220,000
Subtotal personnel compenstion	**$496,158,000**	**$526,308,000**	**$30,150,000**
Civilian benefits (12.1)	$136,597,000	$151,409,000	$14,812,000
Military benefits (12.2)	$8,186,000	$8,299,000	$113,000
Total Pay Costs	**$640,941,000**	**$686,016,000**	**$45,075,000**
Travel and transportation of persons (21.0)	$5,621,000	$6,753,000	$1,132,000
Communication, utilities, and misc. charges (23.3)	$310,000	$310,000	$0
Printing and reproduction (24.0)	$2,036,000	$3,545,000	$1,509,000
Other Contractual Services:			
Other services (25.2)	$2,000,269,000	$2,216,974,000	$216,705,000
Purchase of goods and services from government accounts (25.3)	$3,318,000	$3,882,000	$564,000
Research and Development Contracts (25.5)	$20,054,000	$18,908,000	($1,146,000)
Medical care (25.6)	$1,264,748,000	$1,301,276,000	$36,528,000
Subtotal Other Contractual Services	**$3,288,389,000**	**$3,541,040,000**	**$252,651,000**
Supplies and materials (26.0)	$1,078,000	$1,153,000	$75,000
Total Non-Pay Costs	**$3,297,434,000**	**$3,552,801,000**	**$255,367,000**
Total Salary and Expense	**$3,938,375,000**	**$4,238,817,000**	**$300,442,000**
Direct FTE 1/	**4,470**	**4,671**	**201**

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$9,535,000	$0	($9,535,000)
Other personnel compensation (11.5)	$150,000	$0	($150,000)
Civilian benefits (12.1)	$2,826,000	$0	($2,826,000)
Other Contractual Services:			
Other services (25.2)	$117,269,000	$65,000,000	($52,269,000)
Total Salary and Expense	**$129,780,000**	**$65,000,000**	**($64,780,000)**
Direct FTE	**87**	**0**	**(87)**

1/ Reflects staffing funded through the Program Management account, only.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2014 Actual	2015 Estimate	2016 Estimate
Office of the Administrator			
Direct FTEs	19	18	18
Reimbursable FTEs	0	0	0
Subtotal	19	18	18
Center for Clinical Standards and Quality			
Direct FTEs	178	193	185
Reimbursable FTEs	35	41	41
Subtotal	213	234	226
Center for Consumer Information and Insurance Oversight			
Direct FTEs	285	286	296
Reimbursable FTEs	0	0	0
Subtotal	285	286	296
Center for Medicaid and CHIP Services			
Direct FTEs	305	304	317
Reimbursable FTEs	0	0	0
Subtotal	305	304	317
Center for Medicare			
Direct FTEs	627	628	652
Reimbursable FTEs	5	8	8
Subtotal	632	636	660
Center for Medicare and Medicaid Innovation			
Direct FTEs	8	3	8
Reimbursable FTEs	0	0	0
Subtotal	8	3	8
Center for Program Integrity			
Direct FTEs	3	3	3
Reimbursable FTEs	0	0	0
Subtotal	3	3	3
Center for Strategic Planning			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Office of Acquisition & Grants Management			
Direct FTEs	167	166	174
Reimbursable FTEs	2	2	2
Subtotal	169	168	176
Office of the Actuary			
Direct FTEs	80	78	83
Reimbursable FTEs	0	0	0
Subtotal	80	78	83
Office of Communications			
Direct FTEs	213	214	221
Reimbursable FTEs	0	0	0
Subtotal	213	214	221
Office of Enterprise Management			
Direct FTEs	164	80	171
Reimbursable FTEs	0	0	0
Subtotal	164	80	171
Office of Equal Opportunity and Civil Rights			
Direct FTEs	33	32	35
Reimbursable FTEs	0	0	0
Subtotal	33	32	35
Office of Federal Coordinated Health Care			
Direct FTEs	25	24	26
Reimbursable FTEs	0	0	0
Subtotal	25	24	26

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2014 Actual	2015 Estimate	2016 Estimate
Office of Financial Management			
Direct FTEs	232	233	241
Reimbursable FTEs	26	29	31
Subtotal	258	262	272
Office of Hearings and Inquiries			
Direct FTEs	114	118	119
Reimbursable FTEs	0	0	0
Subtotal	114	118	119
Office of Information Services			
Direct FTEs	418	412	435
Reimbursable FTEs	2	2	2
Subtotal	420	414	437
Office of Legislation			
Direct FTEs	54	57	56
Reimbursable FTEs	0	0	0
Subtotal	54	57	56
Office of Minority Health			
Direct FTEs	14	14	14
Reimbursable FTEs	0	0	0
Subtotal	14	14	14
Office of Operations Management			
Direct FTEs	247	249	257
Reimbursable FTEs	0	0	0
Subtotal	247	249	257
Office of Public Engagement			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	142	140	148
Reimbursable FTEs	0	0	0
Subtotal	142	140	148
Office of Enterprise Data and Analystics (OEDA)			
Direct FTEs	0	66	0
Reimbursable FTEs	0	0	0
Subtotal	0	66	0
Consortia			
Direct FTEs	1,165	1,151	1,211
Reimbursable FTEs	33	41	42
Subtotal	1,198	1,192	1,253
Total, CMS Program Management FTE 1/	**4,598**	**4,592**	**4,796**
Total, CMS Military Staffing (Non-Add) 1/	*168*	*168*	*168*
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE 1/	**102**	**87**	**0**

1/ FY 2014 reflects actual FTE consumption. Excludes directly-appropriated ACA provisions.

Average GS Grade

FY 2012	**13.3**
FY 2013	**13.4**
FY 2014	**13.4**
FY 2015	**13.4**
FY 2015	**13.4**
FY 2016	**13.4**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2014 Actual	2015 Enacted	2016 Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$165	$165	$165
Subtotal	72	72	72
Total - ES Salaries	$12,175	$12,266	$12,389
GS-15	569	589	617
GS-14	631	653	684
GS-13	2,086	2,174	2,277
GS-12	735	761	798
GS-11	139	144	151
GS-10	1	1	1
GS-9	133	138	145
GS-8	5	5	5
GS-7	71	73	77
GS-6	7	7	8
GS-5	10	11	11
GS-4	5	5	5
GS-3	0	0	0
GS-2	3	3	3
GS-1	0	0	0
Subtotal 1/	4,394	4,566	4,783
Total - GS Salary 1/	$441,360	$460,155	$489,659
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$100.446	$100.769	$102.384

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 2012			FY 2013			FY 2014			FY 2015			FY 2016		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated																
Health Insurance Consumer Information	1002										-					
Rate Review Grants	1003															
Pre-existing Condition Insurance Plan Program	1101		18			12			7		-	0			0	
Reinsurance for Early Retirees	1102		4			11			4		-	5			0	
Affordable Choices of Health Benefit Plans	1311	$1,587,000	44		$2,147,000	56		$784,000	51		$496,000	65		$51,521	66	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP)	1322	$ (400,000)	6		$ (2,278,544)	18			15			18			18	
CO-OP Contingency Fund	1322/644	-			$ 240,259						-					
Adult Health Quality Measures 2/	2701	$ 60,000	5		$ 56,940	10		$ 55,680	9			0			0	
Medicaid Emergency Psychiatric Demonstration	2707								0			0			0	
Quality Measurement 2/	3014	$ 20,000	4		$ 18,980	6		$ 18,560	9			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		163			258			355			518			625	
Independence At Home Demonstration 2/	3024	$ 5,000	3		$ 4,745	2		$ 4,640	1		$ 4,635	2			0	
Community Based Care Transitions	3026		2			1			0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		2			1			0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1			1			1	
Community Prevention and Wellness	4202		1			1			0			0			0	
Graduate Nurse Education 2/	5509	$ 50,000	1		$ 47,450	0		$ 46,400	0		$ 46,350	0			0	
Sunshine Act	6002				$ 16,050	11		$ 1,024	14		$ 21,399	24		$ 29,075	24	
LTC National Background Checks	6201		3			4			5			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401		8		$ 5,000	10			12		$ 18,035	15		$ 10,000	15	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 10,000	2		$ 13,000	1		$ 3,000	1		$ 27,377	2		$ 18,077	2	
Expansion of the Recovery Audit Contractor Program 1/	6411		2		$ 3,300	1		$ 3,783	2		$ 3,975	2		$ 4,530	2	
Termination of Provider Participation under Medicaid 1/	6501								0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$302,000	2		$417,560	1		$316,448	1		$ 548,548	2		$600,000	2	
Total ACA Direct Appropriated FTEs			**271**			**405**			**487**			**660**			**761**	

1/ From FY 2012 through FY 2016, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2013 (-5.1%), FY 2014 (-7.2%) and FY 2015 (-7.3%).

Physicians' Comparability Allowance Worksheet. For agencies that use or are planning to use the Physicians' Comparability Allowance (PCA), please provide a populated PCA worksheet with data for FY 2014 actuals, FY 2015 estimates, and FY 2016 estimates for all items in the worksheet. Information on PCA, including the PCA worksheet and instructions, are available on the Office of Personnel Management's website:
http://www.chcoc.gov/Transmittals/TransmittalDetails.aspx?TransmittalID=4207

Response:

Physicians' Comparability Allowance (PCA) Worksheet
DHHS: Centers for Medicare and Medicaid Services
Table 1

		PY 2014(Actual)	CY 2015 (Estimates)	BY 2016* (Estimates)
1) Number of Physicians Receiving PCAs		45	54	56
2) Number of Physicians with One-Year PCA Agreements		1	1	1
3) Number of Physicians with Multi-Year PCA Agreements		44	54	56
4) Average Annual PCA Physician Pay (without PCA payment)		$148,478	$148,478	$148,478
5) Average Annual PCA Payment		$26,178	$26,178	$26,178
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position			
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	45	54	56

** PY 2014 totals were generated on January 12. We have 45 Medical Officers receiving PCA. We hired 4 additional Medical Officers in FY 2015.
*CY 2016 data will be approved during the FY 2017 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Additional physician categories have not been designated by CMS.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

The maximum amount of PCA varies depending on the GS level, the number of years as a Government physician, if they sign a one year or multi-year contract, board certified and mission-specific which is a factor based on the physician's duties that are directly related to the strategic mission and goals of CMS. CMS completed a new policy to help provide guidance which will provide a consistent yet flexible framework for determining recommended amounts for the two discretionary factors in PCA contracts. The maximum for less than 24 months as a Government Physician is $14,000 and for more than 24 months as a Government Physician is $30,000. Each time that the physician is eligible for a new contract, the package is reviewed to see if they meet the criteria for additional money due to the number of years as a Government Physician.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

In order to attract and retain highly skilled and qualified Medical Officers, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) which is mostly used within CMS and Physician's and Dental Pay (PDP) which is used primarily for dentists. CMS Medical Officers are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. Positions recruited and filled by Medical Officers require the knowledge and skills of a licensed physician to perform such duties as, evaluation of medical technology, Medicare coverage decisions, advising the Regional Offices on Medicare coverage and claims, women and children's health issues, managed and long term care coverage decisions, hospital and physician reimbursement and payment policy.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

With the implementation of the Affordable Care Act, CMS had to set up several new program offices to implement new programs. CMS continues to staff up to meet the aggressive deliverables and fast deadlines. Some of these mandates require establishing additional new Medical Officer positions or quickly filling vacated Medical Officer position to fill very specific needs. Many of these positions were also supervisory positions. PCA and PDP pay systems were used as a recruitment tool to fill these highly specialized positions. Without this recruitment and retention allowance CMS would not be able to attract and retain highly qualified physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

CMS currently has 6 – 7 Medical Officer positions that will still need to be filled in FY15.

DISCONTINUED PERFORMANCE MEASURES

Centers for Medicare and Medicaid Innovation Discontinued Measures

Measure	FY	Target	Result
CMMI 4.1 Increase the percentage of models with performance plans for continuous improvement operationalized within 3 months of launch. Baseline: 2014 TBD	*2015*	95%	Nov 2015

CMMI 4: Enhance evaluation and research capabilities

CMS is discontinuing this measure for because no data will be available for this fiscal year and the data will not be meaningful once they are available. The problem is that the numerator for this measure must be limited to new CMMI models within the last six months (for data availability reasons) and there are no new models that have been operational for the required three months. Moreover, CMS doesn't expect the denominator for this measure to be meaningful for at least two more years, due to the small number of models launched per year.

Medicaid Discontinued Measures

Measure	FY	Target	Result
PHI4.2: Percentage of States using streamlined application fully approved to enroll individuals in Medicaid and CHIP	2015	100%	10/1/2015
	2014	100%	27% (Target Not Met)
PHI4.3 Percentage of States with an approved implementation Advanced Planning Document (APD) for enhanced funding for eligibility and enrollment systems that have a dynamic electronic application	2015	N/A	Discontinued
	2014	100%	27% (Target Not Met)

PHI4.2 – PHI4.3: Increase Medicaid Coverage for Non-disabled Adults under Age 65 in States that Take Up the Option, and Simplify Medicaid and CHIP Eligibility Rules and Processes in all States This measure is being discontinued.

Measure	FY	Target	Result
MCD4: Percentage of Beneficiaries who Receive Home and Community-Based Services	*2015*	Maintain prior year	Sept 30, 2017
	2014	Maintain prior year	Sep 30, 2016
	2013	Maintain prior year	Sep 30, 2015
	2012	1% over prior FY	Sep 30, 2014
	2011	1% over prior FY	Sep 30, 2013
	2010	1% over prior FY	Pending
	2009	3% over prior FY	19% (1,253,689 Beneficiaries)
	2008	3% over prior FY	+8.3% over FY 2007 (1,053,733 Beneficiaries) (Goal exceeded)
	2007	2.1%	Baseline (972,912 Beneficiaries)

MCD4: Percentage of Beneficiaries who Receive Home and Community-Based Services
Since FY 2006, this goal has encountered long data lags as well as many data collection issues. The most recent result that we have reported is for FY 2009. We understand that the Home and Community Based Services program is a priority area for HHS. With that said, CMS will discontinue the existing measure after FY 2015 and develop a replacement measure..

Measure	FY	Target	Result
MCD5: Percentage of Section 1115 demonstration budget neutrality reviews completed	*2015*	100%	March 31, 2016
	2014	100%	Mar 31, 2015
	2013	98%	100% (Target Exceeded)
	2012	98%	100% (Target exceeded)
	2011	98%	100% (Target exceeded)
	2010	96%	100% (Target exceeded)
	2009	94%	100% (Target exceeded)
	2008	92%	100% (Target exceeded)
	2006	N/A	100% (Baseline)

MCD5: Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed Out of Total Number of Operational Demonstrations for Which Targeted Budget Reviews are Scheduled - The original purpose of this goal, established in FY 2006, was to ensure state compliance with the Administration's policy of budget neutrality; that is, any state demonstration

should not cost the Federal government more than what it would cost absent the demonstration (i.e., "budget neutral"). CMS conducted budget neutrality reviews on a 3-year cycle and each year exceeded the Agency target by achieving 100 percent. CMS will complete reporting on this goal in FY 2015, and will then change the focus of this goal to measure development of an automated infrastructure to support current section 1115 Medicaid demonstrations testing innovations focusing on payment and/or service delivery reform. This measure is being discontinued after FY 2015 and will be replaced with a new developmental measure.

Medicare Survey and Certification Discontinued Measures

Measure	FY	Target	Result
MSC4**:** Decrease the percentage of long-stay nursing home residents who have experienced one or more falls with major injury.	*2014*	Discontinue	N/A
	2013	3.2%	3.2% (Target met)
	2012	Baseline	3.3%

MSC4: Decrease the percentage of long-stay nursing home residents who experience one or more falls with major injury

Research focused on nursing home falls suggests that reducing falls and major injuries from falls is a very complex issue. While certain interventions may be beneficial in the community setting, less is known about which interventions are effective in preventing falls with injury in nursing homes. We would not want providers to implement interventions that are ineffective, harmful, or not feasible for that setting. Current research indicates that generally, multi-dimensional interventions to prevent major injury from falls in nursing facilities would be required to have a significant impact on this measure. However there is not clear evidence for the effectiveness of any one type of intervention. Starting from a baseline of 3.3 percent, it would be difficult to reduce the percentage of falls with injury without clear evidence as to what intervention works.

As a current priority, CMS' intervention to reduce the unnecessary use of antipsychotics is continuing to make progress and has the active involvement and support of advocates, medical directors and nursing facility providers. Therefore at this time, CMS will not be undertaking a specific large-scale intervention around falls that would require the ongoing measurement that the GPRA goal and tracking provide. We anticipate that based on the literature, a significant reduction in the use of antipsychotic medications may lead to a reduction in nursing home falls (there is some data to suggest that reducing overall psychopharmacological medication use may lead to fewer injurious falls).

Program Operations Discontinued Measures

Measure	FY	Target	Result
MCR22 Improve the accuracy of Medicare Physician Fee Schedule (PFS) payments by identifying, reviewing, and appropriately valuing potentially misvalued codes (including high expenditure or high cost services) under the Medicare PFS through the potentially misvalued code analysis process.	*2016*	Discontinue	N/A
	2015	Review & Value Appropriately 40% of potentially misvalued codes identified in 2014 Review & Value Appropriately 20% of potentially misvalued codes identified in 2013 Review & Value Appropriately 20% of unreviewed potentially misvalued codes identified 2012	*December* 2015
	2014	Review & Value Appropriately 40% of potentially misvalued codes identified in 2013 Review & Value Appropriately 20% of potentially misvalued codes identified in 2012 Review & Value Appropriately 20% of unreviewed potentially misvalued codes identified 2008 to 2011	February 2015
	2013	Reviewed & valued appropriately 40% of potentially misvalued codes identified in 2012 Reviewed & valued appropriately 20% of unreviewed potentially misvalued codes identified 2008 to 2011	47% (46 of 98) 20% (232 of 256) Target Exceeded
	2012	Reviewed & valued appropriately 20% of potentially misvalued codes identified 2008 to 2011	78% (911 of 1,167 codes)* Target Exceeded

*This reflects number of codes originally identified as potentially misvalued and does not reflect any resulting changes in CPT coding structure or description post hoc.

MCR22 Improve the Accuracy of Medicare Physician Fee Schedule Payments:

We are discontinuing this measure after 2015. CMS believes that the GPRA target for misvalued codes has been superseded by the recent statutory target requirements in the Protecting Access to Medicare Act of 2014 and the Stephen Beck, Jr., ABLE Act of 2014, which add a formal target for estimated expenditures under the fee schedule of redistributed dollars resulting from the misvalued code initiative. Failure to redistribute the target amount of expenditures results in a reduction in overall physician payment for the difference.

Measure ID	FY	Target	Result
MCR28.1: Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013.	Out-Year Target	Discontinued as HAI Agency Priority Goal (see discussion below)	N/A
	2014	Discontinued-Further movement and reduction of hospital-acquired CLABSI is felt to optimally benefit from targeted intervention in areas where NHSN hospital and unit data show rates to be highest. As such, this goal is not recommended for continuation as a broader HAI high priority goal however is being recommended for close monitoring and continued reporting as a CDC GPRA goal.	N/A
	2013	25%[1]	19% reduction (Target Not Met)
	2012	12.5%	17% reduction (Target Exceeded)

MCR28.1: Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013

The March 2014 CLABSI SIR (reflecting data through September 2013 in this goal), is 0.55 which reflects a final reduction of 19 percent from the CLABSI SIR baseline of 0.68. Despite the continual CLABSI reductions seen throughout the FY2011-2013 HAI APG period, it did fall short of the final target which was a 25 percent reduction in CLABSI or a final SIR of 0.51. The HAI workgroup has decided not to recommend CLABSI for inclusion in FY2014. Although the workgroup did not recommend continuation of CLABSI as part of the FY 2014-15 HAI APG, there are and continue to be significant, evidence-based interventions that when implemented in units, can prevent infection and further drive down CLABSI incidence. The impact of on-going CLABSI prevention work will be monitored as a CDC GPRA goal for FY 2014-15.

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

Measure	FY	Target	Result
PHI1: Percent of required individual health plans reporting data that is accurate and displayed on HealthCare.gov FY 2010 Baseline = 56%	2014	85%	72% (Target not met)
	2013	82%	68% (Target not met)
	2012	85%	80% (Target not met)
	2011	80%	71% (Target not met)
	2010	Baseline	56%

PHI1: Percent of required individual health plans reporting data that is accurate and displayed on HealthCare.gov

CMS may propose new metrics based on the results of the independent data quality contract at future times. At minimum, the current metric does not reflect the collection of details on small group insurance products which are undertaken by the collection efforts. Additionally, progress on such issues as the incorporation of the Summary of Benefits and Coverage to provide insurance information in a consistent manner, and providing the public automatic programming interface (API) are not recognized.

Measure	FY	Target	Result
PHI3: Increase the percentage of submissions where issuers reduce the implemented rate increase as a result of Effective Rate Review. Baseline: FY 2012 – 50%	2015	Discontinue	N/A
	2014	60%	0% (Target not met)

PHI3: Protect Individual and Small Businesses from potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review Program

This measure is being discontinued because CMS has no authority to compel issuers to reduce rate increases. We expect a smaller percentage of rate submissions to need to be adjusted downward over time, not more, as issuers learn what CMS and States are looking for in their justifications. Due to the 2014 ACA reforms, we received only 7 rate increase submissions of 10 percent or more for 2014 and all were implemented as submitted. Our FY 2014 was 0 percent, not at all close to the target of 60 percent, and is based on a very small number of submissions. This measure is being replaced with PHI6.

Measure	FY	Target	Result
PHI4.1: Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Affordable Insurance Marketplaces	2014	Establish Individual & Small Business Health Options Program (SHOP) Marketplaces in 50 States +DC *"Established"* *1. Consumers enrolling in Qualified Health Plans* *Advanced Premium Tax Credit (APTC) & Cost Sharing Reduction (CSR) payments made to issuers on behalf of eligible enrollees*	Target met.
	2013	1) Release 2014 HHS notice of benefit and payment parameters 2) Data sharing agreements for hub use in place with every State 3) Health plans certified in all Federally-facilitated Marketplace States	1) Target met. 2) Target met. 3) Target met.
	2012	Award all qualifying applications for Establishment Grants within 60 days of receiving the application	Target met.
	2011	Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process = 50 States +DC	45 States + DC (Target not met)

PHI4.1: Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Affordable Insurance Exchanges (Marketplaces)

This measure was created to track the development of the Marketplaces. New measures will be developed to track the outcomes of the Marketplaces.

Quality Improvement Organizations Discontinued Measures

Measure	FY	Target	Result
QIO4: Increase percentage of timely antibiotic administration	*2014*	99.0%	Jun 30, 2015 (Pending)
	2013	98.5%	98.7% (Target Exceeded)
	2012	98.0%	98% (Target met)
	2011	97.5%	97.8% (Target Exceeded)
	2010	92%	97% (Target Exceeded)
	2009	89%	95.6% (Target Exceeded)
	2008	85%	91.6% (Target Exceeded)

QIO4: Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

This goal has reached its upper-limits. Moreover, any additional increase could risk encouraging antibiotic overuse without additional benefit. We propose discontinuing this goal after FY 2014 with the final result expected (June 30, 2015).

Measure	FY	Target	Result
QIO5: Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	*2015*	62%	Nov 30, 2015 (Pending)
	2014	62%	62.4% (Target Exceeded)
	2013	61%	61.6% (Target Exceeded)
	2012	60.5%	61.2% (Target Exceeded)
	2011	58%	59.8% (Target Exceeded)
	2010	57%	56.8% (Target Not Met)
	2009	54%	54% (Target Met)
	2008	51%	51%

QIO5: Protect the Health of Medicare Beneficiaries by Increasing the Percentage of prevalent Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis

Development of a new Quality Improvement contract the 11th SOW has caused a delay in FY 2014 results which will now be determined in the summer of FY 2015 (June 30, 2015). This goal will be retired after 2015. Moving the target to a percentage greater than 62 percent may not

represent significant change. Clinically viable vascular accesses have been achieved with a national level of less than 10 percent of ESRD patients utilizing a catheter as their primary access point. An additional increase in the target may cause negative consequences in this population.

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

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Item

Access to Home Health Care- The agreement requests that in the fiscal year 2016 budget request, CMS quantify and explain how the policy directing physicians to conduct face-to-face certifications for home health care has prevented fraud, increased access to health care, and impacted costs to the Medicare and Medicaid programs. The agreement requests that CMS include in the budget request how provider documentation for face-to-face encounters can be simplified. In addition, CMS should provide a public analysis related to rebasing Medicare home health agencies within 90 days of enactment of this act.

Action Taken or To Be Taken

In the most recent CY 2015 HH PPS Rate Update final rule, CMS finalized changes to simplify the face-to-face encounter regulatory requirements. The face-to-face encounter requirement was enacted, in part, to discourage physicians certifying patient eligibility for the Medicare home health benefit from relying solely on information provided by Home Health Agencies (HHAs) when making eligibility determinations and other decisions about patient care. Home health services have been under scrutiny by the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (or GAO), and improper payments for these services have increased in recent years. Concerns with home health services were discussed in a report issued by the GAO entitled ''Improvements Needed to Address Improper Payments in Home Health'' (GAO–09–185). This report concluded, in part, that ''In the absence of greater prevention, detection, and enforcement efforts, the Medicare home health benefit will continue to be a ready target for fraud and abuse.'' Given the GAO report, recent reports of fraud and scrutiny of home health services by the OIG, and the ACA provision mandating a face-to-face encounter with a physician or an allowed non-physician practitioner before the physician certifies eligibility for the home health benefit, relying solely on the HHA record to substantiate eligibility is no longer appropriate.

In that same final rule, CMS implemented the second year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. The rule also provides information on our efforts to monitor the potential impacts of the rebasing adjustments and the mandated face-to-face encounter requirement. CMS will work to provide the requested public analysis.

Item

Budget Request - The CMS is expected to provide detailed plans for all of the agency's mandatory and discretionary resources. The CMS tables should include the prior year actual, current year request level, current year actual (based on the operating plan) and budget request year level. Further, include a description in the fiscal year 2016 budget request on the CMS fiscal management process.

Action Taken or To Be Taken

This request will be provided under separate cover.

Item

Congressional Notice - CMS has not been providing congressional notification on issues of importance to the Committees, such as the ACA innovation grants and Health Insurance Marketplace enrollment figures. These notifications often are provided to organizations and the media prior to notification to the House and Senate Committees on Appropriations, and in some cases without any notification provided to the House and Senate Committees on Appropriations.

CMS is directed to notify the House and Senate Committees on Appropriations not less than one full business day before ACA-related data and grant opportunities are released by the Department.

Action Taken or To Be Taken
HHS is happy to work with the Committees to provide notification on issues of importance.

Item
CMS Test Environment for Testing Industry Solutions - The agreement requests an update in the fiscal year 2016 budget request on how CMS is making users aware of this IT solution test space.

Action Taken or To Be Taken
CMS continues to promote and expand the use of the Virtual Research Data Center. Currently, there are approximately 80 external researchers using the VRDC. In order to accommodate continued increases in demand, CMS will monitor and expand VRDC capacity on an ongoing basis. CMS continues to conduct a number of outreach efforts to promote use of the VRDC, including presentations to other federal agencies and external researchers at events such as the annual Academy Health Research Conference, Health Datapalooza, and the Federal Committee on Statistical Methodology. In addition, ResDAC, CMS' research data assistance contractor, promotes the VRDC on its website, as well as providing training materials and webinars to assist researchers interested in research use of CMS data resources.

Item
Critical Access Hospitals (CAH) - The agreement continues to be concerned about the proposal to eliminate CAH status from facilities located less than 10 miles from another hospital as this would require individuals to travel long distances to access proper care and would fail to consider whether nearby hospitals are capable of providing the services that would be lost if a CAH is closed as a result of losing designation. It would also cause individuals to delay seeking medical treatment and preventive care. The agreement requests that CMS provide a report within 90 days of enactment of this act to the appropriate Committees of the House and Senate on how this proposal is expected to impact access to services in rural communities, including the analysis and criteria.

Action Taken or To Be Taken
The Administration believes that the proposal to prevent hospitals that are within 10 miles of another hospital from maintaining designation as a critical access hospital (CAH) will not have an adverse impact on rural communities' access to care. It is our expectation that the vast majority of affected hospitals will continue to participate in Medicare as hospitals and would continue to provide services to their community, even without the designation as a CAH.

In the event that some of these CAHs were to close, it is unlikely that increased travel time of up to 10 more miles would constitute a significant access to care barrier for area residents, particularly given the lower volume of traffic found on roads in rural areas and the resulting

faster travel times. Further, given that CAHs generally provide fewer and less specialized services than do hospitals, it is unlikely that nearby hospitals would not be capable of providing the same services.

As requested, CMS will conduct an analysis of claims and cost report data for the potentially affected CAHs, as well as the hospitals near them, to confirm that there is sufficient capacity to adequately serve affected communities in the unlikely event that the affected CAHs close.

Item

Demonstration of Part C and D Update - The agreement requests CMS provide an update in the fiscal year 2016 budget request on demonstrations related to Part C and D. It should specifically include evaluations that examine the advantages and disadvantages of the service area of such plans that may impact senior housing options in a given geographical area.

Action Taken or To Be Taken

In an effort to further advance the Medicare program in the face of evolving market needs, CMS conducts a number of innovative demonstration projects to help CMS determine the effect of potential Medicare program changes that may offer new methods of service delivery, types of services, or payment approaches on a variety of stakeholders. Health plans increasingly have responded to market developments and fiscal pressures with innovations in care delivery, plan design, beneficiary and provider incentives, and network design. Though evidence suggests that these innovations may reduce cost, improve quality, and enhance beneficiary satisfaction, adoption of some of these innovations has been limited in stand-alone Medicare Prescription Drug Plans (PDP), Medicare Advantage (MA) and Medicare Advantage Prescription Drug plans (MA-PD), Medicaid managed care plans (Medicaid plans), Medigap plans, and Retiree Supplemental health plans. In 2014, the CMS Innovation Center sought input from stakeholders on initiatives to test innovations in plan design, including but not limited to value-based insurance design (VBID); care delivery; beneficiary and provider incentives and engagement; and/or network design in Medicare health plans and Medigap and Retiree Supplemental health plans. Specifically related to senior housing options, Section 3208 of the Affordable Care Act made a CMS senior housing facility demonstration permanent following evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration in 2008. The full results of that evaluation are available here: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Ptaszek-2008.pdf. CMS is happy to work with the Committee to provide additional information on other specific demonstrations related to Part C or Part D.

Item

Dialysis Facilities - The agreement notes that dialysis facilities and manufacturers may be receiving contradictory guidance from State surveyors regarding conditions for coverage. CMS is directed to review this issue and take appropriate corrective actions as needed.

Action Taken or To Be Taken

CMS is responsible for ensuring that the nearly 7000 State surveyors across the country consistently apply the Conditions for Coverage during initial surveys, recertification surveys and complaint investigations of End Stage Renal Dialysis Facilities (ESRD). CMS develops Interpretive Guidance and agency policies for survey and enforcement as well as periodic training of the surveyors. All surveyors must complete the basic ESRD training course before being allowed to survey these facilities independently. There is an ESRD update provided annually. CMS also maintains a website where surveyors and the public can submit questions regarding the ESRD Conditions for Coverage.

Pursuant to the concerns noted, the CMS will work to identify any issues of inconsistency nationally, provide additional surveyor training as indicated and develop additional agency policies regarding the survey process and enforcement as indicated.

Item

Emergency Preparedness Plans - The agreement encourages CMS to partner with the Assistant Secretary for Preparedness and Response as the Department moves forward on the rule to require emergency preparedness planning for all Medicare and Medicaid providers.

Action Taken or To Be Taken

During the development of the proposed rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (CMS-3178-P), published December 27, 2013, CMS collaborated closely with Assistant Secretary for Preparedness and Response (ASPR) staff. ASPR provided CMS with technical assistance, guidance and support throughout the regulation clearance process. CMS will continue this relationship during the rule making process for publishing the final rule.

Item

Enteral Nutrition - In 2004, CMS concluded in a report to Congress that enteral nutrition formulas and supplies were not well suited for competitive acquisition. CMS is directed to submit a report within 90 days after enactment of this act that assesses the impact of the program on changes in treatment patterns of enteral nutrition patients residing in skilled nursing facilities, nursing facilities, and intermediate care facilities, including the impact on the patient's health, whether access has been reduced, and if costs have increased due to new suppliers unfamiliar with the clinical demands associated with such care.

Action Taken or To Be Taken

CMS appreciates the Committee’s interest in this area, and will work to provide the information requested.

Item

Fraud, Waste, and Abuse - The agreement requests an update in the fiscal year 2016 budget request on CMS’ process, across all operations, to ensure CMS maintains a focus on preventing improper payments and paying claims right the first time. The update shall include a proposal to measure prevention as opposed to ‘pay and chase’ measures reported by CMS.

Further, CMS is directed to increase its collaboration with HHS OIG on the oversight of ACA-related contracts to ensure all contract recipients meet their performance obligations and are held accountable for any actions not in accordance to the contract. The agreement requests a report no later than 90 days after enactment of this act describing the current oversight measures in place for contracts awarded by CMS, including the recourse available in the event that an organization fails to meet its contractual obligations.

Action Taken or To Be Taken

CMS continues to pursue strategies at specific regions, providers, and error types, including the development of new data analysis procedures to identify payment aberrancies and contractors to prevent improper payments.

These strategies include continued refinement of the Fraud Prevention System (FPS). In CMS' Report to Congress on the Fraud Prevention System's Second Implementation Year, CMS calculated adjusted savings, defined as those dollars conservatively estimated to be returned to the Trust Funds or prevented from being paid, in accordance with OIG recommendations for adjusting savings to meet financial audit standards. To meet goals related to reducing fraud, FPS developed a new anti-fraud tool using predictive and real-time data to spot abnormalities for fee-for-service claims. This functional requirement integrates fully with the Medicare FFS claims flow. Upon completion of a transition to FPS 2.0, the system will be more user friendly and have an increased number of valid data elements that increases search capabilities, therefore enabling more robust identification of potentially fraudulent cases. Transition costs have been built into the FY 2016 request. By 2016, CMS is projecting that the FPS will be supporting 1,250 users with potential to increase to approximately 2,000. It will be utilized to focus on preventing payments prior to claims finalizing, creating complex algorithms, and identifying fraudulent social network activities. These efforts will increase return on investment and achieve efficiencies that will reduce costs in the out-years.

Another initiative, and one of the Secretary's key health care fraud prevention initiatives, is to establish an ongoing partnership with the private sector to fight fraud across the health care system. As part of this initiative, CMS launched the Healthcare Fraud Prevention Partnership with HHS/OIG, DOJ, FBI, private health insurance companies, and other health care and anti-fraud groups and associations. The mission of the HFPP is to exchange data and information between partners to help improve capabilities to detect and combat fraud, waste and abuse. These exchanges of data and information take the form of targeted data exchange studies.

In November 2014, CMS established the CMS Program Integrity Board (PI Board) to ensure CMS maintains a focus on preventing improper payments and paying the claims right the first time. The PI Board identifies and prioritizes improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in the Agency's programs. The Board directs corrective actions to combat each of the high priority vulnerabilities. The PI Board is comprised of CMS executive leaders, all of whom have a stake in the identification and prevention of improper and fraudulent payments.

CMS has been working closely with OIG related to their on-going study of CMS planning and procurement efforts for the Federal Marketplace contracts. CMS has moved aggressively to implement extensive contracting reforms, bring in new leadership to oversee Marketplace operations, hire a systems integrator, and move to a new type of Health Insurance Exchange contract that rewards performance and reduces risk to the federal government. CMS is working to ensure effective management of the Marketplace with a focus on clear lines of authority, prioritization of requirements and deliverables, and metric-driven quality reviews for its Healthcare.gov contracts and for contracts across the agency. A task force has been appointed to develop a program-wide view of the cost of the Marketplace in order to strategically manage Marketplace acquisitions. Additionally, CMS is enforcing a strict governance structure for contracts and is training a stronger acquisition workforce. CMS is taking the HHS OIG's findings and recommendations seriously, and is using the report as an opportunity to make needed change.

Item

Health Insurance Marketplace Transparency - The agreement includes modified bill language in section 226 that requires CMS to provide cost information for the following categories: Federal Payroll and other Administrative Costs; Marketplace related Information Technology (IT); Non IT Program Costs, including Health Plan Benefit and Rate Review, Marketplace Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Marketplace Quality Review; Small Business Health Options Program and Employer Activities; and other Marketplace Activities. Costs information should be provided for each fiscal year since the enactment of Public Law 111-148. CMS is also required to include estimated costs for fiscal year 2016

Action Taken or To Be Taken

FY 2016 Health Insurance Marketplace Transparency
(Dollars in Thousands)

Health Insurance Marketplace Activity 1/	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015 Spend Plan 2/	FY 2016 PB
Health Plan Benefit, Rate Review, and Oversight		$ 300	$ 21,936	$ 40,595	$ 33,497	$ 45,108	$ 65,497
Payment and Financial Management		$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 62,238	$ 90,250
Marketplace-related IT	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 846,279	$ 656,820
Federal Payroll and Other Administrative Costs	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000
Eligibility and Enrollment		$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 316,417	$ 416,585
Consumer Information & Outreach		$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 741,790	$ 808,349
Call Center (non-add)			*$ 22,000*	*$ 505,446*	*$ 545,600*	*$ 570,000*	*$ 545,000*
Navigator Grants & Enrollment Assisters (non-add)				*$ 107,468*	*$ 97,152*	*$ 101,771*	*$ 137,849*
Consumer Education and Outreach (non-add)			*$ 7,043*	*$ 77,436*	*$ 49,334*	*$ 55,019*	*$ 75,000*
Marketplace Quality Review					$ 17,189	$ 14,701	$ 18,000
SHOP and Employer Activities		$ 366	$ 18,479	$ 25,076	$ 30,541	$ 34,050	$ 42,499
Other Marketplace Activities	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 6,000	$ 6,000
Total	**$ 4,654**	**$ 125,392**	**$ 325,142**	**$ 1,543,461**	**$ 2,032,418**	**$ 2,146,583**	**$ 2,189,000**

1/ Fiscal years 2010 through 2014 include obligations as of September 30, 2014.

2/ FY 2015 spending plan estimate is still under development and subject to change.

NOTE: Before the Health Insurance Marketplaces were part of CMS, $4.7 million obligations occurred in FY 2010 and $66.3 million obligations occurred in FY 2011.

Item

Hepatitis C- The agreement encourages CMS to consider the prevalence of chronic viral hepatitis among beneficiaries and the cost of providing care to those who are in the late stages of the disease. The agreement encourages CMS to educate Medicare beneficiaries and healthcare providers about hepatitis C and the need for screening while identifying opportunities to improve quality of treatments and services.

Action Taken or To Be Taken

CMS appreciates the Committee's interest in this issue. On September 5, 2013, CMS opened a National Coverage Analysis for Screening for Hepatitis C Virus (HCV) in Adults which is recommended with a grade B by the USPSTF. CMS issued a proposed National Coverage Determination (NCD) on March 4, 2014 and a final NCD on June 2, 2014. As a result, CMS will cover a single screening test for HCV for adults born from 1945 through 1965, or at high risk for infection, defined as persons with a current or past history of illicit injection drug use and persons who have a history of receiving a blood transfusion prior to 1992.

Repeat screening is covered annually for those persons who have continued illicit injection drug use since the prior negative screening test. CMS will cover screening for the HCV infection for certain individuals with the appropriate FDA approved/cleared tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, and when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting.

CMS has taken a number of steps to inform the public and providers of the HCV screening coverage policy. Specifically, CMS has issued claims processing instructions, published a Medicare Learning Network article and included information on this new benefit in a number of Medicare beneficiary-focused publications.

Item

Implantable Pain Pumps - For 20 years, both pharmacies and providers have billed Medicare directly for patient-specific Part B drugs prescribed by providers and used for certain implantable pain pumps. The agreement encourages CMS to review their technical billing change made in 2013 whereby only providers could bill CMS for these Part B drugs, so that patient access to these medications will not be restricted in States where State law prohibits pharmacies from selling these medications to providers who directly bill CMS.

Action Taken or To Be Taken

Under Section 1861(s)(2), Medicare pays for drugs and biologicals furnished "incident to" a physician's service, that is, the drugs are furnished by or under the supervision of the physician. Under this benefit category, only the physician who is furnishing the drug can bill for the program for that item or service. Pharmacies may not bill for drugs that are compounded or otherwise prepared by the pharmacy but are injected by the physician during a procedure in the office.

Since the January 1, 2013 effective date of the clarification that reaffirms Medicare's longstanding policy that only physicians can bill for drugs furnished under the "incident to" benefit, CMS has discussed this issue with stakeholders and Congressional staff and monitored for reports of problems related to the policy clarification. CMS is not aware of any significant access issues that were a result of the policy clarification.

Item

Indian Eligibility - The agreement directs CMS to work with the Internal Revenue Service to review federal regulations under their respective jurisdictions to determine who is eligible as an Indian for the benefits and protections provided to Indians. The agreement directs CMS to submit a report with the agency's finding to the Senate and House Appropriations Committees within 180 days of enactment of this act.

Action Taken or To be Taken:

The Affordable Care Act defines the term "Indian" by referencing three definitions: Section 4(d) of the Indian Self-Determination and Education Assistance Act; Section 4 of the Indian Health Care Improvement Act, and Section 45A(c)(6) of the Internal Revenue Code. CMS will work with the Internal Revenue Service to review federal regulations under their respective jurisdictions to determine who is eligible as an Indian for the benefits and protections provided to Indians and will provide the Committees information on the agencies' findings.

Item

Medicaid Authority - CMS is strongly urged to continue any hospital pool payment authorities granted under Section 1115 of the Social Security Act on the same terms and conditions as the authorities currently apply to the demonstration project for states not provided a disproportionate share hospital allotment by law.

Action Taken or To be Taken:

CMS will continue to review requests made by states for uncompensated care pool payments as part of an 1115 demonstration on the individual merits of each request.

Item

Medicare Appeals Process - The Committee is pleased by CMS' proposed list of changes that will be included in the next round of RAC contracts. The Committee directs CMS to submit a report on the status and recommendations for the cross-agency working group reviewing the entire Medicare appeals process within 180 days after enactment of this act. This report should include a comprehensive strategy analyzing the entire appeals process including the Office of Medicare Hearing and Appeals [OMHA]. The report should address how CMS will: improve the overall appeals process moving forward, including the quality of medical reviews across all Medicare audit contractors; identify any statutory changes to remove current barriers, outline strategies to eliminate the existing appeals backlog and address the high overturn rates at OMHA; and create stakeholder confidence that Medicare policies are interpreted consistently and transparently throughout the appeals process.

Action Taken or To Be Taken

HHS has implemented a broad range of administrative initiatives to reduce the both the backlog and the number of appeals that reach the OMHA level. Additionally, the President' FY 2016 Budget contains a comprehensive legislative package to increase adjudication efficiency and reduce the number of incoming appeals.

Item

Medicare Star Quality Rating System's (Stars) - The agreement requests CMS provide an update on the status of implementing the changes to the Stars methodology in the fiscal year 2016 budget request.

Action Taken or To Be Taken

In addition to maintaining several existing Compare website, CMS is considering new star ratings for three providers, , while continuing to offer star ratings for Nursing Homes and Medicare Advantage.

Nursing Home Compare-

On October 6, 2014 CMS announced that in 2015 there would be additional improvements to the information on Nursing Home Compare and the Five Star Quality Rating System. These improvements include additional quality measures and an improved scoring methodology. In 2016, CMS plans to include more complete and timely staffing data derived from nursing home

payroll records, as well as quality measures for rehospitalization and successful community discharge.

Hospital Compare-
CMS anticipates rolling out 5 stars for HCAPHS on Hospital Compare in April 2015. CMS with its contractor will be working throughout 2015 with technical expert panel to develop a methodology for an overall hospital 5-star quality rating.

Physician Compare-
CMS is currently conducting outreach and testing to determine the best course forward on a star rating methodology for group practice and individual health care professional quality measures for the Physician Compare website. Currently, Physician Compare does include stars as a graphical representation of the measure performance rate for the small set of group-level measures being publicly reported; however, at this time, this is not a rating or ranking system.

Dialysis Facility Compare-
CMS is scheduled to launch star ratings for Dialysis Facility Compare on January 22, 2015. In FY2016 CMS plans to expand the methodology to capture additional domains of quality such as patient experience of care measures, additional measures of quality care, and survey findings.

Home Health Compare-
Home Health Compare star ratings are scheduled to be launched in CY 2015. In FY2016, CMS plans to expand the methodology to capture additional domains of quality such as additional outcome measures and survey findings. All Star methodologies will benefit from ongoing analysis, evaluation and monitoring of provider performance.

Medicare Parts C and D Plan Finder/Compare –
CMS continues to maintain the Medicare Advantage and Prescription Drug Benefit Plan Finder and measurement. CMS also continues to provide 5 Star Ratings for Medicare Advantage.

Item
Ophthalmology- The agreement directs CMS to review its current policy regarding awarding in-patient hospital status for the purpose of Medicare and Medicaid reimbursement for specialty eye hospitals and report to the Senate and House Appropriations Committees on results of the review within 180 days of enactment of this act.

Action Taken or To Be Taken
Section 1861(e) of the Social Security Act defines a “hospital” for Medicare participation purposes and includes as the first requirement in the definition that the facility “….(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;….” Further, for Medicaid purposes, a hospital must satisfy the Medicare participation requirements.

As stated in the August 2006 Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005, CMS conducts a case-specific review of the circumstances of each facility that seeks to participate as a hospital in the Medicare program. CMS declined to engage in rulemaking to propose a one-size-fits all, quantitative formula for determining whether a healthcare facility is primarily engaged in providing services to inpatients. Instead CMS will continue to interpret “primarily engaged” on a case-by-case basis as it continues to explore other options for addressing this issue.

The statute does not provide authority to exempt facilities that seek to participate as specialty eye hospitals from the requirement to be primarily engaged in providing inpatient care. For such facilities CMS will continue to review their case-specific circumstances, including, but not limited to, the volume and frequency of inpatient services they provide and whether or not they have a substantial infrastructure, including both staffing and physical plant, to support the provision of inpatient services.

Item

Physician Fee Schedule - The agreement is concerned that CMS has not provided adequate opportunity for public comment on changes to surgical procedures described in the annual Medicare Physician Fee Schedule (MPFS) final rules, and is concerned appropriate methodology has not been tested to ensure no negative impact on patient care, patient access, and undue administrative burdens are not placed on providers and CMS. The agreement believes additional consideration should be given to these changes prior to implementation of changes outlined in MPFS.

Action Taken or To Be Taken

The HHS Office of Inspector General has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians. CMS proposed to transform all 10- and 90-day global codes to 0-day global codes beginning in CY 2017. After consideration of all comments, CMS finalized the proposal beginning with 10-day global services in CY 2017 and following with the 90-day global services in 2018. As the agency begins revaluation of services as 0-day global periods, we will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care. There will be additional opportunities for public input, including through notice and comment rulemaking, into this valuation process prior to proposing new rates for surgical procedures prior to adopting them in both 2017 and 2018 under our current schedule for 10 and 90 day global revisions. We further note that many of these codes have not been re-valued since the fee schedule was implemented. Section 3134 of the Affordable Care Act and section 220 of the Protecting Access to Medicare Act provide specific statutory directives for addressing misvalued physician fee schedule services.

Item

Provider Nondiscrimination - The fiscal year 2014 omnibus directed HHS to correct the 2013 FAQ on Section 2706 of the ACA to reflect the law and congressional intent; CMS has not complied with this directive. CMS is directed to provide a corrected FAQ by March 3, 2016 or an explanation for ignoring congressional intent.

Action Taken or To Be Taken

The Departments of Health and Human Services, Labor, and the Treasury continue to consider additional guidance on the Public Health Service Act section 2706.

Item

Outpatient Drug Dispensing - Directs CMS to develop additional proposals designed to encourage short-cycle dispensing of outpatient prescription drugs in long-term care facilities and investigate the effects of dispensing fee changes on cost savings in the short-cycle dispensing program. These proposals should be submitted to the Senate and House Appropriations Committees no later than 90 days after enactment of this act.

Action Taken or To Be Taken

On January 10, 2014, CMS proposed a rule that would prohibit Part D sponsors from penalizing long-term care (LTC) facilities' choice of more efficient uniform dispensing techniques by prorating dispensing fees based on days' supply or quantity dispensed. In addition, the proposed rule would require Part D sponsors to ensure that any difference in payment methodology among LTC pharmacies incentivizes more efficient dispensing techniques. Although this provision was not finalized in a final rule issued on May 23, 2014, CMS stated that it intended to finalize this provision at a later time. This is still CMS' intention. Additionally, CMS continues to review the effect of the regulatory requirement that LTC facilities dispense brand Part D drugs in increments of 14 days or less, which was effective on January 1, 2013.

Item

Recovery Audit Contractors (RACs) - Unintended consequences of RAC audits can reduce patient access to care and jeopardize the economic viability of critical health care providers. The Office of Medicare Hearings and Appeals (OMHA) has a backlog of nearly 75,000 appeals. The length of time to resolve an appeal, including OMHA's assignment of an Administrative Law Judge, can take over five years. CMS has an obligation to find a reasonable balance to eliminate true fraud and abuse while not slowing payment to the majority of honest providers that are negatively impacted by the RAC process. CMS is directed to educate providers on how to reduce errors, develop procedures to reduce the OMHA backlog; and establish a process that provides educational feedback from the OMHA to CMS and RAC contractors to reduce the identification of claims that are likely to be overturned once elevated to the OMHA. The fiscal year 2016 budget request shall include a timeline, milestones, and measurable goals to address these concerns with the RACs to reduce the appeals backlog. The budget request for fiscal year 2016, and subsequent years, shall include an actuarial estimate on the amount of improper payments, actual and estimated recoveries by year with percentage of recovered payments. CMS is directed to submit a report to the appropriate committees of the House and Senate,

within 180 days of enactment, on the cross-agency working group reviewing the Medicare appeals process and recommendations. The report should include the agency's strategy to analyze and improve the entire appeals process, as well as areas related to Medicare audit contractors' quality of medical reviews, proposed statutory challenges; timeline and strategy to eliminate backlog; steps to address the high overturn rates at OMHA; and steps to improve stakeholder confidence that Medicare policies are interpreted consistently and transparently throughout the system.

Action taken or to be Taken:
On August 29, 2014, CMS presented an offer to hospitals to resolve backlogged claims appeals. The period for submitting an intent to participate ended on October 31, 2014. Although over 2,000 hospitals have entered the process, it is unknown how many hospitals will complete the process and choose to accept the offer.

The Recovery Audit Program has included several improvements into the Statement of Work (SOW) for the new contracts, as follows: **1)** Recovery Auditors are required to offer a 30-day discussion period to providers, with the goal of trying to resolve the claim, before referring a claim to a MAC for collection. One small study indicated that such discussions resulted in approximately 42% fewer claims reopened by Recovery Auditors, leading to fewer appeals. The estimated impact for FY 15 is that 17,143 fewer appeals will reach the OMHA level of appeals. **2)** For appealed determinations, Recovery Auditors will not be paid their contingency fees until their decisions have been upheld at the first two (MAC and QIC) levels of the appeals process. The estimated impact for FY 15 is that 2,900 appeals will be avoided. **3)** Recovery Auditors are required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected by the provider during the appeal process. Failure to do so will result in CMS placing the Recovery Auditor on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions. **4)** CMS will continue to use a validation contractor to assess the accuracy of Recovery Auditor identifications. Recovery Auditors will be required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of 95% will result in a progressive reduction in the number of medical records/documents that can be requested for review.

CMS has also made improvements to their internal process for approving and monitoring Recovery Auditor reviews. These include: **1)** approving only a limited number of claims to be reviewed for each review topic, and **2)** closely monitor those reviews throughout the appeals process. If CMS has concerns regarding the accuracy of Recovery Auditor determinations, for a specific review topic, further reviews on that topic will be stopped. These improvements will be implemented in each region upon award of each new contract.

Item

Rehabilitation Innovation Centers - Comprehensive rehabilitation research centers in the United States serve a unique role in complex fields such as brain injury, strokes, multiple traumas, and wartime injuries. Given the high volume of Medicare and Medicaid patients served by these centers, HHS is urged to evaluate the current prospective payment rate with the goal of maintaining these centers of excellence and continuing the high quality of care provided by these centers.

Action Taken or To Be Taken

CMS is committed to ensuring that individuals with complex conditions, such as traumatic brain injury, receive quality rehabilitation care by providing accurate payment for rehabilitation services furnished to beneficiaries in inpatient rehabilitation facilities. As CMS continues to refine the quality measures in the Inpatient Rehabilitation Facility Quality Reporting Program, we hope to further improve the quality of care provided to patients in inpatient rehabilitation facilities.

Item

Ventricular Assist Devices - The agreement is concerned with the Medicare National Coverage Analysis for Ventricular Assist Decides for Bridge-to-Transplant and Destination Therapy (CAG-00432R), Decision Memo dated October 30, 2013. CMS is encouraged to review the decision, and upon receipt of appropriate new evidence, to consider whether to cover ventricular assist devices for 1) individuals who are undergoing an evaluation to determine candidacy for heart transplantation; and 2) individuals who would be potential heart transplant candidates, but are not eligible because of a contradiction that may be favorably modified by the use of a ventricular assist device.

Action Taken or To Be Taken

CMS appreciates the Committee's recommendation. CMS continues to closely follow this issue to ensure that beneficiaries have access to appropriate health care services. CMS will review and evaluate any new evidence provided to us related to Ventricular Assist Devices and will determine whether to conduct an NCD reconsideration based on the process described in the August 2013 Federal Register notice "Revised Process for Making National Coverage Determinations" (CMS-3284-N).

Transparency in Health Plans - The agreement directs the Secretary to provide additional clarification to qualified health plans, based upon relevant and related GAO findings, to ensure greater consistency and full transparency of coverage options included in health insurance plans prior to plan purchase in the marketplace enrollment process. The agreement requests a timeline for such clarifying guidance to be submitted to the House and Senate Committees on Appropriations within 30 days after enactment of this act.

Action Taken or To Be Taken

In the Statement of Managers accompanying the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), the Labor/HHS Appropriations Subcommittee directed the Secretary to provide additional clarification to Qualified Health Plans, within 30 days of

enactment, based upon relevant GAO findings, to ensure greater consistency and full transparency of coverage options included in health insurance plans prior to plan purchase in the Marketplace enrollment process. To address this request, the Office of the Assistant Secretary for Financial Resources (ASFR) notified the House and Senate Appropriations Committee staff members on December 22, 2014 that the Department would be issuing proposed rules to provide additional clarification to Qualified Health Plans on requirements for the Summary of Benefits and Coverage, which would ensure greater consistency of plan information to consumers and support full transparency of coverage of abortion services prior to enrollment in a Marketplace plan. Specifically, the proposed rule, published in the federal register on December 30, 2014 (79 FR 78578), would require a Qualified Health Plan offering coverage through an individual market Exchange to disclose on the Summary of Benefits and Coverage whether abortion services are covered or excluded, and whether coverage is limited to services for which federal funding is allowed (in instances of rape, incest, or when the life of the woman is endangered).

FY 2015 Health Insurance Marketplace Reporting

Marketplace Data Services Hub Milestones

Federal Data Services Hub (DSH) Description and Time Line

Data Services Hub (DSH) Description:

The Data Services Hub (DSH) is a single interface to the States and Federal partners to provide information exchange and business functionality in support of Marketplace operations; it interfaces with many Federal entities and performs multiple tasks including verifying citizenship, immigration status, and tax information with the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS). In addition, DSH facilitates submission of Enrollment reports from Marketplaces to IRS for tax credit reconciliations, performs current Income validation with Equifax, remote identity proofing with Equifax, and eligibility verifications with data sources from multiple Federal agencies like Peace Corp, Veteran's Health Administration, TRICARE, Office of Personnel Management, Medicare, and various State Medicaid and CHIP agencies. This Data Services Hub delivers information to the States for Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP). The Data Services Hub reduces costs and improves reliability by organizing a single set of interfaces that would otherwise require multiple point-to-point interfaces.

Data Services Hub (DSH) Timeline:

- 09/30/2011 – Contract Kick-Off
- 09/30/2011 – CMS awards Data Services Hub (DSH) Contract to QSSI vendor. The QSSI contractor began program setup, engaging CMS stakeholders, and gathering system requirements.
- 10/13/2011 – CMS issues a Stop Work Order for the Data Services Hub (DSH) contract due to award protests.
- 01/18/2012 – CMS lifts the Stop Work Order to the Data Services Hub (DSH) contract due to the closing of the protest.
- 01/30/2012 - Project Startup Review including revised program scope, project schedule, and revised initial requirements; development started.
- 03/31/2012 - Began development for Data Services Hub to verify Social Security Number (SSN) and Citizenship with Social Security Administration (SSA), verify Advance Premium Tax

Credit (APTC) and Family Size with the Internal Revenue Service (IRS), and to verify lawful presence with the Department of Homeland Security (DHS).

- 09/30/2012 - Development begins for connecting Federal Marketplace Eligibility and Enrollment (E&E) functionality with Hub services. The Eligibility and Enrollment functionality verifies consumer information in the process of eligibility determination for premium tax credits, Qualified Health Plans (QHPs) and the Medicaid/Children's Health Insurance Program (CHIP).

- 01/25/2013 - Test Plan, Testing Schedule, and Test Data delivered to States for the start of State testing.

- 05/31/2013 - Development for Enrollment Transactions sent from Federal Marketplace to health plan providers to initiate enrollment for consumer policy or to cancel/terminate enrollment.

- 06/06/2013 - Start testing with health plan providers.

- 06/30/2013 - Marketplace online application fully integrated with Hub Verification Services (Social Security Administration (SSA), Internal Revenue Service (IRS), Department of Homeland Security (DHS), and other sources including States.

- 08/19/2013 - DSH Security Control Assessment (SCA) testing conducted. The Security Control Assessment (SCA) requires that controls supporting the Data Services Hub are tested every 3 years by a third party vendor. And at least 1/3 of the controls are tested on a yearly basis. An Authority To Operate (ATO) is not granted unless a Security Control Assessment (SCA) is performed, all controls have been tested, and is signed off by the CMS Chief of Information Security Officer (CISO).

- 09/06/2013 – CMS Chief Information Officer granted, as well as approval by the CMS Administrator, DSH Authority To Operate (ATO) the Federal Marketplace Go-Live after passing security testing. This process is an essential part of the CMS enterprise-wide information security program used in making a risk determination decision for the operation of the subject system. When the level of risk to the CMS enterprise is deemed acceptable, the system is granted an Authority To Operate (ATO for up to three years).

- 09/16/2013 - Operational Readiness Review (ORR) conducted to review Federal Marketplace and Hub systems, Operations support, Help support, etc. for Go-Live readiness. The purpose of the Operational Readiness Review (ORR) is to conduct a formal inspection to determine if the final information technology (IT) solution or automated system that has been developed, implemented and tested is ready for release into the production environment for sustained operations and maintenance support.

- 10/01/2013 - Start of Open Enrollment

- 11/2013 – Updates to support PY2014 Open Enrollment activities. Development of Multifactor Authentication (MFA) VeriSign Identity Protection Authentication (ADD) made available to all State agencies as a service.

- 01/2014 – Updates to Verify Lawful Presence (VLP) service enhancement from the Department of Homeland Security (DHS). Enhancements to Non-Employer-Sponsored Insurance (ESI) Minimal Essential Coverage (MEC) and Eligibility Verification Orchestration services.

- 03/2014 – Development of FY2015 Plan Management's Validation & Transformation Service to incorporate new plan data elements and enable submission of Plan Data by Issuers utilizing System for Electronic Rate and Form Filing (SERFF) platform for plan data submissions. Development of Marketplace Generation of Monthly Enrollment Report to Internal Revenue Service (IRS).

- 07/2014 - Development of Business Application Acknowledgement (BAA) for Small Business Health Options program (SHOP) transactions. Development of bulk services for Advance Payment Computation (APC) Service and Renewal and Redetermination Verification (RRV) Composite Service.

- 08/2014 - Development of Reinsurance Contribution Service and completion of service refactoring and testing with CMS' Healthcare Integrated General Ledger Accounting System (HIGLAS) platform for financial management transactions. Updates to enrollment service to accommodate Small Business Health Options Program (SHOP) enrollments.

- 08/29/2014 - DSH Security Control Assessment (SCA) testing performed for all new DSH functions and one-third of the DSH controls required to be tested on a yearly basis to maintain an Authority-To-Operate (ATO). Results of SCA testes were approved and is not granted unless a signed off by the CMS Chief of Information Security Officer (CISO).

- 10/2014 – Completed end-to-end testing for Small Business Health Options Program (SHOP) and SHOP's Premium Aggregation Service (PAS) functions.-SHOP and SHOP-PAS fully integrated with the DSH. Completed Offline Income Verification service with Internal Revenue Service (IRS) and Federally-facilitated Marketplace (FFM) to facilitate analysis of enrolled consumers and sending notices to potential returning consumers in preparation for PY2015 Open Enrollment.

- 11/15/2014 - Start of Open Enrollment for FY2015