DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2011

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2011 performance budget. Our programs will touch the lives of almost 102 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2011. We take our role very seriously, as our oversight responsibilities impact millions of vulnerable citizens and have grown dramatically over the last few years.

CMS is committed to transforming and modernizing Medicare, Medicaid, and CHIP for America. This budget request reflects this commitment, highlighting our progress on agency performance goals and on improving program effectiveness. Additional information about CMS performance may be found in our Online Performance Appendix at **http://www.cms.gov/performancebudget.**

In FY 2011, CMS will improve program efficiency and quality of services through contracting reform and the implementation of ICD-10 healthcare coding changes; expand our program integrity focus by establishing new Health Care Fraud Prevention and Enforcement Action Teams (HEAT) Strike Force locations, addressing new and evolving fraud and abuse schemes, and seeking seven new program integrity proposals; and increase quality health care through our value-based purchasing and health promotion initiatives. CMS will also begin a new multi-year, health care data improvement initiative that will transform our data, systems, and infrastructure to meet the needs of future growth and financial accountability, promote broader and easier access to data, enhance data integration, increase cyber security, and improve analytic capabilities.

CMS will play a key role in implementing the Administration's health priorities, including those articulated in the recently enacted *American Recovery and Reinvestment Act of 2009* and the *Children's Health Insurance Program Reauthorization Act of 2009*. CMS advocates the adoption of health information technology by incentivizing the meaningful use of electronic health records by Medicare and Medicaid providers. We will advance wellness and prevention activities by helping to reduce the incidence of healthcare-acquired infections. We will promote enrollment of eligible children in Medicaid and CHIP and endorse a core set of child health quality measures for States to use. These efforts are intended to improve quality of care for our beneficiaries, increase transparency, and reduce costs.

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. Our FY 2011 Program Management request reflects a 3.8 percent increase over the enacted FY 2010 level. While our needs are growing, we continue to look for efficiencies to offset escalating costs.

On behalf of our beneficiaries, I thank you for your continued support of CMS and its FY 2011 budget request.

Charlene Frizzera

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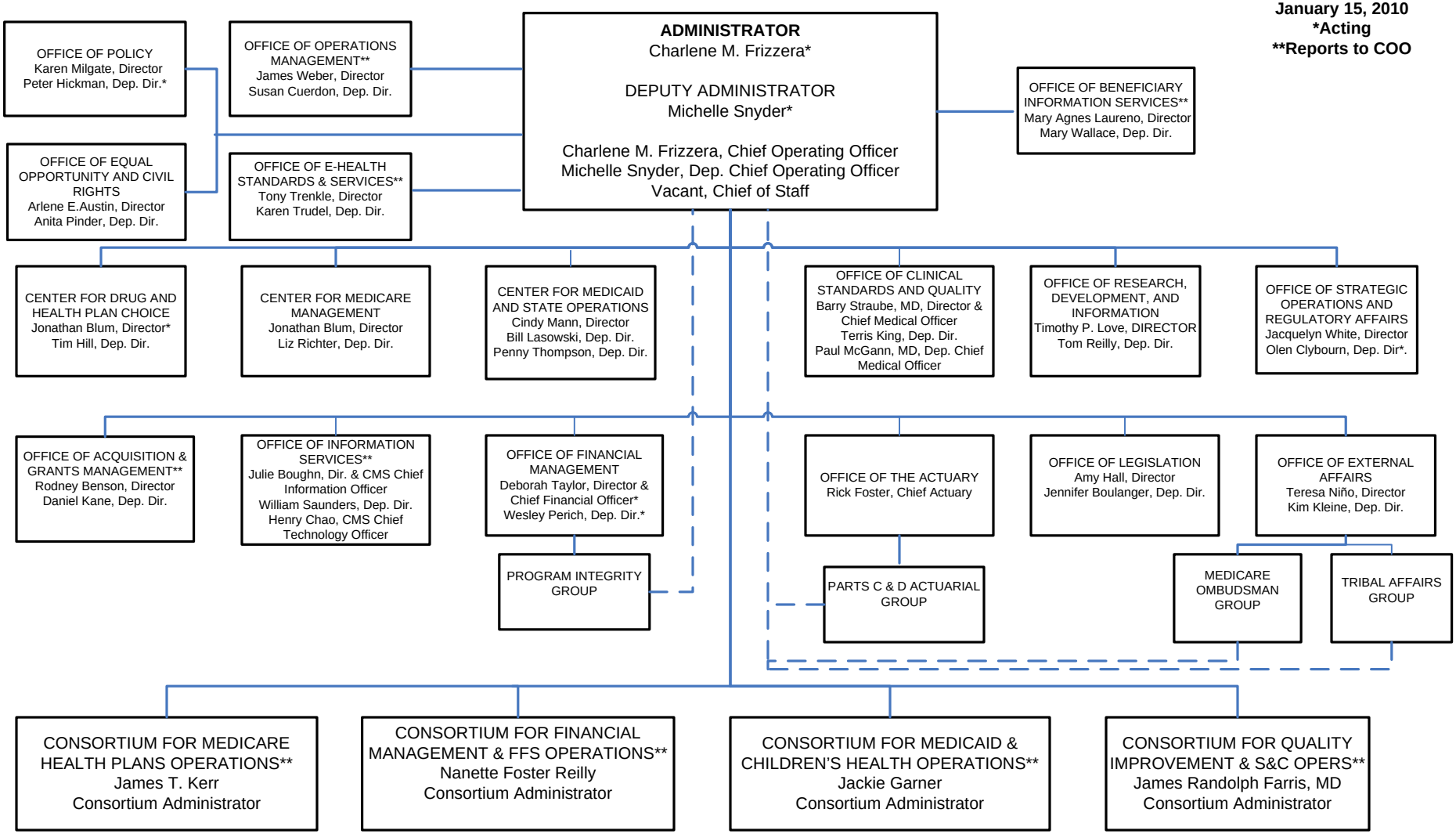
For alternate text document, go to http://www.cms.hhs.gov/CMSLeadership/

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

APPROVED LEADERSHIP

As of January 15, 2010
***Acting**
****Reports to COO**



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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.

Recent legislation has significantly expanded CMS' responsibilities. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made sweeping changes to the Medicare program including the addition of a prescription drug benefit, the most significant expansion of this program since its inception in 1965. In 2005, Congress passed the Deficit Reduction Act (DRA) with 98 provisions impacting Medicare and Medicaid including changes in Medicare reimbursements, Medicaid prescription drug reforms, and the creation of a Medicaid Integrity 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, established incentives for reporting on electronic prescribing and renal dialysis quality measures, enhanced beneficiary services, and improved access to health care.

More recently, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), enacted on February 4, 2009, extends the CHIP through FY 2013, improves outreach, enrollment, and access to benefits within the Medicaid and CHIP programs, mandates development of child health quality measures and reporting for children enrolled in Medicaid and CHIP, and promotes the use of health information technology and electronic health records for Medicaid and CHIP beneficiaries.

The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act"), enacted on February 17, 2009, promotes economic recovery, assists those affected by the recession, including the middle class, provides investments for technological advances, invests in infrastructure, and stabilizes State and local government budgets. Among other things, the Recovery Act provides for measures that stimulate the economy and preserve and improve access to affordable health care. ARRA directly impacts CMS and its work. CMS will advocate the adoption of health information technology by incentivizing the use of electronic health records by Medicare and Medicaid providers. CMS will also advance wellness and prevention by helping reduce the incidence of healthcare-associated infections. ARRA also temporarily increases the Federal medical assistance percentage (FMAP) and the disproportionate share hospital (DSH) allotments for States and Territories, extends the Transitional Medical Assistance (TMA) and Qualified Individual (QI) programs, and provides protections for Native Americans under Medicaid and CHIP.

CMS remains the largest purchaser of health care in the United States. For more than 40 years, Medicare and Medicaid have helped pay the medical bills of millions of older and low-income Americans, providing them with reliable health benefits. We expect to serve almost 102 million beneficiaries in FY 2011, roughly one in three Americans. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures. Few programs, public or private, have such a positive impact on so many Americans.

CMS outlays more benefits than any other Federal agency and we are committed to administering our programs as efficiently as possible. In FY 2011, benefit costs are expected to total $823 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 Clinical Laboratory Improvement Amendments program (CLIA), among others, are estimated at $23.5 billion or 2.8 percent of total benefits. CMS' non-benefit costs are minute when compared to Medicare benefits and the Federal share of Medicaid and CHIP benefits. Remarkably, Program Management costs are less than one-half of one percent of these benefits.

Mission

CMS' mission is to ensure effective, up-to-date health care coverage and to promote quality care for its beneficiaries.

Vision

CMS envisions a transformed and modernized health care system for America that promotes efficiency and accountability, aligns incentives toward quality, and encourages shared responsibility. We will make CMS an active purchaser of high quality, efficient care; make sure that those who provide health care services are paid the right amount at the right time; work toward a high-value health care system where providers are paid for giving quality care; increase consumer confidence by giving them more information; strengthen our workforce to manage and implement our programs; and continue to develop collaborative partnerships with our stakeholders.

CMS is playing a major role in implementing the following Recovery Act efforts:

- Health Information Technology: The Recovery Act makes a significant investment in a health information technology (IT) system through which information about patients, their treatment, and outcomes would be accessible to providers. The use of electronic health records (EHRs) is expected to facilitate improvements in the quality of health care, prevent unnecessary health care spending, and reduce medical errors. The law establishes incentives for adopting and using certified EHR technology and includes eventual Medicare penalties for failing to use EHRs. CMS is charged with ensuring that eligible providers begin using this technology for Medicare and Medicaid beneficiaries in a meaningful way. The Recovery Act provides CMS with over $1 billion for implementation costs over eight years: $140 million annually from FY 2009 through FY 2015 and $65 million in FY 2016.

- Prevention and Wellness: The Recovery Act provided $1 billion in preventive care and wellness benefits to help move beyond treating the sick to preventing illness and improving health. Of the funds appropriated, $50 million was provided to States for

prevention of Healthcare Associated Infections (HAI). Recent research has projected that implementation of the CDC's HAI prevention recommendations can reduce these infections by 70 percent. Of the $50 million appropriated, CMS has been provided with a total of $10 million--$1 million in FY 2009 and $9 million in FY 2010--to increase State surveys and certifications of the Nation's ambulatory surgical centers (ASCs) to help ensure that proper HAI controls are in place.

Overview of Budget Request

CMS' FY 2011 request for its four annually-appropriated accounts totals $493.8 billion, a decrease of $17.3 billion from FY 2010. These accounts include Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds.

Major activities within each of CMS' four annually-appropriated accounts are discussed in more detail below.

CMS Annually-Appropriated Accounts
($ in millions)

Accounts	FY 2010 Appropriation	FY 2011 Request	FY 2011+/- FY 2010
Program Management	$3,470.2	$3,601.1	+$130.9
HCFAC -- Discretionary	$311.0	$561.0	+$250.0
Grants to States for Medicaid	$292,662.5	$259,933.2	-$32,729.3
Payments to Health Care Trust Funds	$214,590.1	$229,664.0	+$15,073.9
Grand Total	$511,033.8	$493,759.3	-$17,274.5

Program Increases

Program Management (+$185.9 million):

- **Medicare Operations (+$20.7 million)**
  CMS requests $2,356.6 million, a net increase of $20.7 million above the FY 2010 appropriation. This will allow CMS to process its fee-for-service workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), make progress implementing the new ICD-10 coding system, enhance education and outreach, and implement selected provisions in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

  Significant increases include:

  - National Medicare and You Education Program (NMEP) –an increase of $51.7 million, mainly for the 1-800-MEDICARE call center and the State Health Insurance Assistance Program (SHIP).
  - MIPPA –an increase of $27.7 million to continue key MIPPA projects, including reporting on physician quality, e-prescribing, and end stage renal disease (ESRD) measures.

Significant decreases within this account include:

- Medicare Contracting Reform – a decrease of $56.5 million. This reflects the anticipated completion of the Fiscal Intermediary and Carrier transitions to the new Medicare Administrative Contractors.
- On-Going Operations – a decrease of $36.6 million in ongoing operations costs at the Medicare Administrative Contractors. This reflects claims processing savings resulting from the Contracting Reform initiative.
- Procurement Savings – a total decrease of $7.1 million resulting from competitively renegotiating several contracts.

- **Federal Administration: (+$28.5 million)**
  CMS requests $725.4 million, an increase of $28.5 million above the FY 2010 appropriation. At this level, CMS can support 4,326 direct FTEs, an increase of 50 FTEs.

- **Survey and Certification: (+$15.1 million)**
  The FY 2011 request is $362.0 million, an increase of $15.1 million above the FY 2010 appropriation. This level will allow CMS to meet statutory survey frequencies and to continue quality efforts in the surveys of Ambulatory Surgical Centers and Accredited hospitals.

- **Research, Demonstration, and Evaluation**: **(+$11.6 million)**
  CMS requests $47.2 million in FY 2011, an increase of $11.6 million above the FY 2010 appropriation. The additional funds support innovative approaches to improving the quality of healthcare furnished to Medicare and Medicaid beneficiaries and slowing the cost of health care spending. Real Choice Systems Change grants are funded at $2.5 million, the same as in FY 2010.

- **Health Care Data Improvement Initiative: (+$110.0 million)**
  CMS requests an investment of $110.0 million for a new, multi-year initiative that will enable CMS to transform its data, systems, and infrastructure to meet the needs of future growth and financial accountability, promote broader and easier access to data, enhance data integration, increase cyber security, and improve analytic capabilities. These enhancements will make CMS' data more easily accessible and more useful to researchers. They will allow CMS to transform Medicare and Medicaid into leaders in value-based purchasing and in data sources for comparative effectiveness research.

Health Care Fraud and Abuse Control (+250.0 million)

The FY 2011 request for the discretionary Health Care Fraud and Abuse Control account is $561.0 million, an increase of $250.0 million over FY 2010. This request will provide additional funding for both Medicare and Medicaid program integrity efforts. Almost half of the increase, $116.1 million, will be used to fund new Health Care Enforcement Action (HEAT) initiatives at CMS, the Department of Justice (DoJ), and the Office of Inspector General. HEAT will establish strike force teams in select cities and increase coordination, data sharing, and training among our investigators, agents and prosecutors in order to more effectively fight fraud and abuse in our programs.

Payments to the Health Care Trust Funds (+$15.1 billion)

The FY 2011 request for Payments to the Health Care Trust Funds account--$229.7 billion--reflects an overall increase of $15.1 billion above the FY 2010 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.

Program Decreases

Program Management: (-$55.0 million)

- **High Risk Pools: (-$55.0 million)**
  In FY 2011, CMS is not requesting funding for High Risk Pools through its Program Management account. From FY 2008 through FY 2010, this activity was funded through Program Management. Prior to that, it was funded through CMS' State Grants and Demonstrations account. CMS expects this activity to be funded from a source other than Program Management in FY 2011.

Grants to States for Medicaid (-$32.7 billion)

The FY 2011 Medicaid request is $259.9 billion, a decrease of $32.7 billion below the FY 2010 estimate. This includes $12.9 billion for Recovery Act provisions for the first quarter of FY 2011. This request, together with an FY 2010 end-of-year unobligated balance of $14.4 billion and an offsetting collection of $150.0 million from Medicare Part B for the Qualified Individuals (QI) program, will fund FY 2011 Medicaid obligations of $274.5 billion including: $254.4 billion in medical assistance benefits; $13.6 billion in administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; $3.7 billion for the Centers for Disease Control and Prevention's Vaccines for Children program; and $2.9 billion for benefit obligations incurred but not yet reported.

CONCLUSION

CMS' FY 2011 request for its four annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $493.8 billion, a decrease of $17.3 billion from FY 2010. The request includes $3.6 billion for Program Management, an increase of $130.9 million over FY 2010. This level will allow CMS to launch a new multi-year Health Care Data Improvement initiative that will transform our systems, enhance data sharing, improve analytic capabilities, simplify identity access management, and provide more effective security and disaster recovery. It will also allow CMS to manage and oversee its substantial ongoing workloads, make significant progress implementing ICD-10 coding changes and recent legislation, improve prevention and wellness, and allow CMS to implement innovative approaches in its research agenda. In addition, this level will support the staff needed to meet the agency's new and ongoing responsibilities. The request includes $561.0 million for discretionary HCFAC activities, an increase of $250 million over FY 2010 to enable CMS

to strengthen its fight against fraud in the Medicare and Medicaid programs, implement the new HEAT strike force teams, and address new and evolving fraud and abuse schemes.

This FY 2011 request supports our dedication to controlling health care costs while improving quality and access. We remain committed to finding additional efficiencies within our base, to providing our beneficiaries and other stakeholders the highest possible levels of service, and to safeguarding our programs.

OVERVIEW OF CMS PERFORMANCE

CMS has 31 performance measures for FY 2011. We carried over most of the measures in the FY 2010 plan, with new FY 2011 targets consistent with the President's goals and priorities and focusing on meaningful outcomes. Several new performance measures have been introduced showcasing CMS responsibilities, including a measure of implementation milestones for the transition to the International Classification of Diseases (ICD) 10th Edition of healthcare codes, as well as a performance goal on how we manage CMS information technology systems and investments in order to minimize risks and maximize returns.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance measures that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. Our FY 2011 targets are outlined in the Outcomes and Outputs Tables at the end of each related program discussion.

Our performance measures reinforce the CMS strategic objectives and Agency initiatives. CMS strives to achieve accurate and predictable payments with the continued success of measuring the Medicare, Medicaid and CHIP payment error rates. CMS will also continue to achieve high valued health care, as well as confident well informed consumers through improvements to the Medicare prescription drug benefit through beneficiary surveys and information published in our online Medicare Prescription Drug Plan Finder. Through collaborative partnerships with the States and other organizations, CMS will continue to reduce the use of restraints and pressure ulcers in nursing homes, and monitor quality of care and health quality measures under the purview of the Quality Improvement Organizations.

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. Among these is CMS' goal to *Broaden the availability and accessibility of health insurance coverage through implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) legislation.* By the end of FY 2011, we will increase CHIP enrollment by seven percent over the FY 2008 baseline levels. The CHIPRA legislation reauthorized the CHIP program and increased funding to maintain State programs and to cover more children.

Performance measurement results provide a wealth of 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 goals also provides a method of clear communication of CMS programmatic objectives to our partners, such as 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.

The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act"), enacted on February 17, 2009, promotes economic recovery, assists those impacted by the recession, provides investments for technological advances, invests in infrastructure and stabilizes State and local government budgets. Among other things, the Recovery Act provides for measures that stimulate the economy and preserve and improve access to affordable health care.

Below, CMS highlights our Recovery Act obligations and key performance measures for major provisions impacting our programs. Additional information about the Recovery Act may be found in a later section of this document.

CMS Summary of Recovery Act Obligations and Performance
(dollars in millions)

ARRA Implementation Plan	FY 2009	FY 2010	FY 2011	FY 2009 – FY 2020
Health Information Technology: Medicare and Medicaid Incentives and Administrative Funding				
Program Management	$4	$123	$175	$1,045
State/Local Admin	$0	$152	$283	$2,343
Medicare Incentives	$0	$0	$2,410	$9,950
Medicaid Incentives	$0	$0	$1,828	$9,841
Total Obligations	**$4**	**$275**	**$4,696**	**$23,179**

ARRA Implementation Plan	FY 2009	FY 2010	FY 2011	FY 2009 – FY 2020
Temporary Increase in Medicaid FMAP	$34,298	$38,100	$14,900	$87,298
Temporary Increase in DSH Allotments	$270	$520	$0	$790
Qualified Individual Extension	$0	$413	$150	$563
Transitional Medical Assistance (TMA) Extension /1	$30	$480	$395	$915
Protections for American Indians/Alaska Natives Under Medicaid and CHIP /1	$5	$10	$10	$170

/1 FY 2009 cost impact for this provision is an actuarial estimate

Selected Performance Measures for Programs Listed Above

Temporary Increase in FMAP

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of Beneficiaries enrolled in the Medicaid Program	51,725,000*	N/A	N/A

Data Source: *CMS Office of the Actuary estimate. 17 States have reported a total of 15,805,766 beneficiaries enrolled. CMS will continue to work with States in order to obtain full reports from every State.

Temporary Increase in DSH Allotments

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of States drawing temporary increase in Medicaid DSH funds	14	N/A	N/A

Data Source: Payment Management System

Qualified Individual (QI) Extension

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Maintain the QI Program	N/A	N/A	N/A

Data Source: Centers for Medicaid and State Operations

Transitional Medical Assistance Extension

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of States streamlining eligibility for the newly employed	12	N/A	N/A *

Data Source: Data regarding number of States implementing the provision is from tracking reports for State Plan Amendments. *ARRA has a sunset on this provision of 12/31/2010. Legislation is necessary to extend this provision.

Protections for Indians Under Medicaid and CHIP

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of States soliciting advice from AI/AN communities	N/A*	100%	100%

Data Source: Data regarding number of States implementing the requirement for Indian consultation is taken from tracking reports for State Plan Amendments. *Guidance including the required State Plan page is currently in clearance and has not been released, consequently no States have been able to comply with the requirement to submit the State plan amendment.

For further information, and to view individual Recovery Act Implementation plans, please follow the links, below:

Temporary Increase in Medicaid Federal Medical Assistance Percentage (FMAP)
http://www.hhs.gov/recovery/reports/plans/cms_section5001.pdf

Transitional Medical Assistance (TMA) Extension
http://www.hhs.gov/recovery/reports/plans/transitionalmedicaidassistanceextension.pdf

Temporary Increase in Disproportionate Share Hospital (DSH) Allotments
http://www.hhs.gov/recovery/reports/plans/cms_section5002.pdf

Qualified Individuals (QI) Program Extension
http://www.hhs.gov/recovery/reports/plans/cms_section5005.pdf

Protections for Indians Under Medicaid and the Children's Health Insurance Program (CHIP)
http://www.hhs.gov/recovery/reports/plans/cms_section5006.pdf

Health Information Technology (HIT) (Medicare and Medicaid)
http://www.hhs.gov/recovery/reports/plans/hit_implementation.pdf

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

Program	FY 2009 Appropriation 1/	FY 2010 Appropriation 1/	FY 2011 Pres. Bgt. Request
Medicare Operations	$2,265,715,000	$2,335,862,000	$2,356,604,000
Federal Administration	$641,351,000	$696,880,000	$725,365,000
State Survey & Certification	$293,128,000	$346,900,000	$362,000,000
Health Care Data Improvement Initiative	$0	$0	$110,000,000
Research	$30,192,000	$35,600,000	$47,178,000
High-Risk Pool Grants 2/	$0	$0	$0
Appropriation/BA C.L. (Discretionary; 0511)	**$3,230,386,000**	**$3,415,242,000**	**$3,601,147,000**
High-Risk Pool Grants 2/	$75,000,000	$55,000,000	$0
Appropriation/BA C.L. (Mandatory; 0511)	**$75,000,000**	**$55,000,000**	**$0**
Comparability Adjustment	$0	$0	$0
Subtotal, Appropriation/BA C.L. (Disc. + Mand.; 0511)	**$3,305,386,000**	**$3,470,242,000**	**$3,601,147,000**
MIPPA (Mandatory; P.L. 110-275)	$182,500,000	$35,000,000	$38,000,000
CHIPRA (Mandatory; P.L. 111-3)	$5,000,000	$0	$0
Total, Appropriation/BA C.L. (0511)	**$3,492,886,000**	**$3,505,242,000**	**$3,639,147,000**
Est. Offsetting Collections from Non-Federal Sources:			
User Fees, C.L.	$178,514,000	$170,604,000	$169,550,000
Recovery Audit Contracts, C.L. 3/	$30,000,000	$259,000,000	$259,000,000
Subtotal, New BA, C.L.	**$3,701,400,000**	**$3,934,846,000**	**$4,067,697,000**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2009) 4/	$138,440,000	$226,890,000	$0
Program Level, Current Law (0511)	**$3,839,840,000**	**$4,161,736,000**	**$4,067,697,000**
Proposed Law User Fees (Recertification/Revisit)	$0	$0	$0
Program Level, Proposed Law (0511)	**$3,839,840,000**	**$4,161,736,000**	**$4,067,697,000**
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
Section 4301 Medicare Moratoria	$2,000,000	$0	$0
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 5/	**$142,000,000**	**$140,000,000**	**$140,000,000**
Total, Program Management Appropriation/BA (All Sources)	**$3,634,886,000**	**$3,645,242,000**	**$3,779,147,000**
Total Prog. Mgt. Program Level, Proposed Law (All Sources)	**$3,981,840,000**	**$4,301,736,000**	**$4,207,697,000**
HCFAC Discretionary	**$198,000,000**	**$311,000,000**	**$561,000,000**
Non-CMS Administration	**$1,961,000,000**	**$2,198,000,000**	**$2,321,000,000**
CMS FTEs: 6/			
Direct (Federal Administration)	4,122	4,276	4,326
Reimbursable (CLIA, CoB, RAC)	104	126	128
Subtotal, Prog. Mgt. FTEs, C. L.	**4,226**	**4,402**	**4,454**
ARRA Implementation 7/	1	100	140
Total, Prog. Mgt. FTEs, C. L.	**4,227**	**4,502**	**4,594**
Medicaid Financial Management (HCFAC)	86	90	100
MIP Discretionary (HCFAC)	0	25	75
Medicaid Integrity (State Grants)	94	100	100
Total, CMS FTEs, Current Law	**4,407**	**4,717**	**4,869**

1/ Reflects net enacted budget authority (BA) in fiscal years 2009 and 2010, after all rescissions, transfers and reprogrammings.
2/ The High-Risk Pool Grants were rebased as mandatory in fiscal year 2009, forward. They are not included in our FY 2011 President's Budget request.
3/ The decrease in FY 2009 Recovery Audit Contractor costs results from a partial year of collections.
4/ Reflects remaining no-year and multi-year funding for managed care redesign, standard systems transitions, HIGLAS, TRHCA, MMSEA, MIPPA and CHIPRA.
5/ Includes ARRA funds directly appropriated to the CMS Program Management account. Excludes transfers of discretionary BA booked to other accounts.
6/ The FY 2009 staffing level reflects actual FTE consumption.
7/ In the FY 2011 Budget Appendix, the ARRA FTE are included within the direct Program Management staffing level.

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Centers for Medicare & Medicaid Services
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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"), and the Clinical Laboratory Improvement Amendments of 1988, not to exceed **[**$3,470,242,000,**]** *$3,601,147,000,* 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; 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 **[**$35,681,000,**]** *$37,687,000,* to remain available through September 30, **[**2011**]** *2012*, shall be for contract costs for the Healthcare Integrated General Ledger Accounting System: Provided further, That **[**$65,600,000,**]** *$9,120,000,* to remain available through September 30, **[**2011**]**, *2012* shall be for the Centers for Medicare and Medicaid Services ("CMS") Medicare contracting reform activities: **[**Provided further, That $55,000,000 shall be available for the State high risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006:**]** *Provided further, That $110,000,000, to remain available through September 30, 2012, shall be for the Centers for Medicare*

and Medicaid Service's Health Care Data Improvement Initiative: Provided further, That the Secretary is directed to collect fees in fiscal year **[**2010**]** *2011* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act**[**: Provided further, That $3,100,000 shall be used for the projects, and in the amounts, specified under the heading "Program Management" in the statement of the managers on the conference report accompanying this 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"), and the Clinical Laboratory Improvement Amendments of 1988, not to exceed **[**$3,470,242,000,**]** *$3,601,147,000,* 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 and Children's Health Insurance 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; 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 **[**$35,681,000,**]** *$37,687,000,* to remain available through September 30, **[**2011**]** *2012,* shall be for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $37,687,000 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 **[**$65,600,000,**]** $9,120,000, to remain available through September 30, **[**2011**]** *2012*, shall be for the Centers for Medicare and Medicaid Services ("CMS") Medicare contracting reform activities:	Authorizes $9,120,000 of this appropriation to be available for obligation over two fiscal years for contracting reform activities.
[Provided further, That $55,000,000, shall be available for the State high risk insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006:**]**	Deletes the separate language provision for high-risk pool grant activities included in the FY 2010 Program Management appropriation.
Provided further, That $110,000,000, to remain available through September 30, 2012, shall be for the Centers for Medicare and Medicaid Service's Health Care Data Improvement Initiative:	Provides two-year authority for CMS' health care data improvement activities in FY 2011.
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2010**]** *2011* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.
[*: Provided further, That $3,100,000, shall be used for the projects, and in the amounts, specified under the heading "Program Management" in the statement of the managers on the conference report accompanying this Act* ***].***	Eliminates funding for mandated research projects included in the FY 2010 Program Management appropriation.

CMS Program Management
Amounts Available for Obligation

	FY 2009 Actual	FY 2010 Estimate	FY 2011 PB
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,230,386,000	$3,415,242,000	$3,601,147,000
Across-the-board reductions (L/HHS)	$0	$0	$0
Subtotal, Appropriation (L/HHS)	$3,230,386,000	$3,415,242,000	$3,601,147,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund discr. appropriation	$3,230,386,000	$3,415,242,000	$3,601,147,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$75,000,000	$55,000,000	$0
MIPPA (PL 110-275)	$182,500,000	$35,000,000	$35,000,000
Subtotal, trust fund mand. appropriation	$257,500,000	$90,000,000	$35,000,000
Comparable transfer from:	$0	$0	$0
Subtotal, adjusted trust fund mand. appropriation	$257,500,000	$90,000,000	$35,000,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$0	$0	$3,000,000
CHIPRA (PL 111-3)	$5,000,000	$0	$0
Subtotal, trust fund mand. appropriation	$5,000,000	$0	$3,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$45,896,000	$43,000,000	$43,000,000
Coordination of benefits user fees	$67,416,000	$51,030,000	$51,744,000
MA/PDP user fees	$68,789,000	$74,300,000	$72,500,000
Revisit user fees	$0	$0	$0
Sale of data user fees	$5,479,000	$2,274,000	$2,306,000
Recovery audit contracts	$2,500,000	$259,000,000	$259,000,000
Subtotal, offsetting collections 1/	$190,080,000	$429,604,000	$428,550,000
Unobligated balance, start of year	$293,271,000	$356,220,000	$129,330,000
Unobligated balance, end of year	-$356,220,000	-$129,330,000	-$129,330,000
Prior year recoveries	$13,750,000	$0	$0
Unobligated balance, lapsing	-$16,807,000	$0	$0
Total obligations 1/, 2/	**$3,616,960,000**	**$4,161,736,000**	**$4,067,697,000**
American Recovery and Reinvestment Act (ARRA):			
Trust Fund Mandatory Appropriation:			
ARRA (PL 111-5)	$2,000,000	$0	$0
Mandatory Appropriation:			
ARRA (PL 111-5)	$140,000,000	$140,000,000	$140,000,000
Unobligated balance, start of year	$0	$136,048,000	$153,225,000
Unobligated balance, end of year	-$136,048,000	-$153,225,000	-$118,225,000
Prior year recoveries	$0	$0	$0
Unobligated balance, lapsing	-$2,000,000	$0	$0
Total obligations	**$3,952,000**	**$122,823,000**	**$175,000,000**

1/ Excludes the following amounts for reimbursable activities carried out by this account:
2009 $18,916,000. Reflects actual budget authority in FY 2009, 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/	$3,505,242,000
(Obligations) 1/	($3,732,132,000)
2011	
Total estimated budget authority 1/	$3,639,147,000
(Obligations) 1/	($3,639,147,000)
Net Change	**$133,905,000**

	2010 Estimate FTE	2010 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. FY 2011 Pay Raise @ 1.4 Percent				$5,883,000
2. Annualization of FY 2010 Pay Raise				$3,421,000
3. Rent and Mortgage				$2,130,000
Subtotal, Built-in Increases				**$11,434,000**
A. Program:				
1. Medicare Operations		$2,370,862,000		$133,583,000
2. Federal Administration	4,276	$696,880,000	50	$21,023,000
3. State Survey & Certification		$346,900,000		$17,750,000
4. Health Care Data Improvement Initiative		$0		$110,000,000
5. Research		$35,600,000		$14,678,000
Subtotal, Program Increases				**$297,034,000**
Total Increases				**$308,468,000**
Decreases:				
A. Program:				
1. Medicare Operations		$2,370,862,000		($109,841,000)
2. Federal Administration		$696,880,000		($3,972,000)
3. State Survey & Certification		$346,900,000		($2,650,000)
4. Research		$35,600,000		($3,100,000)
5. State High-Risk Pools		$55,000,000		($55,000,000)
Subtotal, Program Decreases				**($174,563,000)**
Net Change				**$133,905,000**

1/ Excludes budget authority and obligations from user fees.

American Recovery and Reinvestment Act (ARRA):

2010	
Total estimated budget authority	$140,000,000
(Obligations)	($122,823,000)
2011	
Total estimated budget authority	$140,000,000
(Obligations)	($175,000,000)
Net Change	**$0**

	2010 Estimate FTE	2010 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. FY 2011 Pay Raise @ 1.4 Percent				$135,000
2. Annualization of FY 2010 Pay Raise				$78,000
B. Program:				
1. Medicare and Medicaid HIT	100	$140,000,000	40	$5,932,000
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT		$140,000,000		($6,145,000)
Net Change				**$0**

CMS Program Management

Budget Authority by Activity

(Dollars in thousands)

	FY 2009 Actual	FY 2010 Estimate	FY 2011 PB
1. Medicare Operations	$2,265,715	$2,335,862	$2,356,604
MIPPA (PL 110-275)	$182,500	$35,000	$38,000
Enacted Rescission	$0	$0	$0
Subtotal, Medicare Operations	$2,448,215	$2,370,862	$2,394,604
(Obligations)	($2,383,042)	($2,591,944)	
2. Federal Administration	$641,351	$696,880	$725,365
CHIPRA (PL 111-3)	$5,000	$0	$0
Enacted Rescission	$0	$0	$0
Subtotal, Federal Administration	$646,351	$696,880	$725,365
(Obligations)	($644,957)	($702,688)	
3. State Survey & Certification	$293,128	$346,900	$362,000
Enacted Rescission	$0	$0	$0
Subtotal, State Survey & Certification	$293,128	$346,900	$362,000
(Obligations)	($293,065)	($346,900)	
4. Research, Demonstration & Evaluation	$30,192	$35,600	$47,178
Enacted Rescission	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	$30,192	$35,600	$47,178
(Obligations)	($30,106)	($35,600)	
5. Health Care Data Improvement Initiative	$0	$0	$110,000
(Obligations)	$0	$0	
6. High-Risk Pool Grants	$75,000	$55,000	$0
Enacted Rescission	$0	$0	$0
Comparability Adjustment	$0	$0	$0
Subtotal, High-Risk Pool Grants	$75,000	$55,000	$0
(Obligations)	($75,000)	($55,000)	
7. User Fees 1/	$187,580	$170,604	$169,550
(Obligations)	($188,312)	($170,604)	
8. Recovery Audit Contracts 1/	$2,500	$259,000	$259,000
(Obligations)	($2,478)	($259,000)	
Total, Budget Authority 2/	**$3,682,966**	**$3,934,846**	**$4,067,697**
(Obligations) 3/	**($3,616,960)**	**($4,161,736)**	
FTE	**4,226**	**4,402**	**4,454**

1/ Reflects actual budget authority (BA) in FY 2009, as opposed to enacted values.

2/ Excludes $18,916,000 for other reimbursable activities carried out by the Program Management account.

3/ Excludes $18,116,000 for other reimbursable activities carried out by the Program Management account.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$142,000**	**$140,000**	**$140,000**
(Obligations)	**($3,952)**	**($122,823)**	**($175,000)**
FTE	**1**	**100**	**140**

CMS Program Management
Authorizing Legislation

	2010 Amount Authorized	FY 2010 Appropriations Act	2011 Amount Authorized	2011 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite	Indefinite	Indefinite
- Section 1115 1/	$2,200,000	$2,200,000	$2,200,000	$2,200,000
b) P.L. 92-603, Section 222	Indefinite	Indefinite	Indefinite	Indefinite
2. Medicare 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. Health Care Data Improvement Initiative:	Indefinite	Indefinite	Indefinite	Indefinite
6. High-Risk Pool Grants:				
Trade Act of 2002; High-Risk Pool Funding Extension Act of 2006	Indefinite	Indefinite	Indefinite	Indefinite
7. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
8. MA/PDP:				
Balanced Budget Act of 1997, 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/
9. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
10. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0

1/ The total authorization for section 1115 is $4.0 million. CMS' request includes $2.2 million in FY 2011.

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
2002				
Trust Fund Appropriation:				
Base	$2,351,158,000	$2,361,158,000	$2,464,658,000	$2,440,798,000
Rescissions (P.L. 107-116/206)	$0	$0	$0	($8,027,000)
Subtotal	$2,351,158,000	$2,361,158,000	$2,464,658,000	$2,432,771,000
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				
Trust Fund Appropriation:				
Base	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,470,242,000
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
Subtotal	$3,465,500,000	$3,463,362,000	$3,431,500,000	$3,505,242,000
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
Trust Fund Appropriation:				
Base	$3,601,147,000	$0	$0	$0
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
Subtotal	$3,601,147,000	$0	$0	$35,000,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	Appropriations in FY 2010

CMS Program Management has no appropriations not authorized by law.

CMS Program Management
Budget Authority by Object

	2010 Estimate	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$426,223,000	$441,679,000	$15,456,000
Other than full-time permanent (11.3)	$12,773,000	$13,001,000	$228,000
Other personnel compensation (11.5)	$8,000,000	$9,218,000	$1,218,000
Military personnel (11.7)	$8,730,000	$8,788,000	$58,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$455,726,000**	**$472,686,000**	**$16,960,000**
Civilian benefits (12.1)	$108,024,000	$114,702,000	$6,678,000
Military benefits (12.2)	$4,497,000	$4,527,000	$30,000
Benefits to former personnel (13.0)	$0		$0
Total Pay Costs	**$568,247,000**	**$591,915,000**	**$23,668,000**
Travel and transportation of persons (21.0)	$8,900,000	$9,000,000	$100,000
Transportation of things (22.0)	$0	$0	$0
Rental payments to GSA (23.1)	$25,100,000	$27,230,000	$2,130,000
Communication, utilities, and misc. charges (23.3)	$0	$0	$0
Printing and reproduction (24.0)	$3,500,000	$3,300,000	($200,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$104,540,000	$224,180,000	$119,640,000
Purchase of goods and services from government accounts (25.3)	$2,000,000	$1,140,000	($860,000)
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$30,000,000	$44,678,000	$14,678,000
Medical care (25.6)	$2,690,291,000	$2,723,140,000	$32,849,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,826,831,000**	**$2,993,138,000**	**$166,307,000**
Supplies and materials (26.0)	$1,064,000	$1,064,000	$0
Equipment (31.0)	$100,000	$100,000	$0
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	$2,500,000	($58,100,000)
Interest and dividends (43.0)	$0	$0	$0
Refunds (44.0)	$0	$0	$0
Total Non-Pay Costs	**$2,936,995,000**	**$3,047,232,000**	**$110,237,000**
Total Budget Authority by Object Class	**$3,505,242,000**	**$3,639,147,000**	**$133,905,000**
American Recovery and Reinvestment Act (ARRA):			
Personnel compensation:			
Full-time permanent (11.1)	$10,243,000	$15,065,000	$4,822,000
Civilian benefits (12.1)	$2,640,000	$3,963,000	$1,323,000
Other Contractual Services:			
Other services (25.2)	$127,117,000	$120,972,000	($6,145,000)
Total Budget Authority by Object Class	**$140,000,000**	**$140,000,000**	**$0**

CMS Program Management
Salaries and Expenses

	2010 Estimate	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$426,223,000	$441,679,000	$15,456,000
Other than full-time permanent (11.3)	$12,773,000	$13,001,000	$228,000
Other personnel compensation (11.5)	$8,000,000	$9,218,000	$1,218,000
Military personnel (11.7)	$8,730,000	$8,788,000	$58,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$455,726,000**	**$472,686,000**	**$16,960,000**
Civilian benefits (12.1)	$108,024,000	$114,702,000	$6,678,000
Military benefits (12.2)	$4,497,000	$4,527,000	$30,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$568,247,000**	**$591,915,000**	**$23,668,000**
Travel and transportation of persons (21.0)	$8,900,000	$9,000,000	$100,000
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)	$0	$0	$0
Printing and reproduction (24.0)	$3,500,000	$3,300,000	($200,000)
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$104,540,000	$224,180,000	$119,640,000
Purchase of goods and services from government accounts (25.3)	$2,000,000	$1,140,000	($860,000)
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$30,000,000	$44,678,000	$14,678,000
Medical care (25.6)	$2,690,291,000	$2,723,140,000	$32,849,000
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,826,831,000**	**$2,993,138,000**	**$166,307,000**
Supplies and materials (26.0)	$1,064,000	$1,064,000	$0
Total Non-Pay Costs	**$2,840,295,000**	**$3,006,502,000**	**$166,207,000**
Total Salary and Expense	**$3,408,542,000**	**$3,598,417,000**	**$189,875,000**
Direct FTE	**4,276**	**4,326**	**50**
American Recovery and Reinvestment Act (ARRA):			
Personnel compensation:			
Full-time permanent (11.1)	$10,243,000	$15,065,000	$4,822,000
Civilian benefits (12.1)	$2,640,000	$3,963,000	$1,323,000
Other Contractual Services:			
Other services (25.2)	$127,117,000	$120,972,000	($6,145,000)
Total Salary and Expense	**$140,000,000**	**$140,000,000**	**$0**
Direct FTE	**100**	**140**	**40**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2009 Estimate	2010 Estimate	2011 Estimate
Office of the Administrator			
Direct FTEs	10	10	10
Reimbursable FTEs	0	0	0
Subtotal	10	10	10
Center for Drug and Health Plan Choice			
Direct FTEs	267	277	281
Reimbursable FTEs	6	6	6
Subtotal	273	283	287
Center for Medicaid and State Operations			
Direct FTEs	298	309	313
Reimbursable FTEs	31	42	42
Subtotal	329	351	355
Center for Medicare Management			
Direct FTEs	407	422	427
Reimbursable FTEs	1	1	1
Subtotal	408	423	428
Office of the Actuary			
Direct FTEs	83	86	87
Reimbursable FTEs	0	0	0
Subtotal	83	86	87
Office of Acquisition & Grants Management			
Direct FTEs	107	111	113
Reimbursable FTEs	2	3	3
Subtotal	109	114	116
Office of Beneficiary Information Services			
Direct FTEs	53	55	56
Reimbursable FTEs	0	0	0
Subtotal	53	55	56
Office of Clinical Standards and Quality			
Direct FTEs	195	202	204
Reimbursable FTEs	0	0	0
Subtotal	195	202	204
Office of E-Health Standards and Services			
Direct FTEs	18	19	19
Reimbursable FTEs	0	0	0
Subtotal	18	19	19
Office of External Affairs			
Direct FTEs	197	204	207
Reimbursable FTEs	0	0	0
Subtotal	197	204	207

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2009 Estimate	2010 Estimate	2011 Estimate
Office of Equal Opportunity and Civil Rights			
Direct FTEs	19	20	20
Reimbursable FTEs	0	0	0
Subtotal	19	20	20
Office of Financial Management			
Direct FTEs	346	359	363
Reimbursable FTEs	28	28	30
Subtotal	374	387	393
Office of Information Services			
Direct FTEs	341	354	358
Reimbursable FTEs	4	4	4
Subtotal	345	358	362
Office of Legislation			
Direct FTEs	43	45	45
Reimbursable FTEs	0	0	0
Subtotal	43	45	45
Office of Operations Management			
Direct FTEs	188	195	197
Reimbursable FTEs	0	0	0
Subtotal	188	195	197
Office of Policy			
Direct FTEs	10	10	10
Reimbursable FTEs	0	0	0
Subtotal	10	10	10
Office of Research, Development and Information			
Direct FTEs	126	130	132
Reimbursable FTEs	0	0	0
Subtotal	126	130	132
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	138	143	145
Reimbursable FTEs	0	0	0
Subtotal	138	143	145
Consortia			
Direct FTEs	1,276	1,324	1,340
Reimbursable FTEs	32	42	42
Subtotal	1,308	1,366	1,382
Total, CMS Program Management FTE 1/	**4,226**	**4,402**	**4,454**
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE 1/	**1**	**100**	**140**

1/ FY 2009 reflects actual FTE consumption.

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2009 Actual	2010 Estimate	2011 Estimate
Subtotal, EX	0	1	1
Total - Exec. Level Salary	$0	$165	$168
Subtotal	66	66	66
Total - ES Salaries	$10,791	$11,116	$11,300
GS-15	426	447	452
GS-14	581	609	617
GS-13	2,029	2,129	2,155
GS-12	688	722	731
GS-11	78	82	83
GS-10	1	1	1
GS-9	161	168	170
GS-8	11	11	11
GS-7	117	123	125
GS-6	14	15	15
GS-5	20	21	21
GS-4	4	4	4
GS-3	0	0	0
GS-2	1	1	1
GS-1	0	0	0
Subtotal 1/	4,131	4,334	4,387
Total - GS Salary 1/	$389,957	$423,218	$438,685
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$94.398	$97.651	$99.997

1/ Excludes ARRA positions.

Program Management
Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Clinical Laboratory Improvement Amendments (CLIA), the Quality Improvement Organizations (QIO), State Grants and Demonstrations, and the Health Care Fraud and Abuse Control (HCFAC) account. The FY 2011 request includes funding for CMS' four traditional Program Management line items--Medicare Operations, Federal Administration, Medicare Survey and Certification, and Research—and one new line item—the Health Care Data Improvement Initiative--each with a distinct purpose:

- Medicare Operations primarily funds the contractors that process fee-for-service claims as well as the IT infrastructure and operational support needed to run this program. It also funds activities for the newer Medicare Advantage and Medicare Prescription Drug programs as well as legislative mandates and other initiatives.

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

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

- CMS' Research line item supports a variety of research projects, demonstrations, and evaluations designed to improve the quality of healthcare furnished to Medicare and Medicaid beneficiaries and slow the cost of health care spending.

- The Health Care Data Improvement Initiative is a new, multi-year project that will create a data-centric environment to support modernized Medicare and Medicaid programs, value-based purchasing, and comparative effectiveness research.

CMS' FY 2011 current law Program Management request is $3,601.1 million, a $130.9 million increase over the FY 2010 appropriation. The FY 2011 request does not include funds for the High Risk Pool activity. The table below, and the following language, presents CMS' FY 2011 Program Management request:

Program Management (PM) Summary Table
($ in millions)

Line Item	FY 2010 Appropriation	FY 2011 Request	Difference
Medicare Operations	$2,335.9	$2,356.6	+$20.7
Federal Administration	$696.9	$725.4	+$28.5
State Survey & Certification	$346.9	$362.0	+$15.1
Research	$35.6	$47.2	+$11.6
Health Care Data Improvement Initiative	$0	$110.0	+$110.0
High Risk Pools	$55.0	$0	-$55.0
CMS PM Approp., C.L.	**$3,470.2**	**$3,601.1**	**+$130.9**
FTEs – Federal Administration	4,276	4,326	+50

- Medicare Operations: $2,356.6 million, a $20.7 million increase over the FY 2010 appropriation. At this level, CMS can process its fee-for-service workloads, administer the Medicare Advantage and Prescription Drug Plan programs, conduct beneficiary education and outreach, implement recent legislative mandates such as MIPPA, and continue with major programmatic improvements such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS) and ICD-10 coding changes.

- Federal Administration: $725.4 million, a $28.5 million increase over the FY 2010 appropriation. At this level, CMS can support 4,326 direct FTEs, an increase of 50 FTEs above the enacted level. This will allow CMS to maintain the new employees that it plans to hire in FY 2010 to meet existing legislative requirements as well as other new requirements such as Value Based Purchasing, ICD-10, and DME Competitive Bidding. It will also allow CMS to begin work on its new data centric environment. The payroll estimate assumes a 1.4-percent cost of living allowance in calendar year 2011.

- Survey and Certification: $362.0 million, an increase of $15.1 million over the FY 2010 appropriation. This funding will allow CMS to maintain the statutorily-mandated frequency levels for nursing homes and home health agencies, improve survey frequencies for Accredited Hospitals, Organ Transplant facilities, and Ambulatory Surgical Centers, and keep all other facility survey frequencies at the FY 2010 enacted levels.

- Research, Demonstration, and Evaluation: $47.2 million, an increase of $11.6 million over the FY 2010 appropriation. The additional funds will support demonstration and research activities identified by CMS leadership that will provide innovative solutions to transform and modernize the American health care system. Real Choice Systems Change grants are again funded at $2.5 million.

- Health Care Data Improvement Initiative: $110.0 million in two-year funding for the first year of a new multi-year initiative that will enable CMS to transform its data, systems, and infrastructure to meet the needs of future growth and financial accountability, promote broader and easier access to data, enhance data integration, increase cyber security, and improve analytic capabilities. These enhancements will make CMS' data more easily accessible and more useful to researchers, and allow CMS to transform Medicare and Medicaid into leaders in value-based purchasing and in data sources for comparative effectiveness research.

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Medicare Operations

(dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Net BA[1]	$2,265,715	$2,335,862	$2,356,604	+$20,742

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 2010 Authorization - One Year

Allocation Method - Contracts

OVERVIEW

Program Description and Accomplishments

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 2003 to include a voluntary prescription drug benefit. Medicare enrollment has increased from 19 million in 1966 to over 48 million beneficiaries in 2011. Medicare benefits, 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 Operations account discussed here is funded annually through the Program Management appropriation. CMS uses these funds to administer the Medicare program, primarily to pay contractors to process providers' claims, to fund beneficiary outreach and education, to maintain the IT infrastructure needed to support various claims processing systems, and to continue programmatic improvements.

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. Historically, Medicare contractors known as fiscal intermediaries (FIs) and carriers have handled Medicare's claims administration activities. The FIs processed Part A workloads and the carriers processed Part B workloads. As part of CMS' contracting reform initiative, CMS will replace FIs and carriers with 15 Medicare Administrative Contractors, or MACs, that will process both Parts A and B workloads. This initiative is described more fully later in this chapter.

[1] Medicare Operations ARRA funding will be displayed in a separate chapter.

Medicare Parts C and D

CMS also administers and oversees the Medicare Part C and Part D programs. 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 such as Health Maintenance Organizations, Preferred Provider Organizations, private fee-for-service plans, and special needs plans. Many MA plans offer Part D, as well as additional services, such as prescription drugs, vision and dental benefits. As of December 2009, close to eleven million beneficiaries - approximately 24 percent of those enrolled in both Part A and Part B, - were enrolled in MA plans. CMS does not anticipate major growth in these enrollment numbers for FY 2011. Rather, the major enrollment growth for Medicare Parts C and D will come in the years following FY 2012 as a result of the baby boomer generation increasing the Medicare beneficiary population.

Medicare Part D provides voluntary prescription drug coverage, either through a stand-alone prescription drug plan (PDP) or a joint MA-prescription drug plan (MA-PDP). CMS introduced this new benefit in 2006. Most Medicare beneficiaries, including approximately ten million low-income beneficiaries, are now receiving comprehensive prescription drug coverage, either through Part D, an employer-sponsored drug plan, or other creditable coverage.

Program Assessment

The Medicare program underwent a program assessment in 2003. The assessment indicated that Medicare has been successful in protecting the health of beneficiaries and is working to strengthen its management practices. We are taking the following actions to improve the performance of the program: continuing to focus on sound program and financial management through continued implementation of HIGLAS; implementation of the Medicare Prescription Drug, Improvement, and Modernization Act; and increasing efforts to link Medicare payment to provider performance.

Funding History

FY 2006	$2,147,242,000
FY 2007	$2,159,242,000
FY 2008	$2,158,906,000
FY 2009	$2,265,715,000
FY 2010	$2,335,862,000

Budget Request

CMS' FY 2011 budget request for Medicare Operations is $2,356.6 million, an increase of $20.7 million above the FY 2010 Appropriation. This reflects $7.1 million in contract savings from competitive renegotiation of IT contracts in this line item. A large portion of the Medicare Operations account funds ongoing fee-for-service activities at the MACs, such as processing claims, responding to provider inquiries, and handling appeals. The remainder funds fee-for-service support, systems activities, operational costs for the Medicare Advantage and Part D programs, beneficiary outreach and education, and initiatives that will improve and enhance the entire Medicare program such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS), ICD-10, and the Medicare Improvements to Patients and Providers Act (MIPPA).

Activity	FY 2010 Appropriation	FY 2011 President's Budget Request	Difference: PB vs. Appropriation
Medicare Parts A and B:			
MAC Ongoing Operations	1,034.8	998.2	-36.6
FFS Operations Support	66.5	69.4	2.9
Claims Processing Investments	86.9	88.3	1.4
Contracting Reform	65.6	9.1	-56.5
Competitive Bidding -- Part B Drugs	0.5	2.5	2.0
Medicare Parts C and D:			
IT Systems Investments	82.2	89.2	7.0
Management and Review	51.0	55.4	4.4
Activities Supporting All Parts of Medicare:			
NMEP	311.5	363.2	51.7
HIGLAS	161.0	156.0	-5.0
CFO Audit	9.0	9.0	0.0
QIC Appeals (BIPA 521/522)	56.2	59.5	3.3
HIPAA	24.2	27.2	3.0
ICD-10 & Version 5010	62.5	60.2	-2.3
MIPPA	61.6	89.3	27.7
Other IT Investments	262.4	280.1	17.7
Total	**$2,335.9**	**$2,356.6**	**$20.7**

MEDICARE PART A AND B OPERATIONS

Program Description and Accomplishments

MAC Ongoing Operations

This category reflects the Medicare contractors' ongoing 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. The Medicare contractors no longer answer general beneficiary inquiries; this activity has been consolidated under the 1-800-MEDICARE number funded through the National *Medicare & You* Education Program (NMEP). This is discussed later in the chapter.

- *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: 99.9 percent for Part A and 97.2 percent for Part B as of November 2009. Although most Part A claims have been electronic for well over a decade, Part B claims have been slower to convert to this format. In FY 2002, for example, only 83.7 percent of Part B claims were electronic. The Health Insurance Portability and Accountability Act of 1996 (HIPAA,

Title II) and the Administrative Simplification Compliance Act (ASCA) of 2005 both had a major impact on the increase in electronic claims. HIPAA established national standards for Electronic Data Interchange (EDI) for the transmission of health care data. Electronic claims must meet HIPAA requirements. ASCA, with limited exceptions, prohibited payments for Medicare services or supplies that were not billed electronically. Through the use of EDI, both Medicare and health care providers can process transactions faster and at a lower cost.

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. 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. However, current systems must be upgraded to maintain this commitment. The Part B claims system in Florida is at its maximum capacity of 54 million claims per year resulting in significant processing delays. The Health Care Data Improvement Initiative (HCDII), described in the HCDII chapter, will allow CMS to make the upgrades necessary to allow the current Fee-for-Service (FFS) systems to continue timely claims processing. In addition, CMS has provided contract incentives to reward contractors for performance exceeding statutory requirements. Continued success of this goal assures timely claims processing for Medicare beneficiaries and providers.

- *Provider Enrollment* – CMS and its Medicare contractors are responsible for enrolling providers and suppliers in the Medicare program and ensuring that these providers and suppliers continue to meet Federal Regulations and State licensing standards. 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 enrolling providers and suppliers or providers and suppliers making a change in enrollment obtain Medicare payments by electronic funds transfer.

  CMS has implemented the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to help streamline the enrollment process. CMS made internet-based PECOS available to all providers and suppliers (with the exception of DMEPOS suppliers) in 2009. DMEPOS Suppliers will have access in FY 2010. By 2011, this system, funded through the Medicare Integrity Program appropriation, will allow all physicians, providers, and other suppliers the opportunity to complete and submit their enrollment application via the Internet, make changes to their existing enrollment information, and review their enrollment information to ensure its accuracy.

  While CMS is beginning to revalidate (i.e. require the submission of updated enrollment information) some providers and suppliers, it will be several years before PECOS contains enrollment information on all providers and suppliers participating in the Medicare program. CMS and its Medicare contractors are educating providers and suppliers about the availability of the internet-based PECOS, and we are beginning to see increased utilization.

- *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 contractor's provider reimbursement area performs the following activities, most requiring substantial manual effort:

    - Establishing and adjusting interim reimbursement rates: The MACs conduct rate reviews to establish interim payment amounts (or add-on payments) for DSH, GME, IME and bad debts. The reviews determine the amount a provider will be paid during the cost report year for these items. These interim payments are later reconciled when the cost report is settled. Based on regulations, the MACs conduct one or two interim rate reviews per year for each provider. In addition, they perform quarterly reviews of provider's payments when the provider has elected to be paid based on the periodic interim payment (PIP) methodology which pays providers on a bi-weekly basis, in lieu of actual claims payments. These amounts are also later reconciled.

    - Hospice Cap reviews: MACs conduct reviews of payments to all hospice providers to determine if the hospice exceeded either the aggregate or inpatient cap.

    - Maintaining files and systems: The MACs must maintain a "pricer" file that contains provider-specific data used to calculate the provider's claims payment. This file contains information such as the disproportionate share adjustment percentage, capital data, periodic interim payment (PIP) indicator, wage index, indirect medical education (IME) adjustment, etc. They also maintain 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 from its due date through the settlement, reopening, and appeal processes.

    - Provider-Based determinations: The MACs review applications and attestations from hospitals regarding provider-based status for their facilities. These determinations are necessary to determine whether a facility is part of a hospital, or a free-standing entity. This status affects the amount of reimbursement the hospital is entitled to receive.

    - Reporting and collecting provider overpayments: When a contractor determines that a provider has been overpaid, it sends the provider a demand letter establishing a debt to the Medicare program. Providers are expected to repay Medicare in a lump sum or they may request an Extended Repayment Schedule (ERS). After an ERS is approved, the contractor monitors the overpayment throughout the life of the debt and is responsible for the accurate and timely financial reporting of the debt.

    - Identifying delinquent debt: Debts that are more than 180 days delinquent can be referred to the Department of Treasury (DOT) for further collection in accordance with the Debt Collection Improvement Act of 1996. Historically,

CMS refers about 98 percent of its eligible delinquent debt to DOT for collection. Although Treasury attempts to collect these debts, the Medicare contractors continue to maintain and report these receivables and provide DOT with any updates to the debt balance and debt status. After Treasury completes its collection processes, the debt is returned to the Medicare contractor for final disposition.

- *Medicare Appeals* – The Medicare appeals process is statutorily mandated. It 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:

  - The first level of appeal is a redetermination of the initial decision. This is conducted by MAC personnel who were not involved in the original claim determination. Contractors generally issue a decision within 60 days of receipt of a redetermination request. The costs of processing these first level redeterminations are reflected here in this Ongoing Operations section of the Medicare Operations account.
  - 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 the Medicare Operations chapter.
  - The third level of appeal is a hearing by an Administrative Law Judge in the Department's Office of Medicare Hearings and Appeals. These costs are paid by the Department and are not part of the CMS budget.
  - The fourth level is a review by the Medicare Appeals Council, also at the Department.
  - The fifth and final level is a judicial review in Federal District Court.

  At the first level, MAC personnel review the initial decision to determine if it should be changed and handle any reprocessing activities. This workload is impacted by changes in the Medicare program, especially changes in policy, medical review strategies, and Medicare Integrity Program directives. A significant number of claims are denied based on an apparent lack of medical necessity of the items or services billed; therefore, the majority of appeals are based on medical necessity issues. Appellants are primarily suppliers and physicians. Less than 10 percent of all appeals are filed by beneficiaries.

  In each fiscal year 2008 and 2009, the contractors processed approximately 2.7 million[2] redeterminations. This is consistent with the volume received in FY 2007.

- *Provider Inquiries* – Due to the various communications channels available today, CMS must coordinate communication between Medicare contractors and providers to ensure consistent responses. To accomplish this, CMS requires the Medicare contractors to maintain a Provider Contact Center (PCC) that offers a range of Medicare expertise to respond to telephone and written (letters, e-mail, fax) inquiries. The primary goal of the PCC is to deliver timely, accurate, accessible, and consistent

[2] The first level appeals activities noted in this document do not include the Recovery Audit Contractor (RAC) appeals workload which began in FY 2007. That workload is being tracked, reported, and funded separately.

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 2009, our contractors responded to 2 million providers who collectively made over 50 million telephone inquiries and about 500,000 written inquiries. The contractors utilize Interactive Voice Response (IVR) systems to automate about 65 percent of their telephone inquiries. This frees up customer service representatives to handle the more complex questions. The call volume decreased in FY 2009 due to our improved/expanded outreach efforts. CMS believes the call volume will stabilize for FY 2010 and FY 2011 assuming no major legislative changes and/or no major initiatives take place. If a major initiative or a significant piece of legislation does go into effect, the call volume could increase significantly.

- *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. To support this program, the MACs conduct an annual enrollment process, monitor compliance with the limiting charge to ensure that the providers are not billing beneficiaries more than Medicare allows, and disseminate information on the participating providers.

  Currently, about 96 percent of enrolled physicians participate in Medicare. There are benefits for participating in Medicare including:
  - Medicare reimbursement rates are five percent higher than for non-participating providers;
  - Payments are issued directly to the participating provider; and
  - Claims information is forwarded directly to Medigap insurers, simplifying the coordination of benefits process.

  CMS has made more information available at its http://www.medicare.gov website about the medical background of physicians participating in Medicare. The National Participating Physician Directory has space for 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 (POE) is to reduce the claims payment error rate by helping providers to manage Medicare-related matters on a daily basis and properly bill the Medicare program. The Medicare contractors 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. The contractors 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 Contractors (RAC) data.

  The Medicare contractors are required to provide critical training and technical assistance to individual physicians and suppliers as part of their delivery of timely, accurate and understandable educational services and products about the fee-for-service Medicare program. CMS encourages the contractors to be innovative in their

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.

- *Coordination of Benefits* – Prior to FY 2008, CMS' Medicare contractors were responsible for transmitting, or crossing over, Medicare claims data to supplemental insurers to calculate their subsequent liability. Under the Coordination of Benefits Agreement (COBA) program, CMS established a national standard contract with other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claims data. CMS transferred the claims crossover functions from the individual Medicare contractors to a national contractor, the Coordination of Benefits Contractor (COBC). This consolidation creates a national repository for COBA information.

- *Enterprise Data Centers* – The Enterprise Data Centers (EDCs) are the foundation of the infrastructure that will support all CMS production data center operations. Traditionally, FI's and carriers have either operated their own data centers or contracted out for these services. As part of the contracting reform initiative, CMS is reducing the number of legacy (FI and carrier) data centers from 20 separate small centers to three large enterprise data centers (EDCs). CMS manages these EDC contracts. 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 MAC transitions that will take place during FY 2010. 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 enterprise data center contracts.

<u>Fee-for-Service Operations Support</u>

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

- *Provider Toll-Free Lines* – Section 1874(A)(g)(3) of the Social Security Act requires CMS to offer toll-free telephone service to providers. CMS maintains over 500 toll-free telephone numbers in order to deliver accurate, consistent, and timely information on over 50 million telephone inquiries received each year at the Medicare contractors' provider contact centers. These include numbers for: general provider inquiries; responding to questions about provider enrollment, electronic data interchange, and Medicare secondary payer issues; and testing, development, and routing. 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.

- *National Provider Education, Outreach, and Training* - In an effort to promote national 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 different channels are designed to accommodate providers' busy schedules with the least amount of disruption. The materials provide an authoritative source of information to providers across the country and supplement the Medicare contractors' local provider education and outreach efforts.

- *Limitation on Recoupment* - Section 1893(f)(2) of the Social Security Act (added by section 935 of the MMA) requires CMS to change the way Medicare recoups certain overpayments. It also changes how interest is to be paid to a provider whose overpayment is reversed at certain levels of administrative appeal and through judicial review. These changes to interest and recoupment are tied to the Medicare fee-for-service claims appeal process. This request funds the ongoing processing of this statutory requirement.

- *A-123 Assessment* - The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The OMB Circular A-123 and implementing guidance from the Department requires a rigorous assessment of internal controls over financial reporting similar to that imposed on publicly traded companies by the Public Company Accounting Reform and Investor Protection Act of 2002 (the "Sarbanes-Oxley Act") and requires the Administrator to submit a statement of assurance on internal controls over financial reporting. This assessment also includes performing internal control reviews (formerly SAS 70 audits) for the remaining Fiscal Intermediaries and Carriers.

- *Medicare Beneficiary Ombudsman* - Section 923 of the MMA established the position of Medicare Beneficiary Ombudsman. This office is responsible for screening 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). The President's Budget request for this activity provides the funding needed to cover the administrative costs of processing the providers' claims.

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

MAC Ongoing Operations

The FY 2011 budget request for MAC Ongoing Operations is $998.2 million, $36.6 million below the FY 2010 Appropriation.

This funding will allow the MACs to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements. By FY 2011, the remaining legacy contractors will be phased out, and the MACs will be handling all Medicare ongoing operations. The reduced budget level reflects the efficiencies gained from the Medicare contracting reform initiative and the completion of the FI/Carrier transfer to MACs. This funding level also covers a projected 1.1 percent increase in claims volume.

In FY 2011, CMS' contractors expect to:

- process 1.2 billion claims
- handle 2.8 million redeterminations
- answer 50 million provider inquiries

The following table displays claims volumes and unit costs for the period FY 2007 to FY 2011. 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. In prior years, we calculated a unit cost that reflected claims processing activities only. With the transition from FI's and Carriers to the A/B MACs, we are no longer able to isolate claims processing costs or associate them with Part A or Part B claims. As a result, we are showing a bottom-line unit cost that encompasses all of the contractor activities required to process a claim to final payment, including those mentioned above. CMS has significantly reduced its unit cost over the last several years. We remain committed to achieving efficiencies in our fee-for-service operations.

Volume (in millions)	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Approp.	FY 2011 Estimate
Part A	185.7	187.1	191.4	194.9	196.1
Part B	970.0	987.8	992.2	1,040.5	1,052.7
Total	**1,155.7**	**1,174.9**	**1,183.6**	**1,235.4**	**1,248.8**
Unit Cost (in dollars)					
Total	**$0.98**	**$0.87**	**$0.85**	**$0.84**	**$0.80**

Fee-for-Service Operations Support

The FY 2011 budget request for fee-for-service operations support is $69.4 million, $2.9 million above the FY 2010 Appropriation.

- *Provider Toll-Free Lines*: $8.5 million, the same as the FY 2010 Appropriation to maintain the operations of the toll-free line.
- *National Provider Education, Outreach, and Training*: $8.0 million, the same as the FY 2010 Appropriation to maintain provider education activities and update the Medicare Learning Network (MLN) educational products.
- Medicare Beneficiary Ombudsman: $1.3 million, $0.1 above the FY 2010 Appropriation.
- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $7.8 million, the same as the FY 2010 Appropriation to process claims expected in FY 2011.
- *Other Operational Costs:* $43.8 million, $2.8 million above the FY 2010 Appropriation. This budget request includes funding for the following:
    - The HSPD-12 activity includes developing links between the logical access systems at CMS and the logical access systems at the Department, as well as personal identification verification (PIV) card maintenance fees.
    - In FY 2009, CMS added a number of new requirements to its Medicare Financial Management Manual which the Medicare contractors are required to implement. These include performing more detailed, stringent reviews of extended repayment schedule requests and providing more specific direction on Medicaid offsets before referral to the Department of the Treasury. FY 2011 funds will support training, as well as revisions to internal control processes in order for the contractors to remain compliant.
    - The Star Rating for Nursing Homes includes the design, implementation, and ongoing maintenance of the national "five-star" system that rates and compares the quality of care for each of the nation's 16,000 nursing homes. This information is posted on CMS' *Nursing Home Compare* website which is located within the http://www.medicare.gov website.
    - In addition, the FY 2011 budget request will fund the limitation on recoupment activity, the A-123 assessment, running the Physician Scarcity & Improvement to Health Professional Shortage Area (HPSA) bonus program, and numerous other activities which support fee-for-service operations.

The following table displays provider toll-free line call volumes from FY 2007 through the FY 2011 estimate:

Provider Toll-Free Line Call Volume

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
Completed Calls	54.4 million	57.1 million	50.1 million	50.1 million	50.1 million

Claims Processing Investments

The FY 2011 budget request for claims processing investments is $88.3 million, an increase of $1.4 million above the FY 2010 Appropriation. This slight budget increase will fund maintenance, updates, and increased storage capacity for the current claims processing systems. These systems enhancements are necessary to handle the increased number of claims from FY 2010 to FY 2011.

CONTRACTING REFORM

Program Description and Accomplishments

Medicare contracting reform changes the face of the traditional Medicare program by integrating Parts A and B 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.

As of January 1, 2010, CMS has fully implemented all four Durable Medical Equipment (DME) MACs. In addition, of the fifteen planned A/B MACs, nine A/B MACs are fully operational while six A/B MAC contract awards are under procurement corrective action. If CMS is able to proceed with the implementation of these six MACs once it takes corrective action, all of the “first-generation” MACs should be fully operational by the end of FY 2011.

The MMA requires that CMS re-compete all Medicare fee-for-service claims contracts within five years of award. CMS continues to plan for this “second generation” of MAC procurements. The planning process will consider both strategic and technical factors. CMS began to develop detailed acquisition plans and solicitation documents for the “second generation” of MAC contracts during FY 2009. CMS issued a solicitation for the first two “second generation” DME MAC contracts (Regions A and B) on December 30, 2009. CMS plans to issue a third solicitation for another “second generation” DME MAC later in FY 2010.

The following table provides a more complete summary of the MAC implementation schedule:

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	Initially awarded January 2006; bid protest activity fully resolved January 2007. Fully operational since June 2007.
A/B MAC J 3	• Awarded July 2006. Fully operational since May 2007.
Cycle I A/B MAC RFP 1	RFP released in September 2006. Three A/B MAC jurisdictions: • J 4 MAC awarded August 2007. • 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 RFP 2	RFP released in December 2006. Four A/B MAC jurisdictions: • J 1 awarded in October 2007 (fully operational). • J 13 awarded March 2008 (fully operational). • J 2 initially awarded May 2008 (under corrective action). • J 7 initially awarded June 2008 (under corrective action) CMS will complete full implementation of each jurisdiction within 12 months of completion of procurement corrective action.
Cycle II A/B MAC RFP 1 & RFP 2	Both RFPs released August 2007. Seven A/B MAC Jurisdictions: • 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 pending). • J 14 awarded November 2008 (fully operational). • J 15 initially awarded January 2009 (corrective action pending). 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).

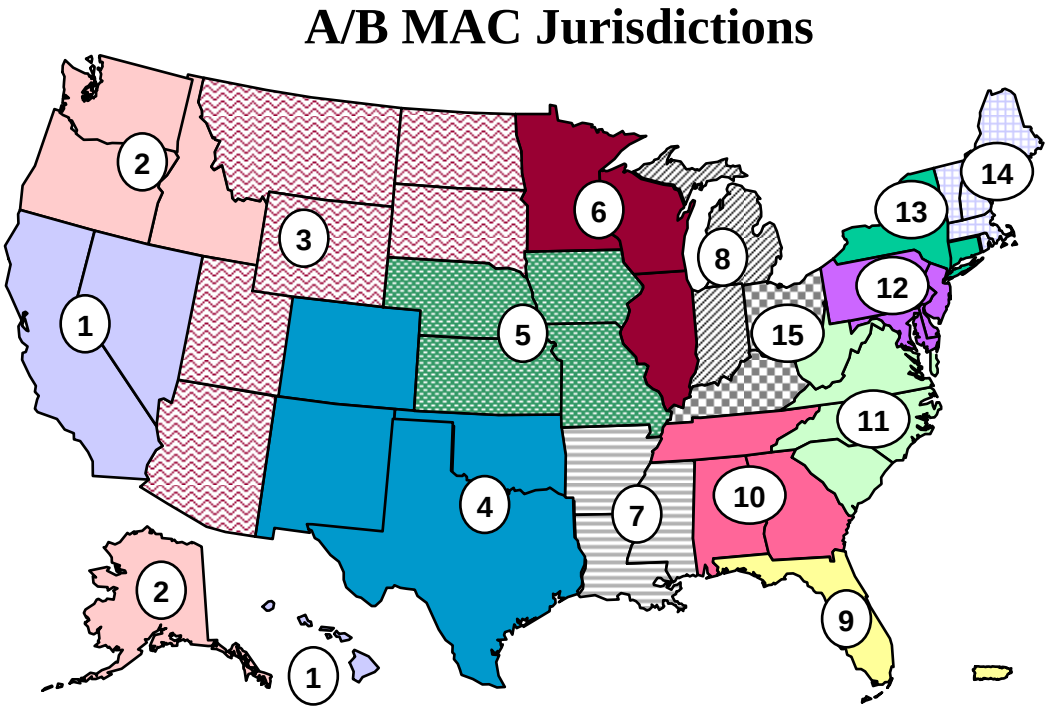
During FY 2009, initial contract awards were completed for all MAC contracts; however, MAC award protests have caused months of delays in several jurisdictions. To address these challenges, CMS has implemented process improvements to better manage these procurements. In those cases where CMS has successfully implemented MAC contracts, the new contracts are generating significant operating efficiencies relative to the fiscal intermediary and carrier operating costs in the pre-competitive environment.

In FY 2009, CMS had reduced its MAC implementation target from 85 percent to 74 percent of FFS workload; however, due to the effect of contract bid protests, CMS was only able to implement 65.2 percent of FFS workload. Our target for FY 2010 is to finalize awards for the 6 remaining MAC contracts before the end of the fiscal year;

however, CMS is currently dealing with complex and legal challenges associated with resolving multiple procurement corrective actions. In FY 2010, CMS also plans to award 3 "second generation" DME MACs.

CMS has also successfully consolidated Medicare FFS data processing operations into three enterprise data centers (EDCs), leaving behind more than one dozen FFS data centers used by the Medicare fiscal intermediaries and carriers as recently as 2005. CMS has achieved administrative efficiencies from this consolidation. This data center consolidation 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 workload continues to grow and Medicare claims processing applications require a more stable environment.

The following map displays the A/B MAC jurisdictions:



Budget Request

The FY 2011 budget request for contracting reform is $9.1 million, $56.5 million less than the FY 2010 Appropriation. This level includes:

- $0.0 million for contractor transitions, a $44.7 million decrease in funding for legacy contractor transition and termination costs. This reflects the implementation of Round One of the "first generation" MAC awards in FY 2010. Round two of the re-bidding cycle for DME MACs began in FY 2009. CMS has not included any funding for the possibility of a DME MAC re-award in FY 2010 or FY 2011 because we believe the cost of a re-award will be minimal unless a DME MAC is awarded to a

different entity. In that case, there will be some transition costs that CMS would need to absorb within our FY 2011 request. As the second generation MAC implementations progress, it may be necessary to revisit the issue of transition costs in future years.

- $2.4 million is for information technology investments, the web-based workload tracking system, and the shared system change management system. This is $9.2 million less than the FY 2010 Appropriation due to the final EDC transitions occurring in FY 2010.
- $6.7 million for several activities that support contracting reform implementation, including a provider satisfaction survey required by the MMA. This funding level is $2.6 million less than the FY 2010 Appropriation mainly due to the final transitions occurring in FY 2010 and a decreased need for business expertise, external validation, and implementation support.

In FY 2011, CMS expects to implement 3 "second generation" DME MACs. CMS also plans to award the 4th "second generation" DME MAC, along with a "second generation" A/B MAC in FY 2011.

We believe that contracting reform will continue to produce significant program savings to contribute toward deficit reduction. CMS' accelerated implementation approach has produced savings earlier than anticipated in the legislation. Savings accrue from: reducing the overall number of Medicare contractors, from about 40 to 19 (15 MACs and 4 DME MACs); combining Part A and Part B functions under the same contractor; allowing CMS greater discretion in the selection of contractors; and reducing data centers. For FYs 2009 – FY 2011, the CMS actuary estimated trust fund savings in the amounts of $280.0 million, $550.0 million, and $580.0 million, respectively.

COMPETITIVE BIDDING

Program Description and Accomplishments

Section 303(d) of the MMA also established a competitive bidding program for Part B drugs known as the Competitive Acquisition Program (CAP). The CAP is an alternative to the average sales price (or "buy and bill") method used to supply drugs that are administered incident to a physician's services.

Earlier in FY 2008, CMS accepted bids for vendor contracts for the 2009-2011 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in the CMS decision to postpone the 2009 program. As a result, physician election for participation in the CAP in 2009 was not held, and CAP drugs were not available from an approved CAP vendor for dates of service after December 31, 2008.

During this postponement, CMS plans to seek feedback on the CAP from participating physicians, potential vendors, and other interested parties. CMS will assess the information and consider implementing changes to the CAP before proceeding with another bid solicitation. As part of the process, CMS hopes to hear from the public about a range of issues, including, but not limited to, the categories of drugs provided under the CAP, the distribution of areas that are served by the CAP, and procedural

changes that may increase the program's flexibility and appeal to potential vendors and physicians.

CMS anticipates that it will re-implement the CAP program in FY 2011. As the CAP program resumes its activities, CMS believes the program will expand in the coming years as the number of physicians who elect to participate in the CAP grows and the number of drug classes available through the CAP increases.

Budget Request

The FY 2011 budget request for Part B competitive bidding is $2.5 million, an increase of $2.0 million above the FY 2010 Appropriation. This funding level will allow the designated CAP carrier to perform bid evaluation, claims processing, physician election, and educational functions.

MEDICARE PART C AND D OPERATIONS

Program Description and Accomplishments

CMS administers and oversees the Medicare Advantage (MA) (Part C) and Medicare prescription drug benefit (Part D) programs.

The following discusses CMS' performance goal relating to Part D.

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 enrollment levels remained at 90 percent. As a result, the FY 2009 target was set at 91 percent. Given the high rates of enrollment, it is becoming increasingly challenging to increase the enrollment rates further. This is evident in the final FY 2009 data, which showed the enrollment data remaining at 90 percent. The target will remain at 91 percent for FY 2010 and FY 2011.

CMS also measures two other aspects of Medicare's prescription drug benefit in this performance goal: (1) a beneficiary survey measuring knowledge of the benefit; and (2) a management/ operations component involving Part D sponsor performance metrics published on the Medicare Prescription Drug Plan Finder (MPDPF) tool. For more information on these performance measures, please refer to the key performance outcomes table at the end of this chapter and the FY 2011 Online Performance Appendix.

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

Parts 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.

Management and Review

Management and review activities needed to run the Part C and Part D programs include actuarial estimates, bid reviews of the prescription drug and MA plans, approval of new plan applicants for the 2011 contract year; reviews of formularies and benefits, monitoring of current plan performance, reconciliation of prior year plan payments, and the processing of Part D appeals. Activities to expand and support Part D enrollment of low-income beneficiaries are also included here. Much of the Parts C and D management and review activities require contractor support.

This section 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 Programs of All-inclusive Care for the Elderly (PACE) organizations. 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 in the Activities Supporting All Parts of Medicare section later in this chapter).

Budget Request

The FY 2011 budget request for Medicare Part C and Part D operations is $144.6 million. This funding level is $11.4 million more than the FY 2010 Appropriation. This increase is explained below:

- *Part C/D IT Systems Investments*: $89.2 million, an increase of $7.0 million over the FY 2010 Appropriation. As MA and Part D plan participation continues to grow, the Part C/D systems must grow as well to accommodate the flow of additional information.

  The FY 2011 budget request also funds improved customer service support for the MMA help desk which provides technical and operational system support for users of several Medicare Advantage and Part D systems.

- *Management and Review*: $55.4 million, $4.4 million more than the FY 2010 Appropriation. The majority of this increase is for the Part C appeal reviews. On average, since 2007, the volume of Part C appeals has increased approximately

50% each year. These increases are most likely due to increases in MA enrollments and increased awareness of appeal rights. For FY 2010 and FY 2011, CMS expects to see similar increases in the appeals volume. Adequate funding for this contract will provide timely due process rights for beneficiaries enrolled in managed care health plans and PACE organizations. CMS will be at risk for litigation if appeals are not timely processed.

This level will also support actuarial estimates, bid reviews of the prescription drug and MA plans, approval of new plan applicants for the 2011 contract year; reviews of formularies and benefits, monitoring of current plan performance, and the reconciliation of 2010 plan payments. In addition, this level provides funding for Part D appeals which are also growing due to rising enrollment and increased awareness of appeal rights.

ACTIVITIES SUPPORTING ALL PARTS OF MEDICARE

NATIONAL MEDICARE AND YOU EDUCATION PROGRAM (NMEP)

Program Description and Accomplishments

The National Medicare and You 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)/1-800-MEDICARE; Internet; community-based outreach; and program support services.

Beneficiary Materials

This category includes the annual *Medicare & You* handbook, initial enrollment packages, and other beneficiary materials. These informational materials will continue to build beneficiary awareness of changes in the Medicare program, and promote Agency resources where beneficiaries can get more information or get help. These materials also provide a clear differentiation of Medicare plans to beneficiaries, assure accountability of plans for performance requirements, comply with formulary guidance, and ensure effective data is present.

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 semi-annually for the monthly mailings to newly eligible beneficiaries.

The chart below displays the actual number of *Medicare & You* handbooks distributed for FY 2007 – 2009 and the estimated distribution for FY 2010 -2011. 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

	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
Number of Handbooks Distributed	40.3 million	41.9 million	42.9 million	44.0 million	45.1 million

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, in both English and Spanish. For the past ten years, this line has provided beneficiaries with responses to general inquiries about Medicare.

Traditionally, fiscal intermediaries and carriers handled beneficiary claims inquiries through their own individual toll-free numbers, while 1-800-MEDICARE handled general inquiries. In FY 2007, CMS merged the claims inquiry and the general inquiry workloads under a single contract known as the Beneficiary Contact Center (BCC). The BCC uses a single toll-free number, 1-800 MEDICARE, for all inquiries. This allows beneficiaries to receive answers to both claims-related and general information and to order Medicare publications with a single phone call.

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.

We continually look for ways to improve the efficiency of the 1-800 MEDICARE operation. For example, in 2008, we implemented BCC command centers and real time schedule adherence to develop and monitor in real time the most effective schedules across the lines of business and hours of operation and to ensure that CSRs are following them.

The "1-800-MEDICARE/Beneficiary Contact Center Call Volume Offered" table below displays call volumes from FY 2007 through the FY 2011 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 2011, CMS expects to receive 30.0 million calls to the 1-800-MEDICARE toll-free line, about 2 million more than FY 2010. All calls are initially answered by the Interactive Voice Response (IVR) system.

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

	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
Number of Calls[3]	29.0 million	27.4 million	25.9 million	28.1 million	30.0 million

Internet

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

The http://www.cms.hhs.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. It encompasses 14 online applications, as well as multiple back-end tools. The site serves as an effective and efficient communication channel and provides self-service options for professionals and stakeholders to have access to accurate and consistent information on CMS' programs to use on a daily basis for important decision-making purposes. The website has expanded self-service channels for professionals and stakeholders to access information online about Medicare, Medicaid, and other CMS programs, guidance, manuals, performance and health care information. Without this investment, professionals, providers and partners would be unable to access payment information, forms, regulations, and manuals critical for their success in carrying out the missions of CMS and HHS. CMS would be unable to meet legislative mandates to provide accurate and critical information online to the public.

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 site has a monthly release schedule for updates and data refreshes. This website includes four separate quality tools, eleven other complex applications, and MyMedicare.gov (most available in English and Spanish). MyMedicare.gov is a portal for beneficiaries to track and receive personalized information regarding their Medicare health and prescription drug plan, preventive services, claims, and drug details and cost share information. The Medicare Options Compare, the Medicare Prescription Drug 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. This website is an integral part of CMS' goals of modernization, contracting reform, accelerated use of electronic health information, and managing the Medicare prescription drug benefit. Without this investment, beneficiaries would be unable to conduct on-line prescription

[3]The Call Volume Projections shown above are based on the combined 1-800-MEDICARE/Beneficiary Contact Center (BCC) operations.

drug plan enrollments and CMS would be unable to meet legislative mandates to provide accurate and critical information online to the public.

In FY 2011, CMS estimates approximately 421 million page views to http://www.medicare.gov, approximately a 1.5 percent increase in traffic from the page views anticipated in FY 2010. 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 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
Number of http://www.medicare.gov Page Views	425.0 million	434.0 million	409.9 million	415.0 million	421.0 million

Community-Based Outreach

CMS administers and conducts many outreach programs, including the State Health Insurance Assistance Program (SHIP), collaborative grassroots coalitions, and national, local, and multi-media training that provide assistance at the local level.

The majority of funding in this category will be provided for SHIP grants to States and SHIP support. SHIPs provide one-on-one counseling to beneficiaries on complex Medicare-related topics, including Medicare entitlement and enrollment, health plan options, Medigap, and long-term care insurance, the prescription drug benefit, and preventive benefits. SHIP funding will provide infrastructure, training, and outreach support to an expanded force of over 12,000 counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The SHIP grant year runs from April 1 through March 31 each year. In grant year 2006, the total number of clients reached by SHIPs was 3.4 million. In grant year 2007, the number was 4.2 million. In grant year 2008, the number was 5.2 million. The SHIPs serve as the primary providers of locally based counseling, information, and assistance. In addition to program management funds, the SHIPs received $15.0 million in FY 2009 from the Medicare Medicaid and SCHIP Extension Act of 2007 (MMSEA); in FY 2009, the SHIPs received $7.5 million from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for targeted beneficiaries for Medicare enrollment assistance.

CMS continues to grow extensive consumer, provider and business service partnership networks that strengthen and expand CMS' grassroots Medicare program. Working collaboratively with the Administration on Aging, Centers for Disease Control and the Food and Drug Administration, CMS enhances its capacity to provide targeted, local outreach and education to vulnerable beneficiaries and their caregivers about , low-income subsidies, optimal, safe medication practices, and best practices in generational communications for "Coming of Agers". CMS's multiple education forums, caregiver webinars, conference presentations, programs and exhibits, and targeted partner listening sessions directly address CMS's mission to promote high quality care, manage chronic diseases and disabilities, and close the prevention gap for beneficiaries.

CMS also provides training to numerous community-level organizations, federal/State/local agencies, providers and others. This includes web-based, audio, and computer-based training on a variety of Medicare topics including low-income subsidy, health plan options, and coverage for preventive services.

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 Handbook.

The multi-media Medicare education campaign raises awareness and educates beneficiaries, caregivers, providers, partners, and others about Medicare benefits and choices. The campaign features grassroots outreach including earned media and paid advertising in relevant markets. To the extent possible, CMS also targets specific, hard-to-reach populations with personalized strategies including Asian American/Pacific Islanders, Hispanics, African Americans, and people with disabilities.

Consumer research and assessment are integral to the success of the NMEP. We have seen a steady improvement over time in beneficiary understanding of features of the program and use and understanding of our educational resources. This is attributable in part to improvements in our education products and services that were made in response to feedback obtained through our consumer testing and assessment activities. Assessment activities include compliance monitoring of 1-800-MEDICARE and the SHIPs, 1-800-MEDICARE satisfaction surveys, handbook testing and development, and testing of general Medicare materials and strategies. CMS will continue to measure progress on the Medicare Prescription Drug Benefit goal. CMS will also conduct tracking surveys to assess the overall effectiveness of our education activities. In addition, Program Support Services 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.

National *Medicare & You* Education Program Budget Summary
(dollars in millions)

	FY 2010 Appropriation	FY 2011 PB Request	Description of Activity in FY 2011
Beneficiary Materials	$51.0 M ($33.0M PM) ($18.0M UF)	$52.7 M ($34.7M PM) ($18.0M UF)	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.
Beneficiary Contact Center/ 1-800-MEDICARE	$244.8 M ($188.5M PM) ($56.3M UF)	$287.0 M ($232.5M PM) ($54.5M UF)	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.
Internet	$34.1 M ($31.6M PM) ($2.5M QIO)	$31.8 M ($31.8M PM) (QIO TBD)	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.
Community-based Outreach	$47.4 M ($47.4M PM)	$52.9 M ($52.9M PM)	SHIP grants and support; collaborative grassroots coalitions; and training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies that provides assistance to people with Medicare in their communities.
Program Support Services	$18.9 M ($10.9M PM) ($8.0M QIO)	$11.3 M ($11.3M PM) (QIO TBD)	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.
Total	$396.3 M[4] ($311.5M PM)[5] ($74.3M UF) ($10.5M QIO)[5]	$435.7 M ($363.2M PM) ($72.5M UF) (QIO TBD)	**Key to Abbreviations:** PM – Program Management UF – User Fee QIO – Quality Improvement Organizations

[4] Totals may not add due to rounding.
[5] QIO funding numbers are estimates; they have not been finalized and are subject to change.

Budget Request

The FY 2011 Program Management request for NMEP totals $363.2 million, an increase of $51.7 million above the FY 2010 Appropriation. The following bullets highlight the FY 2011 Program Management level:

- Beneficiary Materials: $34.7 million
- 1-800-MEDICARE/Beneficiary Contact Center: $232.5 million
- Internet: $31.8 million
- Community-Based Outreach: $52.9 million
- Program Support Services: $11.3 million

In addition to Program Management funding, the budget request also includes $72.5 million in user fees bringing the NMEP total to $435.7 million. The chart on the preceding page provides additional detail on these activities.

Beneficiary Materials

The FY 2011 budget request for Beneficiary Materials is $34.7 million, approximately 9 percent of the NMEP program level funding. This is an increase of $1.7 million above the FY 2010 Appropriation. This estimate is based on historical publication usage data and current market prices for printing and mailing. This increase will be used to cover an increase for the initial enrollment packages and the Medicare & You Handbook. The increase in the funding level is also aligned with expected increases in beneficiary population, printing costs, and mailing costs. CMS must comply with the legal mandates for this activity (see next paragraph) and must ensure that beneficiaries have access to this information so that they can make informed health care decisions.

The *Medicare & You* handbook satisfies numerous legal mandates (including section 1851-(d) for Medicare Advantage and section 1860D-1(c) for Part D in the Social Security Act) to provide print information to current and newly eligible beneficiaries about general and plan comparison information, including the Medicare prescription drug benefit and new options available under Medicare Advantage. If CMS is unable to mail the *Medicare & You* handbook in its entirety, the mandates will not be met, thus making us vulnerable to legal action. This occurred in 2001 when, following a change in the date when plans were allowed to submit data, CMS mailed a handbook that lacked plan comparison information. As a result, CMS was sued and was required to produce and mail a supplemental booklet which included the plan comparison data. This resulted in increased costs for this activity.

1-800-MEDICARE/Beneficiary Contact Center (BCC)

The FY 2011 budget request for 1-800-MEDICARE/BCC activities is $232.5 million, approximately 64 percent of the NMEP program management level funding. This reflects an increase of $44.0 million from the FY 2010 Appropriation. This reflects an increase of nearly 2 million calls from FY 2010 to FY 2011 as well as an increase in CSR wage rates as set by the Department of Labor. The increase also covers additional training for CSRs due to the increasingly complex nature of call inquiries. The request will support a 5-minute average speed of answer (ASA) during open enrollment and an 8-minute ASA during non-open enrollment.

The requested level will allow CMS to provide adequate services at the BCC. Without this funding, Customer Service Representative (CSR) staffing would be reduced which, in turn, would result in longer call wait times. A reduction in funding may mean that CSRs will only be able to answer 60 percent of the callers who have questions. 1-800-MEDICARE would not be able to handle the remaining call volume, and those callers' questions would not be answered. The number of repeat callers would increase due to callers not expecting or wanting to wait, thus hanging up and calling back. This, in turn, would increase wait times even more as more callers try to reach a CSR.

Internet

For the FY 2011 budget request, $31.8 million or approximately 9 percent of the NMEP program management level funding will be spent on Internet activities. This funding level represents an increase of $0.2 million above the FY 2010 Appropriation. These funds will be used for ongoing maintenance costs, renewing software licenses, and 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. Several improvements are underway that may impact web traffic such as Search Engine Optimization and expanded "Email this Page" capabilities. This funding will also support several tools that require complex data updates (e.g. Medicare Prescription Drug Plan Finder) that are necessary to ensure that accurate and consistent information is provided to U.S. citizens, Medicare beneficiaries, and health care professionals for decision-making purposes on a daily basis.

Community-Based Outreach

For the FY 2011 budget request, $52.9 million or approximately 15 percent of the NMEP program management level funding will be spent on community-based outreach activities. This funding level represents an increase of $5.5 million above the FY 2010 Appropriation. $5.0 million of this request will be used to fund the SHIPs, while the remaining $0.5 million will be used to fund other Community-Based Outreach activities

Of the $52.9 million request, the total SHIP budget request is $50.0 million which is consistent with funding in previous years. The following legislative action has taken place since FY 2008 which has directed the SHIP funding levels in subsequent fiscal years:

- The Medicare, Medicaid, and SCHIP Extension Act of FY 2007 (MMSEA) provided the SHIPs with an additional $15.0 million in FY 2008.
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided the SHIPs with an additional $7.5 million in FY 2009.
- The FY 2009 Omnibus report language recommended an additional $5.7 million for SHIPs.

CMS intends to align the FY 2011 budget request for the SHIPs to match the previous years' Congressional actions. The $5 million budget increase for SHIPs will provide additional grant funding for States as well as a minimal increase to support contracts. This will provide for volunteer recruitment to meet the increased demand for one-on-one counseling, training, quality assurance, and statewide program infrastructure support to meet the demanding activities carried out by local community-based organizations that serve as local SHIP programs. Additional funding would also be provided for performance incentive grants to States for SHIPs that are meeting and/or exceeding performance measures. Finally, a minimal increase would be provided to support contracts for the SHIP program to include upgrades needed for the SHIP National Performance Reporting (NPR) data system. Given the importance of SHIPs in CMS' education and outreach efforts, the increasing numbers of coming-of-agers, and the additional funding received in past years, it is essential that the SHIPs be funded at an adequate level. Of the $52.9 million request, the remaining $2.9 million will be used for other Community-Based Outreach activities such as collaborative grass roots coalitions and training to numerous community-level organizations, federal/State/local agencies, providers and others.

SHIP Funding Chart
(Dollars in Millions)

Funding Source	FY 2008 Actual	FY 2009 Actual	FY 2010 Appropriation	FY 2011 Request
Program Management	$39.3	$45.0	$45.0	$50.0
MIPPA	-	$7.5	-	-
MMSEA	$15.0	-	-	-
Total	**$54.3**	**$52.5**	**$45.0**	**$50.0**

Program Support Services

For the FY 2011 budget request, $11.3 million or approximately 3 percent of the NMEP program management level funding will be spent on Program Support Services activities. This funding level represents an increase of $0.4 million above the FY 2010 Appropriation. The majority of this request will fund the multi-media Medicare education campaign.

The FY 2011 request for campaign work is $8.1 million, an increase of $1.1 million above the FY 2010 Appropriation. The plan for the FY 2011 multi-media Medicare education campaign is 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. The campaign will continue to promote the following Medicare information channels as resources available to answer Medicare: 1-800-MEDICARE, www.medicare.gov, the *Medicare and You* handbook, and personalized counseling and assistance at the local level from partners and other government agencies.

The remaining $3.2 million will fund consumer research and assessment, other activities required to support the *Medicare and 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.

ACCOUNTING AND AUDITS

Program Description and Accomplishments

Healthcare Integrated General Ledger and Accounting System (HIGLAS)

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 program. HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS directly supports DHHS efforts to meet compliance goals of FFMIA by encompassing all CMS program dollars (Medicare, Medicaid, Children's Health Insurance Program (CHIP) 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 is a critical success factor towards ensuring DHHS meets 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. The improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection 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 fee-for-service (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 amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than 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. Through FY 2009, CMS estimates that $197 million in additional interest was earned in the Medicare Trust Funds due to HIGLAS automation and improved processes. Assuming this level of increased collections continues in the outyears, CMS estimates the total amount of additional interest earned could potentially exceed $387 million through FY 2011.

During FY 2009, CMS realigned its HIGLAS implementation schedule in accordance with the Agency's adjusted MAC implementation schedule. We continue to closely and

actively monitor and manage implementation efforts in an integrated manner and at the highest levels within the Agency. As of fiscal year end 2009, CMS had deployed HIGLAS at fourteen traditional Medicare FFS contractors and one Medicare Administrative Contractors (MACs), achieving 62 percent of full FFMIA compliance including Medicaid and Children's Health Insurance Program (CHIP) federal funding. In FY 2009, CMS facilitated numerous workload splits and "renames" in support of the Agency's MAC implementation efforts. The transitioning of Medicare contractor claims processing workloads to the MAC environment also includes the movement of existing HIGLAS financial workload and data from one HIGLAS organization to another. In many cases, the existing HIGLAS workload must be moved to multiple MAC jurisdictions. When a single existing HIGLAS Medicare contractor/organization is split among multiple MACs, it results in a "workload split." A "rename" occurs when the financial workload in an existing HIGLAS contractor/organization is moved in its entirety to a MAC. CMS expects to meet its HIGLAS planned transition activities in accordance with the Agency's FY 2010 integrated transition schedule. During FY 2010, CMS anticipates achievement of substantial FFMIA compliance with the planned transition of ten additional MAC entities onto HIGLAS as well as the incorporation of Medicare Part C and Part D accounting onto HIGLAS.

In FY 2011, CMS plans to transition 10 MAC entities to HIGLAS; obtain 94.04 percent FFMIA compliance; continue the development of the increased Administrative Program Accounting on HIGLAS including analysis of future development efforts related to manual and interfaced payments processes and the final development of all agency mandated financial statements.

To date, the HIGLAS project continues to progress on schedule and within budget. HIGLAS costs for FY 2009 through FY 2011 are as follows (in millions):

	DM&E	O&M	Total
FY 2009 Appropriation	$35.7	$123.0	$158.7
FY 2010 Appropriation	$35.7	$125.3	$161.0
FY 2011 Request	$37.7	$118.3	$156.0

Key to Abbreviations:
DM&E – Development, Modernization, and Enhancement
O&M – Operations and Management

CFO/Financial Statement Audits

This section covers CMS' audit activities including 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

The FY 2011 budget request for audits and HIGLAS is $165.0 million, a net decrease of $5.0 million from the FY 2010 Appropriation. 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*: $156.0 million, a decrease of $5.0 million from the FY 2010 Appropriation. This request will support the production and application maintenance at the 25 Medicare MAC/legacy Medicare contractor entities that will be utilizing HIGLAS by the end of FY 2010. 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 (O&M) 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.

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

QUALIFIED INDEPENDENT CONTRACTOR (QIC) APPEALS

Program Description and Accomplishments

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.

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.

Budget Request

The FY 2011 budget request for QIC appeals (BIPA sections 521 and 522) is $59.5 million, $3.3 million more than the FY 2010 Appropriation. The QICs processed 456,849 reconsideration requests in FY 2009[6], an increase of over 45,000 from FY 2008. CMS believes this growth is a result of increased familiarity by the provider community regarding the reconsiderations process and continued program integrity initiatives. In FY 2011, CMS anticipates a slight increase in the ongoing QIC workload..

- *QIC Costs*: $52.5 million, an increase of $2.8 million above the FY 2010 Appropriation. The request covers the expected QIC costs of processing appeals.
- *Medicare Appeals System (MAS):* $7.0 million, $0.5 million more than the FY 2010 Appropriation. The increased budget level represents systems enhancements occurring in FY 2011. This request also incorporates the cost of operating the system, as well as the cost of developing security mechanisms to control MAS administration and access to appeals data.

The following chart details the number of QIC appeals from FY 2007 through the FY 2011 estimate:

QIC Appeals Workloads

Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
QIC Appeals	358,443	411,600	456,849	465,986	475,305

HIPAA ADMINISTRATIVE SIMPLIFICATION

Program Description and Accomplishments

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

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

efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange. The request covers several HIPAA activities for which CMS is responsible:

- *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 will assign NPIs and process NPI applications. CMS developed the NPPES to process the NPI applications and to make any 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. CMS estimates that new providers applying for NPIs equate to 1.6 percent of providers that existed in the prior year. In addition, we estimate that 12.6 percent of all enumerated providers will submit changes to their records annually. So far, 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 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* – This project includes outreach programs for covered entities and other affected organizations, as well as enforcement efforts:
    - Outreach efforts include national HIPAA roundtable discussions, web support, conferences, and educational materials. Outreach efforts also include HIPAA On-Line (HOL), an outreach tool developed to publicize HIPAA protections. It is a free, interactive internet-based program that provides timely, correct information to consumers and employers.
    - Enforcement activities consist of investigative contractor activity to support HIPAA 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. Another enforcement tool is the administrative simplification enforcement tool (ASET), a web-based application that provides online complaint filing and management to parties who wish to file a HIPAA complaint. HIPAA 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 about 1,200 complaints.

- This activity also involves conducting pilot tests of the HIPAA technical standards.

Budget Request

The FY 2011 budget request for HIPAA Administrative Simplification is $27.2 million, an increase of $3.0 million above the FY 2010 Appropriation. This request includes the following activities:

- *NPI & NPPES*: $11.2 million, $0.1 million above the FY 2010 Appropriation. 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 ongoing as 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 (PECOS).
- *HIPAA Claims-Based Transactions*: $14.1 million, $3.1 million above the FY 2010 Appropriation. CMS is making changes to its information technology infrastructure in FY 2010 to provide this beneficiary eligibility information on a real-time basis. This application is considered mission critical as it provides beneficiary health care eligibility information to health care providers and institutions, as well as assists in determining how Medicare should be billed for the services rendered. The FY 2011 request will support the continued implementation of this information technology infrastructure, as well as fund the maintenance and operation of the system.
- *HIPAA Electronic Data Interchange (EDI):* $0.6 million, the same as the FY 2010 Appropriation. This funding level allows CMS to be in compliance with the HIPAA EDI standard stated in the previous section.
- *HIPAA Outreach, Enforcement, Compliance Reviews, & Pilots:* $1.3 million, approximately $0.2 million less than the FY 2010 Appropriation. A portion of the FY 2010 Appropriation funded the implementation of outreach tools such as HIPAA On-Line (HOL). The FY 2011 budget is reduced now that these outreach tools only need funding for maintenance purposes.

The chart below details the CMS funding levels for HIPAA Administrative Simplification:

HIPAA Standard (dollars in millions)	FY 2008 Actual	FY 2009 Actual	FY 2010 Approp.	FY 2011 Request
National Plan & Provider Enumeration System (NPPES)	$8.4	$7.1	$8.0	$8.6
National Provider Identifier (NPI)	$4.2	$3.3	$3.1	$2.6
HIPAA Claims-Based Transactions	$9.1	$10.5	$11.0	$14.1
HIPAA Electronic Data Interchange (EDI)	$0.4	$0.4	$0.6	$0.6
HIPAA Outreach, Enforcement, Compliance Reviews & Pilots	$1.5	$1.4	$1.5	$1.3
Total	**$23.6**	**$22.7**	**$24.2**	**$27.2**

ICD-10 AND VERSION 5010 INITIATIVE

Program Description and Accomplishments

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 (WHO). Although ICD-10 has been in use in much of the industrialized world since 1995, the United States, including CMS, still uses ICD-9-CM, an older version developed over 30 years ago. Known collectively as ICD-9-CM, volumes 1 and 2 of the code set includes codes for medical diagnoses, and volume 3 has codes for medical procedures.

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

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. The ICD-10-CM code set for diagnosis codes, and ICD-10-PCS for procedure codes, collectively referred to as ICD-10, is much more specific, making it easier to determine if a claim was appropriately billed. Although the ICD-10 code set will not eliminate all fraud, waste, and abuse, CMS believes that its 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.

The ICD-9-CM code set also does not provide the level of specificity needed for value-based purchasing, which considers both quality and cost of care over an appropriate period of time. Specific and accurate data is vital to the success of a value-based purchasing program. 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 ICD-9-CM code

book. However, this makes it difficult for medical coders to find these new procedures and compromises the integrity of the code set.

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 X12 Version 5010 and NCPDP Version D.0 for HIPAA transactions. In this rule, HHS also adopts 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 separate final rule, HHS modifies the standard medical data code sets for coding diagnoses and inpatient hospital procedures by concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (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 the ICD-10 code sets, and as such, has an earlier compliance date than ICD-10 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 requiring modification fall into three major categories: 1) “Front-End” systems maintained by Medicare Administrative Contractors (MACs) in 15 jurisdictions, who exchange electronic transactions with providers and clearinghouses and introduce these transactions into the claims processing systems; 2) the “core” claims eligibility, history, adjudication, and financial systems for Medicare Parts A and B; and 3) all “downstream” systems that contain claims data, such as risk adjustment, payment analysis, and national utilization databases. Systems development has begun on modifications to core systems and several downstream systems, and will soon begin on the front-end systems. Systems development will be completed in 2010 and testing and integration will continue through 2010 and into 2011. All health care plans must be ready to accept the new Version 5010 transactions by January 1, 2011 and discontinue use of the current Version 4010 transaction formats by December 31, 2011. All health care providers must be ready to use the new Version 5010 transactions by January 1, 2012.

In 2008, CMS also began assessing the impact of the ICD-10 transition on CMS systems and business operations. The purpose was to identify the touch points of ICD codes across the agency. An impact analysis that includes an in-depth assessment of the risks associated with ICD-10 implementation, the opportunities of ICD-10, and the work required for transitioning CMS to ICD-10 has been finalized, from which CMS will develop implementation recommendations, timelines and strategies for this transition. This analysis was used as the basis for outlining the key decisions that the agency needs to consider for transitioning to ICD-10 along with solution concepts for those key decisions, which have also been finalized and are being shared with CMS components to assist them in their ICD-10 transition activities. . From these, CMS is working to finalize recommendations and timelines for the agency to implement ICD-10 throughout our systems and business operations.

With the ICD-10 impact analysis and solution concept completed, CMS anticipates that modifications to CMS systems and business operations for ICD-10 will begin at the start of FY 2010 with internal testing occurring during the start of FY 2012. FY 2011 activities will build upon those initiated in FY 2010, with a continuation of industry and State Medicaid program implementation monitoring. CMS also expects that external testing of ICD-10 will occur during FY 2012 in order to ensure that transactions between trading partners that include ICD-10 codes 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 beginning in FY 2010, 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 mechanisms to ensure timely CMS, contractor and industry transition to ICD-10-CM and ICD-10-PCS on October 1, 2013.

Budget Request

The FY 2011 budget request for ICD-10 and Version 5010 is $60.2, $2.3 million less than the FY 2010 Appropriation. The breakout between ICD-10 and Version 5010 is shown below:

- *ICD-10:* The FY 2011 budget request for ICD-10 is $40.1 million. This request includes funding to develop and initiate an industry-wide provider education and outreach strategy; conduct code and policy analysis in order to update CMS processes that utilize ICD codes; develop and initiate program management support for ICD-10 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.

- Version 5010: The FY 2011 budget request for Version 5010 is $20.1 million. This funding level will support the continuance of the systems cost related to the completion of Version 5010. These systems include CMS's core and downstream systems, along with MAC systems.

MEDICARE IMPROVEMENTS TO PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

Program Description and Accomplishments

MIPPA, P.L. 110-275, enacted on July 15, 2008, includes numerous provisions which improve services for beneficiaries, enhance access to health care, expand value-based purchasing and quality reporting, and make payment and coverage changes.

MIPPA provided CMS with $307.5 million in Program Management funding. Of this total, $167.5 million was earmarked for three specific provisions: DME Competitive Bidding, State Health Insurance and Assistance Program grants, and a contract with a consensus-based entity for performance measurement work.

The remaining $140.0 million was intended to cover more than 40 other provisions. Several of these other provisions mandate major new initiatives such as section 132, which makes incentive payments to professionals who successfully use E-prescribing, and section 153 which makes payments to renal dialysis providers and facilities who successfully report on End-Stage Renal Disease (ESRD) quality performance measures. Some expand existing programs such as section 131 which extends the Physician Quality Reporting program through 2010, establishes a physician feedback program to provide confidential reports that measure the resources used in furnishing care to Medicare beneficiaries, and requires a plan for transitioning to a value-based purchasing program for covered professional services under Medicare. CMS spent $36 million of the $140 million in FY 2009. Of this total, $24 million, or two thirds, was spent on sections 131 and 132 (Physician and E-prescribing reporting). CMS projects that the balance of the $140 million will be spent in FY 2010. Over 80 percent is projected to be spent on Physician and E-prescribing reporting, primarily on IT systems activities.

CMS received $61.6 million in the FY 2010 Appropriation for the following five key provisions that were partially funded with the $140 million appropriated in the bill:

- Section 125: Ensuring Accreditation for Medicare Hospitals -- $1.4 million;
- Section 153: End Stage Renal Disease (ESRD) Pay for Performance -- $52.5 million;
- Section 165: Specialized Medicare Advantage Plans for Special Needs Individuals -- $3.9 million;
- Section 185: Addressing Health Care Disparities -- $2.7 million; and
- Section 189: Federal Payment Levy Program -- $1.1 million.

Budget Request

In FY 2011, CMS is requesting a total of $89.3 million. This level would fully fund the estimated costs of continuing its work on three major MIPPA provisions including:

- Section 131 -- quality reporting and incentives for physicians;
- Section 132 – quality reporting and incentives for physician use of electronic prescribing; and
- Section 153 -- quality reporting and incentives for facilities furnishing ESRD services.

In general, these funds will be used to support activities in all three sections including ongoing measure development and refinement; business, systems, and technical requirements; financial accounting and reporting; feedback and physician resource use reporting; development and refinement of scoring methodologies to determine incentive payment amounts and future payment reductions where appropriate; help desk support; provider education and inquiries; training and certification of vendors; data infrastructure; data analysis; and other activities. For Section 131, MIPPA extends the physician quality reporting system through FY 2010. These funds will be used primarily to make accurate incentive payments in FY 2011 for professional services furnished in FY 2010. For Section 132, this funding will allow CMS to evaluate data at the prescriber level to determine the number of prescriptions written through e-prescribing and if that level meets the standards defined by the Secretary. For Section 153, this funding will allow CMS to meet the statutory deadline (January 1, 2012) for developing a quality incentive program for facilities furnishing ESRD services; this program would also reduce payments by up to 2.0 percent for facilities that do not meet or exceed a total performance score. Since it takes approximately 18 months before data collection can begin among ESRD facilities, CMS must make significant investments in FY 2011.

This funding will ensure that incentive payments for these programs will continue to be made appropriately and timely.

OTHER INFORMATION TECHNOLOGY SUPPORTING ALL PARTS OF MEDICARE

Program Description and Accomplishments

Enterprise IT Activities

Enterprise IT activities encompass CMS' critical systems infrastructure 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 of CMS' enterprise-wide infrastructure which includes 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:

- *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).

- *Early Warning Dashboard:* There are several business drivers for development of an Early Warning Dashboard for presentation of CMS data. Information is an essential component of transforming the health care system. To improve the United States healthcare system, decision makers must utilize timely, integrated information to support the development of improved healthcare delivery and financing strategies. CMS and the rest of the healthcare system must use information and processes to take proactive action in both individual patient encounters and in healthcare policy. CMS has an enormous amount of healthcare information that can inform healthcare transformation. The process to develop a system to employ this information will be utilized by the CMS Early Warning Dashboard.

- *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.

<u>Infrastructure Investments</u>

This section includes several key IT infrastructure projects, including:

- *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.

There are four FY 2011 performance measures included in the outcomes and outputs table at the end of this chapter on effective management of 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

The FY 2011 budget request for other information technology investments supporting all parts of Medicare is $280.1 million, $17.7 million greater than the FY 2010 Appropriation. This category includes two major IT investment activities: enterprise and infrastructure.

Enterprise IT Activities: $256.4 million, $17.8 million more than the FY 2010 Appropriation. This increase is the result of inflationary increases such as increased cost of maintenance, capacity upgrades, end of life replacements, and technology improvements.

Infrastructure Investments: $23.7 million, $0.1 million less than the FY 2010 Appropriation. This funding level will continue to support the activities of the virtual call center strategy as well as the web hosting project.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCR3.1a: Beneficiary Survey Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	FY 2008: 64% (Target Exceeded)	N/A	N/A	N/A
MCR 3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	FY 2008: 75% (Target Exceeded)	72%	73%	+1
MCR3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	FY 2008: 69% (Target Exceeded)	61%	62%	+1
MCR3.2: Program Management/ Operations	FY 2009: Published the 2008 High Risk Medication patient safety measure (Target Met)	N/A	N/A	N/A
MCR3.3: Enrollment Increase percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources	FY 2009: 90% (Target Not Met)	91%	91%	Maintain
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 2009: 99.7% (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 2009: 99.3% (Target Exceeded)	95%	95%	Maintain
MCR12: Maintain an unqualified opinion	FY 2009: Maintained unqualified opinion (Target Met)	Maintain	Maintain	N/A
MCR13.1: Award Medicare FFS Workload to MACs	FY 2009: Award 100% (Target Met)	Award 3 DME MACs (2nd round)	Award 1 DME and 1 A/B MAC (2nd round)	N/A
MCR13.2: Implement Medicare FFS Workload to MACs	FY 2009: 65.2% implemented (Target Not Met but Improved)	Implement 100%	Implement 3 DME MACs (2nd round)	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCR20: Implement the International Classification of Diseases (ICD)-10	FY 2010: Step 3 has been completed. Industry compliance level baselines developed	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	Update ICD-10 industry and State Medicaid program compliance measurement	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	New in FY 2011	N/A	80%	N/A
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution Baseline: 0% in FY 2009	New in FY 2011	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	75%	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	2 PIRs	N/A
Program Level Funding ($ in millions)	**N/A**	**$65.6**	**$9.1**	**-$56.5**

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Federal Administration

(dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$641,351	$696,880	$725,365	+$28,485
Direct FTEs [1/]	4,122	4,276	4,326	+50

[1/] The FY 2009 staffing level reflects actual year-end consumption.

Authorizing Legislation – Reorganization Act of 1953

FY 2010 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 Children's Health Insurance Program (CHIP). CMS is the largest purchaser of health care in the United States and expects to serve almost 102 million beneficiaries in FY 2011. In FY 2009, CMS spent $782 billion on benefits and other costs.

The Federal Administration account funds CMS staff and operating expenses for planning, developing, managing, and evaluating healthcare financing programs and policies. Through either its employees or contractors, CMS establishes program eligibility and benefit coverage, processes over one billion Medicare claims annually, recovers improper payments, plays a national leadership role in Health Insurance Portability and Accountability Act (HIPAA) implementation, oversees coverage policies for beneficiaries, and works with the States and Territories to administer Medicaid and CHIP. CMS also ensures quality of healthcare for its beneficiaries and safeguards the Medicare, Medicaid, and CHIP programs from fraud, waste, and abuse.

In 2006, CMS launched a Strategic Action Plan to ensure effective, up-to-date health care coverage and promote quality care for our beneficiaries. Using our Strategic Action Plan as a roadmap, we strive to pay providers the right amount at the right time, work toward a high-value health care system, increase consumer confidence by giving the beneficiaries more information, and strengthen our workforce to manage and implement our programs.

CMS currently employs approximately 4,600 Federal employees working in Baltimore, 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 and Washington: write health care policies and regulations; set payment rates; develop national operating systems for the Medicare, Medicaid, and CHIP programs; provide funding and guidelines for the Medicare contractors and monitor their performance; develop and implement customer service improvements; provide education outreach to Medicare providers; work with

State insurance agencies; 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 on Medicaid and CHIP issues; and work with healthcare providers, beneficiaries, and the general public on outreach awareness about the Medicare, Medicaid, and CHIP programs. 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); and, most recently, the American Recovery and Reinvestment Act (ARRA). 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. The Agency's recent staffing levels have made it difficult to keep pace with the volume of new activities and initiatives. The FY 2010 Omnibus bill includes funding to support 4,276 direct full-time equivalents (FTEs). Ten years ago, in FY 2000, CMS utilized 4,366 direct FTEs, a higher staffing level.

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, 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 and are subject to annual cost-of living increases for the contract workers. 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. Prior to the construction of this facility in 1995, CMS housed staff in 15 different buildings located around Baltimore. To improve management, enhance communications, and promote productivity, CMS proposed a facility that would house all of its Baltimore-based employees in one location. Congress approved the single-site construction project in FY 1989. Groundbreaking ceremonies were held in July 1993 and construction was completed in March 1995. 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 the Baltimore Human Resources Center (BHRC). In 2007, the Department developed the "One HHS" initiative to eliminate duplication of effort and achieve economies of scale. As part of this initiative, it consolidated personnel activities, previously performed separately by each Operating Division within the Department, and created the BHRC, which now provides HR services to CMS. The BHRC consists of three divisions: Workforce Relations, Client Services, and Strategic Programs:

  - 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.

- 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 CMS' Medicaid data systems that provide access to Medicaid eligibility and utilization claims data processed by all 50 States, the District of Columbia, and the five territories. Finally, a portion of this category helps to support 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:

- State-Federal Medicaid Performance Measurement Partnership Project: This project is an ongoing collaborative effort with State Medicaid programs and other Federal agencies to assist and educate them on the collection of nationally recognized standards of care and to develop a benchmark report on performance and technical assistance tools to improve the baseline. The tasks will result in the integration of performance measurement, pay for performance, dissemination of best practices, and reduction of health care disparities through data collection, analysis, technical assistance, and facilitation of collaborative, development of web materials, and identification and dissemination of best practices.

- 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, primarily due to annual cost-of-living adjustments for the Federal OGC employees who work on CMS issues.

- 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. Under Presidential Decision Directive 63 and Homeland Security Presidential Directive 7, CMS is classified 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 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 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 Medicare beneficiaries 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 new 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

2006	$633,065,000
2007	$642,355,000
2008 *	$636,132,000
2009	$641,351,000
2010	$696,880,000

** Includes $5.0 million in Supplemental funding provided by P.L. 110-252*

Budget Overview and Supported Activities

The FY 2011 President's Budget request for the Federal Administration account totals $725,365,000. This reflects an increase of $28**,**485,000 over the FY 2010 appropriated level. This increase consists of $23,668,000 for pay increases and $4,817,000 for non-pay increases.

Personnel Compensation and Benefits ($591.9 million): The CMS FY 2011 President's Budget request includes $591.9 million to support 4,326 direct FTEs, a 50 FTE increase over the budgeted FY 2010 staffing level. The additional staffing will allow us to begin the transformation of our data environment, implement recent mandatory legislation including the MIPPA and the CHIPRA, implement Secretarial priorities such as value-based purchasing and ICD-10, and maintain our traditional workloads. Equipping CMS with sufficient staff to implement existing legislative responsibilities will be key in positioning the Agency for new responsibilities.

Rent, Communication & Utilities ($27.2 million): The FY 2011 Rent, Communication & Utilities estimate is $27.2 million, an increase of $2.1 million over FY 2010 appropriated level. This is due to increases in rent and several office relocations, which were arranged by GSA.

Building Loans ($10.9 million): The FY 2011 estimate for Building Loans is $10.9 million. This estimate remains the same as the FY 2010 appropriated level.

Service and Supply Fund ($14.0 million): The FY 2011 Service and Supply Fund estimate is $14.0 million. This estimate is $0.3 million below the FY 2010 appropriated level.

BHRC Human Resources Support ($8.4. million): The FY 2011 BHRC Human Resources Support estimate is $8.4 million. This estimate remains the same as the FY 2010 appropriated level.

Administrative Service ($5.0 million): The FY 2011 Administrative Service estimate is $5.0 million. This estimate is $2.0 million below the FY 2010 appropriated level.

Administrative Information Technology (IT; $25.5 million)): The FY 2011 Administrative IT estimate is $25.5 million. This estimate remains the same as the FY 2010 appropriated level.

Inter-Agency Agreements ($1.1 million): The FY 2011 estimate in this category is $1.1 million. This estimate is $0.9 million below the FY 2010 appropriated level

Supplies and Equipment ($1.2 million): The FY 2011 estimate is $1.2 million, which is the same as FY 2010 appropriated level.

Administrative Contracts and Intra-Agency Agreements ($25.4 million): The administrative contracts and Intra-Agency Agreements estimate for FY 2011 is $25.4 million, an increase of $6.4 million over the FY 2010 appropriated level. This increase reflects cost of living increases for ongoing contractual arrangements.

Training ($2.4 million): The training estimate for FY 2011 is $2.4 million. This estimate is $0.5 million below the FY 2010 appropriated level

Travel ($9.0 million): The travel estimate for FY 2011 is $9.0 million. This estimate is $0.1 million higher than the FY 2010 appropriated level

Printing and Postage ($3.3 million): The printing and postage estimate for FY 2011 is $3.3 million. This estimate is $0.2 million below the FY 2010 appropriated level

Federal Administration Summary
(Dollars in thousands)

Object of Expense	FY 2010 Appropriation	FY 2011 President's Budget Request	Increase or Decrease
Personnel Compensation	$568,247	$591,915	+$23,668
Rent, Communication & Utilities	$25,100	$27,230	+$2,130
Central Office Loan	$10,900	$10,900	$0
Service/ Supply Fund	$14,300	$14,000	-$300
Human Resources	$8,400	$8,415	+$15
Administrative Services	$7,000	$5,000	-$2,000
Administrative IT	$25,477	$25,477	$0
Inter-Agency Agreements	$2,000	$1,140	-$860
Supplies and Equipment	$1,164	$1,164	$0
Administrative Contracts and Intra-Agency Agreements	$18,954	$25,385	+$6,431
Training	$2,938	$2,439	-$499
Travel	$8,900	$9,000	+$100
Printing and Postage	$3,500	$3,300	-$200
Subtotal, Other Objects Expense	$128,633	$133,450	+$4,817
Total, Federal Administration	**$696,880**	**$725,365**	**+$28,485**

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Medicare Survey and Certification Program

(dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$293,128	$346,900	$362,000	$15,100

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

FY 2010 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 2008, 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 requested level in the FY 2010 Presidents Budget, have enabled CMS to restore these survey frequencies to The Recovery Act provided $50 million to States for prevention of healthcare-associated infections (HAI), and $10 million of this total is being 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 38% between 2002 and 2007. 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 SAs, 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 will enable 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 will support 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.

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 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 a performance measure to assess CMS' and survey partners' success in meeting the core statutory obligations for carrying out nursing home surveys with routine frequency. The measure tracks the percentage of States that survey nursing homes every 15 months. CMS exceeded its FY 2008 target with a result of 96 percent. Targets for FY 2009 and FY 2010 are 85 percent and 95 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 4 percent in FY 2008. The FY 2008 result means that between the end of FY 2003 and the end of FY 2008, there are almost 50 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. Because efforts have been more successful than anticipated, CMS lowered its FY 2009 target from 6.0 percent to 5.1 percent and the FY 2010 target is 3.8 percent.

After many years of steady levels, CMS has met or exceeded targets to reduce the prevalence of pressure ulcers in nursing homes since FY 2004, including FY 2008, where we exceeded our target of 8.5 percent with an actual prevalence of 8.0 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 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. Because recent results have been more successful than anticipated, CMS lowered its FY 2009 target from 8.5 percent to 8.2 percent while the FY 2010 target is 8.1 percent. 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.

Surveys of hospital transplant centers represent a new area of S&C responsibility, with about half the surveys being conducted by States and the other half by a national contractor as a CMS support contract.

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 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. The 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

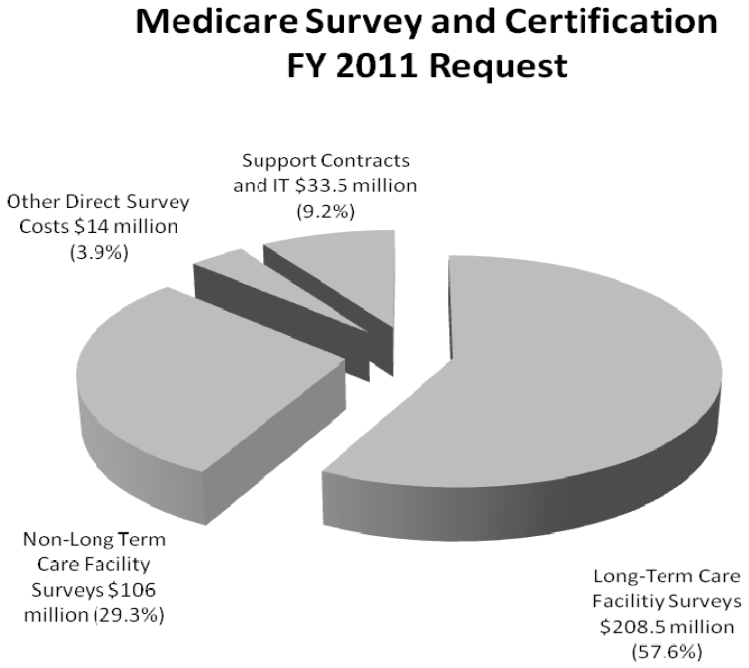
FY 2006	$258,128,000
FY 2007	$258,128,000
FY 2008	$281,186,000
FY 2009	$293,128,000
FY 2010	$346,900,000

Budget Request

CMS' FY 2011 request for Medicare Survey and Certification is $362.0 million, an increase of $15.1 million, or 4 percent above the FY 2010 Appropriations 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, $314.6 million of this amount will support direct survey costs, $14.0 million will support additional costs related to direct surveys, and $33.4 million will be used for support contracts and information technology.

About 93 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).

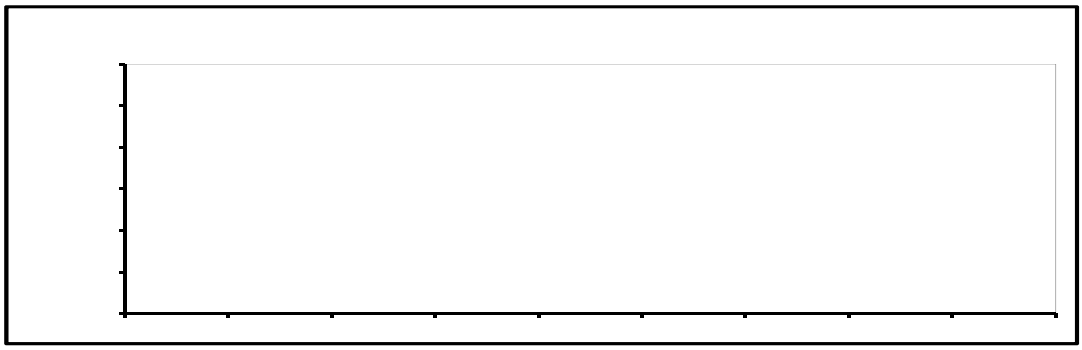
The following pie chart breaks down the program request to show direct survey costs for long-term care and non-long term care facilities, other direct survey costs, support contracts, and information technology (IT).



Direct Survey Costs - $314.6 million

The FY 2011 President's Budget includes $314.6 million for direct survey costs, about a $2.8 million increase over the FY2010 Appropriations level. This funding will enable CMS to meet statutory survey frequencies and allow CMS to continue quality improvement efforts in the surveys of ambulatory surgical Centers and accredited hospitals.

Between FY 2003 and FY 2011, the number of Medicare-certified facilities increased by 20 percent, from 46,232 facilities in FY 2003 to an estimated 55,370 facilities in FY 2011, as shown in the following graph.



As shown in the next chart, 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 2009 Appropriations	FY 2010 Appropriations	FY 2011 President's Budget
Skilled Nursing Facility (SNF)	$10.5	$12.3	$12.2
SNF/NF (dually-certified)	$174.0	$196.4	$196.3
Home Health Agencies	$28.9	$32.8	$30.1
Accredited Hospitals	$19.2	$20.3	$19.9
Non-Accredited Hospitals	$10.8	$15.9	$17.8
Ambulatory Surgery Centers1	$2.6	$4.2	$9.2
ESRD Facilities	$10.2	$17.3	$15.2
Hospices	$4.7	$6.7	$6.3
Outpatient Physical Therapy	$1.0	$1.9	$1.9
Outpatient Rehabilitation	$0.2	$0.5	$.3
Portable X-Rays	$0.1	$0.2	$0.2
Rural Health Clinics	$1.2	$1.9	$1.8
Transplant Centers	$0.8	$1.5	$3.4
Subtotal, Direct Survey Costs	**$264.3**	**$311.8**	**$314.6**
Other Direct Survey Costs	$9.4	$10.2	$13.9
Total, Direct Surveys2	**$273.7**	**$322.0**	**$328.5**

CMS' FY 2011 President's Budget request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. The FY 2011 target

1 Does not include ARRA funding.

2 Total may not add due to rounding.

is for 97 percent of States to survey nursing homes at least every 15 months. To meet the FY 2011 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 2011. 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 increase in funding requested will allow CMS to maintain more rigorous survey frequencies of at least once every six years for all facility types. The 2011 request continues to fund surveys of organ transplant centers which were surveyed for the first time in FY 2007.

The FY 2011 request also supports the efforts made by the American Recovery and Reinvestment Act (ARRA) by increasing survey frequencies of Ambulatory Surgical Centers (ASCs) to every 4 years. The tools developed with the ARRA funds for healthcare associated infections (HAIs) are pivotal in promoting quality in one of the fastest growing facilities in healthcare, and will be continued under the request. The four year frequency puts CMS on track to survey all ASCs with the new process by the end of FY 2012. As the number of surgeries performed on an outpatient basis continues to increase, a four year survey frequency is necessary to ensure the protection of beneficiary health and safety.

The FY 2011 request also increases survey frequencies for Accredited Hospitals in response to GAO concerns. In response to these concerns, CMS plans to ultimately increase the survey frequency for Accredited Hospitals to 5% per year; the increase to 3.3% per year is a step in this direction. The following chart includes updated frequency rates for fiscal years 2009 through 2011.

Type of Facility	Recertification FY 2009 Appropriations	Recertification FY 2010 Appropriations	Recertification FY 2011 Request
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1% Per Year	2 % Per Year	3.3% Per Year
Non-Accredited Hospitals	Every 5 Years	Every 3 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 3 Years	Every 2.6 Years
ESRD Facilities	Every 4.6 Years	Every 3 Years	Every 3 Years
Hospices	Every 11.5 yrs	Every 6 yrs	Every 6 yrs
Outpatient Physical Therapy	Every 11.5 yrs	Every 6 yrs	Every 6 yrs
Outpatient Rehabilitation	Every 11.5 yrs	Every 6 yrs	Every 6 yrs
Portable X-Rays	Every 11.5 yrs	Every 6 yrs	Every 6 yrs
Rural Health Clinics	Every 11.5 yrs	Every 6 yrs	Every 6 yrs
Ambulatory Surgery Centers[3]	Every 11.5 yrs	Every 6 yrs	Every 4 yrs

CMS expects to complete a total of over 25,500 initial and recertification inspections in FY 2011, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates over 55,000 visits in response to complaints. As the Survey and Complaint

3 Does not reflect Recovery Act funding, which supported survey frequencies in FY 2010 of every three years.

Visit table shows, the majority of both surveys and complaint visits in FY 2011 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. The 2011 restraints target is set at 3.7 percent. CMS' ability to continue to lower restraint use is impacted by QIO efforts and other efforts that contribute to this goal, such as the *Advancing Excellence in America's Nursing Homes* campaign. The target for pressure ulcers for FY 2011 is 8.0 percent. The prevalence of pressure ulcers is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers.

Survey and Complaint Visit Table

	FY 2010 Appropriations				FY 2011 Estimate			
Type of Facility	**Total Recert Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**	**Total Recert Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	873	42	873	1788	835	36	936	1807
SNF/NF (dually-certified)	14396	171	48040	62607	14295	146	45759	60200
Home Health Agencies	2784	648	1660	5092	2745	687	1660	5092
Accredited Hospitals	97	0	4220	4317	138		4853	4991
Non-accredited Hospitals	580	151	630	1361	580	170	993	1743
ESRD Facilities	1747	216	575	2538	1798	239	715	2752
Transplant Ctrs	7	70	51	128	88	87	100	275
Hospices	464	235	575	1274	506	210	595	1311
Outpatient Physical Therapy	498	173	10	681	486	129	9	624
Outpatient Rehabilitation	95	43	7	145	94	22	7	123
Portable X-Rays	94	35	7	136	94	27	5	126
Rural Health Clinics	638	223	15	876	629	169	28	826
Ambulatory Surgery Centers	720	307	95	1122	1035	284	133	1452
Total	**22,993**	**2,314**	**56,758**	**82,065**	**23,323**	**2,206**	**55,793**	**81,322**

The FY 2011 direct survey cost estimate also includes $13.9 million, a $3.8 million increase from the FY 2010 Appropriations, 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 ($5.5 million);
- 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 ($4.5 million);
- 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 ($3.7 million).
- Emergency preparedness costs. Developing plans to continue operations in preparation of any unforeseen events. ($0.2 million)

Support Contracts and Information Technology - $33.4 million

Support Contracts

Support contracts, managed internally by CMS, constitute approximately $28.1 million of the FY 2011 Presidents budget. This is an increase of $6.4 million from the FY 2010 Appropriations level.

The largest category in support contracts continues to be surveyor training. Implementing more efficient and effective training of surveyors is an area that has a high return on investment. Through web-based and case-study training, surveyors can gain the skills necessary to perform proficiently, while providing quality care for beneficiaries. Training and oversight constitutes an increase of $4.9 million over the FY 2010 Appropriations. This increase also includes federally directed surveys that substitute for State surveys on psychiatric hospitals, for comparative surveys and funding for transplant center oversight. The additional $1.5 million increase in the FY 2011 request will provide funds for the evaluation and support of the Quality Indicator Survey (QIS) and improved nursing home enforcement.

Information Technology

The Medicare Survey and Certification request includes approximately $5.3 million in IT funding, for activities such as maintenance and enhancements to the OSCAR system and the FOSS redesign. This is an increase of $2.1 million over the FY 2010 Appropriation. 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 2011 request will provide an additional $1.0 million in IT 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.

The IT request also includes an additional $1.1 million in funding for emergency preparedness and improvements in the deficiency finding forms automation system. These funds will enhance security and increase efficiency with the automation of more CMS systems.

Outcomes and Output Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCR 4: Decrease the prevalence of restraints in nursing homes	FY 2008: 4.0% (Target Exceeded)	3.8%	3.7%	-0.1
MCR 5: Decrease the prevalence of pressure ulcers in nursing homes	FY 2008: 8.0% (Target Exceeded)	8.1%	8.0%	-0.1
MCR 6: Percentage of States that survey nursing homes at least every 15 months	FY 2008: 96% (Target exceeded)	95%	97%	+2
MCR 7: Percentage of States that survey HHAs at least every 36 months	FY 2008: 94% (Target exceeded)	90%	95%	+5
MCR 8: Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds	FY 2009:100% (Target Exceeded)	80%	90%	+10
Program Level Funding ($ in millions)	**N/A**	**$346.9**	**$362.0**	**$15.1**

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Research, Demonstration and Evaluation

(dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$30,192	$35,600	$47,178	+$11,578

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 2010 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 102 million beneficiaries in FY 2011.

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

- Research investments of $28 million 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' RD&E program have been adopted by State Medicaid programs and private payors.
- 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, multipurpose 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. The use of MCBS data was most clear in the policy research that preceded the Part D drug benefit.

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.

CMS completed the 2007 access to care file and the 2006 cost and use user files for the MCBS.

Other Activities

Other innovative research projects include program evaluations, demonstration design, implementation and evaluation, 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.

In 2009, CMS released the following program evaluation Reports to Congress:

- Evaluation of Medicare Advantage Special Needs Plans

- Geographic Variation in Drug Prices and Spending in the Part D Program
- Best Practices for Enrolling Low-Income Beneficiaries into the Medicare Prescription Drug Benefit Program

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.

In 2009, CMS also released the following demonstration evaluation Reports to Congress:

- Medicare Hospital Gainsharing Demonstration Update on Quality Improvement and Savings
- Evaluation of Cancer Prevention and Treatment for Racial and Ethnic Minorities
- Evaluation of Phase I of the Medicare Health Support Pilot Program
- Final Report on Informatics for Diabetes Education and Telemedicine Demonstration

In 2009, CMS implemented six new demonstrations:

- Acute Care Episode
- Indiana Health Information Exchange (Medicare Modernization Act sec 646)
- Nursing Home Quality Based Purchasing
- Physician Hospital Collaboration
- Medicare Hospital Gainsharing
- Senior Risk Reduction

Three of these demonstrations continue to test our value-based purchasing (VBP) initiative where providers are paid based on performance. In 2009, CMS continued to provide strong evidence that paying for quality based on performance can be the catalyst to change Medicare from a passive payer to an active purchaser of higher quality, more efficient health care. In 2009, under demonstration authority, CMS rewarded hundreds of providers in hospital and physician care settings financial incentive payments for improvements in delivery and quality of care while saving costs to the Medicare program. CMS awarded incentive payments to over 560 small and solo practices for performance on 26 quality measures in California, Arkansas, Massachusetts, and Utah.

Our research agenda includes 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.

A range of activities build and improve our health services research capacity increasing the efficiency and strengthening our internal research operations and benefiting external health care research related to CMS' programs. These activities include multiple data collection and dissemination tools, research studies, and grant programs.

In 2009, cost and resource use (CRU) data collection began in all market areas under the Deficit Reduction Act (DRA) post acute care demonstration. The chronic conditions

warehouse (CCW) supports studies to improve the quality of care and reduce the costs for chronically ill beneficiaries. CMS has loaded 100 percent of Medicare 2008 data into the CCW. The Research Data Assistance Center (ResDAC) develops and enhances the capabilities or expertise of the overall health services research system. The purpose of the ResDAC is to increase the number of researchers skilled in accessing and using CMS data for research studies which may improve 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. In FY 2009, CMS awarded one new and one continued grant under each program for a total of four grants.

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. Since 2001, approximately $306 million in RCSC grants have been awarded to States. States 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

CMS used the FY 2008 solicitation responses to make four grant awards in FY 2009.

Funding History

FY 2006	$57,420,000
FY 2007	$57,420,000
FY 2008	$31,301,000
FY 2009	$30,192,000
FY 2010	$35,600,000

Budget Request

The FY 2011 budget request for RDE is $47.2 million, an increase of $11.6 million above the FY 2010 appropriation level. This level of funding supports:

- $15.2 million for the MCBS, an increase of $0.4 million above the FY 2010 appropriation level to operate and maintain the only source of information on all characteristics about the Medicare program.

- $9.8 million for other research activities, an increase of $0.1 million above the FY 2010 appropriation level. This funding continues investments for mandated and Administration priorities across several research areas:
    - Program evaluations on the Medicare Advantage and Part D programs
    - Demonstration design, implementation and evaluation on the physician group practice, electronic health records, acute care episode, Premier, Medicare care management performance, senior risk reduction, medical home, Medicare health care quality, frontier extended stay clinics, cancer prevention, and vision rehabilitation demonstrations
    - Prospective payment systems monitoring, evaluation, and refinement on the end-stage renal disease (ESRD) and inpatient psychiatric systems
    - Research building and improving through the chronic conditions warehouse and the research data assistance center
    - Historically Black College University and Hispanic Serving Institutions grant programs to award new and continued grants

- $2.5 million for the Real Choice Systems Change Grants, the same level of funding as the FY 2010 appropriation level.

- $19.7 million for demonstration and research activities identified by CMS leadership that will support and provide innovative solutions to transform and modernize the American health care system. These are potential activities and are not meant to be exclusive of other efforts or initiatives. These topics build upon existing CMS efforts and are intended to improve the value of the Medicare and Medicaid programs for their beneficiaries, health care providers, and taxpayers.

  Targeted Chronic Care Management - CMS and external researchers have yet to find the key to effective chronic care management. However, much has been learned about what does not work, and that targeting certain interventions to specific populations shows promise. These activities build on the base of initial CMS work and envision an iterative process where the demonstrations are continually evaluated for additional research findings.
    - Establish accountable health teams demonstration
    - Research to analyze beneficiary patterns of utilization to identify services and associated payment amounts necessary to provide effective care
    - Conduct and evaluate a multi-payer primary care practice demonstration

  Delivery System Reforms - A barrier to a seamless delivery of care is the current fragmented payment and delivery system. These demonstrations and research activities identify unique delivery mechanisms or unique payment methods, such as

shared savings and bundling, to encourage improved coordination that aligns with provider incentives to create new models of care.

- Per capita bundling to integrated delivery systems demonstration
- Allow hospitals and physicians to form “bonus eligible organizations”
- Comprehensive care for beneficiaries with ESRD
- Establish a Statewide Quality Improvement Network (SQIN)
- Research on bundling options
- Conduct and evaluate a demonstration to test the “medical home” concept to the federally qualified health centers

Improve Part C and D Value - Medicare Advantage (MA) and the prescription drug program provide critical coverage to millions of Medicare beneficiaries. Yet much more could be done to quantify the value of MA plans to beneficiaries. The Part D program has been a critical source of funding for seniors purchasing prescriptions, yet the “donut hole” remains a serious gap in coverage.

- Test whether beneficiaries have the same clinical outcomes in Part D stand-alone drug plans that provide generic coverage only in the “donut hole” as those in Part D stand-alone drug plans that provide brand and generic coverage in the “donut hole” and assess beneficiary and Medicare spending differences between generic only versus brand and generic “donut hole” coverage
- Test whether limiting the number of Part D plan options will result in beneficiaries choosing lower cost plans

HEALTH CARE DATA IMPROVEMENT INITIATIVE (HCDII)

(dollars in thousands)

	FY 2009 Enacted	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Net BA	$0	$0	$110,000	+$110,000

Authorizing Legislation – N/A

FY 2010 Authorization – N/A

Allocation Method - Contracts

OVERVIEW

Program Description and Accomplishments

CMS is requesting $110.0 million in two-year funds for several health care data improvement activities, enabling a wide-ranging IT infrastructure, systems and data transformation to position CMS to meet the needs of future growth, financial accountability, and data content and availability. The HCDII is the cornerstone of a business strategy that seeks to optimize the delivery of efficient, high-quality health care services. Successful implementation depends on complete, timely and accurate data across programs. This budget request will enable CMS to address these critical needs.

In just the past few years, CMS has witnessed an explosion in new programs and new business requirements. More complete and timely data which is integrated using well planned and tested methods is needed to manage these and other changes. Historically, CMS' enormous volume of data (more than one billion Fee-For-Service claims, one billion prescription drug events, and two billion Medicaid claim events per year) has been maintained in cumbersome flat files and stove-piped databases that are not well integrated. Additional manipulation is required before the data can be used for analysis. CMS will use these funds to build upon its Integrated Data Strategy, introduce modern reporting and data analysis tools, create more opportunities for public reporting and dissemination of CMS data and improve overall program integrity and program administration capabilities.

Because the HCDII is a large, complex, multi-year investment, affecting several national programs, successful implementation will require unprecedented coordination and collaboration within CMS and HHS, and with external stakeholders such as Medicare Administrative Contractors and states. CMS will direct this initiative by utilizing enterprise architecture and project management best practices to carefully plan, control and evaluate every activity that comprises the HCDII. In fact, CMS is developing a strategic plan for the HCDII that will be released in the spring of 2010 and will describe in detail the limitations of the as-is environment and our approach for improving the business processes and analytical capabilities of our data enterprise. This is simply the first step in the IT governance process that will inform our project management and investment approach throughout the lifecycle.

In addition, the CMS Data Governance Board is sponsoring a strategic transformation study by the National Academy of Sciences, Computer Science and Telecommunications Board (CSTB) to guide the CMS transition to become an information-centric organization. The CSTB provides

independent assessments of technical and public policy issues relating to computing and communications, and will bring an interdisciplinary approach to study the current state of CMS technical architecture and systems infrastructure, and make recommendations for modernizing business processes, practices and information systems to meet growing information demands and transform into an information-centric organization. The study is expected to begin in the second quarter of FY 2010 with an interim report issued in the fourth quarter that will inform multi-year plans for CMS data infrastructure improvements.

Data Improvement Initiative: CMS proposes to develop the initial steps for creating a modernized analytical data environment which, over multiple years, will include:

- *Data about Beneficiaries and Providers* that ensures CMS systems consistently use only authoritative data, thereby avoiding costly business mistakes caused by incomplete, out of date, conflicting or incorrect data. Initial steps will include developing a master data repository for providers and beneficiary data management capabilities.
- *Claims, assessment, and drug event data from both Medicare and Medicaid* will be integrated and aggregated using formal, standard, and transparent methods. Initial steps will include adding Medicare data to one of the central data repositories, and beginning the process of standardizing Medicaid data.
- *Comparative Effectiveness Research* on clinical outcomes, effectiveness, risk and benefits of medical treatments and services, and the use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.
- *Adoption of common enterprise-class services will exchange data using standard data formats* approved by HITSP and other standards development organizations recognized by the Secretary of HHS.
- *Business intelligence portals* will allow user-friendly, self-service access to next generation data products. Initial steps will include the development of a limited-use business intelligence portal, as well as the development of configuration mapping for future expansion.
- *Service Oriented Architecture* services and methods will be used to retrieve and send data to and from CMS.

Medicare Transformation Initiative: Transformation of FFS systems will build upon the systems currently in place and being used to process 1 billion claims per year. This transformation effort will extend over multiple years and, therefore, some investment will continue to be needed in these systems. Initial steps will include creating the high-level architecture necessary for overall development, as well as developing the business requirements for several provider and beneficiary management projects such as the consolidation of selected provider data, common provider services, and the beneficiary membership module. This work will lay the foundation for improved program integrity capabilities as well as for future health care payment systems including value-based purchasing.

Encounter Data for Medicare Advantage Plan Analysis: This initiative will begin the initial steps for the collection, editing, storage, and pricing of new data for the more than 10 million MA beneficiaries. This data collection effort will give CMS the capacity to measure price utilization for all MA enrollees for the purposes of accurately paying Part C plans through risk adjustment, evaluating coverage, and comparing service utilization and quality across the original FFS and MA sectors. All encounters from the MA plans for all services rendered would be submitted to CMS and available for data analysis.

Modernize IT Infrastructure: In order to support the data initiative there is a need to increase computer capacity to improve collection and dissemination of data. CMS will modernize and add capacity to the infrastructure of the current systems. Upgrading these systems will also allow CMS to prepare for disaster recovery readiness and strengthen our communications network. Initial steps will include the purchase of hardware/software necessary to meet data capacity requirements, as well as conduct the engineering studies necessary to develop a robust disaster recovery capability for critical systems.

Systems Security: Security Situational Awareness and Response: Allowing greater access to CMS data requires that situational awareness and response be dramatically improved at all levels, greatly improving CMS' ability to detect, prevent and respond to cyber-attacks and weaknesses. CMS will begin the initial steps to establish an enterprise vulnerability management program that will closely examine every device in the CMS data network that processes, stores or transmits CMS data. The up-to-date inventory, which will be controlled by active monitoring, will reduce the likelihood of attackers finding unauthorized and potentially unprotected systems to exploit and facilitate a more timely response to the acts.

Systems Sustainability for Medicare Parts A, B, C and D: The needed transformation of the FFS systems will extend over multiple years and investment is needed in the existing systems to sustain them during the transformation. The necessary changes cannot be accommodated in the ongoing system releases that are implemented each year. Similarly, the systems supporting Parts C and D need sustaining corrective maintenance to protect and ensure business quality. These sustainability efforts will better position the systems to work successfully in a modernized infrastructure and data base environment.

Budget Request

CMS is requesting $110.0 million in two-year funds for the Health Care Data Improvement Initiative. Funding for the multi-year Health Care Data Improvement Initiative activities will position CMS for future growth, improved program analysis and oversight, and better protection of sensitive information. In the first year, the FY 2011 funding request is broken out as follows:

- Data Improvement Initiative: $45.0 million
- Medicare Transformation Initiative: $15.5 million
- Encounter Data for Medicare Advantage Plan Analysis: $6.0 million
- Modernize IT infrastructure: $33.5 million
- Systems Security: $5.0 million
- Systems Sustainability for Medicare Parts A, B, C and D: $5.0 million

CMS' Health Care Data Improvement Initiative two-year funding authority justification:
Designation of the Health Care Data Improvement Initiative funds as available for two-years is vital to the smooth and successful implementation of this effort. CMS needs two-year funding authority because the CMS IT enterprise is so vast, complex and dynamic. Beneficiaries, plans, and providers come into and out of our programs. Payment and coverage policies change often. Software and system platforms require periodic updates, and contracts must periodically be re-competed, which may lead to transitions of workloads between vendors. Making "routine" changes to the CMS IT environment requires extensive coordination across lines of business and numerous systems. Implementing the HCDII to continue CMS' transformation into a data-centric organization at the center of the Federal health enterprise will require a tremendous degree of coordination and precise timing. CMS is prepared to manage that risk. CMS will utilize enterprise architecture and project management best practices to carefully plan and

execute HCDII activities. However, we need the flexibility to adjust our schedule in the event of operational, legislative, regulatory, or industry changes that necessitate adjustments to this initiative's critical path, and two-year funding authority provides this flexibility.

Two additional factors support the need for two-year funding authority. Designating the HCDII funds as two-year money allows for acquisition timelines that enable contracts to be awarded on a competitive basis to the maximum extent possible. The other major reason to designate HCDII funds as two-year money is the likelihood of delayed or partial funding. In five of the last ten fiscal years, CMS' Program Management appropriation was enacted during the *second* quarter of the fiscal year. In three of the other five years, CMS' appropriation was enacted after December 21 — virtually the end of the first quarter of the fiscal year. Adding in the time it takes to negotiate operating plans and process apportionment documents means funds may not actually be available until the *third* quarter of a given fiscal year. Working backward from the September 30th end of the fiscal year, the lead time and schedules required by the Federal procurement process further compress the real "window" for utilizing funds. These timing issues create an urgency to award contracts before funding expires, even when the operational and other considerations described above may dictate patience. This adds unnecessary risk to a successful IT implementation. Designating the HCDII funds as available for two years will significantly mitigate this risk.

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

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$*220,962,473,000] $173,143,799,000* to remain available until expended.

For making, after May 31, [2010] *2011,* 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 [2010] *2011* 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 [2011] *2012,[$86,789,382,000] $86,445,289,000* 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, $173,143,799,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $86.8 billion provided for the first quarter of FY 2011 under the Omnibus Appropriations Act of 2010. 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, 2011, 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 2011 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 2011 to meet unanticipated costs. It makes clear that the language provides budget authority to the Vaccines for Children 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 2012, $86,445,289,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of fiscal year 2012 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, 2011. 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[1/]
(dollars in thousands)

	2009 Actual	2010 Estimate	2011 Estimate
Appropriation Annual	$216,627,700	$292,662,511	$259,933,181
Appropriation Indefinite	38,262,365	0	0
Unobligated balance, start of year	8,988,360	8,178,880	14,411,421
Adjustment to Unobligated balance	0	(8,162,892)	0
Unobligated balance, end of year	(8,178,880)	(14,411,421)	0
Recoveries of Prior Year Obligations	8,909,057	0	0
Offsetting Collections	449,467	562,500	150,000
Total Gross Obligations	$265,058,068	$278,829,578	$274,494,602
Medicare Part B Transfer	(449,420)	(562,500)	(150,000)
VFC Program Collection	(47)	0	0
Obligations Incurred but not Reported	(508,273)	(2,899,000)	(2,899,000)
Total Net Obligations	$264,100,328	$275,368,078	$271,445,602

[1/] Numbers may not add due to rounding.

Medicaid Program
Summary of Changes
(dollars in thousands)

2010 Budget Authority [1/]		$292,662,503
2011 Estimated Appropriated Budget Authority		$259,933,181
Net Change		-$32,729,322
Explanation of Changes	2010 Current Base Budget Authority	FY 2011 Change From Base Budget Authority
Program Increases		
State Administration	$10,749,196	$2,860,006
Fraud Control Units	205,065	10,254
State Certification	230,646	3,954
Vaccines for Children Program	3,323,770	327,584
Financial Management Reviews	-546,000	128,000
Supplemental Appropriations Act 2008, P.L. 110-252	-59,000	59,000
Offsetting Collections From Medicare Part B	-562,500	412,500
QI Supplemental Funding Act of 2008, P.L. 110-379 [/2]	-5,000	5,000
Obligations Incurred But Not Reported	2,719,000	0
Obligations Incurred But Not Reported (ARRA)	180,000	0
Total Program Increases	$16,235,177	$3,806,298
Program Decreases		
Medical Assistance Payments	$274,000,000	-$19,353,000
Medical Assistance Payments (ARRA – QI Program)	412,500	-262,500
State and Local Administration Financial Adj.	1,103,404	-1,595,046
Medicare Improvement for Patients & Providers Act, P.L. 110-275[/2]	242,500	-242,500
Fostering Connections to Success Act of 2008 P.L. 110-351[/2]	15,000	-15,000
Emergency Economic Stabilization Act of 2008 P.L. 110-343[/2]	60,000	-60,000
Children's Health Insurance Program Reauthorization Act P.L 111-3	501,000	-501,000
5010/ICD-10	92,922	-92,922
Family Smoking Prevention	0	-2,231
Unobligated Balance Start of Year	0	-14,411,421
Total Program Decreases	276,427,326	-36,535,620
TOTAL	**$292,662,503**	**-$32,729,322**

[/1] Reflects the FY 2010 President's budget request; the actual FY 2010 appropriation was $292,662,511,000.
[2/] The FY 2011 impact of this legislation is reflected in Medical Assistance Payments.

Medicaid Program
Authorizing Legislation

	2010 Amount Authorized	2010 President's Budget	2011 Amount Authorized	2011 Budget Request
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$289,010,322,000	Indefinite	$256,281,827,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,652,189,000		$3,651,354,000
Total Appropriations		$292,662,511,000		$259,933,181,000

Medicaid Program
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2001	124,175,254,000	124,175,254,000	124,175,254,000	129,418,807,224	1/
2002	143,029,433,000	143,029,433,000	143,029,433,000	147,340,339,015	2/
2003	158,692,155,000	158,692,155,000	158,692,155,000	164,550,765,542	3/
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	4/
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	5/
2010	292,662,503,000	292,662,511,000	292,662,511,000	292,662,511,00	
2011	259,933,181,000				

1/ Includes $5,243.6 million under indefinite authority.
2/ Includes $4,310.9 million under indefinite authority.
3/ Includes $5,858.6 million under indefinite authority.
4/ The House and Senate did not provide an FY 2007 allowance amount. The Appropriation level reflects the FY 2007 continuing resolution appropriation.
5/ Includes $38,262.4 million under indefinite authority.

Medicaid
(Dollars in Thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010 Omnibus
Medical Assistance Payments (MAP)	$214,430,122	$221,593,738	$238,904,769	$17,311,031
MAP, Recovery Act	$34,567,342	$39,614,200	$15,472,000	($24,142,200)
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$313,353	$2,719,000	$2,719,000	$0
IBNR, (Recovery Act)	$194,920	$180,000	$180,000	$0
Vaccines for Children	$3,382,875	$3,652,189	$3,651,354	($835)
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$12,169,299	$10,918,711	$11,456,919	$538,208
State & Local Administration, (Recovery Act)	$157	$151,740	$2,110,560	$1,958,820
Obligations (gross)	$230,295,649	$238,883,638	$256,732,042	$17,848,404
Obligations (gross), Recovery Act	$34,762,419	$39,945,940	$17,762,560	($22,183,380)
Unobligated Balance, Start of Year	($8,988,360)	($8,178,880)	($14,411,421)	($6,232,541)
Adjustment to Unobligated Balance, Start of Year	$0	$8,162,892	$0	($8,162,892)
Unobligated Balance, End of Year	$8,178,880	$14,411,421	$0	($14,411,421)
Recoveries of Prior Year Obligations	($8,909,057)	$0	$0	$0
Appropriation Budget Authority (gross)	$255,339,532	$293,225,011	$260,083,181	($33,141,830)
Offsetting Collections	($449,467)	($562,500)	($150,000)	$412,500
Total Budget Authority (net)	$254,890,065	$292,662,511	$259,933,181	($32,729,330)
Indefinite Authority	($38,262,365)	$0	$0	$0
Advanced Appropriation	($67,292,669)	($71,700,038)	($86,789,382)	($15,089,344)
Annual Appropriation	$149,335,031	$220,962,473	$173,143,799	($47,818,674)

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

FY 2010 Authorization - Public Law 111-8 and Public Law 111-117

Allocation Method - Formula Grants

Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid is 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 long-term care supports to seniors and individuals with disabilities. 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 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 Federal Government and States share the cost of the program. The State share varies from State to State. In FY 2009, the average State share was approximately 34 percent, with the remaining 66 percent provided by the Federal Government. This Federal share percentage is composed of 57 percent from the regular Federal medical assistance percentage (FMAP) and an additional 9 percent that is attributable to the increased FMAP provisions of the American Recovery and Reinvestment Act (ARRA, P.L. 111-5). All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have elected to establish Medicaid programs.

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 aging or disabled individuals.

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.

As a result of a program assessment, CMS implemented new performance measures that assess health quality, improve program management and protect program integrity. CMS is also executing improvement actions: working with the States to measure, track, and

improve quality of care in Medicaid; reducing fraud, waste, and abuse in the Medicaid program and improving overall program integrity; and working with States to establish baseline data for the Medicaid performance measures.

To ensure that Medicaid beneficiaries gain access to and receive quality of care with their benefit dollars, CMS developed a long-term measure to increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Improvement Program (MQIP). The MQIP provides technical assistance to States regarding quality improvement, quality measurement, and External Quality Review and bolsters their targeted health quality improvement projects.

CMS reviewed data sources and data collection tools to document State quality activities. Comprehensive, individualized Quality Assessment Reports (QARs), the primary vehicle for assessing States' ability to assess quality and access to care, were developed for both informational purposes and validation of State quality activities. CMS completed nine QARs to meet its FY 2009 target. The FY 2010 target is set at ten QARs. Although the QARS have been instrumental in assessing barriers and gaps in quality measurement and improvement within States, this measure will be discontinued and will be replaced with new quality initiatives outlined in recent legislation.

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. While CHIPRA focuses on children, the legislation requires the development of a National Medicaid and CHIP Quality Framework, which will demonstrate improvement in both programs. To improve quality of pediatric care in State CHIP and Medicaid programs, CMS is developing a new measure. The new measure, "Improve Health Care Quality across Medicaid and CHIP through implementation of CHIPRA Quality Initiatives", has set an FY 2011 target to work with States to ensure that 90 percent of States report on at least one quality measure 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 American Recovery and Reinvestment Act (ARRA) 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, and protections for Indians under Medicaid and CHIP. Importantly, ARRA also provides incentives for providers and State Medicaid programs to establish an infrastructure for implementing health information technology that improves the quality of care to Medicaid beneficiaries through meaningful use of electronic health records.

A more detailed explanation of these ARRA provisions can be found in the "Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation" section.

Medicaid Integrity Program

On February 8, 2006, section 6034 of the Deficit Reduction Act (DRA) of 2005 (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 to 2013.

The Medicaid Integrity Program (MIP) offers a unique opportunity to identify, recover and prevent inappropriate Medicaid payments. Discussed in the "Health Care Fraud and Abuse Control" program section of this congressional budget justification are CMS' efforts to measure Medicaid error rates through the Payment Error Rate Measurement (PERM) program. This program enables States to identify the causes of improper payments in their claims payment systems and eligibility processes, and to address them with corrective actions.

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 the VFC program, the Centers for Disease Control and Prevention provide 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 elderly, one of 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 over 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 each State agency operating the Medicaid program. The MFCUs investigate State law violations 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 that office and must have authority to prosecute Statewide or be able to refer to local prosecutors.

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, 2008 nearly 71 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.

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 DRA 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 ensure 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 33 statewide health care reform demonstrations in 28 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Virginia, and Wisconsin) and the District of Columbia. CMS has also approved one sub-State health reform demonstration (Kentucky) and 22 demonstrations specifically related to family planning (Alabama, Arkansas, California, Florida, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Oregon, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Washington, Wisconsin 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

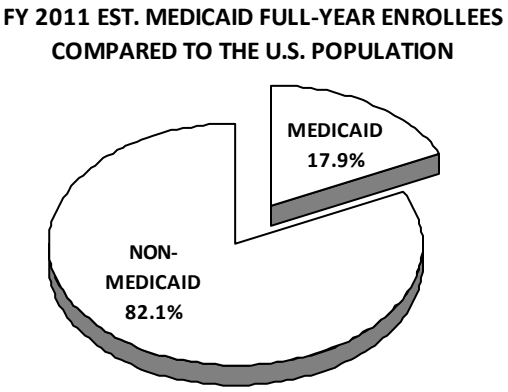
The following table reflects the estimated annual Medicaid enrollment in number of person years, which represents full-year equivalent enrollment, receiving Federal Medical Assistance. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment (Person-Years in Millions)[1/]

	FY 2009	FY 2010	FY 2011	+/- FY 2010 to FY 2011
Aged	4.8	4.9	5.1	.2
Disabled	9.0	9.3	9.5	.2
Adults	11.5	12.4	12.8	.4
Children	25.4	27.0	27.8	.8
Territories	1.0	1.0	1.0	.0
Total	51.7	54.6	56.1	1.5

[1/] Totals may not add due to rounding.

According to our projections of Medicaid enrollment in FY 2011, as shown in the pie chart, 17.9 percent, or 56.1 million, of the projected 313.2 million U.S. population, will be enrolled in Medicaid for the equivalent of a full year during FY 2011. In FY 2011, Medicaid will provide coverage to more than one out of every five children in the Nation.

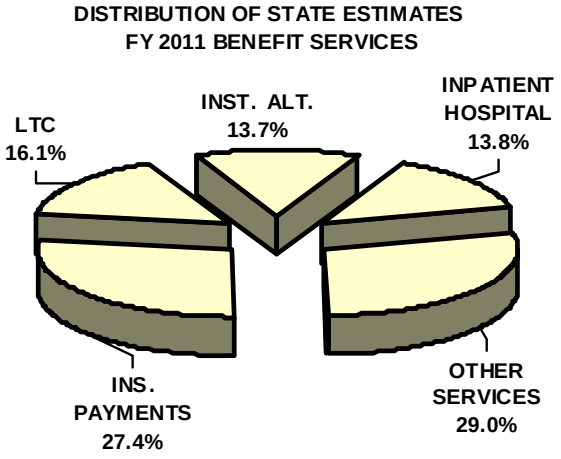


CMS projects that in FY 2011, children and non-disabled adults under age 65 will represent 74 percent of the Medicaid population excluding the Territories, but account for approximately 36 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 26 percent of the Medicaid population excluding the Territories, yet account for approximately 64 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services

As displayed in the table on the following page, the State estimates for medical assistance payments including additional ARRA monies decreases from $265.0 billion for FY 2010 to $244.2 billion for FY 2011.

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 $66.8 billion in funding for FY 2011 representing 27.4 percent of the State-submitted benefit estimates for FY 2011. The second largest FY 2011 Medicaid category of service is long-term care services. It is composed of nursing facilities and intermediate care facilities for the mentally retarded. The States have submitted FY 2011 estimates totaling $39.4 billion or about 16.1 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2011 are inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($33.8 billion or 13.8 percent), followed by institutional alternative services such as home health, personal care, and home and community-based care ($33.6 billion or 13.7 percent). Together these 4 benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for over 71.0 percent of the State estimated cost of the Medicaid program for FY 2011.

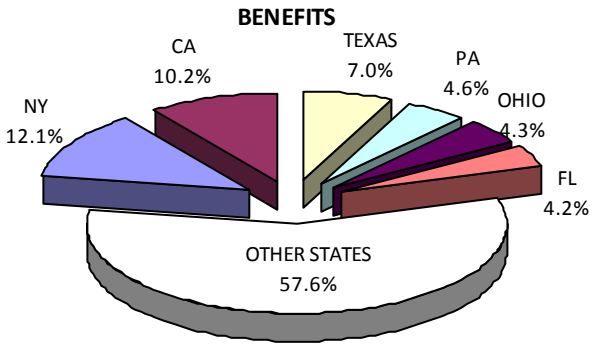


Estimated Benefit Service Growth, FY 2010 to FY 2011
November 2009 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2010	Est. FY 2011	Dollar Growth	Annual Percent Growth	Percent Of State Estimate Change
Health Insurance Payments (Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums)	$70,957,028	$66,811,656	-$4.145.372	-5.8%	20.0%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$36,467,713	$33,596,503	-$2,871,210	-7.9%	13.8%
Other (Targeted case management, hospice, all other services, and collections)	$15,895,895	$14,272,483	-$1,623,401	-10.2%	7.8%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$43/480/904	$39,415,163	-$4,065,741	-9.4%	19.6%
Outpatient Hospital	$10,241,292	$9,518,576	-$722.716	-7.1%	3.5%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$13,158,302	$12,429,574	-$728.728	-5.58%	3.5%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$37,880,182	$33,784,333	-$4,095,849	-10.8%	19.7%
Physician/Practitioner/Dental	$15,706,920	$14,551,964	-$1.154.956	-7.4%	5.6%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$10,758,118	$9,768,489	-$989,629	-9.2%	4.8%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$10,439,511	$10,073,967	-$365,544	-3.5%	1.8%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$264,985,865	$244,222,708	-$20,763,146	-7.8%	100.0%
Adjustments	-$4,509,165	+$10,274,292	NA	NA	NA
TOTAL	$260,476,700	$254,497,000	-$5,979,700	-2.3%	NA

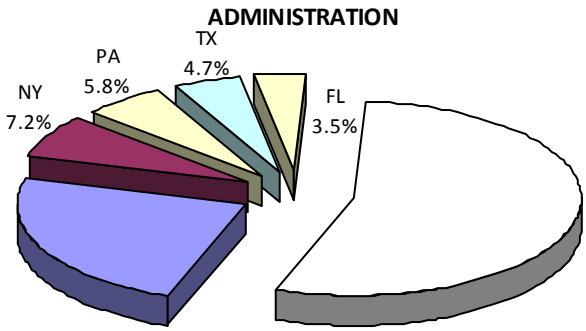
Distribution of Benefit Monies

According to the State-submitted estimates, $244.2 billion will be required to fund their Medicaid benefit programs during FY 2011. As displayed, New York, California, Texas, Pennsylvania, Ohio, and Florida account for $103.4 billion, or over 42.4 percent, of the State-submitted estimates for benefits for FY 2011.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2011 State and local administration costs total $11.5 billion. This represents about 4.7 percent of the total State-submitted estimates for Medicaid costs for FY 2011. As displayed, California, New York, Pennsylvania, Texas, and Florida account for $5.2 billion or 45.2 percent of expenditures for State and local administration.



Funding History (Appropriation)

FY 2007	$168,254,782,000
FY 2008	$206,885,673,000
FY 2009	$216,627,700,000
FY 2010	$292,662,511,000
FY 2011	$259,933,181,000

Budget Request

CMS estimates its FY 2011 appropriation for Grants to States for Medicaid is $259.9 billion, a decrease of $32.8 billion relative to the FY 2010 level of $292.7 billion. This appropriation is composed of $173.1 billion in monies for FY 2011 and $86.8 billion in advance appropriation monies from the FY 2010 appropriation.

Under current law, the estimated Medicaid net budget authority request for FY 2011 is $259.9 billion in appropriated monies. This budget authority request is composed of $86.8 billion from the FY 2010 appropriation and $173.1 billion in FY 2011

appropriated monies. These monies, together with an estimated FY 2010 unobligated balance of $14.4 billion brought forward to FY 2011, an estimated offsetting collection of $150.0 million from Medicare Part B for the Qualified Individuals (QI) program will fund $274.5 billion in anticipated FY 2011 Medicaid obligations. These obligations are composed of:

- $254.4 billion in Medicaid medical assistance benefits;
- $2.9 billion for benefit obligations incurred but not yet reported;
- $13.6 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $3.7 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 2009. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget for use with the FY 2011 President's Budget.

Under current law, the Federal share of Medicaid outlays is estimated to be $271.4 billion in FY 2011. This represents a decrease of 1.4 percent relative to the estimated net outlay level of $275.4 billion for FY 2010. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 2.7 percent during this time period.

Medical Assistance Payments (MAP)

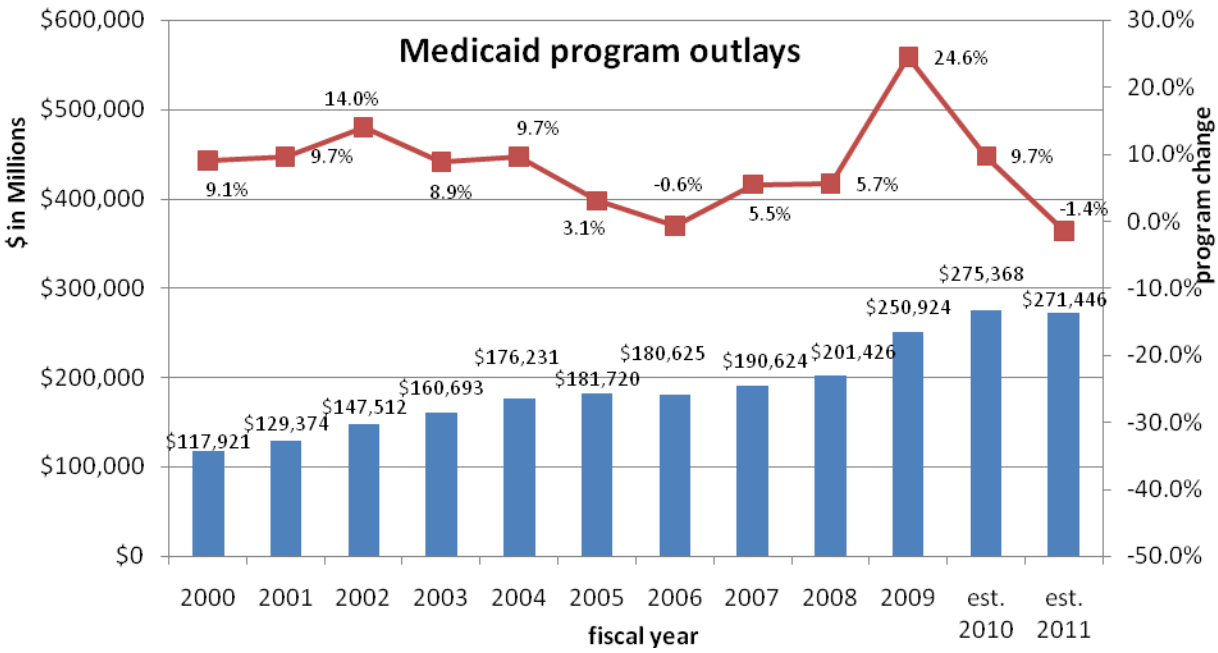
In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2009 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2009 State estimates for MAP in FY 2011 are the first State-submitted estimates for FY 2011. Typically, State estimation error is most likely to occur early in the budget cycle because most States are most interested on 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 2011. Using the first three quarters of FY 2009 State-reported expenditures as a base, expenditures for FY 2010 and FY 2011 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 2009 State-submitted estimates.



Factors Impacting Medicaid Expenditure Growth

In the mid 1990s, the factors impacting the historical growth in the Medicaid program began to lessen as a result of an improving economy, legislative restrictions on tax and donation programs and DSH payments, and welfare reform. The slower program outlay growth averaged about 3.5 percent in FY 1996 and FY 1997. By the early part of this decade, Medicaid program cost growth accelerated with a sharp increase in enrollment due primarily to the 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 this decade has abated as enrollment growth has slowed and as the Federal government and the States have taken 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, skilled 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 a substantially higher Federal match rate provided in ARRA. Projected growth rates of Federal expenditures in FY 2010 are expected to continue to be high as enrollment continues to increase with sustained high rates of unemployment and with the increased Federal match rates under ARRA. After the first quarter of FY 2011, the ARRA temporary increases in the Federal match rates expire, leading to a decline in Federal Medicaid spending for FY 2011.

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation

Family Smoking Prevention and Tobacco Control Act, P.L. 111-31

(Estimated FY 2011 savings are $2.2 million)

This legislation provides the Secretary the authority to require tobacco companies to disclose the contents of tobacco products, require more effective health warnings on tobacco products and to restrict tobacco advertising and promotions. This legislation is expected to lower consumption of tobacco and result in savings to the Medicaid program.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews

(Estimated FY 2011 savings are $418 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $418 million in FY 2011. 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.

American Recovery and Reinvestment Act (ARRA), P.L. 111-5

The Recovery Act, signed into law in February 2009, contains the following Medicaid provisions.

Temporary Increase in Medicaid FMAP (Section 5001)
(Estimated FY 2011 costs are $14.9 billion)

ARRA provides a temporary increase in the FMAP rate from October 1, 2008 through December 31, 2010. This provision increases the FMAP in three ways. First, States are held harmless for any decreases from their base FY 2008 FMAP rate through the first quarter of FY 2011. Second, ARRA provides a general 6.2 percentage point increase in the rates for all States. Third, ARRA provides an additional increase for States facing high growth in unemployment, revised quarterly to reflect new State unemployment data. All Commonwealths and Territories elected the option of a 30 percent increase in their Medicaid caps instead of a 6.2 percentage point increase in their FMAP rates combined with a 15 percent increase in their Medicaid cap.

Extension of Transitional Medical Assistance (TMA) (Section 5004)
(Estimated FY 2011 costs are $395 million)

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 July 1, 2009 through December 31, 2010.

Extension of the Qualified Individual (QI) Program (section 5005)
(Estimated FY 2011 costs are $150 million)

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, 2010.

Protection for Indians under Medicaid and CHIP (Section 5006)
(Estimated FY 2011 costs are $10 million)

This provision eliminates cost sharing requirements for American Indians and Alaska natives when services are provided from an Indian health care provider or from a contract health services provider. It exempts certain properties from being counted as an asset when determining Medicaid and CHIP eligibility or estate recovery. This provision also requires States to consult on an ongoing basis with Tribes and Indian Health Programs to maintain access to care.

Interactions of the Temporary Increase of Medicaid FMAP With Other Medicaid Provisions
(Estimated FY 2011 costs are $20 million)

This captures the budget impacts of the provision to temporarily increase the Medicaid FMAP with other Medicaid provisions of the Recovery Act.

Incurred but not Reported Obligations Associated with the Medicaid ARRA Provisions
(Estimated FY 2011 costs are $180 million)

The FY 2011 estimate of $180 million represents the increase in the liability for ARRA associated costs for Medicaid medical services incurred but not paid from October 1, 2010 to September 30, 2011. 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.

Entitlement Benefits Due and Payable (incurred but not reported, or IBNR)

The FY 2011 estimate of $2.7 billion represents the increase in the liability for the non-ARRA Medicaid medical services incurred but not paid from October 1, 2010 to September 30, 2011. 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

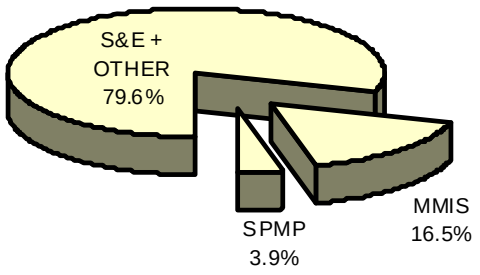
The nation's childhood immunization coverage rates are at high levels for every vaccine and for all vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. In addition to the health benefits of vaccines, they also provide 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 current FY 2011 estimate for the VFC program is $3.7 billion, which is $835,000 less than their FY 2010 request. This slight reduction is the net result of increases in vaccine purchase and evaluation activities, as well as, decreases mainly in program administrative activities such as Vaccine Tracking System (VTrckS) development costs. 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. The budget will also be used to purchase vaccines for the VFC stockpile, 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)

In November 2009 the States estimated the Federal share of State and local administration outlays to be $11.4 billion for FY 2010 and $11.5 billion for FY 2011.
The FY 2011 estimate is composed of $1.9 billion for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS

STATE ESTIMATES FOR FY 2011



automated data processing activities; $0.4 billion for skilled professional medical personnel (SPMP); and $9.2 billion for 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 2011 State-submitted estimates of $11.5 billion to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when States submitted estimates. In addition, the State estimates were also adjusted to reflect recent legislation (ARRA) ($2.1 billion). After these adjustments the FY 2011 estimate for State and local administration is $13.1 billion.

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

- (FY 2011 estimate is $1.8 billion for State and Local Administration for provider incentives payments)
- (FY 2011 estimate is $282.6 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.

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 2011 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2011 estimate for Medicaid State survey and certification is $234.6 million. This represents an increase of $3.9 million above the current FY 2010 estimate of $230.6 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)

The Medicaid Fraud Control Units mission is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in State Medicaid programs. MFCUs also have jurisdiction to investigate patient abuse and neglect in State Medicaid programs. In FY 2011, State Medicaid fraud control unit operations are estimated to require $215.3 million. This represents an increase of $10.2 million over the estimated FY 2010 funding level of $205.1 million. Currently, 49 States and the District of Columbia participate in the Medicaid fraud control unit grant program.

Although the cases that the MFCUs engage in involving the abuse and neglect of beneficiaries in Medicaid sponsored facilities usually would not result in monetary gains to

the State Medicaid programs, the pursuit of such cases by the State MFCUs is necessary in providing a measure of protection to vulnerable Medicaid beneficiaries.

In addition to their primary mission, the MFCUs are involved in other pursuits, including: (1) presenting proposals to State legislators that will positively affect the Medicaid program, (2) making recommendations to State Medicaid agencies to effect positive change to Medicaid policies and regulations, and (3) participating in joint case investigations and prosecutions involving both Federal and State law enforcement agencies, as well as other State and local agencies.

MFCUs engage in significant civil actions that result in expected monetary recoveries to the program. During FY 2008, the MFCUs reported 971 successful civil settlements of judgments. The MFCUs received $186 million in funding during FY 2008 and are expected to receive more than $1.3 billion in recoveries.

Impact of Proposed Legislation

1. ARRA FMAP Extension

   The Recovery Act provided States a temporary FMAP rate increase from October 1, 2008 through December 31, 2010. This proposal would extend the temporary FMAP increase for States for six months through June 30, 2011.

   Five-year budget cost for ARRA/Medicaid: $25.5 billion

2. Track High Prescription Drug Utilizers and Prescribers

   This proposal improves Medicaid integrity and beneficiary quality of care by requiring States to track and monitor prescription drug billing, prescribing, and utilization patterns that could be indicative of abuse or overutilization.

   Five-year budget savings: $1.59 billion

3. Department of Veterans Affairs Pension Proposal

   This Department of Veterans' Affairs proposal extends through FY 2016 the authority to reduce veterans' pension payments in order to preserve eligibility for Medicaid nursing home benefits. This proposal increases costs to Medicaid but is a savings to the Federal Government overall.

   Five-year budget cost for Medicaid: $1.33 billion

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4. Exclude refundable tax credits

This multi-agency proposal excludes refundable tax credits from countable income and assets for means-tested programs beginning with the 2009 tax year.

Five-year budget cost for Medicaid: $.075 billion

MEDICAID PROGRAM
Proposed Law
(dollars in millions)

	FY 2010	FY 2011
6-Month Temporary FMAP Increase	$0	$25,500
Medicaid Integrity: Track High Prescription Drug Utilizers and Prescribers	$0	-$120
Department of Veterans Affairs Pension Proposal— (Medicaid impacts start in FY 2012	$0	$0
Exclude Refundable Tax Credits from Means-tested Programs	$15	$15
TOTAL	$15	$25,395

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCD 1.1: Estimate the Payment Error Rate in the Medicaid Program	FY 2008: Goal Met (Target Met)	Report national error rates in the FY 2011 AFR based on 17 States measured in FY 2010 and baseline rolling average error rate based on States measured in FY 2008 – FY 2010	Report national error rates in the FY 2012 AFR based on 17 States measured in FY 2011 and rolling average error rate based on States measured in FY 2009 – FY 2011. Target below baseline established in FY 2010.	N/A
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2009: Target not met. Final Regulation delayed until FY 2010.	Publish Final Regulation in accordance with Section 601 of CHIPRA.	Report national error rate in the FY 2012 AFR based on 17 CHIP States measured in FY 2011.	N/A
MCD 2: Increase the Number of States that Have the Ability to Assess Improvements in Access and Quality of Health Care through Implementation of the Medicaid Quality Improvement Program.	FY 2009: 9 States (Target Met)	10 States	Goal discontinued	N/A
MCD 3: Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	FY 2008: 45.9% (Target Exceeded)	47%	47.1%	+0.1%
MCD 4: Percentage of Beneficiaries who Receive Home and Community-Based Services	FY 2007: 2.1% baseline	1% over prior FY	1% over prior FY	N/A
MCD 5: Percentage of Section 1115 demonstration budget neutrality reviews completed	FY 2008: 100% (Target Exceeded)	96%	98%	+2%

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCD6: Improve Health Care Quality Across Medicaid and CHIP through Implementation of CHIPRA Quality Initiatives	N/A	N/A	Work with States to ensure that 90 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	N/A
Program Level Funding ($ in millions)	**N/A**	**$248,414**	**$247,035**	**($1,378)**
Recovery Act Level Funding ($ in millions)	**N/A**	**$ 44,248**	**$ 12,897**	**($31,351)**

Medicaid Program
Budget Authority by Object

	2010 Estimate	2011 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$289,010,322,000	$256,281,827,000	($32,728,495,000)
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,652,189,000	$3,651,354,000	($835,000)
Total Budget Authority	$292,662,511,000	$259,933,181,000	($32,729,330,000)

FY 2011 MANDATORY STATE/FORMULA GRANTS
(Dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate	Difference +/- 2010
Alabama	$3,889,001	$3,649,485	$3,618,184	-$31,301
Alaska	780,279	877,155	850,791	-26,364
Arizona	6,897,889	7,768,000	7,646,295	-121,705
Arkansas	2,990,996	3,161,639	3,145,104	-16,535
California	29,581,974	31,658,614	27,755,624	-3,902,990
Colorado	2,240,392	2,358,577	2,356,903	-1,674
Connecticut	3,431,016	3,269,629	2,794,915	-474,714
Delaware	775,558	801,985	738,040	-63,945
District of Columbia	1,445,138	1,529,042	1,479,942	-49,100
Florida	11,113,001	11,836,469	10,564,207	-1,272,262
Georgia	6,019,317	6,014,925	5,636,219	-378,706
Hawaii	1,048,817	926,831	764,028	-162,803
Idaho	1,132,993	1,173,327	1,157,834	-15,493
Illinois	8,570,759	9,147,874	7,510,926	-1,636,948
Indiana	5,274,065	5,360,517	5,191,714	-168,803
Iowa	2,137,716	2,367,605	2,294,851	-72,754
Kansas	1,735,812	1,746,001	1,583,795	-162,206
Kentucky	4,391,309	4,698,726	4,391,265	-307,461
Louisiana	5,222,313	5,339,345	4,457,063	-882,282
Maine	1,960,901	2,019,776	1,601,783	-417,993
Maryland	4,135,897	4,697,622	4,515,712	-181,910
Massachusetts	7,817,268	7,708,389	6,845,016	-863,373
Michigan	7,727,955	8,245,439	8,131,760	-113,679
Minnesota	4,791,471	5,305,476	4,836,755	-468,721
Mississippi	3,597,041	3,888,937	3,859,159	-29,778
Missouri	5,723,176	6,023,645	5,681,707	-341,938
Montana	681,445	787,561	756,036	-31,525
Nebraska	1,184,475	1,262,599	1,205,380	-57,219
Nevada	973,065	1,109,074	1,064,412	-44,662
New Hampshire	805,488	901,901	854,494	-47,407
New Jersey	6,267,539	6,645,298	6,135,283	-510,015
New Mexico	2,689,309	3,084,080	2,995,324	-88,756
New York	29,691,242	33,257,281	30,285,860	-2,971,421
North Carolina	8,813,332	7,405,222	6,386,562	-1,018,660
North Dakota	448,509	513,866	488,023	-25,843

FY 2011 MANDATORY STATE/FORMULA GRANTS
(Dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program + ARRA

State/Territory	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate	Difference +/- 2010
Ohio	10,688,223	11,187,257	10,733,429	-453,828
Oklahoma	3,179,899	3,599,993	3,827,722	227,729
Oregon	2,870,964	3,338,515	3,409,476	70,961
Pennsylvania	11,917,541	12,216,118	11,748,758	-467,360
Rhode Island	1,259,859	1,236,055	1,127,429	-108,626
South Carolina	3,912,443	4,303,971	3,925,097	-378,874
South Dakota	551,403	596,888	573,148	-23,740
Tennessee	6,439,612	5,610,907	5,375,840	-235,067
Texas	16,222,418	18,767,376	17,763,043	-1,004,333
Utah	1,384,409	1,515,632	1,501,232	-14,400
Vermont	817,352	878,591	774,172	-104,419
Virginia	3,671,916	4,282,407	4,079,191	-203,216
Washington	5,080,304	4,758,882	4,343,113	-415,769
West Virginia	2,050,254	2,161,746	2,063,915	-97,831
Wisconsin	4,570,461	4,585,730	4,076,350	-509,380
Wyoming	328,057	364,029	342,081	-21,948
Subtotal	**260,931,573**	**275,946,009**	**255,244,962**	**-20,701,047**
American Samoa	11,793	12,342	10,204	-2,138
Guam	17,563	19,036	15,784	-3,252
Northern Mariana Islands	6,393	6,786	5,612	-1,174
Puerto Rico	366,199	418,745	346,270	-72,475
Virgin Islands	17,982	19,479	16,108	-3,371
Subtotal	**419,930**	**476,388**	**393,978**	**-82,410**
Total States/Territories	**261,351,503**	**276,422,397**	**255,638,940**	**-20,783,457**
Survey & Certification	207,175	230,646	234,600	3,954
Fraud Control Units	195,300	205,065	215,319	10,254
Vaccines For Children	3,382,875	3,652,189	3,651,354	-835
Medicare Part B Transfer	449,420	562,500	150,000	-412,500
Incurred But Not Reported	508,273	2,899,000	2,899,000	0
VFC Offsetting Collections	47	0	0	0
Adjustments	(1,036,524)	(5,142,219)	11,705,389	16,847,608
TOTAL RESOURCES	**265,058,069**	**278,829,578**	**274,494,602**	**-4,334,976**

Medicaid Program
Medicaid Requirements
(dollars in thousands)

	2010 Estimate	2011 Estimate
November 2009 State Estimates		
MAP and ADM	$231,761,397	$242,673,850
State Certification	230,646	234,600
Fraud Control Units	205,065	215,319
Total Unadjusted Estimates	$232,197,108	$243,123,769
Adjustments		
American Recovery and Reinvestment Act (ARRA)	$44,661,000	$13,047,500
Federal Poverty Line Adjustment, P.L. 111-118	9,300	0
Family Smoking Prevention	-1,062	-2,231
State and Local Administration Financial Adj.	-953,532	-491,642
Obligations Incurred But Not Reported	2,719,000	2,719,000
CHIPRA, P.L. 111-3	285,000	0
Financial Management Reviews	-387,000	-418,000
Actuarial adjustments	-3,352,425	12,864,852
Total Adjustments	42,890,281	27,719,479
Vaccines For Children Program	$3,652,189	$3,651,354
Current Law Requirement	$278,829,578	$274,494,602
Unobligated Balances		
Start of Year	-8,178,880	-14,411,421
Adjustment to Unobligated Balance, Start of Year	8,162,892	0
End of Year	14,411,421	0
Gross Budget Authority	$293,225,011	$260,083,181
Offsetting Collections	-562,500	-150,000
Appropriation/Net Budget Authority	$292,662,511	$259,933,181

MEDICAID
(State Submitted Estimates)
MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY
(dollars in thousands)

	FY 2010 Amount	FY 2010 Percentage	FY 2011 Amount	FY 2011 Percentage
Medicaid HIP / MCO	52,870,584	19.95%	50,104,398	20.52%
Nursing Facility / Regular Payments	33,924,351	12.80%	30,800,811	12.61%
Inpatient Hospital / Regular Payment	33,206,741	12.53%	29,373,620	12.03%
Home-Comm Serv/Regular Payment (Waiver)	24,218,340	9.14%	22,530,436	9.23%
Prescribed Drugs	19,565,124	7.38%	18,461,822	7.56%
Outpatient Hospital / Regular Services	9,919,574	3.74%	9,181,344	3.76%
Other Care Services	9,536,492	3.60%	8,600,999	3.52%
Inpatient Hospital / DSH Adj. Payment	8,709,934	3.29%	8,233,511	3.37%
Physician and Surgical / Regular Payments	8,811,808	3.33%	8,065,558	3.30%
Personal Care / Regular Payments	8,767,943	3.31%	7,842,490	3.21%
Medicare HIP / Part B Prem.	6,223,316	2.35%	5,791,885	2.37%
Clinic Services	6,283,676	2.37%	5,596,423	2.29%
Prepaid Inpatient Health Plan	6,925,844	2.61%	6,177,974	2.53%
Int. Care Facility - Mentally Retarded: Public Pmnts	5,370,782	2.03%	4,716,269	1.93%
Dental Services	3,659,647	1.38%	3,366,942	1.38%
Int. Care Facility - Mentally Retarded: Priv. Pmnts	3,535,004	1.33%	3,143,204	1.29%
Home Health Services	3,103,516	1.17%	2,849,362	1.17%
Mental Health / Regular Payment	2,357,046	0.89%	2,194,672	0.90%
Inpatient Hospital / Supplemental Payments	2,010,631	0.76%	1,933,232	0.79%
Medicare HIP / Part A Prem.	2,078,431	0.78%	1,924,869	0.79%
Mental Health / DSH Adj. Payment	1,729,577	0.65%	1,840,456	0.75%
Targeted Case Mgmt. / Community Case-Mgmt.	2,022,428	0.76%	1,836,398	0.75%
Other Practitioners' Services / Regular Payment	1,765,232	0.67%	1,610,284	0.66%
Hospice Benefits	1,685,005	0.64%	1,600,529	0.66%
Medicaid HIP / Other	1,719,428	0.65%	1,589,381	0.65%
Federally Qual. Health Center	1,605,108	0.61%	1,462,284	0.60%
Lab/Radiological Services	1,168,213	0.44%	1,100,693	0.45%
Rehabilitative Services (non-school-based)	856,193	0.32%	1,021,433	0.42%
EPSDT Screenings	901,234	0.34%	862,218	0.35%
All-Inclusive Care for Elders	801,296	0.30%	753,822	0.31%
Nursing Facility / Supplemental Payments	639,412	0.24%	744,774	0.30%
Emeg. Service Undoc. Aliens	826,681	0.31%	744,191	0.30%
School Based Services	580,282	0.22%	689,586	0.28%
Rural Health Clinic	622,944	0.24%	580,894	0.24%

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MEDICAID
(State Submitted Estimates)
MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY
(dollars in thousands)

	FY 2010 Amount	FY 2010 Percentage	FY 2011 Amount	FY 2011 Percentage
Medicare HIP / Coinsurance	597,952	0.23%	536,221	0.22%
Non-Emergency Medical Transportation	709,136	0.27%	397,858	0.16%
Medicaid HIP / Group	172,148	0.06%	362,690	0.15%
Outpatient Hospital / Supplemental Services	321,718	0.12%	337,232	0.14%
Private Duty Nursing	314,332	0.12%	311,237	0.13%
Primary Care Case Mgmt. Services	325,836	0.12%	290,262	0.12%
Inpatient Hospital - GME Payments	305,764	0.12%	282,809	0.12%
Physician and Surgical / Supplemental Payments	265,972	0.10%	280,264	0.11%
Emergency Hospital Services	232,430	0.09%	251,513	0.10%
Critical Access Hospitals	168,777	0.06%	158,061	0.06%
Prosthetic Devices, Dentures, Eyeglasses	144,083	0.05%	145,972	0.06%
Sterilizations	88,951	0.03%	87,580	0.04%
Services for Speech, Hearing and Language	62,604	0.02%	63,160	0.03%
Physical Therapy	56,520	0.02%	59,848	0.02%
Home-Comm Serv/State Pl 1915(i) Only Payment	48,456	0.02%	47,836	0.02%
Occupational Therapy	41,619	0.02%	41,904	0.02%
Nurse Practitioner Services	185,144	0.07%	40,326	0.02%
Case Mgmt. / State Wide	32,125	0.01%	23,779	0.01%
Personal Care / SDS 1915(j)	15,126	0.01%	15,142	0.01%
Medicaid HIP / Coinsurance	11,364	0.00%	10,197	0.00%
Int. Care Facility - Mentally Retarded: Suppl. Pmnts	11,355	0.00%	10,105	0.00%
Diagnostic Screening & Preventive Services	8,166	0.00%	7,916	0.00%
Nurse Mid-Wife	2,181	0.00%	2,245	0.00%
Abortions	70	0.00%	59	0.00%
Collections/Adjustments	(730,959)	-0.28%	(836,024)	-0.34%
Drug Rebate Offset	(6,406,822)	-2.42%	(6,032,248)	-2.47%
Total State Submitted Estimates	$264,985,865	100.00%	$244,222,708	100.00%

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, **[**$207,286,070,000**]** *$229,664,000,000*.

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, $229,664,000,000.	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 2009 Actual	FY 2010 President's Budget	FY 2011 Estimate
Appropriation: Annual	$195,383,000,000	$207,286,070,000	$229,664,000,000
Indefinite Annual Appropriation, for SMI Premium Match	4,500,000,000	7,304,000,000	--
Indefinite Annual Appropriation, for Part D Benefits	---	---	---
Lapse in Supplemental Medical Insurance	-1,467,854,000	--	--
Lapse in General Revenue Part D: Benefits	-1,712,442,000	-5,386,000,000	--
Lapse in General Revenue Part D: Federal Administration	-314,780,000	-86,000,000	--
Lapse in Program Management	---	-189,070,000	---
Lapse in Transfer for HCFAC Reimbursement	-198,000,000	---	---
Lapse in Quinquennial Adjustment	-60,000,000	---	---
Adjustment from Expired Accounts (for FY 2009 HCFAC)	---	197,000,000	---
Total Obligations	$196,129,924,000	$209,126,000,000	$229,664,000,000

Payments to the Health Care Trust Funds

Summary of Changes

2010 Appropriation

Total Budget Authority (Appropriated) - $207,286,070,000

Projected Indefinite Annual Appropriation - $7,304,000,000

2011 Estimate

Total Budget Authority - $229,664,000,000

Net Change, Total Appropriation - + $15,073,930,000

Changes	FY 2010 President's Budget	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance (SMI)	$153,060,000,000	+ $20,813,000,000
Indefinite Annual Appropriation, SMI	7,304,000,000	(7,304,000,000)
Hospital Insurance for the Uninsured	-414,000,000	+414,000,000
Hospital Insurance for Uninsured Federal Annuitants	272,000,000	+3,000,000
Program Management Administrative Expenses	393,070,000	(213,070,000)
General Revenue for Part D (Drug) Benefit	53,180,000,000	+1,213,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---
General Revenue for Part D Federal Administration	484,000,000	(102,000,000)
Part D: State Low-Income Determination	---	---
Reimbursement for HCFAC	311,000,000	+250,000,000
Net Change	$214,590,070,000	+ $15,073,930,000

Payments to the Health Care Trust Funds
Budget Authority by Activity

(Dollars in thousands)

	FY 2009	FY 2010	FY 2011
Supplementary Medical Insurance (SMI)	$147,716,000	$153,060,000	$173,873,000
Indefinite Annual Appropriation, SMI	4,500,000	7,304,000	---
Hospital Insurance for Uninsured	351,000	(414,000)	---
Hospital Insurance for Uninsured Federal Annuitants	263,000	272,000	275,000
Program Management Administrative Expenses	281,000	393,070	180,000
General Revenue for Part D Benefit	44,999,000	53,180,000	54,393,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
General Revenue for Part D Federal Administration	547,000	484,000	382,000
Part D: State Low-Income Determination	---	---	---
Reimbursement for HCFAC	198,000	311,000	561,000
Quinquennial Adjustment	1,028,000	---	---
Total Budget Authority	$199,883,000	$214,590,070	$229,664,000

Payments to the Health Care Trust Funds

Authorizing Legislation

	2010 Amount Authorized	2010 Budget Estimate	2011 Amount Authorized	2011 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)	$214,590,070,000	$214,590,070,000	N/A	$229,664,000,000
Total Budget Authority	$214,590,070,000	$214,590,070,000	N/A	$229,664,000,000

Annual Budget Authority by Activity

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$199,883,000,000	$214,590,070,000	$229,664,000,000	+$15,073,930,000

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 includes 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; 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	$229,664,000,000

Budget Request

Hospital Insurance for the Uninsured

The FY 2011 estimate of $0 for Hospital for the Uninsured is $414 million more than the FY 2010 appropriated request of -$414 million. No further adjustments in funding for this group of beneficiaries is needed.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2011 estimate of $275 million for Hospital Insurance for Uninsured Federal Annuitants is $3 million more than the FY 2010 appropriated request of $272 million.

Program Management Administrative Expenses

The FY 2011 estimate of $180 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare, is $213 million less than the FY 2010 appropriated request of $393 million. The FY 2010 appropriation for this line item is now estimated to be higher than current year need.

Federal Contribution for SMI

The estimate of $173.9 billion for the FY 2011 Federal Contribution for SMI is a net increase of $20.8 billion over the FY 2010 appropriated request. 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 2011 estimate of $54.4 billion for General Revenue for Part D (Benefits) is $1.2 billion more than the FY 2010 appropriated request of $53.2 billion. This estimate reflects updated data on the Part D benefit, feeding into the FY 2011 re-estimates of the Part D benefits baseline.

General Revenue for Part D Federal Administration

The FY 2011 estimate of $382 million for General Revenue for Part D Federal Administration is $102 million less than the FY 2010 appropriated request of $484 million.

General Revenue for Part D State Eligibility Determinations

The FY 2011 estimate for General Revenue Part D State Eligibility Determinations is $0.

Reimbursement for HCFAC

The FY 2011 estimate of $561 million for Reimbursement for HCFAC is $250 million more than the FY 2010 appropriated request of $311 million.

Permanent Budget Authority

(dollars in thousands)

	FY 2009 Actual	FY 2010 President's Budget	FY 2011 Request	FY 2011 +/- FY 2010
Tax on OASDI Benefits	$12,376,000	$15,005,000	$17,471,000	+ $2,466,000
SECA Tax Credits	20	---	---	---
HCFAC, FBI	126,258	126,258	126,258	--
HCFAC, Criminal Fines	620,965	167,653	216,725	49,072
HCFAC, Civil Penalties and Damages: Administration	17,096	14,000	14,000	---
Total BA	$13,140,339	$15,312,911	$17,827,983	+ $2,515,072

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 2009 Appropriation	FY 2010 President's Budget	FY 2011 Estimate
Grants, subsidies and contributions: Non-Drug	$147,716,000,000	$153,060,000,000	$173,873,000,000
Indefinite Annual Appropriation	4,500,000,000	7,304,000,000	---
Grants, subsidies and contributions: Drug	44,999,000,000	53,180,000,000	54,393,000,000
Indefinite Annual Appropriation, Part D Benefits	---	---	---
Insurance claims and indemnities	614,000,000	-142,000,000	275,000,000
Administrative costs-General Fund Share	1,026,000,000	1,188,070,000	1,123,000,000
General Revenue Part D: State Eligibility Determinations	---	---	---
Quinquennial Adjustment	1,028,000,000	---	---
Total Budget Authority	$199,883,000,000	$214,590,070,000	$229,664,000,000

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

(Dollars in Thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Outlays	$497,365,543	$521,710,000	$555,118,000	$33,408,000

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 2011 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. Please see the ARRA chapter at the end of this section for more information.

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 over 47 million beneficiaries in 2010.

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people age 65 and over who qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. 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 and Medicare Part D, 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. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. Beginning January, 2007, Part B premiums are income-related for individuals with incomes greater than $80,000 or couples with income(s) greater than $160,000. 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, 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 premium, and must provide all Medicare covered services. Further, with the exception of regional preferred provider organizations, MA plans assume full 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 B. MA plans have an estimated 11.3 million enrollees in 2010.

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 and 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 34.2 million in FY 2010.

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 2011 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.

The Medicare program underwent a program assessment in 2003. Please refer to the Medicare Operations section of this document for a summary of the Medicare assessment.

Outlays History

FY 2006	$375,174,976,000
FY 2007	$434,591,000,000
FY 2008	$454,300,596,000
FY 2009	$497,365,543,000
FY 2010*	$521,710,000,000
*Under Current law	

Budget Estimates

The budget estimates for Medicare benefits for FY 2011, by trust fund account, is shown in the following table.

	FY 2011	Increase over FY 2010
HI	$265,794,000,000	$16,763,000,000
SMI – Part B	$222,565,000,000	$8.667,000,000
SMI – Part D	$66,759,000,000	$7,978,000,000
Total	$555,118,000,000	$33,408,000,000

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

The estimate for FY 2011 is an increase of $33,408,000,000 over FY 2010. The increase is due to growth in enrollment, services costs, and utilization.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MCR 1.1a: Percent of beneficiaries in Medicare Advantage (MA) who report access to care *(Outcome)*	FY 2009: 90% (Target Met)	90%	90%	Maintain
MCR 1.1b: Percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care; *(Outcome)*	FY 2009: 90% (Target Met)	90%	90%	Maintain
MCR 1.2a: Percent of beneficiaries in MA who report access to prescription drugs. *(Outcome)*	FY 2009: 93% (Target Exceeded)	91%	91%	Maintain
MCR 1.2b: Percent of beneficiaries in MFFS who report access to prescription drugs. *(Outcome)*	FY 2009: 91% (Target Exceeded)	91%	91%	Maintain
Program Level Funding ($ in millions)	**N/A**	**$521,710**	**$555,116**	**$33,408**

Children's Health Insurance Program

	FY 2009 Appropriation	FY 2010 President's Budget	FY 2011 Request
State allotments (CHIPRA of 2009, P.L. 111-3)	$10,562,000,000	$12,520,000,000	$13,459,000,000
CHIPRA Sec. 3(c) (Include amount from SSA Sec 2104 (c)(4))	$40,000,000	$0	$0
Total Budget Authority for State Allotments	**$10,602,000,000**	**$12,520,000,000**	**$13,459,000,000**
CHIP Performance Bonus Payments (P.L. 111-3)	$3,225,000,000	$4,229,362,000	$4,156,362,000
Child Health Quality Improvement (P.L. 111-3)	$45,000,000	$45,000,000	$45,000,000
Total Budgetary Resources	**$13,872,000,000**	**$16,794,362,000**	**$17,660,362,000**
Total Outlays	**$7,546,665,978**	**$8,903,000,000**	**$10,285,000,000**

Child Enrollment Contingency Fund

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

	FY 2009 Appropriation	FY 2010 President's Budget	FY 2011 Planning Level
Child Enrollment Contingency Fund	$2,112,400,000	$2,113,591,211	$1,986,577,211
Interest Estimate	$1,191,211	$72,986,000	$81,945,000
Total Budgetary Resources	**$2,113,591,211**	**$2,186,577,211**	**$2,068,522,211**
Total Outlays	**$0**	**$200,000,000**	**$200,000,000**

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), and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3).

FY 2011 Authorization - Funding expires after September 30, 2013
Allocation Method - Formula Grants

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.

In 2008, eleven years after CHIP was created, States reported that 7.4 million children were enrolled in the program. The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44 billion through 2013 to maintain State programs and to cover more insured children. In response to the funding increase, CMS revised a performance measure to decrease the number of uninsured children by working with States to enroll children in CHIP. CMS exceeded its FY 2008 target to increase CHIP enrollment by 2 percent over the FY 2006 baseline enrollment figure. The FY 2006 baseline was 6,600,000 and our FY 2008 result was 7,368,479, an increase of over 11 percent.

Since CMS substantially exceeded its FY 2008 target, CMS has established FY 2008 as the new baseline beginning with the FY 2009 target. For FY 2009 and FY 2010, CMS will aim to increase enrollment over the FY 2008 baseline by one percent and five percent, respectively. The FY 2011 target is to increase enrollment by 7 percent over the FY 2008 baseline.

This long-term measure proposes to steadily increase enrollment through 2013, although enrollment figures can be affected by States' economic situations, programmatic changes, and the reporting accuracy and timeliness of States' reporting. 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 supports the Department's high priority goal to "*Broaden the availability and accessibility of health insurance coverage through implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) legislation".*

As of September 1999, all States, Territories, and the District of Columbia 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 2009, a total of 337 amendments to CHIP plans have been approved.

Most recently, CHIPRA has adjusted the budgetary resources available to States for CHIP through September 30, 2013. Federal funding for the program has also increased by $44 billion through FY 2013, above prior law levels of $25 billion. In addition to increased funding for States, there are several new provisions provided by CHIPRA. A few of the major provisions include:

- CHIP Performance Bonus Payments – creates 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. Performance bonus payments are funded initially with a $3.2 billion appropriation and in future years by 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.

- Child Health Quality Improvement in Medicaid and CHIP – requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. A notice for comment was published in the Federal Register in December 2009. 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 title XIX or XXI, 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) will be 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.

- Child Enrollment Contingency Fund – this fund is established in the Treasury of the United States, and is used to increase allotments to States that exceed their allotment due to a higher-than-expected child enrollment. The fund received a total of $1,191,211 in interest in FY 2009. 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 receives an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2013, the bill 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.

CHIPRA provisions affecting other accounts include:

- Grants to Improve Outreach and Enrollment – please refer to the State Grants and Demonstrations chapter for more detailed information.

- Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics - please refer to the State Grants and Demonstrations chapter for more detailed information.

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 measures through the Performance Measurement Partnership Project, which is detailed in the measure to Improve Health Care Quality Across CHIP (CHIP2). CMS has established a target for FY 2010 to lead efforts to develop a National Quality Framework for the CHIP

program. Although this measure will be discontinued after FY 2010, CMS has created a solid foundation from which future quality measures will be established. A new quality measure (MCD6), based on initiatives established through CHIPRA legislation, is being developed for FY 2011.

Recent CHIPRA legislation appropriated $45 million annually through FY 2013 for a number of activities aimed at improving child health quality: establishment of voluntary child health quality measures; demonstration projects for improving child health quality through evaluating new performance measures; health information technology, and provider-based models such as care management; and development of a model electronic health record. CMS is developing a new measure, "Improve Health Care Quality Across Medicaid and CHIP through Implementation of CHIPRA Quality Initiatives". 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. The measures include three of the CHIP clinical performance measures that States reported under the discontinued CHIP Quality Measure. 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. Our FY 2011 target is to work with states to ensure that 90 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.

CMS is also aiming to increase 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. We are currently developing a final regulation addressing CHIP PERM, as required by section 601 of CHIPRA. CMS published a proposed rule on July 14, 2009. We expect to continue full implementation of these measurements and to report a national error rate after the regulation is published. A national error rate will be reported no earlier than six months after publication of the regulation, as required by CHIPRA.

A program assessment reported that the CHIP program has been successful in enrolling and providing health coverage to uninsured children. CMS continues to take the following actions to improve the performance of the program: working with States to develop long-term goals and implement a core set of national performance measures to evaluate the quality of care received by low-income children; working with States to develop goals for measuring the impact of the program on targeted low-income children through the annual State reporting process; and establishing a methodology to measure improper payments, including producing error rates.

State Allotment Funding History

FY 2003	$3,175,200,000
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	$12,520,000,000
FY 2011	$13,459,000,000

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 $12,520,000,000 in FY 2010 and $13,459,000,000 in FY 2011. Under this appropriation, funding to States increased by $44 billion over five years, and $68.9 billion over 10 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.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
CHIP 2: Improve Health Care Quality Across CHIP *CHIP2 is being replaced by MCD6.	FY 2008: Goal met. CMS analyzed States' responses to four clinical performance measures and communicated findings to States. Six promising practices from four States were posted to CMS website. CMS provided technical assistance to States and provided States with a reporting "checklist" on performance measures and has included CHIP performance quality improvement information in the Medicaid Quality Assistance reports provided to States. (Target Met)	CMS will lead efforts to develop a National Quality Framework for CHIP. The target is to develop a consensus-based quality framework that States can use to create high-quality "systems" of care. States will be able to use the Framework as a guide for assessing their current quality programs and for determining next steps for future improvement.	Goal discontinued.*	N/A
CHIP 3: Decrease the Number of Uninsured Children by Working with States to Enroll Children in CHIP **High Priority Performance Goal**	FY 2008: +11%over baseline 7,368,479 children (Target Exceeded)	+5% over 2008 7,736,903 children	+7% over 2008 7,884,273 children	+147,370 children
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2009: Target not met. Regulation delayed until FY 2010.	Publish Final Regulation in accordance with Section 601 of CHIPRA.	Report national error rates in the FY 2012 AFR based on 17 CHIP States measured in FY 2011.	N/A
MCD6: Improve 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* *This measure replaces CHIP2.	N/A	N/A	Work with States to ensure that 90 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	N/A
Program Level Funding ($ in millions)	**N/A**	**$12,520**	**$13,459**	**+$939**

FY 2010 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	FY 2009 Actual*	FY 2010 Estimate	FY 2011 Estimate**	Difference +/- 2010
Alabama	$140,301	$147,158	$147,158	$0
Alaska	24,565	25,717	25,717	0
Arizona	171,133	182,592	182,592	0
Arkansas	133,753	140,776	140,776	0
California	1,552,910	1,629,092	1,629,092	0
Colorado	100,696	107,060	107,060	0
Connecticut	45,645	47,785	47,785	0
Delaware	15,096	15,889	15,889	0
District of Columbia	14,180	14,845	14,845	0
Florida	356,095	372,791	372,791	0
Georgia	302,055	320,022	320,022	0
Hawaii	20,889	21,928	21,928	0
Idaho	44,515	47,219	47,219	0
Illinois	344,562	360,717	360,717	0
Indiana	137,585	144,186	144,186	0
Iowa	65,255	68,492	68,492	0
Kansas	57,164	60,287	60,287	0
Kentucky	126,014	132,153	132,153	0
Louisiana	207,403	229,089	229,089	0
Maine	39,272	42,268	42,268	0
Maryland	194,774	216,082	216,082	0
Massachusetts	310,476	403,133	403,133	0
Michigan	221,124	231,492	231,492	0
Minnesota	83,960	87,897	87,897	0
Mississippi	192,939	214,132	214,132	0
Missouri	158,829	166,276	166,276	0
Montana	32,989	34,691	34,691	0
Nebraska	41,955	44,180	44,180	0
Nevada	61,397	65,135	65,135	0
New Hampshire	14,845	15,540	15,540	0
New Jersey	484,402	634,745	634,745	0
New Mexico	277,128	345,313	345,313	0
New York	433,473	453,796	453,796	0
North Carolina	241,660	257,369	257,369	0
North Dakota	15,822	16,596	16,596	0

FY 2010 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
(dollars in thousands)				
STATE/TERRITORY	**FY 2009 Actual***	**FY 2010 Estimate**	**FY 2011 Estimate****	**Difference +/- 2010**
Ohio	285,275	298,650	298,650	0
Oklahoma	151,400	159,709	159,709	0
Oregon	100,198	105,695	105,695	0
Pennsylvania	310,309	324,858	324,858	0
Rhode Island	66,993	75,436	75,436	0
South Carolina	106,863	112,887	112,887	0
South Dakota	20,656	21,764	21,764	0
Tennessee	156,629	164,728	164,728	0
Texas	867,350	925,033	925,033	0
Utah	65,264	69,926	69,926	0
Vermont	9,490	9,935	9,935	0
Virginia	175,860	184,455	184,455	0
Washington	94,285	99,438	99,438	0
West Virginia	43,263	45,292	45,292	0
Wisconsin	204,276	213,853	213,853	0
Wyoming	11,327	12,063	12,063	0
Subtotal	**9,334,295**	**10,120,161**	**10,120,161**	**0**
American Samoa	1,332	892	892	0
Guam	5,177	3,963	3,963	0
Northern Mariana Islands	1,221	818	818	0
Puerto Rico	148,643	117,254	117,254	0
Virgin Islands	3,329	2,396	2,396	0
Subtotal	**159,702**	**125,323**	**125,323**	**0**
Total States/Territories	**9,493,997**	**10,245,484**	**10,245,484**	**0**
Technical Assistance	0	0	0	0
State Penalties	0	0	0	0
Contingency Fund	0	0	0	0
Other Adjustments	0	2,274,516	3,213,516	939,000
Subtotal Adjustments	**0**	**2,274,516**	**3,213,516**	**939,000**
TOTAL RESOURCES	**$9,493,997**	**$12,520,000**	**$13,459,000**	**$939,000**

*FY 2009 amounts include additional allotments provided to "shortfall" states as described in Section 2104(l) of the Act

**Allotments are rebased in FY 2011 based on FY 2010 spending estimates.

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, $561,000,000, to remain available through September 30, 2012, 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 $376,167,000 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, for activities listed in section 1893 of such Act *and for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities*; of which $94,830,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act; and of which $90,003,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2011 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. (Department of Health and Human Services Appropriations Act, 2010.)

Language Analysis

Language Provision	**Explanation**
In addition to amounts otherwise available for program integrity and program management, *$561,000,000, to remain available through September 30, 2012*, 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 *$376,167,000* 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. Provides funding for Medicaid and CHIP program integrity activities.
of which *$94,830,000* shall be for the Department of Health and Human Services Office of Inspector General *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act*;	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which *$90,003,000* shall be for the Department of Justice *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act]*	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year *2010* 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 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
Mandatory				
Medicare Integrity Program (MIP)	$768,000	$780,000	$780,000	$0
FBI	$126,258	$126,258	$126,258	$0
OIG	$177,205	$177,205	$177,205	$0
DOJ Wedge	$55,328	$55,328	$55,328	$0
HHS Wedge	$33,892	$33,892	$33,892	$0
Subtotal, Mandatory	$1,160,683	$1,172,683	$1,172,683	$0
Discretionary Allocation Adjustment *				
CMS Program Integrity	$160,066	$251,420	$376,167	$124,747
Medicare Integrity(non-add)	*$147,038*	*$220,320*	*$328,423*	*$108,103*
Medicaid Integrity(non-add)	*$13,028*	*$31,100*	*$47,744*	*$16,644*
OIG	$18,967	$29,790	$94,830	$65,040
DOJ	$18,967	$29,790	$90,003	$60,213
Subtotal, Discretionary	$198,000	$311,000	$561,000	$250,000
Total	**$1,358,683**	**$1,483,683**	**$1,733,683**	**$250,000**

***** CMS Program Integrity is broken out in detail later in this chapter.

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

FY 2011 Authorization – Public Law 104-191

Allocation Method - Other

OVERVIEW

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse.

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides a stable stream of mandatory funds. Beginning in FY 2009, the General Fund also finances program integrity efforts by providing discretionary funds on an annual basis.

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 focused on beneficiary outreach; increasing funding for program integrity demonstrations/special initiatives; improving our capacity to identify and prevent excessive payments in FFS Medicare; developing processes for identifying problems; and enhancing provider oversight efforts.

In addition to fighting Medicare fraud, CMS is also committed to fighting fraud in the Medicaid program. The mission of the Medicaid Integrity Program is to protect 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. In addition, it will expand activities that involve data analysis, sharing algorithms of known improper billings, and fraud awareness through education and outreach.

Program Assessment

The Medicare Integrity Program underwent a program assessment in 2002. As a result of the program assessment, CMS continues to develop and implement safeguards to protect the Medicare Advantage (Part C) program and the Medicare prescription drug benefit (Part D) against fraud, waste, and abuse. We also continue implementation of contracting reform authority to move claims processing contractors to performance-based contracts that tie payments to success in reducing the claims payment error rate. We are developing error rate measures to reduce the percentage of improper payment made under the Part C and Part D programs. In 2009, we reported a baseline error rate of 15.4 percent for Part C. The FY 2010 Part C target is 14.3 percent and the FY 2011 target is 13.7 percent. In both FY 2010 and FY 2011, CMS will further develop component measures of payment error for the Part D program.

Funding History

FY 2005	$1,074,558,000
FY 2006	$1,186,558,000
FY 2007	$1,111,677,000
FY 2008	$1,132,134,000
FY 2009	$1,358,683,000
FY 2010	$1,483,683,000

Budget Request Overview

The FY 2011 Budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2011 HCFAC program level is $1.7 billion, $250 million more than in FY 2010. Of this total program level, approximately $1.2 billion is mandatory, the same level as FY 2010, and $561 million is discretionary, an increase of $250 million over FY 2010.

HCFAC Mandatory Funds

The $1.2 billion in mandatory funds is financed from the Medicare Hospital Insurance or Part A Trust Fund. This funding is allocated into three major parts: 1) Medicare Integrity Program (MIP); 2) the Federal Bureau of Investigation (FBI); and 3) the "Account," an amount that includes funding for the Office of Inspector General (OIG) and a "wedge" amount (difference between the amount OIG receives and the total amount in the funding stream) that is available to DHHS and the Department of Justice (DOJ). Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis. Mandatory HCFAC funding has a proven record of returning money to the Federal Health Insurance Trust Fund for each dollar spent. For MIP, the actual return on investment (ROI) based on a 3-year rolling average is 14 to 1, and for the HCFAC Account, the ROI averages 6 to 1. From 1997 to 2008, HCFAC activities (excluding MIP) have returned over $13 billion to the Trust Fund. MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade. In FY 2008, over $1.9 billion in recoveries was returned to the Trust Fund and approximately $344 million in Medicaid recoveries was returned to the Treasury as a result of program integrity efforts.

HCFAC Discretionary Funds

The FY 2011 Budget requests $561 million in discretionary HCFAC funding, an increase of $250 million over FY 2010. This total will be allocated as follows: Medicare: $328.4 million; Medicaid: $47.7 million; DOJ: $90.0 million; and OIG: $94.8 million.

The additional funding will better equip CMS and its program integrity partners to minimize inappropriate payments, close loopholes, and provide greater value for program expenditures to beneficiaries and taxpayers. It will fund the implementation of new program integrity authorities, increased oversight of Medicare Part C and D, additional Medicaid audits, and most importantly, a joint initiative between HHS and DOJ to combat fraud on the front lines, referred to as the Health Care Fraud Prevention and Enforcement Action Team (HEAT) program, that will expand operations to an additional 13 Strike Force cities, bringing the total to 20 Strike Force cities.

The additional $250 million in discretionary funding will also expand the improvement of real-time data sharing and coordination between CMS, its partners, and DOJ. This increased data sharing will not only help stop fraudulent schemes and practices before they take root, but will also expose systemic vulnerabilities that have been exploited by health care providers.

HCFAC discretionary funds complement the program integrity activities funded with mandatory HCFAC dollars. Based on the proven success of the mandatory HCFAC program, it is expected that this additional discretionary investment will also aid in the

reduction of improper payments and recoup many times its initial investment. CMS actuaries currently estimate that for every new dollar spent by HHS to combat health care fraud, $1.55 is saved or averted. The $561 million in HCFAC discretionary funding is projected to yield nearly $4.5 billion in mandatory Medicare and Medicaid savings over five years and $9.9 billion over 10 years.

Below is a breakout of the HCFAC discretionary funding request:

(dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
Discretionary				
Medicare Integrity Program (MIP)	$147,038	$220,320	$241,173	$20,853
CMS HEAT	$0	$0	$16,250	$16,250
CMS Medicare PI Proposals	$0	$0	$71,000	$71,000
CMS Medicaid Integrity	$13,028	$31,100	$42,744	$11,644
CMS Medicaid PI Proposals	$0	$0	$5,000	$5,000
OIG	$18,967,000	$29,790	$54,790	$25,000
OIG HEAT	$0	$0	$40,040	$40,040
DOJ	$18,967	$29,790	$30,203	$413
DOJ HEAT	$0	$0	$59,800	$59,800
	$19,146,033	$311,000	$561,000	$250,000

*****The PI proposals are described in detail under the FY 2011 Program Integrity Proposals section.

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 innovation approaches to fighting fraud (such as HEAT). Past experience has also proven that we get better results when we take a hybrid approach to combating fraud, with some limited level of redundancy. This includes using a variety of in-house, contractor, law enforcement, and auditing staffs 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; increased oversight of Medicare Advantage and Part D prescription drug plans; and using our 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 beneficiary hotlines for reporting suspected fraud in high-risk areas and services; and,
- Issued guidance for helping beneficiaries guard against identity theft.

Below are the major initiatives CMS will be pursuing with MIP funding:

Health Care Enforcement Action Team (HEAT): The HEAT team is a working group of key stakeholders at the highest levels of DOJ and HHS that will increase coordination, intelligence sharing and training among our investigators, agents and prosecutors. As a top priority, this taskforce will look at how we can better share real-time intelligence data on health care fraud patterns and practices, by closely monitoring claims payment data, identifying problematic billing patterns immediately, and conducting interviews and surveillance of targeted providers and individuals. The taskforce also will ensure that critical, up-to-date information about health care services, pharmaceuticals, and medical devices is readily exchanged between HHS and DOJ, increasing the efficiency and prompt resolution of complex health care fraud cases. It will also explore improvements in technology and training that will provide our analysts and agents with the best tools to effectively prevent fraud and abuse.

Past collaborations between the DOJ, HHS, OIG and CMS have proven to be effective. In 2008, the above groups worked together to secure 588 criminal convictions through the criminal and civil systems, obtain 337 civil administrative actions against individuals and organizations that were committing Medicare Fraud, and recovered more than a billion dollars in health care fraud monies under the False Claims Act. Final statistics for 2009 are not yet available, however, it is expected that over one billion dollars in health care fraud monies have again been recovered.

To date, the Strike Forces have been very successful as well. As of the end of CY 2009, Strike Force activities in the existing seven cities have resulted in more than 200 convictions, almost 500 indictments, and an estimated $235 million in expected recoveries. Strike Forces have proven to be effective tools in fighting and preventing fraud, and this HCFAC increase will help to expand this model to an additional 13 cities.

Medicare Drug Integrity Contractors (MEDICs): Oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud, waste and abuse (FWA). With the implementation of the Medicare prescription drug benefit, it became necessary for CMS to effectively deal with any issues related to potential

FWA in the Part D program and to ensure that they are minimized. CMS developed a Medicare Part D integrity contractor scope of work that strives to address all areas of potential fraud, waste and abuse related to the Part D benefit, including any new or emerging problems. The MEDICs are responsible for performing program safeguard functions to detect and prevent fraud, waste and abuse and to mitigate vulnerabilities associated with Part D.

At the beginning of FY 2009, CMS added fighting fraud, waste and abuse in Part C to the scope of work for the MEDICs. Medicare Part C has many of the same fraud and abuse oversight needs as Part D such as:

- Review of actions of individuals or entities furnishing items or services that are alleged to be fraud, waste or abuse;
- Investigate allegations of FWA;
- Provide data analysis to law enforcement; and
- Perform proactive data analysis to find potential FWA.

Comprehensive Error Rate Testing (CERT): CMS developed the Comprehensive Error Rate Testing (CERT) program to produce 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.

In the past, the Quality Improvement Organizations (QIOs) measured the error rate for acute care inpatient PPS hospital claims and long-term care hospital claims under the Hospital Payment Monitoring Program (HPMP). In response to recommendations from the OIG and DHHS, CMS transitioned this workload to the CERT program effective April 1, 2008 for the November 2009 report period. The consolidation of the error rate measurement activities will ensure consistency in methodology and uniformity in reporting.

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 – making its review requirements more stringent and in line with CMS policies and manuals. As a result of the revised and improved method for calculating the error rate, CMS will revise the baseline for the performance measure.

One Program Integrity (One PI): Begun in FY 2006, One PI will, for the first time, provide a centralized source of standardized Medicaid data across multiple States, integrated with data from Medicare Parts A, B, and D. The Integrated Data Repository (IDR) currently houses Part A and B claims data back to January 1, 2006 and prescription drug event records back to January 1, 2006. CMS will continue to add additional data streams and reference data to the IDR. One PI will gather data from a wide variety of sources, transform the data into standard data models, integrate data, add valuable information such as reference data and acceptable practice standards, and store the results in a data repository. Users will access the information through a secure portal using a standard set of analytic tools. The availability of a centralized source for accessing the tremendous volume of data on claims, providers, and beneficiaries will enable consistent, reliable, and timely analyses. This will, in turn, improve the ability to detect fraud, waste, and abuse in both the Medicare and Medicaid programs. Currently, Parts A, B, and D data dating back to January 2006 have been loaded into the system. Development of the One PI system continues.

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 Office of Inspector General (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, Department of Justice, and the US attorney and State law enforcement officials.

Fraud Hot Spots: CMS currently has three field offices in high vulnerability areas of the country (New York City, Los Angeles and Miami). In addition to establishing a presence in those areas, the benefit of Program Integrity field offices has been significant due to their ability to have "feet on the street" and get out quickly in the areas which are most impacted by fraud and abuse. Staff in these offices conduct in-person interviews with beneficiaries and providers to verify if 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 DOJ strike force efforts.

CMS Field office staff can be deployed more rapidly and often less expensively and 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.

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 on the of 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

Benefit Integrity (BI): BI activities deter and detect Medicare fraud through concerted efforts with the OIG, the Government Accountability Office, the 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 integrity contractors (Program Safeguard Contractors, Zone Program Integrity Contractors) 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 Zone Program Integrity Contractors (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 audit. 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. This includes 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 CMS' primary instrument 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.

HMO Audits: 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.

Provider Outreach and Education (POE): POE concentrates on educational activities that communicate appropriate billing practices in compliance with Medicare rules, regulations and manual instructions. It focuses on assisting providers to avoid and detect waste, fraud, and abuse. In addition, some POE activities are funded from the Program Management appropriation. These activities are directed more toward on-going program information so that providers can best serve Medicare beneficiaries and reduce costly claims processing errors.

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 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.

CMS MIP Budget Request

The FY 2011 request includes mandatory funding of $780,000,000 to continue the activities discussed in the Program Description and Accomplishments Section. In addition, CMS is requesting discretionary funding of $328,423,000 for MIP, an increase of $108,103,000 over FY 2010, for new activities and expansion of Strike Force Cities. In line with its hybrid approach to combating fraud, CMS proposes to add 25 additional staff in the field. A dedicated number of these would form a rapid response team which would be deployed to

high-risk areas when potential vulnerabilities are identified. These staff will be deployed from the three existing regional field offices, and CMS' Central Office.

The request level of $328.4 million funds the following expanded and new activities:

- Expansion of Strike Force Cities ($16.3 million): In a short amount of time, Strike Forces have allowed multi-agency teams of investigators and data analysts to identify fraudsters on the ground, prosecute the responsible criminals, and return money to the Trust Fund. We believe that expanding Strike Force cities nationally will allow even more criminals to be caught and even more funds to be returned. CMS and its partners will expand to thirteen new Strike Force cities bringing the total to twenty. Currently, we have seven Strike Force city locations: Baton Rouge, Tampa, New York City, Miami, Los Angeles, Houston and Detroit. Strike Forces have been very successful. Within two years the Miami Strike Force prosecutors filed 87 indictments charging 159 defendants with fraud offenses. Within one year, the Los Angeles Strike Force prosecutors had filed 21 cases and three superseding indictments charging 37 defendants and healthcare fraud offenses.

- Increased Program Oversight Activities ($20.8 million): 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, increase the number of data analysts that are tracking 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.

- Implementation of Medicare Program Integrity Proposals $71.0 million): CMS requests funding for six program integrity proposals, including three legislative and three administrative proposals, designed to target fraudulent providers and strengthen program oversight. See the end of this chapter for a detailed description of each proposal. This robust package of proposals targets fraudulent providers and strengthens program oversight. It will generate nearly $15 billion in savings over ten years.

- Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D ($158.6 million): CMS will continue to strengthen PI activities through the use of MEDICs, Part C & D Contract/Plan Oversight, Monitoring Performance Assessment and Surveillance, Program Audit and Compliance and Enforcement.

- Establishing Additional Regional Call Centers and Focused Beneficiary Outreach ($19.3 million): CMS will fund regional fraud hotlines and call centers in each of the five high fraud areas in the country. CMS will work with the Administration on Aging to conduct beneficiary outreach and education so that beneficiaries understand the types of fraud that occur and how to read their Medicare Summary Notices to better detect potentially fraudulent billings.

- Increasing Funding for Program Integrity Demonstrations/Special Initiatives ($17.4 million): CMS and its contractors will identify and interview, or conduct site visits to the highest paid/highest risk DMEPOS suppliers, highest ordering physicians and highest ordering beneficiaries.

- Capacity to Identify and Prevent Excessive Payments in FFS Medicare ($14.5 million): This additional funding for ZPICs will fund data analysis projects to support field office probes.

- Enhanced Provider Oversight Efforts ($10.5 million): CMS will use these funds to perform onsite verifications of providers before enrollments are issued and conduct background checks. Also, funding will be used to perform more frequent surveys of home health providers. CMS will revalidate approximately 50,000 providers/suppliers that are due to update their Medicare enrollment information.

CMS MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

Medicaid Integrity Program: The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program to prevent, identify, and recover inappropriate Medicaid payments, and to provide technical assistance to State agencies. CMS conducts program integrity reviews of each State Medicaid program on a triennial basis in order to both ensure compliance with Federal program integrity regulations and provide technical assistance to State's program integrity operations. Although the primary responsibility for this program falls under Title XIX, the DRA did provide funding that is managed under the HCFAC account.

CMS will move forward with actions that include issuing a State Medicaid Director Letter giving guidance to States on minimum requirements that should be part of any Program Integrity (PI) program as well as a list of elements that should be avoided. The Unacceptable Payment Errors in the Medicaid guidance letter will provide for each element a list of remedies or controls (prevention strategies). CMS will continue to enter into contracts that support Medicaid integrity, such as the review of provider actions; identification and audit of paid claims; education of providers with respect to payment integrity and quality of care; and support and assistance to States through training and other educational programs.

In addition, CMS will continue to conduct comprehensive State program integrity reviews throughout 2010 and will pilot a second generation of State program integrity reviews with increased emphasis on PI effectiveness and outcomes. CMS will also initiate a national Medicaid alert system to share information across states about newly identified emerging schemes designed to defraud the Medicaid program.

Payment Error Rate Measurement (PERM): In FY 2006, CMS implemented the national PERM program in order to comply with the Improper Payments Information Act of 2002 (IPIA). 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. CMS uses a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected State Medicaid and CHIP fee-for-service (FFS) and managed care claims. Starting in FY 2007, CMS expanded PERM to include reviews of FFS and managed care claims, as well as beneficiary eligibility, in both the Medicaid and CHIP programs. CMS developed Corrective Action Plans (CAPs) for Medicaid and the Children's

Health Insurance Program (CHIP) based on the outcomes of previous improper payment rate measurements and is in the process of developing the 2009 CAP for Medicaid based on recent findings. In addition, CMS requires CAPs from each State measured.

CMS Medicaid Integrity Budget Request

The FY 2011 request includes discretionary funding of $47,744,000, an increase of $16,644,000 over FY 2010. This expanded funding will allow CMS to conduct activities that will further mature the Medicaid Integrity Program.

The request level of $47.7 million funds the following activities:

Increased Medicaid Audits ($11.6 million): This much needed increase will fund additional Medicaid audits to improve oversight and recoveries. This is an important investment for both the Federal government and the States, and will become even more necessary as the number of Medicaid beneficiaries increases.

CMS will rely more heavily on data in its program integrity efforts and will provide States with evidence-based tools that they can use to combat waste, fraud and abuse in Medicaid.

CMS will also increase its focus on Medicaid audits involving cross-border, regional and national issues. CMS will increase collaboration between the Medicaid and Medicare programs to address areas of common concern across both programs to help drive program integrity efforts.

PERM ($31.1 million): CMS is taking actions to safeguard Federally matched funds and prevent improper payments by measuring State program error rates through the Payment Error Rate Measurement (PERM) program. CMS will conduct the following PERM activities in FY 2011:

- Contracting with a statistical contractor to quality control each State's Medicaid and CHIP universe data, determine each State's Medicaid and CHIP sample size; randomly select a statistically valid sample of claims for each State on a quarterly basis; format claims data received from the States; provide these samples to the review contractor; review State eligibility sampling plans; compute State error rates; calculate a national error rate; assist in writing the final PERM report; and work with States on corrective action plans.

- Contracting with a review contractor to work with the States to collect state Medicaid and CHIP policies; work with the State and local providers to request and retrieve medical records of selected claims; make a payment determination for each Medicaid and CHIP FFS sampling unit by performing data processing reviews and medical reviews; conduct a data processing review of Medicaid and CHIP managed care capitation payments; provide review findings to the States and the statistical contractor; maintain a difference resolution process; jointly write the final report with the statistical contractor; and submit the report to CMS.

- Funding a System Test & Evaluation (ST&E) review on each of the PERM contractors' systems.

- Contracting with a provider education contractor as part of the corrective action plan process to take findings from the error rate measurement cycles and create educational materials to be distributed to states and providers in order to decrease error rates.

- Aligning PERM data request with the Medicaid Statistical Information System Plus (MSISPLUS) initiative. Select States will submit Medicaid and/or CHIP data for PERM purposes using the PERM Plus data submission method. This method simplifies the PERM data submission process by requesting States submit claims, recipient, and provider data simultaneously, eliminating the need for the PERM contractors to request additional information from States prior to requesting medical records. PERM Plus also requires less up front analysis and data modifications by the State because the PERM contractor is responsible for distinguishing between fee-for-service and managed care, identifying sampling units, and identifying and excluding adjustments within the data, all responsibilities which previously belonged to the States. The PERM Plus data submission method not only reduces State staffing and programming burden in the short term, but also prepares PERM for the eventual use of MSISPLUS data. The PERM contractor will also conduct a pilot with MSISPLUS data collected by CMSO to move further towards fully using MSISPLUS data for PERM. The contractor will obtain the MSISPLUS data submitted by the States, extract the data elements needed for PERM, and test the data's ability to meet PERM program requirements. This initiative will also allow PERM to start moving towards its future goal of using One PI as a data source, and, as a result, move towards a reduction in the PERM timeline.

- Enhancing oversight and funding special projects to identify vulnerabilities. For example, we will initiate special projects in the measurement process to target program vulnerabilities.

Implementation of Medicaid Program Integrity Proposal ($5 million): CMS requests $5 million for implementation of the legislative proposal to track drug utilizers and prescribers to reduce over-utilization of prescription drugs under Medicaid, as described under the FY 2011 Program Integrity Proposals section.

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 Request

The FY 2011 request includes mandatory funding of $126,258,000 for the FBI. It is equal to the FY 2010 appropriation.

OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

OIG uses HCFAC funds to conduct numerous 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 industry guidance to HHS program participants. In FY 2009, OIG's Health Care Oversight funding, including HCFAC, supported participation in investigations or other inquiries that resulted in 515 criminal actions, 387 civil actions, and 2,556 program exclusions against individuals or entities that engaged in misconduct relating to the provision of, or payment for, health care. These efforts resulted in $3 billion in HHS and $986 million in non-HHS expected investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs. In addition, based on OIG recommendations, CMS program managers agreed to disallow approximately $463 million in improperly paid health care funds.

OIG Budget Request

The FY 2011 estimate for OIG HCFAC activities is $272,035,000, an increase of $65,040,000 above the FY 2010 funding level. The OIG estimate includes mandatory funding of $177,205,000, the same as FY 2010, and a request for a discretionary allocation adjustment of $94,830,000 an increase of $65,040,000 above the FY 2010 enacted level. This increase includes (1) $25,000,000 for oversight of Medicaid and Medicare program activities previously funded through mandatory DRA appropriations, and (2) $40,040,000 in support of the Administration's HEAT initiative to prevent and prosecute health care fraud. This increase will support OIG's role in HEAT activities, including 13 additional cities.

Additional information on OIG's accomplishments and planned activities can be found at: http://oig.hhs.gov/publications.asp

DEPARTMENT OF JUSTICE WEDGE

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

The FY 2011 request includes mandatory funding of $55,328,000, the same as FY 2010, and discretionary funding of $90,003,000 for the DOJ, an increase of $60,213,000 over FY 2010. Of this increase, $59.8 million will be used for the DOJ's role in HEAT.

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 negotiation and agreement between the Attorney General and the Secretary of HHS. For FY 2010, negotiated allocations were $33,893,000 for distribution among HHS components and $55,328,000 for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects, as well as the Medicaid projects, using HCFAC funding in FY 2011.

The HHS portion of the wedge, $33.9 million, funded the following activities in FY 2010:

Medicaid and Children's Health Insurance Plan Financial Management Project ($13.3 million): Under this project, funding specialists, including accountants and financial analysts, work to improve CMS' financial oversight of the Medicaid and CHIP programs. These specialists activities include reviews of proposed Medicaid state plan amendments that relate to reimbursement; collaboration with States to resolve the Medicaid and CHIP portions of the "Single State" audits; and identification of sources of the non-Federal share of Medicaid program payments to ensure proper financing of Medicaid program costs.

Office of General Counsel (OGC) ($8.7 million): OGC provides legal support consistent with the statutory authority of the HCFAC program. While a considerable portion of these funds support OGC's litigation activity, both administrative and judicial, OGC continues to focus on program integrity review.

Administration on Aging ($3.3 million): The AoA will use these funds to develop and disseminate consumer education information targeted to older Americans, with a particular focus on persons with low literacy, individuals from culturally diverse backgrounds, persons living in rural areas, and other vulnerable populations. AoA and its nationwide network of agencies support community education activities designed to assist older Americans and their families to recognize and report potential error or fraudulent situations in the Medicare and Medicaid programs.

Food and Drug Administration ($1.7 million): A new pilot program designed to detect, prosecute, and prevent pharmaceutical fraud, focusing fraudulent marketing schemes. Currently, most global settlements of pharmaceutical fraud, such as the off-label marketing investigation of Eli Lilly, which resulted in a $1.4 billion settlement, begin as lawsuits through the help of whistle-blowers. FDA's pilot program would take a more proactive approach by using outreach and intelligence-gathering from sources both inside and outside of FDA.

Fraud Summit ($0.2 million): A HEAT initiative; A summit with senior administration officials at HHS and DOJ, private sector leaders (esp. insurance companies and major providers), law enforcement leaders, and other key stakeholders to have a dialogue to develop a better common understanding of the extent of fraud and abuse (measurement), share best practices, and develop a common strategic plan to reduce fraud, waste and abuse.

CMS One Program Integrity (PI) Database ($1 million): A one-time $1 million investment would allow CMS to expand access to this database, including training, to 25 additional users, bringing the total current users to 75. CMS plans to have 150 trained users by March 2010. Data access is a critical component to the Strike Forces.

Secretarial Priorities ($5.7 million): Solicited proposals that are new, prevention-focused projects.

HHS Wedge Budget Request

The FY 2011 request includes mandatory funding of $33,892,000, assuming that HHS receives the same amount as FY 2010, which is subject to negotiation 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.

FY 2011 PROGRAM INTEGRITY BUDGET PROPOSALS

Executive Order Implementation

As outlined in the Executive Order, CMS will consolidate and coordinate all program integrity activities across all programs within the agency under a single accountable official.

Description of Administrative and Legislative Proposals

CMS requests funding for seven program integrity proposals. This robust package of proposals targets fraudulent providers and strengthens program oversight. It will generate nearly $15 billion in savings over 10 years.

Administrative Proposals

Consolidate Medical Review: Consolidate medical review activities into fewer Medicare Administrative Contractors (MACs) to promote efficiency and encourage consistency in reviewing and paying for Medicare claims.

Consolidate Medicare Provider Enrollment Activities: Create a limited number of MACs to carry out provider enrollment. Each contractor would enroll providers for designated regions of the country, standardizing the process and creating efficiencies.

Expand Medicare Revocations for Abuse of Billing Privileges: Allow CMS to revoke Medicare billing privileges in response to abusive billing practices, such as instances where a provider or supplier claims to have provided a service or supply, but the beneficiary and/or physician attest that they did not receive and/or prescribe the service.

Legislative Proposals

Modify Medical Review Limitations: Modify existing statutory provisions that currently limit random medical review and place statutory limitations on the application of Medicare prepayment review. [Effective CY 2011]

Establish a CMS-Internal Revenue Service (IRS) Data Match to Identify Fraudulent Providers: Authorize CMS to work collaboratively with the IRS to determine which providers

have not filed Federal tax returns to help identify potentially fraudulent providers sooner. The data match will primarily target certain high-risk provider types in high-vulnerability areas. This proposal also ensures that both IRS and Medicare recoup any monies owed to the Federal government through this program. [Effective CY 2013]

Extrapolate Medicare Advantage Plan Sample Error Rate to Entire Plan Payment in Risk Adjustment Audits: Clarify in statute that CMS can extrapolate the error rate found in the risk adjustment validation (RADV) audits to the entire MA plan payment for a given year when recouping overpayments. Extrapolating risk scores enables CMS to recover risk adjustment overpayments. [Effective CY 2011]

Track Drug Utilizers and Prescribers to Reduce Over-utilization under Medicaid: Require States to monitor and remediate high-risk billing activity, not just claims limited to high volume, to improve Medicaid integrity and beneficiary quality of care. 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 of care where possible. [Effective FY 2011]

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
MIP 1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	FY 2009[1]: 7.8% (Target Not Met)	Develop new baseline	TBD	N/A
MIP 4: Percentage of Contractors with an error rate less than or equal to the previous year's national paid claims error rate	FY 2009: (Target Not Met)	Goal discontinued	Goal discontinued	N/A
MIP 5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program (Developmental)	Baseline 15.4%	14.3%	13.7%	N/A
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program (Developmental)	N/A	Further develop component measures of payment error for the Part D program	Further develop component measures of payment error for the Part D program	N/A
Program Level Funding ($ in millions)	**N/A**	**$780**	**$780**	**+ $0**

[1] For FY 2009, if HHS reported a national paid claims error rate for those claims reviewed under the strictest criteria, applied to the entire year, the error rate would have been 12.4 percent. Given the change in the Medicare FFS methodology, HHS will use 12.4 percent as an estimated baseline, implement corrective actions to reduce improper payments, and set targets not greater than 9.5 percent, 8.5 percent, and 8.0 percent, respectively for FY 2010 through FY 2012.

State Grants and Demonstrations

(Dollars in thousands)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + /- FY 2010
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$45,763	$46,678	$46,678	$0
Sec. 204 – Demonstration to Maintain Independence & Employment	$0	$0	$0	$0
Subtotal – TWWIIA	**$45,763**	**$46,678**	**$46,678**	**$0**
Medicare Modernization Act (MMA)				
Federal Reimbursement of Emergency Health Services for Undocumented Aliens	$0	$0	$0	$0
Subtotal – MMA	**$0**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Site Development Grants-Rural Programs of All-Inclusive Care for the Elderly (PACE)	$0	$0	$0	$0
Drug Surveys & Reports[1]	$5,000	$5,000	$0	-$5,000
Expansion of State Long-Term Care (LTC) Partnership Program	$3,000	$3,000	$0	-$3,000
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Demonstration Projects Regarding Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children	$49,000	$53,000	$57,000	+$4,000
Money Follows the Person (MFP) Demonstration	$348,900	$398,900	$448,900	+$50,000
MFP Research & Evaluations	$1,100	$1,100	$1,100	$0
Medicaid Transformation Grants	$0	$0	$0	$0
Medicaid Integrity Program	$75,000	$75,000	$75,000	$0
Subtotal – DRA	**$482,000**	**$536,000**	**$582,000**	**+$46,000**
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)				
Grants to Improve Outreach and Enrollment	$100,000	$0	$0	$0
Application of Prospective Payment System	$5,000	$0	$0	$0
Subtotal – CHIPRA	**$105,000**	**$0**	**$0**	**$0**
Appropriations/BA	**$632,763**	**$582,678**	**$628,678**	**+$46,000**

[1] This activity is temporarily suspended and will continue once the injunction is lifted.

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; Trade Act of 2002, State High Risk Pool Extension Act of 2006, Public Law 109-172; Child Health Insurance Program Reauthorization Act of 2009, Public Law 111-3

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, the medically uninsurable, the homeless, and eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight to combat fraud, waste and abuse, improving the effectiveness and efficiency in providing Medicaid, establishing or delivering programs of the all-inclusive care for the elderly services in rural areas, 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 created two new programs: an outreach grant program to increase children's enrollment and retention in Medicaid and the Children's Health Insurance Program, and transition grants for the application of the Medicaid prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

Funding History

FY 2006	$2,565,520,000
FY 2007	$698,049,000
FY 2008	$763,834,000
FY 2009	$632,763,000
FY 2010	$582,678,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration program, 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).

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants, section 203 of the TWWIIA, provide 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.

A key performance measure in the State Grants and Demonstrations Program relates to the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. The annual target for this measure is to prepare an annual report on TWWIIA.

To meet our FY 2009 target, the fourth of these annual reports was prepared, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2008. The report is available at: **http://www.cms.hhs.gov/TWWIIA/03_MIG.asp#TopOfPage**, and focuses primarily on quantitative data currently available for all States with MIG funding, using selected measures that are expected to be reported reliably and consistently over time.

In 2010, CMS will highlight continuing MIG achievements in these existing measures, and will build on this report using any additional data collected from States. CMS continues to use these reports to set conditions for future grants to the States, and believes that one of the strongest management tools it can employ is providing feedback to the grantees on their performance. This measure will be discontinued after FY 2010 due to the culmination of funding for this task as well as the end of the MIG program in 2011.

Through FY 2009, 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, 2009 there were approximately 100,000 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.

In addition, Pennsylvania will continue to carry out employment goals for the working disabled population by spending previous 2009 grant awards through a no-cost extension of funding.

Demonstration to Maintain Independence & Employment (Section 204)

The Demonstration to Maintain Independence & Employment (DMIE), section 204 of the TWWIIA, provides funding for States to establish a demonstration that provides Medicaid benefits and services to impaired workers who, without medical assistance, would potentially end up on disability. The demonstration projects seek to evaluate the potential benefit of providing these services.

Since inception of the section 204 grant program, eight States (Rhode Island, Texas, Mississippi, Louisiana, Kansas, Hawaii, Minnesota, Iowa) and the District of Columbia have been awarded DMIE funding. These demonstration grant programs provide Medicaid-equivalent services to targeted populations of working individuals with potentially disabling conditions, including individuals with mental illness, HIV/AIDS, diabetes, and other high-risk physical conditions. The demonstrations ended on September 30, 2009 and states are in the closeout phase of the project. An evaluation of the demonstration program is being completed and will be available in the spring of 2010. The table on the following page lists the grant awards by State.

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). Any remaining funding rolls over into the final FY 2011 funding appropriation. In FY 2011 section 203 of TWWIIA authorizes and appropriates $47 million for 100 percent Federally-funded Medicaid Infrastructure Grants to States.

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 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

Medicaid Infrastructure Grant Program – Sec. 203

State	*2001 -2008 Grant Awards*	*2009 Grant Awards*	*2010 Grant Awards*	*2011 Estimated Grant Awards*
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	$0	$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
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**	**$74,577,840**	**$70,100,000**

The DMIE (section 204) provided an appropriation of $42 million for each of the fiscal years 2001 to 2004, and $41 million in both FY 2005 and FY 2006 for demonstration projects for a total not to exceed $250 million. Funding was distributed to the States before the end of FY 2009, when the program expired. The Omnibus Appropriations Act of 2009 rescinded $21.5 million in section 204 of TWWIIA.

By statute, funding for the DMIE program ended on September 30, 2009. Each demonstration state has submitted a phase down plan and is working to transition individuals enrolled in the demonstration to services provided under existing state programs.

Demonstration to Maintain Independence and Employment Grants – Sec. 204

State	5 Year Award/ Commitment
Mississippi	$27,505,250
District of Columbia	$20,713,679
Texas	$22,187,602
Kansas	$21,312,114
Louisiana	$20,418,922
Minnesota	$54,246,962
Hawaii	$9,118,068
Iowa	$500,000
Support and National Evaluation Contracts	**$5,591,308**
TOTALS	**$181,593,905**

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS ("SECTION 1011")

Program Description and Accomplishments

Authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA), the Section 1011 program 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))[2] and related services. Section 1011 provided $250 million per year during each of Federal Fiscal Years (FFY) 2005 through 2008.

As of November 2009, Section 1011 provides funding to a total of 2,230 hospitals, 52,279 physicians, and 517 ambulance providers. Since inception of the program in May 2005, Section 1011 has disbursed $679 million in provider payments, in response to 980,000 claims.

Aliens for which providers may seek reimbursement include 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

[2] 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.

Service or by an Indian tribe or tribal organization (as described in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Eligible physicians include doctors of medicine, doctors of osteopathy, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, doctors of optometry, chiropractors or doctors of dental surgery. Eligible ambulance suppliers include state-licensed providers of ambulance services.

Budget Overview

Section 1011 of the MMA appropriated $250 million per year during each of FFYs 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.

SITE DEVELOPMENT GRANTS FOR 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.

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. As of September 1, 2009, no awardees have requested payment for cost outlier protection.

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 budget authority for FY 2011.

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[3] 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 AMP became subject to an injunction by the DC District Court which prevents the publication of this data. Because the States cannot obtain the AMP data necessary to evaluate and reconsider their payment levels, the retail drug surveys and reports activities have been temporarily suspended until the injunction has been lifted. There is no budget authority for FY 2011.

[3] 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 – those that have one or more therapeutically equivalent drug versions. The DRA expanded the FUL listed multiple source drugs to include those with one or more equivalents.

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 29 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	Idaho	Nebraska	Oklahoma	Tennessee
Arizona	Kansas	Nevada	Oregon	Texas
Arkansas	Kentucky	New Hampshire	Pennsylvania	Virginia
Colorado	Maryland	New Jersey	Rhode Island	Wisconsin
Florida	Minnesota	North Dakota	South Carolina	Wyoming
Georgia	Missouri	Ohio	South Dakota	

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 November 2009, 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 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 this activity beyond FY 2010.

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 adds a new subsection 1916A(e) to the Social Security Act and provides funding in the amount of $50 million in Federal grant funds to States. This funding which provides State options to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver. This provision also adds 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.

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 budget. All nine States with approved waivers have enrolled 1,068 children and youth as of December 2009. It is estimated that approximately 8,000 children and youth will be served by the end of the demonstration.

The table on the following page shows the total five year commitment, the grant awards funded in FY 2007-2009 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 $21 million in FY 2007-2009 to ten States less the rescission by Florida of $2,104,693 leaving a total award of over $35 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 provided $37 million for FY 2008 and in FY 2009 $49 million was authorized and appropriated. CMS 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 funds as supplemental grant 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. In FY 2010 the DRA provides $53 million. In FY 2011 the DRA provides for an additional $57 million.

State	5 Year Award Commitment	Grant Funded increased FMAP-based on Recovery Act	Total 5-year Award Commitment with ARRA FMAP Increase	FY 07-09 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	$4,398,238	$19,799,804
MT	$5,073,153	$121,338	$5,194,491	$2,522,085	$2,672,406
MS	$56,066,025	$1,343,796	$57,409,821	$11,560,391	$45,849,430
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	$1,189,509	$20,883,389
Totals	**$182,110,009**	**$4,243,624**	**$186,353,633**	**$32,630,839**	**$153,722,794**

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, 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 12 months for qualified home and community-based services for each person transitioned from an institution to the community during the demonstration period. Eligibility for transition is dependent upon residence in a qualified institution. The State may establish the minimum timeframe for residence between six months and two years. The State must

continue to provide community-based services after the 12-month demonstration period for as long as the person needs community services and is Medicaid eligible.

The table on the following pages shows awards that were made in FY 2007- FY2009. Supplemental awards for FY 2010 were reviewed and awarded on December 1, 2009.

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. States participating in the MFP demonstration will also be awarded an enhanced FMAP rate to transition people from the institutional setting to a home or community-based setting of their choice. The enhanced FMAP will increase the regular FMAP rate by the number of percentage points equal to 50% of the difference between their State share and 100%. The provision appropriated $250 million for FY 2007, $300 million in FY 2008 and $350 million in FY 2009. CMS has also authorized the grantees that grant funding matching the increased FMAP provided for in the Recovery Act of 2009 will be available for service claims for the allowable nine fiscal quarters and is reflected in the chart below. Of the $1.75 billion total, up to $2.4 million of the amount appropriated over the FY 2007 and FY 2008 period 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 2011 can be used to carry out evaluation and a required report to Congress.

As of December 2009, CMS committed $415,031,004 in grants to 30 States. With these funds and the increased FMAP funds, States have transitioned 4,452 individuals as of December 2009 and they propose to transition over 20,000 individuals out of institutional settings over the five-year demonstration period. As grantees continue to make progress in implementing their projects, there are additional opportunities to seek supplemental awards for program expansions. 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 (FY2010 award requests are due Jan. 31, 2019)					
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 2007-2009 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	$19,178,626
CA	$130,387,500	$3,944,569	$134,332,069	$41,595,564	$127,482,622
CT	$24,207,383	$732,338	$24,939,721	$3,502,893	$22,753,758
DE	$5,372,007	$162,518	$5,534,525	$1,647,904	$5,324,522
DC	$26,377,620	$797,993	$27,175,613	$15,452,033	$23,729,567
GA	$34,091,671	$1,031,364	$35,123,035	$14,566,538	$32,646,527
HI	$10,263,736	$310,505	$10,574,241	$3,727,968	$9,598,918
IL	$55,703,078	$1,685,166	$57,388,244	$13,586,744	$45,976,358
IN	$21,047,402	$636,740	$21,684,142	$11,895,328	$18,836,260
IA	$50,965,815	$1,541,851	$52,507,666	$14,684,199	$42,962,233
KS	$36,787,453	$1,112,918	$37,900,371	$17,686,555	$23,069,567
KY	$49,831,580	$1,507,538	$51,339,118	$14,973,118	$46,366,000
LA	$30,963,664	$936,733	$31,900,397	$3,470,863	$29,505,077
MD	$67,155,856	$2,031,643	$69,187,499	$22,308,438	$52,533,256
MI	$67,834,348	$2,052,169	$69,886,517	$7,797,406	$67,037,173
MO	$17,692,006	$535,230	$18,227,236	$10,390,132	$10,150,694
NE	$27,538,984	$833,128	$28,372,112	$6,429,087	$24,406,829
NH	$11,406,499	$345,077	$11,751,576	$4,063,775	$8,528,382
NJ	$30,300,000	$916,656	$31,216,656	$17,493,088	$24,144,876
NY	$82,636,864	$2,499,985	$85,136,849	$9,028,994	$76,107,855
NC	$16,897,391	$511,191	$17,408,582	$4,369,872	$16,506,325
ND	$8,945,209	$270,616	$9,215,825	$3,721,883	$8,235,417
OH	$100,645,125	$3,044,783	$103,689,908	$29,789,971	$93,878,207
OK	$41,805,358	$1,264,723	$43,070,081	$17,637,095	$38,112,135
OR	$114,727,864	$3,470,823	$118,198,687	$29,948,463	$110,130,610
PA	$98,196,439	$2,970,704	$101,167,143	$21,339,337	$97,261,028
SC	$5,768,496	$174,512	$5,943,008	$976,997	$4,966,011
TX	$142,700,353	$4,317,065	$147,017,418	$33,315,183	$139,466,071
VA	$28,626,136	$866,017	$29,492,153	$7,268,542	$27,926,528
WA	$19,626,869	$593,765	$20,220,634	$8,978,316	$18,313,134
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	$415,031,004	$1,305,805,428

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. Table A and Table B on the following pages lists all of the Medicaid Transformation Grants awarded in the two rounds of applications.

There is no new budget authority for FY 2011.

Table A: FY 2007 Medicaid Transformation Grants, Round 1

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Alabama	Together for Quality - Health Information Systems (HIE/EHR)	$7,587,000	Health Information Technology
Arizona*	Medicaid Health Information Exchange and Utility Project	$11,749,500	Health Information Technology
Arkansas	Electronic Verification of Proof of Citizenship	$285,513	Fraud, Waste & Abuse
Connecticut	Health Information Exchange and e-Prescribing	$5,000,000	Quality & Health Outcomes

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
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
New Mexico	e-Prescribing	$855,220	e-Prescribing

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
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

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, section 6034 of the DRA of 2005 (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 2008 ROI, which was calculated with a partial year of data, was 300 percent. To calculate the FY 2008 ROI, the numerator was the annual total Federal dollars of identified overpayments by Medicaid Integrity Program activities (e.g., Medicaid Integrity Contractors). The denominator was the annual Federal funding of the Medicaid Integrity Contractors (MICs).

The FY 2009 ROI was 175 percent, exceeding the target for annual ROI to be greater than 100 percent. For FY 2009, a new formula was applied. The numerator included overpayments identified in FY 2009 and the denominator included the annual federal funding for MIP for FY 2009. 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 activities of our MICs. In addition to the work of the MICs, CMS data analysis activities have identified systemic errors in State payment systems, which have resulted in the identification and recovery of significant overpayment amounts, without requiring audits by the MICs. Additionally, we believe that other activities conducted by MIG staff (e.g., State program integrity reviews) have the potential to identify overpayments without necessarily needing to conduct audits. Therefore, we believe the revised methodology more accurately captures the full spectrum of MIG overpayment identification activities. The FY 2010 target is for FY ROI to be greater than 100 percent and the FY 2011 target is for the ROI to be greater than 200 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 2009, CMS hired 95 full-time employees and plans to hire the remaining employees in FY 2010, 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 statute appropriated $5 million in FY 2006, $50 million in FYs 2007 and 2008 respectively, and $75 million in FY 2009 and each year thereafter. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

In February 2009, section 201 of the Children's Health Insurance Program Reauthorization Act was signed providing funds for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. 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 that will distribute the $40 million in Federal funds across 42 States and the District of Columbia.

National Enrollment Campaign

The statute also provides funds to develop and implement a national enrollment campaign to improve the enrollment of underserved child populations.

To date, the campaign has 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 from November 4 – 6, 2009 in Chicago, IL. The summit had over 500 people in attendance and served as the kick-off for a national outreach and enrollment campaign. This event provided an opportunity for 69 organizations that were recent recipients of a total of $40 million in grant funds to receive information and training about successful enrollment strategies that have been developed and refined over the 12-year history of the CHIP program. The summit supported local grantees through hands on training, breakout sessions with subject matter experts, and promoted the outreach toolkit available on www.insurekidsnow.gov The toolkit included materials in English, Spanish, Chinese, Korean, and Vietnamese as well as materials targeting the Native American population.

Future campaign activities may include:

1.The establishment of partnerships with other Federal agencies, as appropriate, to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each agency administers that often serve the same children;

2. The integration of information about the programs in public health awareness campaigns administered by the Secretary;

3. Increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

4. The establishment of joint public awareness outreach initiatives with other Federal agencies, as appropriate, regarding the importance of health insurance to building strong communities and the economy;

5. The development of additional outreach materials for Native Americans or for individuals with limited English proficiency;

6. The establishment of technical assistance and communication with States.

7. The sustainment of enthusiasm for Children's Health Insurance by regularly following up with conference attendees via email updates, webinars, and other communications on topics of interest;

8. The use of paid and earned media to support outreach efforts;

9. Education about best practices in enrollment and retention efforts; and.

10. Such other outreach initiatives as the Secretary determines would increase public awareness of the outreach and enrollment programs.

Outreach to Indian Children

There is also provided within this statute $10 million appropriated to be used 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 are due by January 15, 2010. Grants will be awarded April 15, 2010.

There is no requirement for State matching funds in order to receive payments for outreach and enrollment grants.

Budget Overview

The statute appropriated a total of $100 million for fiscal years 2009 through 2013. Of the appropriated amount $80 million is to be used for outreach and enrollment grants to children who are eligible for Medicaid or CHIP but not enrolled; $10 million is to be used for a National Enrollment Campaign; and $10 million is to be used for outreach to Indian Children. Of the total, $60 million was granted in FY 2009 - $40 million for the outreach

grants and the full $10 million for the national enrollment campaign and Indian outreach. The remaining $40 million in grant funds will be awarded following a second solicitation in FY 2011.

APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Program Description and Accomplishments

In February 2009, section 503 of the Children's Health Insurance Program Reauthorization Act was signed establishing transition grants to States with State child health plans under CHIP that are operated separately or in combination with other CHIP programs to apply the prospective payment system (PPS) to services provided by Federally-qualified health centers (FQHC) and rural health clinics (RHC).

The CHIPRA transition grants will provide funding to States that operate a separate or combination Children's Health Insurance Program (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. The funding is to remain available until expended.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2009
SGD1: Prepare an annual report by December 31 for the preceding calendar year on the status of grantees in terms of States' outcomes in providing employment supports for people with disabilities.	FY 2009: Annual Report on CY 2008 produced. (Target Met)	Annual Report on 2009	Goal discontinued	N/A
SGD2: Medicaid Integrity Program, Percentage Return on Investment	FY 2009: 175% (Target Exceeded)	ROI>100%	ROI>200%	+100%
Program Level Funding ($ in millions)	**NA**	**$75**	**$75**	**$0**

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Clinical Laboratory Improvement Amendments of 1988

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 Estimate
BA	$43,000,000	$43,000,000	$43,000,000
FTEs	68	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 19,336 laboratories during the FY 2009-2010 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, 210,367 laboratories are registered with the CLIA program. Approximately 172,941 or 82.2 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 109,093, or 51.9 percent, of the laboratories registered under the CLIA program. Approximately 90,064 or 82.6 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 2009-2010 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 2011 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 2-year cycle. Workloads projected for the FY 2010-2011 cycle include surveys of 19,836 non-accredited laboratories, State validation surveys of 815 accredited laboratories, and approximately 1,609 follow-up surveys and complaint investigations.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
CLIA1: Percent of pathologists receiving an initial passing score of 90% or greater in gynecologic cytology proficiency testing	FY 2008: 96.6% (Target Met)	94.5%	95%	.5
Program Level Funding ($ in millions)	**N/A**	**$43**	**$43**	**0**

Quality Improvement Organizations

(dollars in thousands)

	FY 2009	FY 2010 Estimate	FY 2011 Request
BA	$535,400	$170,400	TBD

Authorizing Legislation - Sections 1862(g) and 1151-1161 of Social Security Act of 1965, as amended

Allocation Method – Contracts

Program Description

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.

The Quality Improvement Organizations (QIOs) operate under three-year contracts. Each contract's Statement of Work (SOW) varies depending on the needs of the Medicare program and beneficiaries. CMS is currently overseeing the 9th SOW of the QIO program. 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. During the 9th SOW, CMS estimates that QIOs will review 211,000 cases.

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 the following: 23,610 fewer restraints, 43,303 fewer patients with pressure ulcers in nursing homes and hospitals, 7,875 fewer MRSA infections, and 14,252 fewer postoperative deaths due to surgical site infection, venous thromboembolic events, or perioperative myocardial infarction.

Budget Overview

The 10th Statement of Work will begin on August 1, 2011. The funding for the contracts is obligated at different times during the three-year SOW.

The 9th SOW began August 1, 2008, supported by $1,099.4 million, and will end July 31, 2011. The FY 2009 total of $535.4 million includes $1.0 million for areas affected by hurricanes Rita and Katrina.

Each SOW is three years in duration and varies to meet current program challenges to protect beneficiaries and protect the Trust Funds. Because the length of the contract funding levels vary by year depending on contractor/programmatic needs, QIO funding is authorized out of the Medicare Trust Funds through a permanent indefinite appropriation provided under Section 1159 of the Social Security Act.

To aid in the oversight of the QIO program, CMS developed a Management Information System (MIS) to capture QIO performance information which will enhance our oversight capability. CMS management of the 9th SOW QIO program will rely on the new MIS to focus on results and oversight of the program, beginning with increasing the level of competition within the program for sub national projects. Active monitoring and reporting of QIO activities are accomplished by holding QIOs to specific predefined performance targets; continued work/funding for each quality improvement effort (Patient Safety, Care Transitions, and Prevention) is predicated on meeting 18-month performance targets. CMS will analyze information from the MIS to determine if QIOs have met their targets. QIOs that meet their 18-month targets are measured again at 28 months. In addition, towards the end of the 9th SOW, CMS will evaluate the QIO program to evaluate its effectiveness and efficiency.

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, including those related to the 9th SOW.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
QIO 1.1: Increase influenza immunization (nursing home subpopulation)	FY 2008: 81.7% (Target Exceeded)	81.8%	82%	+0.2
QIO 1.2: Increase national pneumococcal Immunization (Discontinued after FY 2008)	FY 2008: 72.4% (Target Exceeded)	N/A	N/A	N/A
QIO 3.1: Increase hemoglobin A1c testing rate	FY 2008: 86.5% (Target Exceeded)	87%	87.5%	+0.5
QIO 3.2: Increase cholesterol(LDL) testing rate	FY 2008: 81.1% (Target Exceeded)	82%	82.5%	+0.5
QIO4: Increase percentage of timely antibiotic administration	FY 2008: 91.6% (Target Exceeded)	92%	92.5%	+0.5
QIO6.1: Methodology for aggregating QIO performance with clinical outcome measures at the theme level	FY 2009: Methodology developed. (Target Met)	N/A	N/A	N/A
QIO6.2: Management Information System (MIS)	FY 2009: MIS implemented (Target Met)	N/A	N/A	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
QIO6.3: Care Transitions, Patient Safety, and Prevention themes *****Performance metrics become progressively more difficult as the contract matures, thus percentage of expected success may decrease in outyears**.**	FY 2009: Baselines and targets established. (Target Met) 12 month Baselines/Progress to date:***** **Prevention** Prevention Core - 98% meeting expectations; Prevention Chronic Kidney Disease - 100% meeting expectations; Prevention Disparities - 100% meeting expectations.	**Prevention** At least 85% of QIOs will meet expectations for the theme components at the 18th month evaluation	**Prevention** At least 85% of QIOS will meet expectations for the components of the prevention theme at the 28th month evaluation	N/A
	Patient Safety 100% of QIOs meeting expectations for all components of Patient Safety theme.	**Patient Safety** At least 85% of QIOs will meet expectation for the theme components at the 18th month evaluation	**Patient Safety** At least 85% of the QIOs will meet expectations for the theme components at the 28th month evaluation	N/A
	Care Transitions - 100% QIOs currently meeting expectations	**Care Transitions** - At least 80% of the QIOs will meet expectations of the theme at the 18th month evaluation	**Care Transitions** - At least 80% of the QIOs will meet expectations of the theme at the 28th month evaluation	N/A
QIO6.4: Beneficiary Protection theme	New in FY 2010	Establish baseline and FY 2011 targets	Beneficiary Protection Theme - Perform and respond to 28th month QIO contract evaluation	N/A
Program Level Funding ($ in millions)		**$170.4**	**TBD**	**TBD**

American Recovery and Reinvestment Act (Recovery Act)

	FY 2010 Estimate	FY 2011 Estimate	FY 2011 +/- FY 2010
Program Management:			
Health IT Implementation	$140,000,000	$140,000,000	$0
Medicare HIT incentives	$0	$2,410,000,000	+$2,410,000,000
HAI Surveys	$9,000,000	$0	-$9,000,000
Comparative Effectiveness Research	$55,000,000	$0	-$55,000,000
Total Program Management	**$204,000,000**	**$2,550,000,000**	**$2,346,000,000**
Medicaid Provisions (includes Medicaid HIT incentives)	$44,248,500,000	$12,897,500,000	-$31,351,000,000
CMS Total, ARRA	**$44,452,500,000**	**$15,447,500,000**	**-$29,005,000,000**

*Table reflects budget authority

Authorizing Legislation – The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. 111-5.

Allocation Method - Formula Grants, Contracts

The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act"), enacted on February 17, 2009, promotes economic recovery, assists those impacted by the recession, provides investments for technological advances, invests in infrastructure and stabilizes State and local government budgets. Among other things, the Recovery Act provides for measures that stimulate the economy and preserve and improve access to affordable health care.

The Recovery Act directly impacts CMS and its mission. The Recovery Act provides CMS with $140 million in FY 2010 and FY 2011 to implement Medicare and Medicaid incentives to encourage the adoption and meaningful use of certified electronic health records (EHRs). These incentive payments begin in FY 2011. Under Medicare, initial incentive payments for each qualified physician for meaningful use of certified EHRs would be a maximum of $18,000, decreasing to zero by 2015. For hospitals, incentive payments will vary based on patient days, hospital discharges, and charity care. Medicare providers who are not meaningful users of certified EHRs will receive reduced payments. Medicaid Health IT incentives provide enhanced Federal financial participation (FFP) of 100 percent for incentive payments to providers for the adoption and meaningful use of EHRs, and 90 percent FFP for associated State and local administrative expenses. CMS will explore the development of an appropriate EHR performance measure in the future.

CMS also received a total of $10 million, including $1 million in FY 2009 and $9 million in FY 2010, through an intra-agency agreement with the Department for increased surveys of ambulatory surgical centers to help reduce healthcare-acquired infections.

The Recovery Act enacted a number of changes to Medicaid, including:

- Federal Medical Assistance Percentage (FMAP): The Recovery Act provides a temporary increase in the FMAP rate from October 1, 2008 through December 31, 2010. This provision increases the FMAP in three ways. First, States are held harmless for any decreases from their base FY 2008 FMAP rate through the first quarter of FY 2011. Second, the Recovery Act provides a general 6.2 percentage point increase in the rates for all States. Third, the Recovery Act provides an additional increase for States facing high growth in unemployment, revised quarterly to reflect new State unemployment data. Commonwealths and Territories elected the option of a 30 percent increase in their Medicaid caps over a 6.2 percentage point increase in the FMAP rates combined with a 15 percent increase in the Medicaid cap.

- Disproportionate Share Hospital (DSH) Payments: The Recovery Act provides a temporary 2.5-percent increase in the DSH allotments to States for both FY 2009 and FY 2010.

- Extension of the Transitional Medical Assistance (TMA) Program: The TMA was created to provide health coverage to families transitioning to the workforce. It 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. The Recovery Act extends the TMA from July 1, 2009 through December 31, 2010.

- Extension of the Qualified Individual (QI) Program: The QI program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of the Federal poverty level. QIs are also deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. The Recovery Act extends the QI program through the first quarter of FY 2011.

- Protections for American Indians/Alaskan Natives (AI/AN): The Recovery Act increases protections for 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. It also exempts certain properties from being counted as an asset when determining Medicaid and CHIP eligibility or estate recovery. This provision also requires States to consult on an ongoing basis with Indian Health Programs to maintain access to care.

The chart below identifies The Recovery Act's impact on the Federal share of Medicaid in FYs 2010 - 2011:

Recovery Act's Impact on the Federal Share of Medicaid

Dollars in thousands

Medicaid Activity	FY 2010 Estimate	FY 2011 Estimate	FY 2011 +/- FY 2010
Temporary FMAP Increase	$38,100,000	$14,900,000	($23,200,000)
FPL Adjustment (ARRA impact)	$1,700	$0	($1,700)
Temporary DSH Allotment increase	$520,000	$0	($520,000)
IBNR	$180,000	$180,000	$0
HIT St & Local Admin [1/]	$151,740	$2,110,560	$1,958,820
HIT efficiency savings	$0	($3,000)	($3,000)
TMA Program Extension	$480,000	$395,000	($85,000)
QI Program Extension [2/]	$412,500	$150,000	($262,500)
AI/AN Protections	$10,000	$10,000	$0
Interaction of FMAP Increase with Other Medicaid Provisions	$90,000	$20,000	($70,000)
Gross Obligations, Recovery Act	**$39,945,940**	**$17,762,560**	**($22,183,380)**
Unobligated Balance Start of Year	$0	($4,715,060)	
Unobligated Balance End of Year	$4,715,060	$0	
Gross Budget Authority	**$44,661,000**	**$13,047,500**	
Offsetting Collections Medicare Part B	($412,500)	($150,000)	
Net Budget Authority	**$44,248,500**	**$12,897,500**	

[1/] Includes Medicaid incentives
[2/] Chart reflects net budget authority (BA) and excludes offsetting collections for the QI Program (from Medicare program).

In FY 2010, CMS received $55 million dollars for Comparative Effectiveness Research (CER) from the Agency for Healthcare Research and Quality through an intra-departmental delegation of authority to do the following:

- Enhance the availability and use of Medicare data to support comparative effectiveness research. ($35.4 million)

- Build a Medicaid Analytic eXtract (MAX) data repository designed to support CER for Medicaid and CHIP populations. ($19.7 million)

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Centers for Medicare & Medicaid Services

Office of National Drug Control Policy (ONDCP) Budget

Resource Summary

	Budget Authority ($ in Millions)			
	FY 2009 Appropriation	FY 2010 Estimate	FY 2011 Request	FY 2010+/- FY 2011
Drug Resources by Function:				
Treatment	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources by Decision Unit:				
Centers for Medicare & Medicaid Services	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources Personnel Summary				
Total FTEs (direct only)	0	0	0	0

Mission

The Centers for Medicare & Medicaid Services' (CMS) mission is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.

Through its coverage of drug treatment services in the Medicaid program, CMS helps support the goals if the Office of National Drug Control Policy (ONDCP) by continuing to meet the challenges of providing drug abuse treatment care to eligible Medicaid patients.

Background

Medicaid is means-tested health care entitlement program financed by States and the Federal government. States have considerable flexibility in structuring their Medicaid programs.

At the request of ONDCP, CMS introduced two new Healthcare Common Procedure Coding System (HCPCS) codes on January 1, 2007 that facilitate Medicaid payment for screening and brief intervention services. This supports national public health initiatives, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative, targeting those with nondependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. These codes are available for health care providers and States to use, though there is no requirement to do so.

The first code, H0049, is for alcohol and/or drug screening, a preventative service. It is generally accomplished using a brief questionnaire concerning a patient's alcohol or drug use and can be carried out in various settings, e.g., a physician's office or a hospital emergency room.

The second code, H0050, covers a brief intervention that generally occurs right after the screening. It is a 15- to 30-minute brief counseling session with a health professional intended to help motivate the beneficiary to develop a plan to moderate their alcohol or drug use.

Budget Summary

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2011 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.

The HCPCS codes discussed above when implemented by States, could improve the adoption of these services across patient status and diagnosis. It is intended that over time these approaches can be refined and improved to be more effective.

Some States began to implement the use of the new HCPCS codes during FY 2008. The amount of spending that would be captured by the use of these codes is dependent on the number and relative size of States which opt to use them. States implementing these SBI reporting codes are responsible for determining their own reimbursement cost schedule.

Medicaid is a State-run program. CMS has no legal authority to mandate that States use these or any other codes. Thus, the use of these HCPS codes by States is voluntary. According to estimates provided by the CMS Office of the Actuary, it is estimated that Federal Medicaid program outlays for these 2 HCPCS codes are $430 million in FY 2010 and $400 million in FY 2011. These actuarial cost estimates assume:

- 17 participating States
- 10 percent effective participation rate;
- An average cost of $21.00 per each screening of a beneficiary;
- An average cost of $61.50 per each brief intervention; and
- 15 percent probability that a given screening will lead to an intervention.

Performance Summary

To represent the purview of the Medicaid program and its potential recipients of drug and alcohol-related services, CMS will report the annual enrollment of the total number of Medicaid beneficiaries. Medicaid enrollment levels depend on a variety of factors outside of CMS' control, including State eligibility definitions and national and state economic factors. As such, while CMS can report enrollment levels in the Medicaid program, it is inappropriate to set performance targets for enrollment.

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CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

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Information Technology

Funds Source	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 Request Level
Medicare Operations 1/	$765,648,000	$786,626,000	$860,974,000
Federal Administration	24,240,000	29,240,000	29,353,000
Survey & Certification	3,540,000	3,245,000	5,345,000
Research	5,700,000	5,700,000	5,700,000
Health Care Data Improvement Initiative (HCDII)	-	-	110,000,000
Subtotal, Program			
Management Appropriation	**$799,128,000**	**$824,811,000**	**$1,011,372,000**
Coordination of Benefits (COB) User Fee	26,500,000	26,250,073	27,835,073
CLIA User Fees	2,040,000	2,040,000	$2,965,000
Health Care Fraud & Abuse Account Medicare Integrity Program (HCFAC/MIP) 2/	47,161,199	45,631,165	111,881,198
Quality Improvement Organizations (QIOs) 2/	88,200,000	93,164,285	116,048,824
ESRD Network	-	4,000,000	4,000,000
Medicaid Integrity Program	6,224,750	8,100,000	8,100,000
MIP Discretionary 3/	52,139,940	57,990,817	-
Total, CMS IT Portfolio	$1,021,393,889	$1,061,987,340	$1,282,202,095

1/ Starting in FY 2009, all enterprise data center (EDC) costs are included in Medicare Operations IT. Prior to the development of the enterprise data centers (EDCs), data center costs were included in the bills/claims payment line in Medicare Operations non-IT. This accounts for $92.1 million in FY 2009, $114.7 million in FY 2010 and $81.1 million of the FY 2011 request.
2/ The HCFAC and the QIO program are funded with mandatory dollars and operate on separate budget cycles from CMS' discretionary Program Management appropriation. The estimates shown are subject to change.
3/ Starting in FY 2011 CMS is proposing that MIP discretionary funding be redistributed to the HCFAC mandatory account.

Program Description and Accomplishments

As shown in the table above, funding for CMS' information technology (IT) investments is 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 throughout various 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 HHS's Exhibit 53 and CMS's 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.

Medicare Operations

The majority of the Agency's IT activities are in the Medicare Operations line.

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 efforts to move data center workload to the Enterprise Data Centers (EDCs), providing a standardized infrastructure and network platform. This effort is an integral part of the contracting reform strategy.

- *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. Each year that Medicare continues to use the current ICD-9 code set, the more likely it becomes that claims could be paid inaccurately, increasing costs and placing the Medicare trust funds at

risk. The ICD-9 code set does not provide detailed information concerning a patient's diagnosis, the procedure or test that a provider orders. This makes detailed medical review necessary to detect if a claim was improperly paid. The ICD-10 code set is much more specific, making it easier to detect if a claim was appropriately billed. Although ICD-10 will not eliminate all fraud, waste, and abuse, CMS believes its increased specificity will make it more difficult for fraud, waste, and abuse to occur.

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 space required for the ICD-10 code sets.

- *Authentication - Individuals Authorized Access to the CMS Computer Services (IACS)* - additional hardware and software support 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 on 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 also CMS' only 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 the HHS Unified Financial Management System (UFMS).

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. In addition, the FY 2011 request supports the continued implementation of the Quality Indicator Survey (QIS), a new initiative that will utilize information technology to support quality in the survey process.

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 (which is being proposed to be redistributed to the HCFAC mandatory funding account), CLIA User fees, ESRD network, and Medicaid Integrity Program. MIP discretionary funds supported Part C & Part D systems, while the other sources of IT continue to provide IT support for program objectives. .

Budget Request

CMS Program Management Appropriation – The FY 2011 request for Program Management Information Technology is $1,011 million, a $186.5 million dollar increase over the FY 2010 appropriation. This increase is mainly due to the FY 2011 request for $110 million for the Health Care Data Improvement Initiative (HCDII). This initiative will support additional data loads, additional systems users, additional ad hoc capabilities, the termination of legacy applications, and an overall increase in efficiency. More information can be found in the Health Care Data Improvement Initiative section of this budget request.

The FY 2011 request also includes increases for for the MyMedicare.gov website. CMS will enhance the online capabilities of MyMedicare.gov to become an integrated online tool where beneficiaries can research and organize their claims, understand their Medicare benefits, and manage their health. The current MyMedicare.gov site provides beneficiaries with primarily enrollment and payment-related information. In order to provide similar services to those offered by current health care insurance organizations, MyMedicare.gov needs to expand its services to include health management capabilities as well as more seamless integration with the various quality and directory tools available currently on Medicare.gov.

The FY 2011 request also includes IT funding increases for ICD-10/5010, MIPPA, Part C/D upgrades and web hostings. More information on these activities can be found in the Medicare Operations section of this budget request.

The Federal Administration request is a small increase of $113,000 from the FY 2010 request due to an increase in the service and supply fund.

The FY 2011 request is $2.1 million over the FY 2010 appropriation for the Survey and Certification budget. This will fund the Quality Indicator Survey (QIS), new security protocols and emergency preparedness.

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 2011 estimates for mandatory accounts will be refined as CMS proceeds through the FY 2011 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 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **CMS** will use **$5,432,960** of its **FY 2011** 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, **$900,572.12** is allocated to developmental government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$9,071.25
Line of Business - Grants Management	$1,437.71
Line of Business - Financial	$18,063.16
Line of Business - Budget Formulation and Execution	$12,000.00
Disaster Assistance Improvement Plan	$325,000.00
Federal Health Architecture	$535,000.00
FY 2011 Developmental E-Gov Initiatives Total	**$900,572.12**

* 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 Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

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

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, **$434,743.24** is allocated to ongoing government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
E-Rule Making	$289,796.42
Grants.Gov	$45,063.76
Integrated Acquisition Environment	$79,159.76
GovBenefits	$20,723.28
FY 2011 Ongoing E-Gov Initiatives Total	**$434,743.24**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

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

Significant Items of Interest to Congress
FY 2010 Senate Appropriations Committee Report Language
(Senate Report 111-66)

Item

Methadone Treatment – The Committee notes that methadone is a highly addictive psychostimulant that is used to treat patients with substance abuse problems, including opiate addiction. In a number of States, methadone treatment is funded by Federal dollars under the Medicaid program. The Committee requests that CMS provide a report to the Committee detailing the total Federal Medicaid dollars spent in each State to fund methadone treatment. Such report should include a list of services and prescription drugs related to methadone treatment funded by Medicaid dollars in each State. (p. 135)

Action Taken or To Be Taken

Trying to quantify the dollar amount spent on Methadone will be a challenge since it may not always be identified in a State Plan or claimed as a separate line item. For example, under the Rehab benefit, Methadone may be included as a component of an intensive Substance Abuse Treatment Program that is billed as one all inclusive unit of service. It would also be possible for methadone treatment to be covered under managed care and the payment (for drugs) would be included in the capitation rate, and we would not be able to distinguish it. The information could be determined by conducting a direct survey of the States to ask how much federal dollars are spent to fund methadone treatment, based on a specific time frame (i.e., one Fiscal Year).

Another option would require direct survey of the States to identify how Methadone Treatment could be identified in State's submissions to CMS. The data could be identified within MSIS either by a combination of identifying the providers, procedure codes, possible diagnoses, type of claim and/or MSIS claim type and then attempting to identify the money within the Medicaid Statistical Information system (MSIS) files. It may still be difficult to identify expenditures for the drug versus treatment.

We cannot use the expenditures for the drug as the drug is used for pain treatments and any expenditure should be only for pain treatment. Methadone for opiate treatment can only be provided by approved Methadone providers.

Item

Medicare Demonstration Projects – The Committee notes the significant health care quality improvements and cost savings made possible by Medicare Demonstration Projects. In order to determine how demonstrations for beneficiaries with high cost conditions can be effective on a larger scale, the Committee suggests that funds for Research, Development and Evaluations be used for programs that have proven successful by meeting quality and savings targets. (p. 136)

Action Taken or To Be Taken

CMS has used research funds to extend demonstrations for beneficiaries with high-cost conditions in two demonstrations for five sites whose results looked promising. The Medicare Coordinated Care Demonstration was extended for two sites to determine whether their results were sustainable and could be achieved on a budget-neutral basis. Three sites participating in the Care Management Demonstration for High Cost Beneficiaries had sufficiently promising results that they were extended in the original geographic areas where the demonstration was conducted and they have been allowed to expand into additional areas to determine whether their models were replicable to other populations and settings.

Item

National Clearinghouse for Long-Term Care Information –The Committee continues to be concerned that many seniors do not have a good understanding of the benefits covered, and not covered, under the Medicare program. In particular, studies have indicated that a majority of adults who are 45 or older overestimate Medicare coverage for long-term care. The Committee commends CMS for its efforts in establishing the National Clearinghouse for Long-Term Care information. (p. 137)

Action Taken or To Be Taken

CMS recognizes that many Americans do not have an adequate understanding of the costs of long-term care or have misperceptions regarding the role of Medicare and long-term care. As part of a public awareness and education campaign, CMS implemented section 6021(d) of the Deficit Reduction Act (DRA) of 2005 in establishing and sustaining the National Clearinghouse for Long-Term Care Information.

There are two components to the National Clearinghouse for Long-Term Care Information: (1) the "Own Your Future" Long-Term Care Awareness Campaign and (2) 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 outreach and education effort designed to promote long-term care planning. As of November 2009, 21 states and the District of Columbia have participated in the Campaign. 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 State Governors' Offices in which a letter discussing the importance of long-term care 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 Long-Term Care. The Planning Kit is available at no cost to the consumer.

  2) State-specific information about local planning resources and information on long-term care services. The material, which is developed and designed by the State, is incorporated into the Planning Kit for Long-Term Care. HHS covers the cost of producing and collating these materials.

  3) Governor's press conference to launch the campaign. The press conference is generally held concurrent 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 television and radio public service announcements that CMS produced.

- Website: The National Clearinghouse for Long-Term Care Information website, www.longtermcare.gov, 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, long-term care services and supports.

CMS is also using other efficient communication methods to clarify widely held misperceptions about Medicare and long-term care. Some examples are as follows:

- CMS revised the language on the National Clearinghouse for Long-Term Care Information website to make clear Medicare's limited coverage of long-term care supports and services.

- CMS worked with the Administration on Aging and the HHS Office of the Assistant Secretary for Planning and Evaluation to update the National Long-Term Care Training Manual that was developed in 2004. The manual is designed to serve as a reference for train-the-trainer at the State Health Insurance Assistance Programs (SHIPs) and the Aging and Disability Resource Centers (ADRCs) among other partners. Like the change made to the National Clearinghouse website, CMS added clarifying language about Medicare's limited coverage of long-term care in order to clarify any potential misperceptions.

- CMS plans to include language in the *2011 Medicare & You* Handbook on Medicare's limited coverage of long-term care services.

- CMS plans to share information regarding Medicare's limited coverage for long-term care through an e-newsletter as part of the Caregiver Campaign.

- CMS plans to conduct a baseline survey of individuals across a broad age range to learn about demographics, attitudes, planning actions taken, literacy levels, etc. around long-term care planning. The survey asks questions regarding consumers' knowledge of long-term care and public financing, including financing of long-term care services by the Medicare program.

- Lastly, CMS plans to include language in train-the-trainer materials for partners and others who share information with people with Medicare. The materials will discuss Medicare's limited coverage of long-term care and the "Own Your Future" initiative described above.

Item

Advance Directives and Living Wills in Medicare Handbook –The Committee directs CMS to include in the next publication of "Medicare & You" information regarding the importance of writing and updating advance directives and living wills. (p. 137)

Action Taken or To Be Taken

The 2010 *Medicare & You* Handbook, which was mailed to beneficiary households in October 2009, includes a new section on planning for end-of-life care, which builds on advanced directive information in prior handbooks. The section encourages people with Medicare to work with a family member, friend, or health care provider to make important decisions that could affect health issues in the future. Specifically, it includes information on advance directives including living wills, durable powers of attorney, and after-death wishes. The handbook refers people to their health care provider, attorney, local Office on Aging, and State health department for additional information.

Item

HIV Testing Guidelines – The Committee applauds CMS for its leadership in clearly outlining the Medicaid and Children's Health Insurance Program policies regarding routine HIV testing and HIV screening in its June 2009 letter to State health officials. The policies are consistent with HIV testing guidelines issued in 2006 by the Centers for Disease Control and Prevention. (p. 137)

Action Taken or To Be Taken

CMS continues to encourage States to adopt these guidelines and will continue to provide technical assistance as required to facilitate implementation of the CDC testing guidelines.

Item

Outcome Measures for Clinical Trials **–** The Committee commends CMS for Collaborating with AHRQ to develop a transparent process to build consensus within the research community to support which appropriate outcomes measures or standards should be used in clinical trials to support research of rehabilitative treatments. The Committee believes that once these outcomes have been identified and good research, such as randomized controlled trials, are underway, patients can be admitted to proper rehabilitation settings without the concern of reimbursement issues. (p. 137)

Action Taken or To Be Taken

We agree that outcome measures/standards should be used in clinical trials and CMS continues to work with AHRQ to ensure that CMS supports good clinical trials. The May 2008 Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), "Desirable Characteristics of Clinical Trials on Rehabilitative Strategies for Stroke" is an example this.

Item

Medication Therapy Management Program – The Committee urges CMS to conduct a demonstration project to identify effective Medication Therapy Management Program models for low-income Medicare Part D enrollees living with HIV/AIDS. The demonstration project should emphasize evidence-based prescribing, prospective medication management, technological innovation and outcome reporting. (p. 137-138)

Action Taken or To Be Taken

We do not believe a demonstration to identify effective medication therapy management (MTM) models should be narrowly focused. By statute, MTM was not intended to be disease-specific. The MTM programs are required to target beneficiaries with multiple chronic diseases and those taking multiple Part D drugs. Medicare beneficiaries with HIV/AIDS and high prescription drug costs who are also low-income are likely to be enrolled in many different Part D plans with many different benefit structures. Furthermore, we would note that a very small proportion of Part D enrolled beneficiaries have HIV/AIDs. It would be very inefficient for CMS to identify these individuals and attempt to provide their MTM services under a demonstration because the MTM provider(s) would have to coordinate with many different Part D plans, their coverage policies for HIV/AIDS and other drugs, and the Pharmacy Benefits Managers who implement the Part D benefit. Moreover, unless the plans were required to adopt the recommendations of the MTM provider, the plans would not necessarily modify their policies to be consistent with good MTM practices. Finally, Medicare Part D plans are already required by law to conduct medication therapy management programs for their enrollees with high prescription drug costs and multiple chronic conditions, though we would note that Part D sponsors are encouraged to consider targeting additional diseases to meet the needs of their unique patient populations and improve

therapeutic outcomes. (To date, a number of MTM programs have established criteria for multiple chronic diseases that include HIV/AIDS as a targeted condition.) More importantly, to the extent that Part D MTM programs already include beneficiaries with HIV/AIDS, CMS would essentially be paying twice for MTM services for the targeted population.

We would note that Medication Therapy Management (MTM) Programs in 2010 will be significantly enhanced from previous years. Expanded requirements were put into place for the upcoming contract year that will increase the number of beneficiaries eligible for MTM services, increase the intensity of interventions, and provide for the collection of more outcomes information. Though HIV/AIDS is not one of the 7 targeted core diseases, Part D sponsors may target any chronic diseases in addition to the specified core diseases, and we would note that all Part D MTM programs must target at least 4 of the 7 core diseases. Once these common and best practices are implemented, it is expected that Part D MTMP will evolve significantly to help achieve the statutory goal of improving therapeutic outcomes.

Item

Long-term Care Acute Hospitals – The Committee has repeatedly requested that CMS develop objective admissibility criteria for long-term acute care hospitals [LTACHs]. In 2007 Congress passed legislation requiring HHS to make recommendations for such criteria by June 2009 and placed a moratorium on certain regulations relating to LTACHs until 2010. With no admissibility criteria forthcoming, legislation has been introduced to extend the moratoria for another 2 years. The Committee urges CMS to adopt workable admissibility criteria as soon as possible. The Committee reaffirms its belief that long-term acute care hospitals are an important part of the Medicare continuum of care. (p. 138)

Action Taken or To Be Taken

Section 114(b) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the Secretary to conduct a study on the establishment of national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at and discharge from long-term care hospitals. Also, not later than 18 months after enactment, the Secretary must submit to Congress a report on the study together with any recommendations for legislation and administrative actions. CMS has awarded a contract for this study and the report to Congress is in preparation. It is expected to be released early in 2010.

In the interim, CMS has done extensive background research with respect to patient criteria. CMS awarded a contract to Research Triangle Institute International (RTI) at the start of FY 2005 for a comprehensive evaluation of the feasibility of developing patient and facility level characteristics for LTCHs that could distinguish LTCH patients from those treated in other hospitals. RTI's research has resulted in an extensive and careful analysis of the Medicare populations served by LTCHs, a comparison of these populations with those treated in other acute settings, including inpatient hospital services paid under the Inpatient Prospective Payment System (IPPS), Inpatient Rehabilitation Facilities (IRFs), and Inpatient Psychiatric populations, as well as those treated in less intensive settings such as Skilled Nursing Facilities (SNFs). The results to date, including input from technical experts and medical professionals, indicates that LTCHs treat medically stable but critically ill patients that are often indistinguishable from those treated in step-down units of acute care hospitals. This research has been important for furthering the discussion regarding the feasibility of developing unique criteria for LTCH patients.

RTI's research to date (both Phase I and Phase II) is posted on the CMS website at:

http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage

Item

Interactive Video Technology – In previous reports, the Committee has recognized the efficacy of using interactive video technology as a means of providing intentional and behavioral challenges, such as autism and other at-risk populations. Such demonstration projects supported by the Committee involved the use of interactive video technology as an in-home service delivery into the home when and where it was needed for children with autism and their families. One of the most serious obstacles to the integration of telemedicine, especially for intensive behavioral health services, is the absence of comprehensive reimbursement policies. The committee urges CMS to analyze the efficacy of telehealth technology and recommend adequate and appropriate reimbursement polices under Medicaid and urges coordination with those entities that have successfully completed demonstration projects supported by the Committee. The Committee requests that CMS provide a report on this to the Committees on Appropriation no later than 180 days after enactment of this act. (p. 138)

Action Taken or To Be Taken

CMS, in partnership with the National Institute of Mental Health, has recently established two task orders to support appropriate service delivery and monitoring of services to people with Autism Spectrum Disorder (ASD). CMS joins with its HHS partners to recognize that ASDs are conditions of urgent public health concern and recent data from the HRSA and CDC indicates that approximately 1 percent of children are affected by an ASD.

For purposes of Medicaid, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a beneficiary's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the provider at the distant site. Telemedicine is viewed as a cost-effective alternative, particularly in rural areas, to the more traditional face-to-face medical care that States may choose to cover under their approved Medicaid State plans. Although the Federal Medicaid statute (title XIX of the Social Security Act) does not recognize telemedicine as a distinct service, telemedicine delivery systems, including Interactive Video Technology, may be used at the present time with few reimbursement barriers. A State could elect to provide an approved Medicaid service using telemedicine, including intensive behavioral health services to people with ASD, so long as the service is in the approved State plan, or covered under the Early, Periodic, Screening, Diagnostic and Treatment benefit for children in Medicaid. States also may provide services to some families that include a person with an ASD, so long as the service is for the direct benefit of the Medicaid-enrolled individual.

Some States have enacted legislation which requires providers using telemedicine technology across State lines to have a valid state license in the State where the beneficiary is located. Any such requirements or restrictions placed by the State are binding under current Medicaid rules. Medicare Conditions of Participation (COPs) applicable to settings such as long-term care facilities and hospitals may also impact reimbursement for services provided via telemedicine technology. For instance, the Medicare COPs for long-term care facilities require physician visits at set intervals and current regulations require that the physician be physically present in the same room as the patient during the visit. This in-person requirement must also be met for Medicaid to pay for services provided to Medicaid-eligible patients while in a Medicaid certified facility. Similarly, Federal regulations require face-to-face visits for home health, and telemedicine cannot be used as a substitute for those visits. However, under current law, a telemedicine encounter may be used as a supplement to the required face-to-face visits.

Item

Data Mining – The Committee encourages CMS to invest in efforts to apply data mining and warehousing methodologies to detect fraud, waste, and abuse. Data mining is increasingly being used to extract relevant information from large data bases, like those maintained by CMS. The Committee has included funds for CMS to expand its efforts, began in 2006, to link Medicare claims and public records data and to initiate new demonstration projects using data mining technologies. The Committee requests that CMS make recommendations to the Committee on how linking CMS data might be used to enhance the Medicare and Medicaid Integrity Programs to reduce fraud and abuse and to better screen providers. (p. 138-139)

Action Taken or To Be Taken

Program integrity data drives CMS PI activities. Advanced algorithms and other data mining techniques are used to identify those Medicaid providers with aberrant billing practices. The sharing of the results of this data analysis among CMS components enables the Agency to leverage resources to respond to cross-cutting program integrity issues.

To support this need, in 2008 CMS began the development of the Medicaid Integrity Group Data Engine (MIG DE), the first national relational database of Medicaid claims and reference files to be used for fraud and abuse analysis. CMS completed this development on time and within budget in 2009. The MIG DE hosts a high-performance, database with terabyte-scale capacity and data mining software. The MIG DE was designed and developed and is hosted at the San Diego Supercomputer Center (SDSC). The data include eligibility and medical claims files for over 60 million Americans from all states. In contains 5 years of paid inpatient hospital claims, long-term care claims, prescription drug claims, and outpatient claims. Approximately 10 billion claims are included with approximately 800 million new claims added each calendar quarter.

Technically, the database software operates on a scalable cluster of high-memory servers that connect to an open-architecture storage area network environment providing high-bandwidth connectivity to expandable storage capacity. Additionally, the system is configured with the appropriate data analysis and mining algorithms and software so that CMS can perform Medicaid fraud and overpayment prevention and detection on the data. CMS personnel and CMS-designated Medicaid Integrity Contractors (MICs) use the MIG Data Engine's storage, analysis, and mining capabilities to perform claims reviews and provider audits in order to detect and prevent fraud, abuse, and unnecessary spending in the Medicaid program. The MIC auditors also use the system to host the data and supporting information as they conduct audits. No downloading of data is allowed from this certified, secure, system. Future plans include the enhancement of functions necessary for this activity.

CMS has identified additional Medicaid claim and related file data elements to be captured for program integrity use. Internal CMS PI areas have collaborated with external program integrity partners (e.g., HHS OIG and U.S. Department of Justice) to include data elements that are applicable to the efforts of all. In 2009 a five state effort was initiated to develop the prototype system that will serve to evaluate the feasibility and value of this effort.

Item

Reducing Fraud, Waste, and Abuse – Reducing fraud, waste, and abuse in Medicare and Medicaid continues to be a top priority of the Committee. The Committee has held a number of hearings on fraud and abuse issues over the past 10 years and expects to begin holding more hearings on this issue over the next 12 months. (p. 139)

Action Taken or To Be Taken

CMS is committed to fighting fraud, waste and abuse in the Medicare and Medicaid programs. In addition, the Administration has been clear that focusing on Medicare and Medicaid fraud is a top priority. For this reason, the Department of Justice and the Department of Health and Human Services established the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative to combine their resources to identify fraud, prosecute criminals, and recover taxpayer dollars through interagency strike forces. Project HEAT has been highlighting the potential and the importance of anti-fraud, waste and abuse measures in securing the long-term future of the Medicare and Medicaid programs.

Efforts in Medicare to Reduce 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; increased oversight of Medicare Advantage and Part D prescription drug plans; and using our 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:

- Increase random site visits to providers – particularly for high-risk areas like durable medical equipment suppliers and home health agencies;
- Aggressively and successfully deactivate inactive provider identification numbers;
- Implement a reform to the home health outlier payment policy to address concerns with disproportionate outlier payments in certain high-fraud areas;
- Develop a more robust system to conduct data analysis for more proactive fraud and abuse identification and program oversight;
- Initiate several geographic and service specific projects to target program vulnerabilities in South Florida, Texas and California;
- Set up beneficiary hotlines for reporting suspected fraud in high-risk areas and services; and,
- Issue guidance for helping beneficiaries guard against identity theft.

Efforts in Medicaid to Reduce Fraud, Waste and Abuse

The mission of the Medicaid Integrity Program is to protect Medicaid by strengthening the national Medicaid audit program while enhancing Federal oversight of and support and assistance to State Medicaid programs. CMS will accomplish this mission by using creative and innovative approaches to provide States with technical assistance and enhance the Federal-State partnership. CMS's top priorities for the coming year include:

1) Innovative data analysis;
2) More effective use of administrative authorities;
3) Support for significant investigations, audits and reviews of Medicaid billings;
4) Education on fraud awareness and provider audit outreach; and,
5) Providing effective support and assistance to States.

CMS will move forward with actions that include issuing a State Medicaid Director Letter giving guidance to States on Program Integrity (PI) 'Never Events' (i.e., things that should never happen in a Medicaid PI program) and a companion list of remedies or controls (prevention strategies) for each item on the list. CMS will continue to enter into contracts that support the Medicaid Integrity Group's main lines of business, such as the review of provider actions;

identification and audit of paid claims; education of providers with respect to payment integrity and quality of care; and support and assistance to States through training and other educational programs.

In addition, CMS will continue to conduct comprehensive State program integrity reviews throughout 2010 and will pilot a second generation of State program integrity reviews with increased emphasis on PI effectiveness and outcomes. CMS will also initiate a national Medicaid alert system to share information across states about newly identified emerging schemes designed to defraud the Medicaid program.

CMS will continue to develop algorithms designed to identify patterns of inappropriate and/or fraudulent provider billing to be shared with States and will use this information to focus on cross-border, regional and national issues. CMS will also develop algorithms to be used for State system review for the purpose of identifying inappropriately billed or uncollected Medicaid claims.

Item

Adolescent Health – The Committee expects that, in the context of national health reform and the renewed commitment to health promotion and disease prevention, the Secretary will place this office within the Office of Public Health and Science, as authorized. The Committee expects the Director of the Office to coordinate efforts among HRSA, CMS, CDC, and SAMHSA to reduce health risk exposure and behaviors among adolescents, particularly low-income adolescents, and to better manage and treat their health conditions. The Committee has also tasked OAH with implementing a new initiative supporting evidence-based teen pregnancy prevention approaches. (p. 158)

Action Taken or To Be Taken

In accordance with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3), the Secretary of Health and Human Services has identified an initial recommended core set of pediatric quality measures for voluntary use by: State programs administered under titles XIX and XXI of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid and Children's Health Insurance Programs, and providers of items and services under these programs. The statute requires, to the extent available, that the measures cover the availability and effectiveness of a full range of preventive services, treatments, and services for acute and chronic conditions for children including adolescents. The initial core set includes three measures applicable to the period of adolescence: BMI ages 2-18 years; adolescent immunization; and chlamydia screening for females ages 16-20.

The Office of Adolescent Health will have the opportunity to provide guidance and recommendations in the development of additional adolescent quality measures as the CHIPRA Quality Measures Program evolves.

Significant Items of Interest to Congress
FY 2010 House Appropriations Committee Report Language
(House Report 111-220)

Item

Hepatitis B and C Screening –The Committee recognizes that the Medicare Modernization Act of 2003 included a Welcome to Medicare physical exam benefit for new Medicare enrollees. However, despite clinical data showing hepatitis B and C are a major health problem in the United States, a hepatitis B and C screening benefit currently is not covered under the Medicare program. To assist in determining whether Congress should add a hepatitis B and C screening benefit to the Welcome to Medicare physical exam, the Committee encourages the Secretary to conduct a three-year hepatitis B and C screening and treatment demonstration project and to submit to the Committees on Appropriations of the House of Representatives and the Senate a report on the demonstration no later than **December 31, 2013**. (p. 157)

Action Taken or To Be Taken

If a physician, in the course of the Welcome to Medicare physical exam or any other visit, suspects that a Medicare beneficiary has hepatitis B or C, the physician can order a test to confirm the diagnosis and Medicare will pay for the test and for treatment of the disease. In addition, Medicare covers hepatitis B vaccine for beneficiaries at medium to high risk for hepatitis B (e.g., dialysis patients, hemophiliacs, health care workers exposed to blood and blood products).

With respect to screening, however, the U.S. Preventive Services Task Force (USPSTF) specifically recommends against general screening of asymptomatic adults for Hepatitis B and C. Its recommendation on hepatitis C reads, in part, "There is no evidence that screening for HCV infection leads to improved long-term health outcomes, such as decreased cirrhosis, hepatocellular cancer, or mortality….Potential harms of screening include unnecessary biopsies and labeling, although there is limited evidence to determine the magnitude of these harms. As a result, the USPSTF concluded that the potential harms of screening for HCV infection in adults who are not at increased risk for HCV infection are likely to exceed potential benefits." The recommendation on hepatitis B screening is similar and arrives at an almost identically worded conclusion. Therefore, we believe it would not be appropriate for the Medicare program to conduct a demonstration that directly conflicts with the recommendations of the USPSTF.

[Note: The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The USPSTF is funded and appointed by the Secretary of Health and Human Services. Its recommendations are considered the "gold standard" for clinical preventive services.]

Item

State Health Insurance Program (SHIP) – The Committee provides $45,000,000 for the State Health Insurance Program (SHIP), which is the same as the fiscal year 2009 funding level and $5,000,000 above the budget request. The Committee believes SHIP is an important vehicle to help the 46.6 million Medicare beneficiaries grapple with changes in coverage and prescription drug plans. SHIP provides one-on-one counseling to those who have trouble accessing the internet or the toll-free hotlines. (p. 158)

Action Taken or To Be Taken
CMS strongly supports the State Health Insurance Assistance Program (SHIP). SHIPs provide one-on-one counseling to beneficiaries on complex Medicare-related topics, including Medicare entitlement and enrollment, health plan options, Medigap and long-term care insurance, the prescription drug benefit, and preventive benefits. SHIP funding will provide infrastructure, training, and outreach support to an expanded force of over 12,000 counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The SHIP grant year runs from April 1 through March 31 each year.

In FY 2010, CMS is planning to allocate $45 million for SHIP grants and support contracts. The FY 2010 funds are from CMS' annual appropriation.

Plans for FY 2010 include:

- April 1, 2010 - grant awards to States with no reduction of funding from CMS from the prior year.
- September 2010 – grant awards to States based on performance.
- Continue to monitor grants awarded to SHIPs in June 1, 2009 for LIS and MSP outreach and enrollment assistance, and Part D outreach – grant awards to States of an additional $7.5 million from the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. This legislation provides for an allocation based on a percentage of low-income beneficiaries and a percentage of rural beneficiaries. These were two-year grants.
- CMS awards contracts during FY 2010 which provides for the overall support of the SHIP program to include a "resource center" contract which is a central national source of information, providing assistance to the 54 SHIPs, the SHIP steering committee and CMS and the National Performance Reporting (NPR) contract, a uniform performance data collections and reporting system for all SHIPs.
- As part of a SHIP quality assurance initiative, expand the number of SHIPs that utilize the CMS/SHIP developed on-line counselor training and certification tool.
- Implement new performance measures and benchmarks for SHIPs. Two of the performance measures relate improving access to underserved populations including Medicare beneficiaries who may be eligible for the low-income subsidy and Medicare beneficiaries with disabilities.
- Provide training and technical support to SHIPs on volunteer recruitment, management, and retention.

Item
Routine HIV Testing –The Committee notes that the CMS Medicaid policy on coverage for routine HIV Testing is unclear, and should be updated to reflect the Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings issued in September 2006 by the Centers for Disease Control and Prevention (CDC). (p. 158)

Action Taken or To Be Taken
Coverage of HIV testing under Medicaid and the Children's Health Insurance Program (CHIP) was explained in a State Health Official letter issued by CMS on June 24, 2009, which affirms Medicaid and CHIP coverage for such testing. The letter informed States of the recommendation by the CDC that opt-out HIV screening be a part of routine clinical care in all health care settings for all adults and adolescents aged 13-64. The letter also included a link to the September 22, 2006 issue of the *Morbidity and Mortality Weekly Report*, in which the

recommendations were published. In addition, CMS encouraged States to post information about Medicaid and CHIP coverage of HIV testing on their websites or via link on HIVtest.org.

The June 24, 2009 State Health Official letter may be accessed at the following link: http://www.cms.hhs.gov/SMDL/downloads/SHO062409.pdf.

Item

State Inspectors Training – The Committee also directs CMS to train all State inspectors on CDC's revised HAI interpretive guidelines. With the increase frequency of inspections, surveyors must be equipped to detect evidence of HAIs or faulty procedures that could result in HAIs. (p. 159)

Action Taken or To Be Taken

CMS has been steadily increasing its guidance and tools to assist State inspectors in assessing health care facilities' compliance with Medicare infection control standards. Those regulatory standards do not require adherence to a specific set of guidelines, such as CDC guidelines related to HAI, but rather require facilities to comply with nationally recognized guidelines, including those issued by CDC but also guidelines from organizations such as Association for Professionals in Infection Control and Epidemiology (APIC), Association of Perioperative Registered Nurses (AORN), and specialty professional groups. For hospitals, in November, 2007 CMS issued updated, comprehensive guidelines for assessing compliance with the hospital infection control Condition of Participation. Subsequent hospital surveyor training courses reflected the expanded guidance. Starting in CY 2009, CDC staff provided the infection control portion of hospital surveyor training. For ambulatory surgical centers CMS adopted comprehensive new regulations governing infection control practices in such facilities, effective in May, 2009. At the same time CMS introduced a comprehensive Infection Control Surveyor tool, jointly developed with CDC, to enable surveyors to assess whether ASCs are employing required practices designed to reduce HAI. CDC and CMS jointly provided training to State inspectors via satellite broadcast in May, 2009 and in person in October, 2009. A DVD of the October training is being developed and will be required viewing for any ASC surveyor who was unable to attend. As a result of the CMS Recovery Act ASC-HAI initiative, one third of all Medicare-certified ASCs will be surveyed in FY 2010, using the new infection control tool. For the longer term, CMS intends to modify the surveyor infection control tool for application in other types of health care facilities, and appropriate State surveyor training will follow.

Item

Alternative Licensure Activities – Because of the growth in the number of facilities seeking survey and certification so that they are permitted to participate in CMS programs, the Committee encourages CMS to explore the use of alternative licensure activities to provide additional resources for initial survey and certification activities. The Committee understands this is particularly acute for dialysis facilities and urges CMS to direct the States to triage first-time applications by length of wait time and remoteness of facility. (p. 159)

Action Taken or To Be Taken

CMS does not have the authority to usurp or alter health facility licensure requirements, which are a State function guided by State laws. However, CMS is undertaking new measures to accommodate the growth in the number of facilities seeking survey and certification and ensure that access to care is not negatively impacted. In particular, CMS has agreed to have a joint workgroup with several State survey agency directors on challenges/issues related to State staffing freezes/furloughs, and meetings will take place in FY2010. Further, in response to the growth in dialysis facilities seeking initial surveys, CMS recently examined and revitalized its

system for prioritizing facility candidates seeking to participate in the Medicare program. CMS will continue to allow dialysis facilities that are waiting for Medicare approval to submit information for an exception that permits a higher priority status for initial ESRD candidates based on “access to care” evidence.

Item

Combating HAIs – As part of its effort to combat HAIs, the Committee directs CMS to include in its "pay for reporting" system, which penalizes hospitals that fail to report quality data to Hospital Compare, two infection control measures developed by the Hospital Quality Alliance (HQA) -- central line-associated bloodstream infections and a surgical site infection rate. These two measures have been agreed upon by the HQA membership, tested, and validated. If the measures are included in Hospital Compare, the public reporting of the date is likely to reduce HAI occurrence, an outcome demonstrated in previous research. (p. 159)

Action Taken or To Be Taken

CMS is very interested in and committed to addressing and reducing HAI’s. These measures were developed by CDC and are currently collected by CDC through a web-based tool where hospitals submit clinical data from medical chart abstraction. CMS is actively considering the Surgical Site Infection (SSI) and Bloodstream Infection (BSI) measures for the hospital pay for reporting program. However, these CDC measures which were originally developed for surveillance purposes and for reporting at the national level cannot be directly implemented by CMS for application at the individual hospital level for comparative purposes. (Note: CDC currently does not have the authority to calculate the measure rates nor publicly report them at a hospital level.) CMS is currently in discussion with CDC regarding implementation issues as well as the optimal data collection mechanism, such as leveraging the CDC electronic health record collection system that was recently implemented in November 2009.

Another issue CMS is addressing relates to National Quality Forum (NQF) re-evaluation and endorsement of these measures. Under the Deficit Reduction Act, measures adopted for the hospital pay for reporting program which are ultimately publicly reported on Hospital Compare must reflect consensus among affected parties. Historically, CMS has used NQF endorsement to satisfy this requirement. NQF will be re-evaluating the BSI measures next year and the measure specifications may be modified or changed. If the measure specifications change, it will impact the timeframe for implementation since specifications for chart abstracted measures historically are provided to hospitals and their vendors 6 months before they are required for data submission to CMS. With respect to the SSI measure, the NQF is scheduled to re-evaluate this measure in the coming year and the CDC intends to submit a risk adjustment methodology for the SSI measure in early 2010. In addition, NQF is considering another similar measure developed by the American College of Surgeons. CMS believes that these issues need to be resolved prior to implementation by CMS in our pay for reporting efforts. CDC is the measure steward for both the BSI and the SSI measures, and is responsible for the development and maintenance of the measures. CDC is actively collecting these two (and other HAI measures) via the National Healthcare Safety Network (NHSN). CMS is in ongoing discussion with CDC regarding the possibility of leveraging their current collection, technical assistance, and validation infrastructure as CMS considers adopting these measures for the hospital pay for reporting program.

CMS is also actively collaborating with the CDC to address the measurement issues regarding NQF re-evaluation and endorsement of the measures and the implementation of these measures. CMS intends to adopt HAI outcome measures for the hospital pay for reporting

program in the near future after CMS has addressed the issues described above and has the resources to support their implementation.

Item

Healthy Start Grow Smart Program – The Committee does not continue bill language authorizing CMS to use funds for the Healthy Start, Grow Smart program for parents of children enrolled in the Medicaid program because of lagging State participation. (p. 159)

Action Taken or To Be Taken

Since the program authorization and funding for Healthy Start Grow Smart (HSGS) was not provided by Congress in FY 2010 appropriations, the following actions will be taken to essentially eliminate all Healthy Start Grow Smart contracts and distribution.

HSGS Contract Actions

- 17 States had HSGS contracts and have been notified regarding the discontinuation of HSGS State contracts.

- 8 of the 17 States had contracts to provide payments for distribution of booklets from the State to Medicaid beneficiaries. These contracts expired on September 30, 2009 and were not extended.

- 9 of the 17 States currently had contracts set to expire on September 30, 2010. These contracts will be closed out one year early.

- CMS has also notified the administrative vendor (NCIS) regarding the discontinuation of this project.

HSGS Administrative Contractor Actions

- Contract modifications will have to be made and issued by CMS with States and NCIS; these modified contracts will require unanticipated administrative resources for close-out costs.

CMS Administrative Management of Existing HSGS Booklets

- Online distribution of the remaining 60 million booklets is being researched as a possible outcome.

- In addition, there is the issue of continued storage for these 60 million booklets.

- An alternative to continued storage is to recycle or destroy the remaining HSGS booklets.

Item

Additional HAI Measures – The Committee also directs CMS to add additional HAI measures in its next expansion of the "pay for performance" system in which hospitals receive lower reimbursement for treatment of conditions that are not present upon admission. Of the 12 general conditions currently tracked under "pay for performance", three are related to HAIs (catheter-associated urinary tract infection, vascular catheter-associated infection, and certain surgical site infections). The Committee directs CMS to report to the Committees on Appropriations of the House of Representatives and the Senate by May 1, 2010 outlining progress in this regard. (p. 159-160)

Action Taken or To Be Taken

CMS and our intra-agency partners, the Office of Public Health and Science (OPHS), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention (CDC), have worked hard to administer the requirements of section 5001(c) of Pub. L. 109-171, the Deficit Reduction Act of 2005. This statute requires that, by October 1, 2007, the Secretary identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. It further provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

In the FY 2007 Medicare Inpatient Prospective Payment System (IPPS) final rule, CMS solicited public comments about which hospital acquired candidate conditions and which evidence-based guidelines should be chosen. Among the candidate conditions noted in public comment were surgical site infections, ventilator associated pneumonia, catheter-associated bloodstream infections, urinary tract infections, pressure ulcers, hospital falls, deep vein thromboses. (71 Federal Register 48052-3)

In the FY 2008 Medicare IPPS final rule, CMS required IPPS hospitals to submit an indicator for the principal and all the secondary diagnoses that are reported on the claim for discharges on or after October 1, 2007. Furthermore, CMS worked with public health and infectious disease experts from the CDC to identify and select a list of hospital-acquired conditions (HACs) pursuant to section 5001(c) of Pub. L. 109-171. CMS and CDC staff also received input from a number of groups and organizations and took into account these public comments in determining the list of conditions that would be subject to payment adjustments beginning October 1, 2008 (FY 2009). In this rule, we developed the following criteria to assist analysis of potential HACs, including ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) coding that clearly identifies and describes the condition, burden (high cost or high volume or both), whether the condition could reasonably have been prevented through application of evidence-based guidelines, and whether the HAC generates a Comorbidity or Complication (CC) or Major Comorbidity or Complication (MCC) under Medicare's coding and classification system, the Medicare-Severity Diagnosis Related Groups (MS-DRG). After taking extensive public comment into consideration, CMS finalized the following conditions as HACs in the FY 2008 IPPS rule: foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers, certain hospital injuries (e.g., falls and trauma), catheter-associated urinary tract infections, vascular catheter-associated infections, and certain surgical site infections (mediastinitis after coronary artery bypass graft). (72 Federal Register 47200-47217)

In our FY 2009 Medicare IPPS rule, CMS continued its collaborative efforts and collection of public input related to its HAC payment policy. As a result, CMS refined definitions associated

with two conditions finalized in the FY 2008 IPPS final rule, foreign objects retained after surgery and pressure ulcers. CMS also solicited public comments on a number of different conditions. After taking extensive public comments into consideration, CMS finalized the following additional conditions as HACs in the FY 2009 IPPS rule: manifestations of poor glycemic control and certain surgical site infections (e.g., following certain orthopedic procedures and following bariatric surgery for obesity). (73 Federal Register 48472-48491)

In our FY 2010 Medicare IPPS rule, CMS continued to engage with stakeholders but did not propose any additional measures. CMS received many oral and written stakeholder comments after the December 2008 annual HAC listening session. Commenters strongly supported using information gathered from early experience with the HAC payment provision to inform maintenance of the HAC list and consideration of future potential candidate HACs, emphasizing the need for a robust program evaluation before modifying the list. (74 Federal Register 43782-43785)

In September 2009, CMS and its intra-agency partners awarded a contract (HHSM-500-2005-00029I) to Research Triangle Institute (RTI) to conduct the Hospital-Acquired Condition Present on Admission (HAC-POA) Program Evaluation. This contract can be extended up to five years. The program evaluation will provide actuarial assessments of cost and reimbursement changes as well as modeling to capture the dynamic process of system change leading to improved clinical outcomes, long-term Medicare program and cost savings, and spillover effects and unintended consequences. As one of the tasks in the evaluation, RTI will provide CMS and its partners with extensive quantitative analysis on the degree to which candidate HACs meet the criteria of being reasonably preventable and the burden (high cost, high volume, or both).

Item

Expand Multilingual Helplines – The Committee is concerned that language and cultural barriers inhibit many minority seniors from accessing Medicare and encourages CMS to expand multilingual help lines to improve access to eligible programs by underserved minority seniors. (p. 160)

Action Taken or To Be Taken

CMS appreciates the Committee's concern for ensuring full access to Medicare for minority seniors, and eliminating language and cultural barriers in our interactions with seniors and caregivers. CMS is constantly looking for new opportunities to provide culturally relevant information and assistance to people with Medicare. The Agency has recently begun a Strategic Language Access Plan, and is committed to ongoing examination of this important issue.

Item

Quality Measures for Hepatitis B and C Screening and Treatment – The Committee encourages the Secretary to adopt quality measures for hepatitis B and C screening and treatment for use by dialysis providers and physicians who treat patients on dialysis. The Committee encourages the Secretary to include these quality measures and an analysis in the CMS Physician Quality Reporting Initiative. (p. 160)

Action Taken or To Be Taken

CMS considers delivery of the highest quality care to ESRD patients a priority. Viral hepatitis is an important and potentially preventable health issue for patients with ESRD. Transmission of both hepatitis B (HBV) and hepatitis C (HCV) can be prevented by stringent facility compliance

with infection control practices recommended by the Center for Disease Control (CDC, 1) that are enforced through the facility survey process.

Screening for HBV is routinely conducted by dialysis facilities on patients starting dialysis and the vaccination is offered to those patients who have not been vaccinated. Evidence suggests that most hemodialysis patients can be protected from hepatitis B by vaccination, and this seems to be the best strategy to combat hepatitis B. Maintaining immunity among vaccinated patients reduces the frequency and costs of serologic screening (2, 3). Since the hepatitis B vaccine became available, no HBV infections have been reported among vaccinated hemodialysis patients who maintained protective levels of anti-HBs (4). This includes defense against HBV outbreaks in this setting (5). Dialysis facilities conduct diagnostic HCV testing on patients when it is clinically indicated. With regard to measures related to the treatment of HBV and HCV for dialysis patients, we believe this is appropriate at the physician level.

The 2010 PQRI includes 9 measures pertaining to hepatitis C. Two of these measures include vaccinating hepatitis C infected patients against hepatitis A and B. There are 5 ESRD (end stage renal disease) measures and 5 CKD (chronic kidney disease) measures in PQRI including measures regarding influenza vaccination in the CKD and ESRD populations.

CMS will work with the National Quality Forum to determine if additional quality measures exist to assess hepatitis prevention strategies for all dialysis facilities and for physicians who treat dialysis patients. Finally, CMS may also work towards the development of physician measures for potential implementation in the future for PQRI that assess HBV and HCV vaccination and treatment for ESRD patients in general, and screening of ESRD patients who are transplant candidates to the extent that such screening is covered by Medicare.

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4. CDC. Recommendations of the Immunization Practices Advisory Committee (ACIP): inactivated hepatitis B virus vaccine.
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Significant Items of Interest to Congress
FY 2010 Senate Conference Omnibus Report 111-117

Item

Healthcare-Associated Infections (HAIs) – The conferees urge the Centers for Medicare and Medicaid Services (CMS) to strengthen the agency's efforts against healthcare-associated infections (HAIs) by considering inclusion of HAIs in the CMS pay-for-reporting system and by expanding the use of HAIs in the CMS pay-for-performance system. The House proposed similar language. The Senate did not propose language. (p. 1036)

Action Taken or To Be Taken

CMS and our intra-agency partners, the Office of Public Health and Science (OPHS), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention (CDC), have worked hard to administer the requirements of section 5001(c) of Pub. L. 109-171, the Deficit Reduction Act of 2005. This statute required that, by October 1, 2007, the Secretary identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. It further provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

In the FY 2007 Medicare Inpatient Prospective Payment System (IPPS) final rule, CMS solicited public comments about which hospital acquired candidate conditions and which evidence-based guidelines should be chosen. Among the candidate conditions noted in public comment were surgical site infections, ventilator associated pneumonia, catheter-associated bloodstream infections, urinary tract infections, pressure ulcers, hospital falls, deep vein thromboses. (71 Federal Register 48052-3)

In the FY 2008 Medicare IPPS final rule, CMS required IPPS hospitals to submit an indicator for the principal and all the secondary diagnoses that are reported on the claim for discharges on or after October 1, 2007. Furthermore, CMS worked with public health and infectious disease experts from the CDC to identify and select a list of hospital-acquired conditions (HACs) pursuant to section 5001(c) of Pub. L. 109-171. CMS and CDC staff also received input from a number of groups and organizations and took into account these public comments in determining the list of conditions that would be subject to payment adjustments beginning October 1, 2008 (FY 2009). In this rule, we developed the following criteria to assist analysis of potential HACs, including ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) coding that clearly identifies and describes the condition, burden (high cost or high volume or both), whether the condition could reasonably have been prevented through application of evidence-based guidelines, and whether the HAC generates a Comorbidity or Complication (CC) or Major Comorbidity or Complication (MCC) under Medicare's coding and classification system, the Medicare-Severity Diagnosis Related Groups (MS-DRG). After taking extensive public comment into consideration, CMS finalized the following conditions as HACs in the FY 2008 IPPS rule: foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers, certain hospital injuries (e.g., falls and trauma), catheter-associated urinary tract infections, vascular catheter-associated infections, and certain surgical site infections (mediastinitis after coronary artery bypass graft). (72 Federal Register 47200-47217)

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In our FY 2010 Medicare IPPS rule, CMS continued to engage with stakeholders but did not propose any additional measures. CMS received many oral and written stakeholder comments after the December 2008 annual HAC listening session. Commenters strongly supported using information gathered from early experience with the HAC payment provision to inform maintenance of the HAC list and consideration of future potential candidate HACs, emphasizing the need for a robust program evaluation before modifying the list. (74 Federal Register 43782-43785)

In September 2009, CMS and its intra-agency partners awarded a contract (HHSM-500-2005-00029I) to Research Triangle Institute (RTI) to conduct the Hospital-Acquired Condition Present on Admission (HAC-POA) Program Evaluation. This contract can be extended up to five years. The program evaluation will provide actuarial assessments of cost and reimbursement changes as well as modeling to capture the dynamic process of system change leading to improved clinical outcomes, long-term Medicare program and cost savings, and spillover effects and unintended consequences. As one of the tasks in the evaluation, RTI will provide CMS and its partners with extensive quantitative analysis on the degree to which candidate HACs meet the criteria of being reasonably preventable and the burden (high cost, high volume, or both).

Item

Telehealth Services – The conferees are concerned that the delivery of telehealth services may be disrupted by HHS requirements that result in duplicative credentialing and privileging of remote providers. The conferees direct the Secretary to report to the Committees on Appropriations of the House of Representatives and the Senate within 6 months of enactment on actions taken by CMS to reduce duplication and streamline federal credentialing and privileging requirements related to telehealth services. Neither the House nor Senate proposed similar language. (p. 1037)

Action Taken or To Be Taken

CMS recognizes the benefits associated with greater use of health information technology, including the use of telehealth services. However, we must assure that telehealth services are high quality, and that hospitals remain accountable for assuring that the qualifications of physicians who are providing care to patients via a telecommunications system conform with required standards. Credentialing, or the gathering and validation of documentation of a practitioner's qualifications, is the labor intensive and potentially duplicative component of the credentialing and privileging process. On the other hand, granting medical staff privileges is an essential component of maintaining the accountability of a hospital's leadership for the quality of care and safety of patients in their hospital. Privileges are always site-specific rather than duplicative, and reflect the hospital governing body's consideration not only of the practitioner's qualifications, but also of the scope of services offered at the hospital, and, in the case of telehealth, the scope of services that are feasible when provided via a telecommunications system. CMS will continue to require each hospital to review the credentialing packages and grant privileges to all practitioners providing care to its patients. Since the privileging component of the process is much less labor-intensive, this requirement is not unduly burdensome.