DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2012

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) 2012 performance budget. Our programs will touch the lives of almost 105 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2012. We take our role very seriously, as our oversight responsibilities impact millions of vulnerable citizens and continue to grow dramatically. We now have an opportunity to provide affordable, quality health care coverage to millions of Americans through the establishment of new health care insurance and protection programs. CMS' three-part goal is better care for individuals, better health for the population, and lower cost through improvements.

In March 2010, the President signed into law the Affordable Care Act. This legislation includes numerous provisions which impact CMS' traditional role as the overseer of the Medicare, Medicaid, and CHIP programs, including: a major expansion of the Medicaid program; a two-year extension of CHIP; the gradual elimination of the Medicare prescription drug "donut hole"; and the creation of a CMS Innovation Center which will explore different care delivery and payment models in Medicare, Medicaid, and CHIP. The legislation also restructures payments for Medicare Advantage plans, expands value-based purchasing, promotes better health through wellness, prevention, and integrated care, and gives CMS unprecedented new tools as well as new resources for fighting fraud, waste, and abuse.

Through its newest center, the Center for Consumer Information and Insurance Oversight, CMS will make affordable health insurance available to more Americans by establishing Health Insurance Exchanges by 2014, providing insurance coverage for uninsured individuals with pre-existing conditions, providing financial assistance for employer-based plans that cover early retirees, and enforcing compliance with market reform provisions. New performance measures were added to represent this massive effort. Additional information about CMS performance may be found in our Online Performance Appendix at http://www.cms.gov/performancebudget.

Our resource needs are principally driven by workloads that grow annually and by our role in leading national efforts to improve healthcare quality and access to care, not just for our traditional beneficiaries but for all Americans. Our FY 2012 Program Management request reflects an increase over the FY 2010 enacted level but one that is consistent with the magnitude and complexity of the new programs and provisions CMS is tasked with implementing. Wherever possible, CMS will leverage its experience and existing systems and programs to achieve efficiencies and avoid duplication of effort.

On behalf of our customers and beneficiaries, I thank you for your continued support of CMS and its FY 2012 Performance Budget**.**

/Donald M. Berwick, M.D./
Donald M. Berwick, M.D.

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As of February 3, 2011
*** Acting**

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EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (DHHS). The creation of CMS (previously the Health Care Financing Administration) in 1977 brought together, under unified leadership, the two largest Federal health care programs at that time--Medicare and Medicaid. In 1997, the Children's Health Insurance Program (CHIP) was established to address the health care needs of uninsured children.

In the past decade, legislation has significantly expanded CMS' responsibilities. In 2003, the Medicare Modernization Act (MMA) added a prescription drug benefit, the most significant expansion of the Medicare program since its inception in 1965. In 2005, the Deficit Reduction Act (DRA) created a Medicaid Integrity Program to address fraud and abuse in the Medicaid program. The Tax Relief and Health Care Act of 2006 (TRHCA) established a physician quality reporting program and quality improvement initiatives and enhanced CMS' program integrity efforts through the Recovery Audit Contractor (RAC) program. The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA) continued physician quality reporting and extended the CHIP, Transitional Medical Assistance (TMA), and other programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended and expanded the physician quality reporting program and established an electronic prescribing incentive program and value-based purchasing for end-stage renal disease services. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) improved outreach, enrollment, and access to benefits within the Medicaid and CHIP programs, and mandated development of child health quality measures and reporting for children enrolled in Medicaid and CHIP. The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act") provided investments for technological advances, including health information technology and the use of electronic health records, and prevention and wellness activities. More recently, in March 2010, the President signed into law the Affordable Care Act. The legislation contains numerous provisions which impact CMS' traditional role as the overseer of the Medicare, Medicaid, and CHIP programs 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 addition, CMS has recently become responsible for the implementation of the Affordable Care Act's consumer protections and private health insurance provisions. These provisions provide: new coverage options for previously uninsured Americans with pre-existing conditions; reimbursement for employers to help pay part of the cost of providing health benefits for early retirees, their spouses and dependents; new requirements regarding the market conduct of private health care insurers; and new consumer outreach and education efforts to help consumers assess their options and determine their eligibility for public programs. By 2014, CMS will work with states to create new competitive health insurance markets that will operate through exchanges and provide millions of Americans with access to affordable coverage.

CMS remains the largest purchaser of health care in the United States. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures. For 45 years, these programs have helped pay the medical bills of millions of older and low-income Americans. In FY 2012, we expect to serve almost 105 million Medicare, Medicaid and CHIP beneficiaries, roughly one in three Americans. With the implementation of the Affordable Care Act provisions, CMS has the opportunity to provide affordable health care to millions of Americans.

CMS outlays more benefits than any other Federal agency and we are committed to administering our programs as efficiently and effectively as possible. In FY 2012, benefit outlays are expected to total $819.4 billion. Non-benefit costs, which include administrative costs such as Program Management, the Federal share of Medicaid State and local administration, non-CMS administrative costs, the Health Care Fraud and Abuse Control account (HCFAC), the Quality Improvement Organizations (QIO), and the new insurance market reforms, among others, are estimated at $28.7 billion or 3.5 percent of total benefits. CMS' non-benefit costs are small when compared to Medicare benefits and the Federal share of Medicaid and CHIP benefits. Remarkably, Program Management costs are only one-half of one percent of these benefits.

Mission

CMS envisions itself as a major force and trustworthy partner for the continual improvement of health and healthcare for all Americans.

Overview of Budget Request

CMS requests funding for its four annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds (PTF). The table below displays our FY 2011 estimates and FY 2012 requests for these accounts.

Within Program Management, funding will enable CMS to implement enhancements and expansions in its traditional health care programs—Medicare, Medicaid, and CHIP--as well as new activities related to insurance market reform and oversight, and consumer information. CMS is also requesting funding for State High Risk Pools in FY 2012. CMS is proposing to transfer the State Health Insurance Assistance Program (SHIP) function to the Administration on Aging (AOA) in FY 2012.

Major activities within each of these accounts are discussed in more detail below.

CMS Annually-Appropriated Accounts
($ in millions)

Accounts	FY 2011 Estimate	FY 2012 Request	FY 2012 Req. +/- FY 2011
Program Management /1	$3,423.2	$4,397.0	+$973.8
HCFAC – Discretionary /1	$311.0	$580.6	+$269.6
Grants to States for Medicaid	$260,782.7	$270,724.4	+$9,941.7
Payments to Health Care Trust Funds	$222,105.0	$231,012.0	+$8,907.0
Grand Total	**$486,621.9**	**$506,714.0**	**$20,092.1**

1/ FY 2011 column reflects an annualized FY 2010 Continuing Resolution (CR) level. FY 2011 Program Management levels have been comparably adjusted for the SHIP transfer to AoA and to include funding for State High Risk Pool grants.

FY 2012

Program Management (+$973.8 million)

CMS is requesting $4,397.0 million in Program Management funding to be used to undertake the following activities:

- Program Operations:
  "Program Operations" replaces the previous "Medicare Operations" line item by including activities that implement CMS' new responsibilities as well as contractor and information technology costs for the Medicaid and Children's Health Insurance Program that were previously in the Federal Administration line. The FY 2012 request for $3,062.0 million is an increase of $771.2 million above the comparably-adjusted FY 2010 enacted level. This funding level will allow CMS to process over 1.2 billion fee-for-service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), continue work on the new ICD-10 coding system, and maintain our 1-800 call centers. This funding level assumes that CMS transfers the State Health Insurance Assistance Program (SHIP) to the Administration on Aging (AOA). The additional funds will allow CMS to improve and enhance its existing programs including quality reporting and incentive payments, health plan oversight, provider and beneficiary outreach, administrative simplification, and information technology infrastructure. They will also support implementation of new insurance market reforms and oversight programs, new State-based and Federally-operated Exchanges that must be built before 2014, and outreach and education for a new and different cohort of consumers.

- Federal Administration:
  CMS requests $859.5 million, an increase of $164.6 million above the comparably-adjusted FY 2010 enacted level. This level will support 4,917 direct FTEs, including FTEs not previously funded through Program Management, as well as increased contracts and space requirements for implementing ACA provisions.

- Survey and Certification:
  CMS requests $400.3 million, an increase of $53.4 million above the FY 2010 enacted level. At this level, CMS can meet both its statutory and policy survey frequencies for all facility types to protect beneficiary quality of care and safety. Funds will also be used to enhance transparency, accountability, best practices, and staff training in the nation's nursing homes.

- Research, Demonstration, and Evaluation:
  CMS requests $31.2 million, a decrease of $4.4 million below the FY 2010 enacted level. At this level, CMS will continue to fund the Medicare Current Beneficiary Survey, the Real Choice Systems Change grant program, and other commitments. It reflects a reconfiguration of research capabilities given the establishment of the Center for Medicare and Medicaid Innovation (CMMI).

- State High-Risk Pool Grants:
  CMS requests $44.0 million, a decrease of $11.0 million below the FY 2010 enacted level. These grants to States help individuals with pre-existing conditions access coverage. Additionally, the new Pre-existing Condition Insurance Plan program (PCIP) enacted in the Affordable Care Act offers new coverage options for individuals with pre-existing conditions who have been uninsured for at least 6 months.

Health Care Fraud and Abuse Control (+$269.6 million)

CMS is requesting $580.6 million in discretionary HCFAC funding in FY 2012, an increase of $269.6 million above the FY 2010 enacted level. This additional funding will allow CMS and its law enforcement partners to invest in activities that will reduce fraud in Medicare, Medicaid, and CHIP. This includes investments in state-of-the-art analytic technology to detect and prevent improper payments; measures to reduce the improper payment error rate by 50 percent, including focused pre-payment review, aggressive representation at cases before administrative law judges, staffing to implement corrective actions, and establishing a CMS overpayment vulnerabilities task force; expansions of existing Strike Forces, used to identify and prosecute fraudulent providers, from seven cities to up to 20 cities; enhancements of Medicaid audits; increased provider and supplier site visits; increased fraud hot lines and beneficiary outreach; and implementation of a robust package of program integrity legislative proposals.

Grants to States for Medicaid (+$9.9 billion)

The FY 2012 Medicaid request is $270.7 billion, an increase of $9.9 billion above the FY 2011 current law estimate. This amount includes: $252.5 billion in medical assistance benefits; $1.4 billion for benefits incurred but not reported; $12.8 billion for administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; $4.0 billion for the Centers for Disease Control and

Prevention's Vaccines for Children program. In total, the FY 2012 request includes $1.0 billion in net budget authority for Recovery Act provisions, a decrease of $11.1 billion from the FY 2011 level.

Payments to the Health Care Trust Funds (+$8.9 billion)

The FY 2012 request for Payments to the Health Care Trust Funds account--$231.0 billion--reflects an overall increase of $8.9 billion above the FY 2011 estimate. This account provides the Supplementary Medical Insurance (SMI) Trust Fund with the general fund contribution for the cost of the SMI program. It transfers payments from the General Fund to the Hospital Insurance and SMI Trust Funds, as well as to the Medicare Prescription Drug Account (Medicare Part D), in order to make the Medicare trust funds whole for certain costs, initially borne by the trust funds, which are properly charged to the General Fund.

CONCLUSION

CMS' FY 2012 request for its four traditional annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $506.7 billion, an increase of $20.1 billion above the FY 2011 estimate.

CMS requests $4.4 billion for Program Management, an increase of $974 million. This level will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs and also fund the provisions enacted in FY 2010 in the Affordable Care Act including activities for new health insurance protections and programs. We are requesting $580.6 million in HCFAC discretionary funding, an increase of $269.6 million which will be devoted primarily to new priorities focused on reducing the payment error rates in both Medicare and Medicaid and to expanded HEAT-related activities.

We remain committed to finding efficiencies within our base, to safeguarding our programs, and to providing our beneficiaries, stakeholders, and health care consumers with the highest possible levels of service.

OVERVIEW OF CMS PERFORMANCE

The CMS FY 2012 performance plan under the Government Performance and Results Act (GPRA) currently has 47 performance goals (74 measures). We carried over many of the measures in the FY 2011 plan, with new FY 2012 targets consistent with the President's goals and priorities and introduced new measures to reflect legislative responsibilities. Some performance measures were retired to focus on significant new CMS responsibilities, challenges and strategic priorities.

CMS added several new FY 2012 measures, to highlight its new responsibilities of the Affordable Care Act. Among these are measures to reduce Medicare hospital readmissions and hospital acquired conditions in Medicare and Medicaid; a measure to improve program integrity in Medicare through administrative actions toward targeted high risk providers and suppliers; and a measure to reduce beneficiary's out-of-pocket expenses for Part D Prescription Drugs. We have adopted measures to increase access to health care including the establishment of new health insurance exchanges making health insurance available and affordable to millions of Americans; increasing the number of young adults under age 26 who are covered as a dependent on their parent's employer-sponsored insurance policy; and providing comprehensive health insurance coverage for individuals with pre-existing conditions. These and other Affordable Care Act measures are included in the CMS budget and its Online Performance Appendix, (OPA) and several are featured in the HHS Strategic Plan (2010-2015.)

We also added a new measure to improve access to and utilization of oral health care services for children enrolled in Medicaid or CHIP, and a goal reflecting CMS' incentive payments to meaningful users of electronic health records to improve the quality, safety and efficiency of health care for our Medicare and Medicaid beneficiaries.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance measures that highlights fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. The FY 2012 targets, along with most recent reporting on key measures, are outlined in the Outcomes and Outputs Table at the end of each related program discussion. Additional details about these and all CMS GPRA performance measure may be found in the CMS OPA.

Our performance measures reinforce CMS Strategic aims to achieve operational excellence and to help provide better care for individuals, better health for populations, and at lower costs and are key to the HHS Strategic goals to Transform Health Care and Increase Efficiency, Transparency, and Accountability of its programs

The Department of Health and Human Services has identified a limited number of priority goals that are an Administration focus. Among these is CMS' goal to *improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.* The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized the CHIP program and increased funding to maintain State programs and to cover more children. This CMS priority goal has been expanded to include Medicaid populations in the future, and is reflected in the new HHS Strategic Plan.

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

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	46	46	100%	42	91%
2008	53	52	98%	46	88%
2009	52	51	98%	42	82%
2010	55	33	60%	27	82%
2011	73	4	5%	4	100%
2012	74	0	0%	0	0%

Summary of the American Recovery and Reinvestment Act (ARRA)

Available Resources, Outlays and Performance

(dollars in millions)

ARRA Implementation Plan	Total Outlays FY 2009 - FY 2019	FY 2009/ FY 2010 Outlays	FY 2011 Outlays	FY 2012 Outlays
Health Information Technology: Medicare and Medicaid Incentives and Administrative Funding				
Program Management	1,045	16	191	220
State/Local Admin	1,592	9	140	144
Medicare Incentives	5,590	0	640	2,830
Medicaid Incentives	12,351	0	1,619	854
Medicaid Program				
Temporary Increase in Medicaid FMAP[/1]	84,512	71,012	13,500	0
Temporary Increase in DSH Allotments	234	234	0	0
Qualified Individual (QI) Extension	417	267	150	0
Transitional Medical Assistance (TMA) Extension [/2]	915	510	395	10
Protections for American Indians/Alaska Natives Under Medicaid and CHIP [/2]	190	15	10	10

[1] Amounts reflect FMAP assistance provided in the Recovery Act (P.L. 111-5), available through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act (P.L. 111-226) extended the enhanced FMAP provision at a phased-down rate through June 30, 2011, providing an estimated $13.5 billion in additional assistance.

[2] Cost impacts for this provision are actuarial estimates.

Selected Performance Measures by Implementation Plan

Temporary Increase in FMAP

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Number of Beneficiaries enrolled in the Medicaid Program	50,100,000/[3]	48,876,944[/4]	December 2011	Program Ended

[3] FY 2009 enrollment is projected.

[4] At this time, reports have not been received from all States. CMS continues to work with States in order to obtain full reports from every State. An Access database has been developed to store this information.

Data Source: Quarterly ARRA Report per Section 5001 of Recovery Act: Temporary Increase of Medicaid FMAP. Data is available between 70 and 90 days after the quarter ends.

The goal of the enhanced Federal Medical Assistance Percentages (FMAP) provision of the Recovery Act is to provide additional Federal support for States during the recession period. The increased Medicaid funding made available through December 31, 2010, will prevent health coverage loss and stabilize the system. The recent Education, Jobs and Medicaid Assistance Act (P.L. 111-226) extends the increased FMAP through June 30, 2011. This will help maintain vital health care programs and provide a critical boost to local economic activity across the country.

Temporary Increase in DSH Allotments

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Number of States drawing temporary increase in Medicaid DSH funds	7	22	Program Ended	Program Ended

Data Source: CMS-64. Data is available 30 days after the quarter ends. States are not double counted.

Eligible hospitals that serve a disproportionate share of low-income or uninsured individuals are entitled to receive DSH payments. The enhanced payments are in addition to the regular DSH payments facilities receive for providing care to Medicaid beneficiaries.

Qualified Individual (QI) Extension

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Maintain the QI Program: Number of individuals who receive QI benefits	4,563,815	5,626,407[/5]	March 2011	Program Ended

[5] CMS is reporting the number of individuals who receive QI benefits for the period 1/1/2010 through 12/31/2010.

Data Source: CMS-64. Data is available 30 days after the quarter ends.

The QI program allows Medicaid to pay the Medicare part B premiums for low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty. QI under the Recovery Act expired December 31, 2010.

Transitional Medical Assistance (TMA) Extension

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Number of States streamlining eligibility for the newly employed	12	14	March 2011	Program Ended

Data Source: Data regarding number of States implementing the provision is from tracking reports for State Plan Amendments.

Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings. The Recovery Act extended TMA until December 31, 2010. Medicare and Medicaid Extenders Act (P.L. 111-127) extended TMA through December 31, 2011.

Protections for Indians Under Medicaid and CHIP

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Number of States soliciting advice from AI/AN communities	N/A	1/6	All States	All States

6 States will be notified that consultation State Plan Amendments (SPAs) need to be submitted by December 31, 2010. Several States are in the process of developing a consultation process with the tribes and tribal health programs in their States. Twenty-seven (27) consultation SPAs are under review.

Data Source: Data regarding number of States implementing the requirement for Indian consultation is taken from tracking reports for State Plan Amendments.

The Recovery Act increases protections for American Indian/Alaska Natives (AI/AN) under Medicaid and CHIP. This provision eliminates cost sharing requirements on AI/ANs when services are provided from an Indian health care provider or from a contract health services provider, and exempts certain properties from being counted as an asset when determining Medicaid and CHIP eligibility or estate recovery.

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

Program	FY 2010 Enacted 1/	FY 2011 CR Level 2/	FY 2012 Budget Request
Program Operations	$2,335,862,000	$2,335,862,000	$3,062,025,000
Federal Administration	$696,880,000	$696,880,000	$859,465,000
State Survey & Certification	$346,900,000	$346,900,000	$400,283,000
Research	$35,600,000	$35,600,000	$31,200,000
High-Risk Pools 3/	$0	$55,000,000	$44,000,000
Subtotal, Appropriation/BA C.L. (Discretionary; 0511)	**$3,415,242,000**	**$3,470,242,000**	**$4,396,973,000**
High-Risk Pool Grants 3/	$55,000,000	$0	$0
Subtotal, Appropriation/BA C.L. (Mandatory; 0511)	**$55,000,000**	**$0**	**$0**
Comparability Adjustment (SHIP Transfer to AoA)	($47,000,000)	($47,000,000)	$0
Subtotal, Appropriation/BA C.L. (Disc. + Mand.; 0511)	**$3,423,242,000**	**$3,423,242,000**	**$4,396,973,000**
MIPPA (Mandatory; P.L. 110-275)	$35,000,000	$38,000,000	$38,000,000
Affordable Care Act (ACA; Mandatory; P.L. 111-148/111-152)	$96,600,000	$25,000,000	$75,000,000
MMEA (Mandatory; P.L. 111-309)	$0	$200,000,000	$0
Total, Appropriation/BA C.L. (0511)	**$3,554,842,000**	**$3,686,242,000**	**$4,509,973,000**
Est. Offsetting Collections from Non-Federal Sources:			
User Fees, C.L.	$170,604,000	$169,550,000	$175,565,000
Recovery Audit Contracts, C.L.	$259,000,000	$259,000,000	$500,000,000
Subtotal, New BA, C.L.	**$3,984,446,000**	**$4,114,792,000**	**$5,185,538,000**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2010) 4/	$146,611,000	$284,477,000	$0
Program Level, Current Law (0511)	**$4,131,057,000**	**$4,399,269,000**	**$5,185,538,000**
Proposed Law User Fees	$0	$0	$0
Program Level, Proposed Law (0511)	**$4,131,057,000**	**$4,399,269,000**	**$5,185,538,000**
Affordable Care Act (ACA; P.L. 111-148/111-152):			
Section 1002 Consumer Assistance Grants	$30,000,000	$0	$0
Total, ACA Appropriation/BA C.L. (Mandatory; 0111) 5/	**$30,000,000**	**$0**	**$0**
Affordable Care Act (ACA; P.L. 111-148/111-152):			
Section 2701 Adult Health Quality Measures	$60,000,000	$60,000,000	$60,000,000
Section 3026 Community-Based Care Transitions	$0	$500,000,000	$0
Section 6201 National Background Checks in LTC Facilities	$160,000,000	$0	$0
Section 10323 Medicare Coverage/Environmental Health Hazards	$300,000	$2,750,000	$4,000,000
Total, ACA Appropriation/BA C.L. (Mandatory; 0509) 5/	**$220,300,000**	**$562,750,000**	**$64,000,000**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):			
Section 4103 Medicare Incentives	$100,000,000	$100,000,000	$100,000,000
Section 4201 Medicaid Incentives	$40,000,000	$40,000,000	$40,000,000
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 5/	**$140,000,000**	**$140,000,000**	**$140,000,000**
Total, Program Management Appropriation/BA (All Sources)	**$3,945,142,000**	**$4,388,992,000**	**$4,713,973,000**
Total Prog. Mgt. Program Level, Proposed Law (All Sources)	**$4,521,357,000**	**$5,102,019,000**	**$5,389,538,000**
HCFAC Discretionary	**$311,000,000**	**$311,000,000**	**$580,580,000**
Non-CMS Administration 6/	**$2,240,065,000**	**$2,180,365,000**	**$2,384,174,000**
CMS FTEs:			
Direct (Federal Administration)	4,276	4,278	4,917
Reimbursable (CLIA, CoB, RAC)	126	115	118
Subtotal, Program Management FTEs	**4,402**	**4,393**	**5,035**
Affordable Care Act (Mandatory)	0	3	37
ARRA Implementation (Mandatory)	100	130	160
Total, Program Management FTEs	**4,502**	**4,526**	**5,232**
Affordable Care Act (Mandatory)	5	188	248
Medicaid Financial Management (HCFAC; Mandatory)	90	97	100
MIP Discretionary (HCFAC; Discretionary)	25	53	55
Medicaid Integrity (State Grants; Mandatory)	100	94	100
Total, CMS FTEs 7/	**4,722**	**4,958**	**5,735**

1/ The CMS Program Management budget authority for FY 2010, including discretionary funds and funds for high-risk pool grants, reflects enacted amounts. This amount differs from the presentation in the President's Budget, which misclassified approximately $320 million of the mandatory funding as discretionary within the trust fund accounts. The FY 2010 staffing level reflects staffing estimates at the time our FY 2010 appropriation was enacted, with the addition of 5 mandatory FTEs for ACA-related activities.

2/ Reflects the annualized Continuing Resolution level of funding provided under P.L. 111-322.

3/ In FY 2010, the High-Risk Pool grants were rebased as mandatory via OMB's CHIMP process.

4/ Reflects remaining no-year and multi-year funding within the traditional Program Management account, excluding user fees.

5/ Includes ACA or ARRA mandatory funds directly appropriated to the CMS Program Management account. Excludes transfers of discretionary budget authority (BA). BA amounts are scored in the first year of availability.

6/ Reflects current BA values reflected in the Budget Appendix. Includes funds for the Social Security Administration (SSA), DHHS/OS and the Medicare Payment Advisory Commission (MedPAC).

7/ Excludes staffing funded from the ACA Implementation Fund in fiscal years 2010 and 2011.

Appropriations Language

Centers for Medicare & Medicaid Services

Program Management

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act; titles XIII and XXVII of the Public Health Service Act (``PHS Act''); the Patient Protection and Affordable Care Act; and the Clinical Laboratory Improvement Amendments of 1988, not to exceed $4,396,973,000, 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 of Health and Human Services pursuant to section 302 of the Tax Relief and Health Care Act of 2006, funds retained by the Secretary pursuant to the Patient Protection and Affordable Care Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That $34,000,000, to remain available through September 30, 2013, shall be for contract costs for the Healthcare Integrated General Ledger Accounting System: Provided further, That the Secretary is directed to collect fees in fiscal year 2012 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act; titles XIII and XXVII of the Public Health Service Act ("PHS Act"); the Patient Protection and Affordable Care Act; and the Clinical Laboratory Improvement Amendments of 1988, not to exceed $4,396,973,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act;	Provides an appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and new consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary of Health and Human Services pursuant to section 302 of the Tax Relief and Health Care Act of 2006, funds retained by the Secretary pursuant to the Patient Protection and Affordable Care Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That $34,000,000, to remain available through September 30, 2013, shall be for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $34,000,000 of this appropriation to be available for obligation over two fiscal years, for the development of the Healthcare Integrated General Ledger Accounting System.

Program Management

Language Analysis

Language Provision	Explanation
Provided further, That the Secretary is directed to collect fees in fiscal year 2012 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.

CMS Program Management
Amounts Available for Obligation

	FY 2010 Actual	FY 2011 Estimate	FY 2012 PB
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,415,242,000	$3,470,242,000	$4,396,973,000
Across-the-board reductions (L/HHS)	$0	$0	$0
Subtotal, Appropriation (L/HHS)	$3,415,242,000	$3,470,242,000	$4,396,973,000
Comparable transfer to (AoA):	-$47,000,000	-$47,000,000	$0
Subtotal, adjusted trust fund discr. appropriation	$3,368,242,000	$3,423,242,000	$4,396,973,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$55,000,000	$0	$0
MIPPA (PL 110-275)	$35,000,000	$35,000,000	$35,000,000
ACA (PL 111-148/152)	$95,300,000	$527,750,000	$29,000,000
Subtotal, trust fund mand. appropriation	$185,300,000	$562,750,000	$64,000,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund mand. appropriation	$185,300,000	$562,750,000	$64,000,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$0	$3,000,000	$3,000,000
ACA (PL 111-148/152)	$251,600,000	$60,000,000	$110,000,000
MMEA (PL 111-309)	$0	$200,000,000	$0
Subtotal, trust fund mand. appropriation	$251,600,000	$263,000,000	$113,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$50,426,000	$43,000,000	$43,000,000
Coordination of benefits user fees	$52,439,000	$51,744,000	$59,122,000
MA/PDP user fees	$70,591,000	$72,500,000	$71,100,000
Revisit user fees	$4,000	$0	$0
Sale of data user fees	$9,542,000	$2,306,000	$2,343,000
Recovery audit contracts	$30,530,000	$259,000,000	$500,000,000
Subtotal, offsetting collections 1/	$213,532,000	$428,550,000	$675,565,000
Unobligated balance, start of year	$356,220,000	$662,212,000	$346,251,000
Unobligated balance, end of year	-$662,212,000	-$346,251,000	-$198,893,000
Prior year recoveries	$19,024,000	$0	$0
Unobligated balance, lapsing	-$16,230,000	$0	$0
Total obligations 1/, 2/	**$3,715,476,000**	**$4,993,503,000**	**$5,396,896,000**
American Recovery and Reinvestment Act (ARRA):			
Trust Fund Mandatory Appropriation:			
ARRA (PL 111-5)	$0	$0	$0
Mandatory Appropriation:			
ARRA (PL 111-5)	$140,000,000	$140,000,000	$140,000,000
Unobligated balance, start of year	$136,048,000	$188,026,000	$137,001,000
Unobligated balance, end of year	-$188,026,000	-$137,001,000	-$76,001,000
Prior year recoveries	$0	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$88,022,000**	**$191,025,000**	**$201,000,000**

1/ Excludes the following amounts for reimbursable activities carried out by this account:
2010 $28,948,000. Reflects actual budget authority in FY 2010, as opposed to enacted values.

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

CMS Program Management
Summary of Changes

2010	
Total estimated budget authority 1/	$3,423,242,000
(Obligations) 1/	($3,434,778,000)
2012	
Total estimated budget authority 1/	$4,396,973,000
(Obligations) 1/	($4,396,973,000)
Net Change	**$973,731,000**

	2010 Estimate FTE	2010 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Annualization of FY 2010 Pay Raise				$3,527,000
2. Rent and Mortgage				$14,572,000
Subtotal, Built-in Increases 1/				**$18,099,000**
A. Program:				
1. Medicare Operations		$2,290,862,000		$937,587,000
2. Federal Administration	4,276	$694,880,000	641	$150,202,000
3. State Survey & Certification		$346,900,000		$57,853,000
4. Research		$35,600,000		$4,222,000
Subtotal, Program Increases 1/				**$1,149,864,000**
Total Increases 1/				**$1,167,963,000**
Decreases:				
A. Built-in:				
1. One Less Day of Pay				($2,157,000)
B. Program:				
1. Medicare Operations		$2,290,862,000		($166,424,000)
2. Federal Administration		$694,880,000		($1,559,000)
3. State Survey & Certification		$346,900,000		($4,470,000)
4. Research		$35,600,000		($8,622,000)
5. State High-Risk Pools		$55,000,000		($11,000,000)
Subtotal, Program Decreases 1/				**($192,075,000)**
Net Change 1/				**$973,731,000**

1/ Reflects discretionary funds, only. Excludes budget authority and obligations from mandatory funds, user fees and reimbursable agreements, except State High-Risk Pools in FY 2010. The FY 2010 base has been adjusted by -$47.0 million for comparability purposes.

American Recovery and Reinvestment Act (ARRA):

2010	
Total estimated budget authority	$140,000,000
(Obligations)	($88,022,000)
2011	
Total estimated budget authority	$140,000,000
(Obligations)	($201,000,000)
Net Change	**$0**

	2010 Estimate FTE	2010 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Annualization of FY 2010 Pay Raise				$78,000
B. Program:				
1. Medicare and Medicaid HIT	100	$140,000,000	60	$8,062,000
Decreases:				
A. Built-in:				
1. One Less Day of Pay				($49,600)
A. Program:				
1. Medicare and Medicaid HIT		$140,000,000		($8,090,400)
Net Change				**$0**

CMS Program Management

Budget Authority by Activity

(Dollars in thousands)

	FY 2010 Actual	FY 2011 Estimate	FY 2012 PB
1. Program Operations	$2,335,862	$2,335,862	$3,062,025
MIPPA (PL 110-275)	$35,000	$38,000	$38,000
ACA (PL 111-148/152)	$65,000	$20,000	$20,000
MMEA (PL 111-309)	$0	$200,000	$0
Comparability Adjustment	-$45,000	-$45,000	$0
Enacted Rescission	$0	$0	$0
Subtotal, Program Operations	$2,390,862	$2,548,862	$3,120,025
(Obligations)	($2,357,768)	($2,671,915)	($3,245,025)
2. Federal Administration	$696,880	$696,880	$859,465
ACA (PL 111-148/152)	$60,000	$60,000	$60,000
Comparability Adjustment	-$2,000	-$2,000	$0
Enacted Rescission	$0	$0	$0
Subtotal, Federal Administration	$754,880	$754,880	$919,465
(Obligations)	($697,201)	($767,427)	($924,823)
3. State Survey & Certification	$346,900	$346,900	$400,283
ACA (PL 111-148/152)	$160,000	$0	$0
Enacted Rescission	$0	$0	$0
Subtotal, State Survey & Certification	$506,900	$346,900	$400,283
(Obligations)	($366,156)	($468,545)	($417,283)
4. Research, Demonstration & Evaluation	$35,600	$35,600	$31,200
ACA (PL 111-148/152)	$61,900	$507,750	$59,000
Enacted Rescission	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	$97,500	$543,350	$90,200
(Obligations)	($38,697)	($602,066)	($90,200)
5. High-Risk Pool Grants	$55,000	$55,000	$44,000
Enacted Rescission	$0	$0	$0
Subtotal, High-Risk Pool Grants	$55,000	$55,000	$44,000
(Obligations)	($55,000)	($55,000)	($44,000)
6. User Fees 1/	$183,002	$169,550	$175,565
(Obligations)	($174,850)	($169,550)	($175,565)
7. Recovery Audit Contracts 1/	$30,530	$259,000	$500,000
(Obligations)	($25,804)	($259,000)	($500,000)
Total, Budget Authority 1/, 2/	**$4,018,674**	**$4,677,542**	**$5,249,538**
(Obligations) 3/	**($3,715,476)**	**($4,993,503)**	**($5,396,896)**
FTE	**4,248**	**4,396**	**5,072**

1/ Reflects actual budget authority (BA) in FY 2010, as opposed to enacted values.

2/ Excludes $28,948,000 for other reimbursable activities carried out by the Program Management account.

3/ Excludes $28,948,000 for other reimbursable activities carried out by the Program Management account.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$140,000**	**$140,000**	**$140,000**
(Obligations)	**($88,022)**	**($191,025)**	**($201,000)**
FTE	**42**	**130**	**160**

CMS Program Management
Authorizing Legislation

	2011 Amount Authorized	FY 2011 Continuing Resolution	2012 Amount Authorized	2012 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite	Indefinite	Indefinite
- Section 1115 1/	$2,000,000	$2,000,000	$2,000,000	$2,000,000
b) P.L. 92-603, Section 222	Indefinite	Indefinite	Indefinite	Indefinite
2. Program Operations:				
Social Security Act, Sections 1816 & 1842	Indefinite	Indefinite	Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. High-Risk Pool Grants:				
Trade Act of 2002; High-Risk Pool Funding Extension Act of 2006	Indefinite	Indefinite	Indefinite	Indefinite
6. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
7. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	2/	2/	2/	2/
8. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
9. 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 2012.
2/ The MMA limits authorized user fees to an amount computed by a statutory formula.

American Recovery and Reinvestment Act (ARRA):				
1. ARRA Implementation:				
American Recovery and Reinvestment Act of 2009 (PL 111-5)	$140,000,000	$140,000,000	$140,000,000	$0

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2003				
Trust Fund Appropriation:				
Base	$2,538,330,000	$2,550,488,000	$2,559,664,000	$2,581,672,000
Rescissions (P.L. 108-7)	$0	$0	$0	($16,781,000)
Subtotal	$2,538,330,000	$2,550,488,000	$2,559,664,000	$2,564,891,000
2004				
Trust Fund Appropriation:				
Base	$2,733,507,000	$2,600,025,000	$2,707,603,000	$2,664,994,000
Rescissions (P.L. 108-199)	$0	$0	$0	($28,148,000)
MMA (PL 108-173)				$1,000,000,000
Subtotal	$2,733,507,000	$2,600,025,000	$2,707,603,000	$3,636,846,000
2005				
Trust Fund Appropriation:				
Base	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,696,402,000
Rescissions (P.L. 108-447)	$0	$0	$0	($23,555,000)
Subtotal	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,672,847,000
2006				
General Fund Appropriation:				
DRA (PL 109-171)	$0	$0	$0	$38,000,000
Trust Fund Appropriation:				
Base	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,170,927,000
Rescissions (P.L. 109-148/149)	$0	$0	$0	($91,109,000)
Transfers (P.L. 109-149)	$0	$0	$0	$40,000,000
DRA (PL 109-171)	$0	$0	$0	$36,000,000
Subtotal	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,155,818,000
2007				
Trust Fund Appropriation:				
Base	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,141,108,000
TRHCA (PL 109-432)	$0	$0	$0	$105,000,000
Subtotal	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,246,108,000
2008				
General Fund Appropriation:				
MMSEA (PL 110-173)	$0	$0	$0	$60,000,000
Supplemental (PL 110-252)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,207,690,000
Rescissions (P.L. 110-161)	$0	$0	$0	($56,038,000)
MMSEA (PL 110-173)	$0	$0	$0	$55,000,000
MIPPA (PL 110-275)	$0	$0	$0	$20,000,000
Subtotal	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,226,652,000
2009				
General Fund Appropriation:				
CHIPRA (PL 111-3)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,305,386,000
MIPPA (PL 110-275)	$0	$0	$0	$182,500,000
Subtotal	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,487,886,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Trust Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$2,000,000
2010				
General Fund Appropriation:				
ACA (PL 111-148/152)	$0	$0	$0	$251,600,000
Trust Fund Appropriation:				
Base **1/**	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,470,242,000
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$95,300,000
Subtotal	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,600,542,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2011				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$60,000,000
MMEA (PL 111-309)	$0	$0	$0	$200,000,000
Trust Fund Appropriation:				
Base	$3,646,147,000	$3,470,242,000	$3,470,242,000	$3,470,242,000
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	$4,032,992,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2012				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Trust Fund Appropriation:				
Base	$4,396,973,000	$0	$0	$0
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$29,000,000
Subtotal	$4,396,973,000	$0	$0	$64,000,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

1/ Base funding for FY 2010 includes $55.0 million for High-Risk Pools, which have since been rebased as mandatory.

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	CR Appropriations in FY 2011

CMS Program Management has no appropriations not authorized by law.

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Program Operations
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR Level	FY 2012 Budget Request	FY 2012 +/- FY 2010
BA	$2,335,862	$2,335,862	$3,062,025	$726,163
Comparability Adjustment 1/	$(45,000)	$(45,000)	$0	$45,000
Adjusted BA	$2,290,862	$2,290,862	$3,062,025	$771,163

1/ The FY 2010 and FY2011 funding levels include comparability adjustments to reflect the FY 2012 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

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

FY 2012 Authorization - One Year
Allocation Method - Contracts

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

FY 2012 Authorization – One Year
Allocation Method - Formula Grants

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).

FY2012 Authorization – One Year
Allocation Method - Contracts

OVERVIEW

CMS is responsible for administering and overseeing 3 of the Nation's largest health care programs. These include: the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with end-stage renal disease; the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; and the Children's Health Insurance Program or CHIP, established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels.

With the passage of recent legislation, CMS has become responsible for several major new workloads and the creation of new centers and offices within CMS, including the

Center for Medicare and Medicaid Innovation. In FY 2011, CMS will assume responsibility for the new Office of Consumer Information and Insurance Oversight (OCIIO) that was created within the Department of Health and Human Services to help implement new consumer rights and benefits, hold insurance companies accountable, increase access to affordable health care for all Americans, and assist in the creation of the new state-based health insurance marketplaces where private insurers can compete on the basis of price and quality. OCIIO will now become the Center for Consumer Information and Insurance Oversight within CMS. CMS will leverage its existing systems and its extensive experience with States and private health plans to implement these new workloads.

CMS has traditionally requested the discretionary funding needed to run the Medicare program in a Program Management line item called Medicare Operations. We have now broadened the scope of that line item to include administrative funding for the provisions mandated in the Affordable Care Act as well as for certain administrative costs for the Medicaid and CHIP programs previously funded through the Federal Administration account. Beginning in FY 2012, this new, more inclusive line item will be called Program Operations.

Program Description and Accomplishments

Medicare

Established in 1965, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 19 million in 1966 to more than 50 million beneficiaries expected in FY 2012. Medicare benefits, that is, the payments made to providers for their services, are permanently authorized. They are explained more fully in the Medicare Benefits chapter in the "Other Accounts" section of this book. The Medicare administrative expenses discussed in this chapter are funded annually through the Program Management appropriation. CMS uses these funds primarily to pay contractors to process providers' claims, to fund beneficiary outreach and education, to maintain the information technology (IT) infrastructure needed to support various claims processing systems, and to continue programmatic improvements such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS), the administrative simplification provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the tenth revision of the International Classification of Diseases (ICD-10), and others.

- **Medicare Parts A and B**

The original Medicare program 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. The original program reflected a fee-for-service approach to health insurance. As of December 2010, approximately 36.7 million beneficiaries were enrolled in the original Medicare program.

- **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 and vision and dental benefits. As of December 2010, approximately 11.9 million beneficiaries – approximately one quarter of those enrolled in both Part A and Part B - were enrolled in MA plans.

Medicare Part D provides voluntary prescription drug coverage. Most Medicare beneficiaries, including approximately 10.7 million low-income beneficiaries, are now receiving comprehensive prescription drug coverage, either through a stand- alone prescription drug plan (PDP) or a joint MA-prescription drug plan (MA-PDP), an employer-sponsored drug plan, or other creditable coverage. As of December 2010, approximately 35.6 million beneficiaries received Part D benefits, including 29.4 million enrolled in Part D and 6.2 million who receive benefits through the Retiree Drug Subsidy.

Medicaid and CHIP

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. In addition, Medicaid provides community based long-term services and supports to seniors and individuals with disabilities, as well as institutional long term services. As a result, Medicaid programs vary widely from State to State. Medicaid benefits, that is, the grants made to States for the Federal share of these services, are appropriated annually. They are explained more fully in the Medicaid chapter in the “Mandatory Appropriation” section of this book. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as systems, contracts, and intra-agency agreements.

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a Federal-State matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program is 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 less than 19 years of age. CHIP grants to States are explained more fully in the CHIP chapter in the “Other Accounts” section of this book. The funding for CHIP included in the Program Operations chapter covers certain administrative expenses such as systems, contracts, and intra-agency agreements.

Consumer Information and Insurance Oversight

CMS in close collaboration with the Departments of Labor and Treasury is now responsible for ensuring compliance with the new insurance market rules enacted in recent legislation, including the prohibitions on rescissions and on pre-existing condition exclusions for children. CMS will also enforce the new medical loss ratio rules, review health insurance rates, and provide guidance and oversight for the new state-based

Health Insurance Exchanges. In addition, CMS will compile and maintain data for an internet portal providing information for consumers on insurance options. The funding requested for these activities is a first-time request. Activities undertaken by OCIIO in FY 2010 and FY 2011 to date were funded through the $1 billion appropriation included in recent legislation.

Funding History

FY 2007	$2,159,242,000
FY 2008	$2,158,906,000
FY 2009	$2,265,715,000
FY 2010	$2,335,862,000
FY 2011 CR Level[1]	$2,335,862,000

Budget Request for Program Operations: $3,062.0 million

CMS' FY 2012 budget request for the Program Operations line item is $3,062.0 million, $771.2 million more than the comparably-adjusted FY 2010 enacted level of $2,290.9 million. The comparability adjustment reflects the proposed transfer of the State Health Insurance Assistance Program (SHIP) from CMS to the Administration on Aging. A large portion of the Program Operations account funds CMS' traditional Medicare operations, such as processing fee-for-service claims, responding to provider and beneficiary inquiries, overseeing Part C and D plans, and providing outreach and education, systems support, and financial management oversight. The FY 2012 request also includes funding for certain Medicaid- and CHIP-related provisions previously funded through the Federal Administration line. It now includes funds for provisions enacted in recent legislation that enhance all three existing health care programs – Medicare, Medicaid, and CHIP—and that establishes and implements new consumer information and insurance oversight and protection programs.

[1] The FY 2010 and FY2011 funding levels do not include comparability adjustments to account for the FY 2012 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

Program Operations

(Dollars in Thousands)

Activity	FY 2010 Enacted Level[2]	FY 2012 Budget Request	FY 2012 +/- FY 2010
Program Operations			
Medicare Parts A&B			
Ongoing Operations	$1,034,800	$1,014,600	$(20,200)
FFS Operations Support	49,300	77,088	27,788
Claims Processing Investments	86,900	76,137	(10,763)
Contracting Reform	65,600	7,446	(58,154)
Other Medicare Operational Costs			
Accounting & Audits	170,000	176,863	6,863
QIC Appeals (BIPA 521/522)	56,200	69,305	13,105
HIPAA Administrative Simplification	24,200	47,600	23,400
ICD-10/5010	62,500	55,600	(6,900)
Medicaid & CHIP			
Medicaid & CHIP Initiatives		37,090	37,090
Health Care Planning & Oversight			
Part C&D IT Systems Investments	82,200	75,834	(6,366)
Oversight & Management	51,000	363,037	312,037
Health Care Quality Improvement Initiatives			
Health Care Improvement Initiatives	61,600	167,550	105,950
Outreach & Education			
Beneficiary Outreach/NMEP	266,500	332,949	66,449
Provider Outreach	17,700	34,381	16,681
Consumer Outreach	0	78,355	78,355
Information Technology			
IT Investments	262,400	448,165	185,765
TOTAL	**$ 2,290,900**	**$3,062,000**	**$771,100**

[2] The FY 2010 enacted level includes a comparability adjustment of -$45 million for NMEP to reflect the FY 2012 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

MEDICARE OPERATIONS: PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

This category reflects the Medicare contractors' ongoing fee-for-service (FFS) workloads including 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.

  Our providers are important partners in caring for our beneficiaries. It is a CMS priority to pay them on a timely basis as illustrated in our goal to "Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements." Under current law, electronic claims generally must be paid between the 14th and 30th day following their receipt; for paper claims, the statutory payment window is between the 29th and 30th day after receipt. CMS added a FY 2012 measure to this goal to include Medicare Administrative Contractors. Our Medicare contractors have been consistently able to exceed the target for timely claims processing by continually improving the efficiency of their processes and by using standard processing systems.

- *Provider Enrollment* - CMS and its Medicare contractors are responsible for 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 newly enrollees or those making a change in enrollment obtain Medicare payments by electronic funds transfer.

- *Provider Reimbursement Services* – Medicare Part A providers are required to file a cost report on an annual basis. In addition to determining the payment amount for items paid on cost, the cost report is used to finalize prospective payment system (PPS) add-on payments such as graduate medical education (GME), indirect medical education (IME), disproportionate share (DSH), and bad debt payments. The contractors' provider reimbursement area performs several activities, most requiring substantial manual effort, including:
  - Conducting rate reviews to establish and adjust interim reimbursement rates for add-on payments.
  - Performing quarterly reviews when the provider has elected to be paid on a bi-weekly basis, in lieu of actual claims payments.
  - Conducting reviews of payments to all hospice providers to determine if the hospice exceeded the aggregate or inpatient cap.

- Maintaining files of provider-specific data (such as the DSH adjustment) to calculate the provider's claims payment.
- Maintaining systems such as the provider statistical and reimbursement system (PS&R) which contains all the claims information needed to settle cost reports and the system for tracking audit and reimbursement (STAR) which tracks the cost report through final settlement.
- Making determinations regarding a hospital's provider-based status which affects the amount of reimbursement the hospital is entitled to receive.
- Reporting and collecting provider overpayments.
- Identifying delinquent debt and referring debts to Treasury for collection.

- *Medicare Appeals* – The statutorily mandated Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse contractor determination, including coverage and payment decisions. There are five levels in the Medicare Part A and Part B appeals process starting with the Medicare contractor 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. These costs are reflected in this section. MAC personnel not involved in the original determination review the decision to determine if it should be changed and handle any reprocessing activities. Contractors 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. Over 90 percent of appellants are suppliers and physicians.

  In FY 2010, CMS contractors processed approximately 2.6 million redeterminations, a minimal decrease from FY 2008 and FY 2009 when they processed 2.7 million redeterminations. Note: the first level appeals activities in this document do not include the Recovery Audit Program appeals workload which began in FY 2007. That workload is tracked, reported, and funded separately.

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

- *Provider Inquiries* – CMS coordinates communications 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 2010, our contractors responded to 2 million providers who collectively made over 44 million telephone inquiries and about 500,000 written inquiries. The contractors utilize Interactive Voice Response (IVR) systems to automate about 68 percent of their telephone inquiries. This frees up customer service representatives to handle the more complex questions. CMS believes the call

volume will stabilize for FY 2011 and FY 2012 assuming no new major legislative changes or initiatives and that the impact of implementing DME Competitive Bidding is not significant.

- *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 contractors conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows.

  CMS has made more information available at its http://www.medicare.gov website about physicians participating in Medicare. The National Participating Physician Directory includes the providers' medical school and year of graduation, any board certification in a specialty, gender, hospitals at which they have admitting privileges, and any foreign language capabilities.

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

- *Enterprise Data Centers* – The Enterprise Data Centers (EDC) are the foundation that supports all CMS production data center operations. Traditionally, the Medicare contractors either operated their own data centers or contracted out for these services. As part of CMS' contracting reform initiative, CMS reduced the number of data centers from more than one dozen separate small centers to three large EDCs. CMS manages these contracts. CMS has achieved administrative efficiencies from this consolidation. It will also deliver greater performance, security, reliability, and operational control. In addition, the new EDC infrastructure gives CMS greater flexibility in meeting current and future data processing challenges. This flexibility is critical as the FFS claims workloads continue to grow and Medicare claims processing applications require a more stable environment.

  As part of CMS' vision, all production applications, including Part C/D systems, will be hosted in one of the EDCs. CMS migrated the entire FFS claims processing workload to the EDCs in February 2009. However, specific FFS workloads within the EDCs will continue to be realigned to match contractor transitions that will take place through FY 2011 and early FY 2012. The Part C/D systems migration is still in the

preliminary planning phases. The request covers the operations and maintenance costs associated with these three contracts.

Budget Request for Ongoing Operations: $1,014.6 million

The FY 2012 budget request for Ongoing Operations is $1,014.6 million, a decrease of $20.2 million below the FY 2010 enacted level. The decrease is primarily attributable to increased efficiencies due to contracting reform. This is reflected in the drop in the projected unit cost.

This funding will allow the contractors to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements. This funding level covers a projected 2.5 percent increase in claims volume from the FY 2011 current estimate as well as an increase in provider inquiries regarding new provisions and benefits.

In FY 2012, CMS' contractors expect to:

- process over 1.2 billion claims
- handle 2.6 million redeterminations
- answer 44.4 million provider inquiries

The following table displays claims volumes and unit costs for the period FY 2007 to FY 2012. The unit costs reflect the total funds provided to our contractors in the Ongoing Operations line for claims processing, data centers, appeals, inquiries, enrollment, outreach and education, provider reimbursement, and PARDOC workloads. CMS has reduced its unit cost over the last several years. We remain committed to achieving efficiencies in our fee-for-service operations.

Claims Volume and Unit Costs
FYs 2007 – 2012

Volume (in millions)	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Estimate**	**FY 2011 Estimate**	**FY 2012 Estimate**
Part A	185.7	187.1	191.4	193.1	197.5	202.5
Part B	970.0	987.8	992.2	994.9	1,017.8	1,043.2
Total	**1,155.7**	**1,174.9**	**1,183.6**	**1,188.0**	**1,215.3**	**1,245.7**
Unit Cost (in dollars)						
Total	**$0.98**	**$0.87**	**$0.85**	**$0.85**	**$0.82**	**$0.81**

Fee-for-Service Operations and Systems Support

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

- *DMEPOS Competitive Bidding* - Section 302(b)(1) of the MMA authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment

amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007.

As required by law, CMS conducted the Round One competition in ten MSAs for ten DMEPOS product categories, and implemented the program on July 1, 2008. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, temporarily delayed the program, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009 in nine MSAs for nine product categories, referring to it as the Round One Rebid. Contracts and prices for the Round One Rebid became effective on January 1, 2011. MIPPA also delayed competition for Round Two in 70 MSAs until 2011 and in additional areas of the country until after 2011. A national mail order competition may be conducted after 2010. Recent legislation expands the number of Round Two MSAs from 70 to 91 and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016.

- *Internal Controls Assessment* - The Office of Management and Budget Circular A-123 requires that CMS establish and maintain internal controls over financial reporting, rigorously assess these controls, and submit a statement of assurance on these controls.

- *Medicare Beneficiary Ombudsman* - Section 923 of the MMA established the position of Medicare Beneficiary Ombudsman. This office is responsible for screening beneficiary complaints, grievances, and requests for information and for referring calls to appropriate Federal, State, and local agencies for resolution.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens* - Section 1011 of the MMA established a fund to reimburse providers for giving emergency treatment to undocumented aliens. (See the State Grants and Demonstrations chapter in the "Other Accounts" section of this book for a discussion of this benefit.) This request provides the funding needed to cover the cost of processing the providers' claims.

Budget Request for Fee-for-Service Operations Support: $77.1 million

The FY 2012 request for fee-for-service operations support is $77.1 million, an increase of $27.8 million above the FY 2010 enacted level. This level will fund a variety of activities including the following:

- *DMEPOS Competitive Bidding:* $5.0 million, an increase of $5.0 million above the FY 2010 enacted level. Due to recent expansions of the DMEPOS Competitive Bidding program, funding is required to perform additional research and analysis; conduct extensive education and outreach to bidders and suppliers; evaluate thousands of additional bids; award a significant number of additional contracts; hire and train additional ombudsmen; and provide oversight and monitoring of the additional metropolitan statistical areas.

- *Medicare Beneficiary Ombudsman*: $1.3 million, $0.1 million above the FY 2010 enacted level.

- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $7.2 million, $0.6 million below the FY 2010 enacted level.

- *Other Operational Costs:* The remaining $63.6 million will support other operational costs including provisions in new legislation. Some of these new activities involve payment adjustments or reforms for Home Health and Hospice Care, or address the need for properly valuing services, including through the identification of misvalued codes.

  Additionally, funding is required for an Information Dashboard and other planning support activities. The dashboard consists of implementation and outcome metrics assessing the result of health care initiatives. This will help CMS identify and track key indicators including contractor support necessary for the project.

CMS is introducing a FY 2012 performance measure to identify, review and appropriately value potentially misvalued codes (i.e., high expenditure or high cost) under the Medicare Physician Fee Schedule through the potentially misvalued code analysis process. Additional information about this measure (MCR22) is in the supplemental Online Performance Appendix.

Claims Processing Investments

CMS' claims processing systems currently process over 1.2 billion Part A and B claims each year. They 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 requested funds cover ongoing systems maintenance and operations. The main systems include:

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

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

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

Budget Request for Claims Processing Systems: $76.1 million

The FY 2012 request for claims processing investments is $76.1 million, a $10.8 million decrease from the FY 2010 enacted level. This reflects increased efficiencies in conducting maintenance and operations in these systems.

Contracting Reform

Medicare contracting reform changes the face of the traditional Medicare program by integrating Parts A and B contracting under a single contract authority, known as a Medicare Administrative Contractor or MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR), and enabling a re-engineering of business processes.

Currently, all four Durable Medical Equipment (DME) MACs and nine of the fifteen planned A/B MACs are fully operational. CMS is actively implementing two of the six remaining planned A/B MACs following recent successful procurements, and anticipates completion of procurement corrective action for an additional two of the six remaining planned A/B MAC contracts by mid-CY 2011. CMS has decided to consolidate the final two originally-planned A/B MACs with other A/B MAC jurisdictions as CMS proceeds with re-competition of these contracts. If CMS is able to proceed with the implementation of these MAC workloads as planned, all of the "first-generation" MACs should be fully operational by early FY 2012.

CMS is required to re-compete all MAC contracts within five years of award. 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. Through December 2010, CMS has issued solicitations for all four of the "second generation" DME MAC contracts and has already implemented one of these four contracts. Moreover, CMS has issued a solicitation for a "second generation" A/B MAC contract that consolidates two of the initial A/B MAC jurisdictions, and anticipates issuing more such solicitations in the near future.

The following table provides a more complete summary of the MAC implementation schedule for past and planned transitions:

DME MAC Regions A & B	Awarded January 2006. Fully operational since July 2006.
DME MAC Region D	Awarded January 2006. Protest resolved May 2006. Fully operational since October 2006.
DME MAC Region C	Awarded January 2006; bid protest activity resolved January 2007. Fully operational since June 2007.
A/B MAC J 3	• Awarded July 2006. Fully operational since May 2007. Contract currently being re-competed.
Cycle I A/B MAC	• J 4 MAC awarded August 2007. Re-compete to be initiated the second quarter of FY 2011. • J 5 MAC awarded September 2007. • J 12 MAC awarded in October 2007 (corrective action completed). All are fully operational.

Cycle I A/B MAC	• J 1 awarded in October 2007 (fully operational). • J 13 awarded March 2008 (fully operational). • J 2 initially awarded May 2008. Procurement cancelled following bid protest activity. J 2 is being consolidated with J3 re-compete. • J 7 initially awarded June 2008. Procurement cancelled following bid protest activity. J 7 is being consolidated with J4 re-compete.
Cycle II A/B MAC	• J 6 initially awarded January 2009 (corrective action pending). • J 8 initially awarded January 2009 (corrective action pending). • J 9 awarded September 2008 (fully operational). • J 10 awarded January 2009 (fully operational). • J 11 initially awarded January 2009. Corrective action resolved and workload re-awarded May 2010. Will be fully operational by June 2011. • J 14 awarded November 2008 (fully operational). • J 15 initially awarded January 2009. Corrective action resolved and workload re-awarded in July 2010. Will be fully operational by October 2011. Four of these contracts (J6, 11, 14 & 15) provide for Medicare home health and hospice claims processing requirements. CMS will complete full implementation of each jurisdiction within 12 months following award (or resolution of procurement corrective action).

Initial contract awards for all MAC contracts have been completed; however, award protests have caused significant delays in several jurisdictions. To address these challenges, CMS has implemented process improvements to better manage these procurements. In those cases where CMS has successfully implemented MAC contracts, the new contracts are generating significant operating efficiencies relative to the legacy contractors operating costs in the pre-competitive environment.

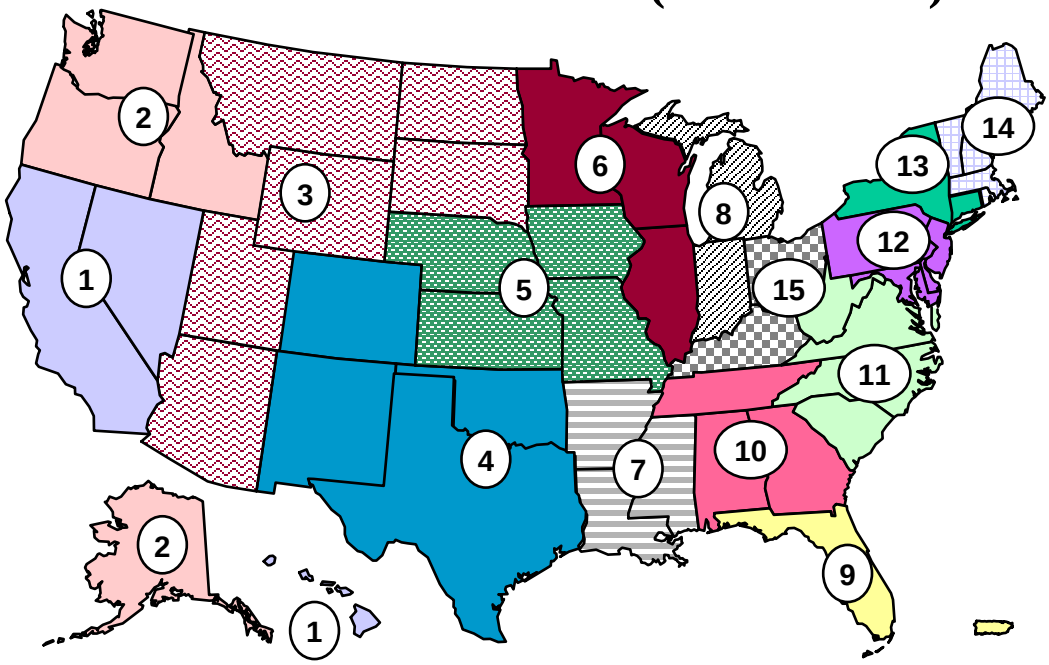
Due to the effect of contract bid protests, CMS was only able to implement 65.6 percent of its target for the FFS workload in FY 2010. CMS is currently dealing with complex program management and legal challenges associated with resolving multiple procurement corrective actions. Our revised target for FY 2011 is to award the 2nd round contracts for 3 DME MACs and 2 A/B MAC contracts, and award the two pending procurement corrective actions from the MAC first round contracts, and make significant progress in implementing these seven MAC contract awards. For FY 2012, CMS plans to award three more 2nd round A/B MAC workloads and to complete implementation of the contract awards made during the latter part of FY 2011.

CMS is incorporating into its re-procurement processes many of the lessons learned from the first round of MAC awards, such as approaches to streamlining and improving the effectiveness of the evaluation process.

On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of procurements. Through a series of incremental actions, CMS plans to reduce the number of A/B MACs to ten by 2016. CMS issued the first solicitation to consolidate two of the “first generation” MACs into a single “second generation” MAC during October 2010, and is presently reviewing proposals for this contract. In FY 2012, CMS expects to complete the re-competition of three DME MAC workloads. CMS also plans to award three A/B MAC contracts.

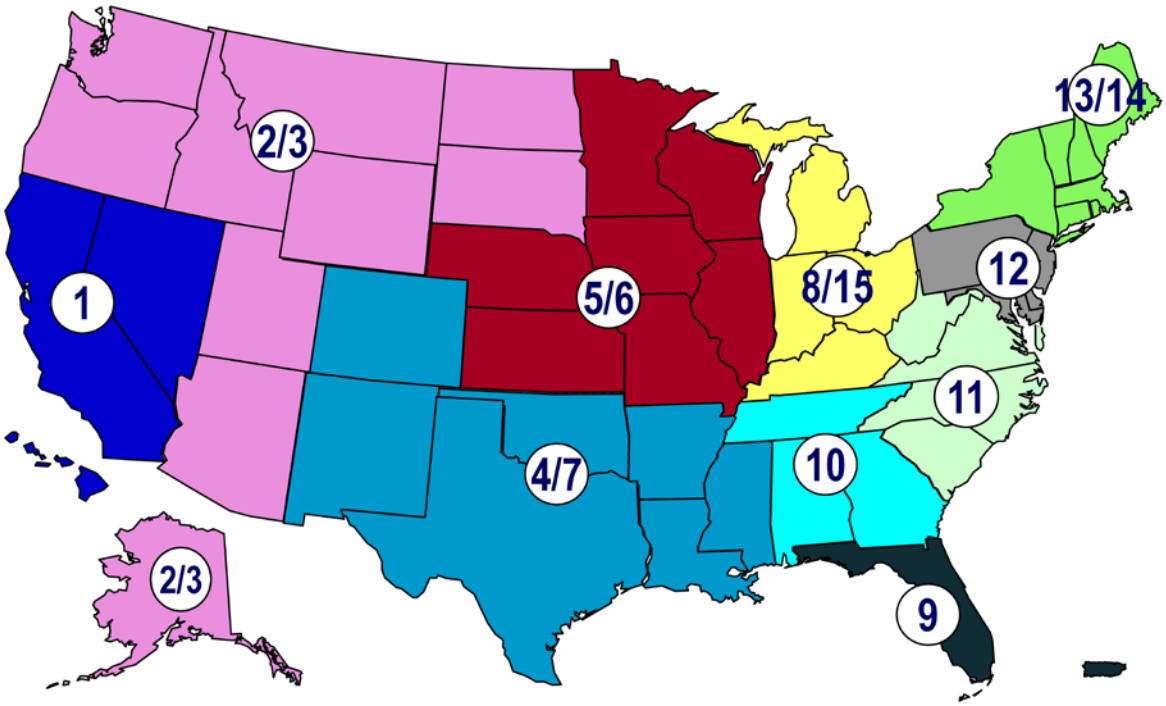
The following map represents the fifteen original A/B MAC jurisdictions that CMS competed during the first generation of MAC procurements.

15 A/B MAC Jurisdictions (First Round)



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

10 A/B MAC Jurisdictions



Budget Request for Contracting Reform: $7.4 million

The FY 2012 budget request for contracting reform is $7.4 million, $58.2 million below the FY 2010 enacted level. The request for Contracting Reform has decreased substantially since the majority of transitions will be successfully completed by the end of FY 2011. This request includes funding for three IT systems needed to manage and oversee the MACs including the Contractor Management Information System (CMIS), maintenance and enhancements for the eChimp system, and the Common Electronic Data Interchange (CEDI) system.

We believe that contracting reform will continue to produce significant program savings to contribute toward deficit reduction. CMS' accelerated implementation approach resulted in savings earlier than anticipated in the legislation. Savings accrue from: reducing the overall number of Medicare contractors, from over 40 legacy contractors to 19 MACs (15 A/B MACs and 4 DME MACs, to be further reduced to ten A/B MACs by 2016); combining Part A and Part B functions under the same contractor; allowing CMS greater discretion in the selection of contractors; and reducing the number of data centers. For the five year period FY 2012 – FY 2016, the CMS actuary estimated trust fund savings in the amounts of $620.0 million, $660.0 million, $730.0 million, $780.0 million, and $840.0 million respectively.

OTHER MEDICARE OPERATIONAL COSTS

Program Description and Accomplishments

Accounting and Audits

- *Healthcare Integrated General Ledger and Accounting System (HIGLAS)* - HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting and replaces the existing separate accounting/payment systems for Medicare and Medicaid. The main objective of this effort is to leverage the use of commercial off the shelf (COTS) software in the federal government to increase automation, increase efficiency, and maximize economies of effort to centralize management and save millions of taxpayer dollars that fund Medicare and Medicaid each year, while at the same time eliminating redundant and inefficient / ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (DHHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with DHHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of DHHS.

  HIGLAS implementation will yield significant improvements and benefits to the Nation's Medicare program which will strengthen the Federal government's fiscal management and program operations/management of the Medicare fee-for-service (FFS) program. Moreover, HIGLAS has a direct impact on the ability of DHHS to leverage financial management information to ensure desired outcomes and affect performance. HIGLAS directly supports DHHS efforts to meet compliance goals of the Federal Financial Management Improvement Act (FFMIA) of 1996, by having all CMS Payment dollars (Medicare, Medicaid, and administrative program accounting)

on HIGLAS by FY 2012. The FFMIA requires each agency to implement and maintain financial management systems that comply with federal requirements and accounting standards. HIGLAS remains a critical success factor towards ensuring DHHS meets it FFMIA compliance requirements. In addition, transitioning Medicare contractors to HIGLAS enables CMS to resolve a material weakness identified in the CFO audits related to the accounting of Federal dollars. Through further implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the continued development and implementation of administrative program accounting functions at CMS central office, CMS continues to make progress in achieving the goals tracked by DHHS and OMB.

The HIGLAS effort has significantly improved the ability of CMS and DHHS to perform Medicare accounting transactions. These improvements and benefits include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection and referral activities, creation of audit trails for every Medicare transaction, payment, or claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare FFS overpayments. Moreover, HIGLAS implementation has resulted in better internal financial controls across Medicare contractor operations.

Implementation of HIGLAS has a significant and positive impact on the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than would normally have occurred in a pre-HIGLAS environment, as a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. These efficiencies result in monies being retained in the Medicare Trust Funds more efficiently, thereby resulting in additional interest earned in the Medicare Trust Funds. From the beginning of HIGLAS implementation in May 2005 through FY 2010, CMS estimates that $275 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes.

CMS is continuing its HIGLAS implementation schedule in accordance with the Agency's adjusted MAC implementation schedule. We continue to closely and actively monitor and manage implementation in an integrated manner and at the highest levels within the Agency. Through November 2010, CMS has deployed HIGLAS at 14 traditional Medicare FFS contractor sites and 12 Medicare Administrative Contractor (MACs) sites, achieving greater than 90 percent of total FFMIA compliance including Medicaid and Children's Health Insurance Program federal funding. During FY 2011, CMS anticipates achieving greater than 94 percent of FFMIA compliance with the planned transition of six additional MAC sites onto HIGLAS.

- *CFO/Financial Statement Audits* - The CFO/Financial Statement Audits include the annual audit required by the Chief Financial Officers (CFO) Act of 1990. Federal agencies' financial statements are audited to ensure the public that they have fairly and accurately represented their financial condition. To accomplish the goal of an unqualified and timely audit opinion, HHS and CMS work with the Office of Inspector General and certified public accounting firms to conduct the audits.

Budget Request Accounting and Audits: $176.9 million

The FY 2012 budget request for HIGLAS and the audits is $176.9 million, an increase of $6.9 million above the FY 2010 enacted level. These efforts are critical to support: the Agency's clean opinion on the CFO audit; the "One HHS" goal to improve financial management; the ability of the Department to realize its UFMS goals and objectives; and the ability to meet OMB-mandated Federal Financial Management Improvement Act (FFMIA) compliancy requirements for CMS and HHS.

- *HIGLAS*: $167.8 million, an increase of $6.8 million above the FY 2010 enacted level. This level will support the production and application maintenance at the 32 Medicare MAC/legacy Medicare contractor entities that will be utilizing HIGLAS by the end of FY 2011. By the time HIGLAS is fully operational, it will include a total of 30 MAC entities (15 Part A and 15 Part B including the 4 DME contractors). Operations and maintenance costs also include: payment to the entity that performs data processing and hosts the HIGLAS application (including hardware and software maintenance); payment for the disaster recovery hot site and continuity of operations support; development and implementation of quarterly software releases to update HIGLAS for changes in two Medicare claims processing and payment rules systems; shared system maintainer costs related to changes made to enable HIGLAS interfaces; HIGLAS production help desk; and HIGLAS system integration technical and analytical services.

  In FY 2012, CMS plans to complete all remaining HIGLAS transition activities and reach 100 percent of total FFMIA compliance; and complete development efforts associated with incorporating the remaining internal CMS Administrative Program Accounting functionality onto HIGLAS. The budget request reflects an increase of $6.8 million over the FY 2010 enacted level and is attributable to additional HIGLAS transition activities including MAC-HIGLAS transitions; MAC and CMS Enterprise Data Center (EDC) accounting organization merges for HIGLAS and Medicare Customer Information Control System (CICS) regions; HIGLAS system operations and maintenance sustainability costs, and HIGLAS systems integration contract re-compete resource requirements.

To date, the HIGLAS project continues to progress on schedule. HIGLAS costs for FY 2010 through FY 2012 are as follows ($ in millions):

	FY 2010 Enacted	FY 2011 CR Level	FY 2012 Request
Development, Modernization & Enhancement	$35.7	$35.7	$34.0
Operations & Management	$125.3	$125.3	$133.8
Total	$161.0	$161.0	$167.8

- *CFO/Financial Statement Audits:* $9.0 million, the same as the FY 2010 enacted level. This estimate is based on the General Services Administration's rate schedules.

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. The QICs replaced the hearing officer function previously performed by the FIs and carriers for Part B appeals and assumed a new Part A workload. Previously, FIs reviewed Part A appeals and then sent requests for second-level Part A reviews to an administrative law judge (ALJ). Now, the QICs adjudicate all second level Part A and Part B appeals. Virtually all QICs complete their cases within the 60 day regulatory timeframe.

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

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

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

Recent legislation aims to increase Nursing Home Transparency and Improvement by utilizing the appeals process. CMS is requesting funding to create a system to track formal appeals and establish an independent informal dispute resolution (IIDR) for both the Federal Government and State Governments. The IIDR will aid CMS in tracking and managing appeals in Nursing Home facilities.

Budget Request for QICs: $69.3 million

The FY 2012 budget request for QIC appeals (BIPA sections 521 and 522) is $69.3 million, a $13.1 million increase above the FY 2010 enacted level. The QICs processed 494,077 reconsideration requests in FY 2010[3], an increase of over 37,000 from FY 2009. CMS believes this growth is a result of increased familiarity by the provider community regarding the reconsiderations process and continued program

[3] The second level appeals activities noted in this document do not include the Recovery Audit Program appeals. That workload is being tracked, reported, and funded separately.

integrity initiatives. Extrapolations of FY 2010 activities indicate a slight decline in reconsiderations during the current year as compared to FY 2009. However, we anticipate an increase in appeals activities in FY 2011 & 2012 given projected increases in program integrity and medical review initiatives.

- *QIC Costs*: $52.9 million, an increase of $3.2 million above the FY 2010 enacted level. This request covers the anticipated 5 percent increase in workload volume.

- *Medicare Appeals System (MAS):* $6.5 million, the same level of funding as the FY 2010 enacted level.

Additional funding will be used for overseeing contractors and developing necessary tracking systems for appeals designing the IIDR process.

The following chart details the number of QIC appeals from FY 2008 through FY 2012:

QIC Appeals Workloads

	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate
QIC Appeals	411,600	456,849	494,077	518,781	544,720

HIPPA 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 the system, known as the NPPES, that assigns NPIs, and processes NPI applications, and makes subsequent changes to the data of enumerated providers. Providers are required to keep their NPPES data current by submitting timely updates to NPPES. CMS estimated that there are approximately 2.3 million covered health care providers who must obtain NPIs and approximately 3.7 million non-covered providers who may be eligible and apply for NPIs. Currently, over 2.9 million NPIs have been assigned and over 2.3 million changes have been applied to the NPPES records of enumerated providers.

- *HIPAA Claims-Based Transactions* – HIPAA requires CMS to provide a standard health care eligibility inquiry and response system to providers and health care

institutions. CMS' "270/271" system provides eligibility information to fee-for-service providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims.

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

- *HIPAA Outreach, Enforcement, Compliance Reviews, Pilots, & Simplification* – This project includes outreach programs for covered entities and other affected organizations, as well as enforcement and simplification efforts:
    - Outreach efforts include national roundtable discussions, web support, conferences, educational materials, and HIPAA On-Line, a free, interactive internet-based program that provides timely information to consumers and employers.
    - Enforcement activities consist of investigative contractor activity to support administrative standards, including a 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), a web-based application that provides online complaint filing and management to parties who wish to file a complaint. Enforcement also includes a HIPAA identification tracking system (HITS) tool which compiles statistics and generates reports for use in managing the complaint process. The system currently has information on 1,200 complaints.
    - Conducting pilot tests of the HIPAA technical standards.

Budget Request for HIPAA Administrative Simplification: $47.6 million

The FY 2012 budget request for HIPAA Administrative Simplification is $47.6 million, an increase of $23.4 million above the FY 2010 enacted level. This includes the following activities:

- *NPI & NPPES*: $10.4 million, $0.7 million below the FY 2010 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 contacts all providers whose data do not match IRS' records and resolves the issue. 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):* $11.0 million, $0.6 million below the FY 2010 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 2012 request will support the maintenance and operation of this eligibility system as well as allow CMS to CMS to be in compliance with the HIPAA EDI standard.

- *HIPAA Outreach, Enforcement, Compliance Reviews, Pilots, & Simplification:* $26.2 million, $24.7 million above the FY 2010 enacted level. The increase in funding is required for the development of strategic simplification processes and the creation of a Medicaid-based web portal. Contractor support will be needed to complete IT system requirements, develop regulations, and conduct training, outreach and education to simplify compliance with HIPPA requirements. CMS's goal is to reduce the clerical burden on patients, providers, and health plans by reducing the amount and complexity of forms and data entry required prior to or at the point of care.

ICD-10 and Version 5010 Initiative

Since the late 19th century, the industrialized world has used a common code set for coding diagnoses. These codes are almost always required on health care claims. ICD-10 is the tenth revision of the International Classification of Diseases, a classification of diseases, injuries, and medical conditions that was developed by the World Health Organization. Although ICD-10 has been in use in much of the industrialized world since 1995 and some have moved to ICD-11, the United States, including CMS, still uses ICD-9-CM, an older version developed over 30 years ago.

The chart below shows the major differences between ICD-9 and ICD-10 codes:

	ICD-9	ICD-10
Diagnosis Codes		
Number of Characters	3-5 Alphanumeric	3-7 Alphanumeric
Number of Codes	15,000	68,000
Procedure Codes		
Number of Characters	3-4 Numeric	7 Alphanumeric
Number of Codes	4,000	72,000

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

Changing from a volume-based healthcare system to a value-based system is another central goal. Specific and accurate data is vital to the success of a value-based purchasing (VBP) program. The ICD-9-CM code set does not provide the level of specificity needed for VBP, which considers both quality and cost of care over an appropriate period of time. ICD-10 provides very specific information about a patient's diagnosis and the procedures that were performed. As a result, payers can ascertain if additional services were performed because of provider error, leading to cost savings when a payer declines to pay for provider errors.

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

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

On January 16, 2009, HHS published two final rules to adopt updated HIPAA standards. In one rule, HHS is adopting ASC X12 Version 5010 and National Council for Prescription Drug Programs Version D.0 for HIPAA transactions. In this rule, HHS also adopted a new standard for Medicaid subrogation for pharmacy claims, known as NCPDP Version 3.0. For Version 5010 and Version D.0, the compliance date for all covered entities is January 1, 2012. This gives the industry enough time to test the standards internally, to ensure that systems have been appropriately updated, and then test between trading partners before the compliance date. The compliance date for the Medicaid subrogation standard is also January 1, 2012, except for small health plans, which will have until January 1, 2013 to become compliant.

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

In 2008, CMS began a multi-year effort to convert all systems that deal with claims data to the new Version 5010 formats for electronic claims and claims-related transactions, completing a gap analysis of the format changes, and initiating an impact assessment of the Medicare FFS systems that will require modification to accommodate the new data. Systems development has begun on modifications to core systems, the front-end systems, and several downstream systems. CMS began accepting test Version 5010 claim submissions in January 2011 and will accept claims in production mode starting April 2011. All health care providers must be ready to use the new Version 5010 transactions by January 1, 2012.

CMS anticipates that modifications to CMS systems and business operations for ICD-10 will continue in FY 2011 with internal testing occurring during FY 2012. FY 2011 activities will include a continuation of industry and State Medicaid program implementation monitoring. CMS also expects that external testing of ICD-10 will occur during FY 2012 and FY 2013 in order to ensure that transactions between trading partners are compliant by the implementation date. All health care covered entities must be ready to accept and receive ICD-10 codes by October 1, 2013. We are measuring activities toward this accomplishment as reflected in the outcomes and outputs table at the end of this chapter. All these activities will provide impacted CMS business areas with the support to ensure timely CMS, contractor, and industry transition on October 1, 2013.

Budget Request for ICD-10 and Version 5010 Initiative: $55.6 million

The FY 2012 budget request for ICD-10 and Version 5010 is $55.6 million, a decrease of $6.9 million below the FY 2010 enacted level.

- *ICD-10:* $47.0 million, an increase of $18.2 million above the FY 2010 enacted level. In FY 2012, additional funds are needed as CMS intensifies efforts to meet the ICD-10 implementation date of October 1, 2013. FY 2012 represents the bulk of CMS implementation efforts, which include systems conversions and more intense outreach and education. CMS will continue to develop and initiate an industry-wide provider education and outreach strategy; conduct code and policy analysis to update CMS processes that utilize ICD-10 codes; develop and initiate program management support for implementation activities such as monitoring and tracking of industry compliance; initiate updating Medicare FFS core processing systems and CMS downstream and front-end systems that utilize ICD-10 codes. The increase in funding also supports training for CMS and contractor staff, and revisions to hundreds of thousands of pages of manuals and forms.

- *Version 5010*: $8.6 million, a decrease of $25.0 million below the FY 2010 enacted level. This decrease in funding reflects that much of the systems work for Version 5010 has been completed, enabling CMS to start accepting claims in production mode in April 2011. All health care providers must be ready to use the new Version 5010 transactions by January 1, 2012. Funds are still needed for outreach and education to ensure that providers make an efficient and effective transition. As CMS makes the successful transition to Version 5010, funding will continue to decrease.

MEDICAID & CHIP

Program Description and Accomplishments

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). In order to carry out these functions, CMS requires funding for certain administrative activities such as contracts, IT systems, and intra-agency agreements. (Information on benefit dollars for these programs can be found in the chapters titled Medicaid and CHIP in the book.) Some of these

administrative activities are described below in more detail. CMS has historically funded these in the Federal Administration account but is now including them in the Program Operations account.

- Neonatal Outcomes Improvement Project: Funding will provide technical assistance to at least ten additional States for coordination and convening local stakeholders required to establish collaboration with clinicians, policy makers, families and other stakeholders within the States to improve outcomes related to the CMS Neonatal Outcomes Improvement Project (NOIP) interventions.

- Medicaid Management Information System (MMIS) Certification Priority: Federal MMIS certification is the procedure by which CMS validates that State Medicaid systems are designed to support the efficient and effective management of the program and satisfy the requirements set forth in the State Medicaid Manual (SMM), as well as, subsequent laws, regulations, directives, and State Medicaid Director (SMD) letters.

- Preparing Medicaid Information Systems for HIE and Electronic Health Record (EHR) Technology: The Medicaid IT Architecture (MITA) initiative is redefining the way that State Medicaid agencies use IT to reduce Medicaid program costs, improve the quality of Medicaid beneficiary care, and share important health-related information with other State agencies and Federal partners.
  .
- The CMS Oral Health Strategy Implementation: This project is intended to improve access to and quality of pediatric dental care for Medicaid and CHIP eligible children by working with key partners and stakeholders. CMS intends to undertake a number of initiatives to provide support and technical assistance to States and strengthen States' efforts to improve delivery of Medicaid and CHIP oral health care and the reporting of this data.

- Strengthening Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program: The purpose of this request is to enable CMS to better understand the scope of services currently being provided through the EPSDT benefit and to identify areas where service delivery, as well as, data reporting on those services can be improved. This funding would be used to continue efforts to improve access to services, data collection and ensure updated, consistent guidance is shared with all States.

Budget Request for Medicaid & CHIP Initiatives: $37.1 million

Funding in this section includes support for certain administrative activities necessary to operate Medicaid and CHIP. Information on benefit dollars for these programs can be found in the chapters titled Medicaid and CHIP later in this book.

- $12.3 million provides funding for a variety of operational activities specific to Medicaid and CHIP programs. These activities, described on the previous page, include policy development and implementation, contracts, intra-agency agreements, and IT systems that were previously funded through the Federal Administration line item.

- $24.8 million for several new initiatives including:
    - Developing a database and reporting guidelines to collect existing State rates for services coded as primary care.
    - Enhancing and modifying the Medicaid and CHIP budget and expenditure systems to develop requirement specification documents and program code for system modifications for disproportionate share hospital payments.
    - Assisting States with implementing new Medicaid coverage options by January 1, 2014. This will help ensure that consumers are able to navigate their way into Medicaid, CHIP, and Exchange coverage systems using the single application that CMS envisions.
    - Increasing the minimum rebate percentage for several classes of drugs.
    - Providing adequate pharmacy reimbursement by conducting monthly nationwide surveys of retail community pharmacy prescription drug prices and generating price databases for the public and for State Medicaid agencies.
    - Reporting on an expanded set of data elements under the Medicaid Statistical Information System (MMIS) to detect fraud and abuse. This funding will support significant new reporting and oversight by CMS for State Medicaid coverage and payments and also extensive changes to the existing Medicaid Statistical Information System (MSIS) and to the States' MMIS.
    - Create methodologies for mandatory State use of the National Correct Coding Initiative to promote correct coding and control improper coding leading to inappropriate payments.

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. Beginning in FY 2011, CMS will also oversee and implement new private health insurance market reforms.

CMS reports on a performance goal that focuses on the Medicare Prescription Drug benefit's enrollment of beneficiaries in Part D. This measure assesses the increase of Medicare beneficiaries with prescription drug coverage from Part D or other sources. The enrollment performance data is now reported by fiscal year instead of calendar year (CY) as previously reported and reflects our effort to be consistent in reporting fiscal year data. The enrollment baseline for FY 2007 (CY 2006 data) was approximately 90 percent, reflecting the initial success of the Medicare prescription drug program. FY 2008 and FY 2009 enrollment levels remained at 90 percent. Given the high rates of enrollment, it is challenging to increase the enrollment rates further; therefore, we have decided to discontinue this target after FY 2011.

In addition to publishing Part D sponsor performance metrics on the Medicare Prescription Drug Plan Finder (MPDPF), CMS conducts a beneficiary survey measuring knowledge of the benefit, which has shown positive results through 2009. For more

information on this performance measure, please refer to the key performance outcomes table at the end of this chapter.

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

Part C and D IT Systems Investments

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

- *Medicare Advantage Prescription Drug Payment System*: processes payments for the prescription drug program.
- *Medicare Beneficiary Database*: contains beneficiary demographic and entitlement information.
- *Retiree Drug Subsidy System*: collects sponsor applications, drug cost data, and retiree data; processes this information in order to pay retiree drug subsidies to plan sponsors.
- *Risk Adjustment System*: uses demographic and diagnostic data to produce risk adjustment factors to support payments to MA plans.

Budget Request for Part C&D IT Systems Investments: $75.8 million

The FY 2012 budget request for Parts C and D IT Systems Investments is $75.8 million, a decrease of $6.4 million below the FY 2010 enacted level.

Oversight and Management of Health Plans

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

  Oversight and management also includes Part C and Part D appeal reviews in which 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 first level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs) (explained later in this chapter).

  Legislation has added many new activities that impact Parts C and D such as closing the Part D coverage gap, simplifying beneficiary election periods, extending special needs plans, improving formularies, improving the system for handling Parts C and D complaints, reducing wasteful dispensing, and improving the Part D Medicare Therapy Management program. We have started to implement these in FY 2011 but will need additional funding to continue this work in FY 2012.

- *Insurance Market Reform and Oversight* - The Insurance Market Reform and Oversight program focuses on implementing insurance market reforms by setting minimum standards for health coverage in the small group, large group, and individual marketplaces. CMS is responsible for preparing and issuing regulations and guidance implementing these new provisions, monitoring compliance with these provisions and regulations, and in some cases, enforcing these provisions where states are not enforcing them.

- *Medical Loss Ratio Requirements and Rate Reviews*

  ❖ Medical Loss Ratio Requirements for Individual and Group Coverage

  The Affordable Care Act requires health insurance issuers offering group or individual coverage to submit a report to the Secretary for each plan year concerning the ratio of the incurred loss (or incurred claims), plus the loss adjustment expense (or change in contract reserves) to earned premiums. This ratio is known as the medical loss ratio or MLR. Each report must include information regarding the amount spent on reimbursement for clinical services to enrollees, quality improving activities, all other non-claims costs including an explanation of the nature of these costs, and Federal and State taxes and licensing and regulatory fees, as well as the amount of premium revenue collected.

  The Secretary is required to make these reports available to the public on the HHS website.

  ❖ Rate Review

  On December 23, 2010, the Secretary published a proposed rule which will establish a process for the annual review of "unreasonable" increases in premiums for health care coverage beginning with rates filed on or after July 1, 2011. The proposed process relies on collaborative efforts with state regulators. As part of this process, insurers would be required to submit to the Secretary and states preliminary justification data for individual or small group rate increases that meet or exceed a defined threshold (ten percent the first year). Those rates would be reviewed by states with effective rate review systems or by HHS in the minority of states that have not yet established effective rate review processes, to determine whether or not the increases are "unreasonable". The justification and determination will be published on the HHS website.

- *Health Care Exchanges* - The Health Insurance Exchange program sets up a new competitive private health insurance market, giving tens of millions of Americans and small businesses access to affordable coverage. Exchanges will allow individuals and small businesses to pool their purchasing power and compare health plan options. The implementation of the Exchange program requires a complex and integrated infrastructure and processes in order to provide a seamless, accurate, and efficient health insurance marketplace. In order that health coverage can begin by the statutory deadline of January 1, 2014, all State- and Federally-operated Exchanges will begin health plan bid review and certification by early 2013 and open their doors for enrollment as early as mid 2013. Before the exchanges are fully developed, CMS will track how insurance coverage is expanding and have new measures to increase the number of young adults between the ages of 18 to 25 who

are covered as a dependent on their parent's insurance policies and the number of individuals who are enrolled in the Preexisting Conditions Insurance Plan.

Budget Request for Oversight and Management of Health Plans: $363.0 million

The FY 2012 budget request for Oversight and Management is $363.0 million, an increase of $312.0 million above the FY 2010 enacted level.

- *Medicare Parts C and D*: $98.8 million. This funding increase supports the on-going Medicare Part C and Part D reconsideration contracts, audits, actuarial reviews, and estimates of Medicare Advantage and Prescription Drug Plans. It also funds new activities such as closing the Medicare Part D coverage gap, reforming MA plan payments, making improvements to Part D plan operations, and simplifying beneficiary election periods.

- *Insurance Market Reform, Oversight, Medical Loss Ratio (MLR) and Rate Reviews:* $28.3 million. The FY 2012 budget request will allow CMS to shift its focus from developing regulations to overseeing the market conduct of health care insurers. New market rules governing health care insurers became effective on September 23, 2010. Under existing regulations, states will be responsible for enforcing many of these new reforms, unless they (1) notify HHS that they do not have legal authority to enforce the statute, or otherwise are not enforcing the statute; or (2) HHS makes a determination that a state is not "substantially enforcing" one or more provisions of the statute. In these cases, CMS will directly enforce the provisions; in others, CMS will monitor the authority and ability of states to enforce legislation through market conduct examinations, which are audits of the activities described above. In states that are doing direct enforcement, CMS will provide any assistance the state regulator might request, and will review state enforcement and compliance activities. CMS is also accountable for ensuring compliance with MLR reporting and rebate requirements. CMS' request for MLR and rate review activities. The majority of this request supports IT systems costs and another large portion supports a contract to conduct MLR audits. This funding level will enable CMS to implement its audit plan, analyze the data submitted by issuers.

- *Office of Health Insurance Exchanges Systems and Operational Costs:* $235.9 million. The budget request includes funding for IT systems needed to support the Exchanges. These will require investments to facilitate health insurance enrollment and access to the new premium tax credits and cost-sharing reductions. New systems will be needed to support and oversee the State-operated Exchanges and implement the Federally-operated Exchange on behalf of non-electing states. Where possible, CMS will leverage its existing systems and expertise to achieve efficiencies and avoid redundancies in systems. This request also funds contractual services needed to ensure the timely and successful implementation of the Exchange program. In order to ensure Americans' access to affordable coverage in an Exchange, CMS will need to build an Exchange program support and infrastructure, establish a Federally-operated Exchange, provide technical assistance to State Exchange programs, and continue research to inform Exchange policy development.

HEALTH CARE QUALITY IMPROVEMENT INITIATIVES

Program Description and Accomplishments

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers, including through initiatives to develop a coordinated quality improvement strategy, adjust 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:

- National Quality Improvement Strategy. CMS will contribute to a Department-wide process to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process.

- Development of quality measures. CMS will develop quality measures for use in programs under the Social Security Act, including new programs, using measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the payment model. In order to accomplish this, CMS must first provide organizational support for the hospital value based purchasing program (HVBP).

- The End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). Starting January 1, 2012, CMS will use the QIP to reduce Medicare payments, by up to 2 percent, to dialysis providers and facilities that fail to meet or exceed a total performance score based on the results of three quality measures related to the treatment of ESRD.

- Medicare Shared Savings Program. CMS will establish a shared savings program in which provider groups and suppliers who meet quality measures can be eligible to share in the cost-savings they achieve through the Medicare program. Groups of providers forming Accountable Care Organizations (ACOs) and agreeing to be held accountable for the efficiency and quality of care rendered to at least 5,000 Medicare beneficiaries will qualify to share in savings generated for Medicare by meeting certain cost and quality benchmarks. CMS must establish this program by January 1, 2012.

- Physician feedback reports and payment adjustments. CMS will provide confidential feedback to physicians that measure the resources involved in providing care and compare patterns of resource use among individual physicians. CMS will also apply a separate, budget-neutral payment modifier to the fee-for- service physician payment formula. This modifier will pay physicians or groups of physicians differentially based upon the quality of care they achieve for Medicare beneficiaries relative to cost.

- Payment reductions to hospitals with poor quality performance. CMS will establish a payment adjustment for Medicare hospitals ranked in the worst quartile nationally in risk-adjusted hospital-acquired-condition rates. If a patient acquired a condition during a stay in one of these hospitals, the payment amount for the discharge would

be reduced by one percent beginning in FY 2015. CMS will also reduce payments to hospitals that have a high rate of readmissions, beginning October 1, 2012.

CMS is introducing a performance measure for FY 2012 to reduce all-cause hospital readmissions by 5 percent per year. We will measure the success of the new Hospital Readmissions Reduction Program, The rate of readmissions is calculated as the number of readmissions to the same or another acute-care hospital that occur within 30 days of discharge from an acute care hospital compared to total hospital admissions for that time period. The numerator will be the number of hospital readmissions to any acute care hospital within 30 days of an acute care hospital discharge. The denominator is the total number of admissions for that time period. This measure is featured in the HHS Strategic Plan, 2010-2015. Please see the Online Performance Appendix for more information.

Budget Request for Health Care Quality Improvement Initiatives: $167.6 million

For FY 2012, CMS requests $167.6 million for health care quality improvement initiatives, an increase of $106.0 million above the FY 2010 enacted level. This funding will be used to implement the quality initiatives like those described above, and will support efforts to develop quality measures, conduct data analysis and validation, develop reporting infrastructure, apply appropriate risk adjustment methodologies, determine appropriate payments, make shared savings calculations, provide help desk support, and conduct program monitoring, outreach and education.

OUTREACH AND EDUCATION

Program Description and Accomplishments

National Medicare Education Program (NMEP)

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

- *Beneficiary Materials* - The majority of funding in this category is used to print and distribute the *Medicare & You* handbook. The *Medicare & You* handbook is updated and mailed each autumn to all current beneficiary households. The handbook contains important information about health plans, prescription drug plans, and rights and protections to help people with Medicare review their coverage options and prepare to enroll in a new plan if they choose. The handbook also contains drug plan comparison information for beneficiaries and information about new preventive benefits. It is available in both English and Spanish. CMS also does monthly mailings of the handbook to newly eligible beneficiaries. Updates to rates and plan information occur when needed for the monthly mailings to newly eligible beneficiaries.

  The chart below displays the actual number of *Medicare & You* handbooks distributed for FYs 2008 – 2010 and the estimated distribution for FYs 2011 - 2012.

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 (in millions)

	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate
Number of Handbooks Distributed	41.9	43.1	43.6	45.1	46.5

- *1-800-MEDICARE/Beneficiary Contact Center (BCC)* – The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSR) in order to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. This line provides beneficiaries with responses to general inquiries about Medicare.

  Beneficiaries also use 1-800-MEDICARE to report fraud allegations. CMS is using the information from beneficiaries' complaints in new ways. For instance, CMS is generating weekly "fraud complaint frequency analysis reports" that compile provider-specific complaints and flags providers who have been the subject of multiple fraud complaints for a closer review. In addition, CMS has developed the capability to map shifts and trends in fraud allegations reported to 1-800-MEDICARE over time using geospatial maps and sophisticated data tools. These tools will allow CMS to gather more information from 1-800-MEDICARE calls for data analysis. The various parameters include claim type, geographic location, and fraud type. CMS is able to verify the information by listening to the original call if necessary. CMS is also exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE.

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

  The following table displays call volume offered from FY 2008 through the FY 2012 estimate. CMS cannot estimate the number of beneficiaries that will call 1-800 MEDICARE. CMS can estimate the number of calls received in a fiscal year based on a number of factors including historical trends and analysis, growth in the program, and the increase in the senior population. In FY 2012, CMS expects to receive 27.5 million calls to the 1-800-MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system.

1-800-MEDICARE/Beneficiary Contact Center Call Volume Offered

	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 Estimate
Number of Calls	27.4 million	25.9 million	25.5 million	26.5 million	27.5 million

- *Internet* - The Internet budget funds both the http://www.cms.gov and the http://www.medicare.gov websites:

  The http://www.cms.gov 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 is the Agency's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools that enable Medicare beneficiaries and their caregivers to receive information on their benefits, plans, and medical options. The Medicare Plan Finder, Hospital Compare, Nursing Home Compare, and the Medicare Eligibility tool are included under this initiative. The website serves as an effective and efficient communication channel and provides self-service options for U.S. citizens, beneficiaries, and caregivers to have access to accurate and consistent information on the Medicare program to use on a daily basis for important decision-making purposes.

  Beneficiaries also use http://www.mymedicare.gov to detect fraud allegations. Beneficiaries can log into mymedicare.gov, a secure website, and now check their claims within 24 hours of the processing date. This information is also available through the 1-800-MEDICARE automated system. A fact sheet and informational card have been developed to educate and encourage beneficiaries or caregivers to check their claims frequently and to report any suspicious claims activity to Medicare.

In FY 2012, CMS estimates approximately 427 million page views to http://www.medicare.gov, approximately a 1.5 percent increase in traffic from the page views anticipated in FY 2011. 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.

	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 Estimate
Number of http://www.medicare.gov Page Views	434.0 million	409.9 million	409.9 million	421.0 million	427.0 million

- *Community-Based Outreach* - Historically, CMS has administered and conducted community based outreach programs, including the State Health Insurance Assistance Program (SHIP), collaborative grassroots coalitions, and national, local,

multi-media training and partnership building efforts that provide assistance at the local level.

CMS proposes to transfer administration of SHIPs, which comprises the bulk of funding for community based outreach to the Administration on Aging in FY 2012.

- *Program Support Services* - This activity includes a multi-media Medicare education campaign, assessment activities, consumer research, production of NMEP materials in different formats (such as Braille and audio), and electronic and composition services for the *Medicare & You* handbook. In addition, it funds *Medicare & You* handbook support activities such as electronic and composition support, translation services, and providing the Handbook in other formats such as Braille and audio. Other support services provided in new legislation help with activities such as providing rebates for the Medicare coverage gap, the “donut hole”, and supporting National Partnership and Outreach for Special Populations.

National Medicare Education Program Budget Summary

(Dollars in Millions)

NMEP Category	Funding Source	FY 2010[4] Enacted Level	FY 2012 Request	Description of Activity in FY 2012
Beneficiary Materials	Total	$51.0	$52.7	National Handbook with comparative information in English and Spanish (national & monthly mailing); initial enrollment packages to new beneficiaries; targeted materials only to the extent that funding is available after payment of the Handbook.
	Program Management	$33.0	$34.7	
	User Fees	$18.0	$18.0	
Beneficiary Contact Center/1-800-MEDICARE	Total	$244.8	$285.6	Call center and print fulfillment services available with 24 hours a day, **7** days a week access to customer service representatives for 12 months. Includes funding previously allotted to FFS Medicare contractors for claims-related inquiries.
	Program Management	$188.5	$232.5	
	User Fees	$56.3	$53.1	
Internet	Total	$34.1	$41.0	Maintenance and updates to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.
	Program Management	$31.6	$41.0	
	QIO	$2.5	(TBD)	
Community-Based Outreach	Total	$2.4	$3.0	Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to people with Medicare in their communities.
	Program Management	$2.4	$3.0	
Program Support Services	Total	$18.9	$21.7	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.
	Program Management	$10.9	$21.7	
	QIO	$8.0	(TBD)	
	Total	**$351.2**	**$404.0**	
	Program Management	**$266.5**	**$332.9**	
	User Fees	**$74.3**	**$71.1**	
	QIO	**$10.5**	(TBD)	

[4] The FY 2010 enacted level includes a comparability adjustment of -$45 million for NMEP to reflect the FY 2012 request to transfer funding for the State Health Insurance Assistance Program from CMS to the Administration on Aging.

Budget Request for NMEP: $332.9 million

The FY 2012 Program Management budget request for NMEP totals $332.9 million, an increase of $66.4 million above the comparably adjusted FY 2010 enacted level. The following bullets highlight the FY 2012 Program Management level:

It is important to note that CMS proposes to transfer the SHIPs to the Administration on Aging (AoA). This transfer accounts for a $45 million reduction to the Community-Based Outreach request, consistent with FY 2010 enacted levels.

- *Beneficiary Materials:* The FY 2012 budget request for Beneficiary Materials is $34.7 million, $1.7 million above the FY 2010 enacted level. Approximately $30 million of the budget request is solely for the cost of producing the *Medicare & You* handbook. This estimate is based on historical publication usage data and current market prices for printing and mailing. The unit cost of producing the handbook is approximately $0.93.

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The FY 2012 budget request for 1-800-MEDICARE/BCC activities is $232.5 million, $44.0 million above the FY 2010 enacted Program Management level. This request supports a growing call volume estimated at 27.5 million calls in FY 2012, 2 million more calls than reflected in the FY 2010 enacted funding level, as well as increases in the complexity of calls and in customer service representatives wage rates as set by the Department of Labor. We will be able to maintain an average speed of answer (ASA) or call wait time of 2 minutes and 30 seconds for FY 2011 and FY 2012 in both peak and non-peak periods with peak periods being open enrollment season at this funding level.

- *Internet*: For the FY 2012 request level, $41.0 million will be spent on Internet activities. This funding level is $9.4 million above the FY 2010 enacted level. These funds will be used for ongoing maintenance costs, renewing software licenses, updating and enhancing the Nursing Home Compare website, redesigning the http://www.cms.hhs.gov website to make it more user friendly, providing database support, as well as support for the Part D prescription drug plan and fall enrollment period requirements. This includes expanded agency programs, ongoing security and testing, and monitoring activities. This funding supports ongoing efforts to increase beneficiary self-service via online channels and provide beneficiaries with expanded, easy to understand Medicare information through interactive tools, including an interactive electronic tool for the Medicare & You handbook along with expanding MyMedicare.gov services to provide integrated health management capabilities.

- *Community-Based Outreach:* CMS proposes to transfer the SHIPs to the Administration on Aging (AoA) and is not requesting funding in FY 2012 for this activity. The transfer accounts for a $45 million reduction to this line. Two-thirds of SHIPs are administered by State Agencies on Aging established by the Older Americans Act. Thus, streamlining the SHIP program into AoA is a natural extension of programs authorized under the Older Americans Act. Below is an historical funding chart for the SHIPs:

SHIP Funding Chart
(Dollars in Millions)

Funding Source	FY 2009 Actual	FY 2010 Enacted	FY 2011 CR Level	FY 2012 Request
Program Management	$45.0	$45.0	$45.0	-
MIPPA	$7.5	-	-	-
ACA	-	$15.0	$15.0	-
Total	**$52.5**	**$60.0**	**$60.0**	**-**

In addition to the SHIPs, collaborative grass roots coalitions and training to numerous community-level organizations, federal/State/local agencies, providers and others require continued funding in the amount of $3.0 million.

- *Program Support Services:* For the FY 2012, $21.7 million will be spent on Program Support Services activities, an increase of $10.8 million above the FY 2010 enacted level. These funds will support the multi-media Medicare education campaign to inform people with Medicare, their caregivers, and coming-of-agers about Medicare benefits and choices including health plan options, prescription drug plans, and preventive benefits. They will provide needed outreach and education about coverage and assistance for beneficiaries in the Medicare Part D donut hole and support outreach to special populations. It will also fund consumer research and assessment, activities required to support the *Medicare & You* handbook (such as producing Braille and audio versions and providing electronic and composition support), and a Generational Communications project which will develop methods for reaching beneficiaries and caregivers with new technologies that are less expensive than traditional print, broadcast, and telephone.

In addition to Program Management funding, the NMEP activity includes $71.1 million in user fees bringing the total to $404.0 million. The previous chart provides additional detail on these activities.

Provider Outreach

- *Provider Toll-Free Service* – Per section 1874(A)(g)(3) of the Social Security Act, CMS is required to offer toll-free telephone service to providers. CMS maintains toll-free numbers for general provider inquiries and questions about enrollment, electronic claims, and Medicare secondary payer issues. Only the costs of the toll-free lines are in this category. The costs of answering the inquiries, including customer service representatives' salaries, are included in Ongoing Operations under Provider Inquiries.

  The following table displays provider toll-free line call volumes from FY 2008 through the FY 2012 estimate:

Provider Toll-Free Service Call Volume

Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate
Completed Calls	57.1 million	50.1 million	44.4 million	44.4 million	44.4 million

- *National Provider Education, Outreach, and Training* - In an effort to promote consistency of information for Medicare providers, CMS developed the Medicare Learning Network or MLN, a brand name for official CMS provider education products. The MLN uses a variety of communications channels, including the Internet, articles, brochures, billing guides, fact sheets, web-based training courses, and videos, to deliver its program. These materials provide an authoritative source of information to providers across the country and supplement the Medicare contractors' local provider education and outreach efforts.

- *National Outreach and Education Support* – Funding is required to support outreach and education efforts (educational articles, brochures, tip sheets, quick reference guides, training, provider conference exhibits, and other outreach activities) to FFS Medicare providers on the provisions that will affect their payment, billing, enrollment and participation in new programs.

Budget Request for Provider Outreach: $34.4 million

The FY 2012 budget request for Provider Outreach is $34.4 million, $16.7 million above the FY 2010 enacted level.

- *Provider Toll-Free Service*: $9.1 million, $0.6 million above the FY 2010 enacted level to maintain the operations of the toll-free service.

- *National Provider Education, Outreach, and Training*: $10.0 million, an increase of $2.0 million above the FY 2010 enacted level to expand provider education activities and update the Medicare Learning Network (MLN) educational products.

- *National Outreach and Education Support:* $15.3 million. CMS is investing in additions and upgrades to its communications technology including Medicare contractors' provider internet portals, CMS' provider websites and interactive applications, systems changes for claims transaction 270/271 eligibility (e.g. preventive services), federal coverage, payment coordination, regulatory issues and other support initiatives.

<u>Consumer Outreach</u>

- *Removing Service Barriers (Indian Health Care)* – Funding provides for studies and other activities designed to implement new authorities and create the fullest opportunities for AI/ANS to access all CMS programs. The provision aids Indian Health programs to provide additional services and remove barriers for community services.

- *HealthCare.Gov* - www.HealthCare.gov provides a single site that enables consumers to compare basic information about health insurance plans in order to make more informed choices regarding their health insurance. The site continues to evolve to provide more and better information for consumers in a format they can understand and use. With this resource, consumers will be able to compare basic information about health insurance plans in standardized formats and make more informed decisions regarding their health insurance choices. This process will improve transparency for consumers while also ultimately making the market more competitive because consumers will be able to judge health insurance plans based on quality and benefit information and not just price.

- *Consumer Support* – CMS will provide consumers with the tools they need to find affordable health insurance coverage that meets their needs, and will provide consumers with an avenue to refute coverage determinations made by their insurance company. Through public forums, increased consumer outreach, and education, CMS ensures that consumers are informed decision makers. Furthermore, by providing an independent, responsive, external appeals process, all consumers will now have the ability to contest coverage determinations.

Budget Request for Consumer Outreach: $78.4 million

- *Removing Service Barriers (Indian Health Care)*: $11.8 million. In FY 2012, funding is required to ensure national consistency in understanding and applying the results of the HHS guiding policy determinations particularly to Indian Americans.

- *HealthCare.Gov*: $38.0 million. In FY 2012, funding is critical for the continuation and realignment of IT systems to ensure that CMS' website provides transparency to consumers in a format consistent with the Public Health Service Act (PHSA). FY 2012 will also see the see the expansion of these data collection efforts to include additional insurance markets and exchanges and an associated increase in the number of users, submitters, and data volume to meet these requirements.

- *Consumer Support*: $28.5 million. Funding supports contractors to conduct external appeals and the database to track consumer complaints and identify trends. Additionally, funding will help increase consumers' access to the appeals process and promote enhanced consumer understanding of the decisions made by insurance companies through culturally and linguistically appropriate communication.

INFORMATION TECHNOLOGY

Program Description and Accomplishments

Enterprise IT Activities

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

- *Ongoing enterprise activities:* Will facilitate and support all application needs, such as enterprise-wide identity management and standards development, with the unique requirements of the given application coming from the Application/Business Owner's pool of resources, software licenses, help desk support, production support, security, software development and testing, cloud computing pilot, unified communications, enterprise web services platform, and enterprise data warehouse and analytics.
- *The Medicare Data Communications Network:* The secure telecommunications network that supports transaction processing and file transmission.
- *Hardware maintenance and software licensing.*
- *Developing and maintaining the mission critical database systems* that house the data required by the CMS business community to perform its core functions.
- *The Modern Data Environment*: A cornerstone of the Agency's data environment, will transition CMS from a claims-centric data warehouse orientation to a multi-view data warehouse orientation capable of integrating data on beneficiaries, providers, health plans, and claims. Without this repository, CMS must extract data from different locations, often resulting in inconsistent and slow answers to queries and costly analyst intervention.
- *CMS enterprise data and database management investment:* This investment allows for the addition of databases, establishing consistent application of data policies and processes in using CMS' data; and assuring the security of data resources as CMS moves to the Enterprise Data Center environment. CMS plans to increase the number of applications that use the "individuals authorized access to CMS computer systems (IACS)" system to authenticate users and meet HSPD-12 requirements. This provides greater security for data and systems, and accelerates the retirement of the Enterprise User Administration (EUA).
- *The Enterprise Information Technology Fund:* This fund supports Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are

approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Infrastructure Investments

This section includes several key IT infrastructure projects, including:

- *Infrastructure Investments:* CMS will also prepare technical infrastructure (i.e., hardware capacity, network connectivity, and software) to accommodate Development, Integration, Testing and Validation and IDR Environments and high availability and corresponding disaster recovery for implementation. Due to the lead times to purchase computing capacity, it is critical to establish contracting vehicles early to acquire the necessary equipment to avoid implementation delays. Contractor support for infrastructure upgrades and project management, additional CPU capacity to support application growth resulting from legislative changes to existing systems, expansion of IDR platform by 20 terabytes, growth of mid-tier and mainframe DASD to support growth of databases (20 terabytes), network connectivity for up to 50 new business partners.
- *The Virtual Call Center strategy*: This critical project has greatly increased the overall efficiency and effectiveness of the 1-800-MEDICARE call center service delivery. Through this project, CMS is able to standardize the management of the Medicare beneficiary call center operations with best practice technology and process improvements, allowing for optimal customer service.

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

- *Exchanges & Integration:* Funding for these projects in Program Operations will provide oversight and planning for Health Insurance Exchanges and education. These funds will specifically support a casework tool for consumer support, an enrollment system for Exchanges, a data collection system for insurance and market oversight, and data reporting tools for Medical Loss Ratio.

There are four FY 2012 performance measures included in the outcomes and outputs table at the end of this chapter on effective management of CMS IT systems and investments to minimize risks and maximize returns. Ensuring that IT investments are managed effectively by adhering to the Enterprise Performance Life Cycle (EPLC), by conducting post-implementation reviews, by ensuring that CMS IT systems have a formal Authority To Operate (ATO), and are included in a vulnerability management program, will protect these key assets and help maintain the public trust in CMS.

Budget Request for Information Technology: $448.2 million

The FY 2012 budget request for other information technology investments supporting all Program Operations is $448.2 million, an increase of $185.8 million above the FY 2010 enacted level. This category includes three major IT investment activities.

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

- *Infrastructure Investments*: Funding is needed to continue to support the activities of the virtual call center strategy as well as the web hosting project. This funding will also include several crosscutting projects such as Enterprise Architecture, Requirements, Data Services Management, Enterprise Services and Infrastructure for new legislative mandates. System Modifications will also be performed on the Medicaid Budget and Expenditure System, the Children's Health Insurance Program Budget and Expenditure systems, Medicaid Management information system, Medicaid IT Architecture System, Medicare Administrative issue Tracking and Reporting of Operations and Complaints Tracking Module. In addition changes will be made to the Provider Enrollment and Chain Ownership System, National Plan and Provider Enumeration System and the Provider Statistical and Reimbursement Redesign to accommodate changes in legislation.

- *Exchanges & Integration:* Funding will support a fully developed Enterprise Performance Life Cycle process that ensures quality and risk-adverse systems, specifically the oversight and planning for Health Insurance Exchanges and education.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
MCR 3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	FY 2009: 73% (Target Exceeded)	72%	74%	+2
MCR3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	FY 2009: 62% (Target Exceeded)	61%	63%	+2
MCR3.3: Enrollment Increase percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources	FY 2010: 90% (Target Not Met)	91%	Target discontinued	N/A
MCR 10.1: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Intermediaries	FY 2010: 99.8% (Target Exceeded)	95%	95%	Maintain
MCR10.2: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers	FY 2010: 99.0% (Target Exceeded)	95%	95%	Maintain
MCR10.3: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for A/B Medicare Administrative Contractors	New in FY 2012 FY 20: 98.7% (Trend)	N/A	95%	N/A
MCR12: Maintain an unqualified opinion	FY 2010: Maintained unqualified opinion (Target Met)	Maintain	Maintain	Maintain
MCR13.1: Award Medicare FFS Workload to MACs	FY 2010: Award 1 DME MAC (2nd round) (Target Not Met)	Award 3 DME MACs (2nd round)	Award 3 A/B MAC Workloads	N/A
MCR13.2: Implement Medicare FFS Workload to MACs	FY 2010: Implement 65.6% (Target Not Met)	Implement 100%	Implement 1 DME MAC and 3 A/B MAC	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2011: 1, External outreach and communications continued. (Target Met) 2, ICD-10 industry compliance level and State Medicaid program readiness baselines updated. (Target Met) 3, ICD-10 Implementation Planning Recommendations finalized. (Target Met)	1. Complete CMS ICD-10 Implementation Plan 2. Initiate External ICD-10 outreach and communications plan 3. Develop ICD-10 industry compliance level baselines 4. Update State Medicaid program readiness baseline	1. Continue external ICD-10 outreach and communications 2. Update ICD-10 industry compliance level and State Medicaid program readiness baselines	N/A
MCR21.1: Percent of CMS Federal Information System Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. Baseline: 114 out of 311 FISMA Systems (36%) have an active Authority to Operate (ATO) as of 10/2009	FY 2010: 78% (Trend)	N/A	90%	N/A
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution Baseline: 0% in FY 2009	FY 2010: 63% (Trend)	N/A	95%	N/A
MCR21.3: Percent of information technology (IT) projects that have adapted to the Enterprise Performance Life Cycle (EPLC) framework Baseline: 10% in FY 2009	New in FY 2011	N/A	85%	N/A
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) Baseline: 0% in FY 2009	New in FY 2011	N/A	4 PIRs	N/A
MCR22: Reduce the growth of health care costs by identifying, reviewing, and appropriately valuing potentially misvalued codes	New in FY 2012	N/A	20%	N/A
MCR26: Reduce all-cause hospital readmission rate by 5 percent per year from 2012 to 2015	New in FY 2012	N/A	Develop Baseline	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
MCR29.1: Develop draft and final ESRD QIP rule for Payment Year (PY) 2014	New in FY 2011	N/A	Publish PY 2014 final rule	N/A
MCR29.3: Implementation of 2012 ESRD QIP payment reduction (to meet statutory requirement)	New in FY 2012	N/A	Adjust payment for facilities not meeting performance standards	N/A
PHI1.1: Percent of eligible individual health insurance market plans reporting data that is accurate and displayed on HealthCare.gov 2010 Baseline = 56%	New in FY 2011	N/A	85%	N/A
PHI1.2: Number of daily "hits" on the HealthCare.gov online portal 2010 Baseline = 6,150 hits	New in FY 2011	N/A	12,300 hits	N/A
PHI2: Number of young adults ages 19 to 25 who are covered as a dependent on their parent's insurance policy 2010 Baseline = 5.7 Million	New in FY 2011	N/A	7.8 million	N/A
Health Insurance Exchanges/Medicaid Expansion PHI4.2: Number of States that have the necessary legal authority to establish and operate an Exchange that complies with Federal requirements 2010 Baseline = 0	New in FY 2012	N/A	50 States +DC	N/A
Health Insurance Exchanges/Medicaid Expansion PHI4.3: Number of States in which there is an agreement drafted regarding coordination with State Medicaid, Department of Insurance and applicable State health subsidy programs, as appropriate 2010 Baseline = 0	New in FY 2012	N/A	50 States +DC	N/A
PHI4.4 Number of States in which an information infrastructure plan is developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment 2010 Baseline = 0	New in FY 2012	N/A	50 States +DC	N/A
PHI5: Number of individuals enrolled in the Preexisting Condition Insurance Plan (PCIP) program nationally Baseline: TBD	New in FY 2011	N/A	TBD	N/A
Program Level Funding($ in Millions)	**N/A**	**$2,290.9**	**$3,062.0**	**+771.2**

Federal Administration

(Dollars in thousands)

	FY 2010 Enacted	FY 2011 Continuing Resolution Level	FY 2012 Budget Request	FY 2012 +/- FY 2010
BA	$696,880	$696,880	$859,465	$162,585
Comparability Adjustment 1/	-$2,000	-$2,000	$0	$2,000
Comparable BA	$694,880	$694,880	$859,465	$164,585
Direct FTEs	4,276	4,278	4,917	641

1/ Comparably adjusted for the SHIP transfer to AoA.

Authorizing Legislation – Reorganization Act of 1953
FY 2012 Authorization – One Year
Allocation Method - Various

Program Description and Accomplishments
The Centers for Medicare & Medicaid Services (CMS) oversees three of the nation's largest health care programs: Medicare, Medicaid, and the Childrens' Health Insurance Program (CHIP); oversees new benefits for consumers and employers through the Pre-existing Condition Insurance Program (PCIP), the Early Retirement Reinsurance Program (ERRP), State High-Risk Pools and State-based Health Insurance Exchanges; enforces new rights and greater accountability for consumers and providers in the private health insurance market; and disseminates an unprecedented level of consumer information regarding coverage options. CMS is the largest purchaser of health care in the United States and expects to serve about 105 million beneficiaries and millions of consumers in FY 2012. In FY 2010, CMS spent $828 billion on benefits and other costs.

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

CMS currently employs approximately 5,400 Federal employees working in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; ten regional offices located throughout the country, and three anti-fraud field offices located in Miami, Los Angeles, and New York. Employees in Baltimore, Bethesda and Washington: write health care policies and regulations; set payment rates; develop national operating systems for a variety of health care programs; provide funding for the Medicare contractors and monitor their performance; develop and implement customer service improvements; provide education and outreach to beneficiaries, consumers, employers and providers; implement guidelines to fight fraud, waste, and abuse; and assist law enforcement agencies in the prosecution of fraudulent activities. Regional Office employees provide services to Medicare contractors; accompany State surveyors to hospitals, nursing homes, labs, and other health care facilities to ensure compliance with CMS health and safety standards; assist

States with Medicaid, CHIP and other health care programs; and conduct outreach and education activities for health care providers, beneficiaries, and the general public. We also have staff in our new fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program.

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

Personnel Compensation and Benefits:

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

CMS' staffing level and related compensation and benefits expenses are largely workload-driven. Over the last decade, CMS' core workloads have increased dramatically due to major legislative and Secretarial initiatives. These include the completion of activities mandated by the Health Insurance Portability and Accountability Act (HIPAA); the Balanced Budget Act (BBA); the Ticket to Work and Work Incentives Improvement Act (TWWIIA); the Balanced Budget Refinement Act (BBRA); the Benefits Improvement and Protection Act (BIPA); the Trade Act; the Medicare Modernization Act (MMA); the Deficit Reduction Act (DRA); the Tax Relief and Health Care Act (TRHCA); the Medicare, Medicaid and SCHIP Extension Act (MMSEA); the Medicare Improvements for Patients and Providers Act (MIPPA); the Children Health Insurance Program Insurance Reauthorization Act (CHIPRA); the American Recovery and Reinvestment Act (ARRA); and most recently, the Affordable Care Act (ACA). In addition, CMS is responsible for the concurrent implementation of a number of Secretarial priorities, including the transformation of our data environment, value-based purchasing, price transparency, consumer choice, e-health initiatives, and enhanced beneficiary outreach.

Other Objects

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

Most of these costs—including rent, communications, utilities, the mortgage for the Central Office building loan, the CMS share of Departmental costs such as the Service and Supply Fund and Human Resources support, the Office of General Counsel inter-agency agreement, and the Federal Protective Services contracts—are determined by the Department or another government agency and are not negotiable. Other costs—including IT infrastructure costs, building maintenance, and most of our inter- and intra-agency agreements—are essential for functioning as a government agency.

- Rent, Communication & Utilities

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

- Building Loans

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

- Service and Supply Fund

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

- Human Resources (DHHS)

CMS reimburses the Department for its share of the costs of our Human Resources (HR) support at the Bethesda Operations Center (BOC). In 2007, DHHS developed the "One HHS" initiative to eliminate duplication of effort and achieve economies of scale. As part of this initiative, the Department consolidated personnel activities, previously performed separately by each Operating Division within DHHS, and created centralized human resource activity to service CMS. Our HR activity currently consists of four operational divisions: Workforce Relations, Client Services, Strategic Programs, and Internal Accountability and Workforce Management:

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

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

  - The Strategic Programs staff advises leadership on strategic human capital planning, human resources program evaluation, and service level agreements. They also develop and implement human resources automation tools and strategies aimed at maximizing the efficiency and effectiveness of the Human Resources Center.

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

- Administrative Services

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

- Information Technology (IT)

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

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

- Inter-Agency Agreements

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

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

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

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

- Supplies and Equipment

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

- Administrative Contracts and Intra-Agency Agreements

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

  - Legal services with the Office of General Counsel (OGC): CMS reimburses the OGC for the legal services and guidance it provides on ethics activities and on legislative, programmatic, and policy issues related to CMS' programs. This contract allows CMS to implement policies and run its programs. In FY 2009, CMS paid $9.0 million for these services. OGC calculates the charge and informs CMS of the amount it must pay. This cost increases each year.

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

health care providers, efficiently and cost-effectively. To date, CMS has provided support for satellite installation at 120 Tribes and Urban Indian health facilities.

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

- Training

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

- Travel

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

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

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

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

- Printing and Postage

The single largest expense in this category is printing and mailing Medicare cards, primarily the replacement of lost or damaged cards. CMS mails out over 5 million Medicare cards annually. When Medicare was enacted in 1965, an administrative decision was made to provide Medicare cards to all entitled beneficiaries. The cards identify the individual to providers as a Medicare beneficiary, provide the beneficiary with proof of entitlement, and simplify the administration of the program.

The next largest expense in this category, almost one-fourth of the total, is for printing notices in the Federal Register and Congressional Record. The law requires CMS to publish regulations that adhere to notice and comment rulemaking procedures. At least one major piece of new authorizing legislation involving CMS's programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

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

Funding History

2007	$642,355,000
2008 [1/]	$636,132,000
2009	$641,351,000
2010 [2/]	$696,880,000
2011 [2/]	$696,880,000

1/ *Includes $5.0 million in Supplemental funding provided by P.L. 110-252.*
2/ Non-comparable values. Reflects the annualized CR level.

Budget Overview and Supported Activities

Personnel Compensation and Benefits ($654.8 million): The FY 2012 President's Budget estimate includes $654.8 million to support 4,917 direct FTEs. This request reflects a $86.5 million (+641 FTE) increase over the FY 2010 enacted level to continue implementation of recent legislation and new Administration priorities. Our payroll estimates assumes a 1.6-percent COLA increase for military personnel, only.

Rent, Communication & Utilities ($39.7 million): Our FY 2012 President's budget level fully-funds rent, communications and utilities at $39.7 million, which is $14.6 million more than the FY 2010 enacted level. This increase primarily funds and new, leased space requirements attributable to new Administration priorities.

Building Loans ($10.9 million): The FY 2012 estimate for Building Loans is $10.9 million. This estimate remains the same as the FY 2010 enacted level.

Service and Supply Fund ($19.1 million): The FY 2012 Service and Supply Fund estimate totals $19.1 million, a $4.8 million increase above the FY 2010 enacted level.

Human Resources Support ($10.2 million): The FY 2012 BOC Human Resources support estimate totals $10.2 million, which is approximately $1.8 million more than the FY 2010 enacted level.

Administrative Service ($9.4 million): The FY 2012 Administrative Service estimate is $9.4 million. This estimate provides funds for anticipated moves and building reconfigurations in FY 2012. This estimate is $2.4 million above the FY 2010 enacted level.

Administrative Information Technology ($32.5 million): The FY 2012 Administrative IT estimate is $32.5 million, which is $7.0 million above the FY 2010 enacted level.

Inter-Agency Agreements ($1.1 million): The FY 2012 estimate in this category is $1.1 million, which is approximately $900,000 less than the FY 2010 enacted level.

Supplies and Equipment ($3.3 million): The FY 2012 request is $3.3 million, a $2.1 million increase over the FY 2010 enacted level.

Administrative Contracts and Intra-Agency Agreements ($60.1 million): The FY 2012 request totals $60.1 million, a $41.1 million increase over the FY 2010 enacted level. This increase is necessary to implement recent legislation and Administration priorities.

Training ($3.4 million): The training estimate for FY 2012 is $3.4 million. This estimate is $500,000 greater than the FY 2010 enacted level.

Travel ($11.7 million): The travel estimate for FY 2012 totals $11.7 million. This estimate reflects a $2.8 million increase over the FY 2010 enacted level. The additional funds are needed to implement recent legislation and new Administration priorities.

Printing and Postage ($3.3 million): The printing and postage estimate for the FY 2012 request is $3.3 million, which is $200,000 less than the FY 2010 enacted level.

Federal Administration Summary
(Dollars in thousands)

Object of Expense	FY 2010 Enacted	FY 2012 Budget Request	Variance
Personnel Compensation	$568,247	$654,758	$86,511
Rent, Communication & Utilities	$25,100	$39,672	$14,572
Central Office Loan	$10,900	$10,900	$0
Service/ Supply Fund	$14,300	$19,144	$4,844
Human Resources	$8,400	$10,200	$1,800
Administrative Services	$7,000	$9,400	$2,400
Administrative IT	$25,477	$32,477	$7,000
Inter-Agency Agreements	$2,000	$1,140	-$860
Supplies and Equipment	$1,164	$3,258	$2,094
Administrative Contracts and Intra-Agency Agreements	$18,954	$60,062	$41,108
Training	$2,938	$3,439	$501
Travel	$8,900	$11,715	$2,815
Printing and Postage	$3,500	$3,300	-$200
Subtotal, Other Objects Expense	$128,633	$204,707	$76,074
Total, Federal Administration 1/	**$696,880**	**$859,465**	**$162,585**

1/ FY 2010 is presented on a non-comparable basis.

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Medicare Survey and Certification Program

(dollars in thousands)

	FY 2010 Enacted	FY 2011 Continuing Resolution Level	FY 2012 Budget Request	FY 2012 - FY 2010 +/-
BA	$346,900	$346,900	$400,283	+ $53,383

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

FY 2012 Authorization - One Year

Allocation Method - Contracts

Program Description and Accomplishments

In order to secure quality care for the elderly, one of the Nation's most vulnerable populations, CMS requires that all facilities seeking participation in Medicare and Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two territories. Utilizing over 6,500 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards. In FY 2009, about 90 percent of Medicare participating nursing home facilities were cited for health deficiencies. The average number of health deficiencies per survey was approximately seven. This demonstrates the profound importance of regular, comprehensive inspections of health care facilities.

Recent reports from the Government Accountability Office (GAO) and the Office of Inspector General (OIG) highlight the need for Federal oversight to ensure quality of care. The GAO placed aspects of survey and certification, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to ensuring Federal dollars support only quality care.

Direct Survey Costs

Direct survey costs represent the funding provided directly to States to perform surveys and complaint visits and to support associated program costs. Two facility types have statutorily mandated survey frequencies: each individual nursing home must be surveyed at least every 15 months and on average all nursing homes every 12 months, and home health agencies must be surveyed at least every 3 years. Survey frequencies for all other facility types are determined by policy and funding levels.

In addition to the cost of conducting surveys, Direct Survey costs also include Other Direct Survey costs, which support State program costs. These costs include support for the Minimum Data Set (MDS) which contains costs, financial and other information to

improve nursing home projects. These costs also include support for the Outcome and Assessment Information Set (OASIS), which serves as the backbone of the home health prospective payment system. Other Direct Survey costs also include emergency preparedness and validation support for non-long term care facilities.

An August 2005 OIG report on CMS oversight of short-term acute care hospitals (which now constitute 72 percent of all non-accredited hospitals) found that, while the percentage of hospitals surveyed within three years had increased, the national annual survey rate for these hospitals was too low to sustain this progress. A growing number of facilities, growth in complaint visits, and demands to survey other facility types led to lower survey frequencies for non-statutorily mandated facility surveys prior to FY 2010. Increases in the FY 2010 budget, which was funded at the level requested in the FY 2010 Presidents Budget, have enabled CMS to restore these survey frequencies to policy levels.

The Recovery Act provided a total of $50 million to States for prevention of healthcare-associated infections (HAI), and $10 million of this total was provided through CMS to States to improve the survey process for Medicare-participating Ambulatory Surgical Centers (ASCs). ASCs account for 43 percent of all same-day (ambulatory) surgery in the United States, amounting to about 15 million procedures every year and have been the fastest growing provider type participating in Medicare, increasing in number by more than 57% between 2002 and 2010. Typical surgical procedures conducted in ASCs include endoscopies and colonoscopies (including removal of identified polyps), orthopedic procedures, plastic/reconstructive surgeries, and eye, foot, and ear/nose/throat surgeries. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various ASCs (potentially affecting more than 50,000 people). Follow-up Medicare surveys throughout Nevada found serious deficiencies at 64% of the ASCs surveyed, primarily with infection control practices. This initiative will significantly expand the awareness of proper infection control practices among ASCs and State Agencies (SA), increase the extent to which infection control deficiencies are both identified and remedied, and prevent future serious infections in ASCs by:

(a) Improving SA inspection capability and frequency for onsite surveys of ASCs nationwide,
(b) Using a new infection control survey tool developed by the CDC and CMS,
(c) Improving the survey process through the use of a CMS tracer methodology, and
(d) Using multi-person teams for ASCs over a certain size or complexity.

The Recovery Act funds enabled the application of the above four-component new survey process nationwide. Twelve States – Maine, New Jersey, Maryland, Florida, North Carolina, Indiana, Michigan, Arkansas, Oregon, Utah, Wyoming and Kansas – surveyed more than 125 ambulatory surgical centers (ASCs) in FY 2009. In FY 2010, the Recovery Act funds supported an increase in the national survey frequency from every six years to every three years, and the continued use of the enhanced survey process. These enhanced surveys are designed to ensure that ASCs are following Medicare's health and safety standards, and particularly that they are adhering to proper infection control practices. Results from the surveys conducted in the 3 pilot States in 2008 were published in the Journal of the American Medical Association in June 2010. For the surveys completed so far in FY 2010 under the Recovery Act, as of July 2010, approximately 59% of the ASCs were found to have one or more infection control deficiencies (either conditional or standard level).

CMS has worked in recent years to evaluate the performance of State survey agencies and ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements. CMS uses the State Performance Standards System (SPSS), developed in 2002, to track State performance on measures such as adequacy of documentation and promptness of reporting survey results, as well as conformance with expected survey frequencies. For example, the percentage of total nursing homes surveyed at mandated 15-month maximum survey intervals has increased from about 97.0 percent in 2002 to 99.9 percent in 2008, and the percent of home health agencies surveyed at mandated frequencies rose from 92.0 percent in 2002 to 99.9 percent in 2008.

CMS has another performance measure to assess CMS' and survey partners' success in meeting the core statutory obligations for carrying out nursing home surveys with routine frequency. This measure tracks the percentage of States that survey nursing homes every 15 months. CMS exceeded its FY 2009 target with a result of 96 percent. Targets for FY 2010 and FY 2011 Continuing Resolution (CR) are 95 percent and 97 percent, respectively. To meet these targets, CMS must ensure that proper operational controls, such as training and regulations, are in place. In addition, CMS issues an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements to meet these targets.

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

CMS has two performance measures related to the quality of care in nursing homes to assess the effectiveness of these and other survey and certification activities in nursing homes. Goals to decrease the prevalence of restraints and pressure ulcers in nursing homes are clinically significant and are closely tied to the care given to beneficiaries. Since implementation of the restraints measure, the prevalence of restraints has declined from 17.2 percent of residents in 1996 to 3.3 percent in FY 2009. The FY 2009 result means that between the end of FY 2003 and the end of FY 2009, there are almost 60 percent fewer nursing home residents in restraints each week.

Nursing homes' recent progress in reducing restraint use has accelerated due to the new and intense collaboration between survey and certification and the Quality Improvement Organizations, as well as careful work between CMS and nursing homes in the *Advancing Excellence in America's Nursing Homes* national campaign. In addition, CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use.

After many years of steady levels, CMS has met or exceeded targets to reduce the prevalence of pressure ulcers in nursing homes in every year since FY 2004, including

FY 2009, where we exceeded our target of 8.2 percent with an actual prevalence of 7.6 percent. The Regional Offices (ROs) have taken the lead in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative. New survey guidance and follow up with States has increased the focus on pressure ulcer reduction.

The prevalence of pressure ulcers in Nursing homes is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers. Nonetheless, a decrease in the prevalence of pressure ulcers of even 0.1 percentage point represents more than 1,000 fewer nursing home residents with a pressure ulcer. The success of the efforts can be attributed to greater collaboration between State survey agencies and Quality Improvement Organizations and the national Advancing Excellence in America's Nursing Homes campaign.

Support Contracts and Information Technology

Support Contracts

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

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

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

Information Technology

CMS maintains several information technology systems that are necessary for survey and certification activities. The OSCAR (Online Survey, Certification, and Reporting System) and FOSS (Federal Oversight/Support Survey System) are, respectively, the State and Federal workload database systems that are essential to the daily operation of the Survey and Certification program. Both of these systems are in the process of being redesigned to integrate with other essential IT systems. The OSCAR system enhancements will upload and convert the data from the current system to the new Quality Improvement and Evaluation System (QIES). The QIES system records and tracks more information on the survey and certification process and quality of healthcare for over 240,000 Medicare, Medicaid, and Clinical Laboratory Improvement Amendments (CLIA) providers. Although the OSCAR system is being redesigned, the

legacy system must be maintained until QIES is fully developed. The FOSS redesign will integrate the database into Automated Survey Processing Environment (ASPEN) which is essential in gathering the data from survey results.

CMS has developed and is implementing an improved data-driven standard survey system to be used in the certification of nursing homes that participate in the Medicare/Medicaid programs. This survey system is called the "Quality Indicator Survey" (QIS) and is in response to concerns identified by CMS, GAO and OIG regarding the current survey process. The concerns focus on the lack of uniformity in the manner in which compliance with federal requirements is assessed for the 15,900 Medicare and Medicaid nursing homes that must be surveyed each year. The new QIS process uses both off site and on site information to develop computer generated quality of care indicators, comparing delivery of care with national norms. The QIS requires surveyors to use computers on site during the survey as the survey team gathers information, generates quality care indicators and identifies those areas that are triggered for investigation in the second stage of the survey. Approximately 5,000 State and Federal surveyors will require training on the new survey process. Training is extensive and expensive, involving CMS contractors. Therefore, CMS is staging national implementation of the QIS as quickly as contracts can be funded and processed. Currently 17 States are either in the process or completely transitioned to the QIS. CMS expects approximately 6-7 States to begin in the next contract year which takes place from July 2010 to June 2011. National implementation will take the next several years. In the meantime, CMS continues to run two survey processes, the traditional survey process and the QIS survey process, which will ensures a timely transition of systems. In addition, transition to the QIS requires significant technology upgrades to support this refined survey process.

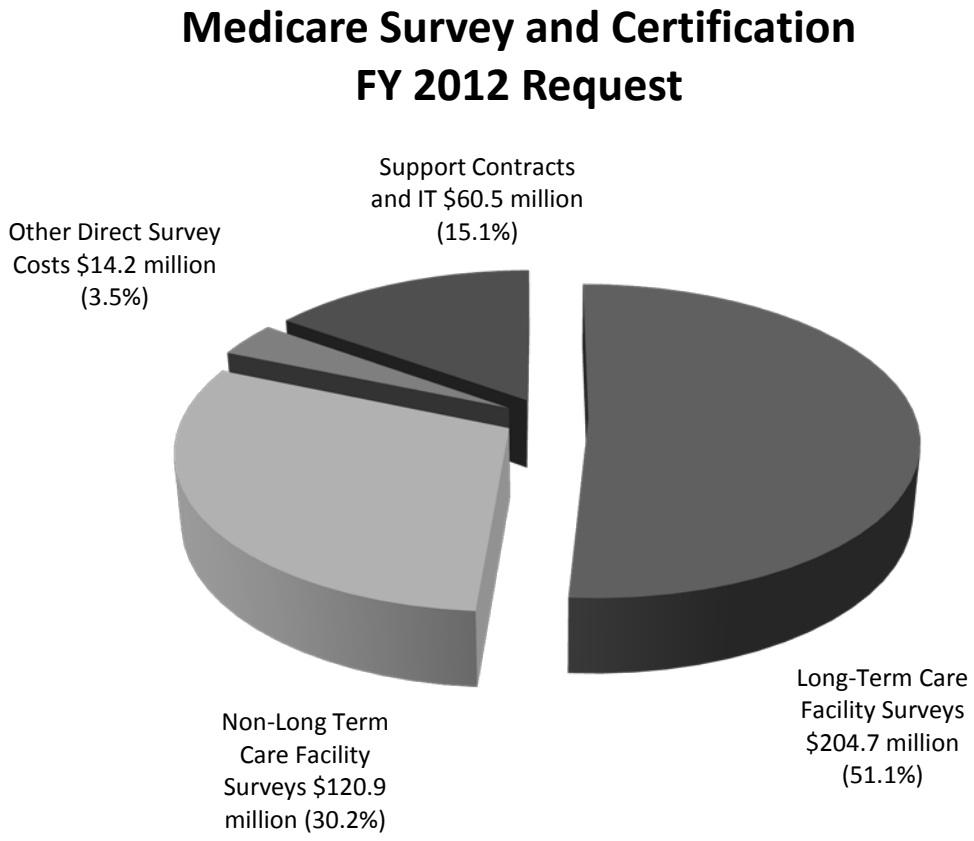
Funding History

FY 2007	$258,128,000
FY 2008	$281,186,000
FY 2009	$293,128,000
FY 2010	$346,900,000
FY 2011	$346,900,000

Budget Request

CMS' FY 2012 request for Medicare Survey and Certification is $400.3 million, an increase of $53.4 million, or 15.4 percent above the FY 2010 enacted level. With facilities growth and inflation, this increase is needed to provide survey frequencies consistent with statutory and policy requirements. As described below in more detail, $325.6 million of this amount will support direct survey costs, $14.2 million will support additional costs related to direct surveys, and $60.5 million will be used for support contracts and information technology.

Approximately 81 percent of the requested funding will go to State survey agencies. This funding will be used for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, organ transplant facilities and ESRD facilities. This funding also supports CMS' policy survey frequencies for the surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics and ambulatory surgery centers. The budget also includes funding for continued program support contracts to strengthen quality improvement and national program consistency, make oversight of accrediting organizations more effective, and implement key recommendations made by the Government Accountability Office (GAO).

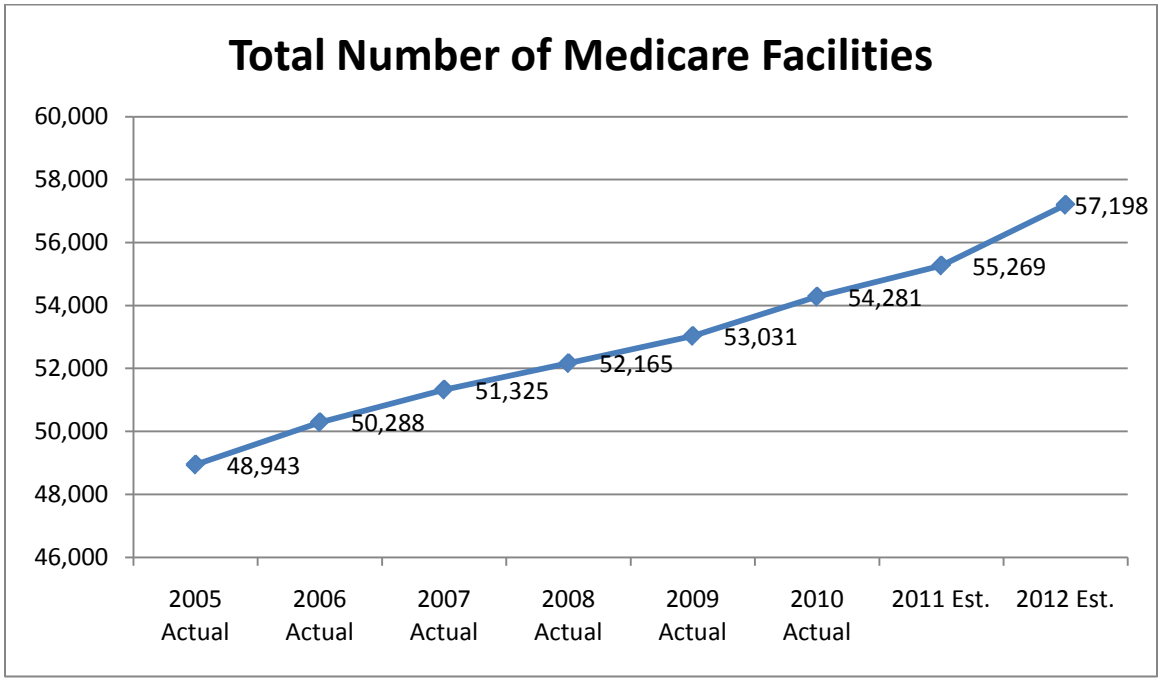


Direct Survey Costs - $325.6 million

The FY 2012 President's Budget includes $325.6 million for direct survey costs, a $16.3 million increase over the FY2010 Enacted Level. This funding will enable CMS to meet statutory survey frequencies as well as CMS policy levels for non-statutory facilities and allow CMS to continue quality improvement efforts in the surveys of ambulatory surgical Centers and accredited hospitals.

These funds will also support the new survey function of community mental health centers (CMHC). Previously there were no Conditions of Participation (COPs) for CMHCs. Without COPs it is difficult to improve quality of care at poorly performing CMHCs because there is no mechanism to terminate them from Medicare participation. CMS will address these concerns by setting minimum quality and safety of care standards that CMHCs will have to meet in order to become and maintain enrollment as a Medicare provider.

Between FY 2005 and FY 2012, the number of Medicare-certified facilities will have increased by 16.8 percent, from 48,943 facilities in FY 2005 to an estimated 57,198 facilities by the end of FY 2012, as shown in the following graph.



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

Direct Survey Costs (dollars in millions)

Provider Type	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Presidents Budget
Skilled Nursing Facility (SNF)	$12.3	$12.2	$12.0
SNF/NF (dually-certified)	$196.4	$194.8	$192.7
Home Health Agencies	$32.8	$30.0	$30.0
Accredited Hospitals	$20.3	$18.2	$27.2
Non-Accredited Hospitals	$15.9	$13.7	$19.4
Ambulatory Surgery Centers 1/	$4.2	$7.9	$10.7
ESRD Facilities	$17.3	$11.8	$20.5
Hospices	$6.7	$5.1	$6.2
Outpatient Physical Therapy	$1.9	$1.3	$1.4
Outpatient Rehabilitation	$0.5	$0.2	$0.3
Portable X-Rays	$0.2	$0.2	$0.2
Rural Health Clinics	$1.9	$1.3	$1.8
Transplant Centers	$1.5	$2.8	$2.5
Community Mental Health Centers	$0.0	$0.0	$0.7
Subtotal, Direct Survey Costs	**$311.8**	**$299.5**	**$325.6**
Other Direct Survey Costs	$10.2	$13.9	$14.2
Total, Direct Surveys 2/	**$322.0**	**$313.4**	**$339.8**

CMS' FY 2012 request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. The FY 2012 target is for 97 percent of States to survey nursing homes at least every 15 months. To meet the FY 2012 targets, CMS ensures that proper operational controls, such as training and regulations, are in place. These targets are also affected by the program's overall approved and appropriated budget level for FY 2012. In addition, CMS will issue an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements.

In recent years, survey frequencies have been longer than once every 10 years for many facility types. The funding requested will allow CMS to maintain more rigorous survey frequencies of at least once every six years for all facility types. The 2012 request continues to fund surveys of organ transplant centers which were surveyed for the first time in FY 2007. It will also fund the survey process for community mental health centers starting in FY 2012.

CMS continues to advance efforts to address healthcare associated infections (HAI). The request continues the enhanced survey process in ASC to target infection control

1/ Does not include ARRA funding.
2/ Total may not add due to rounding.

deficiencies, with a survey frequency of every 4 years. The request also includes funding for a hospital HAI pilot which will be conducted with CDC as part of the HHS HAI strategic plan. The pilot will concentrate primarily on critical access hospitals and smaller hospitals, and we expect 10-25 States to participate with 700-950 surveys in total.

The following chart includes updated frequency rates for FY 2012.

Type of Facility	Recert Level FY 2010	Recert Level FY 2011 CR	Recert Level FY 2012 CMS Request
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Non-Accredited Hospitals	Every 3 Years	Every 5 Years	Every 3 Years
Accredited Hospitals	2% per Year	Not Funded	3.3% per Year
ESRD Facilities	Every 3 Years	Every 4.2 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 5 Years	Every 3 Years
Ambulatory Surgical Center	Every 6 Years	Every 5 Years	Every 4 Years
Community Mental Health Centers	N/A	N/A	Every 3.9 Years
All Other Non-LTC Facilities 1/	Every 6 Years	Every 10 Years	Every 6 Years

1/ All Other Non-LTC Facilities includes: hospices, outpatient physical therapy, outpatient rehabilitation, rural health clinics and portable x-rays.

As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2012 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of restraints and pressure ulcers in nursing homes. CMS is encouraged by recent downward trends in both measures. Beginning in October 2010, all nursing homes began submitting nursing home clinical assessment date using the Minimum Data Set (MDS), version 3.0, an upgrade from version 2.0. The pressure ulcer and restraints measures will be affected by the changes in the MDS; therefore, CMS will need to rescale and rebase both measures beginning in FY 2011. Targets for FY 2012 are TBD. Nonetheless, CMS remains committed to reducing the prevalence of restraints and pressure ulcers in nursing homes.

Survey and Complaint Visit Table

	FY 2011 CR Level				
Type of Facility	Projected # Fac (Beg of FY)	Total Recert Surveys	Total Initial Surveys	Total Complaint Visits	Total Surveys & Visits
Skilled Nursing Facility (SNF)	835	835	36	936	1,807
SNF/NF (dually-certified	14,295	14,295	146	45,759	60,200
Home Health Agencies	9,885	2,709	687	1,660	5,056
Non-accredited Hospitals	1,742	0	0	4,881	4,881
Accredited Hospitals	4,125	348	170	993	1,511
ESRD Facilities	5,395	1,297	239	715	2,251
Transplant Centers	265	53	87	100	240
Hospices	3,375	289	210	595	1,094
Outpatient Physical Therapy	2,915	292	129	9	430
Outpatient Rehabilitation	562	56	22	7	85
Portable X-Rays	565	57	27	5	89
Rural Health Clinics	3,775	378	169	28	575
Ambulatory Surgical Centers	5,330	769	283	133	1,185
CMHC	0	0	0	0	0
Total	**53,064**	**21,378**	**2,205**	**55,821**	**79,404**

	FY 2012 Request				
Type of Facility	Projected # Fac (Beg of FY)	Total Recert Surveys	Total Initial Surveys	Total Complaint Visits	Total Surveys & Visits
Skilled Nursing Facility (SNF)	816	816	32	878	1,726
SNF/NF (dually-certified	14,295	14,460	142	44,118	58,720
Home Health Agencies	10,950	2,712	1,038	1,595	5,345
Non-accredited Hospitals	1,830	609	101	1,025	1,735
Accredited Hospitals	4,135	141	0	4,575	4,716
ESRD Facilities	5,512	1,837	257	715	2,809
Transplant Centers	267	89	11	10	110
Hospices	3,422	490	176	582	1,248
Outpatient Physical Therapy	2,801	467	45	9	521
Outpatient Rehabilitation	490	82	8	5	95
Portable X-Rays	565	94	21	5	120
Rural Health Clinics	3,775	629	155	40	824
Ambulatory Surgical Centers	5,423	943	246	85	1,274
CMHC	660	169	25	10	204
Total	**54,941**	**23,538**	**2,257**	**53,652**	**79,447**

The decrease in surveys from 2011 to 2012 is due to the projected decrease in total complaint visits from FY 2011 to FY 2012.

The FY 2012 direct survey cost estimate also includes $14.2 million, an increase of $4 million from the FY 2010 enacted level, in other direct survey costs for several continuing activities:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects.
- Outcome and Assessment Information Set (OASIS) State program costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support.
- Validation Support. This includes conducting validation surveys of the non-long-term care accredited facilities; home health agencies, ASCs, and hospices. The increase focuses primarily on ASCs and the efforts started with ARRA funding.

Support Contracts and Information Technology - $60.5 million

Support Contracts ($56.7 million)

Support contracts, managed internally by CMS, constitute $56.7 million of the FY 2012 request. This is an increase of $33.0 million from the FY 2010 enacted level.

- Training

The largest category in support contracts continues to be surveyor training. Implementing more efficient and effective training for surveyors is an area that has a high return on investment. Through web-based and case-study training, surveyors can gain the skills necessary to perform proficiently while providing quality care for beneficiaries. New in FY 2012 are requests for dementia and abuse prevention training, as well the Elder Justice – National Surveyor Training Institute. CMS will fund facilities to include dementia management and abuse prevention training as part of pre-employment initial training for staff. CMS will create a National Training Institute to improve the training of surveyors with respect to investigating allegations of elder abuse, neglect and misappropriation of property. The request for training and oversight is $22.7 million.

- Support Surveys

The request includes $8.3 million for federally directed surveys that substitute for State surveys on psychiatric hospitals, for comparative surveys and funding for transplant center oversight.

- Oversight, Accountability, and Transparency

The request also includes $1.0 million for the Hospital and Ambulatory Surgical Centers Oversight Improvement Program. This program addresses quality and oversight concerns and accredited hospitals and other types of accredited facilities, and was developed in response to the GAO concerns and the expanded requirement for oversight included in MIPPA. This funding will support a database to track accrediting organization activities and also costs for databases for the ASC-HAI initiative.

The FY 2012 request also includes $14.7 million for the following accountability and transparency improvement initiatives. CMS must comply with required disclosure of a nursing facility's ownership and organizational structure and will develop a standardized complaint form and complaint resolution process. This funding will include the design of a new data system receiving electronic, detailed staffing and residential census data from 15,800 nursing homes four times per year. CMS will also construct and display new staffing measures for each nursing home. CMS will require that nursing home administrators must submit written notice of impending closure (60 days prior to closure) to HHS, State long-term care ombudsman, facility residents, and other responsible parties. CMS will also implement major systems reform for long term care, including a new system for internal quality assurance and performance improvement in all nursing homes and a program to ensure compliance with all criminal, civil, and administrative requirements in all nursing homes.

- Best Practices

The FY 2012 budget request includes $10.0 million to conduct two demonstration projects to develop best practices. One project is for the development of best practices in nursing homes involved in the culture change movement, a national movement to improve quality by addressing root causes of poor quality in nursing homes. The second will develop best practices for the use of information technology to improve resident care.

Information Technology ($3.8 million)

The Medicare Survey and Certification request includes approximately $2.8 million in IT funding for activities such as maintenance and enhancements to the Online Survey, Certification, and Reporting (OSCAR) system and the Federal Oversight Survey System (FOSS) redesign. This is an increase of $0.3 million from the FY 2010 enacted level. The FOSS redesign will develop a user's operational manual and post it on the CMS website, and revise FOSS reports for the State Performance Standard Report.

This FY 2012 request includes $1.0 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. IT expenses are incurred for systems work, regardless of the number of States. In FY 2012, we expect two forms of expansion: (1) expansion within existing States to get to statewide implementation, and (2) adding 3-6 new States, depending on the size of the States.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
MCR 4: Decrease the prevalence of restraints in nursing homes	FY 2009: 3.3% (Target Exceeded)	3.8%	TBD	N/A
MCR 5: Decrease the prevalence of pressure ulcers in nursing homes	FY 2009: 7.6% (Target Exceeded)	8.1%	TBD	N/A
MCR 6: Percentage of States that survey nursing homes at least every 15 months	FY 2009: 96% (Target Exceeded)	95%	97%	+2 percentage points
MCR 7: Percentage of States that survey HHAs at least every 36 months	FY 2009: 94% (Target Exceeded)	90%	96%	+6 percentage points
MCR 8: Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds	FY 2010: 100% (Target Exceeded)	80%	92%	+12 percentage points
Program Level Funding ($ in millions)	N/A	$346,900	$400,283	+53,383

Research, Demonstration and Evaluation

(dollars in thousands)

	FY 2010 Enacted	FY 2011 CR Level	FY 2012 Budget Request	FY 2012 +/- FY2010
BA	$35,600	$35,600	$31,178	-4,422

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

FY 2012 Authorization - One Year

Allocation Method - Contracts, Competitive Grants, Cooperative Agreements

Program Description and Accomplishments

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at a reasonable cost. CMS develops, implements, and evaluates a variety of innovative research and demonstration projects to expand efforts that improve the efficiency of payment, delivery, access and quality of our health care programs that will serve almost 105 million beneficiaries in FY 2012.

Our research and demonstration activities have significantly contributed to major program reforms and improvements:

- Research investments to revamp hospital, skilled nursing facility, and durable medical equipment payments yielded an estimated $64 billion in program savings over ten years, according to actuarial estimates.
- Many of the Medicare payment systems developed and tested under CMS's RD&E program have been adopted by State Medicaid programs and private payers.
- Payment systems based on our development of diagnosis-related groups are the most common form of hospital payment in the United States today.
- CMS also developed a system of risk-adjusted payment for managed care organizations and end stage renal disease (ESRD) enrollees and a risk-adjusted model to pay Part D prescription drug plans.
- Our demonstrations have had major influences on the evolution of the Medicare managed care program and Congress has enacted numerous changes to the services and benefits provided under our programs because of our RD&E activities, including hospice care, rural swing-bed program for small rural hospitals, and the Medicaid 1915(b) waiver program.

CMS continues to invest in innovative research and demonstration projects to help transform and modernize the American health care system into a system that constrains costs, expands access and improves quality.

Medicare Current Beneficiary Survey (MCBS)

The MCBS is a continuous, multi-purpose survey that represents our Medicare population. The survey's design aids CMS' administration to monitor and evaluate the Medicare program. The survey's focus is on health care use, cost and source of payment. The MCBS is the only comprehensive source of multi-dimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the program including self-reported Medicare beneficiary drug cost and utilization under the Part D benefit.

The MCBS data is of importance to: decision-makers for crafting legislation; the Congressional Budget Office (a prime user of our MCBS data) in developing legislative estimates; actuaries for compiling the annual Trustees' Report as well as calculating figures in the National Health Accounts; and, internal CMS researchers, policy analysts, and external researchers projecting the consequences of alternative policies for the Medicare population and the Medicare budget. Foundations such as Kaiser, R W Johnson, and the Commonwealth Fund also use MCBS data for policy analyses.

The MCBS is essential in CMS payment policy for the demographics used in calculating the adjusted average per capita cost (AAPCC), defining risk-adjustment formulas, and evaluating outcomes of managed care payments. One recent study found unexplained variations in risk-adjustment payments, leading to the inclusion of health status as an element in the payment formula.

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

In 2010, CMS completed production of the 2008 Medicare Current Beneficiary Survey Access to Care Data Files, all activities associated with the 2010 MCBS Sample Draw, and the 2007 MCBS Cost and Use claim imputation process.

Demonstrations

Our agency plans, designs, conducts, and monitors demonstrations to test potential improvements in Medicare coverage, expenditures, delivery, access and quality of care. We translate research and concepts into demonstrations. We evaluate demonstrations and apply knowledge gained to program improvements. Our demonstrations are real-world tests that yield real-world impacts of potentially new policy approaches on beneficiaries, providers and program expenditures. Past demonstration projects have influenced almost every major new payment system and/or method, the evolution of the Medicare managed care program, and delivery system and benefits decisions.

In 2010, CMS continued to test for potential improvements in Medicare by designing, implementing, and evaluating demonstrations with interventions and/or changes to Medicare in the following key areas: Health Information Technology (IT), Care Coordination/Disease Management/Prevention, Value-Based Purchasing, Payment/Delivery System, and Other areas.

A number of demonstration evaluation reports were prepared in 2010, including:

- Evaluation of the Premier Hospital Quality Demonstration: Analysis Design Report
- Post Acute Care Payment Reform Demonstration Interim Findings Report
- Evaluation of the Chiropractic Services Demonstration – Report to Congress
- Evaluation of the Medical Adult Day Care Demonstration – Report to Congress

Other Activities

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

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

CMS produced a number of studies pertaining to these topics in 2010, for example:

- Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2008
- Evaluation of Medical Spending Accounts (MSA) under Medicare Advantage - Cross Cutting Report
- Impact of Payment Reform for Part B Covered Outpatient Drugs and Biologicals
- Anemia Management Trending Report using data through November 2009
- Two Studies on Monitoring Chronic Disease Care and Outcomes among Elderly Medicare Beneficiaries with Multiple Chronic Diseases - University of Minnesota (approved for website release)

Our research agenda also incorporates the evaluation of all new and existing prospective payment systems (PPS) as they proceed through stages of implementation, refinement or monitoring. Our PPS systems include inpatient psychiatric services, inpatient diagnosis-related groups, home health services, physician payments, end-stage renal disease (ESRD), inpatient acute care hospital, long-term care and skilled nursing facility.

In 2010, CMS prepared the following reports evaluating prospective payment systems:

- Impacts Associated with the Inpatient Psychiatric Facility PPS
- Impacts Associated with the Medicare Psychiatric PPS: A Study of Partial Hospitalization Programs
- Revision of Medicare Wage Index: Final Report, Part II

CMS carries out additional activities that build, support and improve both internal and external health services research capacity. These activities include multiple data collection and dissemination tools, research studies, and grant programs.

One such tool is the chronic conditions warehouse (CCW). The CCW houses CMS data that are easily linked, at the individual patient level, for all Medicare claims data, eligibility data, nursing home and home health assessments, and CMS beneficiary survey data. This data warehouse transforms and summarizes this administrative health insurance information into

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

The CMS 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.

Real Choice Systems Change Grants (RCSC)

RCSC grants are intended to support States' efforts to create enduring systems reforms that enable people to live independent lives in the community. RCSC grants have made great strides in creating and maintaining effective systems that support real people as a result of this funding. The grants have enabled the States to:

- Develop infrastructure to transition nursing home residents into home and community–based care
- Develop programs to increase the numbers and training of personal care assistants
- Implement new quality assurance and quality improvement programs
- Change State organizational structures to improve the delivery of home and community-based services
- Test Money Follows the Person (MFP) models, the forerunner of the MFP demonstration program
- Help States to rebalance long-term care systems by addressing the need for single point of entry to access services

Funding History

FY 2007	$57,420,000
FY 2008	$31,301,000
FY 2009	$30,192,000
FY 2010	$35,600,000
FY 2011 CR Level	$35,600,000

Budget Request

The FY 2012 budget request for RDE is $31.2 million, $4.4 million less than the FY 2010 Enacted Level. This level of funding supports activities associated with:

- MCBS

  $15.7 million for the MCBS, an increase of $0.9 million above the FY 2010 Enacted Level, to operate and maintain a critical source of information for health care researchers on characteristics of Medicare program beneficiaries.

- Demonstrations & Other Activities

  CMS demonstrations and other activities funding request is $13.0 million for FY 2012, a $5.3 million decrease from the FY 2010 Enacted Level. FY 2012 request will support demonstration-related activities including design, implementation and evaluation activities that have been mandated through legislation and/or are aligned with departmental and agency priorities, and are intended to improve the value of our health care programs.

  Funding for other activities in FY 2012 will also support efforts to build and improve CMS' health service research, data and analytical capacity as well as carry out program evaluations and monitoring. These activities include, for example, the Chronic Condition Warehouse (CCW), Research Data Assistance Center (ResDAC), and grants to Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs).

- Real Choice Systems Change Grants

  $2.5 million for the Real Choice Systems Change (RCSC) Grants, the same level of funding as the FY 2010 Enacted Level.

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State High Risk Pool Grants

	FY 2010 Enacted 1/	FY 2011 CR Level	FY 2012 Budget Request	FY 2012 +/- FY 2010
BA	$55,000,000	$55,000,000	$44,000,000	-$11,000,000

1/ In FY 2010, the State High Risk Pools were scored as mandatory funding. In FY 2011, under an annualized continuing resolution, CMS assumes that this activity will be funded at $55.0 million, the same level as the FY 2010 appropriation.

Authorizing Legislation - Trade Act of 2002, State High Risk Pool Extension Act of 2006

Allocation Method - Grants

Program Description and Accomplishments

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

In FY 2006, section 6202 of the DRA and State High Risk Pool Funding Extension Act of 2006 extended the funding of grants under section 2745 of the Public Health Service Act by authorizing and appropriating $15 million for seed grants to assist States to create and initially fund qualified high-risk pools and $75 million for grants to help fund operational losses and bonus grants for supplemental consumer benefits to the existing qualified State high-risk pools. CMS awarded grants to 36 States in FY 2006 and to 5 States in FY 2007. These funds were included in CMS' mandatory State Grants and Demonstrations account (discussed in the Other Accounts section of this book).

The Consolidated Appropriations Act of 2008 (P.L. 110-161) appropriated $49.1 million for State high-risk health insurance pools for FY 2008 in CMS' discretionary Program Management account. The Omnibus Appropriations Act of 2009 (P.L. 111-8) appropriated $75.0 million for the State high-risk pools in CMS' Program Management account in FY 2009. The Consolidated Appropriations Act of 2010 (P.L. 111-117) appropriated $55.0 million for State high-risk pools but this was scored as mandatory funding and was not counted as part of CMS' discretionary Program Management funding. CMS included funding for the State high-risk pools in its FY 2011 President's Budget request. Under an annualized Continuing Resolution, we assume that this activity would be funded at $55.0 million, the same as the FY 2010 appropriation. This amount is now considered discretionary. The table on the following pages displays the FY 2010 grant appropriation allocated to 31 States. Nearly 200,000 individuals were covered by the State High Risk Pool program in FY 2009.

FY 2010 State High Risk Pool Operational and Bonus Funds Grantees

State	Operational Losses	Bonus Grant	Total	Bonus Grant Statutory Category
Alabama	$897,711	$0	$897,711	N/A
Alaska	$564,305	$ 308,920.	$873,225	Low-Income Premium Subsidy
Arkansas	$892,960	$479,488	$1,372,448	Disease Management & Low-Income Premium Subsidy
Colorado	$1,463,519	$774,338	$2,237,857	Premium Reduction
Connecticut	$762,421	$411,685	$1,174,106	Disease Management
Idaho	$666,251	$361,780	$1,028,031	Supplemental Consumer Benefits
Illinois	$2,235,834	$1,175,287	$3,411,121	Premium Relief
Indiana	$1,226,401	$652,078	$1,878,479	Disease Management & Low-Income Premium Subsidy
Iowa	$786,431	$0	$786,431	N/A
Kansas	$741,781	$401,084	$1,142,865	Disease Management
Kentucky	$1,045,602	$558,578	$1,604,180	Disease Management
Louisiana	$978,938	$525,120	$1,504,058	Premium Reduction & Expanded Consumer Benefits
Maryland	$1,835,090	$965,340	$2,800,430	Low-Income Premium Subsidy
Minnesota	$2,225,203	$1,165,051	$3,390,254	Low-Income Premium Subsidy
Mississippi	$946,680	$507,377	$1,454,057	Disease Management
Missouri	$1,052,931	$562,795	$1,615,726	Premium Reduction
Montana	$715,673	$386,956	$1,102,629	Low-Income Premium Subsidy
Nebraska	$869,335	$466,294	$1,335,629	Premium Reduction
New Hampshire	$615,508	$335,342	$950,850	Low-Income Premium Subsidy
New Mexico	$1,131,383	$602,047	$1,733,430	Low-Income Premium Subsidy
North Carolina	$1,358,588	$722,998	$2,081,586	Premium Reduction
North Dakota	$588,430	$321,139	$909,569	Disease Management
Oklahoma	$880,943	$473,700	$1,354,643	Premium Reduction
Oregon	$1,609,756	$848,990	$2,458,746	Disease Management & Expanded Consumer Benefits
South Carolina	$953,051	$511,207	$1,464,258	Premium Reduction
South Dakota	$554,159	$303,576	$857,735	Premium Relief
Texas	$4,948,506	$2,587,527	$7,536,033	Premium Reduction
Utah	$884,957	$474,951	$1,359,908	Low-Income Premium Subsidy
Washington	$1,062,856	$567,967	$1,630,823	Disease Management & Premium Reduction
Wisconsin	$1,638,831	$863,386	$2,502,217	Disease Management & Low-Income Premium Subsidy
Wyoming	$550,965	$0	$550,965	N/A
TOTAL	**$36,685,000**	**$18,315,000**	**$55,000,000**	

Discretionary Funding History

FY 2008	$49,127,000
FY 2009	$75,000,000
FY 2010 1/	$0
FY 2011 CR Level Estimate	$55,000,000

1/ $55.0 million in mandatory funding was appropriated in FY 2010.

Budget Request

CMS is requesting $44.0 million in discretionary funding for this activity in its FY 2012 Program Management account, a decrease of $11 million below the estimated funding level in FY 2011. The new Pre-existing Condition Insurance Plan (PCIP) program enacted in the Affordable Care Act offers new coverage options for individuals with pre-existing conditions who have been uninsured for at least 6 months.

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

Grants will be awarded to States under this program to partially cover losses incurred by States in connection with the operation of the pools and to provide supplemental consumer benefits.

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Medicaid

Appropriation Language

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

For making, after May 31, 2012, payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2012 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2013, $90,614,082,000 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, $184,279,110,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $86.4 billion for the first quarter of FY 2012 anticipated to be provided under FY 2011 appropriations acts. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
For making, after May 31, 2012, payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2012 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.	This section provides indefinite authority for payments to States in the last quarter of fiscal year 2012 to meet unanticipated costs. It makes clear that the language provides budget authority to the Vaccines for Children's program for payments on behalf of States during this time period.

Medicaid

Language Analysis

Language Provision	Explanation
For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2013, $90,614,082,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of fiscal year 2013 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 2012 is not enacted by October 1, 2012. It makes clear that the language provides budget authority to the Vaccines for Children program during the first quarter of a fiscal year.
Payment under 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)

	2010 Actual	2011 Estimate	2012 Estimate
Appropriation Annual	$292,662,511	$259,933,181	$270,724,399
Appropriation Indefinite	0	849,534	0
Unobligated balance, start of year	15,988	17,006,269	0
Unobligated balance, end of year	(17,006,269)	0	0
Recoveries of Prior Year Obligations	14,016,927	2,880,000	0
Collections	772,103	630,000	165,000
Total Gross Obligations	$290,461,260	$281,298,984	$270,899,399
Offsetting Collections Medicare Part B QI Program	(515,251)	(630,000)	(165,000)
Obligations Incurred but not Reported	0	(1,539,500)	(1,359,500)
Total Net Obligations	$289,906,009	$279,129,484	$269,364,899

Medicaid Program
Summary of Changes
(dollars in thousands)

2012 Estimated Budget Authority		$270,724,399
2011 Budget Authority Request from PB 2011		$259,933,181
Net Change		$10,791,218
Explanation of Changes	FY 2011 Current Base Budget Authority	FY 2012 Change From Base Budget Authority
Program Increases		
Fraud Control Units	$215,319	$10,766
State Certification	234,600	4,000
State and Local Administration Financial Adjustment	-491,642	885,908
Vaccines for Children Program	3,651,354	379,642
Legislation (The Affordable Care Act (P.L.111-148, 111-152), The Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), The Tax Relief and Jobs Creation Act (P.L. 111-312), and The Family Smoking Prevention Act (P.L. 111-58)	-2,231	1,981,638
Financial Management Reviews	-418,000	128,000
Unobligated Balance Start of Year	-14,411,421	14,411,421
Total Program Increases	-$11,222,021	$17,801,375
Program Decreases		
Medical Assistance Payments	$254,647,000	-$3,646,000
State Administration	13,609,202	-1,659,657
Medical Assistance Payments for Qualified Individuals	150,000	-150,000
Collections from Medicare Part B for Qualified Individuals	-150,000	-15,000
Obligations Incurred But Not Reported	2,899,000	-1,539,500
Total Program Decreases	$271,155,202	-$7,010,157
TOTAL	**$259,933,181**	**$10,791,218**

Medicaid Program
Authorizing Legislation

	FY 2011 Amount Authorized	FY 2011 Current Law	FY 2012 Amount Authorized	FY 2012 Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$256,034,087,860	Indefinite	$ 266,693,403,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,899,093,140		$4,030,996,000
Total Appropriations		$259,933,181,000		$270,724,399,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2002	143,029,433,000	143,029,433,000	143,029,433,000	147,340,339,015	1/
2003	158,692,155,000	158,692,155,000	158,692,155,000	164,550,765,542	2/
2004	176,753,583,000	176,753,583,000	182,753,583,000	182,753,583,000	
2005	177,540,763,000	177,540,763,000	177,540,763,000	177,540,763,000	
2006	215,471,709,000	215,471,709,000	215,471,709,000	215,471,709,000	
2007	200,856,073,000	------	------	168,254,782,000	3/
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	4/
2010	292,662,503,000	292,662,511,000	292,662,511,000	292,662,511,00	
2011	259,933,181,000				
2012	270,724,399,000				

1/ Includes $4,310.9 million under indefinite authority.
2/ Includes $5,858.6 million under indefinite authority.
3/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
4/ Includes $38,262.4 million under indefinite authority.

Medicaid
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	FY 2012 +/- FY 2011
Medical Assistance Payments (MAP)	$274,729,006	$262,998,260	$252,690,407	($10,307,853)
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$0	$1,539,500	$1,359,500	($180,000)
Vaccines for Children	$3,760,638	$3,905,644	$4,030,996	$125,352
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$11,971,616	$12,855,580	$12,808,496	($47,084)
Obligations (gross)	$290,461,260	$281,298,984	$270,889,399	($10,409,585)
Unobligated Balance, Start of Year	($15,988)	($17,006,269)	$0	$17,006,269
Unobligated Balance, End of Year	$17,006,269	$0	$0	$0
Recoveries of Prior Year Obligations	($14,016,927)	($2,880,000)	$0	$2,880,000
Appropriation Budget Authority (gross)	$293,434,614	$261,412,715	$270,889,399	$9,476,684
Collections	($772,103)	($630,000)	($165,000)	$465,000
Total Budget Authority (net)	$292,662,511	$260,782,715	$270,724,399	$9,941,684
Indefinite Authority	$0	($849,534)	$0	$849,534
Advanced Appropriation	($71,700,038)	($86,789,382)	($86,445,289)	$344,093
Annual Appropriation	$220,962,473	$173,143,799	$184,279,110	$11,135,311

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

FY 2011 Authorization - Public Law 111-8, Public Law 111-117, Public Law 111-148, Public Law 111-152, Public Law 111-226

Allocation Method - Formula Grants

Program Description and Accomplishments

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

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

The Department of Health and Human Services has identified a limited number of priority performance goals that will be a particular focus over the next two years. The Medicaid enrollment measure supports the Department's priority goal to "Improve availability and accessibility of health insurance coverage by increasing enrollment in CHIP and Medicaid". The FY 2012 target is to increase enrollment of children in Medicaid by 12 percent over the FY 2008 baseline (from 29,943,162 children to 33,536,341 children).

The Federal Government and States share the cost of the program. The State share varies from State to State. In recent years, the Federal Government has provided 57 percent of State medical assistance expenditures. However, in FY 2010, the estimated average State share is approximately 32 percent, with the remaining 68 percent provided by the Federal Government. A significant portion of the increased Federal share is attributable to the temporarily increased Federal Medical Assistance Percentage (FMAP) rates of the American Recovery and Reinvestment Act (ARRA, P.L. 111-5). The temporary FMAP increase has been extended for six months by Public Law 111-226 at phased-down levels and is scheduled to expire on June 30, 2011.

Medicaid covers a broad range of services to meet the health needs of beneficiaries. Federally-mandated services for categorically-eligible Medicaid beneficiaries include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and x-ray services, physician services, and nursing home care for individuals age 21 or older. Commonly offered optional services for both categorically- and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, and services in intermediate care facilities for the mentally retarded. 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.

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

The 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 measures. CMS has a new measure to "Improve Children's Health Care Quality across Medicaid and CHIP through the implementation of CHIPRA Quality Initiatives". The FY 2012 target is to work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures. CMS will continually assess options for revising and improving targets so that information collected from States can be used in the most efficient and effective manner to improve health outcomes. The Affordable Care Act also called for the establishment of an adult quality measures program in Medicaid. CMS is developing a new measure to "Improve Adult Health Care Quality Across Medicaid". A recommended core set of measures was published in December 2010 and an initial core set of adult health quality measures that are applicable to Medicaid eligible adults are to be published by January 1, 2012.

CMS has also developed a measure to improve access to and utilization of oral health care services for children enrolled in Medicaid or CHIP. Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the single most preventable common chronic disease of childhood. The FY 2012 target is to increase the national rates of preventive dental service by 2 percent over the FY 2011 baseline.

The American Recovery and Reinvestment Act (ARRA), (P.L. 111-5) intended to provide economic stimulus to the economy, was signed into law on February 17, 2009. ARRA contains Medicaid provisions to provide a temporary increase in the Federal Medical Assistance Percentages (FMAPs) from October 1, 2008 through December 31, 2010, a temporary increase in the Disproportionate Share Hospital (DSH) allotments, extension of moratoria on certain Medicaid regulations, an extension of Transitional Medical Assistance, extension of the Qualified Individual program, protections for Indians under Medicaid and CHIP, and monies for administration and incentive payments to promote the adoption and meaningful use of health information technology (HIT).

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152) into law. These new laws (known together as the Affordable Care Act) usher in major improvements in health care coverage, cost and quality for all Americans. Under the law, Medicaid is the mechanism by which affordable coverage is guaranteed to the lowest income Americans. To accomplish this, Medicaid eligibility is expanded and simplified, with the Federal government picking up most of the new coverage costs. Beyond these eligibility and financing changes, the new law improves access to home and community-based services, enhances the Federal commitment to assuring program integrity, and makes other program improvements. A more detailed explanation of these provisions can

be found in the "Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation" section.

Medicaid Integrity Program

The Medicaid Integrity Program (MIP), though not funded from the Medicaid appropriation, supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. MIP represents the most significant single, dedicated investment the Federal government has made in ensuring the integrity of the Medicaid program. MIP offers an opportunity to ensure the efficient administration of the program and to promote sound stewardship of State and Federal resources. CMS is measuring the implementation and success of the Medicaid MIP by calculating an annual return on investment. Further discussion of the Medicaid Integrity Program can be found in the Medicaid Integrity section located in the State Grants and Demonstrations chapter.

Vaccines for Children

The Vaccines for Children (VFC) program is 100 percent Federally-funded by 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 lacks an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, Federally purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention provides funding to 61 State and local public health immunization programs that include all 50 States, six city/urban areas, and five U.S. territories and protectorates.

Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities and intermediate care facilities for the mentally retarded 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 all 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 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 the Medicaid program, unless the State receives a waiver from the Secretary. The MFCUs investigate State law violations of Medicaid fraud and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities. The MFCU must be part of the State Attorney General's office or coordinate with another office with statewide prosecutorial authority.

Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Prior to 1982, 99 percent of Medicaid recipients received coverage through fee-for-service arrangements. Since the passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997, the number of Medicaid recipients enrolled in managed care organizations has vastly increased. As of June 30, 2009 nearly 72 percent of all Medicaid beneficiaries (more than 33.4 million) in 48 States, the District of Columbia, and Puerto Rico were enrolled in some type of managed care delivery system. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization, contain costs, improve access to services, and achieve greater continuity of care. Increasingly, States are using managed care to provide acute, primary, mental health and substance use services, and long term services and supports to individuals who are aging, individuals with disabilities and individuals with chronic conditions.

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

The Balanced Budget Act of 1997 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 has enabled States to mandate enrollment for certain non-exempt populations in Benchmark Benefit Packages under section 1937 of the Social Security Act. If a State opts to implement the alternative benefit packages, the State may also use a managed care delivery system to provide the services.

As Medicaid managed care programs continue to grow, CMS remains committed to ensuring that high-quality, cost-effective health care is provided to Medicaid beneficiaries. CMS' efforts include evaluating and monitoring demonstration and waiver programs, improving information systems, providing expedited review of State proposals, and improving coordination with other HHS components providing technical assistance to States related to managed care. In particular, CMS works directly with States to evaluate effectiveness of State managed care quality improvement strategies and external quality review organization technical reporting processes.

Section 1115 Health Care Reform Demonstrations

States have sought section 1115 demonstrations to expand health care coverage to the low-income uninsured and test innovative approaches in health care service delivery. Currently, CMS has approved 40 statewide health care reform demonstrations in 30 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island,

Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin) and the District of Columbia. CMS has also approved three sub-State health reform demonstrations (Kentucky, Louisiana and Missouri) and 21 demonstrations specifically related to family planning (Alabama, Arkansas, California, Florida, Georgia, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Oregon, Oklahoma, Pennsylvania, Texas, Virginia, Washington, and Wyoming).

Some statewide demonstrations expand health coverage to the uninsured, and others test new methods for delivering health care services. Many of the demonstrations include low-income families and the Temporary Assistance for Needy Families (TANF)-related populations, and some include the elderly and the disabled. Although the demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care delivery systems for the Medicaid population. By implementing managed care, States hope to provide improved access to primary care for low-income beneficiaries, along with increased access to preventive care measures and health education. Another typical approach in many demonstration States is to use managed care savings to assist in offsetting the cost of providing coverage for the uninsured.

Recipients

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

Medicaid Enrollment (Person-Years in Millions) /1

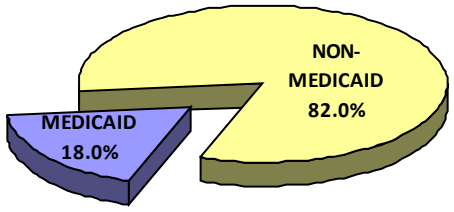
	FY 2010	FY 2011	FY 2012	+/- FY 2011 to FY 2012
Aged	4.8	4.9	5.0	.1
Disabled	9.5	9.6	9.7	.1
Adults	11.9	12.2	12.4	.2
Children	26.8	28.3	29.0	.7
Territories	1.0	1.0	1.0	0
Total	53.9	56.0	57.0	1.0

1/ Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2012, as shown in the pie chart, 18 percent, or 57.0 million, of the projected 316.3 million U.S. population, will be enrolled in Medicaid for the equivalent of a full year during FY 2012. In FY 2012, Medicaid will provide coverage to more than one out of every five children in the Nation.

CMS projects that in FY 2012, children and non-disabled adults under age 65 will represent 74 percent of the Medicaid population excluding the Territories, but account for approximately 38 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 26 percent of the Medicaid population excluding the Territories, yet account for approximately 62 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

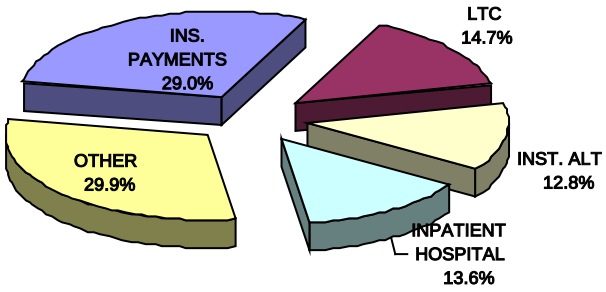
FY 2012 MEDICAID FULL YEAR ENROLLEES AND THE U.S. POPULATION



Benefit Services

As displayed in the table on the following page, the State estimates for medical assistance payments including additional ARRA monies decreases from $267.1 billion for FY 2011 to $246.8 billion for FY 2012.

FY 2012 STATE ESTIMATES OF BENEFITS



Health insurance payments are the largest Medicaid benefit service category. These benefit payments are comprised primarily of premiums paid to Medicaid managed care plans. These services are estimated to require $71.8 billion in funding for FY 2012 representing 29.1 percent of the State-submitted benefit estimates for FY 2012. The second largest FY 2012 Medicaid category of service is institutional long-term care services. It is composed of nursing facilities and intermediate care facilities for the mentally retarded. The States have submitted FY 2012 estimates totaling $36.4 billion or about 14.7 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2012 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($33.6 billion or 13.6 percent), followed by institutional alternative services such as home health, personal care, and home and community-based services ($31.6 billion or 12.8 percent). Together these four benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for over 70 percent of the State-estimated cost of the Medicaid program for FY 2012.

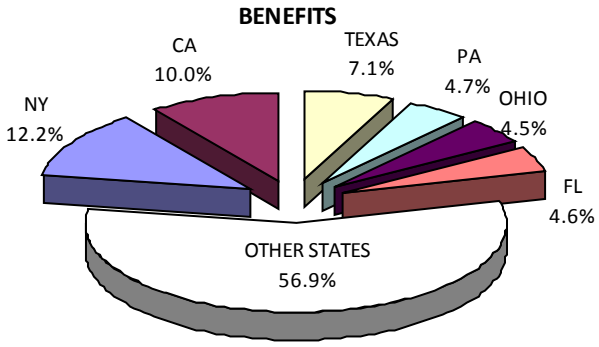
Estimated Benefit Service Growth, FY 2011 to FY 2012
November 2010 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2011	Est. FY 2012	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)	$73,451,717	$71,831,657	-$1,620,060	-2.2%	8.0%
Institutional Alternatives (Personal care, home health, and home and community-based services)	$34,018,980	$31,594,477	-$2,424,503	-7.1%	11.9%
Other (Targeted case management, hospice, all other services, and collections)	$23,188,853	$18,608,622	-$4,580,231	-19.8%	22.5%
Institutional Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$39,713,747	$36,364,920	-$3,348,827	-8.4%	16.5%
Outpatient Hospital	$10,905,508	$10,096,561	-$808,947	-7.4%	3.8%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$12,039,508	$11,915,735	-$123,773	-1.0%	0.6%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$39,475,945	$33,638,983	-$5,836,962	-14.8%	28.7%
Physician/Practitioner/Dental	$15,803,996	$14,948,663	-$855,333	-5.4%	4.2%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$9,304,915	$8,524,305	-$780,610	-8.4%	3.8%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$9,208,666	$9,239,364	$30,698	0.3%	-0.2%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$267,111,835	$246,763,287	-$20,348,548	-7.6%	100.0%

Note: FY 2011 amounts include impact of the temporary increase in the Federal Medicaid matching rates provided in P.L. 111-5 and P.L. 111-226.

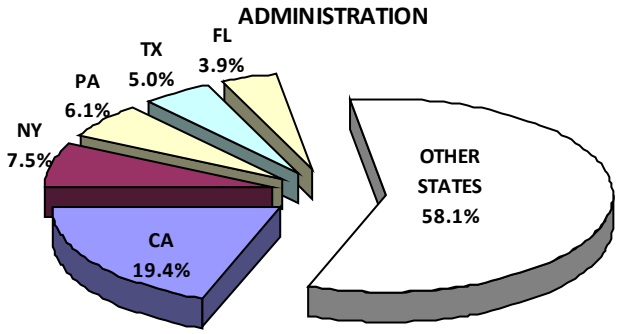
Distribution of Benefit Monies

According to the State-submitted estimates, $246.8 billion will be required to fund their Medicaid benefit programs during FY 2012. As displayed, New York, California, Texas, Pennsylvania, Ohio, and Florida account for $106.5 billion, or over 43.1 percent, of the State-submitted estimates for benefits for FY 2011.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2012 State and local administration costs total $10.0 billion. This represents about 4.1 percent of the total State-submitted estimates for Medicaid costs for FY 2011. As displayed, California, New York, Pennsylvania, Texas, and Florida account for $4.2 billion or 42.0 percent of expenditures for State and local administration.



Funding History (Appropriation)

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

Budget Request

CMS estimates its FY 2012 appropriation request for Grants to States for Medicaid is $270.7 billion, an increase of $10.8 billion relative to the requested FY 2011 level of $259.9 billion. This appropriation is composed of $184.3 billion in monies for FY 2012 and $86.4 billion in advance appropriation monies from the anticipated FY 2011 appropriation.

These monies, together with an estimated offsetting collection of $165.0 million from Medicare Part B for the Qualified Individuals (QI) program will fund $270.9 billion in anticipated FY 2012 Medicaid obligations. These obligations are composed of:

- $252.7 billion in Medicaid medical assistance benefits;
- $1.4 billion for benefit obligations incurred but not yet reported;
- $12.8 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $4.0 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 using Medicaid expenditure data through the first three quarters of FY 2010. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget for use with the FY 2012 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $269.4 billion in FY 2012. This represents a decrease of 2.6 percent relative to the estimated net outlay level of $276.2 billion for FY 2011. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 1.8 percent during this time period.

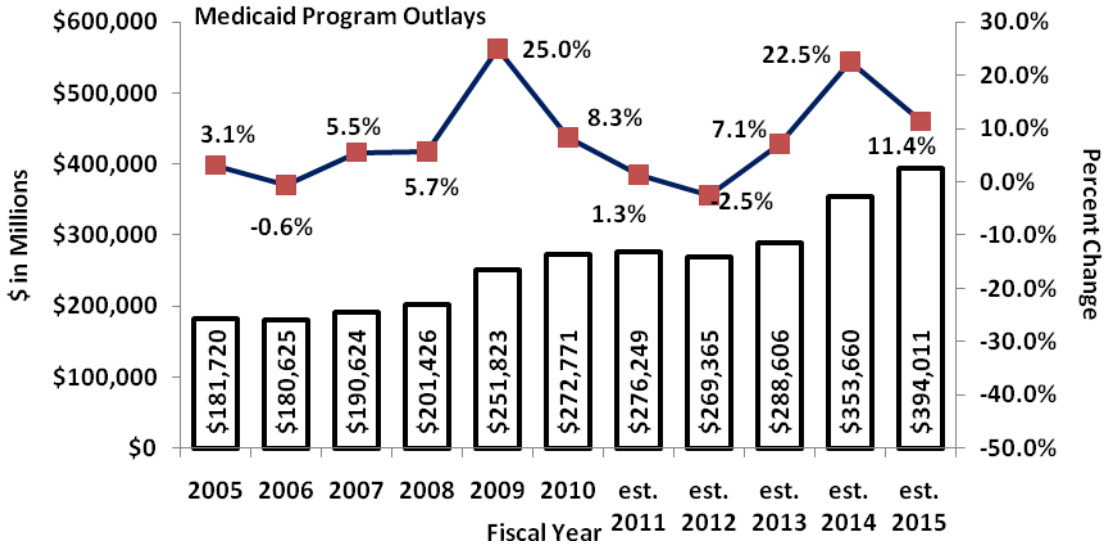
Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2010 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2010 State estimates for MAP in FY 2012 are the first State-submitted estimates for FY 2012. Typically, State estimation error is most likely to occur early in the budget cycle because States are most interested with their current year budget and have not yet focused on their projections for the Federal budget year.

CMS' Office of the Actuary developed the MAP estimate for FY 2012. Using the first three quarters of FY 2010 State-reported expenditures as a base, expenditures for FY 2011 and FY 2012 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 Office of Management and Budget and demographic trends in Medicaid enrollment. CMS' Office of the Actuary also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the November 2010 State-submitted estimates.



Factors Impacting Medicaid Expenditure Growth

Medicaid program cost growth accelerated with a sharp increase in enrollment resulting from a downturn in the economy, as well as growth in medical prices and utilization. Medicaid capitation premiums, long-term care and prescription drugs were among the most significant sources of expenditure growth. The growth in the second half of the decade has abated as enrollment growth has slowed and as the Federal government and the States took steps to curb the growth of Medicaid expenditures.

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

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

In March 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, as amended by the Health Care and Education Recovery Act of 2010, P.L. 111-152, together known as the Affordable Care Act will usher in major improvements to health care coverage, cost and quality for all Americans. Some of the changes are already in place, while others will be implemented in the coming years.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation
(Estimated FY 2012 costs are $2.0 billion)

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

- Expanded and Simplified Eligibility Standards and Enrollment

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

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

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

- Enhanced Federal Funding

  Coverage for newly eligible beneficiary groups will be fully financed by the Federal government for three years beginning in 2014. Beginning in 2017 Federal funding for these newly eligible adults will scale down, but will not fall below 90 percent for any State. Most States that had previously expanded coverage for low-income adults (through waivers) will also receive an increased Federal matching rate (which will phase up to 90 percent by 2020) for these adults. Overall, 95 percent of all coverage costs related to the Affordable Care Act's Medicaid coverage changes will be borne by the Federal government.

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

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

  The Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in the community, including a new option for States to provide community-based attendant services and supports; improvements to an existing State plan option to provide

home and community-based services; additional financial incentives for States to rebalance the provision of long-term care to include more home and community-based services; and an extension of the "spousal impoverishment" protections to people who receive home and community-based services and supports.

- Enhancing Prevention and Primary Care

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

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

- Enhanced Quality Assurance and Information Sharing About Healthcare Facilities

  The law provides for enhancements to the popular Nursing Home Compare web site that will include detailed staffing data from 15,800 nursing homes, updated 4 times per year. CMS will also design a provider performance and oversight database that will enable the agency to more effectively monitor facility activities. Finally, CMS will establish a national program of background checks for all prospective employees that will have direct access to patients receiving care in long-term care facilities or from long-term care providers. CMS has awarded grants to 14 states already and plans to continue awarding funds to enable more states to take advantage of these new resources to help safeguard patients in long term-care facilities.

- Commitment to Transparency and Information Sharing

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

Medicare and Medicaid Extenders Act of 2010
(P.L. 111-309)

Extension of Transitional Medical Assistance (TMA)

TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This provision extends the TMA program from January 1, 2011 through December 31, 2011.

Extension of the Qualified Individual (QI) Program

The Qualified Individual (QI) program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. In addition, QI beneficiaries are deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. This provision extends the QI program through December 31, 2011.

Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P.L. 111-312)

Under section 728 of this legislation any tax refund or advance payment with respect to a refundable credit received by an individual after December 31, 2009 begins a period of 12 months during which such refund may not be taken into account as a resource for purposes of determining the eligibility of an individual for benefits or assistance under any Federal program or under any State or local program financed in whole or in part with Federal funds.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments
(Estimated FY 2012 savings are $290 million)

Medicaid Financial Management Reviews

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $290 million in FY 2012. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure State compliance with Federal regulations governing Medicaid and State financing. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific high-risk areas, and other ongoing oversight and enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

Entitlement Benefits Due and Payable (Incurred but not Reported, or IBNR)

The FY 2012 estimate of $1.4 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2011 to September 30, 2012. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Vaccines for Children (VFC) Program

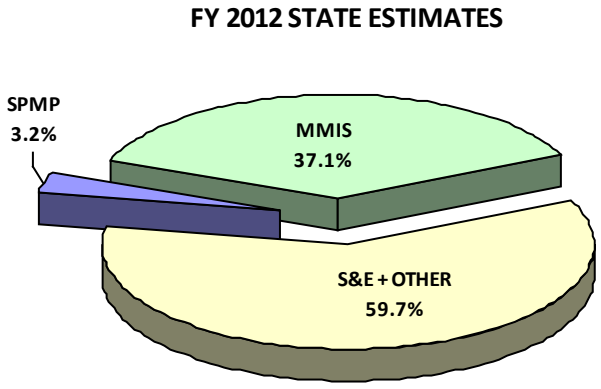
The nation's childhood immunization coverage rates are at high levels for every vaccine and for all vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. In addition to the health benefits of vaccines, they also provide significant economic value. An economic evaluation in the December 2005 issue of the Archives of Pediatrics and Adolescent Medicine entitled, "Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the US, 2001" of the impact of seven vaccines (DTaP, Td, Hib, Polio, MMR,

hepatitis B, and varicella) routinely given as part of the childhood immunization schedule found that the vaccines are cost-effective. Routine childhood vaccination with these seven vaccines prevent over 14 million cases of disease and over 33,500 deaths over the lifetime of children born in any given year, and result in an annual cost savings of $10 billion in direct medical costs and over $40 billion in indirect societal costs.

The FY 2012 estimate for the VFC program is $4.0 billion, which is $125.4 million above the FY 2011 request. This net increase includes increases for vaccine purchase and ordering, distribution, and operations, and decreases for the grantee order processing; and vaccine management business improvement plan contractual support. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 95 percent of the VFC budget is used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of vaccine-preventable diseases and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports immunization grantee vaccine management activities, quality assurance and quality improvement site visits to VFC enrolled providers, immunization coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2012, based on recent actual data and the November 2010 State estimates, CMS estimated the Federal share of State and local administration costs to be $12.8 billion. This estimate is composed of $11.3 billion for Medicaid State and local administration, $1.0 billion for the costs of the health information technology provisions contained in section 4201 of ARRA, and additional funds for Medicaid State survey and certification and State Medicaid fraud control units ($0.5 billion).



In November 2010 the States estimated the Federal share of State and local administration outlays to be $10.0 billion for FY 2012. State and Local Administration monies provide funding for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing activities; skilled professional medical personnel (SPMP); and salaries, fringe benefits, training, and other State and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

CMS adjusted the FY 2012 State-submitted estimates of $10.0 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions

relative to the conditions when States submitted estimates. In addition, the State estimates were also adjusted to reflect the estimated costs of ARRA. After these adjustments the FY 2012 estimate for State and local administration is $12.3 billion.

ARRA Health Information Technology, (HIT) (Section 4201) Administration

- (FY 2012 estimate is $854 million for State and Local Administration for provider incentives payments)
- (FY 2012 estimate is $143.7 million for State and Local Administration to administer incentives program)

To encourage adoption and meaningful use of electronic health records (EHRs), Medicaid will provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced Federal financial participation (FFP) of 100 percent for incentive payments to providers for the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for State and local administrative expenses associated with administering the incentive payments. CMS anticipates that all 56 States and territories will be in the full implementation phase of their Medicaid EHR Incentive Programs by the end of FY 2012.

Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

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

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for the mentally retarded in FY 2012 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2012 estimate for Medicaid State survey and certification is $238.6 million. This represents an increase of $4.0 million above the current FY 2011 estimate of $234.6 million. This increased funding level includes monies to support increasing workload requirements; costs associated with survey and certification activities covering over 21,000 Medicaid participating facilities with nearly 22,000 health and life safety code annual certifications, as well as over 48,000 complaint survey investigations; and direct State survey costs associated with nursing home quality.

State Medicaid Fraud Control Units (MFCUs)

In FY 2012, State Medicaid fraud control unit operations are estimated to require $226.1 million in Federal matching funds. This represents an increase of $10.7 million over

the estimated FY 2011 funding level of $215.3 million. Currently, 49 States and the District of Columbia participate in the program.

Although the MFCUs return substantial amounts of recoveries to the Medicaid program, their primary mission is to prosecute wrongdoing criminally and thus much of their work does not result in monetary gains to the State Medicaid programs. This includes patient abuse and neglect cases for residents of nursing homes and other facilities, which are a critical part of the MFCU mission.

MFCUs report on a quarterly basis on both their criminal and civil cases. During FY 2009, the MFCUs reported 642 successful civil settlements of judgments. The MFCUs received $195.3 million in funding during FY 2009 and are expected to receive more than $1.3 billion in recoveries.

Impact of Proposed Legislation

1. Track High Prescribers and Utilizers of Prescription Drugs

   This proposal requires States to monitor and remediate high-risk billing activity to identify 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 where possible to improve Medicaid integrity and beneficiary quality of care.

   Effective October 1, 2011, require States to monitor high prescribing activity by physicians and high utilization activity by beneficiaries and to remediate identified claims.

   Five-year budget savings: $1.270 billion

2. Reduce Medicaid Provider Tax Threshold Beginning in FY 2015

   This proposal would limit States' ability to use provider taxes to pay the State share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014 to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond.

   Five-year budget savings: $3.51 billion

3. Strengthen Medicaid Third-Party Liability

   This proposal strengthens third-party liability by enabling States to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, collecting medical child support where health insurance is derived from a non-custodial parent, and recovering Medicaid expenditures from beneficiary liability settlements.

   Five-year budget savings: $650 million

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

   Require drug manufacturers to repay States for coverage of items improperly reported for Medicaid prescription drug coverage. This proposal requires full restitution to States in the form of a rebate for items improperly reported by the manufacturer on the Medicaid drug coverage list.

   Five-year budget savings: $50 million

5. Enforce Drug Rebate Agreements

   Conduct audits of drug manufacturer compliance with requirements of Medicaid drug rebate agreements on a regular basis, as cost-effective.

   Five-year budget impact: none

6. Increase Penalties on Drug Manufacturers for Fraudulent Non-Compliance with Drug Rebate Agreements

   Increase the amount of penalties that can be levied on drug manufacturers for fraudulent noncompliance with Medicaid prescription drug rebate agreements.

   Five-year budget impact: none

7. Require Drugs to be Properly Listed with the Food and Drug Administration (FDA) to Receive Medicaid Coverage

   Effective October 1, 2011, require drugs to be properly listed with the FDA to receive Medicaid coverage. This proposal aligns Medicaid coverage requirements with Medicare by conditioning Medicaid coverage on manufacturer compliance with FDA law mandating drugs be listed with that agency.

   Five year budget impact: none

8. Use a Portion of Recovery Audit Contractor (RAC) Recoveries to Implement Actions That Prevent Improper Payments and Fraud (Medicaid Impact)

   This proposal allows CMS to use a portion of funds recovered by RACs to be spent for new processing edits and training to prevent future improper payments. Effective October 1, 2011, retain a portion (up to 25 percent) of the Medicare and Medicaid RAC recoveries to implement corrective action.

   Five-year budget savings: $20 million

9. Provide Flexibility to the Secretary in Implementing Predictive Analytics Technologies for Claims Payment to Maximize Cost-Effectiveness (Medicaid Impact)

   This proposal grants greater flexibility in carrying out the predictive modeling provisions of the Small Business Jobs Act (PL 111-240). The Small Business Jobs Act provided CMS with $100 million to implement an extensive development and rollout of predictive

modeling capabilities. Greater flexibility will allow CMS to adjust the rollout timeframe and project plans to best fit the agency's need.

Five-year budget impact: none

10. Limit the Discharge of Debt in Bankruptcy Proceedings in Cases of Fraudulent Activity (Medicaid Impact)

Effective October 1, 2011, this proposal limits the discharge of debt in bankruptcy proceedings in cases of fraudulent activity.

Five-year budget savings: $30 million

11. Strengthen Penalties for Illegal Distribution by Others of Medicare, Medicaid or CHIP Beneficiary Identification or Billing Privileges (Medicaid Impact)

Effective October 1, 2011, this proposal strengthens penalties for illegal distribution of Medicare, Medicaid, or CHIP beneficiary identification or billing privileges. This will not apply to beneficiaries of these programs.

Five-year budget impact: none

12. Permit Exclusion of Individuals Affiliated with Entities Sanctioned for Fraudulent or Other Prohibited Actions from Federal Health Care Programs (Medicaid impact)

Effective October 1, 2011, this proposal would close a loophole that currently prevents the Office of Inspector General from excluding certain individuals from programs such as Medicare, Medicaid and CHIP.

Five-year budget impact: none

13. Prevent Federal Funds from Being Used as Medicaid/CHIP State Share unless Specifically authorized by Law

Effective October 1, 2011, would prohibit States from using Federal funds as the State share of Medicaid or CHIP, unless authorized under law for that specific use.

Five-year budget impact: none

14. Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics

Effective October 1, 2011, provide brand biologic medications seven years of exclusivity rather than 12 years and prohibit additional periods of exclusivity for brand biologics due to changes in product formulations (i.e., "evergreening").

Five-year budget savings: $30 million

15. Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs

Effective October 1, 2011, give the Federal Trade Commission the authority to prohibit "pay-for-delay" agreements between brand and generic pharmaceutical companies that delay entry of generic drugs into the market. Currently, brand name companies are allowed to pay generic companies through anticompetitive agreements intended to keep generic drugs off the market. This practice increases costs of public and private insurance companies and consumers who have reduced access to more affordable generic drugs.

Five-year budget savings: $850 million

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

As the number of uninsured individuals decreases as a result of the ACA coverage expansions, uncompensated care costs for hospitals will also decrease. The Affordable Care Act includes annual aggregate DSH reductions for FY 2014 through FY 2020, but allotments revert to pre-ACA levels in FY 2021. This proposal would rebase the FY 2021 allotments to maintain the FY 2020 level of ACA reductions, and grow future allotments off of the rebased level using current law methodology.

Five-year budget impact: none

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

The Medicare program is in the process of implementing innovative ways to increase efficiency for payment of DME through the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, which is expected to save more than $17 billion in Medicare expenditures over ten years. Effective in FY 2012, this proposal extends some of these efficiencies to Medicaid, by limiting Federal reimbursement for a State's aggregate Medicaid spending on certain DME services to what Medicare would have paid in the same State for the same services.

Five-year budget savings: $2.35 billion

18. Extend Transitional Medical Assistance (TMA)

Extend authorization and funding of the TMA through September 30, 2012. The TMA program extends Medicaid coverage for at least six months and up to 12 months for low-income families who lose cash assistance due to an increase in earned income or hours of employment. Current law extends this program through December 31, 2011, and this proposal will allow States to continue the TMA program through the end of FY 2012.

Five-year budget cost: $665 million

19. Supplemental Security Income (SSI) Extension for Refugees (Medicaid Impact)

Extend the SSI for Elderly and Disabled Refugees Act for two years beginning FY2012.

Five-year budget cost: $95 million

20. Establish Hold-Harmless for Federal Poverty Guidelines (Medicaid Impact)

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

Five-year budget impact: none

21. Extend the Qualified Individuals (QI) Program

Extend authorization and funding of the QI program through September 30, 2012. The QI program pays the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal Poverty Level (FPL). States pay the Medicare Part B premium costs for QIs, which are in turn offset by reimbursement from Medicare Part B. Current law extends this program through December 31, 2011, and this proposal allows States to receive 100 percent Federal funding through the end of FY 2012.

Five-year budget cost: $495 million

MEDICAID PROGRAM

Proposed Law

	FY 2012
Track High Prescribers and Utilizers of Prescription Drugs	-$80,000,000
Reduce Medicaid Provider Tax Threshold Beginning in FY 2015	$0
Strengthen Medicaid Third-Party Liability	-$65,000,000
Require Manufacturers that Improperly Report Items for Drug Coverage to Fully Repay States	-$10,000,000
Enforce Drug Rebate Agreements	$0
Increase Penalties on Drug Manufacturers for Fraudulent Non-Compliance with Medicaid Drug Rebate Agreements	$0

Require Drugs to be Properly Listed with the FDA to Receive Medicaid Coverage	$0
Use a Portion of Recovery Audit Contractor Recoveries to Implement Actions that Prevent Improper Payments and Fraud (Medicaid impact)	$0
Provide Flexibility to the Secretary in Implementing Predictive Analytics Technologies for Claims Payment to Maximize Cost-Effectiveness (Medicaid impact)	$0
Limit the Discharge of Debt in Bankruptcy Proceedings in Cases of Fraudulent Activity (Medicaid impact)	$0
Strengthen Penalties for Illegal Distribution by Others of Medicare, Medicaid, or CHIP Beneficiary Identification or Billing Privileges (Medicaid impact)	$0
Permit Exclusion of Individuals Affiliated with Entities Sanctioned for Fraudulent or Other Prohibited Actions from Federal Health Care Programs (Medicaid impact)	$0
Prevent Federal Funds from Being Used as Medicaid/CHIP State Share Unless Specifically Authorized by Law	$0
Modify Length of Exclusivity to Facilitate Faster Development of Generic Biologics	$0
Prohibit Brand and Generic Drug Companies from Delaying the Availability of New Generic Drugs	-$110,000,000
Rebase Medicaid DSH Allotments in FY 2021	$0
Limit Medicaid Reimbursement of DME Based on Medicare Rates	-$210,000,000
Extend TMA	$240,000,000
SSI Act Extension for Refugees (Medicaid Impact)	$45,000,000
Establish Hold-Harmless for Federal Poverty Guidelines (Medicaid Impact)	$0
SUBTOTAL	-$190,000,000

Extend the Qualified Individuals (QI) Program (Medicaid Part B Transfer)	$495,000,000
TOTAL	$305,000,000

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
MCD 1.1: Estimate the Payment Error Rate in the Medicaid Program	FY 2009: Target met. 9.4% baseline rolling average error rate based on States measured in 2007 – 2009	Report rolling average error rate in the FY 2012 AFR based on States measured in 2010-2012. Meet or exceed target error rate of 7.4%.	Report rolling average error rate in the 2013 FY AFR based on States measured in 2011-2013. Meet or exceed target error rate of 6.4%.	N/A
MCD5: Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed	FY 2009 100% (Target Exceeded)	98%	98%	N/A
MCD6: Improve Children's Health Care Quality Across Medicaid and CHIP through Implementation of CHIPRA Quality Initiatives	N/A	Work with States to ensure that 70% of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80% of States report on at least five quality measures in the CHIPRA core set of quality measures.	N/A
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), who receive any preventive dental service.	N/A	Set Baseline	+2 percent over FY 2011 baseline	N/A
MCD8: Improve Adult Health Care Quality Across Medicaid	N/A	Published recommended core set of adult quality measures in the Federal Register (Goal met)	Publish core set of adult quality measures in the Federal Register	N/A

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
CHIP3.2 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid **Priority Performance Goal**	FY 2010: +15% over baseline 34,441,217 children*	+11% over FY 2008 33,236,910 children	+12% over FY 2008 33,536,341 children	+299,431 children
Program Level Funding ($ in millions)	**N/A**	**$260,783**	**$270,724**	**$9,941**

*FY 2010 actual enrollment data became available shortly before publication. CMS is examining whether adjustments should be made to outyear targets based on this data.

FY 2012 MANDATORY STATE/FORMULA GRANTS

(Dollars in thousands)

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

State/Territory	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	Difference +/- 2012
Alabama	$2,599,912	$3,509,899	$4,231,721	$721,822
Alaska	873,805	940,454	894,103	-$46,351
Arizona	7,297,083	7,480,128	7,688,453	208,325
Arkansas	3,255,656	3,429,653	3,349,779	-79,874
California	27,639,009	34,562,832	26,673,676	-7,889,156
Colorado	2,555,101	2,633,338	2,344,234	-289,104
Connecticut	3,418,530	3,387,342	3,224,606	-162,736
Delaware	829,599	810,670	759,273	-51,397
District of Columbia	1,477,180	1,482,482	1,344,678	-137,804
Florida	12,054,019	12,236,856	11,747,526	-489,330
Georgia	5,960,877	5,927,768	5,668,707	-259,061
Hawaii	964,201	975,776	858,109	-117,667
Idaho	1,120,504	1,247,698	1,272,249	24,551
Illinois	9,560,814	9,004,930	8,118,905	-886,025
Indiana	4,627,196	5,237,847	5,209,060	-28,787
Iowa	2,273,031	2,319,170	2,162,359	-156,811
Kansas	1,748,072	1,778,554	1,605,441	-173,113
Kentucky	4,503,630	4,591,515	4,578,517	-12,998
Louisiana	5,437,675	5,175,105	4,480,417	-694,688
Maine	1,792,977	1,609,225	1,455,325	-153,930
Maryland	4,474,549	4,522,964	4,251,553	-27,411
Massachusetts	7,518,487	8,070,044	6,838,372	-1,231,672
Michigan	8,694,016	8,875,589	8,735,947	-139,642
Minnesota	4,819,550	4,976,396	4,733,327	-243,069
Mississippi	3,532,919	3,823,776	4,113,296	289,520

FY 2012 MANDATORY STATE/FORMULA GRANTS
(Dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	Difference +/- 2012
Missouri	6,076,129	6,023,774	5,844,970	-178,804
Montana	761,723	756,734	769,871	13,137
Nebraska	1,158,863	1,209,565	1,163,096	-46,469
Nevada	1,001,917	952,428	959,092	6,664
New Hampshire	827,967	886,806	849,572	-37,234
New Jersey	6,362,524	6,541,395	6,212,464	-328,931
New Mexico	2,870,026	2,960,787	2,972,076	11,289
New York	31,434,531	33,715,356	30,877,828	-2,837,528
North Carolina	8,029,255	7,099,637	6,628,176	-471,461
North Dakota	505,155	548,707	473,568	-75,139
Ohio	11,267,688	11,411,806	11,254,421	-157,385
Oklahoma	3,103,379	3,539,708	3,273,194	-266,514
Oregon	3,053,082	3,616,062	3,754,777	138,715
Pennsylvania	12,674,444	13,077,629	12,037,959	-1,039,670
Rhode Island	1,254,119	1,266,456	1,162,740	-103,716
South Carolina	4,022,265	4,039,350	3,792,084	-247,266
South Dakota	612,332	586,713	545,461	-41,252
Tennessee	6,597,330	6,162,088	5,967,395	-194,693
Texas	19,063,390	19,639,095	18,331,275	-1,307,820
Utah	1,431,912	1,430,540	1,429,329	-1,211
Vermont	872,532	892,565	824,861	-67,704
Virginia	4,075,453	4,077,503	3,719,557	-357,946
Washington	4,609,523	4,626,829	4,195,531	-431,298
West Virginia	2,168,094	2,233,656	2,116,043	-117,613
Wisconsin	4,682,939	4,894,357	4,714,112	-180,245
Wyoming	354,022	341,941	309,657	-32,284
Subtotal	**267,898,986**	**281,141,528**	**260,518,742**	**-20,622,786**
American Samoa	13,004	17,578	17,578	0
Guam	16,691	26,726	29,534	2,808
Northern Mariana Islands	6,803	9,059	9,059	0
Puerto Rico	554,333	410,600	410,600	0
Virgin Islands	24,013	19,855	19,039	-816
Subtotal	**614,844**	**483,818**	**485,810**	**1,992**
Total States/Territories	**268,513,830**	**281,625,346**	**261,004,552**	**-20,620,794**

FY 2012 MANDATORY STATE/FORMULA GRANTS
(Dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	Difference +/- 2012
Survey & Certification	214,361	234,600	238,600	4,000
Fraud Control Units	149,876	215,319	226,085	10,766
Vaccines For Children	3,760,638	3,905,644	4,030,996	125,352
Medicare Part B Transfer	515,251	630,000	165,000	(465,000)
Incurred But Not Reported	0	1,539,500	1,359,500	(180,000)
Adjustments	17,307,304	(6,851,425)	3,864,666	10,716,091
TOTAL RESOURCES	**$290,461,260**	**$281,298,984**	**$270,889,399**	**($10,409,585)**

Medicaid Program
Budget Authority by Object

	2011 Estimate	2012 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$256,034,087,860	$266,693,403,000	$10,659,315,140
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,899,093,140	$4,030,996,000	$131,902,860
Total Budget Authority	$259,933,181,000	$270,724,399,000	$10,791,218,000

Medicaid Program
Medicaid Requirements
(dollars in thousands)

	2011 Estimate	2012 Estimate
November 2010 Estimates		
MAP and ADM	$281,194,048	$256,809,021
State Certification	234,600	238,600
Fraud Control Units	215,319	226,085
Total Unadjusted Estimates	$281,643,967	$257,273,706
Legislation: (CHIPRA (P.L. 111-3), Enhanced FMAP Extension (P.L. 111-226), Affordable Care Act (P.L.111-148, 111-152), Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), Tax Relief and Jobs Creation Act (P.L. 111-312))	$12,295,260	$1,979,407
Administrative Actions (Eligibility Determinations and Enrollment Activities)	560,000	906,110
State and Local Administration Financial Adj.	-159,725	394,266
Obligations Incurred But Not Reported	1,539,500	1,359,500
Financial Management Reviews	-274,000	-290,000
Actuarial Adjustments	-18,211,662	5,235,414
Total Adjustments	-$4,250,627	$9,584,697
Vaccines For Children Program	$3,905,644	$4,030,996
Current Law Requirement	$281,298,984	270,889,399
Unobligated Balances		
Start of Year	-17,006,269	0
End of Year	0	0
Recoveries	-2,880,000	0
Gross Budget Authority	$261,412,715	$270,889,399
Offsetting Collections	-630,000	-165,000
Appropriation/Net Budget Authority	$260,782,715	$270,724,399

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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) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, ***[****$222,105,000,000****]*** *$231,012,000,000.*

In addition, for making matching payments under section 1844, and benefit payments under section 1860D-16 of the Social Security Act, not anticipated in budget estimates, such sums as may be necessary. (Department of Health and Human Services Appropriations Act, 2009.)

Payments to the Health Care Trust Funds

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $231,012,000,000.	Provides a one-year appropriation from general revenues to make the HI and SMI Trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844, and benefit payments under section 1860D-16 of the Social Security Act, 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 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate
Appropriation: Annual	$207,286,070,000	$222,105,000,000	$231,012,000,000
Indefinite Annual Appropriation, for SMI Premium Match	7,338,000,000	---	--
Indefinite Annual Appropriation, for Part D Benefits	---	---	---
Lapse in Supplemental Medical Insurance	---	--	--
Lapse in General Revenue Part D: Benefits	-1,944,000,000	---	--
Lapse in General Revenue Part D: Federal Administration	-83,000,000	---	--
Lapse in Program Management	---	---	---
Lapse in Transfer for HCFAC Reimbursement	---	---	---
Lapse in Quinquennial Adjustment	---	---	---
Adjustment from Expired Accounts (for FY 2009 HCFAC)	197,000,000	---	---
Total Obligations	$212,794,070,000	$222,105,000,000	$231,012,000,000

Payments to the Health Care Trust Funds

Summary of Changes

2011 Appropriation

Total Budget Authority (Appropriated) - $222,105,000,000

2012 Estimate

Total Budget Authority - $231,012,000,000

Net Change, Total Appropriation - + $8,907,000,000

Changes	FY 2011 Estimate	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance (SMI)	$165,338,000,000	+ $12,703,000,000
Indefinite Annual Appropriation, SMI	---	---
Hospital Insurance for the Uninsured	---	---
Hospital Insurance for Uninsured Federal Annuitants	275,000,000	(13,000,000)
Program Management Administrative Expenses	229,000,000	(7,000,000)
General Revenue for Part D (Drug) Benefit	55,548,000,000	(4,117,000,000)
Indefinite Annual Appropriation, Part D Benefits	---	---
General Revenue for Part D Federal Administration	404,000,000	+71,000,000
Part D: State Low-Income Determination	---	---
Reimbursement for HCFAC	311,000,000	+270,000,000
Net Change	$222,105,000,000	+ $8,907,000,000

Payments to the Health Care Trust Funds
Budget Authority by Activity

(Dollars in thousands)

	FY 2010	FY 2011	FY 2012
Supplementary Medical Insurance (SMI)	$153,060,000	$165,338,000	$178,041,000
Indefinite Annual Appropriation, SMI	7,338,000	---	---
Hospital Insurance for Uninsured	(414,000)	---	---
Hospital Insurance for Uninsured Federal Annuitants	272,000	275,000	262,000
Program Management Administrative Expenses	393,070	229,000	222,000
General Revenue for Part D Benefit	53,180,000	55,548,000	51,431,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
General Revenue for Part D Federal Administration	484,000	404,000	475,000
Part D: State Low-Income Determination	---	---	---
Reimbursement for HCFAC	311,000	311,000	581,000
Total Budget Authority	$214,624,070	$222,105,000	$231,012,000

Payments to the Health Care Trust Funds

Authorizing Legislation

	2011 Amount Authorized	2011 Budget Estimate	2012 Amount Authorized	2012 Budget Estimate
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$222,105,000,000	$222,105,000,000	N/A	$231,012,000,000
Total Budget Authority	$222,105,000,000	$222,105,000,000	N/A	$231,012,000,000

Annual Budget Authority by Activity

	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate	FY 2012 +/- FY 2011
BA	$214,624,070,000	$222,105,000,000	$231,012,000,000	+$8,907,000,000

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds. This account has no sources of funds - rather, it is a source of funds to the HI and SMI Trust Funds. These payments make the Medicare trust funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to general funds, and also provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.

Through this appropriation, the trust funds are made whole for:

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

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

This appropriation also reimburses the HI Trust Fund for:

Program Management Administrative Expenses: This includes that portion of CMS' administrative costs, initially borne by the Hospital Insurance Trust Fund, which is properly chargeable to general funds, e.g., Federal administrative costs for the Medicaid program, and

Health Care Fraud and Abuse Control (HCFAC) account. The HCFAC program pays for program integrity activities in Medicare Fee-For-Service, Medicare Advantage, Medicare Part D, and Medicaid.

This appropriation also includes the Federal Contribution for SMI. This reflects a Federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is currently set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

Finally, as a result of enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this account now includes two new activities: General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. They are funded by payments from the general fund to the new Medicare Prescription Drug Account. Most of these activities started in FY 2006.

Funding History

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

FY 2007	$188,389,975,000
FY 2008	$188,445,000,000
FY 2009	$195,383,000,000
FY 2010	$207,286,070,000
FY 2011	$222,105,000,000

Budget Request

Hospital Insurance for the Uninsured

The FY 2012 estimate is $0 for Hospital for the Uninsured. The FY 2010 appropriated request of -$414 million was the final funding activity for this group. No further adjustments in funding for this group of beneficiaries is needed.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2012 estimate of $262 million for Hospital Insurance for Uninsured Federal Annuitants is $13 million less than the FY 2011 estimate of $275 million.

Program Management Administrative Expenses

The FY 2012 estimate of $222 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare, is $7 million less than the FY 2011 estimate of $229 million.

Federal Contribution for SMI

The estimate of $178.0 billion for the FY 2012 Federal Contribution for SMI is a net increase of $12.7 billion over the FY 2011 estimate. The cost of the Federal match continues to rise from year to year because of beneficiary and program cost growth.

General Revenue for Part D (Benefits)

The FY 2012 estimate of $51.4 billion for General Revenue for Part D (Benefits) is $4.1 billion less than the FY 2011 estimate of $55.5 billion. This estimate reflects updated data on the Part D benefit, feeding into the FY 2012 re-estimates of the Part D benefits baseline.

General Revenue for Part D Federal Administration

The FY 2012 estimate of $475 million for General Revenue for Part D Federal Administration is $71 million more than the FY 2011 estimate of $404 million.

General Revenue for Part D State Eligibility Determinations

The FY 2012 estimate for General Revenue Part D State Eligibility Determinations is $0.

Reimbursement for HCFAC

The FY 2012 estimate of $581 million for Reimbursement for HCFAC is $270 million more than the FY 2011 estimate of $311 million.

Permanent Budget Authority

(dollars in thousands)

	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Request	FY 2012 +/- FY 2011
Tax on OASDI Benefits	$13,760,000	$14,874,000	$15,303,000	+ $429,000
SECA Tax Credits	---	---	---	---
HCFAC, FBI	126,258	128,405	130,202	1,797
HCFAC, Criminal Fines	1,196,000	216,725	221,060	4,335
HCFAC, Civil Penalties and Damages: Administration	16,000	16,000	16,000	---
Total BA	$15,098,258	$15,235,130	$15,670,262	+ $435,132

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. In addition, the following permanent appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account will pass through the Payments to the Health Care Trust Funds account: FBI, criminal fines, and civil monetary penalties. FBI activities include prosecuting health care matters, investigations, financial and performance audits, inspections, and other evaluations. Criminal fines and civil monetary penalties are fines collected from health care fraud cases and reported as appropriations from the trust fund for HCFAC activities.

Payments to the Health Care Trust Funds
Budget Authority by Object

	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Estimate
Grants, subsidies and contributions: Non-Drug	$153,060,000,000	$165,338,000,000	$178,041,000,000
Indefinite Annual Appropriation	7,338,000,000	---	---
Grants, subsidies and contributions: Drug	53,180,000,000	55,548,000,000	51,431,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
Insurance claims and indemnities	-142,000,000	275,000,000	262,000,000
Administrative costs-General Fund Share	1,188,070,000	944,000,000	1,278,000,000
General Revenue Part D: State Eligibility Determinations	---	---	---
Total Budget Authority	$214,624,070,000	$222,105,000,000	$231,012,000,000

Proposal

Expected Impact of Establishing Hold-Harmless for Federal Poverty Guidelines

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

Part D would be affected by this proposal's impact on the Medicare Prescription Drug Low Income Subsidy.

Medicare Benefits
(Dollars in Thousands)

	FY 2010 Appropriation	FY 2011 President's Budget	FY 2012 Budget Request	FY 2012 + / - FY 2011
Outlays	$518,948,805	$565,136,000	$550,218,000	-$14,918,000

Note: Funding for Medicare benefits is permanent and mandatory, and is not subject to the appropriations process.

Authorizing Legislation - Title XVIII of the Social Security Act

FY 2012 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 will add significant new funding and incentives for physician and hospital expansion in electronic health records and quality information, beginning in FY 2011. Implementation of these ARRA provisions will build on Medicare's ongoing transformation into an active purchaser of high quality services. The Affordable Care Act of 2010 (P.L.111-148) has created a number of changes that will improve the Medicare program. The Affordable Care Act provides broader access to health care, covering an additional 35-40 million beneficiaries while strengthening the traditional Medicare programs to seniors, children, and the disabled. Additionally, the law puts into place comprehensive health insurance reforms that will hold insurance companies more accountable as well as lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. While many aspects of the law have been implemented, full implementation is expected to take several years.

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 50.1 million beneficiaries in FY 2012.

The Medicare Hospital Insurance program, also known as Medicare Part A or HI, is normally provided automatically to people age 65 and over who qualify for Social Security benefits. This program is also extended to most disabled people entitled to Social Security or Railroad

Retirement benefits. The HI program pays for hospital care, as well as skilled nursing, home health, and hospice care; and is financed primarily through payroll taxes paid by workers and employers. While the taxes paid each year are used mainly to pay benefits for current beneficiaries, funds not currently needed to pay benefits and related expenses are held in the HI Trust Fund and invested in U.S. Treasury securities.

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. Beneficiaries who choose the optional Part B coverage are subject to monthly premium payments. Beginning January, 2007, Part B premiums are income-related for individuals with incomes greater than $85,000 or couples with income(s) greater than $170,000. About 93 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI Trust Fund, and invested in U.S. Treasury securities.

The Medicare Advantage (MA) program, also known as Medicare Part C, created in 2003 by the MMA, is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join an MA plan, if they are entitled to Part A and enrolled in Part B, and if there is a plan available in their area. Those who are eligible for Medicare because of ESRD may join an MA plan only under special circumstances. All MA plans are currently paid a per capita payment, and must provide all Medicare covered services. Further, MA plans assume financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits to beneficiaries, which are not available under Part A or Part B. MA plans have an estimated 11.8 million enrollees in FY 2011.

The Prescription Drug Benefit Program, also created by the MMA, constitutes the most significant change to the Medicare program since its inception in 1965. The prescription drug benefit is funded through the SMI account and provides for an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A or Part B. Beneficiaries who qualify for both Medicare and Medicaid (“dual eligibles”) automatically receive the Medicare drug benefit. The statute also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and qualified low-income beneficiaries. In general, coverage for this benefit is provided under private prescription drug plans, which offer only prescription drug coverage, or through Medicare Advantage plans which integrate prescription drug coverage with the general health care coverage they provide to Medicare beneficiaries. In addition, plan sponsors of employer and union plans offering a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the retiree drug subsidy program to fund some of their costs. Part D benefits are funded through premiums paid by beneficiaries and general fund subsidies. Enrollment in Part D plans is estimated to be 35.3 million in FY 2011 including 29 million enrolled in Part D plans and 6.3 million who receive benefits through the retiree drug subsidy. The Affordable Care Act authorized a rebate program for those applicable beneficiaries who reach the coverage gap before the end of the 2010 calendar year. In addition it will offer 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. We are introducing a performance measure for FY 2012 to reduce the average out-of-

pocket share of prescription drug costs while in this coverage gap for non-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap. We will measure the success of the new Affordable Care Act Coverage Gap Discount Program which will reduce the cost Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap. This will be accomplished through a combination of rebate checks, significant manufacture discounts, and increased Medicare coverage on according to a predetermined scale. This measure is featured in the HHS Strategic Plan, 2010-2015.

Another provision of the Affordable Care Act removes the beneficiary co-pay for covered preventative services including colorectal cancer screening (CRC). The removal of the co-pay is intended to increase utilization of preventative services. To represent this new benefit, CMS introduced an FY 2012 performance measure to increase the proportion of Medicare beneficiaries, ages 50-75, who receive colorectal cancer screening. This measure is also included as a performance measure in the HHS Strategic Plan, 2010-2015.

Passage of the MMA prompted modifications in the Medicare Consumer Assessment of Health Care Providers and Systems (CAHPS) to include measurement of experience and satisfaction with the care and services provided through the Medicare Prescription Drug Plans as well as the Medicare Advantage (MA) and Medicare Fee for Service (MFFS). As a result, we are monitoring and achieving four related measures of beneficiary satisfaction with access to medical care and prescription drugs for both MA and MFFS. The FY 2012 targets (90 percent for MA and MFFS beneficiary access to care measures, and 91 percent for MA and FFS access to prescription drugs) demonstrate a commitment by Medicare to assure continually high levels of care satisfaction in measures that are purposeful and meaningful. Medicare will also analyze data at the plan, enrollee subgroup, and geographic levels to assist plans in developing interventions that are both actionable and targeted to maintain or improve measures. The four specific measures are as follow:

- Percent of persons with Medicare Advantage (MA) Plans report they usually or always get needed care right away as soon as they thought they needed it;
- Percent of persons with Medicare Fee-for-Service (MFFS) report they usually or always get needed care right away as soon as they thought they needed it;
- Percent of persons with MA Plans report that it is usually or always easy to use their health plan to get the medicines their doctor prescribed; and
- Percent of persons with MFFS and a standalone drug plan report it is usually or always easy to use their Medicare prescription drug plan to get the medicines their doctor prescribed.

Outlays History

FY 2007	$434,591,000,000
FY 2008	$454,300,596,000
FY 2009	$497,635,667,000
FY 2010	$518,948,805,000
*FY 2011	$565,136,000,000
*Estimate Under Current law	

Budget Estimates

The budget estimates for Medicare benefits for FY 2012, by trust fund account, are shown in the following table.

	FY 2012	+/- from FY 2011
HI	$265,616,000,000	$1,331,000,000
SMI – Part B	$222,038,000,000	-$12,821,000,000
SMI – Part D	$62,564,000,000	-$3,428,000,000
Total	$550,218,000,000	-$14,918,000,000

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

The estimate for FY 2012 is a decrease of $14,918,000,000 from FY 2011. The decrease is predominantly due to implementation of the Affordable Care Act. In regards to Part D, there is a slight decrease due to lower enrollment than expected.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
MCR1.1a: Percent of beneficiaries in Medicare Advantage (MA) who report access to care	FY 2010: 91% (Target Met)	90%	90%	Maintain
MCR1.1b: Percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care.	FY 2010: 90% (Target Met)	90%	90%	Maintain
MCR1.2a: Percent of beneficiaries in MA who report access to prescription drugs.	FY 2010: 93% (Target Exceeded)	91%	91%	Maintain
MCR1.2b: Percent of beneficiaries in MFFS who report access to prescription drugs.	FY 2010: 91% (Target Exceeded)	91%	91%	Maintain
MCR23: Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap.	N/A	N/A	55%	N/A
MCR25: Proportion of Medicare beneficiaries, ages 50-75, who receive colorectal cancer screening	FY 2009: 67.9% (Trend)	N/A	68%	N/A
Program Level Funding ($ in millions)	N/A	$565,136,000,000	$550,218,000,000	-$14,918,000,000

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Children's Health Insurance Program

	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	FY 2012 +/- FY 2011
State allotments (CHIPRA of 2009, P.L. 111-3)	$12,520,000,000	$13,459,000,000	$14,982,000,000	$1,523,000,000
MACPAC Transfer (Sec. 2801 of the Health Care Reform Bill)	($2,000,000)	$0	$0	$0
Total Budget Authority for State Allotments	**$12,518,000,000**	**$13,459,000,000**	**$14,982,000,000**	**$1,523,000,000**
CHIP Performance Bonus Payments [1] (P.L. 111-3)	$4,236,651,000	$4,161,279,000	$3,955,121,000	($206,158,000)
Child Health Quality Improvement (P.L. 111-3)	$45,000,000	$45,000,000	$45,000,000	$0
Total Budgetary Resources	**$16,799,651,000**	**$17,665,279,000**	**$18,982,121,000**	**$1,316,842,000**
Total Outlays	**$7,887,143,000**	**$9,068,808,000**	**$9,781,500,000**	**$712,692,000**

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

FY 2012 Authorization – Public Law 111-3
Allocation Method - Formula Grants

Authorizing Legislation - The Balanced Budget Act of 1997 (BBA) (P.L. 105-33), the Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113), the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3), and the Patient Protection and Affordable Care Act (P.L. 111-148)

Child Enrollment Contingency Fund

(The Child Enrollment Contingency Fund is set up as a separate interest-bearing account in the United States Treasury Department)

	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	FY 2012 +/- FY 2011
Child Enrollment Contingency Fund	$2,113,400,000	$2,114,767,000	$2,018,690,000	($96,077,000)
Interest Estimate	$1,367,000	$3,923,000	$15,733,000	$11,810,000
Total Budgetary Resources	**$2,114,767,000**	**$2,118,690,000**	**$2,034,423,000**	**($84,267,000)**
Total Outlays	**$0**	**$100,000,000**	**$200,000,000**	**$100,000,000**

FY 2011 and FY 2012 figures reflect carry-forward balances from previous year and do not represent new appropriations.

Authorizing Legislation - The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3).

Program Description and Accomplishments

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

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44 billion through FY 2013 to maintain State programs and to cover more insured children. More recently, the Affordable Care Act extended funding for CHIP through FY 2015, providing an additional $28.8 billion in budget authority over the baseline.

The Department of Health and Human Services has identified a limited number of high priority performance goals that will be a particular focus over the next two years. The CHIP enrollment measure to decrease the number of uninsured children by increasing enrollment in CHIP supports the Department's high priority performance goal to "Improve the availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid". The additional resources provided through CHIPRA and the Affordable Care Act are key to the Administration's strategy to achieve this goal. CMS did not meet its FY 2010 target to increase enrollment by 5 percent. In FY 2010, CHIP enrollment increased by 4.6 percent (7,705,723 children). CMS fell short of the FY 2010 target since the growth in CHIP leveled off in 2010, likely influenced by the economic downturn which made more children eligible for Medicaid. This long-term measure proposes to steadily increase enrollment, although enrollment figures can be affected by States' economic situations, programmatic changes, and the reporting accuracy and timeliness of States' reporting. The FY 2012 target is to increase CHIP enrollment by +11 percent over the FY 2008 baseline.

Since September 1999, all States, Territories, and the District of Columbia have had approved CHIP plans. CMS continues to review States' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibility of CHIP to make innovative changes. As of September 2010, CMS has approved a total of 371 amendments to CHIP plans.

In addition to increased funding for States, CHIPRA created several new programmatic features of the CHIP program. A few of the major provisions include:

- CHIP Performance Bonus Payments – The CHIP Performance Bonus Payments were created as an incentive for States to enact policies that promote enrollment and retention of eligible children. States receive bonus payments for the increase on a per child basis equal to a portion of the State's annual Medicaid per capita expenditure on children. In order to receive a performance bonus payment, States must implement 5 of 8 enrollment and retention provision throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation and in future years any unobligated national allotments,

unexpended State allotments, unexpended set-asides for childless adults, and excess funds beyond the aggregate cap for Child Enrollment Contingency Fund amounts may be transferred to this account.

- Child Health Quality Improvement in Medicaid and CHIP – Section 1139A of the Social Security Act (the Act) requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. Other CHIPRA requirements include developing a standardized reporting format that encourages States to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the State plan under Medicaid or CHIP, and several grants and contracts to develop and test these quality measures. A total of $225 million ($45 million per year for FYs 2009-2013) was appropriated for the Secretary to carry out these activities. Funds for these activities are available until expended. This initiative is also discussed in the performance measurement section of this chapter.

  The current status of Child Health Quality Improvement activities in Medicaid and CHIP include:

  CHIPRA Pediatric Quality Measures Program:
  - CMS published an initial core set of quality measures for children in the Federal Register on December 29, 2009.
  - CMS is on target to disseminate voluntary reporting guidance and procedures in February 2011.
  - In collaboration with AHRQ, grants and contracts for enhancement of existing measures, and development of new quality measures over the next four years are scheduled to be awarded in calendar year 2011. Technical reviews of the grant applications were completed in November 2010, and funding assessments were initiated in December 2010. AHRQ is targeting award of grants by March 15, 2011.

  CHIPRA Electronic Health Records Program:
  - A $5 million contract has been awarded (in collaboration with AHRQ) to develop a pediatric electronic health record format.
  - Additional electronic health record program components are currently under development.

  CHIPRA Quality Demonstration Grants:
  - CMS awarded the first $20,000,000 in demonstration grants to ten States on February 22, 2010. Year 2 demonstration awards are targeted by February 22, 2011.
  - All State grantees successfully submitted a final operational plan and first progress report to CMS by November 22, 2010. On August 1, 2011 all grantees will be expected to submit their first web-based semi-annual progress reports.

- Child Enrollment Contingency Fund – This fund is used to provide supplemental funding to States that exceed their allotment due to a higher-than-expected child enrollment. A State may qualify for a contingency fund payment if it projects a funding shortfall for the

fiscal year and its average monthly child enrollment exceeds its target average number of enrollees for the fiscal year.

The fund received an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2015, Section 2104(n) of the Act appropriates the amount necessary to make payments to eligible States, but not to exceed 20 percent of the total annual allotment appropriation for CHIP. Any amounts in excess of the aggregate cap will be made available for CHIP Performance Bonus Payments. Also, the contingency fund will be invested in interest bearing securities of the United States. The income derived from these investments constitutes a part of the fund. The fund accrued a total of $1,366,571 in interest in FY 2010.

Performance Measurement

CMS is committed to improving quality of care and program integrity in CHIP, as illustrated by our efforts to track and improve performance in these areas. Our past efforts have resulted in dramatic improvement in States' reporting of CHIP health quality performance. CMS has a performance measure to, "Improve Health Care Quality across Medicaid and CHIP through Implementation of CHIPRA Quality Initiatives".

As discussed above, CHIPRA appropriated $45 million annually through FY 2013 for a number of activities aimed at improving child health quality. The first step to developing a national pediatric quality measures program was the December 2009 publication of a core set of twenty-four pediatric quality measures. While State reporting on the core set is voluntary, CMS is encouraging all States to use and report on the core set in order to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures specific to Medicaid and CHIP programs. CMS's FY 2012 target is to work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures.

CMS has also developed a measure to improve access to and utilization of oral health care services for children enrolled in Medicaid or CHIP (MCD7). Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the single most preventable common chronic disease of childhood. CMS has established an FY 2012 target to increase the national rates of preventive dental service by 2 percent over the FY 2011 baselines.

CMS is also aiming to improve CHIP program integrity through its nationally implemented Payment Error Rate Measurement (PERM) program. The PERM measurement includes fee-for-service, managed care and eligibility components for the CHIP program. The new final rule for PERM required by section 601 of CHIPRA was published on August 11, 2010 and was effective on September 10, 2010. CHIPRA prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is in effect. Therefore, CMS will resume CHIP measurement with the FY 2011 cycle and establish a baseline in the FY 2014 AFR. After establishing a baseline, HHS will set out-year reduction targets.

State Allotment Funding History

FY 2004	$3,175,200,000
FY 2005	$4,082,400,000
FY 2006	$4,365,400,000
FY 2007	$5,690,000,000
FY 2008	$6,640,000,000
FY 2009	$10,602,000,000
FY 2010	$12,518,000,000
FY 2011	$13,459,000,000
FY 2012	$14,982,000,000
FY 2013	$17,406,000,000
FY 2014	$19,147,000,000
FY 2015	$21,061,000,000

Budget Request

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) authorized and appropriated $40 billion for CHIP allotments to States, Territories, Commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113) authorized and appropriated additional funding for CHIP allotments to Commonwealths and Territories. The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) authorized funding for States, Commonwealths, and Territories in the amount of $13,459,000,000 in FY 2011 and $14,982,000,000 in FY 2012. 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. Information regarding additional provisions provided by CHIPRA can be found in the State Grants and Demonstrations chapter. In addition to CHIPRA, the Affordable Care Act extends Federal funding for CHIP through FY 2015, appropriating $19.1 billion in FY 2014 and $21.1 billion in FY 2015.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
CHIP 3.1: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP **Priority Performance Goal**	FY 2010 +4.6% over baseline 7,705,723 children (Target not met)	+9% over baseline 8,031,642 children	+11% over FY 2008 8,179,012 children	+147,370 children
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2010: Final regulation published 8/11/2010. (Target Met)	Report national error rates in the FY 2012 AFR based on 17 CHIP States measured in FY 2011.	Report national error rates in the FY 2013 AFR based on 17 CHIP States measured in FY 2012.	N/A
MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives	N/A	Work with States to ensure that 70% of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80% of States report on at least five quality measures in the CHIPRA core set of quality measures.	N/A
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), who receive any preventive dental service	N/A	Set baseline	+2 percentage points over FY 2011 baseline	N/A
Program Level Funding ($ in millions)	**N/A**	**$13,459**	**$14,982**	**+$1,523**

FY 2011 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	FY 2010 Enacted*	FY 2011 Current Law	FY 2012 Request	Difference +/- 2011
Alabama	$147,158	$135,448	$135,448	$0
Alaska	$25,717	$19,830	$19,830	0
Arizona	$182,592	$61,462	$61,462	0
Arkansas	$140,776	$90,853	$90,853	0
California	$1,629,092	$1,254,895	$1,254,895	0
Colorado	$122,852	$123,499	$123,499	0
Connecticut	$47,785	$31,320	$31,320	0
Delaware	$15,889	$13,570	$13,570	0
District of Columbia	$14,845	$11,989	$11,989	0
Florida	$372,791	$324,871	$324,871	0
Georgia	$320,022	$239,369	$239,369	0
Hawaii	$21,928	$33,257	$33,257	0
Idaho	$47,219	$36,206	$36,206	0
Illinois	$360,717	$273,211	$273,211	0
Indiana	$144,186	$94,539	$94,539	0
Iowa	$68,492	$75,497	$75,497	0
Kansas	$60,287	$55,864	$55,864	0
Kentucky	$132,153	$129,601	$129,601	0
Louisiana	$229,089	$186,019	$186,019	0
Maine	$42,268	$35,490	$35,490	0
Maryland	$216,082	$168,778	$168,778	0
Massachusetts	$403,133	$316,955	$316,955	0
Michigan	$231,492	$120,970	$120,970	0
Minnesota	$87,897	$20,498	$20,498	0
Mississippi	$214,132	$160,649	$160,649	0
Missouri	$166,276	$112,711	$112,711	0
Montana	$96,382	$38,466	$38,466	0
Nebraska	$52,978	$38,943	$38,943	0
Nevada	$65,135	$24,078	$24,078	0
New Hampshire	$15,540	$12,821	$12,821	0
New Jersey	$634,745	$592,188	$592,188	0
New Mexico	$345,313	$245,492	$245,492	0
New York	$453,796	$525,836	$525,836	0
North Carolina	$351,156	$382,336	$382,336	0
North Dakota	$16,596	$15,258	$15,258	0

FY 2011 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	**FY 2010 Enacted***	**FY 2011 Current Law**	**FY 2012 Request**	**Difference +/- 2011**
Ohio	$298,650	$277,965	$277,965	0
Oklahoma	$159,709	$120,389	$120,389	0
Oregon	$281,059	$91,102	$91,102	0
Pennsylvania	$324,858	$321,847	$321,847	0
Rhode Island	$75,436	$30,345	$30,345	0
South Carolina	$112,887	$98,027	$98,027	0
South Dakota	$21,764	$20,067	$20,067	0
Tennessee	$164,728	$134,225	$134,225	0
Texas	$925,033	$832,714	$832,714	0
Utah	$69,926	$63,916	$63,916	0
Vermont	$9,935	$5,794	$5,794	0
Virginia	$184,455	$175,234	$175,234	0
Washington	$99,438	$41,894	$41,894	0
West Virginia	$45,292	$41,268	$41,268	0
Wisconsin	$213,853	$102,733	$102,733	0
Wyoming	$12,063	$9,989	$9,989	0
Subtotal	**10,475,594**	**8,370,277**	**8,370,277**	**0**
American Samoa	$892	$1,205	$1,205	0
Guam	$3,963	$4,178	$4,178	0
Northern Mariana Islands	$818	$861	$861	0
Puerto Rico	$117,254	$99,567	$99,567	0
Virgin Islands	$2,396	$0	$0	0
Subtotal	**125,323**	**105,810**	**105,810**	**0**
Total States/Territories	**10,600,916**	**8,476,088**	**8,476,088**	**0**
Technical Assistance	0	0	0	0
State Penalties	0	0	0	0
Contingency Fund	0	0	0	0
Other Adjustments	1,997,563	$4,982,912	$6,505,912	1,523,000
Subtotal Adjustments	**1,997,563**	**4,982,912**	**6,505,912**	**1,523,000**
TOTAL RESOURCES	**$12,598,479**	**$13,459,000**	**$14,982,000**	**$1,523,000**

*includes increased FY 2010 allotments as determined under section 2104(m)(6) and 2104(m)(7) of the Social Security Act.

Note: Obligations remain available for Federal payments for two years. FY 2012 estimates will be increased according to growth factors in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3).

Note: The Virgin Islands received no Federal payments from available allotments in 2010, resulting in no new obligations in 2011 per rebasing methodology in CHIPRA. The Virgin Islands' 2010 allotment remains available for Federal payments through 2011.

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, $580,580,000 to remain available through September 30, 2013, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $389,938,260 shall be for Centers for Medicare and Medicaid Services Program Integrity Activities, including administrative costs, to conduct oversight activities for Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act and for activities listed in section 1893 of such Act and for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities; of which $97,556,404 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act; and of which $93,085,336 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2012 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, $580,580,000, to remain available through September 30, 2013, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which $389,938,260 shall be for the Centers for Medicare and Medicaid Services Program Integrity Activities, including administrative costs, to conduct oversight activities for Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act for activities listed in section 1893 of such Act and for Medicaid Children's Health Insurance Program (CHIP) program integrity activities;	Provides funding, including administrative costs, for the Medicare Integrity Program; and funding for Medicaid and CHIP program integrity activities.
of which $97,556,404 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 $93,085,336 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2012 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.	Provides that the annual report on discretionary spending in the HCFAC account include specified information about activities funded from this appropriation.

Health Care Fraud and Abuse Control
(dollars in thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Budget Request	FY 2012 + / - FY 2010
Discretionary				
CMS Program Integrity	$251,420	$251,420	$389,939	$138,519
Medicare Integrity(non-add)	*$220,320*	*$220,320*	*$345,295*	*$124,975*
Medicaid Integrity(non-add)	*$31,100*	*$31,100*	*$44,644*	*$13,544*
OIG	$29,790	$29,790	$97,556	$67,766
DOJ	$29,790	$29,790	$93,085	$63,295
Subtotal, Discretionary	$311,000	$311,000	$580,580	$269,580

	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Budget Request /3	FY 2012 + / - FY 2011
Mandatory				
Medicare Integrity Program (MIP) **/2**	$780,000	$871,526	$851,230	($20,296)
Predictive Modeling **/1**	$0	$100,000	$0	($100,000)
FBI **/2**	$126,258	$128,405	$129,945	$1,540
OIG **/2**	$177,205	$197,998	$193,387	($4,611)
DOJ Wedge **/2**	$55,328	$61,820	$60,381	($1,439)
HHS Wedge **/2**	$33,892	$37,869	$36,987	($882)
Subtotal, Mandatory	$1,172,683	$1,397,618	$1,271,930	($125,688)

Total Funding	**$1,483,683**	**$1,708,618**	**$1,852,510**	**$143,892**

This table reflects all funding provided from The Affordable Care Act (P.L. 111-148 & P.L. 111-152) and The Small Business Jobs Act of 2010 (P.L. 111-240),as well as OMB's Fiscal year CPI-U Annual Averages and Percent Change inflationary adjustment. Narrative details related to ACA activities are described near the end of this book.

/1 Funding provided from Small Business Jobs Act of 2010 (P.L. 111-240)

/2 Inflationary adjustment is included based on OMB Economic Assumptions in the FY 2012 President's Budget request.
/3 HCFAC mandatory funding decreases for many programs in FY 2012 compared to FY 2011 because the Affordable Care Act appropriated more funding in FY 2011 than FY 2012. In addition, the Small Business Jobs Act of 2010 appropriated one-time funding in FY 2011, until expended.

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

FY 2011 Authorization – Public Law 111-322

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 2010, the discretionary appropriation was authorized to be available for obligation over two fiscal years.

HCFAC has traditionally focused on Medicare fraud, waste and abuse through activities such as Medical Review, Benefit Integrity and Provider Audits. With the receipt of discretionary funds, HCFAC has been able to expand its activities to include strengthening program integrity activities in Medicare Advantage and Medicare Part D; establishing additional regional call centers and focused beneficiary outreach; increasing funding for program integrity demonstrations/special initiatives; improving the capacity to identify and prevent excessive payments in Fee-For-Service (FFS) Medicare; and enhancing provider oversight efforts; and error rate measurement.

In addition to fighting Medicare fraud, CMS is also committed to fighting fraud, waste and abuse in the Medicaid program. The Medicaid Integrity Program protects Medicaid by strengthening the national Medicaid audit program while enhancing Federal oversight of and support and assistance to State Medicaid programs. The Medicaid Integrity Program will accomplish this by providing States with technical assistance and support that enhances the Federal-State partnership.

HCFAC has been steadily growing since it began in 1997, and as shown in the recent FY 2010 HCFAC report which was released at the end of January, this investment in fraud fighting resources is paying dividends. The HCFAC report demonstrates the value of this program; since its inception and through FY 2010, HCFAC has resulted in the return of $18 billion to the Medicare trust funds. The return-on-investment (ROI) from various HCFAC activities ranges from 6 to 1 for audit, investigative, and prosecutorial work performed by OIG and DOJ to 14 to 1 for the Medicare Integrity Program's activities. ROI is currently the highest is has ever been, according to the 2010 HCFAC report. The 3 year average for ROI (2008-2010) is 6.8 to 1.

CMS is committed to working with our law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Strike Forces, which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs. In 2009 the Strike Forces were reorganized under the HEAT. HEAT consolidated the fraud efforts of DOJ's Civil Division and U.S. Attorneys' Offices, HHS/OIG, the Food and Drug Administration and CMS.

In the three and a half years since the inception of the Medicare Fraud Strike Force, Strike Force prosecutors filed 465 cases charging 829 defendants who collectively billed the Medicare program more than $1.9 billion; 481 defendants plead guilty and 48 others were convicted in jury trials; and 358 defendants were sentenced to imprisonment averaging nearly 44 months in duration.

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

CMS has been actively implementing the antifraud provisions of the Affordable Care Act since shortly after enactment. To date, five major proposed rules have been published dealing with provider screenings, NPI requirements on enrollment applications, payment suspensions, and recovery audit programs for Medicaid and Medicare Part C&D:

- April 30, 2010: CMS published an Interim Final Rule that implements National Provider Identifier requirements for claims and enrollment applications found in section 6402(e), the ordering and referring provisions found in section 6405, and the requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse in section 6406.
- July 23, 2010: Proposed rule, final rule November 17, 2010 to implement section 6407(a), requiring face-to-face encounters for home health and hospice provider settings.
- August 3, 2010: Proposed rule to implement section 6001, which imposes limitations on hospital referral safe harbors.
- Sept. 17, 2010: Proposed rule, final rule January 24, 2011, effective March 23, 2011, and will enhance provider and supplier screening and payment suspensions and provide for enrollment moratoria under sections 6401, 6402, 6501,10603, and 1304:

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

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

- November 10, 2010: CMS proposed new rules to help states reduce improper payments under section 6411. Medicaid health care claims will be audited through the use of Medicaid Recovery Audit Contractors (RACs) that will be working for States to identify Medicaid payments that may have been underpaid or overpaid, and recover overpayments or correct underpayments, similar to the RAC program in Medicare.

In addition, CMS has been reaching out to its private and public partners to build better relationships. CMS has co-hosted a series of summit on health care fraud, bringing together Federal and State officials, law enforcement experts, private insurers, health care providers, and beneficiaries for a comprehensive meeting to discuss and identify the scope of fraud, weaknesses in the current health care systems, and opportunities to move towards new collaborative solutions. Building on the momentum generated by the National Healthcare Fraud Summit in January 2010, Regional Health Care Fraud Prevention Summits have been held across the country. Additionally, CMS held an industry day in October 2010 that approximately 300 industry representatives attended.

In FY 2012, the CPI will continue to shift efforts from planning to implementation. Lessons learned from the pilots and projects started in FY 2010 will be implemented on a larger scale if proven successful. In addition, CPI will continue to focus efforts on testing and developing more innovative approaches and technologies to attain CPI's overarching mission of protecting the Trust Funds and other public resources against losses from fraud and other improper payments and to improve the integrity of the health care system.

CPI has targeted four major program areas to carry out its mission. Activities are grouped by the four major program areas to help strategically identify, evaluate and target resources, and projects. These areas are Prevention, Detection, Recovery, and Transparency & Accountability. All existing and new activities are categorized into one or more of the major program areas. Elements of the program areas are defined as follows:

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

- *Engaging Medicare Beneficiaries and Other Stakeholders in Combating Fraud*
- *Strengthening Provider and Supplier Safeguards*
- *Improving Payment Accuracy*
- *Coordination with Law Enforcement*

Detection -- To foster collaboration with the HEAT, components of HHS, DOJ, states and others with a shared interest in protecting health insurance program integrity. CPI will promote the best use of tools, techniques and technology to detect improper payments.

CMS is implementing several analytics pilots designed to identify and detect trends of improper payment activity, such as: predictive modeling for risk-based provider and supplier enrollment, geographic heat mapping based on fraud reported to 1-800-MEDICARE, and fraud detection techniques used as part of Recovery Act monitoring but applied to Medicare.

Recovery -- Identify and recover overpayments, with strong emphasis towards projects that support the President's goal to reduce improper payments by 50 percent by 2012. CMS ensures that action is taken when fraud and abuse is found. CMS will continue to work with our 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. CMS is working to increase its recovery of overpayments to providers through the expansion of Recovery Audit Program, through additional field investigations, implementation of mandatory Medicare Secondary Payment information and better coordination with the Office of Medicare Hearings and Appeals (OMHA).

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

Mandatory spending provided for in the HCFAC account has traditionally supported many high ROI activities that help to protect the Trust Funds, such as medically reviewing claims to assure correct payment. This continues to be the focus; however, some of the activities supported under this funding are being augmented to reflect new initiatives.

In 2010, the passage of the Affordable Care Act (ACA) provided an additional $350 million over ten years, and an inflationary adjustment to the mandatory base. In addition, it also provided a comprehensive set of tools to strengthen CMS' program integrity efforts. With this funding, CMS will work with law enforcement to:

- *Strengthen screenings for health care providers* who want to participate in Medicare Medicaid, and/or CHIP with a special focus on new DME suppliers and home health suppliers;

- *Make it easier for law enforcement to see Medicare claims data* and state reported data for Medicaid and CHIP programs. Giving law enforcement agents access to the big picture will help them identify suspicious patterns in claims data that can indicate fraud;

- *Expand the Recovery Audit Contractors for Part C & D, as well as Medicaid;*

- *Share data across Medicare and Medicaid, as well as with other federal health care payers, to keep fraudsters out of these programs;*

- *Get more boots on the ground to fight fraud* in communities across the country; and

- *Increase the penalties for fraud*. People who commit Medicare, Medicaid or CHIP fraud are stealing from the beneficiaries of these programs and from every US taxpayer and should be punished accordingly.

Congress provided an additional $100 million through the Small Business Jobs Act of 2010 to advance CMS' work in the area of predictive modeling.

Funding History

FY 2007	$1,111,677,000
FY 2008	$1,132,134,000
FY 2009	$1,358,683,000
FY 2010	$1,483,683,000
FY 2011	$1,708,618,000

Budget Request

The FY 2012 Budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2012 HCFAC program level is $1.8 billion, $369 million more than in FY 2010. Of this total program level, approximately $1.3 billion is mandatory, an increase of $99 million over FY 2010, and $581 million is discretionary, an increase of $270 million over FY 2010.

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

Medicare Integrity Program (MIP) activities include both traditional methods such as Medical Review, Benefit Integrity, Medicare Secondary Payer, Audits and Provider Education, as well as some newer innovative approaches to fighting fraud (such as HEAT). Past experience has also proven that better results are gained when a hybrid approach to combating fraud is adopted, with some limited level of redundancy. This includes using a variety of in-house, contractor, law enforcement, and auditors to analyze, investigate, and prosecute individuals committing fraud, waste and abuse.

Some of the specific steps CMS is taking under current authorities and resources involve more stringent scrutiny of applicants seeking to bill the Medicare program; more aggressive application of payment suspensions; oversight of Medicare Advantage and Part D prescription drug plans; and using existing demonstration authority to test new methods to detect and deter potential fraudulent behavior at both the pre-enrollment stage as well as after suppliers are enrolled in the Medicare program. Some of the other activities CMS has conducted to prevent fraud and abuse in the Medicare program include:

- Increased random site visits to providers – particularly for high-risk areas like durable medical equipment suppliers and home health agencies;
- Aggressively and successfully deactivated inactive provider identification numbers;
- Implemented a reform to the home health outlier payment policy to address concerns with disproportionate outlier payments in certain high-fraud areas;
- Developed a more robust system to conduct data analysis for more proactive fraud and abuse identification and program oversight;

- Initiated several geographic and service specific projects to target program vulnerabilities in South Florida, Texas and California;
- Set up a beneficiary hotline for reporting suspected fraud in high-risk areas and services; and,
- Issued guidance to help beneficiaries guard against identity theft.

CMS is introducing a performance measure for FY 2012 to strengthen CMS' Provider Enrollment actions to prevent fraudulent providers and suppliers from enrolling in the Medicare program and to assure that existing providers continue to meet enrollment requirements. CMS will measure the proportion of the number of "high-risk" provider site visits that result in administrative action to the number of "high risk" provider site visits conducted. By conducting enrollment site visits to "high-risk" targeted providers and suppliers and by taking appropriate and timely administrative actions, contractors will focus their activities toward areas where incidence or opportunity for improper payments and/or fraud are greatest.

Below are the major initiatives CMS will be funding under the MIP account:

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

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

As part of contracting reform (specified in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003), seven zones were created based on the MAC jurisdictions. The contracting strategy implemented in FY 2008-FY 2009 created ZPICs to operate within the seven zones to perform the benefit integrity work previously performed by the PSCs. With the creation of the ZPICs, there is an emphasis on designated high-risk fraud areas. Single contracts will be issued for each zone with separate task orders for: 1) Medicare Parts A, B, durable medical equipment (DME) and home health and hospice, 2) Medicare-Medicaid data match program, 3) Medicare Parts C and D, and 4) cost report audits. This strategy increases the ability to look at providers across all benefit categories; achieve economies of scale through the consolidation of contractor management; analyze data/IT requirements; consolidate facility costs, etc.; streamline CMS costs in acquisition, management and oversight; and, provide for better coordination and fewer resources required for the States.

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

the PSCs/ZPICs are frequently called upon to perform medical review or data analysis for cases initiated by OIG or the FBI.

Provider Audit: Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report. The audit process includes the timely receipt and acceptance of provider cost reports, desk review and audit of those cost reports, and the final settlement of the provider cost reports. In addition, the audit/settlement process determines that providers are paid properly in accordance with CMS regulation and instructions for areas such as Graduate Medical Education, disproportionate share hospital payments, bad debts and other cost reimbursable items. The audit process includes such administrative functions as intermediary hearings and appeals to the Provider Reimbursement Review Board. The audit effort also reviews data reported in the Medicare cost reports for a specific provider type such as end-stage renal dialysis facilities. CMS contracts with managed care organizations (MCOs) to provide services to Medicare enrollees on a cost reimbursement basis. The agency determines the monthly payments that are made to these MCOs on a prepayment basis and is responsible for the proper settlements of final cost reports. To ensure accurate reimbursement, CMS contracts with an independent CPA firm to audit cost reports submitted for settlement. CMS' performance goal is to increase the ratio of recoveries to audit dollars spent.

Medicare Secondary Payer (MSP): The MSP effort ensures that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on the proper order of payers, and makes sure that Medicare only pays for those claims where it has primary responsibility for payment of health care services for Medicare beneficiaries. When mistaken Medicare primary payments are identified, recovery actions are undertaken.

Medical Review (MR): MR activities can be conducted either pre-payment or post-payment, and serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the following conditions:

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

Medicare/Medicaid Data Match Project (Medi-Medi): Within CMS, both Medicare and Medicaid program integrity staff work closely with each other to coordinate activities and facilitate information sharing in instances of suspected fraud and abuse. The Medicare-Medicaid Data Match Program, authorized by the Deficit Reduction Act (DRA), is a partnership between Medicaid and Medicare that enhances collaboration by identifying aberrant practices and by collecting and analyzing data from both programs with the intent of detecting fraud, waste, and abuse that may otherwise go undetected in each program. The One PI system will be integral in this process. The Medi-Medi program examines the health care claims data from two programs that share many common beneficiaries and

providers to look for billing patterns that may be indicative of potential fraud, waste or abuse that may not be evident when provider billings from either program are viewed in isolation.

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

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

Provider Outreach and Education (POE): POE funding is used by the Medicare Fee-for-Service claims processing contractors (Medicare Administrative Contractors, fiscal intermediaries and carriers) to educate Medicare providers and their staffs about the fundamentals of the Medicare program, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such mechanisms as provider inquiries, claim submission errors, medical review data, CERT data and Recovery Audit Contractor data. The primary goal of the POE program is to reduce the Comprehensive Error Rate Testing (CERT) error rate by giving Medicare providers the timely and accurate information they need to understand the Medicare program, be informed about changes and correctly bill. Medicare contractors utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms.

Provider Enrollment and Chain Ownership System (PECOS): The Provider Enrollment Chain and Ownership System (PECOS) is the national enrollment system for Medicare providers and suppliers. It collects and stores enrollment information in a national database. PECOS allows all Medicare providers/suppliers to enroll in PECOS for any of the family of CMS 855 forms (855 A, I, R, B, and S). PECOS is used by Medicare contractors to enter, update and review data. Providers and suppliers use PECOS in order to submit their enrollment data, as well as view and update their existing information.
Funding in this category is used to maintain the system; enhance the usability to align with regulations, statutes and agency needs; and provide training to the Medicare contractors and the provider and supplier community.

Comprehensive Error Rate Testing (CERT): The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), requires the heads of Federal agencies to: annually review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, submit those estimates to Congress, and

submit a report on actions the Agency is taking to reduce improper payments. The Medicare Fee-for-Service (FFS) program was identified as a program at risk for significant erroneous payments.

As part of the original IPIA compliance efforts, and to help all Medicare FFS contractors better focus review and education efforts, CMS established the Comprehensive Error Rate Testing (CERT) program to randomly sample and review claims submitted to Medicare. The CERT program produces Medicare FFS national paid claim error rates specific to contractor, service type, and provider type. The program calls for independent reviewers to periodically review a systematic random sample of claims that are identified after they are accepted into the claims processing system at carriers, fiscal intermediaries, and MACs.

These sampled claims are then followed through the system to their final disposition. The independent reviewers medically review claims that contractors paid or denied to ensure that the payment decision was appropriate. The decisions of the independent reviewers are entered into a tracking database. Annual reports are produced that provide the basis for program planning, evaluation, and corrective actions.

CMS needs precise, timely sub-national estimates of billing and payment errors in order to manage the Medicare program properly. The sub-national estimates include contractor groups, specific contractors, types of providers, and services. The data from the reviews must provide a robust source of information for identification of aberrant billing.

During the 2009 report period, CMS significantly revised and improved the way that it calculates the Medicare FFS error rate based on recommendations from the Office of Inspector General. CMS has made its review requirements more stringent and in line with their policies and manuals. For FY 2009, if CMS reported a national paid claims error rate for those claims reviewed under the strictest criteria, applied the entire year, the error rate would have been 12.4 percent. Given the change in methodology, CMS will use 12.4 percent as an estimated baseline, implement corrective actions to reduce improper payments and set targets, not greater than 8.5 percent and 6.2 percent, respectively for FY 2011 and FY 2012. CMS did not meet the 2010 target for this measure, reporting a Medicare FFS error rate of 10.5 percent. During FY 2012, CMS will continue to review claims in accordance with the significantly revised and improved methodology implemented in 2009.

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

CMS Program Integrity Budget Request

The FY 2012 discretionary request level of $389.9 million will fund the following expanded and new activities:

I. <u>Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D ($166.0 million):</u>

<u>Medicare Drug Integrity Contractors (MEDICs):</u> MEDICs detect, combat, and prevent fraud, waste, and abuse in the Medicare Part D program by investigating complaints, referring

cases to law enforcement, auditing Part D sponsors for benefit integrity and compliance, conducting outreach to Part D plans, law enforcement, and CMS partners, and issuing fraud alerts. The current scope of work divides coverage of the United States between two MEDICs.

Additional funding for the MEDIC program will be used to implement increased data analysis, trending, and benchmarking for both Part C & D and to focus on the fraud-fighting efforts of the plans. Specifically, the increase in funds is required to:

1. Develop innovative analysis tools and with data made available, begin analyzing Part C encounter data. In order to support internal program integrity efforts and law enforcement, the MEDIC will become familiar with the data, determine validity and accuracy of the fields, and initiate the development of trends analyses and benchmarking both nationally and geographically.

2. Increase the number of CMS conducted on-site fraud, waste, and abuse (FWA) audits of Part C and Part D contractors. The increase in number of audits will result in an increase in MEDIC technical assistance and MEDIC involvement in the implementation of corrective actions.

3. Enhance collaborative efforts with the Part C and Part D contractors. Part C contractors experience the same fraud activity as is seen in FFS Medicare (and in their commercial business). Beginning in 2008, Part C contractors were the targets of infusion therapy fraud and it has been noted that other fraud committed in Medicare Part B makes its way to Part C. To increase CMS' effectiveness at fighting fraud, waste, and abuse in Part C there is a need to increase our collaborative efforts through information-sharing, joint taskforces, and technical assistance to plans.

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

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

- *Medicare Advantage Operations Support - Plan Oversight* - This funding will support core contracts to aid in MA oversight. Part of the funding will target the annual review of plan benefit packages submitted by MA organizations to ensure

benefits are non-discriminatory with an emphasis on establishing stricter lines for discrimination. In addition, funding will target annual collection and analysis of information for the Marketplace Competition Provision.

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

- *Part C and D Audits (one-third)* - This activity involves the review of documentation used by MA organizations and PDPs sponsors to prepare their bids. Prompt audits of the bids will permit CMS to evaluate and refine CMS' bid review, thereby assuring accurate bidding and creating a clearer, more stable message to contractors. Section 1857 (d) (1) and 1860D-12 (b) (3) (C) of the Social Security Act requires the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MA organizations and PDPs offering plans. Over the past several years, the number of MA organizations and PDPs participating in the Medicare program has substantially increased. As a result, a larger number of audits have to be performed.

- *Health Plan Management System (HPMS) Audit Support* - HPMS is a web-enabled information system that supports the ongoing business operations of the MA and Part D programs. HPMS software modules collect data for and manage the following MA and Part D plan enrollment processes: application submission, formulary submission, bid and benefit package submissions, marketing material reviews, plan monitoring and oversight, complaints tracking, plan connectivity, financial reporting, financial and plan bid audits, plan surveys, operational data feeds for enrollment, payment, and premium withhold, and data support for the Medicare & You handbook and the www.medicare.gov website. Although a substantial amount of effort in this project relates to the Part C & D Contract/Plan Oversight category, it also relates to the Monitoring, Performance Assessment, and Surveillance, the Program Audit, and the Compliance/Enforcement categories.

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

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

Monitoring, Performance Assessment, and Surveillance: This category emphasizes the day-to-day use of plan-reported, CMS data and data received from outside sources to ensure accurate payment and compliance with program requirements. This category includes funding for Managed Care Payment Validation, Marketing Investigation and State Referral, Marketing Protocol for Prescription Drug Plan (PDP) and MA Plans, Encounter Data, Part D Reconciliation Support Contractor, Validation and Analysis of Part C and D Payments, Medicare Advantage Operations Support – Monitoring/Surveillance, Plan Finder Quality Assurance, Part C and D Error Rate, and Part C and D IT systems needed to support MIP Discretionary activities.

- *Managed Care Payment* Validation - This project focuses on processing retroactive requests for changes to enrollments and de-enrollments, demographic data, and special health status categories. This project supports CMS' program integrity effort by processing all retroactive payment adjustments and enrollment adjustments requests submitted by MAOs and PDPs, making reconsideration determinations with plans that are appealing decisions regarding payment adjustments, receiving and processing monthly certification forms (Attestations) from MAOs and PDPs, and completing monthly analysis of plan discrepancies.

- *Marketing Investigation and State Referral* - This project provides CMS with a mechanism to track agent/broker activities and marketplace surveillance services, HPMS CTM complaints, enrollment issues, and marketing misrepresentation. This project supplies data analysis on new and existing agent/broker licensing information from HPMS and the National Producer Registry (NIPR) and ultimately produces a report to assist in the tracking and oversight of monitoring agent/broker activities.

- *Marketing Protocol for PDP and MA Plans* - CMS must establish, investigate and enforce limitations on marketing activities for PDP and MA plans. This requires funding to develop new, or revise existing, audit protocols and testing tools, and to increase capacity in the Integrated Data Repository (IDR) to accommodate agent broker compensation and training data. CMS will expand its increasingly sophisticated and successful marketing oversight strategy – such as secret shopping marketing events and using a clipping service to survey non-compliant advertisements. Secret shopping activities will be expanded to in-home settings (where complaint data suggests the incidence of deceptive and pressure marketing has increased). CMS will develop tailored secret shopping scenarios from which we can determine if low-income, limited cognition and other particularly vulnerable

beneficiaries are being targeted through deceptive marketing. Further, CMS plans to retain a first-time contractor with an investigative skill to triage marketing misrepresentation complaints so that this important data source can be more effectively used to identify Part C and Part D plans with poor internal controls of their marketing channels. In addition, these contactors can work more effectively with State regulators who hold the licenses of the insurance agents linked to deceptive or high pressure marketing. CMS will develop training and testing modules for brokers and agents and will retain a contractor to develop content and structure.

- *Encounter Data* - The Encounter Data project will enhance payment accuracy by giving CMS the capacity to measure and price utilization for all MA enrollees for the purposes of accurately paying MA plans through risk adjustment, evaluating coverage, and comparing service utilization and quality. This initiative requires the collection, editing, storage, and pricing of new data for more than 11 million MA beneficiaries. FY 2009 funds enabled the commencement of the risk adjustment "encounter" data collection. Encounter data will provide information on what MA services are being provided, including whether they are medically necessary and appropriate. The ability to fully collect encounter data will be complete by 2012, but the project will be ongoing as a way to ensure more accurate payment to MA plans.

- *Part D Reconciliation Support Contractor* - This project consists of analyzing the results of the Part D reconciliation calculations to understand plan impacts and to support decision-making about potential major adjustments to Part D payments. It also involves receiving, tracking, and analyzing any issues raised by plans with respect to reconciliation after it's complete, including appeals.

- *Validation and Analysis of Part C and D Payments* - This project consists of validating and analyzing monthly Part C and D payments to ensure that the proposed payment amounts are accurate prior to authorization. This process involves in-depth analyses of payment data and the recalculation of payments for approximately 27 million beneficiaries outside of the MARx payment system. The accuracy of beneficiary and plan-level data is also evaluated. This involves running complex mainframe programs to generate beneficiary level payment calculations in short turnaround timeframes and troubleshooting when potential discrepancies/errors are identified.

- *Medicare Advantage Operations Support – Monitoring/Surveillance* - This funding will support core contracts to aid in MA oversight. Activities include the redesign and standardization of additional plan materials to ensure that beneficiaries understand the communication they are receiving from plans and continue and expand surveillance of MA and Part D sales agents/brokers and plan marketing.

- *Plan Finder Quality Assurance (QA)* - The Medicare Prescription Drug Plan Finder (MPDPF) is a web tool that is available to beneficiaries and other stakeholders that allows beneficiaries to make informed choices about Part D plans by comparing the plans' benefit package (PBP), formulary, pharmacy, and pricing data. Part D sponsors submit these data to CMS and its contractors. In addition, the web tool also provides performance ratings which can be used by beneficiaries to evaluate operational and quality performance of plans available in their service area. The project will continue to assist CMS in analyzing and assessing PBP, formulary, pharmacy, and pricing data files as part of the overall monitoring strategy of Part D

to ensure that accurate data are posted on to the MPDPF tool. In addition to the QA of MPDPF data files submitted by Part D sponsors, this contract will be responsible for performing drug basket, negotiated retail price, and longitudinal analyses as well as the comparison of MPDPF pricing and any additional ad hoc request related to these data. All of these tasks are essential in the monitoring and oversight of these data that are displayed to the public.

- *Part C and D Error Rate* - This project estimates payment error for Part C and Part D at the national level. Payment error is first estimated for the component parts of each program. As a second step, the component error estimates are aggregated to create a composite payment error rate for each program. A significant cornerstone of this work is payment error associated with risk adjustment.

- *Part C and D IT systems* - This funding will support the increased capacity, storage, access, database modifications, and security needed in CMS' Part C and D IT systems as a result of the additional data collection and analysis needed to administer MIP discretionary activities.

Program Audit: This category's function is to review and assess previously supplied documentation to ensure compliance with program requirements. This category includes funding for Accrediting Organization Validation Studies for Medicare Advantage, Part C and D Audit Support, Risk Adjustment Data Validation, and Retiree Drug System (RDS) Compliance, Audit, and Payment Error Reduction Activities.

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

- *Part C and D Audit Support* - This funding will provide clinical and technical audit support to assist CMS in conducting MA and Part D program audits. The clinical support portion of the project will require clinical experts to conduct program audits. Such audits will include but not limited to all PACE organizations (as required by statute), SNP audits and appeals and grievances audits. In addition, technical audit assistance will be utilized for program audits.

- *Risk Adjustment Data Validation* - This activity is focused on ensuring the accuracy of annual Part C risk adjusted payments. Diagnostic data submitted by plans is validated to check for incorrect reporting of diagnoses which can lead to overpayments and underpayments. This payment validation process involves conducting approximately 60,000 medical record reviews, continuing a documentation dispute process, estimating national and plan level payment errors, conducting payment adjustments, and implementing an appeals process.

- *Retiree Drug Subsidy (RDS) Compliance, Audit, and Payment Error Reduction Activities* - The regulations require that RDS plans be actuarially equivalent to Part D plans. Therefore, RDS plan sponsors must attest that their plans are actuarially equivalent to a Part D plan. CMS is auditing plan sponsors to ensure that RDS plans are in fact actuarially equivalent. CMS will also audit payment requests and may audit other factors to ensure appropriate payment.

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

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

- *Compliance/Enforcement Support* - This funding will provide compliance and enforcement audit support to assist CMS in conducting MA and Part D program audits. This project requires technical experts to conduct compliance program effectiveness audits for approximately 290 parent organizations and to conduct agent/broker compensation audits on approximately 110 sponsors who use agents. In addition, funding will be utilized toward experts who will ensure a sponsor's readiness (other than systems) to participate in the MA and Part D programs. Compliance plan effectiveness audits need to be conducted on all plan sponsors' compliance programs. These audits ensure that plan sponsors have effective compliance programs, including effective compliance monitoring and internal controls, which are key components to ensuring effective oversight with CMS requirements.

II. Establishing Additional Regional Call Centers and Focused Beneficiary Outreach ($12.3 million):

Fraud and Abuse Customer Service Initiative: This project will fund a regional fraud hotline in South Florida. Trained, bi-lingual staff will field and route calls, as well as acknowledge receipt of complaints in writing. FY 2012 funds will enable CMS to address other high fraud areas, if needed, as well as continue existing beneficiary outreach efforts.

Field Offices/Rapid Response Staffing: CMS currently has three field offices in high vulnerability areas of the country (New York City, Los Angeles, and Miami). In addition to establishing an on-the-ground presence in those areas, the benefit of PI field offices has been significant due to their ability to have "feet on the street" and get out in the areas which are most impacted by fraud and abuse. Staff in these offices conducts in-person interviews with beneficiaries and providers to verify whether or not services have been rendered and if those services met Medicare coverage guidelines. They also work with law enforcement to help increase prosecutions and provide direct support to Strike Force efforts. Federal government staff can be deployed more rapidly and often more efficiently than contractor staff. As CMS employees, they can travel "on demand" without issuing contract modifications and without the high overhead costs associated with contractor activities

III. Increasing Funding for Program Integrity Demonstrations/Special Initiatives ($27.4 million):

DME Initiative: The DME Stop Gap Plan in 7 High Risk States (CA, FL, IL, MI, NC, NY & TX), was initiated in 2009 and will carry over into FY 2011 and 2012. CMS and its contractors will (1) identify and interview, or conduct site visits to the: (a) highest paid/highest risk DMEPOS suppliers; (b) highest ordering physicians; and (c) highest utilizing beneficiaries; and (2) identify and scrutinize the highest billed/highest risk DMEPOS equipment and supplies. The DME Stop Gap initiative continues to produce strong results that include initiation of auto denial edits and other administrative actions (suspension, revocation, deactivation, prepay review) as appropriate, revised/improved LCDs, and regulatory and policy recommendations to better protect the Trust Fund. Stop Gap has proven itself to be extraordinarily effective by both introducing a powerful sentinel effect within these States and through the implementation of corrective actions to stop the fraud identified through the project.

Predictive Modeling Prepayment/Provider Enrollment: CPI is using advanced statistical methodologies and multiple data sources to develop models to identify high-risk providers. The purpose of the pilots is to develop models that will allow CMS to prevent payments for claims that are high-risk of being improper AND are unlikely to produce false positives. This effort supports the strategic objectives of transitioning to prevention (rather than relying only on "pay and chase") and targeting interventions based on risk. This effort supports the long term vision of a national prevention program (as introduced during CPI's Industry Day). The techniques to be used to refine scoring methodologies will include outlier analysis, behavioral analysis, neutral networks, linkage analysis, predictive modeling, and other advanced analytic methods. Traditional data sources (e.g. claims and enrollment) and new data sources (e.g. complaints and compromised numbers) will be linked together at a national level to provide more robust and precise scoring. CMS is enhancing its capabilities to prevent fraudulent providers from being enrolled in Medicare, Medicaid and CHIP. CMS needs to assure the accuracy and completeness of the enrollment records and systems information, and to enhance ongoing analytic capacity to enable identification of patterns of provider behavior that appear suspect. Our funding request will support enhancements to PECOS as well to improve its analytic capabilities to meet these new challenges.

1-800 Next Generation Desktop: CMS is working to make available other data analytic tools at its disposal to improve access to near real-time data and comprehensive beneficiary Medicare records for both CMS and law enforcement, most especially providing access to the Next Generation Desktop (NGD). Analysis suggests that more frequent data

would allow us to detect fraud early in its tracks and prevent improper payments from being made. We intend to explore opportunities for using NGD as an investigative and identification tool. If this endeavor proves fruitful, CMS will utilize findings and issues from 1-800 Medicare calls and incorporate them into our workloads as potential leads.

Case Management System: CPI will test ways to case manage the leads that are received by the Zone Program Integrity Contractors from multiple sources, including complaints, tips, and data analysis. This effort supports targeting interventions based on risk (by prioritizing leads) and measuring outcomes (through national tracking). This effort supports the long term vision of a national prevention program (as introduced during CPI's Industry Day). The projects will test ways to 1) provide a feedback loop to refine predictive models based on results, 2) measure outcomes, 3) provide CMS a method for quickly refining priorities, 4) provide systematic national tracking, and 5) increase efficiency.

Medicare Summary Notice (MSN) Improvements: In FY 2010 CPI redesigned the MSN to make it easier to read by the beneficiaries. This would enable the beneficiary to focus attention on checking the MSN and contacting Medicare with concerns. This effort supports the strategic objective of detecting fraud (by engaging beneficiaries to review the MSNs and communicate concerns early to CMS). The Florida model increased the frequency of MSNs in a high-fraud area. CMS will continue to strategize ways in which further improvements can be made to the MSN.

IV. Capacity to Identify and Prevent Excessive Payments in Fee-For-Service (FFS) Medicare ($31.9 million):

Automated Fraud Edits: This would provide additional funding for medical directors at the Medicare Administrative Contractors (MACs) to develop and implement benefit integrity automated controls (prepay edits) based on data analysis and clinical expertise. Many of these edits are identified through CMS' fraud and abuse field offices and ZPICs, and are implemented quickly to target a specific fraud scheme or area of growing concern. The appropriate implementation of the edit requires coordination with other CMS claims processes. We expect HEAT and the widespread growth of fraud schemes migrating outside of high fraud zones will increase the need for more localized edits.

Edit Validation Module: Medicare claims are subjected to numerous types of edits such as coding, pricing, eligibility, coordination of benefits, medically-unlikely edits, anti-fraud edits, local coverage decisions, etc. Currently, claims editing is not performed within a single information system, but rather with a combination of different editing functions from different systems. The major systems that edit claims transactions are the Medicare claims processing systems—FISS for Part A claims, MCS for Part B claims, and VMS for DME claims; the Common Working File, and the HIGLAS.

There is no systematic process for ensuring that all edits are maintained, updated or managed across these multiple systems. The ideal state would be a single edit module which would apply edits uniformly throughout the country, including geographic edits where local healthcare practices vary based on local coverage decisions.

A single edit module would provide CMS with many advantages both operationally and with our ability to detect and prevent improper payments from occurring. Operationally, a single edit module would allow for changes to be made once, rather than changing multiple

systems multiple times. Also, contractors would not be able to change or turn off uniform edits if a single edit module exists. Currently, contractors can suppress edits under certain circumstances in order to process claims timely. The ideal single edit module would be designed as a management information system for CMS to not only prevent improper payments but to also measure their effectiveness. The module would produce reports that clearly indicate which edits are in place and working, including the total number and dollar savings for each edit based on the claims denied. An edit module would also contain a test feature to simulate what would happen if CMS installed an edit as part of a standard procedure, this simulation would allow CMS to test the edit before installing the edit with live claims. Edits produce a wealth of management information that can inform CMS about provider behavior and information about what is happening with individual edits. These reports and their information would allow CMS to know which providers are hitting the edit so that provider education or possible fraud investigations could be better targeted.
In FY 2012, CMS will begin developing a system based on business requirements and systems design alternatives analysis completed in FY 2011. Our goal is to complete all programming by the end of the fiscal year and to begin testing a pilot model on one or more CMS shared maintainer systems, or within a specific geographic area. We intend to migrate most of the localized fraud edits used today into this module by the close of the year, and provide new edits to be tested based on data uncovered through HEAT and a variety of demonstration projects that will be conducted in FY 2011. Full implementation of the system will most likely occur in FY 2013.

Executive Order -- Do Not Pay: On June 18, 2010, the President issued a Executive Order directing that a Do Not Pay List be established, a single source through which all agencies can check the status of a potential contractor or individual. The Do Not Pay List will allow CMS to access essential information they need to determine, for example, if an individual is alive or dead or if a contractor had been debarred in a timelier and cost effective manner. As a result, this will help reduce improper payments and save taxpayer dollars.

CMS started sharing information in FY 2010 about providers who have been terminated from the Medicare program to State Medicaid agencies within 30 days of provider termination. By providing this information, CMS has enabled States to work through any issues involved in removing terminated Medicaid providers before they were required to do so on January 1, 2011, per the Affordable Care Act.

The funding request will help us continue work started in FY 2010, and handle any new activities that may arise.

Medical Review & Provider Enrollment Consolidation: Combining medical review activities into fewer Medicare Administrative Contractors (MACs), as well as centralizing and streamlining provider enrollment activities will ensure more automation, consistency, efficiency, and reduction in duplication of effort, creating savings for the Medicare program.

No medical review operations were consolidated in FY 2010. We are working with the Center for Medicare to develop an implementation plan, but anticipate that actual consolidations will occur on an iterative basis -- specifically when we have legacy FFS contractors transitioning to MAC contracts. This could take several years to complete. All medical review activities will be considered for consolidation.

The provider enrollment consolidation also builds on existing A/B MAC awards and allows Medicare to compete provider enrollment activities as a specialty MAC contract. Under this

approach, CMS proposes to reduce the number of Part A and Part B enrollment contractors. CMS is working to automate some of the manual processes that are currently required in processing provider and supplier enrollment applications. Our goal is to simplify the enrollment process and reduce the time it takes to process enrollment applications by automating as much of that process as possible. This should further reduce the overall cost of enrolling providers and suppliers in the Medicare program. Our funding request in FY 2012 will allow us to continue consolidation efforts begun in FY 2011.

V. Enhanced Provider Oversight Efforts ($42.4 million):

Revalidation of Providers/Suppliers/Site Visits: Funding is needed to perform onsite verifications of providers before enrollments are issued and to conduct background checks. Funding is also needed to perform more frequent surveys of home health providers. CMS also needs to revalidate approximately 50,000 providers/suppliers that are due to update their Medicare enrollment information.

Overpayment/Payment Suspension: On November 19, 2008, the CMS published a final rule with comment titled, “Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Final Rule" in the Federal Register. In part, this regulation permits CMS or its designated contractor to deny additional Medicare billing privileges to a physician or non-physician practitioner who has an existing overpayment or is currently under payment suspension.

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

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

DMEPOS Validation Contractor: In addition, CMS plans to expand DME supplier onsite reviews on both a pre- and post-enrollment basis to help increase DME supplier compliance with current enrollment standards. A contractor will also assist CMS in performing validation and onsite surveys for the ten DMEPOS accreditation organizations that are tasked with accrediting DMEPOS suppliers as a requirement for being enrolled in Medicare.

Compromised Numbers Database: In FY 2012, CMS will have completed a centralized database for compromised beneficiary numbers. As of January 2011, this data set has already helped CMS to identify 326 false front providers and Part B savings of $133 million. The Compromised Numbers Database will require $6 million annually to maintain.

Prevention / Detection: CMS will use this additional program integrity funding to refine and expand access to the One-PI database, implement necessary changes to reduce improper payments, maintain existing program integrity staffing levels, and increase staffing to track billing patterns to identify fraudulent schemes and vulnerabilities in the health care system, increase Medicare Parts C and D oversight. These activities are an important investment to protect Trust Fund dollars, taxpayers, and beneficiaries.

Access by the One PI tools to additional data sources such as the Compromised Numbers database, enrollment data and other sources will also be added requiring extensive development of reports views and tool access modifications.

One PI will require ongoing Operations and Maintenance investment. Investment in the development of algorithms, reports, views, and access to relevant data with the One PI portal will continue as technology, tools, methodologies, models and data required for analysis evolves.

VI. Error Rate Measurement ($59.3 million):

Payment Error Rate Measurement (PERM) in Medicaid and CHIP: In FY 2006, CMS implemented the national PERM program in order to comply with the Improper Payments Information Act of 2002 (IPIA). The IPIA was later amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) in order to strengthen improper payment programs and reduce improper payment amounts by $50 million by 2012. CMS uses Federal contractors to measure Medicaid and CHIP error rates in a subset of States every year. PERM enables States to identify the causes of improper payments in their claims payment systems and eligibility processes, and to address them with the appropriate corrective actions. CMS created a 17-State rotation cycle so that each State will participate in PERM once every 3 years.

The PERM final rule (75 FR 48816) was published on August 11, 2010 and was effective September 10, 2010. This final rule implements provisions from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 with regard to the PERM program. Section 601 of CHIPRA prohibits HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is effective. HHS will begin CHIP error rate measurement in 2011 with the results being published in November 2012.

The PERM program will also be conducting the following activities:

- Funding a system test & evaluation (ST&E) review on each of the PERM contractors' systems. In addition, providing contractors with additional funding to meet the information technology security requirements.
- Conducting provider education and outreach to educate providers on medical documentation requirements in order to decrease documentation errors. Creating and disseminating educational materials to be distributed to states and providers in order to decrease error rates.
- Complying with the additional reporting requirements of the Executive Order on Improper Payments.

CMS is perpetually researching, developing and implementing corrective actions to identify improper payments, prevent improper payments, improve the accuracy of the measurement process and generally help mitigate PERM program vulnerabilities.

The CMS PERM team consists of approximately 10 FTEs. In additional to normal FTE costs including training and supplies, CMS conducts annual site visits to the 17 States involved in the current cycle measurement for the PERM program. During the site visits, CMS educates the States regarding PERM requirements and identifies any State-specific

issues that may hinder an accurate error rate measurement. This proactive measure will help CMS achieve a more accurate error rate for the Medicaid and CHIP programs.

Presidential Initiative – Reducing Improper Payments: On November 20, 2009, the President issued an executive order laying out a strategy to reduce improper payments through boosting transparency, holding agencies accountable, and creating strong incentives for compliance. Specifically, the executive order required the identification of high-priority programs, the selection of accountable officials to coordinate agency program integrity efforts, the development of supplemental measures of payment error for high-priority programs, a public website to track progress in reducing improper payments (PaymentAccuracy.gov), and the pursuit of tough penalties on contractors for failing to timely disclose credible evidence of significant overpayments received on government contracts.

On March 10, 2010, the President signed a presidential memorandum directing all federal departments and agencies to expand and intensify their use of payment recapture audits. These are audits which offer specialized private auditors financial incentives to root out improper payments, and have been demonstrated through pilot programs to be highly effective. It is anticipated that using the payment recapture audits will return at least $2 billion over the next three years to American taxpayers, and more than that with new authorities to use these audits made available in the Improper Payment Elimination and Recovery Act.

On June 8, 2010, the President announced that the Administration would cut the improper payment rate in the Medicare Fee for Service program in half by 2012.

There are several, new activities currently underway to meet this goal including:

- Supplemental error rate measurements for power wheel chairs, pressure reducing support surfaces, short hospital stays, and chiropractic services within the Medicare FFS program. CMS will report its findings for the supplemental measures in March and September 2011, and then quarterly thereafter.
- Supplemental measures in high risk areas of the Medicaid program. The initial focus will be pharmacy-based (over prescribing providers) and the intervention will include provider education tailored to mitigate the identified vulnerabilities in each State. This program launched in October.
- Reporting information about improper payment measurement programs such as CERT (Medicare) and PERM (Medicaid) on the Department of Treasury's website. CMS submitted information about the improper payment for the Treasury website in May. The public website was launched on June 29 and is available at www.PaymentAccuracy.gov. CMS is on target to issue quarterly reports.
- Developing and executing corrective actions to reduce future improper payments. In February, States submitted to CMS corrective action plans addressing how they will decrease Medicaid payment errors in their State. In March, Medicare contractors submitted Medicare FFS error rate reduction plans addressing how they will decrease Medicare FFS errors in their jurisdictions.
- CMS will continue national education calls to educate Medicare and Medicaid providers on CERT and PERM and their responsibilities.
- Published PERM regulation on August 11, 2010. This regulation allows CMS to begin issuing an error rate for the CHIP program in FY 2012.

The proposed funding request will allow the above activities to continue into 2012. In addition, we will use new funding to continue or initiate the following corrective actions:

- Increase the number of claims subjected to prepayment review;
- Issuing a quarterly Medicare Provider Compliance Newsletter to physicians, providers and suppliers to educate them on common errors found in the Medicare program.
- Developing Comparative Billing Reports (CBRs) to help Medicare non-hospital providers analyze administrative claims data. CBRs compare a provider's billing pattern for various procedures or services to their peers on a state and national level. CMS also utilizes the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows Medicare inpatient hospital providers to also analyze their billing patterns through a comparison to other providers in their State and in the nation.
- Conducting a competition to procure private sector edits to implement within the Medicare program. As part of this effort CMS will evaluate the accuracy of commercial products and determine whether these products are feasible in the Medicare FFS environment and whether they can reduce improper payments in the Medicare FFS program.
- Procuring predictive modeling for use in medical review.
- Implementing enhanced medical review policies including a Face to Face requirement for DME in accordance with Section 6407 of the Affordable Care Act.
- Implementing the Electronic Submission of Medical Documentation (esMD) to create greater program efficiencies, allow a quicker response time to documentation requests, and provide better communication between the provider, the Medicare contractors, and CMS.
- Approving additional areas for Medicare FFS Recovery Auditors to review including inpatient hospital stays and DME.
- Increasing medical record request limits for Recovery Auditors.
- Exploring avenues to allow for proper accounting of errors due to inappropriate place of service.

These activities do not encompass the entire scope of work that CMS is conducting now to reduce improper payments. In fact, several other areas of funding have some level of effect in reducing improper payments. Some specific examples include: medical review, audit, Medicare secondary payer, benefits integrity, error rate measurement and MEDI-MEDI. These activities will continue and newer initiatives will be started based on lessons learned in future years.

VII. New Activities Integral to HEAT Goals ($50.7 million):

HEAT Support / Strike Force: The first Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse among Durable Medical Equipment (DME) suppliers and Human Immunodeficiency Virus (HIV) infusion therapy providers in South Florida. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of these efforts, DOJ and HHS expanded the Strike Force model to include teams of investigators and prosecutors in a total of seven cities – Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston,

Texas; Brooklyn, New York; Baton Rouge, Louisiana; and Tampa, Florida. The Departments will continue to expand Strike Forces to cities where Medicare claims data reveal aberrant billing patterns and intelligence data analysis suggest that fraud may be occurring. HEAT's goal is to expand from seven to up to twenty cities.

Each Medicare Strike Force combines data analysis capabilities of CMS and the investigative resources of the FBI and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the USAOs. Strike Force accomplishments from cases prosecuted in all seven cities during FY 2010 include[1]:

- 140 indictments involving charges filed against 284 defendants who collectively billed the Medicare program more than $590 million;

- 217 guilty pleas negotiated and 19 jury trials litigated, winning guilty verdicts against 23 defendants;

- Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration; and

In the three and a half years since its inception, Strike Force prosecutors filed 465 cases charging 829 defendants who collectively billed the Medicare program more than $1.9 billion; 481 defendants pleaded guilty and 48 others were convicted in jury trials; and 358 defendants were sentenced to imprisonment for an average term of nearly 44 months.[2]

CMS has been able to utilize existing staff to date to assist the OIG and DOJ. However, as Strike Forces expand to additional cities, more funding will be needed to continue this effort.

Enhanced Medicaid Audits: This funding will fund additional Medicaid audits to improve oversight and recoveries. This is an important investment not only for both the Federal government and the States, but will become even more necessary as the number of Medicaid beneficiaries increases.

CMS will rely more heavily on data in its PI efforts and will provide States with evidence-based tools that they can use to combat fraud, waste and abuse in Medicaid.

CMS will also increase its focus on Medicaid audits involving cross-border, regional and national issues. In addition, its increased collaboration between the Medicaid and Medicare programs to address common areas of concern across both programs will greatly enhance its PI efforts.

[1] The accomplishments figures presented in the bullets include all reported Strike Force cases handled by DOJ Criminal Division attorneys and Assistant United States Attorneys in the respective U.S. Attorneys' Offices during FY 2010. During previous fiscal years, the U.S. Attorneys' Offices in the Southern District of Florida and Central District of California implemented the Strike Force model for criminal health care fraud prosecutions. However, Strike Force prosecution statistics from previous years did not include all Strike Force cases because more complete reporting procedures were not in place at that time.

[2] These statistics are for the period of May 7, 2007 through September 30, 2010.

Heat Maps -- CPI will create visual representations of fraud complaint volumes through "heat maps" to inform investigators on targeting priorities and identifying "hot spots." This effort supports the strategic objective of targeting interventions based on risk. CPI will test the value of producing these reports and sharing them with contractors. As calls come into 1-800-MEDICARE, data will be geographically displayed, which will allow CMS to quickly see shifts in fraud calls over time and to drill down by various parameters such as claim type, geographic location, and fraud type, and to listen to the actual call if necessary. CMS is also exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE. These updated processes will help CMS to more quickly and efficiently examine and address waste, fraud, and abuse issues.

Administrative Law Judges (ALJ) Expansion Participation: As CMS increases its fraud fighting efforts through more investigations, claim reviews, and pre-payment editing, we can expect to receive comparable increases in the number of appeals. There will be a need to expand the participation of Administrative Law Judges to accommodate the expected increase.

Appeals & Provider Inquiries: As CMS increases its fraud fighting efforts through more investigations, claim reviews, and pre-payment editing, we can expect to receive comparable increases in the number of provider appeals & inquiries as well. Workloads are estimated to potentially increase 7-10% as a result of the increased focus on eliminating improper payments.

Parts B, D, & Medi-Medi IDR: In FY 2012, funding is being requested to integrate data from Medicare Part A, B, and D into the data repository. In addition, it is anticipated that Medicaid data will be added, as well, to support the Medi-Medi analysis.

PREDICTIVE MODELING

Program Description and Accomplishments

The Small Business Jobs Act of 2010, which provides $100 million available until expended, includes an anti-fraud provision requiring that CMS implement new software with "predictive modeling," a type of analytical technology that already has been adopted in the credit card industry to identify potentially fraudulent bills. The provision requires CMS to launch a competitive bidding process by January 2011 for predictive modeling software contractors and to begin implementing the technology by July in the ten states with the highest Medicare fraud rates.

Predictive modeling can work in the Medicare FFS program; however, it will take time to implement this type of tool successfully. The term predictive modeling refers to a system that uses information such as claims, demographic information, and public databases, etc. to produce models that predict behavior.

Some of the models will be simple. An example would be comparing the location where a beneficiary receives services to where the beneficiary resides. For example, it would not be a suspicious pattern when a beneficiary lives in San Diego and receives services in Los Angeles. However, if predictive modeling were able to identify a specific provider who has a

statistically significant number of patients that fell within this pattern, this could indicate a problem that called for investigation.

These types of models use data (e.g., paid and denied claims) to predict which claims and providers look suspicious based on the patterns seen within the data. Successful implementation of a predictive modeling tool will depend on several critical activities, such as:

• Data formatting – ensuring that data elements are commonly defined across systems
• Data integrity – validating that the data is correct and up to date
• Training – ensuring that staff are trained on the predictive modeling tools
• Resources – providing adequate resources to fully monitor and investigate potential abuses identified by the tools.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. The FBI leverages its resources in both the private and public arenas through investigative partnerships with various Federal, State and local agencies.

FBI Budget Overview

The FY 2012 budget includes mandatory funding in the amount of $129.9 million, an increase of $1.5 million above the FY 2011 current law. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year CPI-U Annual Averages and Percent Change.

OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

OIG uses HCFAC funding, to conduct audits, investigations, evaluations, and inspections of the Medicare and Medicaid programs; recommend corrective actions for vulnerabilities identified during these inquiries; refer suspected criminal action for prosecution; impose administrative sanctions such as exclusions from Federal health programs and civil monetary penalties; and provide guidance to the health care industry and HHS program participants. In FY 2010, OIG's CMS oversight funding, which includes HCFAC, supported participation in investigations or other inquiries that resulted in 552 criminal actions and 371 civil actions against individuals or entities that engaged in health-care-related offenses. These efforts resulted in $3.2 billion in HHS and $570.2 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

OIG Budget Request

OIG's FY 2012 HCFAC request for CMS oversight activities, including both mandatory and discretionary funds, is $290.9 million. The OIG estimate includes $193.4 million in mandatory funding and a request for a discretionary allocation adjustment of $97.6 million,

an increase of $67.8 million above the FY 2010 enacted level. This increase includes (1) $25.0 million for oversight of Medicaid and Medicare program activities previously funded through mandatory DRA appropriations and (2) $42.8 million in support of OIG's CMS-related program integrity efforts, including sustaining and expanding HEAT Strike Force efforts and addressing improper payment rates.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

United States Attorney's Offices (USAOs) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse litigation. The USAOs 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

DOJ's FY 2012 HCFAC request for CMS oversight activities, including both mandatory and discretionary funds, is $153.5 million. The DOJ estimate includes $60.4 million in mandatory funding and a request for a discretionary allocation adjustment of $93.1 million, an increase of $63.3 million above the FY 2010 enacted level. The mandatory increase reflects an estimated inflationary adjustment based on OMB's Fiscal Year CPI-U Annual Averages and Percent Change. This funding will support DOJ's role in HEAT activities and resources for additional EOUSA and Civil Division civil case work, including pharmaceutical fraud cases.

HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING PROJECTS

Program Description and Accomplishments

In addition to MIP, CMS also will use resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2011, negotiated allocations were $33.9 million for distribution among HHS components and $55.3 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding in FY 2012.

The HHS portion of the wedge, $33.9 million, funded the following activities in FY 2011:

CMS Medicaid Financial FTE ($13.6M): These Funding Specialists work in the field to review proposed Medicaid State plan reimbursement amendments, develop financial management reviews, research state Medicaid financing policy and practices, and promote proper State Medicaid financing methods prior to implementation. An estimated $204 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with states to promote proper state Medicaid financing.

Office of the General Council (OGC) ($8.9M): OGC primarily uses HCFAC funds in support of litigation activities that assist in the recovery of program funds. OGC also works to prevent the wrongful disbursement of program funds by providing assistance in regard to

the False Claims Act, Medicare Secondary Payer recoveries, the defense of CMS' suspension of payments, and more.

Grants for Senior Medicare Patrol (SMP) Programs ($4.5M): SMP programs recruit retired professionals to educate and assist Medicare beneficiaries to detect and report health care fraud, error, and abuse in the Medicare and Medicaid programs. Suspect complaints reported to SMPs are referred to law enforcement for further investigation. Since the program's inception, SMPs have educated over 3.84 million beneficiaries in group or one-on-one counseling sessions and have reached almost 24 million people through community education outreach events.

Administration on Aging (AoA) SMP Support ($3.3M): This funding supports infrastructure, technical assistance, and the other SMP program support and capacity-building activities designed to enhance the effectiveness of State-wide SMP programs.

Food and Drug Administration (FDA) Pharmaceutical Fraud Pilot Program (PFPP) ($3.4M): This pilot program began in the second half of FY 2010 and is designed to detect, prosecute, and prevent pharmaceutical fraud. Pharmaceutical fraud settlements typically begin as lawsuits through the help of whistle-blowers; this funding continues the PFPP, which takes a more proactive approach. Through the PFPP, FDA has opened, within a relatively short time, criminal investigations that FDA continues to investigate, including off-label promotion, manufacturing fraud, and falsified data matters.

Assistant Secretary for Planning and Evaluation (ASPE) Fraud Baseline ($1.0M): ASPE is working with CMS to develop a methodology to estimate the total amount of fraudulent payments in the Medicare program, using the same framework that is used to calculate improper payments.

Assistant Secretary for Public Affairs (ASPA) Media Campaign ($3.2M): In FY 2010, in response to feedback from the National Fraud Summit, ASPA was given funds to develop a media campaign and outreach events focused on preventing health care fraud. This FY 2011 funding continues these activities.

HHS Wedge Budget Request

The FY 2012 request includes mandatory funding of $37.0 million for HHS, 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.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
MIP 1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	FY 2010: 10.5% (Target Not Met)	8.5%	6.2%	-2.3
MIP 5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program (Developmental)	FY 2010: 14.1% (Target exceeded)	13.7%	13.2%	-0.5
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program (Developmental)	FY 2010: Additional component measure reported. (Goal met)	Report composite error rate for the Part D program	Report composite error rate for the Part D program that is lower than the 2011 rate	N/A
MIP7: HEAT Law Enforcement personnel training and access to Near Real Time CMS Systems Data * up to approximately 200 LE personnel annually	N/A	100% of the LE personnel referred for training/access*	100% of the LE personnel referred for training/access*	N/A
MIP8: Increase the percentage of Medicare enrollment site visits to "high-risk" providers and suppliers that result in administrative actions.	N/A	N/A	15%	+15
MCD 1.1: Estimate the Payment Error Rate in the Medicaid Program	FY 2009: Target met. 9.4% baseline rolling average error rate based on States measured in 2007 – 2009	Report rolling average error rate in the FY 2012 AFR based on States measured in 2010-2012. Meet or exceed target error rate of 7.4%.	Report rolling average error rate in the 2013 FY AFR based on States measured in 2011-2013. Meet or exceed target error rate of 6.4%.	N/A
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2010: Target met. Final Regulation published 8/11/2010.	Report national error rate in the FY 2012 AFR based on 17 CHIP States measured in FY 2011.	Report national error rate in the FY 2013 AFR based on 17 CHIP States measured in FY 2012.	N/A
Program Level Funding ($ in millions)	**N/A**	**$871,526**	**$851,230**	**- $20,296**

Project or Activity	FY 2012 Budget Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D	
Medicare Drug Integrity Contractors (MEDICs)	$20,900
Part C & D Contract/Plan Oversight	$29,648
Monitoring, Performance Assessment, and Surveillance	$52,318
Program Audit	$38,200
Compliance/Enforcement	$24,900
Total	**$165,966**
II. Regional Call Centers and Focused Beneficiary Outreach	
Fraud & Abuse Customer Service Initiative	$7,300
Field Offices/Rapid Response Staffing/Oversight (3 field offices and additional rapid response team)	$5,000
Total	**$12,300**
III. Increasing Funding for Program Integrity Demonstrations/Special Initiatives	
DME Initiative	$7,800
Predictive Modeling Pre-payment	$5,500
Predictive Modeling / Provider Enrollment Screening	$5,500
1-800 next generation desktop	$2,450
Case Management System	$5,000
MSN Improvements	$1,100
Total	**$27,350**
IV. Capacity to Identify and Prevent Excessive Payments in FFS Medicare	
Automated Fraud Edits	$3,400
Edit Validation Module (National)	$10,110
Executive Order - Do Not Pay List	$3,950
Medical Review and Provider Enrollment Consolidation	$14,445
Total	**$31,905**

Project or Activity	FY 2012 Budget Request
V. Enhanced Provider Oversight Efforts	
Revalidation of Providers/Suppliers/Site Visits	$8,900
Overpayment / Payment Suspension Screening	$5,000
DMEPOS Validation Contractor	$1,500
Compromised Numbers Database	$6,000
CMS: Prevention / Detection - OnePI data analysis & staffing	$21,000
Total	**$42,400**
VI. Error Rate Measurement	
Payment Error Rate Measurement (PERM) - ***MEDICAID***	*$33,000*
Executive Order - 50% reduction in error rate	$26,286
Total	**$59,286**
VII. New Activities Integral to HEAT Goals	
CMS: HEAT Support / Strike Force Team	$23,788
CMS: Enhanced Medicaid Audits - ***MEDICAID***	*$11,644*
Heat Maps	$300
ALJ Expansion Participation	$4,000
Appeals / Provider Inquiries	$2,000
Parts B, D, & Medi-Medi Integrated Data Repository	$9,000
Total	**$50,732**
VIII. HCFAC Summary	
Total Medicaid Integrity subtotal (non-add)	***$44,644***
Total Medicare Integrity subtotal (non-add)	**$345,295**
Total CMS Program Integrity	**$389,939**

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State Grants and Demonstrations

(Dollars in thousands)

	FY 2010 Appropriation	FY 2011 President's Budget	FY 2012 Budget Request	FY 2012 +/- FY 2011
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$45,763	$46,540	$0	-$46,540
Subtotal – TWWIIA	**$45,763**	**$46,540**	**$0**	**-$46,540**
Medicare Modernization Act (MMA)				
Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Rural Programs of All-Inclusive Care for the Elderly (PACE)	$0	$0	$0	$0
Drug Surveys & Reports	$5,000	$0	$0	$0
Expansion of State Long-Term Care (LTC) Partnership Program	$3,000	$3,000[1]	$3,000	$0
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Alternatives to Psychiatric Residential Treatment Facilities for Children	$53,000	$57,000	$0	-$57,000
Money Follows the Person (MFP) Demonstration	$398,900	$448,900	$448,900[2]	$0
MFP Research & Evaluations	$1,100	$1,100	$1,100[3]	$0
Medicaid Transformation Grants	$0	$0	$0	$0
Medicaid Integrity Program	$75,000	$76,275[4]	$77,190	$915
Subtotal – DRA	**$536,000**	**$586,275**	**$530,190**	**-$56,085**
Children's Health Insurance Program Reauthorization Act (CHIPRA)				
Grants to Improve Outreach and Enrollment	$40,000[5]	$0	$0	$0
Application of Prospective Payment System	$0	$0	$0	$0
Subtotal – CHIPRA	**$40,000**	**$0**	**$0**	**$0**
Affordable Care Act				
Medicaid Emergency Psychiatric Demonstration Project	$0	$75,000	$0	-$75,000
Incentives for Prevention of Chronic Diseases in Medicaid	$0	$100,000	$0	-$100,000
Subtotal – Affordable Care Act	**$0**	**$175,000**	**$0**	**-$175,000**
Appropriations/BA	**$621,763**	**$807,815**	**$530,190**	**-$277,625**

[1] P.L. 111-148 extended this funding through FY 2015 and added five years of new appropriations beginning FY 2011.
[2] P.L. 111-148 extended this funding through FY 2015 and added five years of new appropriations beginning FY 2012.
[3] P.L. 111-148 extended this funding through FY 2015 and added five years of new appropriations beginning FY 2012.
[4] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U.
[5] P.L. 111-148 added $40 million in new funds in FY 2010.

	FY 2010 Appropriation	FY 2011 President's Budget	FY 2012 Budget Request	FY 2012 +/- FY 2011
Proposed Legislation				
Wireless Innovation Fund	$0	$0	$20,000	+$20,000
Total Appropriation/BA, including Proposed Law	**$621,763**	**$807,815**	**$550,190**	**-$257,625**

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; Tax Relief and Health Care Act of 2006, Public Law 109-432; Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3; Affordable Care Act, Public Law 111-148 together with Public Law 111-152

Allocation Method - Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The grants assist in providing State-infrastructure support and services to targeted populations. Targeted populations include working individuals with disabilities, undocumented aliens, and other eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight to combat fraud, waste and abuse, improving the effectiveness and efficiency in providing Medicaid, expanding private long-term care insurance programs, establishing alternate non-emergency service providers, and modernizing Medicaid programs to be more sustainable while helping individuals achieve independence. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created two new programs: an outreach grant program to increase children's enrollment and retention in Medicaid and the Children's Health Insurance Program (CHIP), and transition grants for the application of the Medicaid prospective payment system for services provided by Federally-qualified health centers and rural health clinics. The Affordable Care Act established two new programs, the Medicaid Emergency Psychiatric Demonstration Project and Incentives for Prevention of Chronic Diseases in Medicaid, as well as extended existing programs.

Funding History

FY 2007	$698,049,000
FY 2008	$763,834,000
FY 2009	$632,763,000
FY 2010	$621,763,000
FY 2011	$807,815,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration programs, determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

Ticket to Work and Work Incentives Improvement Act Grant Programs

Program Description and Accomplishments

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA - P.L. 106-170) established two grant programs starting in FY 2001: the Medicaid Infrastructure Grants and the Demonstration to Maintain Independence & Employment (DMIE). By statute, funding for new grant awards for the DMIE program ended on September 30, 2009.

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants (MIG), section 203 of the TWWIIA, provides funding to States to build the infrastructure necessary to support working individuals with disabilities. These infrastructures include:

- Increased outreach on Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs on Medicaid and other work incentives.

A major goal of the program is to support the expansion of Medicaid coverage for workers with disabilities (also known as “Medicaid buy-in”). With this infrastructure funding, States make systemic changes to help individuals with disabilities gain employment and retain their health care coverage. These changes include, but are not limited to, creating Medicaid buy-in programs and enhancing State personal assistance service programs.

Through FY 2010, a total of 50 entities (49 States and the District of Columbia) have been approved for Medicaid Infrastructure Grants. By 2009, 37 States, who also received MIG funding, had created Medicaid buy-in programs for working adults with disabilities. As of December 2010, there were approximately 150,000 workers receiving Medicaid benefits under the buy-in options. A total of 32 States applied for and received 2010 MIG continuation grant awards. Ten States received new 2010 MIG competitive grant awards. FY 2011 marks the final year for this program.

Budget Overview

The Medicaid Infrastructure Grant Program (section 203) is authorized for 11 years beginning in fiscal year 2001 with an appropriation of $150,000,000 for the first 5 years. Beginning in FY 2006, the funding level is tied to the 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 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 authorizes and appropriates $46 million, $74.6 million has been granted to States (which

includes 28.6 million in carryover funding from previous years). In FY 2011 section 203 of TWWIIA authorizes and appropriates $47 million for 100 percent Federally-funded Medicaid Infrastructure Grants to States. There is no new appropriation for this activity beyond FY 2011.

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Estimated Grant Awards*
Alabama	$3,625,000	$500,000	$500,000	$500,000
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	$750,000
California	$10,099,274	$2,640,006	$4,028,900	$4,000,000
Colorado	$500,000	$0	$750,000	$750,000
Connecticut	$14,510,205	$4,631,665	$7,260,844	$5,000,000
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	$500,000
Illinois	$3,725,001	$500,000	$500,000	$500,000
Indiana	$2,450,000	$750,000	$1,443,000	$1,500,000
Iowa	$5,533,450	$744,000	$750,000	$750,000
Kansas	$4,815,277	$750,000	$959,627	$1,000,000
Kentucky	$500,000	$0	$0	$0
Louisiana	$3,600,000	$750,000	$1,700,000	$750,000
Maine	$4,702,003	$750,000	$870,000	$900,000
Maryland	$2,525,440	$600,000	$750,000	$750,000
Massachusetts	$14,236,084	$5,600,409	$6,353,521	$6,000,000
Michigan	$2,262,000	$750,000	$1,320,000	$1,500,000
Minnesota	$14,256,400	$5,434,648	$6,089,210	$6,500,000
Mississippi	$500,000	$0	$0	$0
Missouri	$3,125,000	$0	$0	$0
Montana	$1,000,000	$750,000	$750,000	$750,000
Nebraska	$4,175,000	NCE	$750,000	$750,000
Nevada	$4,175,000	$500,000	$750,000	$750,000
New Hampshire	$7,033,998	$1,480,863	$2,357,893	$2,000,000
New Jersey	$3,775,000	$500,000	$1,754,890	$2,000,000
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	$6,000,000
North Carolina	$2,349,339	$600,000	$600,000	$600,000
North Dakota	$359,177	$750,000	$750,000	$750,000
Ohio	$2,786,416	$500,000	$500,000	$500,000
Oklahoma	$1,045,053	$0	$0	$0
Oregon	$4,373,563	$750,000	$935,000	$1,000,000
Pennsylvania	$2,946,470	$5,327,141	$5,327,000	$1,000,000
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	$600,000
Texas	$1,500,000	$750,000	$750,000	$750,000
Utah	$4,225,000	$750,000	$750,000	$750,000

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Estimated Grant Awards*
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	$10,000,000
Wyoming	$2,050,000	$750,000	$750,000	$750,000
TOTAL	**$202,355,700**	**$64,501,104**	**$79,577,840**	**$70,100,000**

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Program Description and Accomplishments

Authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA), Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, provides funding to hospitals, physicians, and ambulance suppliers for their un-reimbursed costs of furnishing emergency health services to undocumented and certain other aliens. Payment of Section 1011 funds is limited to services required by section 1867 of the Social Security Act (Emergency Medical Treatment and Labor Act (EMTALA))[6] and related services. Section 1011 provided $250 million per year during each of Federal fiscal years 2005 through 2008.

As of November 2010, Section 1011 provides funding to a total of 2,282 hospitals, 53,037 physicians, and 534 ambulance providers. Since inception of the program in May 2005 through November 2010, Section 1011 has disbursed $833 million in provider payments, in response to 1,194,887 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.

[6] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals participating in Medicare to medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those having an emergency condition, regardless of an individual's method of payment or insurance status.

Budget Overview

Section 1011 of the MMA appropriated $250 million per year during each of FYs 2005 through 2008. Individual state allocations 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.

RURAL PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PROGRAMS AND FUNDING FOR PACE OUTLIERS

Program Description and Accomplishments

Section 5302 of the DRA established the Rural Programs of All-Inclusive Care for the Elderly (PACE) program in order to promote the development of the PACE provider program in rural service areas. The PACE is a capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

At the end of FY 2006, CMS awarded 15 organizations individual grants of $500,000 each to start and operate a PACE provider in a rural geographic area. Awardees have access to the grant award only after executing a signed three-way agreement between the PACE provider, the State, and CMS prior to September 30, 2008. By the end of FY 2008 CMS had executed signed PACE agreements with all of the organizations except for one of the organizations which withdrew from the grant program. The grant from the withdrawn awardee was redistributed among the remaining 14 awardees as supplemental awards. All the awardees are operational rural PACE providers having enrolled Medicare and Medicaid beneficiaries and providing services to these individuals. Hale Makua (Maui PACE), a rural PACE grantee in Hawaii, closed at the end of August 2010.

Due to enrollment challenges, Billings Clinic PACE, a rural PACE grantee in Montana, ceased operations at the Livingston location effective December 31, 2010.

This grant program also provides technical assistance, outreach, and education to State agencies and provider organizations interested in serving rural areas. Additionally, the grant provides cost outlier protection to awardees for recognized outlier costs equal to 80 percent of costs exceeding $50,000 for an eligible outlier participant with a $100,000 per participant payment limitation and a $500,000 PACE provider payment limitation for a 12-month period. Senior Community Care (SCC), a rural PACE grantee in Colorado, made two requests for cost outlier payments in 2010.

Budget Overview

Section 5302 of the DRA appropriated $7.5 million for FY 2006 for rural PACE site development grants. On September 28, 2006, CMS made rural PACE provider grant awards in the amount of $500,000 each to 15 awardees in 13 States. By the end of FY 2008 all but one PACE agreement was executed due to the withdrawal of one of the organizations. The funds from the withdrawn grant were distributed among the 14 organizations as supplemental awards. All appropriated funds are available for expenditure through FY 2008. Additionally, grant dollars may also be used to cover expenses as outlined in the DRA for delivering PACE program services in a rural area.

The Tax Relief and Health Care Act of 2006 (P.L. 109-432) established cost outlier protection funding for rural PACE pilot sites and appropriated $10 million in FY 2006 to be available for obligation through FY 2010. Congress intended that the outlier fund would provide additional monies to rural PACE pilot sites that incur more than $50,000 in recognized costs in a 12-month period for PACE program eligible individuals residing in the rural areas. Any services offered need to be provided under a contract between a pilot site and the provider. Each rural PACE cannot receive more than $500,000 in total outlier expenses in a 12-month period with costs incurred during its first three years of operation. There is no funding for this activity beyond FY 2010.

DRUG SURVEYS AND REPORTS

Program Description and Accomplishments

Section 6001(e) of the DRA provides that the Secretary may contract with a vendor to conduct a survey of retail prices for covered outpatient prescription drugs. The contract may include a provision to update the Secretary each time a therapeutically equivalent drug becomes available; the Secretary then has seven days to determine if the drug is eligible for inclusion on the federal upper limit[7] list. In addition, the provision provides that the Secretary shall provide information obtained on retail survey prices to States on at least a monthly basis.

Budget Overview

The DRA appropriated $5 million dollars for each of fiscal years 2006 through 2010 to carry out this requirement. CMS provides the overall leadership for the survey. This provision was delayed awaiting the publication of the average manufacturer price (AMP) information. However, an injunction by the District of Columbia District Court currently prevents the publication of AMP data. Because the States could not obtain the AMP data necessary to evaluate and reconsider their payment levels, the retail drug surveys and reports activities were temporarily suspended until the injunction was lifted. Section 2503(c) of the Affordable Care Act clarified the application of the Survey of Retail Prices required under the DRA. Due to this clarification and the December 2010 dismissal of the litigation that had led to the injunction, CMS is in the process of securing a contractor in order to conduct the Survey.

[7] Federal reimbursements to States for State spending for certain outpatient prescription drugs are subject to ceilings called Federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs.

No funding was appropriated under the Affordable Care Act and, as previously noted, budget authority under the DRA for this activity expires after FY 2010.

EXPANSION OF STATE LONG-TERM CARE (LTC) PARTNERSHIP PROGRAM

Program Description and Accomplishments

Section 6021 of the Deficit Reduction Act provides expansion authority for Long-Term Care (LTC) Partnership programs and the establishment of a National Clearinghouse for LTC Information. The DRA authorized and appropriated a total of $1 million for the period of fiscal years 2006 through 2010 for reporting on the Partnership for LTC and $3 million for each of fiscal years 2006 through 2010 for the establishment of a National Clearinghouse for Long-Term Care information.

The Partnership for LTC

This was enacted under section 6021 of the DRA and established authority for all States to implement LTC insurance plans that provide a dollar-for-dollar disregard, both for eligibility and estate recovery, of assets or resources equal to the amount of insurance benefits paid on behalf of the individual. This could help individuals prepare financially for future health care needs by allowing individuals to protect their assets while remaining eligible for Medicaid if their LTC needs exceed the period covered by their private insurance policy. Previously, only four States had programs under which resources could be disregarded in return for the purchase and use of an LTC insurance policy (California, Connecticut, Indiana, and New York). As of September 1, 2009, CMS has approved 31 Medicaid State plan amendments implementing the DRA provision related to the LTC partnership. The States that have opted to operate Partnership for LTC programs since the passage of Deficit Reduction Act of 2005 are:

Alabama	Louisiana	Nebraska	Oregon	Texas
Arizona	Kansas	Nevada	Pennsylvania	Virginia
Arkansas	Kentucky	New Hampshire	Rhode Island	Wisconsin
Colorado	Maine	New Jersey	South Carolina	Wyoming
Florida	Maryland	North Dakota	South Dakota	
Georgia	Minnesota	Ohio	Oregon	
Idaho	Missouri	Oklahoma	Tennessee	

The National Clearinghouse for LTC Information

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

- Educates consumers with respect to the availability and limitations of coverage for LTC under the Medicaid program;
- Provides contact information for obtaining State-specific information on LTC coverage, including eligibility and estate recovery requirements under State Medicaid programs;

- Provides objective information to assist consumers with the decision-making process for determining whether to purchase LTC insurance or to pursue other private market alternatives for purchasing long-term care;
- Provides contact information for additional objective resources on planning for LTC needs; and
- Maintains a list of States with State LTC insurance partnerships under the Medicaid program that provide reciprocal recognition of LTC insurance policies issued under such partnerships.

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

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

1. Direct mail supported by the State Governor in which a letter discussing the importance of LTC planning, signed by the Governor, is sent to every household with members between 45-65 years of age. The letter includes a tri-fold brochure which provides additional information about long-term care planning, and encourages each target household to order an "Own Your Future" Planning Kit for LTC. The Planning Kit is available at no cost to the consumer.
2. State-specific information about local planning resources and information on LTC services. This is incorporated into the Planning Kit for LTC. HHS covers the cost of producing and collating these materials.
3. A Governor's press conference to launch the campaign. The press conference is held concurrently with the mailing of the Governor's letter. The purpose of the press conference is to generate local media interest in the Campaign and reinforce the message being sent to targeted households through the direct mail effort.

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

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

The website also provides information about Medicare's limited coverage of, and payment for, LTC services and supports.

Budget Overview

The DRA authorized and appropriated $1 million total for the period of fiscal years 2006 through 2010 for reporting on the Partnership for LTC and $3 million for each of fiscal years 2006 through 2010 for the establishment of a national clearinghouse for LTC information. There is no funding for the reporting on the Partnership for LTC beyond FY 2010. Section 8002(d) of the Affordable Care Act amends section 6021(d) of the DRA by extending the funding for the National Clearinghouse. As a result there is authorized and appropriated $3 million for each of fiscal years 2011 through 2015.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Program Description and Accomplishments

Section 6043 of the DRA enacted the Emergency Room Co-Payments for Non-Emergency Care. This provision added a new subsection 1916A(e) to the Social Security Act and provided funding in the amount of $50 million in Federal grant funds to States. This funding provides State options to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver. This provision also added a new subsection 1903(y) authorizing Federal grant funds for States to use for the establishment of alternative non-emergency service providers, or network of such providers. States were encouraged to apply for grant funds to implement projects that would create new primary care access points (such as additional evening and weekend hours or new primary care sites closely located to large hospitals), target chronic disease management and outreach to high-emergency department users, utilize mental health triage nurses, and use health information technology to streamline and support emergency department referrals to the beneficiaries' medical homes.

States may not use funds as the State's share of the Medicaid program costs or to supplement disproportionate share hospital (DSH) payments. Grant applicants are limited to the 51 State Medicaid agencies and the Medicaid agencies in the Federal territories.

Budget Overview

The DRA made available a total of $50,000,000 over four years (FY 2006-2009) for the establishment of alternate non-emergency service providers or networks of such providers to provide non-emergency care. CMS released one solicitation on August 15, 2007 available for all four years (FY 2006, FY2007, FY 2008, and FY 2009). On April 17, 2008, Emergency Room Diversion Grants were awarded to 20 State Medicaid agencies, for a total of 29 projects (Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, and Washington). Priority was given to applicants targeting medically-underserved areas whose emergency department utilization rate for non-urgent issues exceeded the state average and to those states who proposed collaboration with local community hospitals. The grants help to align States with CMS efforts to avoid unnecessary emergency room visits through improved physician care and implementation of strategies to slow spending growth while maintaining and even improving access to coverage.

The two-year Emergency Room Diversion Grants were scheduled to end on April 14, 2010 for all 20 States. During April 2010, all 20 grantees requested and were granted a 12 month, no-cost-extension to spend down their remaining grant funds and to complete their projects. All Emergency Room Grants are scheduled to end April 14, 2011. The table below details the States who received a no-cost-extension.

The goal for the extension period was to provide the grantees additional experience delivering the full array of services within the program structure they have been developing. The grantees needed additional time to develop a sustainable base for emergency department diversion services. Grant extensions will also increase improvement in beneficiary satisfaction in relationships and access to their primary care medicial home. The grant extension will continue to allow grantees to collect, measure and evaluate behavior changes by trending Medicaid claims history before and after redirection management.

State	Fund Amount Extended	End-Date
Colorado	$ 360,751	April 14, 2011
Connecticut	$ 718,558	April 14, 2011
Georgia	$ 755,000	April 14, 2011
Illinois	$ 457,350	April 14, 2011
Indiana	$ 831,530	April 14, 2011
Louisiana	$2,769,393	April 14, 2011
Massachusetts	$ 113,780	April 14, 2011
Maryland	$ 956,643	April 14, 2011
Michigan	$ 192,280	April 14, 2011
Missouri	$ 170,910	April 14, 2011
New Jersey	$1,555,000	April 14, 2011
North Carolina	$ 448,739	April 14, 2011
North Dakota	$ 210,888	April 14, 2011
Oklahoma	$ 698,240	April 14, 2011
Pennsylvania	$1,664,560	April 14, 2011
Rhode Island	$3,485,000	April 14, 2011
South Dakota	$2,615,259	April 14, 2011
Tennessee	$2,167,438	April 14, 2011
Utah	$ 185,000	April 14, 2011
Washington	$1,007,065	April 14, 2011
Total Funds Extended	$21,363,384	

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 youths with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, many States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to care, which would keep youth in their homes and with their families.

Section 6063 of the DRA addressed this issue by authorizing ten States to develop demonstration programs that provide home and community-based services to youth as alternatives to institutionalization in PRTFs.

To participate in this demonstration, Medicaid eligible individuals must be under the age of 21 and require the need for a PRTF as defined in the State's Medicaid State plan. For the purposes of this demonstration, youth are defined as "any child, adolescent or young adult under the age of 21."

This program assesses the cost effectiveness of the provision of home and community-based services and evaluates whether children and youth in this demonstration maintain and/or improve their functional level. The ten participating States submitted a 5-year, web-based 1915(c) demonstration waiver 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 a combined enrollment of 2,550 children and youth as of September 30, 2010. It is estimated that approximately 6,000 children and youth will be served by the end of the demonstration.

The table on the following page shows the total five year commitment for the grant awards funded in FY 2007-2010 by State.

Budget Overview

The DRA provided ten States with up to $218 million for a period of five years (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 committed over $186 million to participating States for the 5-year demonstration project. Of that amount, CMS made awards totaling $57,721,954 million in FY 2007-2010 to ten States less the rescission by Florida of $2,104,693 leaving a total award of over $55.6 million. Funds not expended in each grant year will continue to be available in subsequent fiscal years of the demonstration. CMS also awarded a contract for the national evaluation in April 2007 for $904,422 and a modification in of $93,690 in FY 2008 totaling $998,112.

The DRA authorized and appropriated $37 million for FY 2008, $49 million in FY 2009, $53,000 in FY 2010, and $57,000 in FY 2011. CMS also has authorized grant funding

matching the increased FMAP provided for in the American Reinvestment and Recovery Act (ARRA) of 2009 as reflected in the table below. CMS will award additional grant funds as supplemental awards to the nine States based on the funding requested in the PRTF 1915 (c) demonstration waiver application submissions and the estimated increased FMAP indicated above. States may request supplemental funding at any time during the fiscal year as the number of children and youth enrollment increases.

State	5 Year Award Commitment	Grant Funded increased FMAP-based on Recovery Act	Total 5-year Award Commitment with ARRA FMAP Increase	FY 07-10 Awards	Balance of 5 Yr. Award
AK	$8,562,190	$191,075	$8,753,265	$555,805	$8,197,460
IN	$23,740,870	$457,172	$24,198,042	$12,302,620	$11,895,422
MT	$5,236,842	$121,338	$5,358,180	$2,522,085	$2,836,095
MS	$56,066,025	$1,343,796	$57,409,821	$23,000,948	$34,408,873
VA	$17,570,744	$316,921	$17,887,665	$3,172,117	$14,715,548
KS	$17,647,731	$304,440	$17,952,171	$4,899,534	$13,052,637
MD	$9,834,597	$515,460	$10,350,057	$3,591,576	$6,758,481
SC	$22,008,638	$526,586	$22,535,224	$741,584	$21,793,640
GA	$21,606,062	$466,836	$22,072,898	$6,864,549	$15,208,349
Totals	$182,273,699	$4,243,624	$186,517,323	$57,650,818	$128,866,505

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 the Affordable Care Act, States now have new options to rebalance their long-term support programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve independence. Specifically, the MFP demonstration supports State efforts to:

- Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
- Transition individuals from institutions who want to live in the community.
- Implement a system that provides the person-centered services and a quality management strategy that ensures provision of, 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 for each person transitioned from an institution to the community during the demonstration period. Eligibility for the increased FMAP was modified by Section 2403 of 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. The State 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- FY2010. Supplemental grant awards for FY 2010 were reviewed and awarded in March of 2010. The Affordable Care Act extend MFP through FY 2016, and provided additional funding to allow continuation of existing demonstrations and participation by new States. A grant solicitation for the 20 non-participating States was released July 26, 2010. Fourteen States submitted applications on January 7, 2011, and CMS is recommending 13 grant awards on or about February 28, 2011.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.75 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. The provision appropriated $250 million for FY 2007, $300 million in FY 2008 and $350 million in FY 2009, $400 million in FY 2010, $450 million in each of fiscal years 2011 and 2012. In addition, Section 2403 of the Affordable Care Act of 2010 extends the demonstration period through FY 2016. The Affordable Care Act appropriated $450 million in each fiscal year from 2012-2016, totaling an additional $2.25 billion. States participating in the MFP demonstration are provided an enhanced FMAP rate for home and community-based services (HCBS) to transition people from the institutional setting to a home or community-based setting of their choice. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50% of the difference between their State share and 100%. CMS has also provided the grantees grant funding matching the increased FMAP provided for in the Recovery Act of 2009 for service claims for the allowable nine fiscal quarters and is reflected in the chart below. Of the $1.75 billion total, $2.4 million of the appropriation is being used to carry out technical assistance and quality assurance activities and made available through the demonstration period. An additional $1.1 million from each year's appropriation in FY 2008 through FY 2016 can be used to carry out evaluation and a required report to Congress.

As of March 2010, CMS committed $512,685,780 in grants to 30 States. With these funds, States have transitioned 12,000 individuals as of December 31, 2010 and they propose to transition over 23,543 individuals out of institutional settings over the first five-year demonstration period. New estimates based on the extension of the program will be developed this fiscal year. As grantees continue to make progress in implementing their projects, there continues to be additional opportunities to seek supplemental funding for program expansion. Additionally, CMS has awarded evaluation, technical assistance and quality assurance contracts to support the implementation of the program.

Money Follows the Person Rebalancing Demonstration Grants (FY2011 award requests are due Jan. 31, 2011)					
State	*5 Year Award/ Commitment* (from initial award letter)*	*Grant Funded Increased FMAP projections based on the Recovery Act increase*	*Total 5 year Award Commitment with increased FMAP for nine quarters*	*FY 2007-2010 Supplemental Award Amount*	*Balance of 5 Yr. Award/ Commitment* (Award/Commitment minus Cumulative Award Total)
AR	$20,923,775	$633,000	$21,556,775	$6,069,871	$15,486,904
CA	$130,387,500	$3,944,569	$134,332,069	$41,595,564	$92,736,505
CT	$24,207,383	$732,338	$24,939,721	$9,495,305	$15,444,416
DC	$5,372,007	$162,518	$5,534,525	$2,384,727	$3,149,798
DE	$26,377,620	$797,993	$27,175,613	$15,452,033	$11,723,580
GA	$34,091,671	$1,031,364	$35,123,035	$17,303,603	$17,819,432
HI	$10,263,736	$310,505	$10,574,241	$3,727,968	$6,846,273
IL	$55,703,078	$1,685,166	$57,388,244	$15,275,858	$42,112,386
IN	$21,047,402	$636,740	$21,684,142	$14,902,910	$6,781,232
IA	$50,965,815	$1,541,851	$52,507,666	$11,895,328	$40,612,338
KS	$36,787,453	$1,112,918	$37,900,371	$17,686,555	$20,213,816
KY	$49,831,580	$1,507,538	$51,339,118	$14,973,118	$36,366,000
LA	$30,963,664	$936,733	$31,900,397	$12,842,198	$19,058,199
MD	$67,155,856	$2,031,643	$69,187,499	$33,442,278	$35,745,221
MI	$67,834,348	$2,052,169	$69,886,517	$14,752,991	$55,133,526
MO	$17,692,006	$535,230	$18,227,236	$11,189,609	$7,037,627
NE	$27,538,984	$833,128	$28,372,112	$4,369,872	$24,002,240
NH	$11,406,499	$345,077	$11,751,576	$3,721,883	$8,029,693
NJ	$30,300,000	$916,656	$31,216,656	$8,979,536	$22,237,120
NY	$82,636,864	$2,499,985	$85,136,849	$4,063,775	$81,073,074
NC	$16,897,391	$511,191	$17,408,582	$13,923,088	$3,485,494
ND	$8,945,209	$270,616	$9,215,825	$9,028,994	$186,831
OH	$100,645,125	$3,044,783	$103,689,908	$40,629,715	$63,060,193
OK	$41,805,358	$1,264,723	$43,070,081	$17,637,095	$25,432,986
OR	$114,727,864	$3,470,823	$118,198,687	$40,269,191	$77,929,496
PA	$98,196,439	$2,970,704	$101,167,143	$21,339,337	$79,827,806
SC	$5,768,496	$174,512	$5,943,008	$976,997	$4,966,011
TX	$142,700,353	$4,317,065	$147,017,418	$63,989,158	$83,028,260
VA	$28,626,136	$866,017	$29,492,153	$7,274,060	$22,218,093
WA	$19,626,869	$593,765	$20,220,634	$16,178,316	$4,042,318
WI	$56,282,998	$1,702,710	$57,985,708	$17,314,847	$40,670,861
Total	$1,435,709,479	$43,434,031	$1,479,143,510	$512,685,780	$966,457,729

MEDICAID TRANSFORMATION GRANTS

Program Description and Accomplishments

This program is authorized by Section 6081 of the DRA which added a new subsection, 1903 (z) to title XIX of the Social Security Act. This section provides new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates through health information technology, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual Payment Error Rate Measurement program, implementing medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and developing methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Grantees must report on cost savings, use of the grant funds and any clinical improvements in beneficiary health status, as appropriate.

There is no requirement for State matching funds in order to receive payments for transformation grants.

Budget Overview

The DRA authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008. CMS released a State Medicaid Director Letter/Grant Solicitation to States on July 25, 2006. On January 25, 2007, CMS awarded 32 Medicaid Transformation Grants to 26 States totaling $97,040,144. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $52,959,856. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

The primary focus of these projects is for the States to adopt innovative methods to improve the effectiveness and efficiency in providing Medicaid through the development, implementation and the use of electronic health records (EHR), Health Information Exchanges (HIE), electronic clinical decision support tools, and e-prescribing programs in an effort to reduce healthcare costs and improve overall patient quality.

Table A and Table B on the following pages lists all of the Medicaid Transformation Grants awarded in the two rounds of applications.

Table A: FY 2007 Medicaid Transformation Grants, Round 1

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Alabama	Together for Quality - Health Information Systems (HIE/EHR)	$7,587,000	Health Information Technology
Arizona*	Medicaid Health Information Exchange and Utility Project	$11,749,500	Health Information Technology
Arkansas	Electronic Verification of Proof of Citizenship	$285,513	Fraud, Waste & Abuse

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Connecticut	Health Information Exchange and e-Prescribing	$5,000,000	Quality & Health Outcomes
District of Columbia	Comprehensive Medicaid Integration (HIE/EHR)	$9,864,000	Health Information Technology Quality & Health Outcomes
Florida	GenRx Expansion (e-Prescribing)	$1,737,861	E-Prescribing
Hawaii*	Open Vista ASP Network (HIE/EHR)	$3,188,535	Health Information Technology Quality & Health Outcomes
Illinois	Predictive Modeling System	$4,849,200	Quality & Health Outcomes Fraud, Waste & Abuse
Indiana*	Medicaid Estate Recovery Centralization and Automation Project	$124,880	Health Information Technology Medicaid Estate Recovery
Kansas	Using Predictive Modeling Technology to improve Preventive Health Care in the Disabled Medicaid Population	$906,664	Quality & Health Outcomes
Kentucky	Health Information Partnership (HIE/EHR)	$4,987,583	Health Information Technology
Maryland	Automated Fraud and Abuse Tracking	$576,228	Fraud, Waste & Abuse
Massachusetts	Secure Verification of Citizenship through Automation of Vital Records	$3,950,440	Citizenship
Michigan	One Source Credentialing	$5,208,759	Quality & Health Outcomes
Michigan	Expansion of Vital Records Automation and Integration into Medicaid	$3,929,317	Citizenship
Minnesota	Communication and Accountability for Primary Care Systems (HIE/EHR)	$2,843,340	Quality & Health Outcomes
Mississippi*	As One - Together for Health (HIE/EHR)	$1,688,000	Health Information Technology
Montana*	Enhancing EHR - Clinical Decision Making	$1,481,152	Quality & Health Outcomes
New Jersey	Medical Information for Children (HIE/EHR)	$1,516,900	Health Information Technology

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
New Mexico	e-Prescribing	$855,220	e-Prescribing
New Mexico	Electronic Health Record Project	$712,301	Health Information Technology
North Dakota	Web-based Electronic Pharmacy Claim Submission Interface	$75,000	e-Prescribing
Rhode Island*	IT Infrastructure Transformation	$725,253	Fraud, Waste & Abuse
Tennessee	E-Prescription Pilot Project	$674,204	e-Prescribing
Texas	Electronic Health Passport for Foster Care	$4,000,000	Health Information Technology
Utah	Developing a Pharmacotherapy Risk Management System with an Electronic Surveillance Tool	$2,881,662	Risk Management
West Virginia	Healthier Medicaid Members through Personal Responsibility	$917,560	Quality & Health Outcomes
West Virginia	Healthier Medicaid Members through a Stronger Medicaid Program	$1,731,680	Health Information Technology
West Virginia	Healthier Medicaid Members through Health Systems Improvement (HIE/EHR)	$3,895,730	Health Information Technology
West Virginia	Healthier Medicaid Members through Applied Technology	$1,766,280	Health Information Technology
West Virginia	Healthier Medicaid Members through Enhanced Medication Management	$4,287,110	Health Information Technology Quality & Health Outcomes
Wisconsin*	Health Information Exchange Initiative	$3,043,272	Health Information Technology
	Round 1Total Funding Awarded	$97,040,144	

*Received MT Grants in both Round 1 and Round 2

Table B: FY 2007 Medicaid Transformation Grants, Round 2

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Arizona*	Transparency - Value Driven Decision Support Tool Box	$4,411,300	Health Information Technology Quality & Health Outcomes
Arkansas	Touch: Telemedicine Outreach Utilizing Collaborative Health Care (Neonatal Outcomes)	$1,458,826	Quality & Health Outcomes
Delaware	Delaware e-Prescribing Pilot	$1,018,065	e-Prescribing
Georgia	Health Information Transparency Website	$3,929,855	Health Information Technology
Hawaii*	Enhanced Electronic Health Record and Information Exchange	$1,815,000	Health Information Technology

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Indiana*	Health Information Exchange Services to Improve the Effectiveness and Efficiency in Providing Medical Assistance Under Medicaid	$1,294,689	Health Information Technology Quality & Health Outcomes
Mississippi*	A Healthy Mississippi - Moving Forward Enhancing Program Integrity	$1,750,700	Fraud, Waste & Abuse
Missouri	Web-Based Tool for Home and Community Based Services	$1,940,175	Health Information Technology Quality & Health Outcomes
Montana*	Improving Lien and Estate Recoveries	$601,126	Medicaid Estate Recovery
Nevada	Building Value Through a Nevada Medicaid Data Warehouse	$29,207	Health Information Technology
North Carolina	Neonatal Outcomes Improvement Project	$1,019,550	Quality & Health Outcomes
Ohio	Neonatal Outcomes Improvement Project	$2,154,948	Quality & Health Outcomes
Oklahoma	Online Enrollment Process	$6,146,640	Health Information Technology
Oregon	The Health Record Bank of Oregon (HIE)	$5,500,093	Health Information Technology Quality & Health Outcomes
Pennsylvania	Implementing Predictive Modeling For High Risk Populations	$4,811,320	Risk Management
Puerto Rico	Reduction of Fraud and Abuse through Validation of Demographic and Socioeconomic Data with the Use of Electronic Data Exchanges	$4,267,231	Fraud, Waste & Abuse Health Information Technology
Rhode Island*	Medicaid Health Information Exchange Integration Initiative	$2,765,265	Health Information Technology Quality & Health Outcomes
Washington	Second Generation Fraud and Abuse Detection System	$5,948,000	Fraud, Waste & Abuse
Wisconsin*	Health Care Quality and Patient Safety - Value Driven Health Care Initiative	$2,097,866	Health Information Technology Quality & Health Outcomes
	Round 2 Total Funding Awarded	$52,959,856	
	Total 2007 Medicaid transformation Grant Awards	$150,000,000	

*Received MT Grants in both Round 1 and Round 2

In FY 2010, CMS approved 32 no-cost extensions through March 31, 2011 for 24 States to spend-down their remaining unobligated funds totaling $44,347,657 and to complete their projects. The goal for the extension period was to provide the grantees the opportunity to fully implement the innovative methods and multiple electronic systems that had been under development. Additionally, extension of this grant will maximize the investment of State and Federal dollars by increasing the effectiveness of assessment and follow-up needed to improve the quality of life for these medically needy individuals.

The table below summarizes the States receiving a no-cost extension.

State	Funding Amount Extended	End-date of the NCE
Arkansas	$ 162,537	March 31, 2011
Arizona Grant #1	$ 25,546	September 30, 2010
Arizona Grant #2	$ 16,574	September 30, 2010
Connecticut	$ 1,394,833	March 31, 2011
DC	$ 5,276,969	March 31, 2011
Florida	$ 361,015	March 31, 2011
Georgia	$ 133,613	June 30, 2010
Hawaii #1	$ 1,686,857	March 31, 2011
Hawaii #2	$ 261,550	March 31, 2011
Illinois	$ 642,040	March 31, 2011
Indiana	$ 942,742	March 31, 2011
Kentucky	$ 4,228,693	March 31, 2011
Massachusetts	$ 164,900	March 31, 2011
Michigan	$ 3,636,469	March 31, 2011
Mississippi Grant #1	$ 1,206,476	March 31, 2011
Mississippi Grant #2	$ 894,292	March 31, 2011
Missouri	$ 647,114	March 31, 2011
Montana	$ 435,000	March 31, 2011
New Jersey	$ 1,516,900	March 31, 2011
Ohio	$ 860,440	March 31, 2011
Oklahoma	$ 125,000	March 31, 2011
Oregon	$ 4,900,000	March 31, 2011
Rhode Island	$ 1,798,392	March 31, 2011
Texas	$ 3,214,375	March 31, 2011
Washington	$ 3,738,000	March 31, 2011
West Virginia Grant #1	$ 284,354	March 31, 2011
West Virginia Grant #2	$ 700,142	March 31, 2011
West Virginia Grant #3	$ 700,142	March 31, 2011
West Virginia Grant #4	$ 1,010	June 30, 2010
West Virginia Grant #5	$ 3,309,846	March 31, 2011
Wisconsin Grant #1	$ 376,921	March 31, 2011
Wisconsin Grant #2	$ 1,011,648	March 31, 2011
Total Funds	**$44,347,657**	

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, section 6034 of the DRA (P.L. 109-171) established the Medicaid Integrity Program in section 1936 of the Social Security Act. With the passage of this legislation, Congress provided CMS with the much needed opportunity to raise awareness of Medicaid program integrity by increasing resources to help CMS in its efforts to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program. Specifically, the

legislation provided CMS with resources to establish the Medicaid Integrity Program, CMS' first national strategy to detect and prevent Medicaid fraud and abuse. The statute provided CMS with the authority to hire 100 full-time equivalent employees to provide support to States. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste and abuse beginning in FY 2006. The first CMIP was published in August 2007 and covered FYs 2007 to 2011. The most recent CMIP was released in June 2009 and covers FYs 2009-2013.

To assure the implementation and success of the plan, CMS is measuring the percentage return on investment (ROI) of the Medicaid Integrity Program. The FY 2009 ROI was 175 percent, exceeding the target for the annual ROI to be greater than 100 percent. The numerator included overpayments identified in FY 2009 and the denominator included the annual federal funding for MIP for FY 2009. The FY 2011 target was revised from greater than 200 percent to greater than 125 percent because Section 6411 of the Affordable Care Act requires States to expand the Recovery Audit Contractor (RAC) Program to Medicaid. We anticipate a decrease in potential ROI once the RACs are up and running. The Medicaid State RACs will target the high dollar, easily recouped claims, which will impact the audit leads that the MICs will have available. As the Medicaid Integrity Program has evolved over the past three years, it has become apparent that our ability to identify overpayments is not, and should not be, limited to the activites of our MICs. CMS will work to capture the value of those many activities. The FY 2012 target is for the ROI to be greater than 150 percent.

Congress mandated that CMS enter into contractual agreements with eligible entities to review provider claims to determine if fraud and abuse has occurred or has the potential to occur; audit claims; identify overpayments; and conduct provider education. These contractors are known as the MICs. In December 2007, CMS awarded umbrella contracts for both the Review MICs and Audit MICs. The contractors began conducting provider reviews and audits in September 2008. In collaboration with the United States Department of Justice, CMS also established the Medicaid Integrity Institute to provide State employees with a comprehensive program of course work encompassing numerous aspects of Medicaid program integrity.

Building upon the accomplishments of the first several years, in FY 2010, CMS continued to hire full-time employees and plans to hire the remaining employees in FY 2011, CMS conducted audits of provider claims, conducted State oversight reviews, and provided technical support and assistance to State Medicaid integrity programs. To address the HHS-OIG's concerns, the program established fraud referral performance standards for State Medicaid agencies, and increased efforts to ensure that States enforce existing policies relating to the proper documentation of pediatric dental services. The program also provided assistance to States to promote provider awareness and documentation requirements.

Budget Overview

The DRA appropriated $5 million in FY 2006, $50 million in FYs 2007 and 2008 respectively, and $75 million in FY 2009 and each year thereafter for the Medicaid Integrity Program. Beginning in FY 2011 section 1303(b)(3) of P.L. 111-152 adjusts this funding by the percentage increase in the CPI-U annually. 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. The Affordable Care Act increased the appropriation to $140 million. These programs will conduct outreach and enrollment efforts designed to increase the enrollment and participation of children who are eligible for Medicaid or CHIP but not enrolled.

Outreach and Enrollment Grants

The grants are proposed to target geographical areas with high rates of eligible but unenrolled children, including children who reside in rural areas; or racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment.

The first $40 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40 million in Federal funds across 41 States and the District of Columbia.

National Enrollment Campaign

The statute also made a set-asid of ten percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. To date, the campaign has focused on a call to action and technical assistance to States, grantees, and other groups to help enroll more children in health insurance. The campaign was highlighted by Secretaries Sebelius and Vilsack in an event last February on the anniversary of the signing of CHIPRA. At this event, Secretary Sebelius announced the "Secretary's Challenge: Connecting Kids to Coverage", which is a five-year campaign that will challenge federal officials, states, governors, mayors, community organizations, faith leaders, and concerned individuals to build on our success and take the next step by finding and enrolling in Medicaid and CHIP the five million eligible children who are not yet covered. The campaign has also supported a webcast on "Affordable Health Care for Kids", conducted research to improve messaging, developed an outreach toolkit for grassroots organizations and states, and conducted the National Children's Health Insurance Summit in November 2009. Summit participants benefited from hands-on training and breakout sessions with subject matter experts, and promoted the outreach toolkit available on www.insurekidsnow.gov The toolkit includes materials in English, Spanish, Chinese, Korean, and Vietnamese, as well as materials targeting the Native American population.

CMS continues to provide additional technical assistance to the grantees and states through a variety of strategies including on-going webinars, supplemental tool-kit materials, an e-newsletter, and the use of social media. Currently tweets are sent out on an ongoing basis. In the near future CMS will launch the first CMS Facebook page.

One of CMS's most exciting developments is the "Get Covered. Get In the Game Campaign." This pilot campaign is a multi-faceted effort that leverages the fall youth sports' season and complements the back-to-school efforts to conduct outreach targeted to

families with children eligible for CHIP and Medicaid. Pilot states include: CO, MD, FL, OR, NY, WI, and OH.

Outreach to Indian Children

There is also provided within this statute a set-aside of ten percent of appropriations to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible American Indian and Alaska Native children in Medicaid and CHIP. The solicitation was issued November 19, 2009 and applications were due by January 15, 2010. A total of 41 Grants were awarded on April 15, 2010.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Budget Overview

CHIPRA appropriated a total of $100 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the Affordable Care Act amended this provision by providing an additional $40 million in fiscal year 2010 and extending the period of availability through fiscal year 2015. Of the total appropriated amount, ten percent is set-aside for the national enrollment campaign and another ten percent is for Indian outreach; therefore, $112 million is to be used for the general grants, and the national campaign and Indian outreach will each receive $14 million. CMS awarded $40 million in FY 2009 for outreach grants and approximately $10 million in FY 2010 for general outreach to Indian children. CMS will award an additional $40 million of the remaining grant following a second solicitation in FY 2011, and work on the National Enrollment Campaign is ongoing.

APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Program Description and Accomplishments

Section 503 of CHIPRA establishes transition grants to States to apply in their CHIP programs the prospective payment system (PPS) established under section 1902(bb) of the Social Security Act to services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

The CHIPRA transition grants will provide funding to States that operate a separate or combination CHIP to assist them in transitioning to a PPS for the FQHC/RHC payments. The goals of this grant appropriation will be to assist States in applying the PPS requirements for this purpose as required by CHIPRA.

Budget Overview

The statute appropriated $5 million for fiscal year 2009. A total of five grants were awarded, however, one grantee declined the award. Currently, the four grantees are: California, Michigan, Colorado, and Pennsylvania, representing $1,934,345 of the appropriated funds. The remaining funding is available until expended.

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Section 2707 of the Affordable Care Act authorizes a demonstration project under which an eligible State shall 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 that is subject to the requirements of section 1867 of the SSA for Medicaid beneficiaries who are at least 21, but have not reached age 65 and require medical assistance to stabilize an emergency medical condition. The demonstration project shall be conducted for a period of three consecutive years. Each eligible State shall be paid an amount each quarter equal to the FMAP of expenditures in the quarter. An evaluation of the demonstration project shall be conducted in order to determine the impact on the functioning of the health and mental health service system and on individual enrolled in the Medicaid program.

Budget Overview

Section 2707 authorizes and appropriates $75 million in fiscal year 2011 to carry out this section. The funds for this program are available for obligation through December 31, 2015.

INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID

Section 4108 of the Affordable Care Act authorizes CMS to provide grants to States to provide incentives to Medicaid beneficiaries who successfully participate, complete, and maintain healthy behaviors by meeting the specific targets of a comprehensive, evidence-based, widely available, and easily accessible program designed to help individuals achieve one or more of the following:

1. Ceasing the use of tobacco products
2. Controlling or reducing their weight
3. Lowering their cholesterol
4. Lowering their blood pressure
5. Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

Any incentives provided to a Medicaid beneficiary participating in this program shall not be used to determine eligibility for Medicaid benefits or any other Federally-funded program.

Budget Overview

Section 4108 authorizes and appropriates $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.

Proposed Legislation

The Wireless Innovation (WIN) Fund will finance emerging wireless technologies in the health care sector to create a world-leading wireless network as part of a critical platform for economic growth.

CMS is proposing $20 million in each of FY 2012 through FY 2016 for this fund.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
SGD2: Medicaid Integrity Program, Percentage Return on Investment	FY 2009: 175% (Target Exceeded)	ROI>125%	ROI>150%	+25%
Program Level Funding ($ in millions)	**N/A**	**$76**	**$77**	**+$1**

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Clinical Laboratory Improvement Amendments of 1988

	FY 2010 Appropriation	FY 2011 CR Level	FY 2012 Estimate
BA	$43,000,000	$43,000,000	$43,000,000
FTEs	84	84	84

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353

FY 2010 Authorization - One Year

Allocation Method - Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA strengthens quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens to diagnose, prevent, or treat illness or impairment. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 19,053 laboratories during the FY 2010-2011 survey cycle.

Laboratories exempt from routine Federal inspections include those performing waived tests only, laboratories in which specified practitioners perform only certain microscopic tests, laboratories accredited by approved independent accrediting organizations, and laboratories in States that approve or license clinical laboratories under their own standards. Waived laboratories perform only simple testing and are not generally subject to CLIA requirements, with the exception of following manufacturers' instructions and paying applicable certification fees. Laboratories which are accredited, or which operate in exempt States, are inspected by the accrediting organization or the State at the same frequency as CMS-certified laboratories, namely every 2 years. The accrediting organizations and exempt States have standards considered equal to or more stringent than those required under the CLIA statute. Laboratories that are subject to Federal surveys (those performing nonwaived testing) can choose to be surveyed either by CMS or by one of the six CMS-approved private accrediting organizations. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Currently, 217,972 laboratories are registered with the CLIA program. Approximately 180,767 or 82.9 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 112,290, or 51.5 percent, of the laboratories registered under the CLIA program. Approximately 93,555 or 83.3 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of 3.5 percent for the FY 2010-2011 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 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 2012 CLIA budget request for CMS is $43,000,000. The CLIA program is a 100-percent user fee-financed program. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories. CMS then sets the national State survey workload at 100 percent of the laboratories to be inspected in a two-year cycle. Workloads projected for the FY 2011-2012 cycle include surveys of 19,053 non-accredited laboratories, State validation surveys of 806 accredited laboratories, and approximately 1,389 follow-up surveys and complaint investigations.

Performance Measurement

In CY 2005, CMS began collecting cytology proficiency testing data and measured the percentage of pathologists obtaining a passing score of 90 percent or greater. As a result, of CMS' educational approach and intervention, the pathologists' performance showed improvement between 2005 and 2009. CMS exceeded its FY 2009 target with 96.75 percent of all pathologists achieving a passing score of 90 percent or greater. The FY 2012 target is 96.9 percent.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
CLIA1: Percent of pathologists receiving an initial passing score of 90% or greater in gynecologic cytology proficiency testing	FY 2009: 96.75% (Target Exceeded)	95%	96.9%	+1.5
Program Level Funding ($ in millions)	**N/A**	**$43.0**	**$43.0**	**0**

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Quality Improvement Organizations

(dollars in thousands)

	FY 2010	FY 2011	FY 2012 Request
BA	$146,100	$85,700	TBD

*This table reflects funding for the 9th SOW only.

Authorizing Legislation - Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended

Allocation Method – Contracts

Program Description and Accomplishments Section

The Quality Improvement Organizations (QIOs) play a central role in CMS's efforts to improve the quality of care provided to Medicare beneficiaries in hospitals, nursing homes, home health agencies, and physician offices. In order to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting, CMS maintains 53 contracts with independent community based organizations (one contract in each State, Washington D.C., Puerto Rico, and the Virgin Islands). The QIO contractors work with State, local partners, and health care providers and suppliers to promote improved health status.

QIOs operate under three-year contracts. Each contract's Statement of Work (SOW) varies depending on the needs of the Medicare program and beneficiaries.

The 9th SOW began August 1, 2008, supported by $1,155.6 million, which included $1.0 million for areas affected by hurricanes Rita and Katrina. The 9th SOW will end July 31, 2011. The FY 2011 total of $85.7 million will conclude funding for the 9th SOW.

CMS is currently overseeing the QIO program 9th SOW. The 9th SOW includes four themes: 1) Beneficiary Protection; 2) Prevention; 3) Care Transitions; and 4) Patient Safety.

Beneficiary Protection activities emphasize mandatory reviews of provider services and quality improvement. Reviews of provider services include utilization reviews, quality of care reviews (including beneficiary complaints), reviews of beneficiary appeals of certain provider notices, and reviews of potential anti-dumping cases. Emphasizing quality improvement, Beneficiary Protection in the 9th SOW engages in more active evaluation of program activities and benefits from more highly advanced reporting and tracking systems.

Prevention efforts emphasize evidence-based and cost-effective care proven to prevent and/or slow the progression of disease. Prevention work impacts health care programs, products, polices, practices, community norms, and linkages and produces higher quality of care for Medicare beneficiaries and significant cost savings. Over time, as disease is mitigated and its progression slowed through preventive measures such as early testing, immunization, and effective and timely intervention, the Nation will see a healthier Medicare population emerge. This downstream impact will be most evident in the reduction of chronic kidney disease (CKD)

and decrease in the rate of progression to kidney failure.

Work in the Care Transitions theme reduces the unnecessary re-hospitalizations of Medicare beneficiaries that both harm patients and unnecessarily strain the Medicare trust funds. Collaborations among QIOs, community coalitions, and professional groups, utilizing chartered value exchanges, publication of performance, and value-based purchasing achieved what none of the parties alone could accomplish.

Patient safety efforts address major areas of patient harm for which there is evidence of how to improve and a record of QIO success in improving safety. This work is predicated on the reduction or elimination of patient harm that is more likely a result of the patient's interaction with the health care system than an attendant disease process. The Patient Safety theme, by definition, increases the value of health care services as it produces higher quality care for Medicare beneficiaries. QIO activities for the Patient Safety theme focus on five topics: Improving inpatient surgical safety; reducing rates of nosocomial methicillin-resistant Staphylococcus aureus (MRSA) infections; improving drug safety; reducing rates of pressure ulcers; and reducing rates of use of physical restraints. QIOs will work with providers to achieve fewer restraints, fewer patients with pressure ulcers in nursing homes and hospitals, fewer MRSA infections, and fewer postoperative deaths due to surgical site infection, venous thromboembolic events, or perioperative myocardial infarction.

Budget Overview

The 10th SOW is currently under development. The 10th SOW contract period is August 1, 2011 thru July 31, 2014. FY 2012 is the first full fiscal year for the 10th SOW.

We believe the improved oversight of the program and increased competition for sub national projects are providing improved outcomes and value. CMS will continue to build on the success from the new management approach.

CMS monitors several key performance measures reflecting efforts to ensure beneficiaries receive the high-quality care they need and depend on. The following table reflects key annual QIO measures related to the 9th SOW.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target[1]	FY 2012 +/- FY 2010
QIO1: Increase influenza immunization (nursing home subpopulation)	FY 2009: 84.23% (Target Exceeded)	81.8%	86.8%	+5
QIO 3.1: Increase hemoglobin A1c testing rate	CY 2009: 88.2% (Target Exceeded)	87%	89.5%	+2.5
QIO 3.2: Increase cholesterol (LDL) testing rate	CY 2009: 82.7% (Target Exceeded)	82%	84.1%	+2.1
QIO4: Increase percentage of timely antibiotic administration	FY 2009: 95.6% (Target Exceeded)	92%	96%	+4

[1] FY 2012 targets are estimates.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target[1]	FY 2012 +/- FY 2010
QIO5: Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	FY 2010: 56.8% (Target Not Met)	57%	59%	+1
QIO6.3: Prevention, Patient Safety, Care Transitions, and Prevention themes *****Performance metrics become progressively more difficult as the contract matures, thus percentage of expected success may decrease in outyears**.**	**Prevention** FY 2010: Target Met. The 18th month evaluation results show 92% of the QIOs met all performance targets in the Prevention Theme.	**Prevention** At least 85% of QIOs will meet expectations for the components of the Prevention Theme at the 18th month evaluation.	**Prevention** 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	+15
	Patient Safety FY 2010: Target Met. The 18th month evaluation results show 99% of the QIOs met all performance targets in the Patient Safety Theme.	**Patient Safety** At least 85% of QIOs will meet expectation for the components of the Patient Safety Theme at the 18th month evaluation.	**Patient Safety** 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	N/A
	Care Transitions FY 2010: Target Met. The 18th month evaluation results show 100% of the QIOs met all performance targets in the Care Transitions Theme.	**Care Transitions** - At least 80% of the QIOs will meet expectations of the Care Transitions Theme at the 18th month evaluation.	**Care Transitions** – 80% of the QIOs will meet the 12th month (quarter 4) 1-4 (interim measure) performance expectations	N/A
QIO6.4: Beneficiary Protection	FY 2010 target was met to establish baseline (88% of the QIOs are meeting all performance targets) and FY 2011 target.	Establish baseline/progress and FY 2011 targets	80% of the QIOs will meet the 12th month (quarter 4) performance expectations	N/A
Program Level Funding ($ in millions)	N/A	$146.1	TBD	TBD

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Pre-Existing Condition Insurance Plan Program

(Dollars in thousands)

	FY 2010 Enacted	FY 2011 Current Law	FY 2012 Estimate	FY 2012 +/- FY 2011
Budget Authority	$5,000,000	-	-	
Gross Outlays	$4,549	$1,470,532	$1,683,134	$212,602
Offsetting Collections	-$554	-$40,532	-$121,577	-$81,045
Total Net Outlays against BA	$3,995	$1,430,000	$1,561,558	$131,557

*Funding available until expended.

Authorizing Legislation – Patient Protection and Affordable Care Act, Public Law 111-148, Section 1101

FY 2010 Authorization - Public Law 111-148

Allocation Method – Contract Application

Program Description and Accomplishments

In July 2010, the Secretary launched the Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to uninsured individuals who have been denied coverage by private insurance companies due to a pre-existing condition. The PCIP program will remain in place until the Health Insurance Exchanges (established under Sections 1311 or 1321 of the Act) become operational on January 1, 2014 and can provide more affordable options for individuals with pre-existing conditions and when insurance companies can no longer deny coverage or charge higher premiums for individuals with pre-existing conditions. The interim final rule implementing this program was published on July 30, 2010.

Funding for this unique, temporary Federal program is limited to $5 billion to pay claims and administrative costs that are in excess of the premiums collected from enrollees in the program. CMS established allocation ceilings for the PCIP program in each State for the life of the program. CMS is also required to establish oversight procedures, including appeals procedures and protections against fraud, waste, and abuse. In addition, CMS must maintain funds for an external medical appeals process for grievances filed on medical necessity decisions. CMS is developing a performance measure to highlight the number of individuals enrolled in PCIP nationally, and will establish the baseline in FY 2011.

Eligibility and Benefits

An individual is eligible to enroll in a PCIP if he or she:

(1) Is a citizen or national of the United States or is lawfully present in the United States as determined in accordance with section 1411 of the Affordable Care Act;

(2) Has not been covered under creditable coverage, as defined in section 2701(c)(1) of the Public Health Service Act as of the date of enactment, during the six-month period prior to the date on which he or she is applying for coverage through the PCIP; and, (3) Has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary. We

further provide that an individual must be a resident of a State that falls within the service area of a PCIP.

Individuals who enroll in a PCIP are entitled to limited costs – a plan's average share of total allowed costs must be at least 65 percent and enrollee out-of-pocket expenses cannot exceed the amount available to individuals with a high deductible health plan linked to a health savings account (this amount is currently $5,950). In addition, a PCIP cannot exclude coverage for any pre-existing conditions.

All PCIP programs cover a wide range of health benefits, including primary and specialty care, hospital care, diagnostic testing, prescription drugs, home health and hospice care, skilled nursing, preventative health, and maternity care. The benefits reflect services most commonly covered by existing State high risk pools (based on a survey conducted by the National Association of State Comprehensive Health Insurance Plans (NASCHIP) in 2009). Premiums are capped at 100 percent of the standard individual market rate in the State. By law, premiums charged in the pool may vary only on the basis of age (by a factor not greater than four to one).

State-administered PCIP Programs

CMS signed contracts with twenty-seven States to operate their own State PCIP programs. Many of these programs began accepting applicants on July 1, 2010. CMS is responsible for ensuring each State performs necessary functions to design, implement, and operate a PCIP program.

Federally-administered PCIP Program

For those States choosing not to operate their own PCIP program, CMS established the Federal PCIP program on July 1, 2010. The Federal PCIP program began operating in twenty-three States and the District of Columbia in October 2010.

CMS entered into agreements with the U.S. Office of Personnel Management (OPM) and the U.S. Department of Agriculture's National Finance Center (NFC) to run the program. The Government Employees Health Association (GEHA) administers the health plan benefits for the Federal PCIP program.

Funding History

FY 2010	$5,000,000,000

Outcomes and Outputs Table

Measure	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
PHI5: Number of individuals enrolled in the Pre-existing Condition Insurance Plan (PCIP) program nationally	Establish baseline	TBD	N/A
Program Level Funding ($ net outlays in millions)	**$1,430.000**	**$1,561.558**	**+$131,557**

Consumer Operated and Oriented Plan (CO-OP) Program

(Dollars in Thousands)

	FY 2010	FY 2011	FY 2012 Request	FY 2012 +/- FY 2011
Appropriation	$6,000,000	-	-	-
Total Loans and Grants*	$0	$0	$592,700	$592,700
Related Payment to the Financing Account	$0	$0	$375,730	$375,730
Total Obligations	$0	$10,000	$387,483	$377,483
Unobligated balance, Start of year	-	$6,000,000	$5,990,000	($10,000)
Unobligated balance, end of year	$6,000,000	$5,990,000	$5,602,517	($387,483)

*Please note that grants are repayable in 15 years.

Program Description and Accomplishments

The Affordable Care Act requires HHS to establish a program to foster the creation of qualified nonprofit health insurance issuers who will offer qualified health plans in the individual and small group markets. Grants (repayable in 15 years) and loans will be awarded to support plan start-up costs and solvency requirements. The grant and loan funds will be repaid in a manner that is consistent with state solvency and reserve requirements. Priority for these grants and loans will be given to applicants that offer Qualified Health Plans (QHPs) on a statewide basis, use an integrated care model, and have significant private support. If no health insurance issuer applies within a state, the Secretary may use funds to encourage the establishment of qualified issuers within the state or the expansion of an issuer from another state to the state with no applicants. Awards must be made no later than July 1, 2013.

CO-OP Advisory Board

A 15-member Federal Advisory Committee was established as required by statute for the purpose of making recommendations to the Secretary with regard to the award of grants and loans. GAO issued the appointments June 2010. The Committee will terminate when it has completed its duties as outlined in the statute or by December 31, 2015.

Authorizing Legislation - ACA, Section 1322
Allocation Method – Direct Federal, Grants, Loans, and Contracts

Funding History (Appropriation)

FY 2010	$0
FY 2011	$10,000,000

CO-OP program operations began in FY 2011 with the first meeting of the CO-OP FACA Committee on January 13. The Committee anticipates convening two more times for meetings during the FY 2011. OCIIO released a Request for Comment in January 2011.

CCIIO also expects to develop and publish regulations governing the award of loans and grants and issue a funding announcement.

FY 2012 Activities ($388 million)

Loan and Grant Subsidy ($376 million)

CCIIO will award loans and grants (repayable in 15 years) to organizations to encourage the establishment of qualified nonprofit health insurance issuers within states. Loans will be provided to help fund start-up cost. In addition, grants will be awarded to enable newly formed CO-OPs to meet state solvency requirements.

Administrative Funding for CO-OP Program ($12 million)

In FY 2012, CCIIO will establish an infrastructure to support the awarding and monitoring of CO-OP funding. The program will hire staff to support reviews of applicant organizations and application materials, support the CO-OP FACA Committee, develop IT systems to enable application processing, establish loan and grant payment systems, and develop a work agreement that will be signed with all grant and loan recipients.

CCIIO will also develop a work agreement with funding recipients and make awards to qualifying entities by the end of FY 2012. CCIIO will continue to support program integrity by monitoring activities by recipient organizations and engaging vendors for applicant reviews.

Early Retiree Reinsurance Program /1

(Dollars in thousands)

	FY 2010	FY 2011	FY 2012	FY 2012 +/- FY 2011
Budget Authority	$5,000,000	-	-	-
Outlays /1	$1,000	$3,584,050	$1,386,050	$(2,198,000)

/1 Outlays are based on OACT estimates.

Authorizing Legislation - PPACA, Section 1102

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Contract Application

Program Description and Accomplishments

The Early Retiree Reinsurance Program (ERRP) was created to address the gradual erosion over the last 20 years in the number of employers and unions providing health coverage to early retirees. Early retirees often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable and inaccessible. Additionally, rising health care costs have made it difficult for employers to provide high quality, affordable health insurance for workers and retirees while also remaining competitive in the global marketplace. The percentage of large firms providing workers with retiree health coverage has dropped from 66 percent in 1988 to 29 percent in 2009. Health insurance premiums in the individual market for older Americans are over four times more expensive than they are for young adults and the deductible these enrollees pay is, on average, almost four times that for a typical employer-sponsored insurance plan.

ERRP provides needed financial help for employer-based plans to continue to provide valuable coverage to plan participants and provides financial relief to plan participants. ERRP provides reimbursement to approved sponsors of certified plans providing health benefits to early retirees, their spouses, and surviving spouses and dependents equal to 80 percent of the actual cost of health expenses paid for an individual between a cost threshold ($15,000) and cost limit ($90,000). The cost threshold and cost limit will be adjusted in future years by linkage to the Medical Care Component of the Consumer Price Index. Savings can be used to reduce employer health care costs, provide premium relief to workers and families, or both.

The Affordable Care Act appropriated $5 billion for this program. It became effective three weeks ahead of schedule, on June 1, 2010, pursuant to the interim final rule published on May 5, 2010.

In October 2010, sponsors with approved applications began to receive reinsurance payments. OCIIO has already approved over 5,000 sponsors, including those from all sectors of the economy and from all areas of the country, into the ERRP. Sponsors of employer-based plans include entities such as businesses, schools and other educational institutions, religious groups, unions, state and local governments, and non-profit organizations.

Funding History

FY 2010	$ 5,000,000,000

Budget Overview

In FY 2012, OCIIO will continue monitoring eligibility and issuing reimbursements to approved sponsors. ERRP reimburses plan sponsors in the order in which they submit reimbursement requests. HHS is closely monitoring the Program, and as further data become available on implementation, we look forward to working with Congress to address emerging issues.

Other program operations include education, training, and outreach efforts, system maintenance, and technical support. Additionally, ERRP's program integrity efforts will continue, which include audits and other reviews of participating sponsors.

Exchange Planning and Establishment Grants

(Dollars in thousands)

	FY 2010 Actuals	FY 2011 Current Law	FY 2012 Estimate	FY 2012 +/- FY 2011
Outlays/1	**$560**	**$249,440**	**$400,000**	**$150,560**

1/ FY 2011 estimate does not reflect expected outlays for Exchange Establishment grants; HHS will update estimates when State proposals for costs related to establishing an Exchange are available.

Authorizing Legislation – Affordable Care Act of 2010 (P.L. 111-148)
Allocation Method - Direct Federal, Competitive Grant, and Co-operative Agreements

Program Description and Accomplishments

The Exchange Planning and Establishment Grants program provides Federal funding for implementation of State-based Health Insurance Exchanges (Exchanges). Exchanges will give millions of Americans and small businesses access to affordable health insurance coverage. By January 1, 2014, Exchanges will help individuals and small employers better understand their insurance options, and assist them to shop for, select, and enroll in high-quality, competitively-priced private health insurance plans. The Exchanges will also facilitate receipt of tax credits to offset premium costs and cost-sharing assistance, as well as help eligible individuals enroll in other Federal or State insurance programs. By providing one-stop shopping, Exchanges will make purchasing health insurance easier and more understandable and will provide individuals and small businesses with more options and greater control over their health insurance purchases.

The Affordable Care Act provides each State with the option to set up an Exchange, or to have the Federal government set up an Exchange in that State. In general, Exchanges must facilitate the purchase of qualified health plans (QHPs), help small businesses enroll their employees in health insurance through a Small Business Health Options Program (SHOP Exchange), and meet other requirements such as providing information to consumers and certifying QHPs.

Section 1311 of the Affordable Care Act provides amounts necessary to enable the Secretary to award Planning and Establishment Grants to States and allows for renewal of grants through January 1, 2015, at which time Exchanges will be self-sustaining. Territories that commit to establishing an Exchange may also receive grant funding.

On September 30, 2010, 48 States and the District of Columbia received Exchange planning grants of up to $1 million. In FY 2011, CMS will award grants to “Early Innovator” States that are in an advanced stage of readiness to build Exchange IT systems. Once built, these systems may be adopted by other States, which will reduce duplication of work and lead to more efficient use of tax payer dollars. States and Territories also currently have the ability to apply for grants geared toward establishment of their Exchanges, with awards for these grants beginning in FY 2011.

In FY 2012, States will perform their most intensive development, building, and testing of systems and business processes needed to establish Exchanges. This work will entail

initiatives in several key areas including:

- Developing and implementing the IT infrastructure including systems for:
  - Eligibility and tax credit determination,
  - Web portal design,
  - Data security and back-up systems,
  - Accounting and financial systems, and
  - Interfaces with other partners such as state Medicaid agencies;
- Planning for advertising, marketing, and outreach campaigns;
- Developing key policy and operational processes;
- Developing capacities to provide assistance to individuals and small businesses;
- Identifying vendors for assistance to enroll in plans, call centers, and financial systems; and
- Finalizing eligibility and tax credit determination guidelines.

Funding from the State Exchange Planning and Establishment Grants account will enable States to hire necessary staff to oversee operations and policy development, procure contracts for information systems development and consultancy services, and perform the analysis necessary to ensure development of the Exchanges is on-track to begin full operations by January, 2014. Additionally, States will be encouraged to use grant funding to develop capacities to provide assistance to individuals and small businesses, as appropriate. Funding for Consumer Assistance Grants is not requested in the 2012 Budget.

In support of the long-term HHS Strategic Plan goal to Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Healthcare Insurance Exchanges and Implementing Medicaid Expansion, CMS has process performance measures reporting on the progress towards setting up the Exchanges.

Budget Request ($400 million)

Funding for FY 2012 will be used to issue grants to States and Territories for Exchange implementation, as well as for administrative costs necessary to manage the grants. The baseline estimates for this grant program are based on the initial estimate at the time of enactment of the Affordable Care Act. As CMS gains more information about individual State implementation plans, and costs to States to implement components of the Exchanges, these estimates will be updated.

Outcomes and Outputs Table

Measure	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
PHI4.1: Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning	50 States +DC	N/A	N/A

process 2010 Baseline = 0			
PHI4.2 Number of States that have the necessary legal authority to establish and operate an Exchange that complies with Federal requirements 2010 Baseline = 0	N/A	50 States +DC	N/A
PHI4.3 Number of States in which there is an agreement drafted regarding coordination with State Medicaid, Department of Insurance and applicable State health subsidy programs, as appropriate 2010 Baseline = 0	N/A	50 States +DC	N/A
PHI4.4 Number of States in which an information infrastructure plan is developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment 2010 Baseline = 0	N/A	50 States +DC	N/A
Program Level Funding ($ in millions)	**$249.440**	**$400.000**	**+$150.560**

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Health Insurance Rate Review Grants

(Dollars in thousands)

	FY 2010	FY 2011	FY 2012	FY 2012 +/- FY 2011
Budget Authority	$250,000	-	-	-
Outlays	$13	$71,400	$65,800	($5,600)

Authorizing Legislation - PPACA, Section 1003, Section 2794 of the Public Health Service Act

FY 2010 Authorization - Public Law 111- 148

Allocation Method – Application for Grants

Program Description and Accomplishments

In 2010, HHS established a program of grants to states, the District of Columbia, and the U.S. territories to enhance the health insurance rate review process. The five-year grants program of $250 million began in fiscal year 2010. Per the Affordable Care Act, no state qualifying for a grant shall receive less than $1 million or more than $5 million for a single grant year. Each grant recipient will establish a process for the annual review of "unreasonable" rate increases and provide the Secretary with information about trends in premium increases in health insurance coverage. Proposed regulations published on December 23, 2010 provide federal guidance on the definition of "unreasonable" rate increases that would apply to rate increases reviewed by HHS, as well as on the justifications required of issuers for rates above federal and state specific threshold levels. The Funding Opportunity Announcement (FOA) for the first grant cycle was published in June 2010, and applications were due in July 2010. In August 2010, 45 states and the District of Columbia were each awarded $1,000,000.

Grant funding for the first cycle of the Health Insurance Rate Review Grant Program are being used to:

1) Enhance the current rate review process in the states;
2) Report data to the Secretary on premium trends; and
3) Implement the optional provision to provide funding to data centers to collect, analyze, and share fee schedule data with the public and other partners. Grants will limit funding for data centers to five percent of the total award.

FY 2010

As mentioned above, the FOA for the first cycle of grants for FY 2010 was published on June 7, 2010. Applications were due on July 7, 2010. Following the receipt of the applications, an objective review committee analyzed the submitted applications and awards were made on August 9, 2010. $51 million was made available to states in FY 2010, for which 46 states applied and were awarded $1,000,000 each. Five million dollars of available funds were carried over to FY 2011. At the beginning of FY 2011, the total amount remaining from the original allocation was $204,000,000.

FY 2011

CCIIO reopened the Cycle 1 grants at the beginning of FY 2011 to the five states and five U.S. territories that did not initially apply, or were not initially eligible for a Cycle 1 grant in FY 2010. The amount available for the reopened Cycle 1 grant in FY 2011 is $10,000,000 ($5,000,000 carried over from the five states that did not initially apply for Cycle 1 grants in FY 2010 plus an additional $5,000,000 for the five U.S. territories that were not initially eligible for the Cycle 1 grants). In addition to the Cycle 1 grants awarded in FY 2011, CCIIO also plans to award Cycle 2 grants to eligible states, territories, and the District of Columbia in FY 2011. These grants will be used to further enhance an awardees' rate review process building upon the progress made with the Cycle 1 grants. The eligibility criteria, the application review criteria, and the total award amount for Cycle 2 is currently under development and will be outlined in the Cycle 2 FOA.

Funding History (Appropriation)

FY 2010	$250,000,000

Budget Overview

HHS projects that $71.4 million will be drawn down in FY 2011 and $65.8 million will be drawn down in FY 2012. The eligibility criteria and available award amount is still under development and the final award amount made available for the years beyond FY 2010 may differ from the original projections provided here. The funding authorized in FY 2012 will continue to support the distribution of grants to states so that states, in collaboration with HHS, will continue to expand upon the rate review activities initiated in the first cycles of the grant program and develop robust processes for the review of "unreasonable" health insurance rates. Funding will be used by states, territories, and the District of Columbia to increase their capacity to conduct reviews of rate filings, publish rate filings, audit filers, educate consumers, and build infrastructure to advance CCIIO's goal of monitoring and reviewing health plan rate filings. The grant funding improving states' processes of reviewing proposed health insurance rate increases will improve transparency in the health insurance market and will discourage insurers from implementing unreasonable premium increases.

Center for Medicare and Medicaid Innovation

(dollars in thousands)

	FY 2010 Appropriation	FY 2011 Estimate	FY 2012 Request	FY 2012 +/- FY 2011
BA	$5,000	$10,000,000	NA	NA
Obligations		$813,000	$1,012,000	+199,000
FTEs	0	82	100	+ 18

Authorizing Legislation - Patient Protection and Affordable Care Act of 2010, Section 3021

Allocation Method - Contracts

Program Description and Accomplishments

The Center for Medicare and Medicaid Innovation (CMMI), established by Section 3021 of the Patient Protection and Affordable Care Act of 2010, is a key engine to drive continuous improvement in health and health care for all Americans. The CMMI was created to test innovative payment and service delivery models that reduce Medicare and Medicaid costs while preserving or enhancing quality of care for beneficiaries. Further, the CMMI has authority to rapidly translate these models into permanent Medicare and Medicaid policy. CMMI is establishing a process for open and collaborative model development and is beginning its work in validating and disseminating promising models, while continuously engaging with collaborators, partners, and other stakeholders to create an environment for continuous learning and improvement.

The CMMI, often referred to as the Innovation Center, was officially launched in November 2010. Major initiatives planned for 2011 will focus on Accountable Care Organizations, Medical Homes, and efforts aimed at reducing patient harm.

Funding History

FY 2010	$5,000,000
FY 2011-2019	$10,000,000,000

The law provides $10 billion in budget authority for 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 to reduce program expenditures while preserving or enhancing quality of care. Preference is given to models that improve the coordination, quality and efficiency of health care services.

Budget Overview

Broadly, the CMMI programmatic activities shall include:

Innovations in Delivery and Payment Transformation

- Evaluating different payment approaches for the development of Accountable Care Organizations (ACOs)
- Evaluating Medical Home Care models
- Evaluating new bundled payment approaches for acute, post-acute, and chronic conditions
- Small-scale prototyping of delivery models
- Implementing demonstrations to evaluate effective models that result in improved care for dually eligible populations

Nationwide Health Care Innovation "Engine"

- Establishing and evaluating the effectiveness of learning systems to facilitate the rapid and widespread diffusion of best practices as well as validated service delivery and payment models, including support of a fellowship program for bolstering rapid adoption of validated innovations
- Setting up an innovation process for harvesting best practice models and identifying need gaps for designing new innovations in care delivery improvement and sustainability

Beyond the activities noted above, the CMMI will need operational support to successfully implement its programs and initiatives including:

- Planning, design, and business process requirements assessment for an information systems environment
- General support for stakeholder outreach and CMMI business planning efforts
- Production of the Innovation Center Report to Congress, as required by the legislation

The CMMI will also incur administrative costs for personnel and related costs, including rent/facilities, travel, training, supplies, and other administrative costs.

Information Technology

Funds Source	FY 2010 Enacted	FY 2011 CR Level	FY 2012 Request
Program Operations 1/	$ 839,402,000	$ 839,402,000	$ 1,137,668,533
Federal Administration	29,240,000	29,240,000	36,353,000
Survey & Certification	3,495,000	3,495,000	12,166,678
Research	5,700,000	5,700,000	4,801,000
Subtotal, Program Management Appropriation	**$ 877,837,000**	**$ 877,837,000**	**$ 1,190,989,211**
Coordination of Benefits (COB) User Fee	26,250,073	27,835,073	31,590,000
CLIA User Fees	2,040,000	2,965,000	4,250,000
Health Care Fraud & Abuse Account Medicare Integrity Program (HCFAC/MIP Discretionary)	103,621,982	107,751,590	111,881,198
Quality Improvement Organizations 2/	39,309,477	TBD	TBD
ESRD Network	4,000,000	4,000,000	4,500,000
Medicaid Integrity Program	8,100,000	8,100,000	8,100,000
MIPPA	26,800,000	27,338,265	28,391,778
Total, CMS IT Portfolio	$1,087,958,532	$1,055,826,928	$1,379,702,187

1/ Starting in FY 2012, new program areas are incorporated into Program Operations
2/ QIO estimates are currently being developed for the 10th scope of work in FY 2011 and FY 2012

Program Description and Accomplishments

As shown in the table above, CMS' information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, and the HCFAC and QIO programs. IT activities support various programs that CMS oversees, including Medicare, Medicaid, CHIP, and associated quality-assurance and program safeguards. This chapter provides an overview of IT activities funded and discussed in various other parts of this budget submission. Additional information can be found in those specific narratives. Further information on specific IT projects can be found within the Exhibit 53 and CMS Exhibit 300s, which can be viewed at www.hhs.gov/exhibit300.

CMS Program Management Appropriation

CMS' IT investments support a broad range of basic operational needs, as well as implementing provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. The following investments are organized similarly to the exhibit 300 portfolios, with an explanation of the type of investments in each.

Program Operations

IT Investment portfolios and activities include:

- *Beneficiary Enrollment and Plan Payment, and Beneficiary E-Services* includes the Medicare Advantage enrollment and plan payment systems such as the premium withhold system, risk adjustment system, and the Medicare Advantage Prescription Drug Payment System (MARx). Our public internet sites www.cms.hhs.gov , www.medicare.gov, and the virtual call center strategy are also included.

- *Data Management Operations* supports the beneficiary enrollment database; Medicare beneficiary database suite of systems; and CMS enterprise data administration.

- *Claims Processing* operates and maintains the Medicare fee-for-service claims processing systems and the Common Working File (CWF), a major component of the Medicare claims processing function.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* includes development, operational, and maintenance costs for CMS' new financial management system.

- *Modernized IT Infrastructure* includes Enterprise Data Centers (EDCs), providing a standardized infrastructure and network platform to process over 1 billion FFS claims.

- *Infrastructure* supports the Consolidated Information Technology Infrastructure Contract (CITIC), which maintains numerous Medicare program applications as well as CMS mid-tier and mainframe operations at the CMS data center; and ongoing systems security activities at Medicare contractors.

- *Claims Interoperability and Standards* provides for the continued standardization of certain electronic transactions required by HIPAA-enacted administrative simplification provisions.

- *Other Investments* includes:

  ICD-10 and Version 5010 **-** ICD-10 is the biggest change in American health care standard coding systems in over 30 years. As discussed in the Medicare Operations section of this budget submission, ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code. Also, in order to implement ICD-10, the current version of the HIPAA transactions must be

upgraded from version 4010 to 5010. Version 5010 accommodates the increased field space required for the ICD-10 code sets.

- *Authentication - Individuals Authorized Access to the CMS Computer Services (IACS)* - hardware and software services to control access to a growing number of web-based applications, while accommodating more users.

Federal Administration

The Federal Administration portion of the Program Management appropriation funds a variety of IT activities that support CMS' IT infrastructure and daily CMS operations, including:

- voice and data telecommunication costs;
- web-hosting and satellite services;
- ongoing systems security activities across the CMS enterprise; and
- systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

The Federal Administration activity is CMS' primary source of funding for IT systems to support the Medicaid program. CMS' Medicaid data systems provide access to all Medicaid eligibility and utilization claims data. In addition, the service and supply fund activity within the Federal Administration line item includes CMS' share of costs for HHS.

Survey and Certification

The Survey and Certification line item in CMS' Program Management budget provides IT funding primarily for operation and maintenance of systems that approximately 6,500 State surveyors use to track and report the results of healthcare facility surveys. The FY 2012 request supports the continued implementation of the Quality Indicator Survey (QIS), an initiative that will utilize information technology to support quality improvements in the survey process. It also includes funds to design a new data system that will construct and display new staffing measures. This system will receive quarterly, detailed staffing and residential census data from approximately 15,800 nursing home facilities. In addition, the FY 2012 request also includes infrastructure redesign that will allow CMS to update information and improve enforcement of the full disclosure of nursing facilities ownership and organizational structure.

Research

IT funding within the Research line item covers data management and processing of the Medicare Current Beneficiary Survey and the chronically ill Medicare beneficiary research, data, and demonstration project.

Additional IT Funding Sources

HCFAC

IT funding from the Medicare Integrity Program (MIP) budget within the HCFAC account pays for a portion of CWF operating costs, as well as the ongoing operations and maintenance of systems related to audit tracking, Medicare secondary payer work, medical

review, and other benefit integrity activities. Examples of MIP-funded systems include the fraud investigation database and the Medicare exclusion database.

QIO

IT activities funded from the QIO program budget include the QIO Standard Data Processing System (SDPS), the Quality Improvement & Evaluation System (QIES), and QIO-related operations at the CMS data center.

Part D Coordination of Benefits (COB) User Fee

A portion of the COB user fees will be used to fund Part D systems.

Other sources of IT

Other sources of IT funding include the Medicare Integrity Program (MIP) discretionary account, CLIA User fees, ESRD network, and Medicaid Integrity Program. MIP discretionary funds support Part C & Part D oversight systems.

Budget Request

CMS Program Management Appropriation –

The FY 2012 Budget level request for Program Management Information Technology is $1.2 billion, a $313.2 million dollar increase from the FY 2010 Enacted Level. The demand on the CMS IT portfolio continues to grow with new legislative workloads. The $298 million increase in the Program Operations line within Program Management will fund extensive systems changes, enhancements and development of new systems for program areas not previously included. These changes include hardware/software needs, network connectivity, developing new reporting features and additional variance analysis. These funds will also provide the ability for data extracts, validating business and system needs, websites redesigns, system and security documentation and additional capacity for storage. In addition, these funds will standardize key elements of Medicaid business operations, inter-agency information exchanges, trading partner data formats, program performance measures and enhance capability to share existing Medicaid standards, models, and business services.

The increase in funds for Program Operations will also provide for insurance market oversight and planning for Health Care exchanges. These funds will specifically support a casework tool for consumer support, an enrollment system for exchanges, a data collection system for insurance and market oversight, and data reporting tools for Medical Loss Ratio.

Program Operations IT also has additional increases in Federal Administration and Survey and Certification. The $7 million increase in Federal Administration over the FY 2010 enacted level will provide funds for administrative support to accommodate new legislative workloads. Survey and Certification will increase by $8.7 million over the FY 2011 enacted level. These funds will develop new systems that capture information on nursing home disclosure and ensure staffing accountability.

Additional Sources of IT Funding for CMS Programs

The HCFAC and the QIO programs are funded primarily with mandatory dollars and operate on separate budget cycles from CMS' discretionary Program Management appropriation. The FY 2012 estimates for mandatory accounts will be refined as CMS proceeds through the budget cycle.

The other areas of IT spending are estimates and are subject to change as CMS continues the Information Technology Investment Review Board (ITIRB) process.

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FY 2012 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

CMS Allocation Statement:

The CMS will use $5,931,346 of its FY 2012 budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, $583,803 is allocated to developmental government-wide E-Government initiatives for FY 2012. This amount supports these initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$8,763
Line of Business - Grants Management	$1,428
Line of Business - Financial	$18,063
Line of Business - Budget Formulation and Execution	$13,263
Disaster Assistance Improvement Plan	$7,186
Federal Health Architecture	$535,100
FY 2012 Developmental E-Gov Initiatives Total	**$583,803**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources (HR) Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and post-award closeout actions. The Administration for Children and Families (ACF), is a Grants Management Line of Business (GMLOB) consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

In addition, $664,687 is allocated to ongoing government-wide E-Government initiatives for FY 2012. This amount supports these initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$313,849
GovBenefits	$14,163
Integrated Acquisition Environment	$304,175
Grants.gov	$32,500
FY 2012 Ongoing E-Gov Initiatives Total	**$664,687**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

NEW INITIATIVES

Titles	Appropriated Amounts		
	FY 2010	FY 2011	FY 2012
Adult Health Quality Measures	$60,000,000	$60,000,000	$60,000,000
Quality Measurement	$20,000,000	$20,000,000	$20,000,000
Medicare Independence at Home Demonstration Program	$5,000,000	$5,000,000	$5,000,000
Community-Based Care Transitions Program	$0	$500,000,000	TBD *
Treatment of Certain Complex Diagnostic Laboratory Tests	$5,000,000	$0	$0
Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries	$50,000,000	$0	$0
Graduate Nurse Education Demonstration	$0	$0	$50,000,000
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers	$160,000,000	$0	$0
Medicare Coverage Environment Hazard (Pilot Program)	Such Sums+	Such Sums+	Such Sums+

* Reflects funds available over a period of years. Appropriations are shown against the first year of availability.

+ Funding as needed.

Adult Health Quality Measures

CMS will convene an advisory committee to oversee the development and technical specifications of a core set of Adult Health Quality Measures. CMS will evaluate and revise the adult core measure set in preparation for an annual report to be published by the Secretary. The report will focus on outcomes related to the establishment of the adult core measure set.

Quality Measurement

CMS will, on an annual basis, receive input from multi-stakeholder groups on the Secretary's selection of measures for implementation, publish a list of measures to be implemented for public transparency, publish the Secretary's rationale for the selection of measures that have not been endorsed, and assess the impact measures implemented on a three year cycle beginning March 1, 2012.

Medicare Independence at Home Demonstration Program

CMS will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. CMS will establish this program by January 1, 2012 and conduct the program for a period of 3 years.

Community-Based Care Transitions Program

CMS established a Community-Based Care Transitions Program and provided funds to eligible entities that furnish improved care transition services to Medicare beneficiaries at high risk for readmission. CMS will conduct the program for a period of 5 years.

Treatment of Certain Complex Diagnostic Laboratory Tests

CMS will develop a demonstration program under part B title XVIII of the Social Security Act under which separate payments are made for complex diagnostic laboratory tests provided to certain individuals. Under the demonstration program, CMS will test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs and establish appropriate payment rates those tests.

Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries

CMS will conduct an evaluation and actuarial analysis of the 5-year community pilot grants on the ability to improve health status of the pre-Medicare population which we anticipate would lower Medicare utilization rates and healthcare costs. CMS will submit a Report to Congress describing any legislative changes and administrative actions to promote healthy lifestyles, and to report the results of the evaluation.

Graduate Nurse Education Demonstration

CMS will implement a demonstration program to increase graduate nurse education training under Medicare for which an eligible hospital may receive payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice nurses. The demonstration shall include up to 5 eligible hospitals.

Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

CMS will establish a national program of background checks for all direct patient access prospective employees in long term care facilities and service providers on a nationwide basis. Provider types include nursing homes, assisted living, home health agencies, hospices, long term care hospitals, Home and community-based services providers, and personal care agencies.

Medicare Coverage Environment Hazard (Pilot Program)

CMS will establish a pilot program in accordance with Section 1881A of the Act to provide Medicare Part A and Part B coverage for a new class of individuals who have been exposed to environmental health hazards. The pilot program will provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care. These pilot programs will also offer expanded Medicare benefits and services for eligible individuals.

Centers for Medicare & Medicaid Services

Office of National Drug Control Policy (ONDCP) Budget

Resource Summary

CMS was designated as a National Drug Control Program Agency in 2007. At that time, per the request of the Office of National Drug Control Policy (ONDCP), CMS introduced two new Healthcare Common Procedure Coding System codes that facilitate Medicaid payment for screening and brief intervention services (H0049, for preventive alcohol and/or drug screening, and H0050, a brief counseling session with a health professional that generally occurs right after the screening). These codes have been made available for health care providers and States to use, though there is no requirement to do so. The estimates that reflected this activity were developed by HHS actuaries based on the number of States that adopted the codes.

Beginning with the FY 2012 President's Budget, ONDCP significantly expanded the scope of CMS's drug control agency designation, to include more Medicaid services as well as Medicare. Long-term, ONDCP and the HHS Office of the Assistant Secretary for Planning and Evaluation are co-sponsoring research to refine the methodology for determining total Federal outlays for Medicare and Medicaid. In the meantime, ONDCP developed its own placeholder estimates of Federal spending on these programs.

ONDCP developed the placeholder outlay estimates for substance abuse treatment spending in Medicare and Medicaid, based on data in the 2008 report '*SAMHSA Spending Estimates: MHSA Spending Projections for 2004–2014'*.[1] ONDCP estimates that Medicare's spending on substance abuse totaled $1.33 billion in FY 2010, and will sum to $1.39 billion in FY 2011 and $1.46 billion in FY 2012. ONDCP estimates that Medicaid spent $3.79 billion in FY 2010 on substance abuse treatment. ONDCP also projects that Medicaid will spend $3.78 billion in FY 2011 and $3.58 billion in FY 2012 on substance abuse treatment. Together, the placeholder estimates for the two programs total $5.11 billion in FY 2010, $5.17 billion in FY 2011, and $5.04 billion in FY 2012.

Mission

The Centers for Medicare & Medicaid Services' (CMS) mission is a major force and trustworthy partner in the continual improvement of health and health care for all Americans.

Through its coverage of drug treatment services in Medicare and Medicaid, CMS helps support the goals of ONDCP by continuing to meet the challenges of providing drug abuse treatment care to eligible beneficiaries.

[1] CMS's Office of the Actuary (OACT) did not develop nor approve these estimates. The estimates are not consistent with the FY 2012 President's Budget Medicare or Medicaid projections, and do not incorporate the impact of recent legislation (including the Recovery Act and Affordable Care Act), nor recent economic and policy changes to the programs. These estimates reflect a methodology change from previous years where OACT estimated baseline outlays of certain treatment codes only for the Medicaid program based on projected State Medicaid program participation; the current placeholder estimates are for use while HHS develops a more accurate estimate consistent with current program spending.

Background

Medicare provides hospital, supplemental medical and prescription drug insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicaid is means-tested health care entitlement program financed by States and the Federal government. States have considerable flexibility in structuring their Medicaid programs.

Budget Summary

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2012 CMS budget submission to the congressional appropriations committees includes a budget decision unit (Resource Summary). However, because CMS has not been tasked with a drug control initiative for which budgetary resources are sought from the Congress, our resource summary reflects no requested funding.

CMS Program Management
Budget Authority by Object

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$426,224,000	$481,338,000	$55,114,000
Other than full-time permanent (11.3)	$12,773,000	$14,239,000	$1,466,000
Other personnel compensation (11.5)	$8,000,000	$10,214,000	$2,214,000
Military personnel (11.7)	$8,730,000	$11,762,000	$3,032,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$455,727,000**	**$517,553,000**	**$61,826,000**
Civilian benefits (12.1)	$108,023,000	$131,146,000	$23,123,000
Military benefits (12.2)	$4,497,000	$6,059,000	$1,562,000
Benefits to former personnel (13.0)	$0		$0
Total Pay Costs	**$568,247,000**	**$654,758,000**	**$86,511,000**
Travel and transportation of persons (21.0)	$8,900,000	$11,715,000	$2,815,000
Transportation of things (22.0)	$0	$0	$0
Rental payments to GSA (23.1)	$25,100,000	$35,424,000	$10,324,000
Communication, utilities, and misc. charges (23.3)	$300,000	$4,548,000	$4,248,000
Printing and reproduction (24.0)	$3,200,000	$3,000,000	($200,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$116,217,000	$116,217,000
Other services (25.2)	$1,358,604,000	$1,823,354,000	$464,750,000
Purchase of goods and services from government accounts (25.3)	$2,000,000	$5,345,000	$3,345,000
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$30,000,000	$28,700,000	($1,300,000)
Medical care (25.6)	$1,354,227,000	$1,354,372,000	$145,000
Operation and maintenance of equipment (25.7)	$0	$25,525,000	$25,525,000
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,744,831,000**	**$3,353,513,000**	**$608,682,000**
Supplies and materials (26.0)	$1,064,000	$1,258,000	$194,000
Equipment (31.0)	$100,000	$275,357,000	$275,257,000
Land and Structures (32.0)	$10,900,000	$10,900,000	$0
Investments and Loans (33.0)	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$60,600,000	$46,500,000	($14,100,000)
Interest and dividends (43.0)	$0	$0	$0
Refunds (44.0)	$0	$0	$0
Total Non-Pay Costs	**$2,854,995,000**	**$3,742,215,000**	**$887,220,000**
Total Budget Authority by Object Class 1/	**$3,423,242,000**	**$4,396,973,000**	**$973,731,000**

1/ Reflects CMS' enacted discretionary appropriation in FY 2010.

American Recovery and Reinvestment Act (ARRA):			
Personnel compensation:			
Full-time permanent (11.1)	$10,243,000	$16,577,000	$6,334,000
Other personnel compensation (11.5)	$0	$351,000	$351,000
Civilian benefits (12.1)	$2,640,000	$4,571,000	$1,931,000
Other Contractual Services:			
Other services (25.2)	$127,117,000	$118,501,000	($8,616,000)
Total Budget Authority by Object Class	**$140,000,000**	**$140,000,000**	**$0**

CMS Program Management
Salaries and Expenses

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$426,224,000	$481,338,000	$55,114,000
Other than full-time permanent (11.3)	$12,773,000	$14,239,000	$1,466,000
Other personnel compensation (11.5)	$8,000,000	$10,214,000	$2,214,000
Military personnel (11.7)	$8,730,000	$11,762,000	$3,032,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$455,727,000**	**$517,553,000**	**$61,826,000**
Civilian benefits (12.1)	$108,023,000	$131,146,000	$23,123,000
Military benefits (12.2)	$4,497,000	$6,059,000	$1,562,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$568,247,000**	**$654,758,000**	**$86,511,000**
Travel and transportation of persons (21.0)	$8,900,000	$11,715,000	$2,815,000
Transportation of things (22.0)	$0	$0	$0
Rental payments to Others GSA (23.2)	$0	$0	$0
Communication, utilities, and misc. charges (23.3)	$300,000	$4,548,000	$4,248,000
Printing and reproduction (24.0)	$3,200,000	$3,000,000	($200,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$116,217,000	$116,217,000
Other services (25.2)	$1,358,604,000	$1,823,354,000	$464,750,000
Purchase of goods and services from government accounts (25.3)	$2,000,000	$5,345,000	$3,345,000
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$30,000,000	$28,700,000	($1,300,000)
Medical care (25.6)	$1,354,227,000	$1,354,372,000	$145,000
Operation and maintenance of equipment (25.7)	$0	$25,525,000	$25,525,000
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,744,831,000**	**$3,353,513,000**	**$608,682,000**
Supplies and materials (26.0)	$1,064,000	$1,258,000	$194,000
Total Non-Pay Costs	**$2,758,295,000**	**$3,374,034,000**	**$615,739,000**
Total Salary and Expense 1/	**$3,326,542,000**	**$4,028,792,000**	**$702,250,000**
Direct FTE 2/	**4,276**	**4,917**	**641**

1/ Reflects CMS' enacted discretionary appropriation in FY 2010.
2/ Reflects CMS' enacted staffing level in FY 2010.

American Recovery and Reinvestment Act (ARRA):

Personnel compensation:			
Full-time permanent (11.1)	$10,243,000	$16,577,000	$6,334,000
Other personnel compensation (11.5)	$0	$351,000	$351,000
Civilian benefits (12.1)	$2,640,000	$4,571,000	$1,931,000
Other Contractual Services:			
Other services (25.2)	$127,117,000	$118,501,000	($8,616,000)
Total Salary and Expense	**$140,000,000**	**$140,000,000**	**$0**
Direct FTE 1/	**100**	**160**	**60**

1/ Reflects CMS' enacted staffing level in FY 2010.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2010 Actual	2011 Estimate	2012 Estimate
Office of the Administrator			
Direct FTEs	31	32	37
Reimbursable FTEs	0	0	0
Subtotal	31	32	37
Center for Consumer Information and Insurance Oversight			
Direct FTEs	0	0	272
Reimbursable FTEs	0	0	0
Subtotal	0	0	272
Center for Medicaid, CHIP and Survey & Certification			
Direct FTEs	311	322	389
Reimbursable FTEs	36	39	40
Subtotal	347	361	429
Center for Medicare			
Direct FTEs	686	709	821
Reimbursable FTEs	5	6	6
Subtotal	691	715	827
Center for Medicare and Medicaid Innovation 1/			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Center for Program Integrity			
Direct FTEs	51	53	57
Reimbursable FTEs	0	0	0
Subtotal	51	53	57
Center for Strategic Planning			
Direct FTEs	157	162	173
Reimbursable FTEs	0	0	0
Subtotal	157	162	173
Office of the Actuary			
Direct FTEs	83	86	90
Reimbursable FTEs	0	0	0
Subtotal	83	86	90
Office of Acquisition & Grants Management			
Direct FTEs	102	106	139
Reimbursable FTEs	2	2	2
Subtotal	104	108	141
Office of Clinical Standards and Quality			
Direct FTEs	197	204	223
Reimbursable FTEs	0	0	0
Subtotal	197	204	223
Office of E-Health Standards and Services			
Direct FTEs	15	15	21
Reimbursable FTEs	0	0	0
Subtotal	15	15	21
Office of Equal Opportunity and Civil Rights			
Direct FTEs	22	23	23
Reimbursable FTEs	0	0	0
Subtotal	22	23	23
Office of Executive Operations and Regulatory Affairs			
Direct FTEs	131	136	141
Reimbursable FTEs	0	0	0
Subtotal	131	136	141

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2010 Actual	2011 Estimate	2012 Estimate
Office of External Affairs and Beneficiary Services			
Direct FTEs	245	253	263
Reimbursable FTEs	0	0	0
Subtotal	245	253	263
Office of Federal Coordinated Health Care			
Direct FTEs	0	0	12
Reimbursable FTEs	0	0	0
Subtotal	0	0	12
Office of Financial Management			
Direct FTEs	296	305	319
Reimbursable FTEs	22	24	25
Subtotal	318	329	344
Office of Information Services			
Direct FTEs	349	361	393
Reimbursable FTEs	4	5	5
Subtotal	353	366	398
Office of Legislation			
Direct FTEs	36	37	41
Reimbursable FTEs	0	0	0
Subtotal	36	37	41
Office of Minority Health			
Direct FTEs	0	0	2
Reimbursable FTEs	0	0	0
Subtotal	0	0	2
Office of Operations Management			
Direct FTEs	186	192	203
Reimbursable FTEs	0	0	0
Subtotal	186	192	203
Consortia			
Direct FTEs	1,243	1,284	1,299
Reimbursable FTEs	37	39	40
Subtotal	1,280	1,323	1,339
Total, CMS Program Management FTE 2/	**4,248**	**4,393**	**5,035**
Total, CMS Military Staffing (Non-Add) 2/	*103*	*109*	*129*
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE 2/	**42**	**130**	**160**

1/ CMMI has only mandatory staffing, which is not reflected in this table.

2/ FY 2010 reflects actual FTE consumption. Reflects discretionary Program Management staffing.

Average GS Grade

FY 2007	**13.4**
FY 2008	**13.4**
FY 2009	**13.4**
FY 2010	**13.4**
FY 2011	**13.3**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2010 Actual	2011 CR	2012 Estimate
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$165	$165	$168
Subtotal	75	75	81
Total - ES Salaries	$12,611	$12,611	$13,620
GS-15	456	485	567
GS-14	553	588	672
GS-13	1,968	2,090	2,308
GS-12	646	686	781
GS-11	122	130	178
GS-10	1	1	1
GS-9	175	186	264
GS-8	14	14	16
GS-7	120	127	142
GS-6	17	18	20
GS-5	33	35	40
GS-4	27	29	32
GS-3	9	10	10
GS-2	4	4	4
GS-1	4	4	4
Subtotal 1/	4,149	4,406	5,038
Total - GS Salary 1/	$409,077	$426,406	$492,311
Average GS grade 1/	13.4	13.3	13.3
Average GS salary 1/	$98.597	$96.778	$97.720

1/ Includes ARRA positions. Excludes user fee-funded positions and other mandatory staffing within the CMS Program Management account.

CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

Significant Items of Interest to Congress
FY 2011 Senate Appropriations Committee Report Language
(Senate Report 111-243)

Item

Diabetes- According to research conducted by AHRQ, the Medicare program has costs of up to $1,300,000,000 attributable to diabetes-related hospital costs that could potentially be avoided by proper disease management. Using insulin is one of the most effective ways to lower blood sugar levels and manage diabetes. The Committee encourages CMS to consider conducting research into the best delivery method for insulin therapy to reduce dosing errors and lower annual treatment costs.

Action Taken or To Be Taken

CMS agrees that proper disease management is essential and is an important part of not only reducing costs in Medicare but also in creating better health for people living with diabetes. Through evidence-based research and demonstrations, CMS intends to look at best practices and better disease management for patients with chronic illnesses.

CMS is conducting the following Research and Demonstration projects that have a diabetes component:

Health Quality Partners (HQP) in Doylestown, Pennsylvania, the one remaining site in the Medicare Coordinated Care Demonstration, provides services to approximately 500 beneficiaries with coronary artery disease or with diabetes, congestive heart failure, or chronic obstructive pulmonary disease and at least one hospitalization in the prior year. For this particular group of patients (which comprises roughly half their original target population), HQP has shown a cost savings as well as a statistically significant reduction in mortality. Authorized under section 4016 of the Balanced Budget Act of 1997, the demonstration was originally implemented in 15 sites in 2002. HQP has been extended through June 30, 2013.

In addition, States will shortly be invited to compete for participation in the Medicaid Incentives for Prevention of Chronic Diseases Program authorized by section 4108 of the Affordable Care Act. This nationwide program will test and evaluate the effectiveness of a program to provide financial and non-financial incentives to Medicaid beneficiaries of all ages who participate in prevention programs to address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition; and demonstrating changes in health risk and outcomes, including the adoption of healthy behaviors.

The Independence at Home demonstration, scheduled to be implemented in January, 2012, will provide home-based primary care to severely chronically ill beneficiaries, i.e., those with two or more chronic conditions, limitations in two or more activities of daily living, a non-elective hospital admission and use of post-acute rehabilitation services in the prior year. Section 3024 of the Affordable Care Act, which mandates the demonstration, lists diabetes as one of the chronic

conditions by which a beneficiary is qualified to participate. This demonstration is in the early stages of design.

The Affordable Care Act (Sec. 4202) charges CMS to conduct an evaluation of the effectiveness of community-based wellness and prevention programs for Medicare beneficiaries. The scope of this work will include diabetes self-management programs. CMS is addressing this charge in two phases: 1) conduct an environmental scan, site visits, evidence reviews and an evaluation design to provide input to the evaluation; and 2) conduct an evaluation of selected programs. In December 2010, Altarum Institute was selected to conduct the first phase of the contract. The environmental scan and site visits will inform the evaluation design; the evidence reviews will be conducted in concert with the scan, and will provide a review of evidence-based programs to be included in a report to Congress in 2013. A second contract to begin the evaluations will be awarded by CMS in late 2011.

Item

Graduate Nursing Education Pilot- The Committee recognizes the value of advanced practice registered nurses [APRNs] for improving the accessibility, quality, and affordability of healthcare. Section 5509 of the Patient Protection and Affordable Care Act includes a demonstration project to test the establishment of a Medicare Graduate Nursing Education program. The Committee encourages CMS to begin the design of this initiative. In this design, the Committee encourages CMS to test a full geographically representative mix of small and large, rural and urban APRN educational programs utilizing different mixes of hospital and non-hospital community-based clinical training sites. In addition, the Committee encourages CMS to assure that reasonable costs for the demonstration take into account all types of clinical training regularly employed in and appropriate to the training of APRNs and are not reduced by a factor related to the proportion of hospital inpatient days that are Medicare inpatient days. The Committee requests a progress report in the fiscal year 2012 budget justification.

Action Taken or To Be Taken

CMS is currently working on the design of the Graduate Nursing Education demonstration as mandated in Section 5509 of the Affordable Care Act; we are planning to publish a solicitation for proposals by the summer of 2011. When selecting eligible organizations for participation in the demonstrations, CMS will include a representative mix of APRN educational programs and clinical training sites as a selection criterion.

In implementing this pilot project, CMS is bound by the requirements of the statute, which specifies that in defining "reasonable costs," CMS is required to use the definition described in the Social Security Act (section 1861 (v) of 42 U.S.C 1395x (v)). The corresponding Medicare regulations state that as part of the reasonable cost determination, net costs are subject to apportionment for Medicare utilization. Thus, the demonstration hospital share of Medicare patients is one of the factors for determining demonstration payments. CMS anticipates that hospitals will reimburse participating schools of nursing and community based clinical training sites as defined by the established written agreements between these partners for purpose of demonstration.

Item

Prosthetic Devices- The Committee is aware of findings in peer reviewed literature that identify significant inconsistencies in the alignment of prosthetic devices through the fitting process. Improper alignment for persons with limb loss can result in trauma to the soft tissue, decreased balance, and co-morbidities ranging from inactivity to back pain and increased stress on the hip and knee joints. Consistent prosthesis alignment may produce costs savings to the Medicare program through reduced need for socket replacements. The Committee encourages the CMS and its Alpha-numeric Working Group to consider utilizing a unique Healthcare Common Procedure Coding System number for technologies and services that produce consistent prosthesis alignment.

Action Taken or To Be Taken

CMS is not authorized under the statute to make separate payments for fitting and adjustment of prosthetics or artificial limbs. Payment for fitting and adjustment of the prosthesis and other services associated with furnishing the prosthesis is included in the Medicare fee schedule payment and separate payment for these services is not allowed under the exclusive payment rule in the statute.

In accordance with Medicare policy, the supplier that furnishes the artificial limb is responsible for necessary follow up fitting and adjustments for 90 days from the date the limb was furnished in situations where the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities. While CMS appreciates the importance of proper fitting and alignment for prosthetics in preventing some co-morbidities, payment for additional follow up fitting and adjustments to prevent the cost of replacing the entire prosthesis or portions of the prosthesis would require an amendment to the statute.

If refinements or improvements in technology produce artificial limbs that result in better alignment and fitting, these requests would be considered though the normal HCPCS editorial process.

CMS has checked the records over several years and there are no complaints, other entities, or individuals pertaining to the alignment of prosthetic devices. CMS and its contractors educate suppliers about the all inclusive nature of the Medicare payment for prosthetics and no issues have been raised by suppliers that this issue is problematic for any reason.

Item

Psychotropic Drugs and Children- The Committee is aware of findings from recent research showing that poor children are more likely to be prescribed antipsychotic medications than their peers. In addition to possibly causing serious long-term health problems for the children, this pattern dramatically increases Medicaid costs. CMS is urged to support research into reasons for this disparity and to determine the cost of this practice to the Medicaid program. CMS is also urged to work with existing treatment programs to identify more effective methods for treating these children and reducing their dependence on drugs to manage behavior.

Action Taken or To Be Taken
CMS plans to work with Federal partners and other stakeholders to support research into reasons for the disparity and to determine the cost of this practice to the Medicaid program. Additionally, CMS plans to work with these Federal partners and stakeholders to identify effective strategies for treating children and reducing their dependence on drugs to manage behavior. Although CMS does not provide funding for research projects, we are committed to sharing best practices that will assist States in the management of their Medicaid programs and help ensure high-quality care for Medicaid beneficiaries.

Item
Home and Community Based Service Programs- The Committee strongly supports efforts by CMS to transform and improve quality and efficiency under the Medicaid program, particularly including expansions to the Home and Community Based Service programs and the creation of health homes for eligible beneficiaries. The Committee urges CMS to ensure that the implementation of such initiatives involve providers in ensuring beneficiary access to necessary food and nutrition services integral to the proper management of chronic illness in a non-institutional setting.

Action Taken or To Be Taken
CMS will continue to collaborate with provider associations and provider groups and seek their input regarding the expansion of existing and development of new Home and Community based Service (HCBS) Programs. CMS is committed to, ensuring participant access to a range of available qualified providers.

Item
HIV Testing- The Committee congratulates CMS for updating its coverage to include HIV testing for at-risk beneficiaries. The Committee urges CMS to update its outreach information to advise beneficiaries of this important new benefit.

Action Taken or To Be Taken
CMS appreciates the Committee's suggestion to update the outreach information. CMS makes every effort to update outreach materials to ensure that beneficiaries are aware of new benefits. To that end, the 2011 Medicare and You Handbook (page 36) discusses Medicare's coverage of HIV screening for Medicare beneficiaries of any age who ask for the test, as well as pregnant women and people at increased risk of infection. Additionally, recent Medicare outreach materials have included information on the Affordable Care Act provisions that eliminate cost sharing for many preventive services, including HIV testing.

Item
340B Drug Discount Program- The Committee also requests that HRSA and CMS convene a working group to ensure that all phases of the 340B drug discount program are administered without redundancy or contradiction by the two agencies of jurisdiction.

Action Taken or To Be Taken

HRSA and CMS have begun regular discussions on issues where there is an intersection between the 340B program and the Medicaid program. HRSA and CMS intend to continue these collaborative efforts in the future. HRSA will take the lead in these discussions and CMS will probably include Medicare/Medicaid representatives.

CMS and HRSA have already been working together to ensure that provisions in the Affordable Care Act expand the list of covered entities in the 340B program are appropriately implemented.

CMS and HRSA also routinely co-host Low-Income Health Access Open Door Forums to address the concerns of beneficiary advocates, providers, and information intermediaries throughout the country interested in improving access to Medicare and Medicaid for lower-income Americans. The forums generally include timely announcements and clarifications regarding important rulemaking, agency program initiatives, and other related areas impacting the lower-income beneficiaries. Service settings such as Federally Qualified Health Centers (FQHC's), Community Health Centers (CHCs) and 340(b) Hospitals and other providers are also often discussed.