DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2009

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

Introduction

The FY 2009 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

The Centers for Medicare & Medicaid Services Congressional Justification and Online Performance Appendix can be found at http://www.cms.hhs.gov/PerformanceBudget/.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) performance budget for fiscal year (FY) 2009. CMS is the largest purchaser of health care in the United States, serving over 92 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries. We take our role very seriously, as our program responsibilities impact millions of people and have grown dramatically over the last few years.

FY 2009 will be a year of transformation and modernization for CMS. We will finalize our efforts to improve program efficiency and quality of services through contracting reform and expand competitive bidding for durable medical equipment. We expect to achieve significant savings for the Medicare trust funds from both of these initiatives. We will initiate the implementation of ICD-10 healthcare coding changes, continue our focus on the prescription drug and Medicare Advantage programs, enhance support for low-income and dual eligible beneficiaries, expand our program oversight activities, and advance a quality agenda through our value-based purchasing initiatives.

CMS' resource needs are principally driven by workloads that grow annually. We formulated this request based on funding these workloads and finding efficiencies to offset escalating costs. Our FY 2009 Program Management current law request reflects a 1.2 percent increase above the FY 2008 enacted level, including the funding provided by the Medicare, Medicaid, SCHIP Extension Act of 2007. We have included a user fee proposal that would recover the costs of revisiting health care facilities to offset the increase to the Survey and Certification activities.

CMS is committed to transforming and modernizing Medicare, Medicaid, and SCHIP for America. This budget request reflects this commitment, highlighting our progress on agency performance goals and on improving program effectiveness by implementing recommendations of the Office of Management and Budget's Program Assessment Rating Tool assessments for Medicare, SCHIP, the Medicare Integrity Program, and Medicaid.

On behalf of our beneficiaries, I thank you for your continued support of CMS and its FY 2009 budget request.

Kerry N. Weems

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP

As of January 24, 2008
* Acting
** Temporary Structure Reporting to DA
*** Reports to COO

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EXECUTIVE SUMMARY

Introduction and Mission

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services (HHS). CMS' mission is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.

The creation of CMS (previously the Health Care Financing Administration) in 1977 brought together, under unified leadership, the two largest Federal health care programs--Medicare and Medicaid. In 1997, the State Children's Health Insurance Program (SCHIP) was established to address the health care needs of uninsured children.

More recently, in 2003, the Medicare Prescription Drug, Improvement, and Modernization Act provided sweeping changes to the Medicare program along with expanded responsibilities for CMS. The most major change was the addition of a prescription drug benefit which was effective January 2006. In 2005, Congress passed the Deficit Reduction Act, which included key reforms to restrain spending in the entitlement programs while ensuring that Americans who rely on these programs continue to get needed care. The Tax Relief and Health Care Act of 2006 established a physician quality reporting program and quality improvement initiatives and enhanced CMS' program integrity efforts through the Recovery Audit Contractor program. The Medicare, Medicaid, SCHIP Extension Act of 2007 continued physician quality reporting and extended the SCHIP, Transitional Medicaid Assistance, and Q1 programs.

CMS launched a new Strategic Action Plan in 2006, which announced our mission to ensure effective, up-to-date health care coverage and promote quality care for beneficiaries. CMS strives to achieve the vision of a transformed and modernized health care system for America. Using our Strategic Action Plan as a roadmap, we will make sure those who provide health care services are paid the right amount at the right time, work toward a high-value health care system, increase consumer confidence by giving them more information, strengthen our workforce to manage and implement our programs, and continue to develop collaborative partnerships.

Size and Scope of CMS Responsibilities

CMS has become the largest purchaser of health care in the United States, serving over 92 million beneficiaries, almost one in three Americans. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures. 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. Few programs, public or private, have such a positive impact on so many Americans.

CMS is committed to administering its programs as efficiently as possible. In FY 2009, benefit costs are expected to total $703.9 billion. Non-benefit costs, most of which are administrative costs such as Program Management, Medicaid State and local administration, non-CMS administrative costs, costs associated with the health care fraud and abuse control account (HCFAC), the Quality Improvement Organizations (QIO), the Clinical Laboratory Improvement Amendments program (CLIA), and the

Medicare Advantage user fees, among others, are estimated at $18.6 billion or 2.6 percent of total benefits under current services. CMS' non-benefit costs are minute when compared to Medicare benefits and the Federal share of Medicaid and SCHIP benefits. Program Management costs are only one half of one percent of these benefits.

FY 2009 Budget Request Overview

For FY 2009, CMS requests a total of $415.4 billion for its three annually-appropriated accounts—Program Management, Grants to States for Medicaid, and Payments to the Trust Funds—and a new discretionary HCFAC account. This represents an increase of $16.7 billion over the FY 2008 enacted level. Major activities within each of these four accounts are discussed in more detail below.

CMS Annually-Appropriated Accounts
($ in millions)

Account	FY 2008 Enacted	FY 2009 Request	+/- FY 2008
Program Management, Current Law	$3,266.7	$3,307.3	+$40.7
Grants to States for Medicaid	$206,885.7	$216,627.7	+$9,742.0
Payments to Health Care Trust Funds	$188,445.0	$195,308.0	+$6,863.0
HCFAC -- Discretionary	$0.0	$198.0	+$198.0
Total	**$398,597.3**	**$415,441.0**	**$16,843.7**

Program Increases:

Program Management:

- Medicare Operations (+$65.8 million)
  Our request will allow CMS to: make a major investment in implementing a new healthcare coding system which will help reduce payment errors, facilitate our value-based purchasing program, and enhance electronic claims processing; expand the Durable Medical Equipment (DME) competitive bidding program to additional metropolitan areas, saving the Medicare trust funds over $1 billion annually beginning FY 2010; provide the necessary funds to enhance our Part C and Part D systems and operations in order to keep up with growth and change in these two new programs and to improve support for dual-eligible and low-income beneficiaries; make critical investments in claims processing systems, enterprise data activities, and other IT infrastructure activities in order to prepare for the growth in Medicare that will begin in 2011 when the baby boom generation begins turning 65 and to ensure that our systems and data are secure; and strengthen our financial management activities in order to protect the Medicare Trust Funds.
- Federal Administration: (+$12.1 million)
  Additional funding is needed to cover payroll expenses for 4,148 direct FTEs, including a 2.9 percent pay raise in 2009. This represents a projected reduction of 74 FTE from the FY 2008 enacted level.
- Survey and Certification: (+$11.9 million)
  This request will maintain the statutorily-mandated survey frequencies for long-term care facilities and keep survey frequencies for other facilities at or close to the FY 2008 enacted level. The FY 2009 Request includes

additional funding to accommodate an increase in the number of facilities that must be surveyed each year.

Grants to States for Medicaid (+$9.7 billion)
The FY 2009 budget requests a total of $216.6 billion for Medicaid including: $207.7 billion in medical assistance benefits, an increase of $13.5 billion over the FY2008 enacted level; $10.3 billion for administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and $2.8 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds (+$6.8 billion)
The FY 2009 request for the annual appropriation for the Payments to the Health Care Trust Funds (PTF) account reflects an overall increase of $6.8 billion above the FY 2008 enacted level. This account provides the SMI Trust Fund with the general fund contribution for the cost of the Supplementary Medical Insurance (SMI) program and transfers payments from the General Fund to the Hospital Insurance (HI) and the 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. The General Fund contribution to SMI increases by $7.0 billion in FY 2009. CMS will also make a quinquennial adjustment for military service wage credits in FY 2009, expected to cost $1.0 billion. The General Fund contribution for the Part D program declines by $1.5 billion.

HCFAC Discretionary (+$198.0 million)
CMS is requesting $198 million through an adjustment to the discretionary spending total to fund program integrity activities. These funds will be used to safeguard the new Medicare Advantage and prescription drug programs against fraud, waste, and abuse as well as to expand financial management oversight of the Medicaid program. The requested amount includes funding for: CMS' Medicare Integrity Program ($147.0 million); the Department of Justice ($18.9 million); the Office of Inspector General ($18.9 million); and CMS' Payment Error Rate Measurement program ($13.0 million). Although CMS requested funding for this activity in the FY 2008 President's Budget, the FY 2008 enacted level did not include any funding for this request.

Program Decreases:

Program Management:

- High Risk Pools (-$49.1 million)
  Funding declines by $49.1 million as CMS is not requesting funding for this activity in FY 2009 through the Program Management account, but requests it through a mandatory account.

CONCLUSION

For FY 2009, CMS requests a total of $415.4 billion for its three annually-appropriated accounts—Program Management, Grants to States for Medicaid, and Payments to the Trust Funds—and a new discretionary cap adjustment in the HCFAC account.

Our discretionary request includes $3,307.3 million for Program Management under current law and $198.0 million for HCFAC. If our proposed user fee is enacted, the Program Management request could be offset by up to $35.0 million from revisit fee collections. While this funding level presents a modest level of growth from the FY 2008 enacted level, 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 from fraud, waste, and abuse. The Program Management request will allow CMS to handle its substantial ongoing workloads for traditional fee-for-service and the newer Medicare Advantage and prescription drug programs, along with many important projects including finalizing contracting reform transitions, initiating ICD-10 implementation, expanding DME competitive bidding, increasing the number of healthcare facility surveys, and continuing important research and demonstration activities. The HCFAC discretionary request will enable CMS to mitigate vulnerabilities in the Parts C and D programs and to improve program integrity in Medicaid. In short, this request supports our dedication to controlling health care costs while improving quality and access.

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

Activity	FY 2007 Actual 1/	FY 2008 Enacted 2/	FY 2009 Estimate
Medicare Operations	$2,159,242	$2,197,293	$2,339,729
Rescission (P.L. 110-161)	$0	($38,387)	$0
Tax Relief and Health Care Act (P.L. 109-432)	$100,760	$0	$0
Medicare, Medicaid and SCHIP Ext. Act (P.L. 110-173)	$0	$115,000	$0
Comparability Adjustment (Revitalization Plan)	$23,963	$0	$0
Net Medicare Operations BA	**$2,283,965**	**$2,273,906**	**$2,339,729**
Federal Administration	$642,355	$642,354	$643,187
Rescission (P.L. 110-161)	$0	($11,222)	$0
Tax Relief and Health Care Act (P.L. 109-432)	$4,240	$0	$0
Comparability Adjustment (JFA/TAPS)	($26)	$0	$0
Net Federal Administration BA	**$646,569**	**$631,132**	**$643,187**
State Survey & Certification	$258,128	$286,186	$293,128
Rescission (P.L. 110-161)	$0	($5,000)	$0
Net State Survey & Certification BA	**$258,128**	**$281,186**	**$293,128**
Research	$57,420	$31,857	$31,300
Rescission (P.L. 110-161)	$0	($556)	$0
Net Research BA	**$57,420**	**$31,301**	**$31,300**
CMS Revitalization Plan	$23,963	$0	$0
Rescission (P.L. 110-161)	$0	$0	$0
Comparability Adjustment (Revitalization Plan)	($23,963)	$0	$0
Net CMS Revitalization Plan BA	**$0**	**$0**	**$0**
High-Risk Pools	$0	$50,000	$0
Rescission (P.L. 110-161)	$0	($873)	$0
Net High-Risk Pools BA	**$0**	**$49,127**	**$0**
Emergency/Supplemental Funds	**$0**	**$0**	**$0**
Appropriation/BA C.L. (Discretionary)	**$3,141,082**	**$3,151,652**	**$3,307,344**
TRHCA FY 2007/ MMSEA FY 2008 (Mandatory)	**$105,000**	**$115,000**	**$0**
Appropriation/BA C.L.	**$3,246,082**	**$3,266,652**	**$3,307,344**
Est. Offsetting Collections from Non-Federal Sources: **Offsetting Collections, C.L. 3/**	**$223,657**	**$141,114**	**$178,058**
Subtotal, New BA, C.L.	**$3,469,739**	**$3,407,766**	**$3,485,402**
P.L. User Fee Offset (Revisit Fee) 4/	$0	$0	($35,000)
Appropriation P.L.	**$3,246,082**	**$3,266,652**	**$3,272,344**
Proposed Law Offsetting Collections (Non-Add)	*$0*	*$0*	*$35,000*
Offsetting Collections, P.L.	$223,657	$141,114	$213,058
Subtotal, New BA, P.L.	**$3,469,739**	**$3,407,766**	**$3,485,402**
No/Multi-Year Carryforward (C.L., FY 98-07) 5/	$22,858	$107,916	$0
Emergency/Supplemental Funds	**$0**	**$0**	**$0**
Program Level, Current Law	**$3,492,597**	**$3,515,682**	**$3,485,402**
Program Level, Proposed Law	**$3,492,597**	**$3,515,682**	**$3,485,402**
HCFAC Discretionary	**$0**	**$0**	**$198,000**
CMS FTEs:			
Direct (Federal Administration)	4,339	4,222	4,148
Reimbursable (CLIA, RAC)	66	95	109
Subtotal, Prog. Mgt. FTEs, C. L.	**4,405**	**4,317**	**4,257**
Medicaid Oversight (HCFAC/State Grants)	121	160	200
Total, CMS FTEs, Current Law	**4,526**	**4,477**	**4,457**

1/ Reflects actual budget authority (BA) in FY 2007. Includes BA attributable to P.L. 109-432 (TRHCA).

2/ The FY 2008 column reflects the enacted (net) appropriation after all rescissions, transfers, adjustments and reprogrammings. The FY 2008 column also includes funding provided by P.L. 110-173, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

3/ The FY 2007 column includes obligations attributable to Recovery Audit Contractor activities and other reimbursable agreements.

4/ If enacted, the proposed user fees collected in FY 2009 will offset our Program Management appropriation on a dollar-for-dollar basis.

5/ Reflects remaining no-year and multi-year funding attributable to CMS' managed care redesign, standard systems transitions, HIGLAS, IT revitalization and TRHCA activities.

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Program Management
Appropriation Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed [$3,207,690,000,] *$3,307,344,000,* to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the Public Health Service Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; 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 Public Health Service Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further*, That [$45,000,000,] *$35,700,000,* to remain available until September 30, [2009,] *2010,* is for contract costs for the Healthcare Integrated General Ledger Accounting System: *Provided further*, That [$193,000,000,] *$108,900,000,* to remain available until September 30, [2009,] *2010,* is for CMS Medicare contracting reform activities: *Provided further*, That funds appropriated under this heading are available for the Healthy Start, Grow Smart program under which the Centers for Medicare & Medicaid Services may, directly or through grants, contracts, or cooperative agreements, produce and distribute informational materials including, but not limited to, pamphlets and brochures on infant and toddler health care to expectant parents enrolled in the Medicaid program and to parents and guardians enrolled in such program with infants and children: *Provided further*, That the Secretary of Health and Human Services is directed to collect fees in fiscal year [2008] *2009* 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 $5,007,000 shall be available for the projects and in the amounts specified in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated act).]

In addition, the Secretary may, contingent upon enactment of authorizing legislation, charge a fee for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys: Provided, That such fees, in an amount not to exceed $35,000,000, shall be credited to this account as offsetting collections, to remain available until expended for the purpose of conducting such revisit surveys: Provided further, That amounts transferred to this account from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds for fiscal year 2009 shall be reduced by the amount credited to this account under this paragraph.

(Department of Health and Human Services Appropriations Act, [2008] *2009*.)

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, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed [$3,207,690,000,] *$3,307,344,000* to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, 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 State Children's Health Insurance programs. The HI Trust Fund will be reimbursed for the Federal Funds allocation 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 Public Health Service Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; 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 total funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fees collected. Authorizes the collection of HMO user fees, fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs including those associated with processing HMO applications, providing data to the public, and other purposes. All of these collections are available to be carried over from year to year.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service 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 [$45,000,000,] *$35,700,000,* to remain available until September 30, [2009,] *2010,* is for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $35,700,000 of this appropriation to be available for obligation over a period of two fiscal years, for contract costs pertaining to the development and implementation of the Healthcare Integrated General Ledger Accounting System.
Provided further, That [$193,000,000,] *$108,900,000,* to remain available until September 30, [2009,] *2010,* is for CMS Medicare contracting reform activities:	Authorizes $108,900,000 of this appropriation to be available for obligation over a period of two fiscal years for contracting reform activities.

Language Analysis

Language Provision	Explanation
Provided further, That funds appropriated under this heading are available for the Healthy Start, Grow Smart program under which the Centers for Medicare & Medicaid Services may, directly or through grants, contracts, or cooperative agreements, produce and distribute informational materials including, but not limited to, pamphlets and brochures on infant and toddler health care to expectant parents enrolled in the Medicaid program and to parents and guardians enrolled in such program with infants and children:	Authorizes the Administration's *Healthy Start, Grow Smart* initiative in FY 2009.
Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year [2008] *2009* 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 organizations for costs related to enrollment, dissemination of information and certain counseling and assistance programs.
[*Provided further*, That $5,007,000 shall be available for the projects and in the amounts specified in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated act).]	Eliminates funding for mandated research projects included in the FY 2008 Program Management appropriation.

Language Analysis

Language Provision	Explanation
In addition, the Secretary may, contingent upon enactment of authorizing legislation, charge a fee for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys: Provided, That such fees, in an amount not to exceed $35,000,000, shall be credited to this account as offsetting collections, to remain available until expended for the purpose of conducting such revisit surveys: Provided further, That amounts transferred to this account from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds for fiscal year 2009 shall be reduced by the amount credited to this account under this paragraph.	Authorizes the collection of user fees for conducting revisit surveys of facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys. CMS' Program Management appropriation will be reduced on a dollar-for-dollar basis from funds collected, up to $35.0 million.

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Program Management Proposed Law Summary

The CMS request includes a proposed user fee totaling $35.0 million in FY 2009. Collections associated with these user fees will offset our current law Program Management appropriation on a dollar-for-dollar basis, up to $35.0 million. This proposal is described below:

Medicare Survey and Certification (S&C) Program Revisit User Fee:
Charge facilities a user fee for corrective action follow-up surveys. ($35,000,000)

To recover from industry the cost of expenditures by the Survey and Certification (S&C) program for revisits performed on those health care facilities previously cited for deficiencies. This proposal is similar to the FDA's proposed reinspection user fee.

Program Objectives

The proposed user fee is expected to recover the costs associated with the Medicare S&C program's revisit surveys. Revisit surveys are the result of deficiencies cited during certification, recertification, or complaint surveys. They are conducted in order to verify that previously cited deficiencies have been corrected.

The current authorization for funding the S&C program does not allow for a user fee program. Legislation will be necessary to replace the authorization of appropriations with aggregate fee revenues in FY 2009 and the authorization to collect such sums as are necessary to fund the user fee program. There is precedent for collecting this proposed user fee. Title V of the Independent Appropriations Act of 1952 (31 U.S.C. 9701); 31 U.S.C. 1111; and Executive Orders 8,248 and 11,541 provide the authority to collect this fee. This user fee proposal conforms to the general policy stated in OMB Circular No. A-25, which establishes Federal policy regarding fees assessed for government services. This policy states that the user fees will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.

This proposal includes a mechanism to allow CMS to annually adjust the user fee rates for the impact of inflation and workload variation. The user fee will be based on national average per facility type and may later be adjusted for other relevant factors including facility size, scope and severity of cited deficiencies.

Among the facilities covered under this user fee program are nursing homes, hospitals, home health agencies, rural health clinics, end-stage renal disease centers, hospices, ambulatory surgical centers, transplant centers, critical access hospitals and psychiatric hospitals. Excluded facilities include outpatient physical therapy centers, comprehensive outpatient rehabilitation facilities, and portable x-ray centers.

CMS Program Management
Proposed Law Summary

Activity	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Medicare Operations	$2,283,965,000	$2,273,906,000	$2,339,729,000
Approp. Offset, Prop. Law	---	---	---
Approp., Net Prop. Law	$2,283,965,000	$2,273,906,000	$2,339,729,000
User Fees, Prop. Law	---	---	---
Subtotal, Approp.+ P.L. User Fees	$2,283,965,000	$2,273,906,000	$2,339,729,000
Federal Administration	$646,569,000	$631,132,000	$643,187,000
Approp. Offset, Prop. Law	---	---	---
Approp., Net Prop. Law	$646,569,000	$631,132,000	$643,187,000
User Fees, Proposed Law	---	---	---
Subtotal, Approp.+ P.L. User Fees	$646,569,000	$631,132,000	$643,187,000
State Survey & Certification	$258,128,000	$281,186,000	$293,128,000
Approp. Offset, Prop. Law 2/	---	---	($35,000,000)
Approp., Net Prop. Law	$258,128,000	$281,186,000	$258,128,000
User Fees, Prop. Law 2/	---	---	$35,000,000
Subtotal, Approp.+ P.L. User Fees	$258,128,000	$281,186,000	$293,128,000
Research, Demonstration & Evaluation	$57,420,000	$31,301,000	$31,300,000
Approp. Offset, Prop. Law	---	---	---
Approp., Net Prop. Law	$57,420,000	$31,301,000	$31,300,000
User Fees, Proposed Law	---	---	---
Subtotal, Approp.+ P.L. User Fees	$57,420,000	$31,301,000	$31,300,000
Revitalization Plan	---	---	---
Approp. Offset, Prop. Law	---	---	---
Approp., Net Prop. Law	---	---	---
User Fees, Proposed Law	---	---	---
Subtotal, Approp.+ P.L. User Fees	---	---	---
High-Risk Pools	---	$49,127,000	---
Approp. Offset, Prop. Law	---	---	---
Approp., Net Prop. Law	---	$49,127,000	---
User Fees, Proposed Law	---	---	---
Subtotal, Approp.+ P.L. User Fees	---	$49,127,000	---
Subt. Approp., Net Prop. Law	**$3,246,082,000**	**$3,266,652,000**	**$3,272,344,000**
Subt. User Fees, Prop. Law 1/	**---**	**$0**	**$35,000,000**
Total Approp. + P.L. User Fees	**$3,246,082,000**	**$3,266,652,000**	**$3,307,344,000**

1/ If enacted, the user fees collected in fiscal year 2009 will offset our appropriation on a dollar-for-dollar basis.

CMS Program Management
Amounts Available for Obligation

	FY 2007	FY 2008	FY 2009
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)..	$3,141,108,000	$3,207,690,000	$3,307,344,000
Across-the-board reductions (P.L. 110-161).....................	$0	($56,038,000)	$0
Subtotal, Appropriation (L/HHS)....................................	$3,141,108,000	$3,151,652,000	$3,307,344,000
Comparable transfer to: (GDM (FY 2007)).......................	($26,000)	$0	$0
Subtotal, adjusted trust fund discr. appropriation............	$3,141,082,000	$3,151,652,000	$3,307,344,000
Trust Fund Mandatory Appropriation:			
Appropriation (P.L. 109-432 (07); P.L. 110-173 (08)).........	$105,000,000	$55,000,000	$0
General Fund Mandatory Appropriation:			
Appropriation (P.L. 110-173)..	$0	$60,000,000	$0
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees...	$4,639,000	$2,200,000	$2,251,000
CLIA user fees..	$44,653,000	$43,000,000	$43,000,000
Coordination of benefits user fees...................................	$32,754,000	$32,289,000	$65,425,000
MA/PDP user fees..	$56,156,000	$61,612,000	$65,252,000
Reimbursables 1/...	$85,455,000	$2,013,000	$2,130,000
Unobligated balance, start of year.......................................	$115,774,000	$206,522,000	$98,606,000
Unobligated balance, end of year..	($206,522,000)	($98,606,000)	($98,606,000)
Change in prior year offsetting collections...........................	($317,000)	$0	$0
Prior year recoveries	$11,283,000	$0	$0
Unobligated balance, lapsing...	($7,232,000)	$0	$0
Total obligations 2/..	$3,382,725,000	$3,515,682,000	$3,485,402,000

1/ Includes $85.5 million in collections and obligations from Recovery Audit Contract ($80.1 million) and other reimbursable ($5.4 million) activities in FY 2007.

2/ Obligations comparably adjusted as shown above.

CMS Program Management
Summary of Changes

2008	
Total estimated budget authority	$3,266,652,000
(Obligations)	($3,266,652,000)
2009	
Total estimated budget authority	$3,307,344,000
(Obligations)	($3,307,344,000)
Net Change	$40,692,000

	2008 Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
Total Increases				$358,425,000
Decreases:				
Total Decreases				($317,733,000)
Net Change				$40,692,000

CMS Program Management

Budget Authority by Activity

(Dollars in thousands)

	2007	2008	2009
		$2,197,293	$2,339,729
		$0	$0
		$115,000	$0
		($38,387)	$0
		$0	$0
Subtotal, Medicare Operations	$2,283,965	$2,273,906	$2,339,729
(Obligations)	($2,197,331)		
	$642,355	$642,354	$643,187
	$4,240	$0	$0
	$0	($11,222)	$0
	($26)	$0	$0
Subtotal, Federal Administration	$646,569	$631,132	$643,187
(Obligations)	($641,970)		
3. State Survey & Certification	$258,128	$286,186	$293,128
Enacted Rescission..	$0	($5,000)	$0
Subtotal, State Survey & Certification	$258,128	$281,186	$293,128
(Obligations)	($257,608)		
4. Research, Demonstration & Evaluation	$57,420	$31,857	$31,300
Enacted Rescission..	$0	($556)	$0
Subtotal, Research, Demonstration & Evaluation	$57,420	$31,301	$31,300
(Obligations)	($63,082)		
5. Revitalization Plan	$23,963	$0	$0
Enacted Rescission..	$0	$0	$0
Comparable Transfer (Revit. Plan).............................	($23,963)	$0	$0
Subtotal, Revitalization Plan	$0	$0	$0
(Obligations)	$0		
6. High-Risk Pools (HRP)	$0	$50,000	$0
Enacted Rescission..	$0	($873)	$0
Subtotal, High-Risk Pools	$0	$49,127	$0
(Obligations)	$0		
	$138,202	$139,101	$175,928
	($137,279)		
	$85,455	$2,013	$2,130
	($85,455)		
Total, Budget Authority	$3,469,739	$3,407,766	$3,485,402
(Obligations)	($3,382,725)		
FTE	4,405	4,317	4,257

CMS Program Management
Authorizing Legislation

	2008 Amount Authorized	2008 Budget Estimate	2009 Amount Authorized	2009 Budget Request
Program Management:				
a) Social Security Act, Title XI,				
				-
109-432, TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level..	---	---	---	---
Total request level against definite authorizations....	---	---	---	---

1/ The total authorization for section 1115 is $4.0 million. CMS' portion of this amount is $2.2 million.
2/ The MMA limits authorized user fees to an amount computed using a statutory formula based on the ratio of Medicare managed care expenditures to Medicare benefits.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2000				
Trust Fund Appropriation:				
Base..	$2,016,126,000	$1,752,050,000	$1,991,321,000	$1,994,548,000
Rescissions (P.L. 106-113).........	$0	$0	$0	($1,214,000)
Transfers (P.L. 106-113)............	$0	$0	$0	$2,992,000
Subtotal..................................	$2,016,126,000	$1,752,050,000	$1,991,321,000	$1,996,326,000
2001				
Trust Fund Appropriation:				
Base..	$2,086,302,000	$1,866,302,000	$2,018,500,000	$2,246,326,000
Rescissions (P.L. 106-554).........	$0	$0	$0	($4,164,000)
Transfers (P.L. 106-554)............	$0	$0	$0	($564,000)
Subtotal..................................	$2,086,302,000	$1,866,302,000	$2,018,500,000	$2,241,598,000
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	$3,664,994,000
Rescissions (P.L. 108-199).........	$0	$0	$0	($28,148,000)
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:				
Base..	$0	$0	$0	$38,000,000
Trust Fund Appropriation:				
Base..	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,206,927,000
Rescissions (P.L. 109-148/149)..	$0	$0	$0	($91,109,000)
Transfers (P.L. 109-149)............	$0	$0	$0	$40,000,000
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	$3,246,108,000
2008				
General Fund Appropriation:				
Base..	$0	$0	$0	$60,000,000
Trust Fund Appropriation:				
Base..	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,262,690,000
Rescissions (P.L. 110-161).........	$0	$0	$0	($56,038,000)
Subtotal..................................	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,206,652,000
2009				
Trust Fund Appropriation:				
Base..	$3,307,344,000			

Program Management

Summary of Request

The Program Management account provides the funding needed to administer CMS' programs, including Medicare, Medicaid, SCHIP, CLIA, QIO, State Grants and Demonstrations, and HCFAC. There are four line items in the Program Management account—Medicare Operations, Federal Administration, Survey and Certification, and Research--each one with a distinct purpose. Medicare Operations primarily funds the Medicare contractors that process fee-for-service claims as well as the IT infrastructure, operational support and oversight needed to run the fee-for-service program and the new Medicare Advantage and Prescription Drug programs. In addition, it funds legislative mandates (e.g., HIGLAS, HIPAA, contracting reform, competitive bidding) which improve and enhance CMS' programs. Federal Administration pays for the salaries of CMS employees and for the overhead (rent, building services, equipment, supplies, etc.) associated with running a large organization. The Survey and Certification account pays State surveyors to inspect health care facilities, both when they enter the program and on a regular basis thereafter, to ensure that they meet Federal standards for health, safety, and quality. The Research line item supports a variety of research projects, demonstrations, and evaluations designed to improve the quality of healthcare furnished to Medicare beneficiaries and slow the cost of health care spending.

CMS' FY 2009 current law Program Management request totals $3,307.3 million, a $40.7 million increase over the FY 2008 enacted level (including $115.0 million in funding from the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)). This assumes that we collect an additional $38.0 million from the current law Part D Coordination of Benefits user fee that will be used to offset Part D activities in the Medicare Operations line. The request also includes a proposal to offset an additional $35.0 million in appropriated funds in the Survey and Certification line through the collection of user fees for facility revisits. Our proposed law request is $3,272.3 million, an increase of $5.7 million over the FY 2008 enacted level. The table below, and the following language, presents CMS' FY 2009 request for the line items within Program Management:

Program Management Summary Table
($ in millions)

Line Item	FY 2008 Enacted	FY 2009 Request	+/- FY 2008
Medicare Operations	$2,273.9	$2,339.7	+$65.8
Federal Administration	$631.1	$643.2	+$12.1
State Survey & Certification	$281.2	$293.1	+$11.9
Research	$31.3	$31.3	--
High-Risk Pools	$49.1	$0.0	-$49.1
CMS Program Mgmt. Approp., C.L.	**$3,266.7**	**$3,307.3**	**+$40.7**
User Fee Offset	$0.0	-$35.0	-$35.0
CMS Program Mgmt. Approp., P.L.	**$3,266.7**	**$3,272.3**	**+$5.7**

FTEs – Program Management Direct	4,222	4,148	-74
FTEs – CMS Total	4,477	4,457	-20

Medicare Operations

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA……………………..	$2,159,242,000	$2,197,293,000	$2,339,729,000	+$142,436,000
Rescission (P.L. 110-161)………..	$0	($38,387,000)	$0	$38,387,000
Subtotal BA………….	$2,159,242,000	$2,158,906,000	$2,339,729,000	+$180,823,000
Tax Relief and Health Care Act (P.L. 109-432)………..	$100,760,000	$0	$0	$0
Medicare, Medicaid and SCHIP Ext. Act (P.L. 110-173)………..	$0	$115,000,000	$0	($115,000,000)
Comparability Adjustment……………	$23,963,000	$0	$0	$0
Net BA…………...……	$2,283,965,000	$2,273,906,000	$2,339,729,000	+$65,823,000

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 2009 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. The program was expanded in 2003 to include a voluntary prescription drug benefit. Medicare benefits, the payments made to providers for their services, are permanently authorized. They are explained more fully in the Medicare Benefits chapter later in this book. The Medicare Operations account discussed here is funded annually through the Program Management appropriation. These funds are used to administer the Medicare program, primarily to pay contractors to process providers' claims and to pay for the IT infrastructure needed to support various claims processing systems.

More than 35 million, or approximately 78 percent of today's Medicare beneficiaries receive benefits through the fee-for-service portion of the program.

Medicare Parts A and B

The original Medicare program consisted of Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) and 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, about 40 FIs and carriers will be replaced with 15 Medicare Administrative Contractors, or MACs, who will process both Parts A and B workloads. This initiative is explained more fully later in this chapter.

Medicare Parts C and D

CMS also oversees and administers the Medicare Part C and Part D programs. Medicare Part C, also known as Medicare Advantage (MA), governs the way Medicare benefits are provided by private health care companies such as Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPOs), private fee for service plans, and Medicare specialty plans that contract with Medicare to provide benefits in a managed care setting. Beneficiaries generally get all of their medical services through an MA plan. In FY 2008, of Medicare beneficiaries enrolled in both Medicare Part A and Part B, nearly nine million - approximately 22% - are enrolled in MA plans.

Medicare Part D provides prescription drug coverage through either a stand alone prescription drug plan (PDP) or a joint MA prescription drug plan (MA-PDP). The Part D program has been an unparalleled success. Most Medicare beneficiaries, including nearly ten million low-income beneficiaries, are receiving comprehensive prescription drug coverage through Part D, an employer-sponsored drug plan, or other creditable coverage. Beneficiary satisfaction with the new drug benefit is high. Independent surveys indicate that over 85 percent of Part D enrollees are satisfied with their coverage.

Program Assessment Rating Tool (PART)

The Medicare program received a PART review in 2003 and was scored Moderately Effective. The review cited 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; continuing timely implementation of the Medicare Prescription Drug, Improvement, and Modernization Act; and increasing efforts to link Medicare payment to provider performance through demonstration projects. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

Funding History

FY 2004	$1,701,038,000
FY 2005	$1,730,920,000
FY 2006*	$2,200,842,000
FY 2007**	$2,260,002,000
FY 2008***	$2,273,906,000

*Includes funding provided under the Deficit Reduction Act (DRA) and the Secretary's One Percent Transfer Authority. **Includes funding provided under the Tax Relief Health Care Act and presented non-comparably. ***Includes funding provided under the Medicare, Medicaid and SCHIP Ext. Act.

Budget Request

CMS' FY 2009 budget request for Medicare Operations is $2,339.7 million, an increase of $65.8 million above the FY 2008 enacted level, including $115.0 million from the Medicare, Medicaid, and SCHIP Extension Act (MMSEA). Our request assumes that we will collect a net increase of $33.0 million in current law Part D Coordination of Benefits (COB) user fees which will be used to fund Part D systems costs. Almost half of the Medicare Operations account funds ongoing operational activities at the FIs, carriers, and MACs, such as processing fee-for-service claims, responding to provider inquiries, and handling appeals. The remainder funds fee-for-service support and systems activities, operational costs for the new Medicare Advantage and Part D programs, and initiatives that will improve and enhance the entire Medicare program such as HIGLAS and HIPAA.

Activity	FY 2008 Enacted	FY 2009 Estimate	Increase or Decrease
Medicare Parts A and B:			
FI/Carrier/MAC Ongoing Operations	$992.0	$1,039.3	$47.3
FFS Operations Support	20.1	38.3	18.2
Claims Processing Investments	58.2	91.1	32.8
Fee-For-Service Reforms	7.1	7.0	-0.1
Contracting Reform	189.6	108.9	-80.7
DME and Part B Competitive Bidding	37.5	50.0	12.5
Medicare Parts C and D:			
*IT Systems Investments	123.9	159.5	35.6
Oversight and Management	25.8	41.4	15.6
Managed Care Appeal Reviews	5.3	5.9	0.6
Activities Supporting All Parts of Medicare:			
**NMEP	302.7	318.7	16.0
HIGLAS	153.7	162.1	8.4
CFO Audit	7.9	8.0	0.1
QIC Appeals (BIPA 521/522)	44.5	57.9	13.4
HIPAA	23.6	23.7	0.1
ICD-10 and Version 5010	0.0	40.3	40.3
Other IT Investments	166.9	187.6	20.7
Subtotal	**$2,158.9**	**$2,339.7**	**$180.8**
Medicare, Medicaid, and SCHIP Extension Act (MMSEA)	$115.0	-	-
***Total**	**$2,273.9**	**$2,339.7**	**$65.8**

*In FY 2009, CMS will collect an additional $38.0 million, a net increase of $33.1 M over FY 2008 estimated collections, in Part D coordination of benefit user fees. These additional fees help fund direct Part D systems costs.

**Funding for beneficiary inquiries has been combined with the NMEP under the Beneficiary Contact Center/1-800-MEDICARE.

***Total may not add due to rounding.

MEDICARE PART A AND B OPERATIONS

Program Description and Accomplishments

FI/Carrier/MAC Ongoing Operations

Medicare contractors will process almost

service claims in FY 2009

This category reflects the Medicare contractors' ongoing workloads including claims processing, 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 beneficiary inquiries; this activity has been consolidated under the 1-800-MEDICARE number funded through the National *Medicare and You* Education Program (NMEP). This is discussed later in the chapter.

Our providers are important partners in providing care to 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." 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. CMS has also 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 Inquiries:* The Medicare contractors are responsible for responding to telephone and written inquiries from over one million Medicare providers. CMS relies on its contractors to keep providers abreast of changes in the program and to answer their questions, either general or claim-specific.

- *Participating Physician/Supplier Program (PARDOC):* This program helps reduce the impact of rising medical costs on beneficiaries by increasing the number of enrolled physicians and suppliers who agree to participate, i.e., accept Medicare's reimbursement rates. The contractors conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than the Medicare fee schedule allows.

- *Provider Outreach and Education:* The Medicare contractors conduct numerous provider outreach activities including holding periodic teleconferences, updating and expanding information on their internet websites, and maintaining electronic mailing lists. A strong communications program makes it easier for providers and suppliers to understand our program and navigate our organization. It also helps reduce claims processing errors and the additional work (e.g., inquiries, appeals, overpayment collections) that flows from these errors.

- *Enterprise Data Center Operations:* Processing large numbers of claims requires data center support. 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 FI and carrier data centers from 20 small centers to three large enterprise data centers (EDCs). CMS will manage these EDC contracts.

  This workload is currently being migrated to the EDCs. By FY 2009, all FFS claims processing operations will be housed at the three EDCs. This request covers the operations and maintenance costs associated with these three enterprise data center contracts. (Transitions costs needed to complete the migrations are reflected in the Contracting Reform discussion later in this chapter.)

Fee-for-Service Operations Support

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

- *Provider Toll-Free Lines*
  Toll-free lines encourage providers to call the Medicare contractors with questions about billing and claims processing issues. This helps reduce payment errors and also eases the financial burden on providers. This line funds the telecommunications costs, technical support, and management of the lines. It does not include the cost of the contractors' customer service representatives which are covered under Provider Inquiries.

- *National Provider Education, Outreach, and Training*
  CMS develops and disseminates national provider educational products--articles, brochures, billing guides, and fact sheets--and also offers web-based training and provider training calls. CMS has several contracts in place to assist with these activities. These materials provide an authoritative source of information to providers across the country and supplement the contractors' local outreach efforts.

- *Other Operations Support Activities*:
  - *Coordination of Benefits* - CMS electronically crosses Medicare primary paid claims to supplemental insurers to calculate their subsequent liability. This request funds a Coordination of Benefits contractor who performs this service.
  - *Limitation on Recoupment* - Section 935 of the MMA changed the way Medicare recoups certain overpayments and the way it calculates interest owed to a provider whose overpayment is reversed. This request funds contractor compliance with the statute.
  - *Provider Internet Transaction Pilots* – Supports the continued development of software and hardware for enterprise provider internet applications including claims-based transactions and a secure process for provider authentication.
  - *A-123 Assessment* - The Office of Management and Budget (OMB) Circular A-123 (Management's Responsibility for Internal Control) requires a rigorous assessment of CMS' internal controls over financial reporting. CMS will contract with a Certified Public Accountant (CPA) firm to conduct this review.

<u>Claims Processing Investments</u>

CMS' claims processing systems process more than 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 do all of the following: 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. Funds cover ongoing systems maintenance and operations. The main systems include:

- *Part A, Part B and DME processing systems* – The FI's, carriers, and DME MACs each currently use standard systems for processing Part A, Part B, and DME claims. 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) -* 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* – 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.

<u>Fee-For-Service Reforms</u>

The MMA mandated several fee-for-service reforms that require funding:

- Section 923 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.
- Section 1011 established a fund to reimburse providers for giving emergency treatment to undocumented aliens (see the State Grants and Demonstrations chapter in this book for a discussion of this benefit). This request provides the funding needed to cover the administrative costs of processing the providers' claims.
- Section 413 enacted improvements to the Health Professional Shortage Area (HPSA) bonus payment program. The law requires CMS to pay the bonus to physicians

providing services in HPSA-designated areas and also implement an additional 5-percent bonus for services provided in Physician Scarcity Areas (PSAs). Regular updates to the bonus programs are statutorily mandated.

Budget Request

FI/Carrier/MAC Ongoing Operations

The FY 2009 request for FI/Carrier/MAC Ongoing Operations is $1,039.3 million, $47.3 million above the FY 2008 enacted level.

The requested funding will allow the FIs, carriers, and MACs to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements. FY 2009 will be a transitional year for the Medicare contractors as we phase out the remaining legacy contractors (FIs and carriers), implement the new MACs, and transition all FFS workloads to the new EDCs. This level of funding will allow CMS to make a smooth and orderly transition between the two business processes. This funding level also covers a projected 2 percent increase in claims volume.

In FY 2009, CMS' contractors expect to:

- process almost 1.3 billion claims
- handle 5.9 million appeals
- answer about 55 million provider inquiries.

The following table displays claims volumes and unit costs from FY 2005 to FY 2009. The decrease in FY 2009 claims unit costs reflects anticipated savings from contracting reform and the Enterprise Data Center initiative.

	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Volume (in millions)					
Part A	185.6	185.9	185.7	194.5	198.4
Part B	979.9	991.5	959.4	1,070.0	1,091.4
Total	1,165.5	1,177.4	1,145.1	1,264.5	1,289.8
Unit Cost (in dollars)					
Part A	$0.96	$0.96	$0.93	$0.91	$0.86
Part B	$0.64	$0.64	$0.51	$0.51	$0.47

Fee-for-Service Operations Support

The FY 2009 request for fee-for-service operations support is $38.3 million. This funding level is $18.2 million more than the FY 2008 enacted level. Although these projects are not new, FY 2009 represents the first year CMS is requesting funds for the Coordination of Benefits contract, limitation on recoupment, provider internet transaction pilots, and the A-123 assessment. These items are responsible for most of the increase.

- Provider Toll-Free Lines: $8.5 million, which is the same as the FY 2008 enacted level.
- National Provider Education, Outreach, and Training: $7.5 million, $1.8 million more than the FY 2008 enacted level for an increase in the number of required provider education activities and updated Medicare Learning Network (MLN) educational products.
- Other Operational Costs: $22.3 million, $16.4 million more than the FY 2008 enacted level. This includes funding for the COB contractor, limitation on recoupment activity, provider internet transactions pilots, the A-123 assessment, etc.

The following table displays provider toll-free line call volumes historically and projected for FY 2008 and FY 2009:

Provider Toll-Free Line Call Volume

Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Completed Calls	51,477,020	55,206,016	54,368,698	57,087,133	59,941,490

Claims Processing Investments

The FY 2009 request for claims processing investments is $91.1 million, an increase of $32.8 million over the FY 2008 enacted level. The increase is needed to maintain the claims processing systems, keep them up to date with the latest legislative changes, and to conduct testing on any changes or enhancements made to the FFS systems. In addition, due to budget constraints, the contract periods for these systems were decreased to less than one year in FY 2008. However, in FY 2009, the contracts periods will revert back to 12 months.

Fee-For-Service Reforms

The FY 2009 request for fee-for-service reforms is $7.0 million, virtually the same as the FY 2008 enacted level. These activities include:

- Medicare Beneficiary Ombudsman: $1.2 million, $0.1 million more than the FY 2008 enacted level.
- Other activities including processing claims for emergency treatment of undocumented aliens; running the Physician Scarcity & Improvement to Health Professional Shortage Area (HPSA) bonus program: $5.8 million, $0.1 million less than the FY 2008 level.

CONTRACTING REFORM

Program Description and Accomplishments

Medicare contracting reform changes the face of the traditional Medicare program by integrating Medicare 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.

CMS has made strong progress towards full implementation of Medicare contracting reform in accordance with section 911 of the Medicare Modernization Act (MMA).

CMS will reduce its number of FFS contracts from 40 to 19.

In late FY 2006, CMS awarded the Jurisdiction 3 Part A/Part B MAC, covering six Western states, with major implementation activities proceeding through the first several months of FY 2007. As part of this process, legacy FI and carrier operations based in Arizona, Montana, and Wyoming were closed out as their responsibilities were transferred to the new MAC, yielding operating savings. Though certain infrastructure tasks still need to be done in order to optimize operations, the J3 MAC is now working under the operational phase of its contract.

CMS had already implemented three of four Durable Medical Equipment (DME) MACs (Jurisdictions A, B and D) by the end of FY 2006. Implementation of the fourth DME MAC contract (Jurisdiction C) was held up for several months due to a bid protest. In mid-January 2007, the Government Accountability Office (GAO) upheld CMS's award of this contract. Following GAO's decision, the outgoing contractor provided a significant level of cooperation to CMS and to the new DME MAC, which began operations in June 2007.

CMS issued two solicitations to launch the competitive bidding for seven Part A/Part B MAC contracts ("MAC Cycle I") during the first quarter of FY 2007. These two solicitations collectively represent over 45% of the national Medicare fee-for-service claims workload. The first solicitation covered Part A/Part B MAC Jurisdictions #4, 5 and 12. The second solicitation covered Part A/Part B MAC Jurisdictions #1, 2, 7 and 13.
The contractor community responded positively to the MAC Cycle I solicitations. In August 2007, CMS awarded the MAC contract for Jurisdiction 4 (comprising Texas, Oklahoma, New Mexico and Colorado). In September 2007, CMS awarded the MAC contract for Jurisdiction 5 (comprising Iowa, Kansas, Missouri and Nebraska). Implementation of both contracts has begun and will continue over the next several months. Several legacy FI and carrier operations will be closed out during this process.

On October 24, 2007, CMS awarded the MAC contract for Jurisdiction 12 which includes the states of Delaware, Maryland, New Jersey and Pennsylvania, as well as the District of Columbia. A competitor of the awardee filed a bid protest. Following a review of the record, CMS notified GAO that the agency would – on its own accord - take corrective action on certain aspects of the procurement. GAO then dismissed the protest. As of mid-January 2008, CMS continues to implement appropriate corrective action for the Jurisdiction 12 procurement.

On October 25, 2007, CMS announced that it had awarded the MAC contract for Jurisdiction 1 which includes the states and territories of American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands. Subsequently, this contract award was also protested to the GAO. CMS expects GAO's decision on the protest to be issued by February 21, 2008. In accordance with law, the protest filing triggered an automatic stay on contract performance pending GAO's decision.

At this time, CMS anticipates that it will award the remaining three MAC Cycle I contracts (Jurisdictions #2, 7 and 13) during the second quarter of FY 2008. These contracts will be implemented in the following months.

CMS issued two additional solicitations for seven MAC contracts ("MAC Cycle II") on August 31, 2007. These two solicitations (covering MAC Jurisdictions # 6, 8, 9, 10, 11, 14 and 15) collectively represent about 45% of the national Medicare fee-for-service workload. Four of these contracts will provide for Medicare home health and hospice claims processing.

Contractor proposals responding to the MAC Cycle II solicitations were received in November 2007. CMS will complete its review of these proposals and expects to award the MAC Cycle II contracts during the latter part of FY 2008 and early in FY 2009. CMS will closely monitor the implementation of the resulting contracts throughout FY 2009. All of the "first-generation" MACs should be fully operational by FY 2010.

The MMA requires that CMS re-compete all Medicare fee-for-service claims contracts within five years of award. CMS has recently begun planning for this "second generation" of MAC procurements. The planning process will consider both strategic and technical factors. CMS anticipates that it will begin to develop detailed acquisition plans and solicitation documents for the "second generation" of MAC contracts during FY 2009.

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

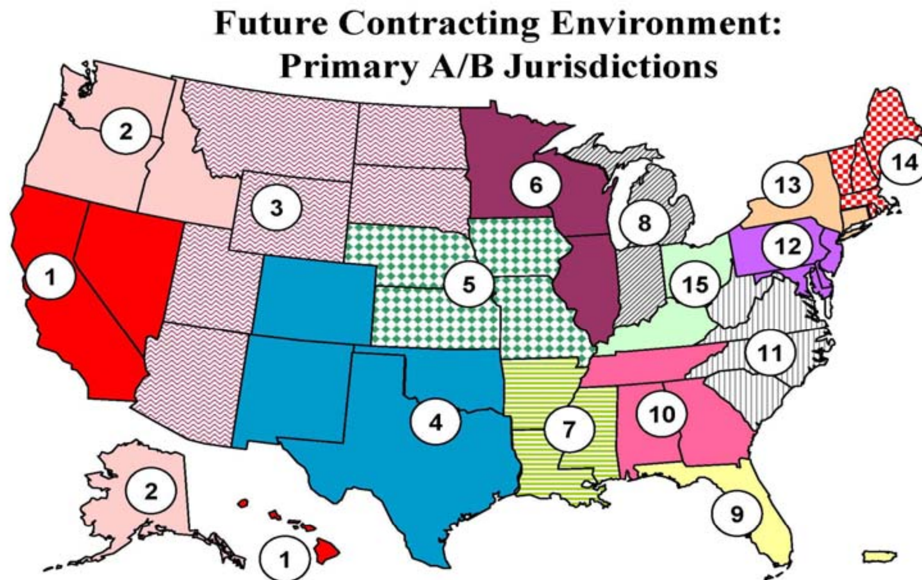
DME MAC Regions A & B	Awarded January 2006. Completed implementation cutover July 2006. These contractors are fully operational.
DME MAC Region D	Awarded on January 2006; protest resolved May 2006. Fully operational since October 2007.
DME MAC Region C	Initially awarded on January 2006; bid protest activity finally resolved January 2007. Fully operational since June 2007.
A/B MAC J3	Awarded July 2006 with most implementation activity completed by December 2006. Fully operational since May 2007.
Cycle I A/B MAC RFP 1	RFP released in September 2006. Jurisdiction 4 MAC was awarded August 2007. Jurisdiction 5 MAC was awarded September 2007. Jurisdiction 12 MAC was awarded in October 2007 (under corrective action). The full implementation of each jurisdiction will be completed within 12 months following award.
Cycle I A/B MAC RFP 2	RFP released in December 2006. There are four A/B MAC jurisdictions (Jurisdictions #1, 2, 7, and 13) to be awarded under this RFP. Jurisdiction 1 was awarded in October 2007 (GAO protest decision expected 2/08). CMS projects that the remaining awards (for Jurisdictions #2, 7 and 13) will be made during the second quarter of FY 2008. The full implementation of each jurisdiction will be completed within 12 months following award.
Cycle II A/B MAC RFP 1 & RFP 2	Seven (7) A/B MAC (RFP 1 & 2) contracts will be awarded during this procurement cycle: Jurisdictions #6, 8, 9, 10, 11, 14 and 15. Four of these A/B MAC jurisdictional contracts provide for Medicare home health and hospice claims processing requirements. CMS issued both RFPs concurrently in August 2007. The MAC awards will be staggered through the final half of calendar 2008. The full implementation of each individual jurisdiction will be completed within 12 months following award.

For FY 2007, CMS implemented 9.1 percent of the start-up cycle FFS workload to the MACs, slightly exceeding the performance target. Also, CMS awarded 22.2 percent of the FFS workload to MACs, which was 31.9 percentage points below the target. Award review has been delayed due to the complexity and magnitude of these procurements and the number of submitted bids which exceeded Agency projections. CMS has added resources (contract officers/specialists, panels, support services contractor) to manage procurements and has implemented process improvements. FY 2008 and FY 2009 performance targets have been adjusted to meet the current Integrated EDC-MAC-HIGLAS (Enterprise Data Center-MAC-Health Care Integrated General Ledger Accounting System) schedule. These results do not impact beneficiary receipt of Medicare benefits. Providers may be served by legacy fiscal intermediaries or carriers for a slightly longer period than originally anticipated, but their payments will not be affected. (Please refer to the key performance outcomes table at the end of this chapter.)

CMS has also made significant progress in reducing the number of data centers operated by the FI's and carriers from 20 small centers to three large enterprise data centers (EDCs). CMS expects to achieve administrative savings from this consolidation. It will also create greater performance, security, reliability, and control over this operation. In addition, the EDC infrastructure gives CMS greater flexibility in meeting current and future data processing challenges. This is critical as the FFS claims workload continues to grow and

applications require a more stable environment. By FY 2009, all FFS claims processing operations will be housed at the three EDCs. This request will cover the remaining transition and project management costs. In addition, the contractor management information system, a web-based workload tracking system, is included in the contracting reform request.

The following map displays the future MAC jurisdictions (Jurisdiction 1 through Jurisdiction 15):



Budget Request

Contracting reform has the potential to produce significant program savings to contribute toward deficit reduction.

The FY 2009 request for contracting reform is $108.9 million, $80.7 million less than the FY 2008 enacted level. This level includes:

- $82.8 million for contractor transitions; a $68.7 million decrease in funding for legacy contractor transition and termination costs.
- $13.8 million for information technology investments, including the final data center transitions and a web-based workload tracking system. This is $16.2 million less than the FY 2008 enacted level due to EDC transitions subsiding; and
- $12.3 million for several activities which support contracting reform implementation, including a provider satisfaction survey required by the MMA. This requested funding level is $4.2 million greater than the FY 2008 enacted level mainly due to the increased need for business expertise, external validation, and implementation support in this final year.

We believe that contracting reform will produce significant program savings to contribute toward deficit reduction. CMS' accelerated implementation approach will produce

additional savings earlier than anticipated in the legislation. Savings will 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 duplicative data centers. For FY's 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. CMS has also estimated administrative savings for FY 2009-FY 2011 as follows: $39.4 million, $80.2 million, and $116.5 million, respectively.

DURABLE MEDICAL EQUIPMENT (DME) AND PART B COMPETITIVE BIDDING

Program Description and Accomplishments

National competitive bidding is a program that uses market forces to set Medicare payment amounts. It also creates incentives for suppliers to provide quality items and services while at the same time providing Medicare and its beneficiaries with reasonable prices. CMS anticipates significant trust fund savings from this initiative. The MMA authorized two competitive bidding programs.

Section 302(b)(1) of the MMA authorized competitive bidding for Durable Medical Equipment (DME). CMS initiated this program in 2007 in ten metropolitan statistical areas (MSAs). We plan to add 70 MSAs in FY 2008 and expand to additional areas in 2009. This request covers the costs of the competitive bidding contractor who solicits bids from suppliers, evaluates the bids, sets prices, and selects the winning bidders; conducts a major education campaign; performs monitoring and complaint resolution; maintains and stores the bid database; and continues necessary maintenance in the MSAs. Bidding in FY 2008 will help ensure that the second phase of prices is in place by 7/1/2009. Bidding must be conducted in FY 2009 to help ensure that the third phase of prices is effective by 4/1/2010.

Section 303(d) of the MMA 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. CMS anticipates expanding this program as the number of physicians who elect to participate in the CAP grows and the number of drug classes available through the CAP increases. This request covers the cost of the competitive bidding contractor.

Budget Request

The FY 2009 request for Durable Medical Equipment (DME) and Part B competitive bidding is $50.0 million. In total, this line is $12.5 million more than the FY 2008 enacted level. DME competitive bidding increased by $12.0 million while Part B increased by $0.5 million. The DME funding increase is needed because CMS will be conducting bidding in additional MSAs and will need to maintain the program in the 80 established MSAs.

- DME Competitive Bidding: $47.5 million, an increase of $12.0 million above the FY 2008 enacted level.
- Part B Competitive Bidding: $2.5 million, an increase of $0.5 million above the FY 2008 enacted level.

CMS' actuaries estimate that DME competitive bidding will produce the following savings for the Medicare trust funds beginning in FY 2009 ($ in millions):

2009 .... $ 640
2010 .... $1,030
2011 .... $1,100
2012……………………………..$1,190
2013……………………………..$1,290

MEDICARE PART C AND D OPERATIONS

Program Description and Accomplishments

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

CMS is measuring three aspects of Medicare's prescription drug benefit for FY 2008 and 2009: (1) a beneficiary survey measuring knowledge of the benefit; (2) a management/ operations component involving Part D sponsor performance metrics published on the Medicare Prescription Drug Plan Finder (MPDPF) tool; and (3) an enrollment component measuring increase of Medicare beneficiaries with prescription drug coverage from Part D or other sources which will start reporting in FY 2009.

During the initial enrollment period and the first open enrollment period, we implemented intensive outreach and education campaigns, with associated media activities. As a result, CMS was able to meet its FY 2007 target indicating that outreach and education campaigns were very effective.

Given that 2009 will be the fourth open enrollment year, and fewer beneficiaries are likely to be interested in Part D messages, we are implementing an open enrollment outreach and education campaign that is less intensive than the prior campaigns. In subsequent years, primarily new enrollees will be motivated to become educated regarding Part D to make an initial choice, and they will be doing so with less intense communication activities directed toward them. Since most existing beneficiaries will be increasingly less likely to rethink their Part D plan choices, and subsequently forget what they know about the program, the result is a decline, and eventual plateau, in Part D knowledge across all beneficiaries. This pattern is typical of intense communication activities pertaining to a new program. We will continue to track beneficiary knowledge in FY 2009 to address this challenge.

CMS is continuing to work with Part D plans and other stakeholders to improve program operations and public knowledge of this valuable program. CMS wants to ensure that beneficiaries receive the best prescription drug coverage available and that they have the data necessary to make the most informed decision about plan selection. To assist beneficiaries making enrollment decisions for the FY 2007 plan year, CMS collected, analyzed and published the results of performance analysis on the MPDPF tool, thus meeting its Program Management/Operations target for FY 2007. The MPDPF offers beneficiaries useful information regarding performance metrics such as: Telephone Customer Service, Complaints, Appeals, Information Sharing with Pharmacists and Drug Pricing. The MPDPF can be found on CMS' website at:

http://www.medicare.gov/MPDPF/Home.asp. In FY 2009, we are planning to add "patient safety" measures, and refine and refresh all report card measures.

For the enrollment performance measure, the baseline for CY 2006 was approximately 90 percent. This figure illustrates the initial success of the Medicare prescription drug program. CY 2007 trend data will be available February 2008, at which point the CY 2009 target will be set. For more information on these performance measures, please refer to the key performance outcomes table at the end of this chapter.

The following discussion elaborates on the systems, oversight, and management 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 MA payments.
- *Health Plan Management System*: manages the MA and Part D plan enrollment process, including the application process; bid and benefit package submission; plan monitoring and oversight; and other activities.

Oversight and Management

Oversight and management of the Part C and Part D programs include actuarial reviews, audits, and estimates for prescription drug and MA plans; approval of new plan applicants for the 2010 contract year; monitoring of current plan performance; and reconciliation of 2009 plan payments. Activities to expand and support Part D enrollment of low-income beneficiaries are also included here. For example, the Point of Sale Facilitated Enrollment (POS-FE) contract helps ensure that eligible low-income Medicare beneficiaries have effective Part D coverage when they arrive at a pharmacy without proof of enrollment. Another contractor will process data submissions from both Part C and Part D plans for dual-eligible and low-income beneficiaries to ensure that these enrollees pay the correct amounts and that the plans are reimbursed correctly.

Much of the Part C and D oversight and management, such as the POS-FE, requires contractor support. Other contracts compare Part D enrollment records to determine premium/co-pay accuracy, provide technical assistance to the plans, and support Part D reconsiderations.

Managed Care Appeal Reviews

CMS contracts with an independent reviewer to conduct reconsiderations of adverse MA plan determinations and coverage denials made by Medicare Health Plans and Programs

of All-inclusive Care for the Elderly (PACE) organizations. This review stage represents the first level of appeal. 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 2009 request for Medicare Part C and Part D operations is $206.8 million. This funding level is $51.8 million more than the FY 2008 enacted level. Oversight and management activities are $15.6 million greater than the FY 2008 enacted level. The increase is due to the Point of Sale Facilitated Enrollment (POS-FE) contract; the joint process contract for dual eligible-low income subsidy beneficiaries; application reviews; Part D audits; and Medicare Managed Care auditing activities.

As the MA and PDP plan participation continues to grow, these systems must grow as well to accommodate the flow of additional information. This request funds the contracts needed to operate and maintain these various systems. In addition, some of these contracts will expire in FY 2009 and must be recompeted. CMS' request includes funds for recompeting these contracts and paying the transition costs if a new contractor is chosen.

- Part C/D IT Systems Investments: $159.5 million, an increase of $35.6 over the FY 2008 enacted level. The FY 2009 estimate represents costs we are currently incurring. Also, CMS' budget request assumes collection of a net additional $33.0 million in Part D coordination of benefits user fees to fund systems in this category.
- Oversight and Management: $41.4 million, an increase of $15.6 million over the FY 2008 enacted level.
- Managed Care Appeal Reviews: $5.9 million, an increase of $0.6 million over the FY 2008 enacted level due to an increase in workload activities.

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 contract center/1-800-MEDICARE; Internet; community-based outreach; and program support services.

Beneficiary Materials

This category includes the annual *Medicare and You* handbook, initial enrollment packages, and other beneficiary materials. The handbook is updated and mailed each autumn to all current beneficiary households The *Medicare and You* 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. It is available in both English and Spanish. CMS also does monthly mailings of the handbook to newly eligible beneficiaries.

The chart below displays the number of *Medicare and You* handbooks distributed for FY 2004 – FY 2009. 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 and You* Handbook Yearly Distribution

	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Number of Handbooks Distributed	38.7 million	39.3 million	40.3 million	41.3 million	42.5 million

Beneficiary Contact Center/1-800-MEDICARE

The 1-800-MEDICARE national toll-free line provides beneficiaries with 24 hour a day, seven day a week access to customer service representatives (CSR) in 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 have handled beneficiary claims inquiries through their own individual toll-free numbers. As part of contracting reform, the new Medicare Administrative Contractors (MACs) will no longer handle these inquiries. As a result, CMS has merged the claims inquiry and the general inquiry workloads under a single contract known as the **Beneficiary Contact Center (BCC)**. The BCC will use the same toll-free number –1-800-MEDICARE—currently used for general inquiries. This will allow beneficiaries to receive answers to both claims-related and general information and to order Medicare publications.

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

The chart below displays CMS' call volumes for FY 2004 – FY 2009. All calls are initially answered by the Interactive Voice Response (IVR) system. If a caller needs to speak with a CSR, they remain on the line. The average monthly wait time to speak to a CSR will be about 8 minutes during the peak enrollment period (November – January) and 9 minutes during the rest of the year. With an 8 minute monthly average speed of answer (ASA), most callers wait between 3 and 26 minutes.

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

	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Number of Calls	21.8 million	42.3 million	29.0 million	30.1 million	34.5 million

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

Internet

This category covers both the www.medicare.gov and www.cms.hhs.gov websites. The www.cms.hhs.gov website serves as a resource for providers, partners, and healthcare professionals. The www.medicare.gov website is a beneficiary-centered site with a variety of real-time, interactive, decision-making tools that enable beneficiaries to receive information on their benefits, plans, and medical options. This website includes four separate quality tools, eleven other complex applications, and MyMedicare.gov. MyMedicare.gov is a portal for beneficiaries to track and receive personalized information regarding their Medicare health and prescription drug plan, preventive services, and drug details and cost share information. The Medicare Options Compare, the Medicare Prescription Drug Plan Finder, Hospital Compare, Dialysis Facility Compare, and the Medicare Eligibility tool are included here.

CMS expects page views on www.medicare.gov to continue to increase as the Medicare beneficiary population increases, as beneficiaries and their caregivers become more internet savvy, and as we continue to implement more self-service features.

In FY 2009, CMS estimates approximately 470 million page views to www.medicare.gov, approximately a 3% increase in traffic from the page views anticipated in FY 2008.

	FY 2005 Actual	**FY 2006 Actual**	**FY 2007 Actual**	**FY 2008 Estimate**	**FY 2009 Estimate**
Number of medicare.gov Page Views	143.0 million	403 million	448 million	455 million	470 million

Community-Based Outreach

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

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 new preventive benefits. The SHIPs serve as the primary providers of locally based information and assistance. Located at the end of the Medicare Operations chapter is a SHIP State grant table that displays a break-out of SHIP funding on a State-by State basis.

CMS has built an extensive partnership network that will help establish a more permanent grassroots Medicare program. CMS has also worked collaboratively with the Administration on Aging to enhance its capacity to provide local assistance through its extensive network of providers. CMS plans to focus on promoting high quality care and raising the level of awareness about chronic diseases to help to 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 multimedia advertising 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 National Advertising Campaign raises awareness and educates beneficiaries, caregivers, 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 rural and low-income beneficiaries, 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 implementation of the Medicare Prescription Drug Benefit goal to include beneficiary awareness. CMS will also conduct tracking surveys to assess the overall effectiveness of our education activities.

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

	FY 2008 Enacted	FY 2009 Request	Description of Activity in FY 2009
Beneficiary Materials	$42.5 M ($28.5M PM) ($14.0M UF)	$50.4 M ($32.4M 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	$256.1 M ($208.5M PM) ($47.6M UF)	$268.5 M ($221.2M PM) ($47.3M UF)	Full call center and print fulfillment services 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. FY 2007 and FY 2008 have been adjusted for comparability. (In FY 2007, calls were still being transitioned from FFS to 1-800 MEDICARE)
Internet	$16.9 M ($14.2M PM) ($2.7M QIO**)	$18.4 M ($15.7M PM) ($2.7M QIO**)	Maintenance, updates and enhancements to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses;
Community-based Outreach	$57.6 M ($42.6M PM) ($15.0M MMSEA)	$41.9 M ($41.9M 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	$18.5 M ($9.0M PM) ($9.5M QIO**)	$17.4 M ($7.5M PM) ($9.9M QIO**)	National advertising 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	**$391.6 M** **($302.8M PM)** **($15.0M MMSEA)** **($61.6M UF)** **($12.2M QIO**)**	**$396.6 M** **($318.7M PM)** **($65.3M UF)** **($12.6M QIO**)**	**Key to Abbreviations:** PM – Program Management MMSEA – Medicare, Medicaid, SCHIP Extension Act UF – User Fee QIO – Quality Improvement Organizations

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

Budget Request

The FY 2009 Program Management request for the National *Medicare and You* Education Program totals $318.7 million, an increase of $15.9 million over the FY 2008 enacted level. This increased funding level is based on the population growth rate of Medicare beneficiaries resulting in increased call volumes to the Beneficiary Call Center as well as an increase in the number of handbooks to be printed and mailed in FY 2009. The BCC/1-800-MEDICARE line now reflects funding previously provided to the Medicare contractors for their beneficiary claims-related inquiry workload. This function has been consolidated under the NMEP. The following bullets highlight the Program Management request.

- Beneficiary Materials: $32.4 million
- Beneficiary Contact Center/1-800-MEDICARE: $221.2 million
- Internet: $15.7 million
- Community-Based Outreach: $41.9 million
- Program Support Services: $7.5 million

In addition to Program Management funding, the request includes $65.3 million in user fees and $12.6 million in QIO funding, bringing the NMEP total to $396.6 million. The chart on the preceding page provides additional detail on these activities.

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). 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 additional Medicare fee-for-service contractors and the continued development and implementation of administrative accounting functions at CMS central office, CMS will make progress to the goals tracked by the GAO.

CMS has achieved a number of milestones in the development and implementation of HIGLAS and continues to make progress according to schedule. To date, CMS has deployed HIGLAS at eleven of the largest Medicare fee-for-service contractors. In FY 2008, CMS will transition an additional three Medicare contractors onto HIGLAS, resulting in a total of 14 sites using HIGLAS by the end of FY 2008. In FY 2009, 7 additional workloads will transition to HIGLAS, impacting 5 MAC jurisdictions.

CMS is currently in the process of conducting internal Agency analyses to compute accounts receivable netting trends and projections for the purpose of estimating the amount of additional interest that will be earned (saved) in the Medicare Trust Funds due to

HIGLAS. Preliminary analyses indicate a projected cumulative total accounts receivable netting increase from FY 2006 through full HIGLAS implementation in FY 2011 of $16 billion, resulting in an anticipated $560 million in cumulative additional interest earned in the Medicare Trust Funds by FY 2011.

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 and rely on the Office of Inspector General and certified public accounting firms to conduct the audits

Budget Request

The FY 2009 request for accounting and audits is $170.1 million, an increase of $8.5 million over the FY 2008 enacted level. CMS will continue to develop additional functionality in the administrative program accounting modules in HIGLAS. This will allow HIGLAS to accommodate Medicare Part C and Part D payments/interfaces by FY 2010. 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; the "green" status of the Department's OMB Scorecard in the area of "Improve Financial Performance"; and the ability to meet OMB mandated FFMIA and FMFIA compliancy requirements for CMS and HHS.

The FY 2009 estimate includes costs associated with transitioning FI/carriers/MAC to HIGLAS and for the ongoing operational and maintenance costs for all entities that use HIGLAS. These activities include:

- HIGLAS: $162.1 million, an increase of $8.4 million to cover additional entities using HIGLAS.
- CFO/Financial Statement Audits: $8.0 million, an increase of $0.1 million due to an expected increase in higher General Services Administration rate schedules.

QUALIFIED INDEPENDENT CONTRACTOR (QIC) APPEALS

Program Description and Accomplishments

In FY 2009, 5 Qualified Independent Contractors (QICs) will process reconsiderations and forward requests for an ALJ hearing to the Department.

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, Part A appeals were reviewed initially by the fiscal intermediaries and then sent to an administrative law judge (ALJ) for a second-level review. All second level Part A and Part B appeals are now adjudicated by the QICs.

In addition to making decisions on second level appeals, the QICs also prepare and ship case files to the ALJs for pending hearings. In addition, QIC Medical Directors routinely

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 FI or Carrier so they can issue payment to the appellant. 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 the Department 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 2009 request for QIC appeals (BIPA sections 521 and 522) is $57.9 million, $13.4 million more than the FY 2008 enacted level. We anticipate a continued increase in the QIC's workloads, including reconsiderations and the number of cases forwarded to an Administrative Law Judge. Also, the QICs will be responsible for two additional workloads, the Hospital Payment Monitoring Program (HPMP) and inpatient hospital expedited appeals workloads. These will result in the need for additional QIC funding. Finally, we are committed to expanding the QIC's responsibilities for case file imaging, consistent with the Administration's electronic health record initiative.

- QIC Workload: $52.0 million, an increase of $12.0 million above the FY 2008 enacted level.
- National Coverage Determinations (NCDs): $0.3 million, the same as the FY 2008 enacted level.
- Medicare Appeals System: $5.6 million, $1.4 more than the FY 2008 enacted level for system enhancements.

The following chart details the number of QIC appeals historically and projected for FY 2008 and FY 2009:

QIC Appeals Workloads

Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
QIC Appeals	6,509	178,680	343,039	400,000	420,000

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 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:

- *National Plan and Provider Enumeration System (NPPES)*: HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health providers and plans that transmit claims electronically. CMS developed the NPPES to process the initial NPI requests and any subsequent changes.

  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 seek NPIs. Currently, over 2.4 million providers have been enumerated with NPIs. Provider enumeration estimates are based on 1.6 percent of the prior year for new providers plus the number of non-covered providers who wish to obtain an NPI. (Non-covered providers do not have to meet a compliance date and may seek enumeration at any time.) In addition, we estimate that 12.6 percent of all enumerated providers will submit changes to their records annually. So far, over 1 million enumerated providers have submitted changes. The compliance date for covered health care providers to become NPI-enumerated was May 23, 2007. However, a contingency plan was developed to provide some relief regarding the compliance date on the usage of NPIs in standard transactions.

- *HIPAA claims-based transactions* - implementation of HIPAA standards for transmitting claims data.
- *HIPAA Electronic Data Interchange (EDI)* - system changes and testing at our contractors' sites to meet HIPAA EDI standards, which involves exchanging data in a standardized form between computers, without human intervention.
- *HIPAA Pilot Testing of Transaction Code Sets* – involves conducting pilot tests of the HIPAA technical standards.
- *National Provider Identifier* - implementation and testing necessary to ensure compliance with this standard which requires all covered health providers to have a unique identification number, the NPI.
- *HIPAA Outreach and Enforcement* – Outreach efforts include national HIPAA roundtable discussions, web support, conferences, and educational materials. 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.
- *Administrative Simplification Enforcement Tool (ASET) and Database* – a web-based application that provides online complaint filing and management to parties who wish to file a HIPAA complaint.

Budget Request

The FY 2009 request for HIPAA administrative simplification is $23.7 million, virtually the same as the FY 2008 enacted level.

- NPPES: $8.2 million
- HIPAA Claims-Based Transactions: $10.6 million
- HIPAA Electronic Data Interchange (EDI): $2.0 million
- HIPAA Pilot Testing of Transaction Code Sets: $1.0 million
- National Provider Identifier: $1.0 million
- HIPAA Outreach and Enforcement: $0.6 million
- Administrative Simplification Enforcement Tool (ASET) and Database: $0.3 million

ICD-10 AND VERSION 5010

Program Description and Accomplishments

Since the late 19th century, the industrialized world has used a common system 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 system 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 still uses ICD-9-CM, an older version developed by the WHO about 30 years ago.

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

	ICD-9	ICD-10
Diagnosis Codes		
Number of Characters	3-5 Alphanumeric	5-7 Alphanumeric
Number of Codes	15,000	120,000
Procedure Codes		
Number of Characters	3-4 Numeric	7 Alphanumeric
Number of Codes	4,000	200,000 - 450,000

Each year that Medicare continues to use the ICD-9 code set, the more likely it becomes that claims could be paid inaccurately, increasing costs and placing the Medicare trust fund at risk. The ICD-9 code set does not provide detailed information concerning a patient's diagnosis, or the procedure or test that a provider orders. This makes detailed medical review necessary to detect if a claim was paid improperly. The ICD-10 code set is much more specific, making it easier to determine if a claim was appropriately billed. Although ICD-10 will not eliminate all fraud, waste, and abuse, CMS believes that its increased specificity will make it more difficult for fraud, waste, and abuse to occur.

The ICD-9 code set does not provide the level of specificity needed for value-based purchasing. A value-based purchasing program considers both quality and cost of care over an appropriate period of time. Specific and accurate data is vital to the success of the program. ICD-10 provides very specific data 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 and will lead to cost savings when a payer refuses to pay for provider errors.

CMS estimates that it will run out of ICD-9 procedure codes sometime in FY 2009, diminishing the ability to capture new technology. As a result, providers will not be able to submit electronic claims, as required by HIPAA, for new procedures and payers. CMS has prolonged the life of ICD-9 codes by placing new technologies in unrelated chapters, making it difficult to find these new procedures. As the ICD-9 code sets expire, it will be impossible for CMS to continue to be HIPAA-compliant.

The process of converting from ICD-9 to ICD-10 will be a major undertaking that will include revision of instruction manuals, claims processing systems, medical software, and analyses. In order to implement ICD-10, the current version of HIPAA transactions must first be upgraded from version 4010 to 5010. Version 5010 accommodates the increased space required for the ICD-10 code sets. CMS intends to have its systems be ICD-10 compliant by 2011.

Budget Request

The FY 2009 request for ICD-10 and version 5010 is $40.3 million. This is a new request.

- ICD-10 Implementation, Planning, and Pilot Testing: $17.9 million
- ICD-10 Systems Changes: $15.6 million
- Upgrading to Version 5010: $6.8 million

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. Additional activities included under this section include:

- the Medicare Data Communications Network, the secure telecommunications network that supports transaction processing and file transmission;
- hardware maintenance and software licensing; and
- developing and maintaining the mission critical database systems that house the data required by the CMS business community to perform its core functions.

In addition, this section also includes the CMS enterprise data and database management investment. This investment allows for the addition of databases; establishing consistent application of data policies and process in using CMS' data; and assuring the security of data resources as CMS moves to the Enterprise Data Center environment. CMS will also 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).

Lastly, enterprise IT activities include the Enterprise Information Technology Fund, which supports the President's Management Agenda e-Gov initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

Infrastructure Investments

This section includes several key IT infrastructure Projects, including:

- The virtual call center strategy, a critical project that has greatly increased the overall efficiency and effectiveness of call center service delivery;
- A web hosting project which covers the transitions of MMA web-hosted applications--such as the Integrated Data Repository, 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 growing workloads. Maintaining systems at the BDC greatly increases the risk of system failure; and
- The integrated data repository (IDR), 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.

Budget Request

The FY 2009 request for other information technology investments supporting all parts of Medicare is $187.6 million. This funding level is $20.7 million greater than the FY 2008 enacted level.

- Enterprise IT Activities: $143.2 million, $16.4 M more than the FY 2008 enacted level. This increase will cover inflationary increases in the CITIC contract and will provide greater security for data and systems, meeting HSPD-12 requirements.
- Infrastructure Investments: $44.4 million, $4.3 million more than the FY 2008 enacted level for inflationary increases in the virtual call center contract.

Key Performance Outcomes Table

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
			Actual	Target	Actual	Target	Actual			
Long-Term Objective: Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements										
MCR 10.1	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Intermediaries	99.5%	99.9%	95%	99.8%	95%	99.8%	95%	95%	N/A
MCR 10.2	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers	99.7%	98.4%	95%	99.5%	95%	99.0%	95%	95%	N/A
Long-Term Objective: Implement Medicare Contracting Reform										
MCR 13.1	Award FFS workload to the MACs	N/A	Delivered Report to Congress	Award 8.8%	Award 9.1%	Award 54.1%	Award 22.2%	Award 79.6%	Award 100%	N/A
MCR 13.2	Implement FFS workload to the MACs	N/A	N/A	N/A	N/A	Implement 8.8%	Implement 9.1%	Implement 54.4%	Implement 100%	N/A
Long-Term Objective: Implement the Medicare Prescription Drug Benefit										

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
			Actual	Target	Actual	Target	Actual			
MCR 3.1a	Beneficiary Survey Percentage of people with Medicare that know that people with Medicare will be offered/ are offered prescription drug coverage starting in 2006	N/A	N/A	49.4%	Goal met 67%	62%	Goal met 63%	63%	64%	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	N/A	N/A	52.5%	Goal met 69%	64%	Goal met 69%	65%	66%	N/A
MCR 3.1c	Beneficiary Survey Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs	N/A	N/A	28.4%	Goal met 50%	45%	Goal met 68%	46%	47%	N/A
MCR 3.2	Program Management/ Operations	N/A	N/A	Implement a Part D Claims Data system, oversight system, and contractor management system.	Goal met	Publish Part D sponsor performance metrics on the Medicare Prescript. Drug Plan Finder (MPDPF) tool.	Goal met	Publish the 2007 report card of Part D plan sponsor performance.	Add "Patient Safety" measures and refresh all report card measures	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
			Actual	Target	Actual	Target	Actual			
MCR 3.3	Enrollment Increase percentage of Medicare beneficiaries with Prescription Drug Coverage from Part D or other sources	N/A	N/A	N/A	90%	N/A	Feb-08	N/A	TBD	N/A
Long-Term Objective: Maintain CMS' Improved Rating on Financial Statements										
MCR 12	Unqualified opinion	Goal met	Goal met	Maintain	Goal met	Maintain	Goal met	Maintain	Maintain	Maintain (2010)

FY 2008 MANDATORY STATE/FORMULA GRANTS

CFDA NUMBER/PROGRAM NAME: (N/A) / State Health Insurance Assistance Program (SHIP)

STATE/TERRITORY	FY 2007 Actual	FY 2008 Enacted [1, 4, 5]	FY 2009 Estimate [5]	Difference +/- 2008 [6]
Alabama	$562,269	$575,774	$654,967	$79,193
Alaska	143,555	144,303	156,150	11,847
Arizona	538,871	553,629	634,543	80,914
Arkansas	469,341	475,714	529,926	54,212
California	2,517,989	2,546,858	2,963,434	416,576
Colorado	386,648	397,496	452,195	54,699
Connecticut	388,459	389,381	441,356	51,975
Delaware	167,665	170,901	187,243	16,342
District of Columbia	128,492	128,492	136,949	8,457
Florida	2,021,745	2,021,745	2,301,215	279,470
Georgia	717,847	739,158	848,396	109,238
Hawaii	197,610	199,089	220,584	21,495
Idaho	258,162	260,473	287,517	27,044
Illinois	1,070,132	1,077,455	1,246,804	169,349
Indiana	619,513	628,730	722,259	93,529
Iowa	505,724	507,980	563,928	55,948
Kansas	378,512	381,308	427,249	45,941
Kentucky	608,130	616,784	691,248	74,464
Louisiana	478,417	478,417	517,508	39,091
Maine	269,137	272,780	301,923	29,143
Maryland	484,120	489,990	560,118	70,128
Massachusetts	676,386	676,386	752,977	76,591
Michigan	958,591	974,037	1,123,699	149,662
Minnesota	525,263	532,132	606,455	74,323
Mississippi	493,461	497,667	551,046	53,379
Missouri	651,209	659,405	754,559	95,154
Montana	237,845	239,619	262,651	23,032
Nebraska	310,018	311,439	344,771	33,332
Nevada	255,721	260,583	292,133	31,550
New Hampshire	204,629	211,544	234,808	23,264
New Jersey	788,086	792,349	913,214	120,865
New Mexico	267,428	272,429	304,591	32,162
New York	1,710,197	1,710,197	1,978,470	268,273
North Carolina	871,625	891,066	1,023,806	132,740
North Dakota	204,235	205,856	224,598	18,742

STATE/TERRITORY	FY 2007 Actual	FY 2008 Enacted [1, 4, 5]	FY 2009 Estimate [5]	Difference +/- 2008 [6]
Ohio	1,132,903	1,147,203	1,322,737	175,534
Oklahoma	457,251	465,820	525,421	59,601
Oregon	417,631	423,632	481,644	58,012
Pennsylvania	1,434,338	1,441,826	1,653,791	211,965
Rhode Island	184,364	184,364	198,150	13,786
South Carolina	$479,651	$496,985	$566,410	$69,425
South Dakota	226,642	228,187	249,371	21,184
Tennessee	662,903	681,671	778,539	96,868
Texas	1,579,155	1,604,722	1,862,909	258,187
Utah	227,375	233,750	261,066	27,316
Vermont	204,758	206,374	225,065	18,691
Virginia	669,212	681,766	784,641	102,875
Washington	561,760	577,421	662,525	85,104
West Virginia	405,055	408,816	451,325	42,509
Wisconsin	602,897	609,071	695,447	86,376
Wyoming	174,638	176,092	191,706	15,614
Subtotal	**30,487,565**	**30,858,866**	**35,124,039**	**4,265,173**
Indian Tribes				
Migrant Program				
American Samoa				0
Guam	35,665	35,665	37,748	2,083
Marshall Islands				
Micronesia				
Northern Mariana Islands				0
Palau				
Puerto Rico	430,378	439,078	498,440	59,362
Virgin Islands	36,391	36,391	39,773	3,382
Subtotal	**502,434**	**511,134**	**575,961**	**64,827**
Total States/Territories	**30,989,999**	**31,370,000**	**35,700,000**	**4,330,000**
Technical Assistance				
State Penalties				
Contingency Fund				
Other Adjustments: (Performance Incentive Grants /2)	1,500,004	1,500,000	1,500,000	0
Other Adjustments: (SHIP Support Contracts /3)	1,697,535	1,530,000	2,000,000	470,000
Add'l funding for SHIPs, above FY 08 Enacted Level /4	0	19,900,000	0	-19,900,000
Subtotal Adjustments	**3,197,539**	**22,930,000**	**3,500,000**	**-19,430,000**
TOTAL RESOURCES	**$34,187,538**	**$54,300,000**	**$39,200,000**	**-$15,100,000**

1/ The FY 2008 Enacted level is based upon the FY 2008 President's Budget less the rescission.

2/ In September, CMS issues "performance incentive grant" funding utilizing performance criteria established by CMS.

3/ Support contract funding provides for support of SHIP resource center, website and performance assessment activities.

4/ The FY 2008 appropriations Omnibus bill provides for $5 million ($4.9 million after the rescission) above the FY 2008 Enacted level and the *Medicare, Medicaid and SCHIP Extension Act of 2007* (S.2499) provides for an additional $15 million for SHIPs. The state-by-state funding distribution displayed is based on the FY 2008 Enacted level and does not account for this additional $19.9 million in funding. CMS is currently analyzing distribution of the increased funding.

5/ The state-by-state distribution of FY 2008 and FY 2009 funding display is based on the current funding distribution formula and is subject to change by the DHHS Secretary. It is also subject to a change of the funding level for FY 2009.

6/ The difference between FY 2008 and FY 2009 in the state-by-state breakout is a comparison of the FY 2008 Enacted level and the FY 2009 request. It does not account for the additional $19.9 million in FY 2008 SHIP funding in the Omnibus bill and the *Medicare, Medicaid and SCHIP Extension Act of 2007.* CMS is currently analyzing the distribution of this additional funding.

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Federal Administration

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 + / - FY 2008
BA…………………..	$642,355,000	$642,354,000	$643,187,000	+$833,000
Rescission (P.L. 110-161)	$0	($11,222,000)	$0	+$11,222,000
Tax Relief and Health Care Act (P.L. 109-432)…	$4,240,000	$0	$0	$0
Comparability Adjustment.	($26,000)	$0	$0	$0
Net BA……………………	$646,569,000	$631,132,000	$643,187,000	$12,055,000
Direct FTEs………………	4,339	4,222	4,148	(74)

Authorizing Legislation......…………………………………………Reorganization Act of 1953

FY 2009 Authorization...One Year

Allocation Method…………...…………………………………………………………..Various

Program Description and Accomplishments

CMS' Federal Administration account funds staff and operating expenses for planning, developing, managing, and evaluating healthcare financing programs and policies. CMS employees working in Baltimore, Maryland; Washington, DC; and ten regional offices nationwide perform many essential activities, such as: providing funds to contractors; developing operating systems used to oversee our Medicare, Medicaid and SCHIP programs; managing programs to fight fraud, waste, and abuse; developing cost-effective health care purchasing approaches; monitoring contractor performance; and assisting States with Medicaid and SCHIP issues. Expenses covered include personnel compensation/benefits, rent, utilities, building loan, information technology, supplies, equipments, training and travel. Administrative expenses include both fixed and variable costs. Fixed costs are expenses that are set and inflexible while variable costs are expenses that fluctuate based on operations.

Fixed Expenses

Personnel Compensation and Benefits

This category consists of payroll, including cost-of-living increases, and fringe benefits for direct staffing funded through the Federal Administration line, only. Funding for CMS' reimbursable staff, along with funding for Medicaid integrity and financial oversight staff, are discussed elsewhere in this justification.

Our FY 2009 President's Budget request totals $522.2 million, an increase of $13.3 million over our FY 2008 Enacted level. The FY 2009 request includes a 2.9 percent cost-of-living increase in calendar year 2009. Our FY 2009 request supports 4,148 direct FTEs, a 74 FTE reduction from our FY 2008 level. This reduction reflects ongoing efforts to achieve administrative efficiencies within DHHS. Our staffing level request will allow CMS to maintain and improve key programs and workload while continuing support for the President's Management Agenda.

Rent, Communication & Utilities

This category funds expenses related to rentals and building operational costs for our single-site facility in Baltimore, Maryland, 10 regional offices and our Washington, DC offices. These include space rental, utilities, grounds maintenance, snow removal, cleaning and trash removal.

Single-Site Building Loan

This category provides funding to pay the General Service Administration (GSA) for the principal and interest on 44 construction loans for our single-site facility in Baltimore, Maryland.

Service and Supply Fund

This category primarily funds CMS' share of DHHS' Program Support Center expenses, including costs for DHHS' financial management service system and the personnel, payroll and e-mail systems. Other activities include regional mail support, EEO complaint investigations, and other services related to the administrative support of our daily operations.

Human Resources (DHHS)

This category pays for CMS' share of Departmental human resource activities, as part of the "One HHS" initiative. This initiative consolidated personnel activities, previously performed independently by each agency within the Department.

Administrative Services

This category funds the physical security of the single-site facility in Baltimore, Maryland and other activities that support the daily operation of CMS' headquarters and regional offices including building maintenance and repairs, medical/health services, machine repairs, mailroom services, and the Baltimore/DC shuttle service.

Variable Expenses

Information Technology

This category primarily funds CMS' administrative systems infrastructure that supports daily operations, including voice and data telecommunication costs, systems security, web-hosting and satellite services and a variety of systems that support grants and contract administration, financial management, data management, and document management services. It also funds the IT systems that support the Medicaid program. CMS Medicaid data systems provide access to all Medicaid eligibility and utilization claims data processed by all 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam.)

Inter-Agency Agreements

This category funds two large interagency agreements (IA): one with the Department of Treasury for agency-wide photocopier support including supplies, training, and preventive maintenance; and one with the Department of Labor to handle CMS share of annual benefits payments for worker's compensation. CMS also has several smaller IAs including one with the Office of Personnel Management (OPM) for employee services.

Supplies and Equipment

This category funds general office supplies and materials for CMS' central and regional offices, including funds for small furniture, office equipment, and replacement purchases.

Administrative Contracts and Intra-Agency Agreements

This category funds over 100 small administrative contracts and intra-agency agreements. CMS obtains a variety of operational services through contractual arrangements. Examples include: Medicare Market Basket & Price Index Studies, legal services with Office of General Counsel, Tribal training/outreach required by MMA, guard services, and Healthy Start, Grow Smart. The Healthy Start, Grow Smart program prints and disseminates a series of 13 brochures in English, Spanish, Chinese, and Vietnamese to Medicaid-eligible pregnant women and mothers of Medicaid-enrolled babies. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build the skills these children need to be successful in school. This category funds the printing and postage costs for the brochures.

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.

Travel

This category primarily funds travel expenses needed for certain activities required by law including overseeing survey and certification, contractor, and overpayment activities. CMS must periodically conduct on-site visits to ensure; compliance with the terms and conditions of contracts and cooperative agreements. In FY 2007, approximately $5.7 million was spent on site visits for overpayments, fraud and abuse investigations, and, the Medicare re-certification program.

Printing and Postage

This line funds the printing of brochures that assist beneficiaries in selecting health care plans; Medicare Cards; Provider, Supplier Enrollment Forms; various Medicare and Medicaid program guides; *Federal Register and Congressional Record* materials; and other printed forms and manuals. Postage expenses to mail these materials and other correspondence are also included in this category.

Funding History

2004	$577,146,000
2005	$581,493,000
2006*	$641,465,000
2007**	$646,595,000
2008	$631,132,000

*Includes $8.4 million in mandatory DRA funding. **Includes $4.2 million in mandatory TRHCA funding.

Budget Request

Below is itemized chart of the Federal Administration account. Our overall budget request is $12.1 million over the FY 2008 Enacted Budget.

Federal Administration Summary
(dollars in millions)

Object of Expense	FY 2008 Enacted	FY 2009 President's Budget	Increase or Decrease
Fixed Expenses			
Personnel Compensation & Benefits	$508.9	$522.2	+$13.3
Rent, Communications & Utilities	25.5	26.7	+1.2
Single-Site Building Loan	9.8	9.8	---
Service and Supply Fund	13.4	14.2	+0.8
Human Resources (DHHS)	8.9	8.2	-0.7
Administrative Services	4.3	3.8	-0.5
Subtotal, Fixed Expenses	**$570.7**	**$584.9**	**+$14.1**
Variable Expenses			
Administration IT	$20.7	$20.4	-$0.3
Inter-Agency Agreements	2.7	2.7	--
Supplies and Equipment	0.9	0.9	--
Administration Contracts and Intra-Agency Agreements	21.4	20.6	-0.8
Training	1.7	1.7	--
Travel	8.0	7.0	-1.0
Printing and Postage	4.8	5.0	+0.2
Subtotal, Variable Expenses	**$60.4**	**$58.3**	**-$1.9**
Total, Federal Administration*	**$631.1**	**$643.2**	**+$12.1**

* Numbers may not add due to rounding.

Medicare Survey and Certification Program

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA………………….	$258,128,000	$286,186,000	$293,128,000	+$6,942,000
Rescission (P.L. 110-161)…….	$0	($5,000,000)	$0	+$5,000,000
Net BA……………	$258,128,000	$281,186,000	$293,128,000	+$11,942,000
Proposed Law:				
Revisit User Fee….	$0	$0	$35,000,000	$35,000,000
Appropriation Offset………………	$0	$0	($35,000,000)	($35,000,000)
Proposed BA……	$258,128,000	$281,186,000	$293,128,000	+$11,942,000

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

FY 2009 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 2007, about 92 percent of nursing home facilities were cited for health deficiencies. The average number of health deficiencies per survey was approximately six. This demonstrates the profound importance of regular, comprehensive inspections of health care facilities.

In FY 2006, 89 percent of nursing home facilities were cited for health deficiencies.

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.

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 have led to lower frequencies for non-statutorily mandated facility surveys.

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 frequencies has increased from about 97.0 percent in 2002 to 99.9 percent in 2006, and the percent of home health agencies surveyed at mandated frequencies rose from 92.0% in 2002 to 99.7% in 2006. CMS has developed a new 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 FY 2008 target is for 80 percent of states to survey nursing homes at least every 15 months. To meet this target, 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. These activities are part of the Special Focus Facilities Program.

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 its implementation, the prevalence of restraints has declined from 17.2 percent in 1996 to 6.1 percent in FY 2006. As a result of the reduction in the prevalence of restraints from 6.6 percent in FY 2005 to 6.1 percent in FY 2006, about 7,000 fewer nursing home residents are physically restrained each day. 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 new national campaign entitled *Advancing Excellence in Nursing Homes*. In addition, CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use. The FY 2008 restraints target is 6.0 percent. CMS revises its targets if they become overly conservative or overly aggressive. While the FY 2006 result exceeds the FY 2007 target of 6.2 percent, CMS plans to examine future data to determine if the trend will continue before considering target revisions.

CMS has met targets to reduce the prevalence of pressure ulcers in nursing homes since FY 2004, including FY 2006, where we exceeded our target of 8.8 percent with an actual prevalence of 8.2 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. This prevalence of pressure ulcers is negatively affected if hospitals discharge patients to nursing homes in less stable condition. Nonetheless, a decrease in the prevalence of pressure ulcers of 0.6 percentage points represents more than 8,000 fewer nursing home residents with a pressure ulcer. While FY 2006 results exceed future targets, we plan to examine future data to determine if the trend will continue before possibly revising targets. The target for FY 2008 is 8.5 percent. For FY 2008, CMS has elected to select states for Comparative Contractor Health Surveys based upon citation rates for the pressure ulcer tag F314. Comparative health surveys are a type of Federal Monitoring Survey. About 50 of these surveys are carried out in nursing homes each year by a contractor. The primary purpose of these surveys is to gauge the effectiveness of the surveys that states conduct. Federal Tags are specific violations of the Code of Federal Regulations and are cited by nursing home surveyors (inspectors) who conduct onsite inspections each year. Specifically, States with the lowest national rates of citation were selected for these surveys.

Support Contracts and Information Technology

Support Contracts

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 produce efficiency and maximize the value of funds spent on training surveyors.

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.

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 nature of 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 off site information and on site information to develop computer generated quality care indicators. The quality of care indicators are used to compare the nursing homes 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 stage II of the survey. Approximately 5,000 state and federal surveyors will require training on the new survey process. In addition, transition to the QIS requires significant technology upgrades to support this refined survey process.

Funding History

FY 2004	$251,252,000
FY 2005	$258,735,000
FY 2006	$258,128,000
FY 2007	$258,128,000
FY 2008	$281,186,000

Budget Request

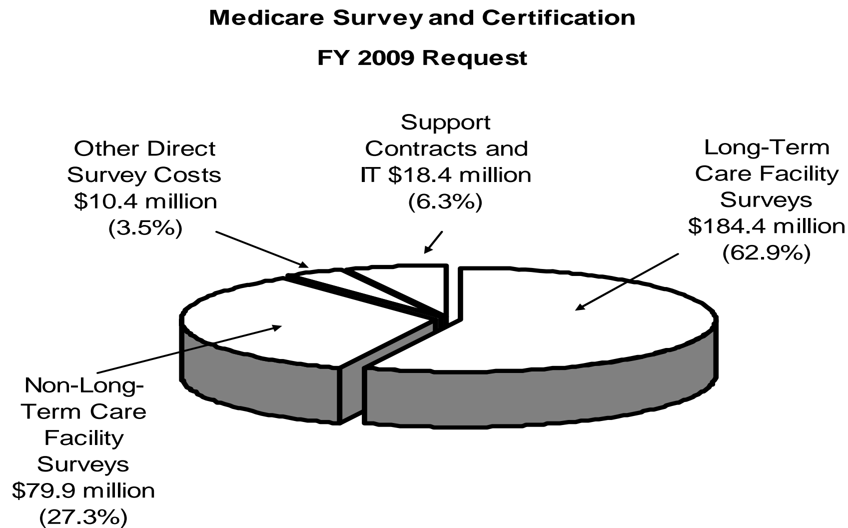
CMS' FY 2009 budget request for Medicare Survey and Certification is $293.1 million, an increase of $11.9 million, or 4 percent, above the FY 2008 Enacted Level. With facilities growth and inflation, this increase is all but absorbed in an effort to keep survey frequencies consistent with statutory and policy requirements. As described below in more detail, $264.3 million of this amount will support direct survey costs, $10.4 million will support additional costs related to direct surveys, and $18.4 million will be used for support contracts and information technology. The FY 2009 funding level will ensure sufficient oversight of federally funded health care.

The request also includes the proposed Survey and Certification Revisit User Fee totaling $35.0 million in FY 2009 (originally proposed in FY 2007 President's Budget and included in Congress' 2007 appropriations bill). If enacted, collections associated with this Revisit User Fee will offset our current law Program Management appropriation on a dollar-for-dollar basis. Further details on the Medicare Survey and Certification user fee proposal can be found in the

Program Management section of this document, following the appropriations language analysis.

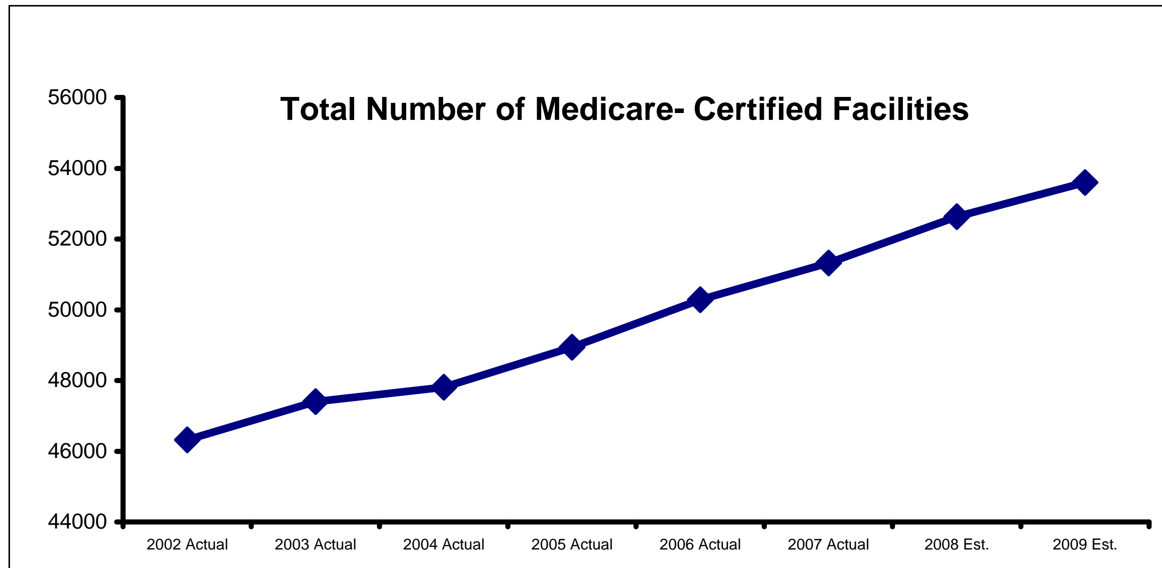
About 93 percent of the total budget request will go to State survey agencies for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals and other non-long term care providers. This budget request 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). The proportion devoted to support contracts and IT has slightly increased, reflecting the continuing effort to automate the survey process. The proportion devoted to all other functions has remained relatively consistent, considering inflation and workload growth.



<u>Direct Survey Costs - $274.7 million</u>

The FY 2009 estimate includes $274.7 million dollars for direct survey costs, which is about a $10 million increase over the FY2008 Enacted Level. Between FY 2002 and FY 2009, the number of Medicare-certified facilities increased by 16% from 46,324 facilities in FY 2002 to an estimated 53,602 facilities in FY 2009, as shown in the graph below. The 2009 request also funds surveys of organ transplant centers which were surveyed for the first time in FY 2007.



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

Direct Survey Costs
(dollars in millions)

Provider Type	FY 2008 President's Budget	FY 2008 Enacted	FY 2009 Estimate
Skilled Nursing Facility (SNF)	$11.0	$10.9	$10.5
SNF/NF (dually-certified)	$171.0	$164.0	$174.0
Home Health Agencies	$29.5	$29.5	$28.9
Accredited Hospitals	$17.2	$16.6	$19.2
Non-accredited Hospitals	$11.3	$10.8	$10.8
Ambulatory Surgery Centers	$4.4	$3.2	$2.6
ESRD Facilities	$12.9	$11.7	$10.2
Hospices	$5.2	$4.1	$4.8
Outpatient Physical Therapy	$1.6	$1.1	$1.0
Outpatient Rehabilitation	$0.5	$0.3	$0.2
Portable X-Rays	$0.2	$0.1	$0.1
Rural Health Clinics	$1.9	$1.4	$1.2
Transplant Centers	$0.7	$0.7	$0.8
Other Direct Survey Costs	$8.6	$10.9	$10.4
Total, Direct Surveys*	**$276.0**	**$265.3**	**$274.7**

* Total may not add due to rounding

CMS' FY 2009 request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. The FY 2009 target is for 85 percent of States to

survey nursing homes at least every 15 months. To meet the FY 2009 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 2009. In addition, CMS will issue an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements. The following chart includes updated frequency rates for fiscal years 2007 through 2009.

Recertification Level Comparison

Type of Facility	Recertification FY 2007 Enacted	Recertification FY 2008 Enacted	Recertification FY 2009 Estimate
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1.5% Per Year	1% Per Year	1% Years
Non-Accredited Hospitals	Every 4.4Years	Every 5 Years	Every 5 Years
Organ Transplant Facilities		Every 3 Years	Every 3 Years
ESRD Facilities	Every 4 Years	Every 4 Years	Every 4.6 Years
Hospices	Every 14 Years	Every 10 Years	Every 11.5 yrs
Outpatient Physical Therapy	Every 14 Years	Every 10 Years	Every 11.5 yrs
Outpatient Rehabilitation	Every 14 Years	Every 10 Years	Every 11.5 yrs
Portable X-Rays	Every 14 Years	Every 10 Years	Every 11.5 yrs
Rural Health Clinics	Every 14 Years	Every 10 Years	Every 11.5 yrs
Ambulatory Surgery Centers	Every 14 Years	Every 10 Years	Every 11.5 yrs

As shown in the recertification level comparison chart, even with an increase of $10 million over the FY 2008 Enacted level for direct survey costs, the FY 2009 frequencies decrease from the FY 2008 Enacted level. This is caused by inflation and facilities growth, which have a major impact on frequency levels.

CMS expects to complete a total of over 23,000 initial and recertification inspections in FY 2009, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates almost 45,000 visits in response to complaints. As the table shows, the majority of both surveys and complaint visits in FY 2009 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. The 2009 restraints target is set at 6.0 percent, which is slightly lower than the FY 2006 actual level of 6.1 percent. CMS' ability to continue to lower restraint use is impacted by the extent of QIO efforts, and other efforts that contribute to this goal, such as the Advancing Excellence campaign, which is currently set to expire in 2008.

The target for pressure ulcers for FY 2009 is 8.5 percent. CMS is encouraged by recent downward trends. The prevalence of pressure ulcers is negatively affected if hospitals discharge patients to nursing homes in less stable condition. While FY 2006 results exceed future targets, we plan to examine future data to determine if the trend will continue before possibly revising targets.

Type of Facility	FY 2008 Enacted Level Funding (Surveys and Investigations)				FY 2009 Estimate (Surveys and Investigations)			
	Total Recert	Total Initial	Total Complaint	Total Surveys	Total Recert	Total Initial	Total Complaint	Total Surveys
Skilled Nursing Facility (SNF)	897	62	609	1,568	897	38	674	1,609
SNF/NF (dually-certified)	14,122	269	33,899	48,290	14,177	208	36,313	50,698
Home Health Agencies	2,772	596	1,210	4,578	2,662	706	1,494	4,862
Accredited Hospitals	45		4,350	4,395	45	-	4,506	4,551
Non-accredited Hospitals	336	328	476	1,140	359	252	532	1,143
ESRD Facilities	1,213	206	575	1,994	1,082	207	575	1,864
Organ Transplant Facilites		30		30		24		
Hospices	295	200	385	880	255	236	546	1,037
Outpatient Physical Therapy	299	175	6	480	260	183	6	449
Outpatient Rehabilitation	66	84	7	157	53	57	7	117
Portable X-Rays	63	30	3	96	50	34	4	88
Rural Health Clinics	372	294	18	684	327	266	18	611
Ambulatory Surgery Centers	465	317	61	843	387	318	103	808
Total	**20,945**	**2,591**	**41,599**	**65,135**	**20,554**	**2,529**	**44,778**	**67,837**

The FY 2009 direct survey cost estimate also includes $10.4 million, which is a $.5 million decrease from the FY 2008 Enacted level, in other direct survey costs for several continuing activities:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects ($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 ($3.4 million);
- Printing, Copying and Miscellaneous expenses. This includes life and fire safety code manuals, surveyor manuals/worksheet, nursing home manuals, offsite training rooms/AV equipment rental, Dept of Appeals Board transcript costs, and travel funds for directors ($1.0 million).
- Validation Support. This includes conducting validation surveys of the non-long term care accredited facilities; HHA, ASC, and Hospice. ($.7 million)
- Security & Emergency Preparedness. This includes support for the States efforts in developing emergency preparedness requirements, and for security measures including encryption software. ($.3 million)

Support Contracts and Information Technology - $18.4 million

Support Contracts

Support contracts, managed internally by CMS, constitute approximately $15 million of the FY 2009 request. This is an increase of $2 million over the FY 2008 Enacted level. The largest category in support contracts continues to be surveyor training. The FY 2009 estimate will provide about $1 million more in funding than the FY 2008 Enacted level for training surveyors and their supervisors to preserve consistency of CMS policy in the various training venues and media. The FY 2009 estimate also provides an additional $1 million for the evaluation/support of the QIS and improving nursing home enforcement. For Federally directed surveys that

substitute for State surveys on psychiatric hospitals and comparative surveys, $2.4 million is being requested. In FY 2009, we estimate that we will fund 155 surveys of psychiatric hospitals, (same number of surveys as in FY 2008), as well as federal monitoring surveys, both to be performed by contractors.

Information Technology

The Medicare Survey and Certification budget includes approximately $3.4 million in IT funding, the same level as the FY 2008 Enacted level, for activities such as maintenance and enhancements to the OSCAR system and the FOSS redesign. 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 key 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 as well. The FOSS redesign will integrate the database into ASPEN, develop a user's operational manual and post it on the CMS website and revise FOSS reports for the State Performance Standard Report.

This request will provide $.8 million in information technology for the continued implementation of the Quality Indicator Survey (QIS). As part of the QIS demonstration process 5 states were selected and the results indicated that 25% of the State Survey Agencies have expressed interest in implementing this system. Minnesota was selected as the first state beyond the demonstration states to implement the QIS. CMS hopes to expand QIS to additional States.

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out year Target
			Actual	Target	Actual	Target	Actual			
Long-Term Objective: Decrease the Prevalence of Restraints in Nursing Homes										
MCR4	Decrease the Prevalence of Restraints in Nursing Homes	7.3%	6.6%	6.4%	6.1%	6.2%	Feb 08	6.1%	6.0%	5.9% (2010)
Long-Term Objective: Decrease the Prevalence of Pressure Ulcers in Nursing Homes										
MCR5	Decrease the Prevalence of Pressure Ulcers in Nursing Homes	8.7%	8.5%	8.8%	8.2%	8.6%	Feb 08	8.5%	8.5%	N/A

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
				Estimate	Actual	Estimate	Actual		
MCR 6	Percentage of States that survey Nursing Homes at least every 15 months	N/A	Baseline 66%	N/A	N/A	N/A	N/A	80%	85%
MCR 7	Percentage of States that survey HHAs at least every 36 months	N/A	Baseline 42%	N/A	N/A	N/A	N/A	70%	75%
MCR8	Percentage of States for which makes a Non-delivery Deduction from the State's subsequent year survey and certification funds	N/A	Baseline 6%	N/A	N/A	N/A	N/A	70%	75%
Appropriated Amount ($ Million)		**$251,252**	**$258,735**	**$258,128**		**$258,128**		**$281,186**	**$293,128**

DEPARTMENT OF HEALTH AND HUMAN SER
CENTERS FOR MEDICARE AND MEDICAID S

FY 2009 DISCRETIONARY

CFDA NUMBER/PROGRAM NAME: 93.777
STATE SURVEY AND CERTIFICATION OF
HEALTH CARE PROVIDERS AND
SUPPLIERS

STATE/TERRITORY	FY 2007 Actual*
Alabama	$3,763,772
Alaska	$697,047
Arizona	$3,009,446
Arkansas	$3,898,796
California	$28,668,436
Colorado	$4,161,177
Connecticut	$4,513,975
Delaware	$732,400
District Of Columbia	$710,548
Florida	$8,523,934
Georgia	$4,528,661
Hawaii	$904,789
Idaho	$1,364,250
Illinois	$10,023,226
Indiana	$5,723,472
Iowa	$2,348,582
Kansas	$3,134,481
Kentucky	$4,034,288
Louisiana	$4,240,353
Maine	$1,953,908
Maryland	$2,934,093
Massachusetts	$6,886,603
Michigan	$7,027,695
Minnesota	$6,580,210
Mississippi	$1,644,795
Missouri	$8,228,360
Montana	$1,530,261
Nebraska	$2,175,044
Nevada	$1,602,229
New Hampshire	$902,318
New Jersey	$5,836,896
New Mexico	$1,676,194
New York	$10,302,331
North Carolina	$6,114,073
North Dakota	$1,191,420

Ohio	$13,105,466
Oklahoma	$3,764,960
Oregon	$2,814,575
Pennsylvania	$8,662,132
Rhode Island	$1,539,299
South Carolina	$2,340,340
South Dakota	$1,197,051
Tennessee	$3,261,653
Texas	$27,176,605
Utah	$1,479,625
Vermont	$639,636
Virginia	$3,246,058
Washington	$5,016,742
West Virginia	$1,775,627
Wisconsin	$5,173,484
Wyoming	$878,119
Subtotal	**243,639,435**
Indian Tribes	$0
Migrant Programs	$0
American Samoa	$0
Puerto Rico	$476,583
Virgin Islands	$15,366
Subtotal	**$491,949**
Total States/Territories	**$244,131,384**
Technical Assistance	$0
Other Adjustments (specify)	$0
Subtotal Adjustments	$0
TOTAL RESOURCES	**$244,131,384**

*Current FY 2007 funding allowances to States a

Research, Demonstration and Evaluation

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 + / - FY 2008
BA……………..	$57,420,000	$31,857,000	$31,300,000	($557,000)
Rescission (P.L. 110-161)...	$0	($556,000)	$0	+$556,000
Net BA…………	$57,420,000	$31,301,000	$31,300,000	($1,000)

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 2009 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 serve over 90 million beneficiaries.

Our research and demonstration activities 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 10 years according to actuary 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 is the most common form of hospital payment in the United States today. We also developed a system of risk-adjusted payment for managed care organizations, End Stage Renal Disease (ESRD) enrollees and a risk-adjuster model for use to pay Part D prescription drug plans.

Our research and demonstration activities significantly contributed to major program reforms and improvements saving an estimated $64 billion in program

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 the Medicaid/Medicare 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 slow the rapid growth of health care spending and improve the efficiency and quality of our health care programs.

Real Choice Systems Change Grants (RCSC)

RCSC grants are intended to assist States to design and implement enduring improvements to community-based support systems that enable people with disabilities and long-term illnesses to live and participate in community life. Between 2001 and 2007, a total of $270.4 million in RCSC grants have been awarded to States. CMS awarded 28 grants in FY 2007. 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; and, help States to rebalance long-term care systems by addressing the need for single point of entry to access services.

Electronic Health Records (EHR)

The EHR demonstration is a five-year initiative that promotes high-quality care through the adoption and use of electronic health records. This proposal will expand the base created by the Medicare care management performance demonstration and is expected to be implemented in locations that include Better Quality Information (BQI) pilot sites or Chartered Value Exchanges (CVEs). The demonstration is to be implemented in approximately 1,200 small- to medium-sized primary care physician practices in up to 12 sites. Under the demonstration, practices will be eligible to earn incentive payments for the implementation and adoption of health information technology in their practice and achieving specified standards on clinical performance measures for diabetes, congestive heart failure, coronary artery disease and the provision of preventive health services. The demonstration is an important step towards meeting the President's goal of nationwide adoption of EHRs by 2014. Physician recruitment is planned for 2008. In FY 2008, CMS estimates $1.9 million in demonstration administrative spending. For more information go to http://www.cms.hhs.gov/DemoProjectsEvalRpts.

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 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. The MCBS data is of importance to the actuaries and ultimately to decision-makers who craft legislation. One of the prime users of MCBS data is the Congressional Budget Office, in developing legislative estimates. The use of MCBS data was most clear in the policy research that preceded the Part D drug benefit. Internal CMS researchers and policy analysts worked with researchers from the University of Maryland and Rutgers University to project the consequences of alternative policies for the Medicare population and the Medicare budget. MCBS has been important in CMS payment policy for the demographics used to calculate the Adjusted Average Per Capita Cost (AAPCC), define risk adjustment formulas and evaluate 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. MCBS is also used for program monitoring. It is a major basis for the annual Trustees' Report developed by the Office of the Actuary as well as the calculations in the National Health Accounts. MCBS also allowed CMS researchers to monitor the level

of prevention and determine how preventive medical care and preventive self-care can be fostered. The MCBS data is now positioned to serve as a means to monitor the Part D program both in terms of understanding the interface between the beneficiary population and that of the CMS and to supplement and give meaning to the claims files. MCBS also feeds into the Agency's measurement of annual Government Performance and Results Act (GPRA) goal attainment, whether it is the level of flu and pneumococcal immunization or the level of understanding of the program. CMS has recently completed the 2005 Access file and the 2004 Cost and Use file for the MCBS.

Other Activities

The implementation and evaluation of demonstration activities including mandated activities continue CMS' ongoing efforts to test potential future improvements in Medicare coverage, expenditures, delivery, access and quality of care. In 2007, CMS released eight Reports to Congress and implemented three new demonstrations. Reports to Congress included Evaluation of the Medicare Replacement Drug Demonstration (Medicare Modernization Act (MMA)), Impact of Increased Financial Assistance to Medicare Advantage Plans (MMA), Evaluation of Phase I of the Medicare Health Support Program (MMA), Physician Group Practice Demonstration (Benefits Improvement and Protection Act (BIPA)), Medicare Hospital Gainsharing (Deficit Reduction Act (DRA)), and the Second Report on the Evaluation of the Medicare Coordinated Care Demonstration. The demonstrations implemented were BIPA cancer prevention and treatment for racial and ethnic minorities, Medicare care management performance (MMA), and PACE for profit. CMS initiated operations for the MMA section 723 chronic conditions warehouse (CCW). The CCW is designed to support studies to improve the quality of care and reduce the costs for chronically ill beneficiaries. CMS loaded 100-percent of Medicare 2005 and 2006 claims into the CCW and maintained up-to-date status on all 2007 data loads.

CMS' commitment to the Secretary's Value-Driven Health Care Initiative is supported through demonstrations conducted in multiple provider settings and research on quality and efficiency. Our research activities will inform the agency on how to develop and implement initiatives that promote value in health care and will provide policymakers with information on the impacts of performance incentives. The acute care episode (ACE) demonstration, a project that supports value-driven health care, assesses the benefits of the global payment methodology tied with competitive bidding, gainsharing and rebates to beneficiaries to encourage selection coupled with program transparency to both market the program and provide quality and outcome information to the public.

Projects that support the Secretary's value-driven health care initiative include:

- *Medicare health care quality (MMA)*
- *Medicare care management performance (MMA)*
- *Medicare Health Support (formerly CCIP) (MMA)*
- *Home health pay for performance*
- *Electronic health records*
- *Premier*
- *Acute care episode*
- *ESRD disease management*
- *Post-acute care*

CMS continues to evaluate and refine our prospective payment systems as they proceed through successive stages of implementation. CMS' research budget also meets the crosscutting research needs of the wider health research community through grant programs for Historically Black Colleges and Universities (HBCUs) and Hispanic researchers. In FY 2007, CMS awarded new and continued HBCU and Hispanic research grants. Also, the Research Data Assistance Center (ResDAC) develops and enhances the capabilities or expertise of the overall health services research system.

Funding History

FY 2004	$77,791,000
FY 2005	$77,494,000
FY 2006*	$69,420,000
FY 2007	$57,420,000
FY 2008	$31,301,000

*Includes $12.0 million in DRA funding.

Budget Request

The FY 2009 request for CMS' RD&E is $31,300,000 a decrease of $1,000 from the FY 2008 enacted level.

- $7.5 million for RCSC grants, a decrease of $2.3 million from the FY 2008 enacted level. CMS plans to award 10 grants in 2009 and 13 grants in 2008.

- $3.8 million for the EHR demonstration, a 50-percent increase from the FY 2008 investment. In FY 2009, CMS will continue Phase I of the demonstration with implementation support, recruitment activities, data collection, and technical assistance for participating practices and conduct an evaluation.

- $14.4 million for the MCBS restores the funding to the pre-FY 2008 spending level. The FY 2009 funding is the estimated annual expenditures necessary to continue to make available the only source of multi-dimensional person based information about the characteristics of the Medicare population.

- $5.6 million to fund all other activities including continued support of mandated and non-mandated demonstration activities, prospective payment systems activities, research grants and data collection and dissemination tools maintenance. With this balance of funding, CMS plans to continue several MMA activities including the rural hospice, rural community hospital, Medicare health care quality and Medicare care management performance demonstrations. CMS also plans to continue additional value-driven health care projects such as the ESRD disease management demonstration and the DRA post-acute care demonstration. Other continued activities include BIPA cancer prevention and treatment for racial and ethnic minorities and the senior risk reduction demonstrations. Research will continue on several prospective payment systems, HBCU/Hispanic research grants and the ResDAC.

High-Risk Pools

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 + / - FY 2008
BA…………………….	$0	$50,000,000	$0	-$50,000,000
Rescission P.L. 109-432)……….	$0	($873,000)	$0	+$873,000
Net BA……………….	$0	$49,127,000	$0	-$49,127,000

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

Allocation Method………...………………………………………………………..Grants

Program Description and Accomplishments

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

In FY 2006, section 6202 of the DRA and State High Risk Pool Funding Extension Act of 2006 extended the funding of grants under section 2745 of the Public Health Service Act by authorizing and appropriating $15 million for seed grants to assist States to create and initially fund qualified high risk pools and $75 million for grants to help fund operational losses and bonus grants for supplemental consumer benefits to the existing qualified State high risk pools. CMS awarded grants to 36 States in FY 2006 and to five States in FY 2007. These funds were included in CMS' mandatory State Grants and Demonstrations account. The table in the State Grants and Demonstrations chapter, High-Risk Pools section, of this book lists the States and award amounts granted for establishing and/or operating high-risk pools under P.L. 107-210 since 2006.

The Consolidated Appropriations Act of 2008 (P.L. 110-161) appropriated $49.1 million for State high-risk health insurance pools for FY 2008 in CMS' discretionary Program Management account.

Budget Request

CMS is not requesting funding for State high-risk pools in FY 2009 in its discretionary Program Management account. Instead, the FY 2009 President's Budget proposes to include $75 million in FY 2009 and FY 2010 in CMS' mandatory State Grants and Demonstrations account for grants to help States offer health insurance options to hard-to-insure populations as authorized by the State High Risk Pool Extension Act of 2006 (P.L. 109-172).

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Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *$149,335,031,000* to remain available until expended.

For making, after May 31, *2009*, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year *2009* 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 *2010, $71,700,038,000* 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, $149,335,031,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $67.3 billion provided for the first quarter of FY 2009 under the FY 2008 Labor, HHS, Education and Related Agencies Appropriations Act. 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, 2009, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2009 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.	This section provides indefinite authority only for payments to States in the last quarter of fiscal year 2009 to meet unanticipated costs. This language does not provide this 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 2010, $71,700,038,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of fiscal year 2010 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 2010 is not enacted by October 1, 2009. 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services
Appropriation
Medicaid Program

Amounts Available for Obligation
(dollars in thousands)

	2007 Actual	**2008 Estimate**	**2009 Estimate**
Appropriation: Annual	$168,254,782	$206,885,673	$216,627,700
Appropriation: Indefinite..................	0	0	0
Unobligated balance, start of year	26,586,131	4,007,661	4,140,628
Unobligated balance, end of year	(4,007,661)	(4,140,628)	0
Recoveries of Prior Year Obligations	13,921,603	0	0
Offsetting Collections	359,188	300,000	0
Total Gross Obligations	$205,114,043	$207,052,706	$220,768,328
Medicare Part B Transfer	(358,675)	(300,000)	0
VFC Program Collection	(513)	0	0
Obligations Incurred but not Reported	(1,614,242)	(3,000,000)	(3,231,000)
Total Net Obligations	$203,140,613	$203,752,706	$217,537,328

MEDICAID PROGRAM
Summary of Changes
(dollars in thousands)

2008 Budget Authority	$206,885,673
2009 Estimated Appropriated Budget Authority	$216,627,700
Net Change	$9,742,027

Explanation of Changes

	2008 Current Base Budget Authority	FY 2009 Change From Base Budget Authority
Program Increases:		
1. Medical Assistance Payments	$191,900,000	$14,800,000
2. State Administration	9,916,341	145,652
3. Fraud Control Units	186,000	9,300
4. State Certification	223,000	5,798
5. Offsetting Collections From Medicare Part B	-300,000	300,000
6. State and Local Administration Financial Adj.	-153,341	440,348
7. Medicare, Medicaid, and SCHIP Extension Act	-15,000	85,000
8. Obligations Incurred But Not Reported	3,000,000	231,000
9. Vaccines for Children Program	2,702,206	64,024
Total program increases	$207,459,206	$16,081,122
Program Decreases:		
1. TMA, Abstinence Education, and QI Programs Extension Act	260,000	-315,000
2. Administrative Actions Affecting State and Local Administrati	-47,200	-422,800
3. Unobligated Balance End of Year	4,140,628	-4,140,628
4. Financial Management Reviews	-633,000	-49,000
5. Administrative Actions Affecting Medical Assistance Paymen	-286,300	-1,178,700
6. 1915(b)(3) Regulation	0	-100,000
7. Unobligated Balance Start of Year	-4,007,661	-132,967
Total program decreases	-573,533	-6,339,095
TOTAL	$206,885,673	$9,742,027

MEDICAID PROGRAM

Authorizing Legislation

	2008 Amount Authorized	2008 President's Budget	2009 Amount Authorized	2009 Budget Request
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$204,183,467,000	Indefinite	$213,861,470,000
Vaccines for Childrens Program (Social Security Act, title XIX, Section 1928)		$2,702,206,000		$2,766,230,000
Total appropriations		$206,885,673,000		$216,627,700,000

MEDICAID PROGRAM
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
1999	102,394,422,000	102,394,422,000	102,394,422,000	102,394,422,000	
2000	114,820,998,000	114,820,998,000	114,820,998,000	117,744,046,209	1/
2001	124,175,254,000	124,175,254,000	124,175,254,000	129,418,807,224	2/
2002	143,029,433,000	143,029,433,000	143,029,433,000	147,340,339,015	3/
2003	158,692,155,000	158,692,155,000	158,692,155,000	164,550,765,542	4/
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	5/
2008	206,885,673,000	206,887,673,000	206,885,673,000	206,885,673,000	
2009	216,627,700,000				

1/ Includes $2,923.0 million under indefinite authority.
2/ Includes $5,243.6 million under indefinite authority.
3/ Includes $4,310.9 million under indefinite authority.
4/ Includes $5,858.6 million under indefinite authority.
5/ The House and Senate did not provide an FY 2007 allowance amount. The appropriation level reflects the FY 2007 continuing resolution appropriation.

Medicaid
(Dollars in Thousands)

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	Estimate +/-
Medical Assistance Payments …………	$189,678,184	$190,925,700	$204,468,000	$13,542,300
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$1,614,242	$3,000,000	$3,231,000	$231,000
Vaccines for Children…………….	$2,735,950	$2,702,206	$2,766,230	$64,024
State and Local Administration, Survey and Certification, and Fraud Control Units..	$11,085,667	$10,124,800	$10,303,098	$178,298
Obligations (gross)...	$205,114,043	$207,052,706	$220,768,328	$13,715,622
Unobligated Balance, Start of Year………..	($26,586,131)	($4,007,661)	($4,140,628)	$132,967
Unobligated Balance, End of Year………	$4,007,661	$4,140,628	$0	-$4,140,628
Recoveries of Prior Year Obligations…...	-$13,921,603	$0	$0	$0
Appropriation Budget Authority (gross)………………	$168,613,970	$207,185,673	$216,627,700	$9,442,027
Offsetting Collections…………	-$359,188	-$300,000	$0	$300,000
Total Budget Authority (net)……...	$168,254,782	$206,885,673	$216,627,700	$9,742,027
Advanced Appropriation……….	($62,783,825)	($65,257,617)	($67,292,669)	($2,035,052)
Annual Appropriation……….	$105,470,957	$141,628,056	$149,335,031	$7,706,975

Authorizing Legislation……………………….. Social Security Act, title XIX, Section 1901.

FY 2009 Authorization .... P. L. 110-161, Expired

Allocation Method ....Formula Grants

Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government that provides health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. 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.

The Federal Government and States share in the cost of the program. The State share varies from State to State. In FY 2007, the average State share was approximately 43 percent, with the remaining 57 percent provided by the Federal Government. 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.

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, puts them within eligibility standards.

Medicaid covers a broad range of services to meet the health needs of beneficiaries. Federally-mandated services for categorically-eligible Medicaid beneficiaries include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and x-ray services, physician services, and nursing home care for individuals age 21 or older. Commonly offered optional services for both categorically- and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, and services in intermediate care facilities for the mentally retarded. In addition, States may elect to offer an array of home and community based services to individuals who are aging or individuals with disabilities through waiver authority granted by the Secretary.

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.

Medicaid received an Adequate score in the FY 2006 Program Assessment Rating Tool (PART) cycle. As a result of the PART evaluation, CMS created new performance measures that assess health quality, improve program management and protect program integrity. CMS is also developing improvement actions as a result of the PART assessment. We are taking the following actions to improve the performance of the program: working with the States to measure, track, and improve quality of care in Medicaid while moving toward a national framework for Medicaid quality; reducing fraud, waste, and abuse in the Medicaid program and improving overall program integrity; and working with States to establish baseline data for the newly developed Medicaid performance measures. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

To ensure that Medicaid beneficiaries gain access to and receive quality of care with their benefit dollars, CMS has 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 Strategy. To develop this measure, CMS released a Quality Roadmap and a Medicaid Quality Strategy. The Medicaid Quality Improvement Program supports States in achieving safe, effective, efficient, timely, equitable, and patient-centered care. More specifically, the measure tracks the number of States participating in the Medicaid Quality Improvement Program. In FY 2007, our baseline year, CMS began to thoroughly review data sources and data collection tools to document State quality activity. Quality Assessment Reports were developed for dissemination to States for both informational purposes and validation of State quality activities.

The FY 2008 target is to have 15 percent (eight States) participating in the Medicaid Quality Improvement Program; with results expected March 2009. The National Association of State Medicaid Directors formally launched the development of the National Quality Framework for Medicaid indicating the agreement of all States to participate in achievement of this goal. The first State quality assessment, the primary vehicle for improving States' ability to assess quality and access to care, was initiated in early 2008. At least seven more packets will be distributed during FY 2008. The FY 2009 target is to have 18 percent (nine States) participating in the program, with results expected in March 2010.

The primary challenge to meeting these targets is that State participation is voluntary. Nonetheless, States recognize that participation in the development of a national Medicaid framework represents important opportunities for improvement. States are looking to CMS for guidance in achieving improved outcomes for their Medicaid beneficiaries and programs. By engaging with representative groups such as the National Association of State Medicaid Directors and the National Medicaid Medical Directors Network, CMS is able to garner support from stakeholders and champions for State participation.

Medicaid Program Integrity

Section 6034 of the DRA requires the Secretary to promote Medicaid integrity by contracting with eligible entities to carry out certain specified activities including reviews,

audits, identification of overpayments, and education. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste and abuse beginning in FY 2006. A recent CMIP was published in August which covers FYs 2007 to 2011. Building upon the accomplishments of the first several years, activities in FY 2009 will include hiring the remaining Medicaid integrity staff, procuring Medicaid integrity contractors, auditing providers of Medicaid services, conducting oversight reviews, and providing technical support and assistance to State Medicaid integrity programs. Some or all of these items have been accomplished.

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.

The Medicaid MIP will also support the efforts of State Medicaid agencies through a combination of oversight and technical assistance. MIP represents the most significant single, dedicated investment the federal government has made in ensuring the integrity of the Medicaid program and offers an opportunity to ensure the efficient administration of the program and promote sound stewardship of state and federal resources. CMS is measuring the implementation and success of the Medicaid MIP by calculating an annual return on investment. Further discussion and funding of this measure can be found in the section on State Grants and Demonstrations.

In implementing the DRA provisions related to MIP, CMS has a unique opportunity to strengthen its leadership of state and federal efforts to control fraud, waste, and abuse in the Medicaid program.

Vaccines for Children

The Vaccines for Children (VFC) program is funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention. This program allows vulnerable children access to lifesaving vaccines as a part of routine preventive care, focusing on children without insurance, those eligible for Medicaid, and American Indian/Alaska Native children. Children with commercial insurance that lacks an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention 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 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. The MFCUs investigate State law violations and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities.

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, 2006 nearly 65 percent of all Medicaid beneficiaries (more than 29.8 million) in 48 States and the District of Columbia 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 Deficit Reduction Act of 2005 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.

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 32 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 two sub-State health reform demonstrations (California and Kentucky) and 21 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, and Wisconsin).

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.

- Benefit Flexibility under the Deficit Reduction Act (DRA) of 2005

  On February 6, 2006, the DRA was enacted and included a provision that permits States the option to provide alternative benefit packages under Medicaid for non-exempt populations. The provision also allows States the ability to provide alternative benchmark packages to exempt populations if the individuals are fully informed of the differences between the State's traditional Medicaid benefits and the benchmark coverage, the beneficiary's choice is documented in the individual's file and the individual can revert back to traditional Medicaid at any time. As of January 2008, CMS has approved nine State plan amendments for alternative benefit coverage: Idaho, Kansas, Kentucky, Missouri, South Carolina, Virginia, Washington, West Virginia, and Wisconsin.

  Enactment of sections 6041, 6042, and 6043 of the Deficit Reduction Act of 2005 (DRA) provides State Medicaid agencies with increased flexibility to implement premium and cost sharing requirements for certain Medicaid recipients. This authority is in addition to the current authority States have already been provided under section 1916 of the Social Security Act to implement nominal premiums and cost sharing amounts. Sections 6041, 6042, and 6043 of the DRA provide States

with additional State plan flexibility to implement alternative premiums for certain recipients and to implement alternative cost sharing for certain medical services (e.g. non-preferred drugs under section 6042 and for non-emergency use of the emergency room under section 6043). These sections also update nominal cost sharing amounts under section 1916 and provide States options with respect to enforceability of premiums and cost sharing for certain recipients.

Recipients

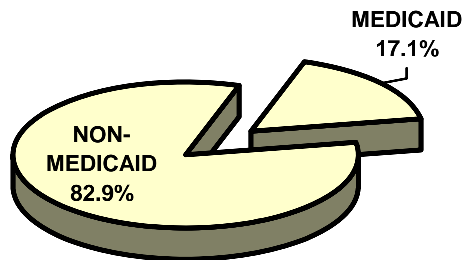
The following table reflects the estimated annual enrollment in number of person years, which represents full-year equivalent enrollment, receiving Federal Medical Assistance. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment (Person-Years in Millions)

	FY 2007	FY 2008	FY 2009	Estimate +/-
Aged	5.0	5.1	5.2	.1
Disabled	8.5	8.6	8.7	.1
Adults	11.1	11.3	11.5	.2
Children	23.5	24.0	24.4	.4
Territories	1.0	1.0	1.0	.0
Total	49.1	50.0	50.8	.8

According to our projections of Medicaid enrollment in FY 2009, as shown in the pie chart, 17.1 percent, or 50.8 million, of the estimated 297.4 million U.S. residents will be enrolled in Medicaid for the equivalent of a full year during FY 2009. In FY 2009 Medicaid will provide coverage to more than one out of every five children in the Nation.

FY 2009 ESTIMATED MEDICAID FULL-YEAR ENROLLEES COMPARED TO THE U.S. POPULATION

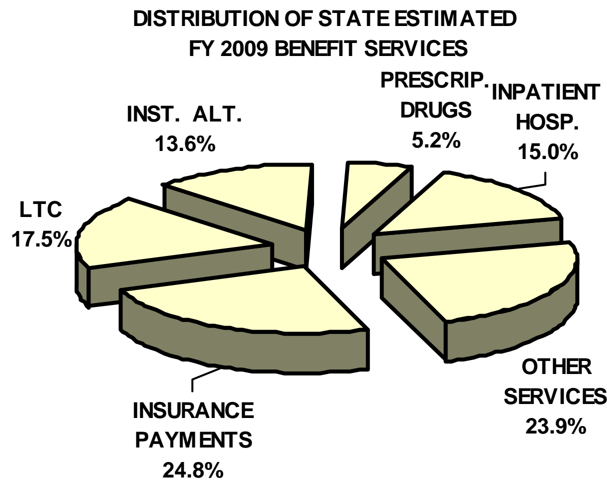


CMS projects that in FY 2009, children and non-disabled adults under age 65 will represent 72 percent of the Medicaid population, but account for approximately 34 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 28 percent of the Medicaid population, yet account for approximately 66 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, medical assistance payments are projected to increase $14.8 billion, or 7.7 percent, from $191.9 billion in FY 2008 to $206.7 billion in FY 2009.

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 $50.6 billion in funding for FY 2009, representing 24.8 percent of the State-submitted benefit estimates for FY 2009. The second largest FY 2009 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 2009 estimates totaling $35.7 billion or about 17.5 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2009 are inpatient hospital services exclusive of disproportionate hospital payment adjustments ($30.7 billion), followed by institutional alternative services such as home health, personal care, home and community-based care ($27.6 billion), and prescription drugs ($10.7 billion). Together these five benefit service categories for health insurance payments, long-term care services, inpatient hospital services, institutional alternative services, and prescription drugs account for over 76 percent of the State estimated cost of the Medicaid program for FY 2009.



According to the State estimates received through December 3, 2007, the fastest growing service category is outpatient hospitals, which displays a growth of $609 million, 7.9 percent, between FY 2008 and FY 2009. States expect the health insurance payments category, which includes Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums, to grow by $3.7 billion, or 7.8 percent, between FY 2008 and FY 2009. The States estimate increases in this service category account for 40 percent of the total FY 2009 benefit growth. Rising enrollments and shifts in how services are paid, e.g., from fee-for-service to capitated plans, explain this growth.

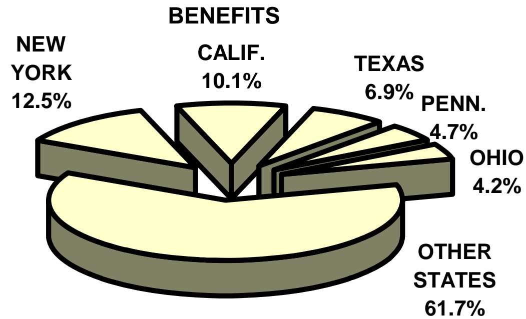
Estimated Benefit Service Growth, FY 2008 to FY 2009

November 2007 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2008	Est. FY 2009	Dollar Growth	Annual Percent Growth	Percent Of State Estimate Growth
Health Insurance Payments (Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums)	$46,968,148	$50,635,488	$3,667,340	7.8%	40.0%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$26,092,782	$27,633,388	$1,540,606	5.9%	16.8%
Other (Targeted case management, hospice, all other services, and collections)	$11,157,892	$12,069,592	$911,700	8.2%	10.0%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$35,029,892	$35,651,476	$621,584	1.8%	6.8%
Outpatient Hospital	$7,634,911	$8,241,732	$606,821	7.9%	6.6%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$10,064,922	$10,651,444	$586,522	5.8%	6.4%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$30,107,667	$30,658,465	$550,798	1.8%	6.0%
Physician/Practitioner/Dental	$10,236,562	$10,624,567	$388,005	3.8%	4.2%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$7,639,290	$7,940,266	$300,976	3.9%	3.3%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$9,672,805	$9,658,483	-$14,322	-0.1%	-0.2%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$194,604,871	$203,764,901	$9,160,030	4.7%	100.0%
Adjustments	-$2,704,871	$2,935,099	NA	NA	NA
TOTAL	$191,900,000	$206,700,000	$14,800,000	7.7%	NA

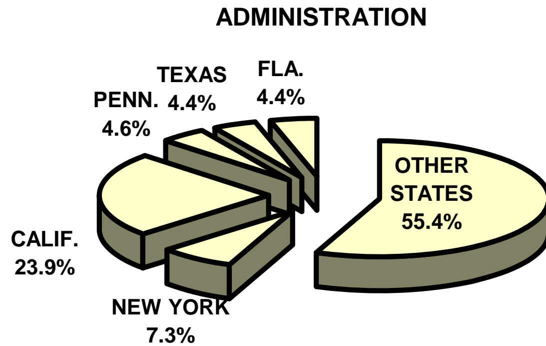
Distribution of Benefit Monies

According to the State-submitted estimates, $203.8 billion will be required to fund their Medicaid benefit programs during FY 2009. As displayed, New York, California, Texas, Pennsylvania, and Ohio account for $78.1 billion, or over 38.3 percent, of the State-submitted estimates for benefits for FY 2009. The next five States in ranking of estimated benefits are Florida (4.2 percent), North Carolina (3.4 percent), Illinois (3.0 percent), Massachusetts (2.9 percent), and Arizona (2.7 percent). These five States account for 16.2 percent of total State-submitted benefit estimates. In total, these 10 States account for nearly 55 percent of benefits in FY 2009.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2009 State and local administration costs total $10.1 billion. This represents about 4.7 percent of the total State-submitted estimates for Medicaid costs for FY 2009. As displayed, California, New York, Pennsylvania, Texas, and Florida account for $4.5 billion, or 44.6 percent of expenditures for State and local administration. The next five States in ranking of estimated expenditures are Illinois (3.8 percent), Washington (3.1 percent), North Carolina (3.0 percent), New Jersey (3.0 percent), and Tennessee (2.6 percent). These five States account for over 15.4 percent of total State and local administration expenditures. In total, these 10 States are expected to account for nearly 60.0 percent of expenditures for State and local administration.



Funding History (Appropriation)

FY 2004	$182,753,583,000
FY 2005	$177,540,763,000
FY 2006	$215,471,709,000
FY 2007	$168,254,782,000
FY 2008	$206,885,673,000

Budget Request

CMS' FY 2009 appropriation request for Grants to States for Medicaid is $221.0 billion, an increase of $12.1 billion above the FY 2008 level of $208.9 billion. The appropriation request is composed of $149.3 billion in monies for FY 2009 and $71.7 billion in advanced appropriation monies for FY 2010.

Under current law, the estimated gross Medicaid budget authority requirement for FY 2009 is $216.6 billion in requested appropriated monies. This budget authority is composed of $67.3 billion from the FY 2008 appropriation and $149.3 billion in FY 2009 appropriated monies. These monies, together with an estimated unobligated balance of $4.1 billion brought forward from FY 2008, will fund $220.8 billion in anticipated FY 2009 Medicaid obligations. These obligations are composed of:

- $204.5 billion in Medicaid medical assistance benefits;
- $3.2 billion for benefit obligations incurred but not yet reported;
- $10.3 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $2.8 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 2007. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget for use with the FY 2009 President's budget.

Under current law, the estimated Federal share of Medicaid outlays is estimated to be $217.5 billion in FY 2009. This represents an increase of 6.8 percent over the estimated net outlay level of $203.8 billion for FY 2008. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 1.6 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 2007 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, Medicaid financial disallowances, and CMS financial management reviews.

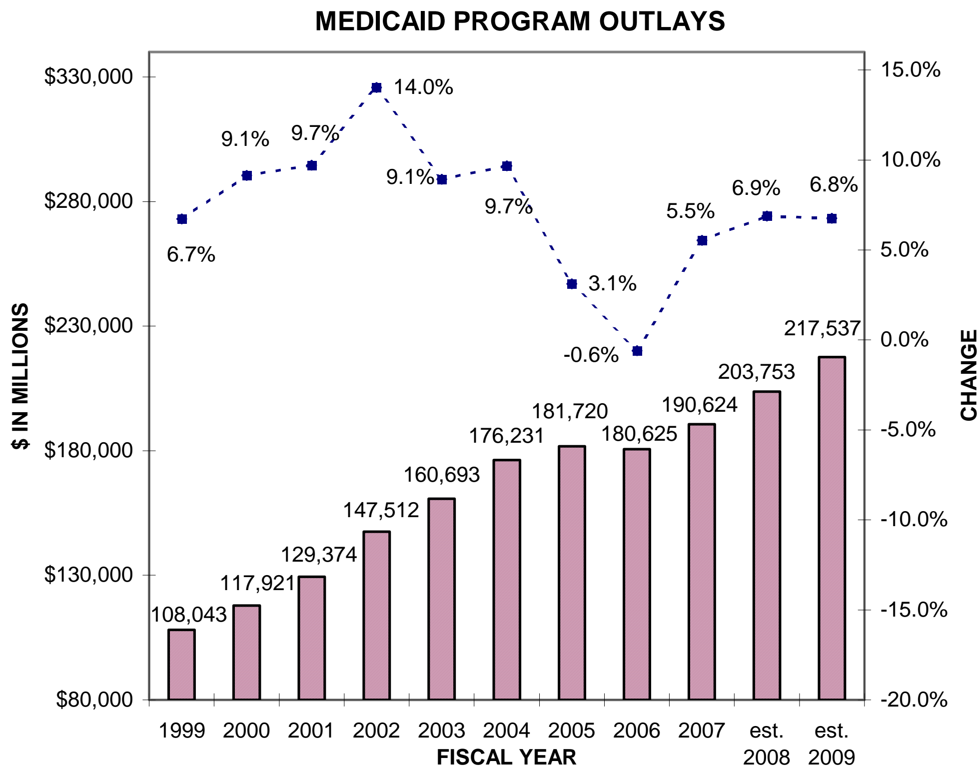
- Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

  The November 2007 State estimates for MAP of $203.8 billion in FY 2009 are the first State-submitted estimates for FY 2009. Typically, State estimation error is most likely to occur early in the budget cycle because most States are focused 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 2009. Using the first three quarters of FY 2007 State-reported expenditures as a base, expenditures for

FY 2008 and FY 2009 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 2007 State-submitted estimates. Based on this analysis, the CMS' Office of the Actuary increased the States' medical assistance payment estimates for FY 2009 by $2.9 billion to $206.7 billion.



In the mid 1990s, the factors impacting the historical growth in the Medicaid program began to moderate 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 fast growth in the recent period 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. Actual FY 2007 spending increased compared to actual

FY 2006 spending and was driven by spending on hospital care, managed care and group health premiums, and home and community-based waivers, while drug growth fell for the second year as a result of the continued shift to Medicare.

Adjustments to the State Estimates for Medical Assistance Payments for Legislation

Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)
(Estimated FY 2009 costs are $70 million)

This legislation extended authorization for the QI and TMA programs through June 30, 2008, and extended the State Children's Health Insurance Program (SCHIP) funding through March 31, 2009. The legislation also implemented a 6 month delay on the implementation of Medicaid regulations relating to rehabilitation services and school-based services until July 1, 2008. In addition, it extended the authority for disproportionate share hospital provisions funding under section 1923 of the Social Security Act for Tennessee and Hawaii through June 30, 2008.

TMA, Abstinence Education and QI Programs Extension Act of 2007 (P.L. 110-90)
(Estimated FY 2009 savings are $55 million)

This legislation extended authorization for the Transitional Medical Assistance (TMA) Program and the Qualified Individual (QI) Program through December 31, 2007. It also extended the Supplemental Security Income (SSI) Web-Based Asset Demonstration Project to the Medicaid Program. This extension allows States to implement an asset verification process similar to the process SSA is currently piloting in three States to verify the assets held by financial institutions of applicants for SSI. States would be able to use such a process to verify assets for those applying for Medicaid who are not also applying for SSI. The extension to Medicaid is limited to States in which the SSI pilot project is operating, currently New York, New Jersey, and California. Lastly, this legislation delays the requirement for States to use "tamper-resistant" pads as required by Public Law 110-28. This legislation delayed implementation of the pads' use by six-months. All States must begin using tamper resistant pads by March 31, 2008.

Adjustments to the State Estimates for Medical Assistance Payments for Administrative Reforms

- FY 2009 Administrative Reforms

  1915(b)3 Regulation
  (Estimated FY 2009 savings are $100 million)

  1915(b) waivers are a common mechanism for establishing Medicaid managed care. Under Section 1915(b)(3) authority, States can share savings generated by managed care with medical assistance recipients. The Administration's guidance in this area is such that services must be health-related. Through regulation, HHS will provide more formal and detailed guidelines for appropriate use of 1915(b)(3) authority.

Clarify Inflation Protection in Partnership Programs
(no budget impact)

Establishes that long-term care insurance policies that include Future Purchase Option inflation protection do not qualify as Partnership policies.

Issue Free Care Regulation
(no budget impact)

Codifies in regulation the longstanding Medicaid "free care" policy. Under this policy, providers cannot bill Medicaid for services furnished to the public and other payors at no cost.

- Recent Administrative Actions

Final Rule: Eliminate Claiming for School-Based Services
(Estimated FY 2009 medical assistance payment savings are $165 million and State and local administration savings are $470 million)

To address long-standing concerns about improper billing by school districts as determined by both HHS's Inspector General and the Government Accountability Office, this final rule specifies that Federal financial participation under the Medicaid program will not be available for school based administrative and certain transportation costs. Final rule published December 28, 2007; moratorium issued in Public Law 110-173 which prevents implementation through June 30, 2008.

Final Rule: Revise Payments for Government Providers
(Estimated FY 2009 savings are $790 million)

This rule builds on past CMS efforts to curb questionable financing practices by recovering Federal funds that are diverted from government providers and retained by the State and caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries. Final rule displayed at the Federal register May 25, 2007; moratorium issued for one year.

Proposed Rule: Eliminate Graduate Medical Education (GME)
(Estimated FY 2009 savings are $150 million)

This proposed rule would clarify that costs associated with GME programs are not considered medical assistance expenditures and thus not eligible for Federal Medicaid funding. Proposed rule published May 23, 2007; moratorium issued for one year in Public Law 110-28.

Proposed Rule: Clarify Rehabilitation Services
(Estimated FY 2009 savings are $360 million)

This proposed rule clarifies the service definition of Medicaid rehabilitative services and provides that these services must be coordinated with services furnished by other programs focused on social or educational development goals and are available as part of other services or programs. Proposed rule published August 13, 2007; moratorium issued preventing implementation through June 30, 2008 in Public Law 110-173.

Other Adjustments to the State Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2009 savings are $682 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $633 million in FY 2008 and $682 million in FY 2009. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure front end 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/enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

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

The FY 2009 estimate of $3.2 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2008 to September 30, 2009. 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 record 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.

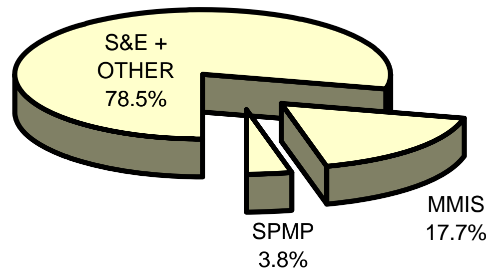
The current FY 2009 estimate for the Vaccines for Children (VFC) program is $2.77 billion. This represents an increase of $64 million from the current FY 2008 estimate of $2.70 billion. This increase reflects the net difference between a rise in vaccine purchase costs based on inflation and a savings of $55.7 million in FY 2008 due to vaccine inventory reduction as additional grantees transitioning to the vaccine management business improvement plan (VMBIP) consolidated distribution contract. This increase is offset by reductions in pediatric vaccine stockpile activities, VMBIP contractual support for the transition of grantees to the centralized distribution contract transition, adolescent infrastructure costs and savings due to the VMBIP consolidated distribution process. For the pediatric vaccine stockpile, fewer funds are required in FY 2009 to continue stockpiling a six month national supply of all recommended vaccines. Additionally, the funds associated with contractual support for the VMBIP consolidated distribution contract terminate in FY 2008, making funding for these activities unnecessary in FY 2009. Adolescent infrastructure funding provided in FY 2007 and FY 2008 for grantees to build an infrastructure to support the establishment of an adolescent vaccination platform, including expanding provider enrollment to increase the number of adolescent providers and increasing outreach to non-traditional immunization settings has ended.

Through this budget, VFC will continue to leverage commercial best practices to address all aspects of vaccine procurement, ordering, distribution, and management and achieve efficiencies through the VMBIP. Vaccine management and accountability needs have grown dramatically since the inception of the VFC program. As of November 2007, approximately half of the 64 immunization program grantees (reflects all Section 317 grantees, 61 of these grantees are eligible to participate in the VFC program) have transitioned to VMBIP's centralized vaccine distribution. VMBIP has increased overall program efficiency through inventory reduction and increased visibility of the location of vaccines throughout the program, enhancing CDC's ability to address public health emergencies such as vaccine shortages. VMBIP also provides accountability at the individual immunization provider level.

State and Local Administration (ADM)

In November 2007, the States estimated the Federal share of State and local administration outlays to be $9.9 billion for FY 2008 and $10.1 billion for FY 2009. The FY 2009 estimate is composed of $1.8 billion for Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing activities; $0.4 billion for skilled professional medical personnel; and $7.9 billion for salaries, fringe benefits, training, and other State and local administrative costs as shown. 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.

STATE ESTIMATES FOR FY 2009



CMS adjusted the FY 2009 State-submitted estimates of $10.1 billion to reflect a growth rate more consistent with recent expenditure history (+$287 million), and (-$470 million) for the following school-based administration reform:

Evidence has shown that Medicaid claiming for Individuals with Disabilities Education Act of 2004 (IDEA) related services in a school setting are prone to abuse and overpayments, especially in the areas of administrative claiming and transportation. To uphold the integrity of the Medicaid program and ensure proper claiming, the CMS issued a rule on December 28, 2007, to eliminate Federal Medicaid reimbursement for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, and for transportation from home to school and back, based on the determination that these activities are neither necessary for the proper and efficient administration of the State plan nor do they meet the definition of an optional transportation benefit under Medicaid. The medical services cost savings are displayed in the medical assistance payments estimate portion of the justification. Final rule published December 28, 2007; moratorium issued in Public Law 110-173 which prevents implementation through June 30, 2008.

After these adjustments, the State and local administration outlays for FY 2009 are estimated to be $9.9 billion, or 1.7 percent higher than the adjusted FY 2008 estimate of $9.7 billion.

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 2009 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2009 estimate for Medicaid State survey and certification is $228.8 million. This represents an increase of $5.8 million above the current FY 2008 estimate of $223.0 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 FY 2009, State Medicaid fraud control unit operations are estimated to require $195.3 million. This represents an increase of $9.3 million over the estimated FY 2008 funding level of $186.0 million.

Currently, 49 States and the District of Columbia participate in the Medicaid fraud control unit grant program.

In FY 2006, the MFCUs were successful in obtaining a total of 1,226 convictions. The MFCUs reported 676 instances in which civil actions undertaken resulted in successful outcomes. During FY 2006, OIG excluded a total of 3,425 individuals and entities from participation in the Medicare and Medicaid programs and other health care programs. Approximately 731 of these exclusions were based on referrals received from the MFCUs.

Although the cases that the MFCUs engage in 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 SMFCUs is necessary in providing a measure of protection to vulnerable Medicaid beneficiaries.

In addition to their primary mission, there are other pursuits that the MFCUs are involved in. They are as follows: (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/prosecutions involving both Federal and State law enforcement agencies, as well as other State and local agencies.

During FY 2006, of the $161.6 million received to fund the MFCU grant program, more than $1.1 billion in recoveries were realized. Based on recent trends in SMFCU recoveries, we expect that in FY 2007 recoveries from MFCU work activities will exceed the amount attained in FY 2006.

Impact of Proposed Legislation

1. Maintain Substantial Home Equity Amount at $500,000

   Section 6014 of the Deficit Reduction Act of 2005 amended section 1917 of the Social Security Act to provide that in determining the eligibility of an individual to receive medical assistance payment for Medicaid nursing facility services or other long-term care services, States must deny payment if the individual's equity interest in his or her home exceeds $500,000. States have the option to substitute an amount exceeding $500,000, but not in excess of $750,000.

   To ensure that Medicaid is protected for those who need it most, the FY 2009 President's Budget proposes to codify the substantial home equity definition at $500,000. In addition, the limits in the proposed law are increasing beginning in 2011 by the CPI-U.

   Five-year budget savings: $480 million

2. Redesign Acute Care Benefits for Optional LTC Groups

   The Deficit Reduction Act of 2005 provided States with more flexibility to offer private sector-type coverage to certain adults and children. The FY 2009 President's Budget would expand the benefit flexibility option established by Section 6044 of the Deficit Reduction Act to certain optional aged, blind and disabled groups. The benefit flexibility would be applied to acute care services only.

   Five-year budget savings: $650 million

3. Repeal Section 1932(a)(2) Special Rules

   Section 1932 of the Social Security Act allows States to use State plan authority to require Medicaid beneficiaries to enroll in managed care. Section 1932(a)(2) lists special rules that exempt children with special health care needs, dual eligibles and Indians from the managed care State plan option. To mandatorily enroll any of these populations in managed care, States must rely on waiver authority.

   The FY 2009 President's Budget proposes to repeal Sec. 1932(a)(2) to allow States to mandate enrollment under their State plan.

   Five-year budget savings: $2.1 billion

4. Extend Section 1915(b) Waiver Period

   Section 1915(b) of the Social Security Act authorizes the Secretary to waive compliance with certain portions of the Medicaid statute. These portions include Freedom of Choice, state wideness, and comparability that prevent a State from mandating Medicaid beneficiaries to obtain their care from a single provider or health plan. Unlike most other Medicaid waivers, 1915(b) waivers are renewed every two years. This frequency is an administrative strain on States and the Federal government. The FY 2009 President's Budget proposes to align the 1915(b) waiver renewal cycle with those of the 1115 and 1915(c) waivers by extending it to three years.

   Five-year budget impact: none

5. Replace Best Price with Budget Neutral Rebate

   Currently, manufacturers have a disincentive from offering deeper discounts in the private sector because it could potentially mean higher rebate liability in their Medicaid business. Since 1990, all drug manufacturers have been required to pay a rebate to States in order to have their drugs covered by Medicaid. The rebate formula is defined in the Social Security Act. For brand name drugs, the rebate is the larger of 15.1 percent of the average manufacturers price (AMP) or the difference between AMP and best price. For generic drugs, the rebate is a flat 11 percent of AMP

   The FY 2009 President's Budget proposes to eliminate best price from the Medicaid drug rebate calculation in order to remove the market distortion it creates. Removing best price will allow manufacturers to negotiate deeper discounts in the private sector without having those discounts affect the Medicaid rebate. The rebate calculation would be set so that it would not affect the amount of rebates to State Medicaid programs.

   Five-year budget impact: none

6. Rationalize Pharmacy Reimbursement

   The Deficit Reduction Act (DRA) established a market-based Federal Upper Limit (FUL) system to limit reimbursement of all multiple-source drugs. The DRA set the pharmacy reimbursement ceiling at 250 percent of average manufacturer price (AMP) in section 1927(e)(5) of the Social Security Act. This proposal would lower the pharmacy reimbursement ceiling further to 150 percent of AMP.

   Five-year budget savings: $1.1 billion

7. Enhance Third Party Liability

   Medicaid agencies generally reject medical claims whenever there is another third party who is legally liable to pay the claims. The claims are returned to the provider instructing them to bill the third party, this is referred to as "cost avoidance." There are some exceptions to this rule found in section 1902(a)(25)(E) and (F) of the Social Security Act. The FY 2009 President's Budget would make changes to statute to enhance third party liability collections.

   - Payment for Prenatal and Preventive Pediatric Care

     The FY 2009 Budget proposes amending the statute to require providers to bill third parties and wait at least 90 days before billing Medicaid. This would enable States to cost avoid claims for prenatal and preventive pediatric care while assuring protection for providers and beneficiaries.

   - Payment in Cases Involving Medical Child Support

     The statute requires Medicaid agencies to pay claims and seek reimbursement from the liable third party in situations where health insurance is derived from a parent's obligation to provide coverage if payment has not been received within 30 days. The FY 2009 President's Budget proposes to require providers to bill third parties and wait at least 90 days before billing Medicaid. This would enable States to cost avoid claims where the third party is derived through a parent's or individual's obligation to provide coverage for a limited time while assuring protection for providers and beneficiaries.

   - Recover Medicaid Expenditures from Beneficiary Liability Settlements

     Section 1917(a)(1) of the Social Security Act provides, with certain exceptions applicable only in the context of institutionalized individuals, that "no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan."

     The FY 2009 President's Budget proposes to explicitly permit States to use liens against liability settlements to recover payments under section 1902(a)(25) and section 1912 of the Social Security Act. The State's lien or claim, less costs of collection, would be reimbursed from any and all recoveries from a liable party regardless of whether the recipient has been fully compensated.

     Five year budget savings: $470 million

8. Modify Asset Verification

   The FY 2009 President's Budget proposes to make technical corrections to the web-based assed verification demonstration included in P.L. 110-90. The technical corrections include addressing issues of financial privacy, authorizing the demonstration under Medicaid statutory authority, and strengthening HHS enforcement tools to ensure State compliance. Participation in the demonstration would be mandatory in those States where the Social Security Administration is currently operating the demonstration for Supplemental Security Income eligibility determinations.

   In addition to the technical changes, the proposal would extend the demonstration permanently (under current law, the demonstration ends in FY 2012).

   Five-year budget savings: $1.2 billion

9. Publish Annual Medicaid Actuarial Report

   As the principal payer of long-term care in the nation, Medicaid spending will face ever increasing fiscal pressure with the aging of the baby boom population. The FY 2009 President's Budget would require the Department of Health and Human Services to publish an annual report that assesses the financial status of the Medicaid program, including current spending, cost drivers, and program trends. The report would be funded out of CMS' discretionary budget. This proposal includes a legislative and administrative component.

   Five-year budget impact: none

10. Implement Cost Allocation

    The 1996 welfare reform law capped Federal funding for administrative costs under Temporary Assistance for Needy Families (TANF) and eliminated the open-ended matching structure for administrative costs in Aid to Families with Dependent Children (AFDC). Under the AFDC structure, States generally allocated most of the common eligibility determination costs for AFDC, Medicaid, and Food Stamps to AFDC/TANF. As a result, administrative costs associated with Medicaid were inappropriately included in the TANF block grant. This proposal would recoup Medicaid administrative costs assumed in the TANF grant.

    Five-year budget savings: $1.8 billion

11. Implement Medicaid Pay-for-Performance

    The Administration proposes to develop a set of universal Medicaid performance measures and link State performance on these measures to Federal funding for Medicaid through administrative and legislative actions. The legislative component of this proposal would link State performance on specific measures to Federal grant awards.

    Five-year budget savings: $310 million

12. Require States Participation in PARIS

In 1997, the Administration for Children and Families (ACF) began a project to help States share eligibility information with one another. The public assistance reporting information system (PARIS) interstate match helps States share information on public assistance programs to identify individuals or families who may be receiving medical assistance inappropriately. Currently, 44 States and territories are participating in the PARIS project on a voluntary basis. The President's FY 2009 Budget proposes to make participating in PARIS mandatory for State Medicaid programs. The requirement would become a condition of receiving Federal Financial Participation (FFP) for the Medicaid Management Information System (MMIS) and the Medicaid eligibility system and consist of:

- State submission of an Advanced Planning Document detailing necessary changes to the respective systems for participation in PARIS;
- Implementation of such changes; and
- State submission of PARIS match data on a quarterly basis for the Medicaid program.

Five-year budget savings: $135 million

13. Mandate National Correct Coding Initiative (NCCI)

The National Correct Coding Initiative is an edit system that was developed by CMS for Medicare to address edits applied to services billed by the same provider for the same beneficiary on the same date of services. The NCCI promotes national correct coding methodologies and controls improper coding, and is mandatory for the Medicare program. The President's FY 2009 Budget proposes to require that all States include NCCI edits into their Medicaid Management Information System (MMIS) as a condition of federal certification, except for those edits which conflict with an individual state's Medicaid reimbursement policy.

Five-year budget savings: $105 million

14. Align Administrative Match Rates

Generally, Medicaid administrative activities are reimbursed at a 50 percent administrative matching rate; however, there are exceptions where reimbursement is at a rate higher than 50 percent. The FY 2009 President's Budget proposes to promote equity in reimbursement among Medicaid administrative activities by aligning administrative matching rates at 50 percent.

Five-year budget savings: $5.5 billion

15. Align Family Planning Match Rate

Under current law, family planning services and supplies are matched at 90 percent FMAP, regardless of a State's normal FMAP. The FY 2009 President's Budget proposes to align reimbursement for family planning services to FMAP to ensure cost effectiveness and efficiency as well as conformity across other Medicaid health services.

Five-year budget savings: $3.3 billion

16. Align Case Management Match Rate

The FY 2009 President's Budget proposes to reimburse all case management activities, whether administrative or medical assistance at a 50 percent rate. Case management activities are inherently the same, whether they are reimbursed as administrative activity or as a medical assistance service. These State activities assist Medicaid eligible individuals in gaining access to needed services. The existence of differing reimbursement rates, based on whether the activity is claimed as an administrative activity or as a medical assistance service, has resulted in States claiming services in the manner that results in the highest reimbursement for the State. The proposed change would remove the incentive to "shop around" for the highest reimbursement and would ensure that case management services are reimbursed in a cost effective and efficient manner.

Five-year budget savings: $1.1 billion

17. Align Qualified Individuals (QI) Program Match Rate

Under current law, States receive 100 percent Federal matching rate for payment of Medicare Part B premiums for Medicare beneficiaries with incomes above 120 percent and 135 percent of the FPL. These beneficiaries are known as Qualifying Individuals (QIs). The FY 2009 President's Budget proposes to reduce the Federal reimbursement for the QI program from 100 percent to the State's FMAP, which aligns this program with Medicaid as well as other Medicare Savings Programs. The FY 2009 President's Budget also includes a proposal to extend the QI program through September 30, 2009.

Five-year budget savings: $200 million

18. Extend Qualifying Individuals Program (QI)

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, QIs are deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. The FY 2009 Budget proposes to extend the QI program through September 30, 2009. The FY 2009 President's Budget also includes a proposal to align the Federal reimbursement for the QI program from 100 percent to the State's FMAP.

Five-year budget cost: $470 million

19. Extend Transitional Medical Assistance (TMA)

    TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. The FY 2009 President's Budget proposes to extend the TMA provision through September 30, 2009.

    Five-year budget cost: $695 million

20. Modify the Health Insurance Portability and Accountability Act

    This proposal would make two HIPAA-related statutory changes:

    In States with premium assistance or other employer-sponsored insurance programs, these beneficiaries may have to wait for their employer's open-enrollment period to register in their private insurance. This proposal would make eligibility for Medicaid and SCHIP a qualifying event, which would allow beneficiaries to enroll in private insurance even if it is not their insurer's open-enrollment period.

    In addition, this proposal would require SCHIP programs to issue certificates of creditable coverage, which promote portable health coverage by verifying the period of time an individual was covered by a specific health insurance policy.

    Five-year budget impact: none

21. Increase Flexibility for Premium Assistance

    States are required to demonstrate that enrollment of Medicaid-eligible individuals into a premium assistance program would be "cost-effective," that is enrollment in a premium assistance program to access health coverage would cost no more than traditional Medicaid coverage. This requirement has been cited by the States as a barrier to implementing robust premium assistance programs. The Administration proposes to provide States with greater flexibility in determining cost effectiveness and information sharing by employers to streamline the implementation process of Medicaid employer-sponsored insurance programs through administrative and legislative action. Under the legislative component of this proposal, the budget proposes to allow States to demonstrate cost effectiveness on an aggregate basis if they prefer not to demonstrate it on an individual basis. The budget proposal would also require participating employers to give States sufficient information to determine the cost effectiveness of premium assistance programs.

    Five-year budget savings: $140 million

22. Extend Refugee Exemption

Most legal immigrants are not eligible for Supplemental Security Income (SSI) benefits or Medicaid until they receive United States citizenship or reside legally in the United States for five years. Refugees and asylees are exempt from this restriction for their first seven years in the United States. The President's FY 2009 Budget extends the seven-year exemption to eight years so that refugees and asylees who follow Federal rules will have one additional year to complete the citizenship application process without penalty. This is a Social Security Administration proposal with a Medicaid impact. This proposal would extend the exemption through FY 2011.

Five-year budget cost: $92 million

23.SCHIP Reauthorization (Medicaid Impact)

The FY 2009 President's Budget proposes to authorize SCHIP through FY 2013, increasing State allotments by $19.7 billion to meet anticipated State need in covering targeted low-income, uninsured children. The Administration proposes to re-focus SCHIP on low-income, uninsured children and pregnant women at or below 200 percent of the Federal poverty level, and seeks the authority to target SCHIP funds more efficiently to States with the most need. The SCHIP reauthorization proposal has a Medicaid impact.

Five-year budget cost: $235 million

MEDICAID PROGRAM
Proposed Law

	FY 2008	FY 2009
Maintain Substanial Home Equity Amount at $500,000		-$80,000,000
Redesign Acute Care Benefits for Optional LTC Groups		-$20,000,000
Repeal Section 1932(a)(2) Special Rules		-$100,000,000
Extend Section 1915(b) Waiver Period		$0
Replace Best Price with Budget Neutral Rebate		$0
Rationalize Pharmacy Reimbursement		-$195,000,000
Enhance Third Party Liability		-$35,000,000
Modify Asset Verification		-$82,000,000
Publish Annual Actuarial Report		$0
Implement Cost Allocation		-$280,000,000
Implement Medicaid Pay-for-Performance		$0
Require State Participation in PARIS		-$5,000,000
Mandate the National Correct Coding Initiative		-$5,000,000
Align Administrative Match Rates		-$950,000,000
Align Family Planning Match Rate		-$570,000,000
Align Case Management Match Rate		-$200,000,000
Extend Transitional Medical Assistance (TMA)	$35,000,000	$485,000,000
Modify HIPAA		$0
Increase Flexibility for Premium Assistance Under Medicaid		$0
Extend Refugee Exemption		$32,000,000
SCHIP Reauthorization (Medicaid Impact)		$130,000,000
SUBTOTAL	$35,000,000	-$1,875,000,000
Align Qualified Individuals (QI) Program Match Rate		-$200,000,000
Extend QI Program	$105,000,000	$470,000,000
TOTAL	$140,000,000	-$1,605,000,000

Outcomes and Outputs Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs										
MCD1.1	Estimate the Payment Error Rate in the Medicaid Programs	N/A	N/A	Begin to implement error measure-ment for Medicaid fee-for-service (FFS) in 17 States. Report a prelim-inary error rate in the FY 2007 PAR with the final error rate reported in the FY 2008 PAR.	Goal met.	Begin full implement-ation of measuring FFS, managed care and eligibility in 17 States for Medicaid. Report national error rate in FY 2008 PAR.	Nov 08	Report national error rates in the FY 2009 PAR based on 17 States measured in FY 2008	Report national error rates in FY 2010 PAR based on 17 States meas-ured in FY 2009	Below Baseline (2012)
MCD1.2	Estimate the Payment Error Rate in the State Children's Health Insurance Program	N/A	N/A	N/A	N/A	Begin full implement-ation of measuring FFS, managed care and eligibility in 16 States for SCHIP. (excludes Tennessee) Report national error rate in FY 2008 PAR.	Nov 08	Report national error rates in the FY 2009 PAR based on 17 States measured in FY 2008	Report national error rates in FY 2010 PAR based on 17 States meas-ured in FY 2009	Below Baseline (2012)
Long-Term Objective: 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 Strategy										
MCD2	Number of States Participating in Medicaid Quality Improvement Program	N/A	N/A	N/A	N/A	Baseline = 0	Feb 08	15% of States (8 States)	18% of States (9 States)	26% of States (13 States) (2013)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
MCD 3	Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	N/A	N/A	N/A	43.6%	N/A	Mar 08	45%	46%
MCD 4	Percentage of Beneficiaries who Receive Home and Community-Based Services	N/A	N/A	N/A	N/A	Baseline	Sep 09	+3% over FY 2007	+3% over FY 2008
MCD 5	Percentage of Section 1115 demonstration budget neutrality reviews completed	N/A	N/A	Baseline	100%	N/A	N/A	92%	96%
MCD 6	Medicaid Integrity Program, Percentage Return on Investment	N/A	N/A	N/A	N/A	N/A	N/A	>100%	>100%
Appropriated Amount ($ Million)/1		$182,754	$177,541	$215,472		$168,255		$206,886	$216,628

/1 The appropriated amount does not include monies for all HCFAC funded portions of Payment Error Rate Measurement for Medicaid or SCHIP. Also, it does not include monies for the State Grants and Demonstrations funded Medicaid Integrity Program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

FY 2009 MANDATORY STATE/FORMULA GRANTS

(dollars in thousands)

CFDA NUMBER/PROGRAM NAME: 93.778 Medical Assistance Program

STATE/TERRITORY	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate	Difference +/- 2008
Alabama	$2,940,192	$2,854,209	$2,902,936	$48,727
Alaska	697,380	784,273	829,820	45,547
Arizona	4,624,960	5,163,537	5,697,855	534,318
Arkansas	2,440,263	2,714,004	2,986,444	272,440
California	22,683,720	22,331,784	22,987,211	655,427
Colorado	1,575,252	1,686,845	1,749,468	62,623
Connecticut	2,236,684	2,381,441	2,484,981	103,540
Delaware	548,117	579,951	629,680	49,729
District of Columbia	1,065,559	1,128,518	1,160,444	31,926
Florida	8,531,917	8,636,353	8,923,940	287,587
Georgia	4,565,846	4,549,510	4,732,392	182,882
Hawaii	704,610	645,876	641,815	-4,061
Idaho	838,439	868,829	949,417	80,588
Illinois	7,155,690	6,676,912	6,554,010	-122,902
Indiana	3,869,405	3,785,158	4,006,475	221,317
Iowa	1,707,669	1,716,131	1,837,941	121,810
Kansas	1,472,038	1,397,881	1,451,626	53,745
Kentucky	3,284,546	3,454,644	3,587,128	132,484
Louisiana	3,803,243	4,556,003	4,988,758	432,755
Maine	1,484,706	1,416,912	1,550,455	133,543
Maryland	2,935,024	2,956,354	3,149,359	193,005
Massachusetts	5,820,039	5,827,467	6,087,855	260,388
Michigan	5,568,026	5,529,730	5,755,101	225,371
Minnesota	3,436,915	3,661,427	3,899,054	237,627
Mississippi	2,552,166	2,821,625	3,037,716	216,091
Missouri	4,360,484	4,852,522	5,351,146	498,624
Montana	543,287	528,498	530,571	2,073
Nebraska	981,488	1,010,665	1,078,282	67,617
Nevada	784,490	765,079	761,832	-3,247
New Hampshire	651,312	688,778	729,834	41,056
New Jersey	5,022,922	4,781,329	4,805,928	24,599
New Mexico	2,100,824	2,216,652	2,445,720	229,068
New York	24,142,473	25,488,362	26,241,144	752,782
North Carolina	6,721,726	6,797,374	7,293,491	496,117
North Dakota	357,941	405,574	406,863	1,289

STATE/TERRITORY	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate	Difference +/- 2008
Ohio	8,055,587	8,131,860	8,741,262	609,402
Oklahoma	2,426,504	2,642,701	2,597,854	-44,847
Oregon	1,988,613	2,145,878	2,350,413	204,535
Pennsylvania	9,197,164	9,420,349	9,980,814	560,465
Rhode Island	993,167	1,003,199	1,060,762	57,563
South Carolina	2,987,929	2,969,534	2,990,390	20,856
South Dakota	425,246	427,429	428,339	910
Tennessee	4,908,617	4,813,880	5,073,891	260,011
Texas	14,379,998	13,968,726	14,431,063	462,337
Utah	1,163,571	1,097,868	1,130,124	32,256
Vermont	628,688	662,876	671,280	8,404
Virginia	2,737,821	2,889,595	3,033,180	143,585
Washington	3,213,924	3,279,825	3,376,379	96,554
West Virginia	1,739,467	1,799,288	1,870,618	71,330
Wisconsin	2,891,600	3,017,857	3,264,916	247,059
Wyoming	248,079	251,148	261,339	10,191
Subtotal	**200,195,328**	**204,182,220**	**213,489,316**	**9,307,096**
American Samoa	8,290	8,831	8,831	0
Guam	12,484	13,645	13,645	0
Northern Mariana Islands	4,574	4,851	4,851	0
Puerto Rico	250,400	297,870	297,870	0
Virgin Islands	12,445	13,795	12,381	-1,414
Subtotal	**288,193**	**338,992**	**337,578**	**-1,414**
Total States/Territories	**200,483,521**	**204,521,212**	**213,826,894**	**9,305,682**
Survey & Certification	200,385	223,000	228,798	5,798
Fraud Control Units	174,800	186,000	195,300	9,300
Vaccines for Children	2,735,437	2,702,206	2,766,230	64,024
Medicare Part B Transfer	358,675	300,000	0	-300,000
Incurred but not Reported	1,614,242	3,000,000	3,231,000	231,000
VFC Collection	513	0	0	0
Adjustments	(453,530)	(3,879,712)	520,106	4,399,818
Subtotal Adjustments				
TOTAL RESOURCES	**$205,114,043**	**$207,052,706**	**$220,768,328**	**$13,715,622**

MEDICAID PROGRAM

Budget Authority by Object

	2008 Estimate	2009 Estimate	Increase or Decrease
CMS - GRANTS TO STATES			
Grants to States, Subsidies, and Contributions	$204,183,467,000	$213,861,470,000	$9,678,003,000
CDC - VACCINES FOR CHILDREN			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$2,702,206,000	$2,766,230,000	$64,024,000
Total budget authority	$206,885,673,000	$216,627,700,000	$9,742,027,000

MEDICAID PROGRAM
Medicaid Requirements
(dollars in thousands)

	2008 Estimate	**2009** Estimate
November 2007 State Estimates (MAP & ADM)	$204,521,212	$213,826,894
State Certification	223,000	228,798
Fraud Control Units	186,000	195,300
Total, unadjusted estimates	$204,930,212	$214,250,992
Adjustments		
State and Local Administration Financial Adj.	-153,341	287,007
Medicare, Medicaid, and SCHIP Extension Act	-15,000	70,000
Obligations Incurred But Not Reported	3,000,000	3,231,000
1915(b)(3) Regulation	0	-100,000
TMA, Abstinence Education, and QI Programs Extension Act	260,000	-55,000
Administrative Actions Affecting State and Local Administration	-47,200	-470,000
Financial Management Reviews	-633,000	-682,000
Actuarial adjustments	-2,704,871	2,935,099
Administrative Actions Affecting Medical Assistance Payments	-286,300	-1,465,000
Subtotal, Adjustments	-$579,712	$3,751,106
Vaccines For Children Program	$2,702,206	$2,766,230
Current law requirement	$207,052,706	$220,768,328
Unobligated Balances,		
Start of Year	-4,007,661	-4,140,628
End of Year	4,140,628	0
Gross Budget Authority	$207,185,673	$216,627,700
Offsetting Collections	-300,000	0
Appropriation/ net budget authority	$206,885,673	$216,627,700

MEDICAID

(State Submitted Estimates with Actuary Adjustments)

MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY

(dollars in thousands)

	FY 2008		FY 2009	
	Amount	%	Amount	%
Ins. Pmts - MCOs	34,382,333	17.67%	$37,323,815	18.32%
Nursing Facility	27,681,382	14.22%	28,086,146	13.78%
Inpatient Hosp - Reg Pmnts	27,073,237	13.91%	27,468,165	13.48%
Home/Community Based Care	17,429,097	8.96%	18,376,679	9.02%
Prescribed Drugs	14,128,784	7.26%	14,949,964	7.34%
All Other	8,417,504	4.33%	9,091,621	4.46%
Outpatient Hospital	7,634,911	3.92%	8,241,732	4.04%
Inpatient Hosp - DSH	7,891,796	4.06%	7,860,557	3.86%
Physician	6,429,639	3.30%	6,573,278	3.23%
Personal Care	6,078,327	3.12%	6,506,709	3.19%
Ins Pmts - Pt B Prms	4,633,348	2.38%	5,034,632	2.47%
Clinic	4,474,008	2.30%	4,581,899	2.25%
ICF/MR Public	4,441,770	2.28%	4,566,036	2.24%
Ins Pmts - Prepaid Health Plans	4,158,987	2.14%	4,124,122	2.02%
Mental Health Facilities	3,034,430	1.56%	3,190,300	1.57%
ICF/MR Private	2,906,740	1.49%	2,999,294	1.47%
Dental	2,352,253	1.21%	2,498,333	1.23%
Home Health	2,259,963	1.16%	2,414,593	1.18%
Mental Health Facilities - DSH	1,781,009	0.92%	1,797,926	0.88%
Targeted Case Management	1,728,648	0.89%	1,797,879	0.88%
Ins Pmts - Pt A Prms	1,559,612	0.80%	1,663,590	0.82%
Other Practitioners	1,454,670	0.75%	1,552,956	0.76%
Federal Qualified Health Ctr	1,255,464	0.65%	1,326,892	0.65%
Hospice	1,198,939	0.62%	1,323,443	0.65%
Ins. Pmts - Medicaid Other	1,089,062	0.56%	1,175,819	0.58%
Lab & Radiological	864,930	0.44%	909,704	0.45%
EPSDT Screening Services	629,581	0.32%	674,078	0.33%
Emergency Srvs Undoc Aliens *	582,386	0.30%	630,743	0.31%
Ins Pmts - Group Health Plan	415,823	0.21%	549,273	0.27%
Medicare Coins & Deduct	476,936	0.25%	499,592	0.25%
Rural Health Clinics	415,307	0.21%	447,693	0.22%
Functionally Disabled Elderly	325,395	0.17%	335,407	0.16%
Prog. of All-Inclusive Care Elderly **	296,588	0.15%	328,269	0.16%
Primary Care Case Mgt Svs	238,483	0.12%	251,559	0.12%
Sterilizations	90,939	0.05%	94,232	0.05%
Medicaid Coins & Deduct - Group Hlth	13,564	0.01%	13,086	0.01%
Abortions	29	0.00%	29	0.00%
Collections/Adjustments	(1,157,141)	-0.59%	(1,196,624)	-0.59%
Drug Rebate Offset	(4,063,862)	-2.09%	(4,298,520)	-2.11%
Total State Submitted Estimates	$194,604,871	100.00%	$203,764,901	100.00%
Part B - Qualified Individuals	300		0	
Actuary Adjustments	(2,705,171)		2,935,099	
Total	$191,900,000		$206,700,000	

* Estimates from reporting prior allotment states

** Estimates of costs provided as an optional service (not under a Section 1115 waiver)

Payments to the Health Care Trust Funds

Appropriations Language

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, ***$195,308,000,000***.

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.

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, $195,308,000,000.	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 drug benefit program in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds
Amounts Available for Obligation

	FY 2007 Actual	FY 2008 Enacted 1/	FY 2009 Estimate
Appropriation: Annual………………………..	$188,389,975,000	$188,445,000,000	$195,308,000,000
Appropriation: Supplemental Medical Insurance Estimated Shortfall……………..…….....	---	$3,695,000,000	---
Lapse in Supplemental Medical Insurance…………..	($4,801,122,789)	---	---
Lapse in General Revenue Part D: Federal Administration……................	($179,803,509)	($136,000,000)	---
Adjustment in Expired Accounts……………………..	$401,614,094	---	---
Lapse in General Revenue Part D: Benefits……………..	($3,996,414,973)	($10,275,000,000)	---
Total Obligations…………………	**$179,814,247,823**	**$181,729,000,000**	**$195,308,000,000**

1/ CMS anticipates that it may be necessary to reprogram in FY 2008 from some of the funds anticipated to lapse in the General Revenue for Part D Benefits line item and to apply them to the Supplementary Medical Insurance line item.

Payments to the Health Care Trust Funds
Summary of Changes

2008 Enacted
Total Budget Authority……………………………………….$188,445,000,000

2009 Estimate
Total Budget Authority……………………………………….$195,308,000,000

Net Change…………………………………………………….. + $6,863,000,000

Changes:	**FY 2008 Enacted Budget Authority**	**Change from Base Budget Authority**
Federal Payment for Supplementary Medical Insurance………...........................	$140,704,000,000	+ $7,012,000,000
Hospital Insurance for the Uninsured………………………………………	269,000,000	+ 82,000,000
Hospital Insurance for Uninsured Federal Annuitants…………………………………...	237,000,000	+ 26,000,000
Program Management Administrative Expenses………..	192,000,000	+ 14,000,000
General Revenue for Part D (Drug) Benefit…………………………………………	46,299,000,000	(1,300,000,000)
General Revenue for Part D Federal Administration………...................................	744,000,000	(197,000,000)
Part D: State Low-Income Determination…………………………………	---	---
Reimbursement for HCFAC…………………	---	+ 198,000,000
Quinquennial Adjustment……………………	---	+1,028,000,000
Net Change……………………………………	**$188,445,000,000**	**+ $6,863,000,000**

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

	FY 2007	FY 2008	FY 2009
Supplementary Medical Insurance……………………………	$142,623,000	$140,704,000	$147,716,000
Indefinite Authority for Supplementary Medical Insurance under "such sums"…........................	---	---	---
Hospital Insurance for Uninsured……….............................	239,000	269,000	351,000
Hospital Insurance for Uninsured Federal Annuitants….......................	229,000	237,000	263,000
Program Management Administrative Expenses……...........	175,000	192,000	206,000
General Revenue for Part D Benefit……………………………….	44,329,000	46,299,000	44,999,000
General Revenue for Part D Federal Administration…………………….........	794,975	744,000	547,000
Part D: State Low-Income Determination………………………...	---	---	---
Reimbursement for HCFAC…………………………………	---	---	198,000
Quinquennial Adjustment…………….	---	---	1,028,000
Total Budget Authority………………………………	**$188,389,975**	**$188,445,000**	**$195,308,000**

Payments to the Health Care Trust Funds
Authorizing Legislation

	2008 Amount Authorized	2008 Budget Estimate	2009 Amount Authorized	2009 Budget Request
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)……………………..	$188,445,000,000	$188,445,000,000	N/A	$195,308,000,000
Total Budget Authority………………..	**$188,445,000,000**	**$188,445,000,000**	**N/A**	**$195,308,000,000**

Annual Budget Authority by Activity:

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA…….	$188,389,975,000	$188,445,000,000	$195,308,000,000	+ $6,863,000,000

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

Allocation Method……………………………………………………………Direct federal/intramural

Program Description and Accomplishments

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

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

- Hospital Insurance for the Uninsured: This 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
- the 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.

Quinquennial Adjustment

Under the Social Security Amendments of 1983, a lump sum was transferred from general revenues to the trust funds to keep them "whole" (for the value of the military service credits) through 2015. The Amendments also stipulated that adjustments would be made every 5 years to reflect changing actuarial calculations of the value military service wage credits. The quinquennial adjustment can be positive, i.e., from general revenues (in Payments to the Health Care Trust Funds account) to the HI Trust Fund. The quinquennial adjustment can also be negative, i.e., from the HI Trust Fund to the general revenues.

Funding History

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

FY 2004	$95,084,100,000
FY 2005	$114,608,900,000
FY 2006	$177,742,200,000
FY 2007	$188,389,975,000
FY 2008	$188,445,000,000

Budget Request

Hospital Insurance for the Uninsured

The FY 2009 estimate of $351 million for Hospital Insurance for the Uninsured is $82 million higher than the FY 2008 appropriation request of $269 million. Most of the increase is due to adjustments for prior years (including interest accrued) and not for FY 2009.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2009 estimate of $263 million for Hospital Insurance for Uninsured Federal Annuitants is $26 million higher than the FY 2008 appropriation request of $237 million. The estimate reflects an increase in payment amount from FY2008 to FY2009, for about the same population.

Program Management Administrative Expenses

The FY 2009 estimate of $192 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare, is $17 million more than the FY 2008 appropriation request of $175 million.

Reimbursement for HCFAC

The FY 2009 estimate of $198 million reimburses the HI Trust Fund for HCFAC activities appropriately paid for by the general fund through a discretionary annual appropriation. The HI Trust Fund, through the HCFAC account, will initially make available resources for additional program integrity activities, predominately for the Part D Drug benefits program, Medicare Advantage, and the Medicaid program. This process started in FY 2008.

Federal Contribution for SMI

The estimate of $147.7 billion for the FY 2009 Federal Contribution for SMI is a net increase of $7.0 billion over the FY 2008 appropriation 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 2009 estimate of $45.0 billion for General Revenue for Part D (Benefits) is $1.3 billion less than the FY 2008 appropriation request of $46.3 billion. This revised estimate reflects updated data on the Part D benefit, including slower-than-expected growth in prescription drug inflation, the ability to begin using some actual data in actuarial estimates, and lower Part D plan bids than previously expected.

General Revenue for Part D Federal Administration

The FY 2009 estimate of $547 million for General Revenue for Part D Federal Administration is $197 million less than the FY 2008 appropriation request of $744 million. This decrease represents increased experience in Part D Federal Administration, resulting in lower costs.

Quinquennial Adjustment

In 2009, it will be necessary to make the quinquennial adjustment for military service wage credits. This adjustment will be positive and will total $1.0 billion.

Permanent Budget Authority
(dollars in thousands)

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Tax on OASDI Benefits……………..	$10,593,000,000	$12,453,000,000	$14,072,000,000	+ $1,619,000,000
SECA Tax Credits…	39,000	---	---	---
HCFAC, FBI………..	118,218,000	120,937,000	124,686,000	+ 3,749,000
HCFAC, Criminal Fines………………..	201,437,000	200,000,000	200,000,000	---
HCFAC, Civil Penalties and Damages: Administration…..….	6,561,000	10,000,000	10,000,000	---
General Revenue for Transitional Drug Assistance Account……………..	---	---	---	---
Transitional Assistance Outlays for Benefits (non-add)……………	[9,815,000]	---	---	---
Total BA…………….	**$10,919,255,000**	**$12,783,937,000**	**$14,406,686,000**	**+ $1,622,749,000**

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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided funds for transitional assistance to low income beneficiaries under the Transitional Prescription Drug Card program until FY 2006. There is no new Budget Authority after FY 2006, and final Transitional Assistance benefit outlays from the General Fund were made in FY 2007. Administrative outlays for Transitional Assistance may continue into FY 2008.

Payments to the Health Care Trust Funds
Budget Authority by Object

	FY 2007 Enacted	FY 2008 Enacted /1	FY 2009 Estimate
Grants, subsidies and contributions: Non-Drug……	$142,623,000,000	$140,704,000,000	$147,716,000,000
Lapse in Supplementary Medical Insurance [Estimated; non-add]………..	-4,801,122,789	[-10,275,000,000]	---
Grants, subsidies and contributions: Drug…………	44,329,000,000	46,299,000,000	44,999,000,000
Shortfall in Part D: Benefits [Estimated; non-add]………..	-3,996,414,973	[3,695,000,000]	---
Insurance claims and indemnities……………………	468,000,000	506,000,000	614,000,000
Administrative costs-General Fund Share…………………..	969,975,000	936,000,000	951,000,000
Lapse in Part D: Federal Administration [Estimated; non-add]………..	-179,803,509	[-136,000,000]	---
Adjustment in Expired Accounts………………………	401,614,094	---	---
Quinquennial Adjustment…...	---	---	1,028,000,000
Total Budget Authority…….	**$179,814,247,823**	**$188,445,000,000**	**$195,308,000,000**

1/ CMS anticipates that it may be necessary to reprogram in FY 2008 from some of the funds anticipated to lapse in the General Revenue for Part D Benefits line item and to apply them to the Supplementary Medical Insurance line item.

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Medicare Benefits

	FY 2007	FY 2008	FY 2009	FY 2009 + / - FY 2008
Outlays	$434,591,000,000	$459,144,000,000	$491,400,000,000	$32,256,000,000

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 2008 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 aged 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 that elect Medicare coverage. In December 2003, the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), P.L. 108-173 which was designed to improve and modernize the Medicare program, including the addition of a drug benefit.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of health care (and within that, of managed care) and accounts for approximately 14 percent of the Federal Budget. 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 approximately 44 million beneficiaries in 2007.

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 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. About 94 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 9.2 million enrollees, as of January 2008.

The Prescription Drug Benefit Program also was created by the MMA, and 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 that offer 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.

Passage of the MMA prompted modifications in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans as well as the Medicare Advantage (MA) and Medicare Fee for Service (MFFS). As a result, we developed four related measures to monitor beneficiary satisfaction with access to medical care and prescription drugs for both MA and MFFS. To meet our FY 2007 target, data on 2006 beneficiary experiences in the new plans were collected in FY 2007 and are reflected in the table following this discussion.

Our 2006 baselines are already high, and our future targets are to continue to achieve those high rates at 90 percent or over. The FY 2008 and 2009 targets of 90 percent for MA and MFFS beneficiary access to care measures, and 91 percent and 90 percent, respectively, for MA and FFS access to prescription drugs demonstrates a commitment by Medicare to assure 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 Medicare program was evaluated by OMB in 2003 under the Program Assessment Rating Tool (PART) earning a "Moderately Effective" rating. Please refer to the Medicare Operations

section of this document for a summary of the Medicare PART. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

Outlays History

FY 2003	$272,578,561,000
FY 2004	$295,336,410,000
FY 2005	$333,426,214,000
FY 2006	$375,174,976,000
FY 2007	$434,591,000,000
FY 2008	$459,144,000,000*

*Under Current Law

Budget Estimates

The budget estimates for Medicare benefits for FY 2009, by trust fund account, is shown in the following table.

	Amount	Increase over FY 2008
HI	$242,234,000,000	$16,112,000,000
SMI – Part B	$194,351,000,000	$6,416,000,000
SMI – Part D	$54,815,000,000	$9,728,000,000
Total	$491,400,000,000	$32,256,000,000

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

The request (estimate) for FY 2009 is an increase of $32,256,000,000 over FY 2008. The increase is due to growth in enrollment and utilization.

Medicare

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
			Actual	Target	Actual	Target	Actual		
Long-Term Objective: Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive									
MCR 1.1a	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	N/A	N/A	Develop survey	Goal met (Trend – 89.9%)	Set base-lines/ targets	Goal met	90%	90%
MCR 1.1b	Percent of persons with Medicare Fee-for-Service (FFS) report they usually or always get needed care right away as soon as they thought they needed it	N/A	N/A	Develop survey	Goal met (Trend – 90.8%)	Set base-lines/ targets	Goal met	90%	90%
MCR 1.2a	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	N/A	N/A	Develop survey	Goal met (Trend – 92.7%)	Set base-lines/ targets	Goal met	91%	91%

#	Key Out-comes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
			Actual	Target	Actual	Target	Actual		
MCR 1.2b	Percent of persons with Medicare FFS and a stand alone drug plan report it is usually or always easy to use their Medicare prescription drug plan to get the medicines their doctor prescribed	N/A	N/A	Develop survey	Goal met (Trend – 91.0%)	Set base-lines/ targets	Goal met	90%	90%

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State Children's Health Insurance Program

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Budget Authority……………	$5,000,000,000			0
BBRA—Additional Funding for Territories……………	40,000,000			0
Medicare, Medicaid and SCHIP Extension Act of 2007, P.L 110-173………...		$5,040,000,000	$5,040,000,000	0
and				
Additional funding for States………………………..		1,600,000,000	275,000,000	-1,325,000,000
Total Budget Authority…..	**5,040,000,000**	**6,640,000,000**	**5,315,000,000**	**-1,325,000,000**
Redistribution from:				
FY 2004 (Available through FY 2007 to States per P.L. 109-482) [/1]…………..	146,880,000			
FY 2005 (Available in FY 2007 to States per P.L. 109-482)[/1]...................	137,832,000 [/2]			
FY 2005/8 (Available through FY 2008) [/1] ………		106,975,320		
FY 2006 and following……...			TBD [/3]	
FY 2007-X U.S. Troop Supplemental for States………	650,000,000			
Total Budgetary Resources…	**$5,974,712,000**	**$6,746,957,320**	**$5,315,000,000**	

[/1] FY 2004 and FY 2005 funding may be used by qualifying States that had high Medicaid income eligibility requirements to spend 20 percent of each year's allotment to cover eligible children under title XXI.

[2/] Determined after the expenditures were finalized as of March 31, 2007 against the FY 2005 allotment as stated in P.L. 109-482.

[/3] To be determined after the expenditures are finalized as of September 30, 2009 against the FY 2006 allotment.

Authorizing Legislation.........The Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173).

FY 2009 Authorization...Funding expires after March 31, 2009

Allocation Method…………………………………………………………………….Formula Grants

Program Description and Accomplishments

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) under title XXI of the Social Security Act. SCHIP 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 SCHIP program, or have a combination of Medicaid expansion and separate SCHIP programs.

CMS successfully increased the number of children enrolled in SCHIP and Medicaid between 1997 and 2005 from over 21,000,000 children to about 36,500,000 children. A new performance measure has been developed regarding CMS efforts to decrease the number of uninsured children by working with States to enroll children in SCHIP. (See table on page 125). This long-term measure proposes to increase enrollment in FY 2009 by 3 percent over FY 2006 enrollment and to continue to steadily increase enrollment through 2012. SCHIP enrollment will undoubtedly be affected by the recently passed Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) and its associated changes in funding levels.

As of September 1999, all States, Territories, and the District of Columbia had approved SCHIP plans. CMS continues to review States' SCHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibility of SCHIP to make innovative changes. As of December 2007, a total of 300 amendments to SCHIP plans have been approved.

Recent legislation has adjusted the budgetary resources available to States for SCHIP through March 31, 2009. Most recently, the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) authorized funding for both FY 2008 and FY 2009 at the FY 2007 funding level of $5,040,000,000. Additionally, up to $1,600,000,000 is designated to address States’ funding issues in FY 2008 and up to $275,000,000 is available to address States’ funding issues in FY 2009. The National Institutes of Health Reform Act of 2006 (P.L. 109-482) authorized the Secretary to accelerate the redistribution of the FY 2005 allotments to States with projected expenditures in excess of available funding in FY 2007 instead of FY 2008. In addition, the U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (P.L. 110-28) authorized and appropriated an additional $650,000,000 to address States’ FY 2007 funding issues in their SCHIP programs.

While the program has evolved through plan amendments and legislation, CMS is committed to improving quality of care and program integrity in SCHIP, as illustrated by our efforts to track and improve performance in these areas. An accomplishment of this program is dramatic

improvement in States' reporting of SCHIP health quality performance measures through the Performance Measurement Partnership Project, which is detailed in the measure to Improve Health Care Quality Across SCHIP. (See table on page 125). In FY 2007, CMS revised quality reporting templates to reflect State improvement efforts. We anticipate a higher caliber of State reporting on quality improvement activities, identification of promising practices that can be disseminated, and ultimately, continuous improvement in the quality of care for SCHIP beneficiaries. CMS is also aiming to increase program integrity through its nationally implemented Payment Error Rate Measurement (PERM) program. The PERM measurement includes a fee-for-service, managed care and eligibility component for the SCHIP program. We expect to continue full implementation of these measurements in 17 states in FY 2009 so we can report a national error rate in the FY 2010 Performance and Accountability Report.

SCHIP received an Adequate score in the FY 2005 Program Assessment Rating Tool (PART) cycle. The PART evaluation cited that the SCHIP program has been successful in enrolling and providing health coverage to uninsured children. We are taking 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. For more information on programs that have been evaluated based on the PART process, see www.Expectmore.gov.

Funding History

FY 2000	$4,249,000,000
FY 2001	$4,249,000,000
FY 2002	$3,115,200,000
FY 2003	$3,175,200,000
FY 2004	$3,175,200,000
FY 2005	$4,082,400,000
FY 2006	$4,082,400,000
FY 2007	$5,040,000,000
FY 2008	$6,640,000,000
FY 2009	$5,315,000,000

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 SCHIP allotments to States, Territories, Commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-133) authorized and appropriated additional funding for SCHIP allotments to Commonwealths and Territories. The total funds that are available for CMS to grant to States, Commonwealths, and Territories for SCHIP in FY 2009 are $5,040,000,000. In addition, the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) authorized up to $1,600,000,000 for States with SCHIP spending in excess of available funding, as well as, $275,000,000 for such States in FY 2009. After March 31, 2009, SCHIP funding sunsets and will need to be reauthorized.

The FY 2009 President's Budget proposes to reauthorize SCHIP through FY 2013 and focuses each of the program elements on SCHIP's original objective to provide health insurance coverage for uninsured, low-income children at or below 200 percent of the FPL.

SCHIP legislative proposals are described below.

A. SCHIP Reauthorization

When SCHIP was established, the focus was on low-income children, primarily children below 200 percent of the FPL. The FY 2009 President's Budget proposes continuing to prioritize health insurance for targeted low-income children by including $19.7 billion in increased allotments through FY 2013 to meet anticipated State need in covering low-income, eligible children.

In addition, the Administration proposes policies to increase the long-term sustainability of SCHIP. The Budget includes proposals to: (1) reprioritize coverage of the low-income children the Program was originally intended to capture; (2) further prevent the substitution of SCHIP for private insurance; and (3) rationalize eligibility for SCHIP by clearly defining income.

In the State Grants and Demonstration chapter, the FY 2009 President's Budget proposes to include annual Outreach Grants to States, localities and community-based organizations to reach children eligible but not enrolled in SCHIP or Medicaid. This proposal includes $50 million in FY 2009 and $100 million in each of the following four years for these outreach grants that will impact both Medicaid and SCHIP.

The SCHIP Reauthorization is fully offset in health care entitlements.

Five-year budget impact:	SCHIP Cost:	$ 18.7 billion
	Medicaid Interaction:	$ 0.2 billion
	Outreach Grants:	$ 0.4 billion
	Total SCHIP Reauthorization cost:	$ 19.3 billion

B. Modify the Health Insurance Portability and Accountability Act (HIPAA)

This proposal would make two HIPAA-related statutory changes:

In States with premium assistance or other employer-sponsored insurance programs, these beneficiaries may have to wait for their employer's open-enrollment period to register in their private insurance. This proposal would make eligibility for Medicaid and SCHIP a qualifying event, which would allow beneficiaries to enroll in private insurance even if it is not their insurer's open-enrollment period.

In addition, this proposal would require SCHIP programs to issue certificates of creditable coverage, which promote portable health coverage by verifying the period of time an individual was covered by a specific health insurance policy.

Five-year budget impact: None

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out year Target
Long-Term Objective: Improve Health Care Quality Across the State Children's Health Insurance Program										
SCHIP2	Improve Health Care Quality Across SCHIP	Goal met. Refine data; produce standard format; collect baseline.	Goal met. Collect core data; use SARTS; Assist States.	25% of States reporting on 4 core performance measures.	Goal met.	Revise Template to reflect State improvement efforts.	Goal met.	Disseminate best practices.	Work with low performers. A "low performer" is any State that doesn't provide quantifiable and measurable performance measures in their FY 2006 SCHIP annual report.	N/A
Long-Term Objective: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP.										
SCHIP3	Decrease the number of uninsured children by working with States to enroll children in SCHIP.	N/A	N/A	N/A	Baseline: 6,600,000 children	N/A	N/A	Increase FY 2006 enrollment by 2%	Increase FY 2006 enrollment by 3%.	In-crease FY 2006 enroll-ment by 12%. (2012)
Long-Term Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs										
MCD1.2	Estimate the Payment Error Rate in SCHIP	N/A	N/A	N/A	N/A	Begin full implement-ation of measuring FFS, managed care and eligibility in 16 States for SCHIP (excludes Tennessee) Report national error rate in FY 2008 PAR.	Nov-08	Report national SCHIP error rates in the FY 2009 PAR based on 17 States measured in FY 2008	Report national SCHIP error rates in FY 2010 PAR based on 17 States measured in FY 2009	Below Base-line (2012)
Appropriate Amount ($ Millions)		**$3,175.2**	**$4,082.4**	**$4,082.4**		**$5,040.0**		**$6,640.0**	**$5,315.0**	

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

FY 2009 MANDATORY STATE/FORMULA GRANTS
(dollars in thousands)

CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program

STATE/TERRITORY	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate	Difference +/- 2008
Alabama	$74,295	$72,328	$72,328	$0
Alaska	15,699	11,186	11,186	0
Arizona	127,859	142,957	142,957	0
Arkansas	49,308	47,544	47,544	0
California	790,789	789,164	789,164	0
Colorado	71,545	71,545	71,545	0
Connecticut	39,891	38,810	38,810	0
Delaware	11,058	12,760	12,760	0
District of Columbia	11,709	12,057	12,057	0
Florida	296,067	301,724	301,724	0
Georgia	287,179	167,924	167,924	0
Hawaii	15,314	15,243	15,243	0
Idaho	24,316	23,803	23,803	0
Illinois	390,740	208,344	208,344	0
Indiana	93,469	97,385	97,385	0
Iowa	50,231	33,177	33,177	0
Kansas	36,542	36,635	36,635	0
Kentucky	70,115	68,237	68,237	0
Louisiana	89,586	84,083	84,083	0
Maine	17,161	15,450	15,450	0
Maryland	111,401	72,403	72,403	0
Massachusetts	153,634	73,335	73,335	0
Michigan	149,383	147,082	147,082	0
Minnesota	52,819	48,613	48,613	0
Mississippi	84,028	60,989	60,989	0
Missouri	72,140	77,618	77,618	0
Montana	15,736	15,922	15,922	0
Nebraska	21,892	21,377	21,377	0
Nevada	52,056	51,072	51,072	0
New Hampshire	10,779	10,657	10,657	0
New Jersey	210,050	105,519	105,519	0
New Mexico	52,045	52,045	52,045	0
New York	340,807	328,680	328,680	0
North Carolina	136,117	136,117	136,117	0
North Dakota	7,738	7,889	7,889	0

STATE/TERRITORY	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate	Difference +/- 2008
Ohio	157,997	157,858	157,858	0
Oklahoma	70,828	70,828	70,828	0
Oregon	56,734	60,116	60,116	0
Pennsylvania	173,554	168,758	168,758	0
Rhode Island	40,939	13,958	13,958	0
South Carolina	70,651	71,017	71,017	0
South Dakota	10,354	10,504	10,504	0
Tennessee	97,460	99,842	99,842	0
Texas	557,980	556,191	556,191	0
Utah	40,486	41,292	41,292	0
Vermont	5,753	5,637	5,637	0
Virginia	94,070	90,339	90,339	0
Washington	79,883	79,883	79,883	0
West Virginia	27,517	25,666	25,666	0
Wisconsin	69,715	69,563	69,563	0
Wyoming	6,942	6,373	6,373	0
Subtotal	**5,594,361**	**4,987,499**	**4,987,499**	**0**
American Samoa	630	630	630	0
Guam	1,838	1,838	1,838	0
Northern Mariana Islands	578	578	578	0
Puerto Rico	48,090	48,090	48,090	0
Virgin Islands	1,365	1,365	1,365	0
Subtotal	**52,501**	**52,501**	**52,501**	**0**
Total States/Territories	**5,646,862**	**5,040,000**	**5,040,000**	**0**
Technical Assistance				
State Penalties				
Contingency Fund		*	*	
Other Adjustments	43,138	1,600,000	275,000	
Subtotal Adjustments				
TOTAL RESOURCES	**$5,690,000**	**$6,640,000**	**$5,315,000**	**-$1,325,000**

*FY 2008 and FY 2009 include additional funding appropriated in P.L 110-173 for States that have projected expenditures in excess of available funding. This funding will be distributed to States according to statute.

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Appropriations Language

Centers for Medicare & Medicaid Services

Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, $198,000,000, 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, of which $147,038,000 is for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services to conduct oversight of activities for Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act, including activities listed in section 1893(b) of such Act (42 U.S.C. 1395ddd(b)); of which $18,967,000 is for the Department of Health and Human Services Office of Inspector General; of which $13,028,000 is for the Medicaid and SCHIP program integrity activities; and of which $18,967,000 is for the Department of Justice: Provided, That the report required section 1817(k)(5) of the Social Security Act for FY 2009 shall include measures of the operational efficiency and impact on fraud, waste and abuse in the Medicare, Medicaid and SCHIP programs for the funds provided by this appropriation.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, $198,000,000, to be available until expended, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act, of which $147,038,000 is for the Centers for Medicare & Medicaid Services for carrying out program integrity activities with respect to title XVIII of such Act, including activities authorized under the Medicare Integrity Program under section 1893 of such Act; of which $13,028,000 is for the Centers for Medicare & Medicaid Services for carrying out Medicaid IPIA Compliance with respect to titles XIX and XXI of such Act; and of which, for carrying out fraud and abuse control activities authorized by section 1817(k)(3) of such Act, $18,967,000 is for the Department of Justice; and $18,967,000 is for the Department of Health and Human Services Office of the Inspector General.	Provides resources for expanded efforts for Medicaid program integrity activities, for safeguarding the Medicare prescription drug benefit and the Medicare Advantage Program and for program integrity activities carried out by other agencies.
Provided further, That the report required by section 1817(k)(5) of such Act for FY 2009 shall include measures of the operational efficiency and impact on fraud, waste and abuse in the Medicare and Medicaid 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

Mandatory	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Medicare Integrity Program (MIP)	$720,000,000	$720,000,000	$720,000,000	$0
Medi-Medi	$24,000,000	$36,000,000	$48,000,000	$12,000,000
FBI	$118,218,000	$120,937,000	$124,686,000	$3,749,000
DoJ Wedge	51,793,000	$53,622,000	$55,284,000	$1,662,000
OIG	$165,920,000	$169,736,000	$174,998,000	$5,262,000
HHS Wedge	$31,746,000	$31,839,000	$32,826,000	$987,000
Subtotal	$1,111,677,000	$1,132,134,000	$1,155,794,000	$23,660,000
Proposed Discretionary				
Cap Adjustment				
MIP/Program Integrity	$0	$0	147,038,000	$147,038,000
FBI	$0	$0	9,483,000	$9,483,000
DoJ	$0	$0	9,484,000	$9,484,000
OIG	$0	$0	18,967,000	$18,967,000
CMS PERM	$0	$0	13,028,000	$13,028,000
Subtotal	$0	$0	198,000,000	$198,000,000
Total	**$1,111,677,000**	**$1,132,134,000**	**1,353,794,000**	**$221,660,000**

Authorizing Legislation……………………..Social Security Act, Title XVIII, Section 1817K

FY 2009 Authorization……………………………………………………..………..Expired

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. HCFAC is comprised of three separate funding streams: 1) the Medicare Integrity Program (MIP); 2) the HCFAC Account; and 3) the Federal Bureau of Investigation (FBI). MIP includes funding for medical review, benefit integrity, provider and Health Maintenance Organization audits, Medicare secondary payer activities, and provider education and training. The HCFAC Account includes funding for the OIG and a "Wedge" amount (the difference between the amount OIG receives and the total amount in the Account) that is available to the Department of Health and Human Services (HHS) and the Department of Justice (DoJ). The statute requires the Secretary and Attorney General to annually negotiate the HHS and DoJ allocations for the Account. The FBI account includes funding for health care fraud enforcement. The Tax Relief and Health Care Act of 2006 (TRHCA) provided a CPI-U inflationary adjustment for fiscal years 2007 through 2010 to the OIG, Wedge, and FBI streams, the first increase since 2002. TRHCA set OIG funding in FY 2007 at a minimum of $160 million plus the CPI-U adjustment.

Reducing fraud, waste, and abuse is a top priority for CMS. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services provided in the appropriate setting to an eligible beneficiary.

CMS follows four parallel strategies in carrying out our program oversight activities. They are: prevention, early detection, coordination, and enforcement.

- Prevention: CMS identifies problems before a claim is paid, through our payment systems, prepayment medical review activities, and education of providers and beneficiaries.

- Early detection: CMS finds problems quickly, using audits and post payment claims reviews, data matches and other sources to detect improper payments.

- Coordination: CMS works with others to identify and fight fraud and abuse. CMS recognizes the importance of working with contractors, beneficiaries, law enforcement partners, and other Federal and State agencies to improve the fiscal integrity of the Medicare trust funds.

- Enforcement: CMS ensures that action is taken when fraud and abuse is found. CMS will continue to work with our partners, including the DHHS/OIG, Department of Justice (DOJ), State agencies for survey and certification, and State Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

The Medicare Integrity Program underwent a PART review in 2002 and received an effective rating. The review cited that performance measures, such as the Medicare error rate, are directly relevant to its purpose. In response to the PART evaluation, the CMS budget request will fund initiatives that support efforts to increase program performance. Funds will support activities that increase detail of error rates through increased sampling size and rolling month error rates. As a result of the PART review, CMS continues to develop and implement safeguards to protect the Medicare Advantage program and the Medicare Prescription drug benefit 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.

For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

Funding History

FY 2004	$1,074,558,000
FY 2005	$1,074,558,000
FY 2006	$1,186,558,000
FY 2007	$1,111,677,000
FY 2008	$1,132,134,000

Budget Request

For FY 2009, CMS is requesting a funding level of $1,353.8 million, an increase of $221.6 million over FY 2008, to carry out the Health Care Fraud and Abuse Control program. This includes $1,155.8 million in permanent, mandatory funds and $198 million in discretionary funds. The first year investment totals $198 million.

The HCFAC program has a ten-year history of recouping improper and fraudulent payments and a solid track record on returns to the Medicare Trust Fund. The historical return on investment for the life of the MIP program has been about 13 to 1. Our HCFAC discretionary cap adjustment proposal is also projected to generate mandatory savings. The discretionary funds are part of a three-year HCFAC discretionary cap adjustment proposal (2009-2011). This proposal supports the Administration's government-wide effort to eliminate improper payments, specifically in the Medicare and Medicaid programs. The FY 2009 request level for the HCFAC discretionary cap adjustment is commensurate with the opportunities we face in battling health care fraud and the returns we generate from this investment. The first year investment totals $198 million. These funds will supplement existing mandatory HCFAC and Medicaid Program Integrity funds and strengthen HHS and DOJ efforts to combat health care fraud and abuse, predominantly in the Part D drug benefits program, Medicare Advantage, and the Medicaid program.

The following pages provide detailed information explaining the program activities within HCFAC.

MEDICARE INTEGRITY PROGRAM (MIP)/PROGRAM INTEGRITY

Program Description and Accomplishments

Below are a few examples of Medicare Integrity Program activities:

Medicare Drug Integrity Contractors (MEDICs): With the implementation of the Medicare Prescription Drug Plan program, it became necessary for CMS to effectively deal with any issues related to potential fraud, waste and abuse 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 payment, pricing, bidding, enrollment and eligibility, and benefit services provided (e.g. medication therapy management, e-prescribing).

CMS would also like to develop specialized MEDICs: 1) for investigating Retiree Drug Subsidy fraud and abuse; and 2) for combining the fraud, waste and abuse work for Medicare Parts C & D. CMS will create a MEDIC-like contractor to handle FWA issues in Medicare Managed Care—thus combining the work for Parts C & D.

- Comprehensive Error Rate Testing (CERT): CMS developed the Comprehensive Error Rate Testing (CERT) program to produce national paid claim error rates specific to contractor, benefit category , 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. The claims subjected to sampling and review include all claims appropriately submitted to a carrier, Durable Medical Equipment Medicare Administrative Contractor (DME MAC), and fiscal intermediary (other than PPS acute care inpatient hospital and PPS long-term care hospital claims).

  These sampled claims are then followed through the system to their final disposition. The independent reviewers medically review claims that contractors paid; the same independent reviewers validate claims that ACs/PSCs denied to ensure that the 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 CMS needs 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 and for evaluation of new fraud detection technology.

  The Quality Improvement Organizations (QIOs) currently measure the error rate for Acute Care Inpatient PPS Hospital claims and Long Term Care Hospitals claims under the Hospital Payment Monitoring Program (HPMP). In response to recommendations from the OIG and DHHS, CMS plans to transition 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.

  The primary performance measure of the fiscal intermediaries, carriers, and MACs is their ability to reduce the fee for service claims payment error rate. This is being measured by the CERT contractor through a sampling of claims and an independent review. Contractors will be expected to decrease their rate to the overall national goal.

  CMS expects to reduce the national paid claims error rate to 3.7 percent by FY 2009. CMS has maintained great success over the years in reducing the national error rate. In addition to the national error rate, CERT findings include

contractor-specific error rates which measure the accuracy of the contractor's claims payments and processing activities. These additional rates allow CMS to quickly identify emerging trends in managing Medicare contractor performance. By FY 2009, CMS expects 90 percent of the contractors to have an error rate less than or equal to the previous year's actual national paid claims error rate.

- Provider Verification Services (ChoicePoint): CMS is increasing its efforts to eliminate fraudulent providers. We now have regulatory authority to eliminate providers who have committed a felony. We are doing criminal background checks on providers who are deemed to be at high risk to commit fraud. Using the verification services offered by ChoicePoint will help us identify these providers more quickly and efficiently.

- One Program Integrity (One PI): CMS plans to consolidate and centralize Medicare and Medicaid data across its various program integrity contractors such as MEDICs, Program Safeguard Contractors (PSCs), Medicare Administrative Contractors (MACs), and CMS staff and streamline data operations and access. We have embarked on an initiative called the Integrated Data Repository (IDR) The IDR has been designated as the target system that represents the "To-Be" architecture for CMS enterprise decision support systems. The IDR is being built incrementally and will not store all of the data needed to perform Program Integrity Part D data analysis. The One PI Data Repository is a database that will support those data requirements not stored in the IDR. Funding is required to continue development of these systems.

- 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 the Inspector General (OIG) listings and d) checking that the supplier meets the newly implemented accreditation requirement.

  Stopping fraud and abuse includes monitoring of suppliers. The NSC will assign fraud level indicators to assist in expanded review procedures of suppliers. These procedures will consist of a) increased unannounced on-site reviews b) monitoring of changes of ownership c) increased reviews of claims for inappropriate billings and d) phone calls to suppliers. The NSC will assure that existing suppliers are accredited in accordance with the announced CMS schedule. The NSC will coordinate fraud and abuse efforts with CMS satellite offices. The NSC will assist fraud and abuse efforts conducted by the OIG, Department of Justice (DOJ), the US attorney and State law enforcement officials.

- Fraud Hot Spots: CMS currently has fraud field offices in Los Angeles, Miami, and New York. These field offices have become an effective way to combat health care fraud and abuse by providing front-line, on-the-ground oversight. Staff in these field offices is able to detect and respond quickly to schemes to defraud the Medicare program. Special fraud projects focused on emerging schemes have yielded about

$2 billion in savings since these field offices opened. CMS will work to establish additional Program Integrity field offices in areas known to have high incidences of fraud. CMS will conduct additional field oversight and develop the capacity to quickly set up "hot spots" that align with Program Integrity field offices. These funds will provide additional FTEs and travel and training support to further develop a highly skilled fraud detection workforce. Finally, CMS will expand Medicare Administrative Contractor oversight based on the seven Program Safeguard Contractor zones to address fraud "hot spots."

- 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:

    - the service fits one of the benefit categories described in title XVIII of the 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.

- Benefit Integrity (BI): BI activities deter and detect Medicare fraud through concerted efforts with the OIG, the General Accountability Office, the Department of Justice, 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.

- Provider Audit: Auditing is CMS' primary instrument to safeguard payments made to institutional providers 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. The audit process includes such administrative functions as intermediary hearings and appeals to the Provider Reimbursement Review Board. The audit effort also helps determine the confidence level in the data reported in the Medicare cost reports and reflects changes in provider behavior.

- 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.

- <u>Provider Outreach and Education (POE):</u> 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.

- <u>Program Safeguard Contractors:</u>
  CMS contracts with twelve 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, the PSC task orders will be aligned with the Medicare Administrative Contractors (MACs) through shifting workload and competition. The contracting strategy being implemented in FY 2008-FY 2009 will create seven Zone Program Integrity Contractors (ZPICs) with an emphasis on designated high-risk fraud areas. Single contracts (Indefinite Delivery / Indefinite Quantity) will be issued for each zone with separate task orders for 1) Medicare Parts A, B, Durable Medical Equipment (DME) and Home Health; 2) Medicare-Medicaid Data Analysis; 3) Medicare Parts C and D; and 4) Cost Report Audit. This strategy will increase the ability to look at providers across all benefit categories; achieve economies of scale through the consolidation of contractor management, data/IT requirements, facility costs, et cetera; streamline CMS costs in acquisition, management and oversight; and provide for better coordination and fewer resources required for the States.

- <u>Part D Drug Benefit Program Integrity:</u> Oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud, waste and abuse. The new Part D program has implemented strong program integrity safeguards, including the Medicare Drug Integrity Contracts (MEDICs) to control fraud, waste and abuse. The MEDICs perform program safeguard functions to detect, deter and prevent fraud, waste and abuse and to mitigate vulnerabilities associated with Part D payment, pricing, bidding, benefit services provided, enrollment and eligibility.

- <u>Part C Managed Care Program Integrity:</u> Medicare Part C has many of the same fraud and abuse oversight needs as Part D and Medicaid, such as:

  - Review of actions of individuals or entities furnishing items or services for fraud, waste or abuse.
  - Educate providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care; and
  - Identify inappropriate payments to entities receiving Federal funds.

CMS plans to further develop program safeguards for Part C using discretionary HCFAC funds in the FY 2009 budget.

- Coordination: The continuum from detection to prosecution of fraudulent activity requires constant and complete coordination with CMS, its contractors and law enforcement partners. The PSCs 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 are frequently called upon to perform medical review or data analysis for cases initiated by OIG or the FBI.

- Medicare/Medicaid Data Match Expansion Project (Medi-Medi): 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 or abuse that may not be evident when provider billings from either program are viewed in isolation.

MIP Budget Request

The FY 2009 request includes mandatory funding of $720 million and discretionary funding of $147 million for MIP. The FY 2009 request includes mandatory funding of $48 million for Medi-Medi. The discretionary cap adjustment for FY 2009 would provide MIP an increase of $147 million over FY 2008 to meet the growing program integrity needs and threats in Parts C and D of the Medicare program.

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.

Budget Request

The FY 2009 request includes mandatory funding of $124.7 million and discretionary funding of $9.5 million for FBI. This request is $13.2 million over the FY 2008 level. payments, specifically in the Medicare and Medicaid programs. The FY 2009 request level for the HCFAC discretionary cap adjustment is commensurate with the opportunities we face in battling health care fraud, the level of bipartisan funding support this activity has received from Congress for FY 2008, and the returns we generate from this investment.

The discretionary funding request will supplement existing mandatory HCFAC and Medicaid Program Integrity funds and strengthen HHS and DOJ efforts to combat health care fraud and abuse. This proposal supports the Administration's government-wide effort to eliminate improper payments, specifically in the Medicare and Medicaid programs.

DEPARTMENT OF JUSTICE WEDGE (DOJ)

Program Description and Accomplishments

United States Attorney's Offices (USAOs) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse litigation. The USAOs dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

Budget Request

The FY 2009 request includes mandatory funding of $55 million and discretionary funding of $9.5 million for DoJ. This request is $11.1 million over the FY 2008 level.

The discretionary funding request will supplement existing mandatory HCFAC and Medicaid Program Integrity funds and strengthen HHS and DOJ efforts to combat health care fraud and abuse. This proposal supports the Administration's government-wide effort to eliminate improper payments, specifically in the Medicare and Medicaid programs.

OFFICE OF THE INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

The OIG conducts numerous audits and evaluations that disclose improprieties in Medicare and Medicaid,and recommends corrective actions that, when implemented, correct program vulnerabilities and save program funds.

Budget Request

The FY 2009 request includes mandatory funding of $175 million and discretionary funding of $19 million for OIG, an increase of $24.2 million over FY 2008.

OIG will use FY 2009 funding for two major purposes. First, they plan to expand the Medicare Fraud and Abuse Task Force model currently in operation in South Florida. Second, OIG will create a Health Information Technology Operations Center that will provide the technology infrastructure and analytic capabilities for advanced analysis of large volumes of health care data to identify instances of fraud, waste, and abuse. See the OIG's justification for additional information.

HHS WEDGE FUNDING FOR MEDICARE AND 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. As noted at the beginning of this section, decisions about wedge funding levels for DoJ and the agencies of the Department of Health and Human Services are made by negotiation and agreement between the Attorney General and the Secretary of HHS. 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 2009.

- Medicaid Integrity Program: During FY 2006, the Deficit Reduction Act (DRA) created the Medicaid Integrity Program. Although the primary responsibility for this program falls under title XIX, the DRA did provide funding that is managed under this account. The DRA provided an additional $25 million for Medicaid oversight to the Office of Inspector General for fiscal years 2006 through 2010. In addition, the DRA provided the Medicare-Medicaid Data Match program (Medi-Medi) with the following funding: FY 2006, $12 million; FY 2007, $24 million; FY 2008, $36 million; FY 2009, $48 million; FY 2010, $60 million and for each fiscal year thereafter.

- Payment Error Rate Measurement (PERM): In FY 2006, CMS nationally implemented the Payment Error Rate Measurement Program in order to comply with the 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. To implement PERM, CMS has elected to use three Federal contractors for the three major functions involved in conducting reviews and determining error rates. Each of their contracts spans 26 months, since that is the time period needed to complete a full measurement cycle. The proposed HCFAC cap adjustment includes $13.0 million in FY 2009 for PERM to support the following activities:

  - Statistical Contractor: Determines each State's Medicaid and SCHIP sample size; randomly selects a statistically valid sample of claims for each State on a quarterly basis; provides these samples to the documentation/database and review contractor(s); reviews State eligibility sampling plans; computes State error rates; calculates a national error rate; and assists in writing the final report.

  - Documentation/Database Contractor: Formats claims data received from the States; works with the States to collect State Medicaid and SCHIP policies; maintains, scans and uploads State policies into a database; works with the State and local providers to request and retrieve medical records of selected claims; scans and uploads the medical records into a database; and works with the review contractor to ensure the receipt of complete State policies and medical records.

  - Review Contractor: Makes a payment determination for each Medicaid and SCHIP fee-for-service sampling unit by performing data processing reviews

and medical reviews; conducts a data processing review of Medicaid and SCHIP managed care capitation payments; provides review findings to the States and the statistical contractor; maintains a difference resolution process; jointly writes the final report with the statistical contractor; and submits the report to CMS.

In November 2007, CMS announced a preliminary Medicaid fee-for-service component error rate for FY 2006. This was the first year in which any component of Medicaid improper payments had been measured.

- Office of the General Counsel (OGC): The OGC provides legal support consistent with the statutory authority of the HCFAC program. OGC reviews programs and activities of CMS in order to strengthen them against potential fraud, waste, and abuse, to prevent the wrongful disbursement of program funds in the first instance, consistent with statutory goals of HCFAC.

- Administration on Aging (AoA): The AoA develops and disseminates consumer education information to older Americans, with a particular focus on persons with low health literacy, individuals from culturally diverse backgrounds, persons living in rural areas, and other vulnerable populations. AoA and its nationwide network of agencies supported community education activities designed to assist older Americans and their families to recognize and report potential errors or fraudulent situations in the Medicare and Medicaid programs.

Budget Request

The FY 2009 request includes mandatory funding of $32.8 million and discretionary funding of $13 million for Medicaid Program Integrity.

In FY 2009 and beyond, PERM contractors will be measuring fee-for-service and managed care payment error rates for both the Medicaid and SCHIP programs. The contractors will also calculate and report on beneficiary eligibility error rates for both programs even though the States conduct the actual reviews. During FY 2009, CMS will have 4 cycles of PERM contractors in play since the FY 2007, FY 2008, FY 2009, and FY 2010 cycles overlap with one another. FY 2009 PERM funding will be used to complete funding the FY 2008 cycle; continue funding the FY 2009 cycle; and begin funding the FY 2010 cycle. The results of the FY 2009 PERM cycle will be included in the FY 2010 Performance and Accountability Report (PAR). For further information on this performance measure, see the outcomes table in the Medicaid section of this congressional justification.

Medicaid and SCHIP Financial Management: CMS expects funding in FY 2009 for Medicaid and SCHIP financial management, for projects such as: enhancement of the current financial management review of State Medicaid/SCHIP programs; and, strengthening financial management staffing.

For 2009, the Budget proposes the following structural changes to the Health Care Fraud and Abuse Control Account: (1) splitting the current funding provided jointly to the Department of Health and Human Services and the Department of Justice into separate funding streams; (2) eliminating the annual negotiations process between the two Departments; and (3) requiring the Federal Bureau of Investigations and the Medicare Integrity Program to contribute to the annual HCFAC report.

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program										
MIP 1	Reduce the Percent-age of Improper Payments Made Under the Medicare Fee-for-Service Program	10.1%	5.2%	5.1%	4.4%	4.3%	3.9%	3.8%	3.7%	TBD (FY 2010)
Long-Term Objective: Reduce the Medicare Contractor Error Rates										
MIP 4	Percent-age of contrac-tors with Error Rates less than or equal to the previous year's national paid claims error rate	Set Base-line	89.6%	50%	82.8%	75%	78.7%	85%	90%	95% (FY 2010)

Supplementary Table

Health Care Fraud and Abuse Control Program
Budget Authority by Object

	2008 Estimate	2009 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)................................			
Other than full-time permanent (11.3)..................			
Other personnel compensation (11.5).................			
Military personnel (11.7)....................................			
Special personnel services payments (11.8).........			
Subtotal personnel compensation.................			
Civilian benefits (12.1)..			
Military benefits (12.2)..			
Benefits to former personnel (13.0).......................			
Total Pay Costs..			
Travel and transportation of persons (21.0).............			
Transportation of things (22.0)...............................			
Rental payments to GSA (23.1)............................			
Communication, utilities, and misc. charges (23.3)..			
Printing and reproduction (24.0).............................			
Other Contractual Services:			
Advisory and assistance services (25.1)..............			
Other services (25.2)..			
Purchase of goods and services from government accounts (25.3)............................		$188,516,000	$188,516,000
Operation and maintenance of facilities (25.4).......			
Research and Development Contracts (25.5)........			
Medical care (25.6)...			
Operation and maintenance of equipment (25.7)...			
Subsistence and support of persons (25.8)...........			
Financial Transfers (94.0)..................................		$9,484,000	$9,484,000
Subtotal Other Contractual Services............		**$198,000,000**	**$198,000,000**
Supplies and materials (26.0)................................			
Equipment (31.0)...			
Land and Structures (32.0)			
Investments and Loans (33.0)...............................			
Grants, subsidies, and contributions (41.0)............			
Interest and dividends (43.0).................................			
Refunds (44.0)..			
Total Non-Pay Costs..	-	198,000,000.00	198,000,000.00
Total New Obligations..	-	198,000,000.00	198,000,000.00

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State Grants and Demonstrations Current Law Summary Table

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Ticket To Work and Work Incentives Improvement Act (TWWIIA)				
Section 203 – Medicaid Infrastructure Grants…..…	$42,849,000	$43,834,000	$45,193,000	+$1,359,000
Section 204 - Demonstration to Maintain Independence & Employment…………….…	$0	$0	$0	$0
Subtotal – TWWIIA Appropriation/BA……….	**$42,849,000**	**$43,834,000**	**$45,193,000**	**+$1,359,000**
Medicare Modernization Act (MMA)				
Federal Reimbursement of Emergency Health Services for Undocumented Aliens..............................	$250,000,000	$250,000,000	$0	-$250,000,000
Subtotal – MMA Programs…………..……..	**$250,000,000**	**$250,000,000**	**$0**	**-$250,000,000**
Deficit Reduction Act (DRA)				
Site Development Grants- Rural Programs of all-Inclusive Care for the Elderly (PACE)…...............	$0	$0	$0	$0
Drug Surveys & Reports…………………….	$5,000,000	$5,000,000	$5,000,000	$0
Expansion of State Long Term Care (LTC) Partnership Program…..…	$3,200,000	$3,200,000	$3,200,000	$0
Alternate Non-Emergency Network Providers…….....	$0	$0	$0	$0
Demonstration Projects Regarding Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children……	$22,000,000	$37,000,000	$49,000,000	+$12,000,000
Money Follows the Person Demonstration…………….	$247,600,000	$298,900,000	$348,900,000	+$50,000,000

MFP Evaluations & Technical Support……….	$2,400,000	$1,100,000	$1,100,000	$0
High Risk Pools…………...	$0	$0	$0	$0
Medicaid Transformation Grants………………………	$75,000,000	$75,000,000	$0	-$75,000,000
Medicaid Integrity Program……………………..	$50,000,000	$50,000,000	$75,000,000	+25,000,000
Subtotal –DRA programs…………………	**$404,200,000**	**$470,200,000**	**$482,200,000**	**+12,000,000**
Appropriation/B.A……....	**$698,049,000**	**$764,034,000**	**$527,393,000**	**-$236,641,000**
Obligations………….……	**$899,118,000**	**$862,751,000**	**$777,638,000**	**-$85,113,000**

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; State High Risk Pool Funding Extension Act of 2006, Public Law 109-172; Tax Relief and Health Care Act of 2006, Public Law 109-432

Allocation Method…………………………………………………………………….Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for 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, 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, surveys of covered outpatient drugs, 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.

Funding History

FY 2004	$142,000,000
FY 2005	$535,500,000
FY 2006	$2,565,520,000
FY 2007	$698,049,000
FY 2008	$764,034,000

Budget Request

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. Following is a description of each grant and demonstration program and the 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:

- Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs for State Medicaid workers so they can provide better service to workers with disabilities in terms of eligibility for 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, grant recipients 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. In 2006, supplemental grant awards were made to States that had Medicaid buy-in programs and Medicaid Infrastructure Grants totaling $2.5 million. In many cases, these awards support outreach to Medicaid buy-in participants on the Medicare Part D Prescription Drug Program since over 75 percent of the buy-in participants are dually eligible in Medicaid and Medicare.

CMS measures TWWIIA program performance progress through an annual report (new in 2006 covering calendar year 2005). This report 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. As more information is collected, future reports will provide a more complete picture of the types of activities supported by MIG funding, and the effect this funding has on people with disabilities who want to work. Providing these reports will allow fellow grantees and interested stakeholders to judge the relative success of the grant program as a whole, and gauge the relative success of each MIG grantee. The latest report, The Status of the Medicaid Infrastructure Grants Program as of December 31, 2006, will be posted shortly on the CMS webpage at http://www.cms.hhs.gov/TWWIIA/.

CMS will 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.

Through FY 2007, a total of 50 entities (49 States and the District of Columbia) have been approved for Medicaid Infrastructure Grants. By 2007, thirty-three States had created Medicaid buy-in programs for working adults with disabilities. As of November 30, 2006, there were 78,402 workers receiving Medicaid benefits under the buy-in options. A total of 26 States applied for and received continuation grant awards in FY 2007. Nine States and the District of Columbia received new competitive grant awards in FY 2007. In addition, five States, South Carolina, Missouri, Iowa, Indiana and Arkansas, continued to carry out employment goals for the working disabled population by spending previous grant awards in FY 2007 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 DMIE 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, seven States (Rhode Island, Texas, Mississippi, Louisiana, Kansas, Hawaii, and Minnesota) and the District of Columbia have been awarded DMIE funding. States implementing demonstration grant programs will provide Medicaid-equivalent services to targeted populations of working individuals with disabilities, including individuals with HIV/AIDS, and various mental illnesses. The table on the following page lists the grant awards by State.

Budget Request

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. The new funding for FY 2008 is $44 million. Any remaining funding rolls over into the FY 2009 funding appropriation. In FY 2009, section 203 of TWWIIA authorizes and appropriates $45,062,000 for 100 percent Federally-funded Medicaid Infrastructure Grants to States.

The DMIE (section 204) provides an appropriation of $42 million for each of the fiscal years 2001 to 2004, and $41 million for both FY 2005 and FY 2006 for demonstration projects. Funding must be distributed to the States before 2009**.** Since authority for section 204 terminated in FY 2007, there is no remaining budget authority.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

Demonstration to Maintain Independence and Employment Grants-Section 204

State		2006	Currently Approved 2007***	2008 projected
District of Columbia		$4,830,667	$0*	$5,708,259*
Texas		$600,000	$21,153,349	$0
Kansas		$21,312,114	$0	$0
Minnesota		$42,362,958	$0	$0
Hawaii		$399,995	$8,718,073	$0
Iowa		$0	$0	$27,021,613**
Louisiana	(grant closed out in 2007)	$0	$0	$0
	Total		**$30,391,584**	**$27,021,613****

*No Cost Extension request under review
**Estimated. CMS has approved Iowa's proposal for this new demonstration. Budget and operational plans currently under review.
***Budgeted funds that are unspent in one year can be drawn down in subsequent years, per the Ticket to Work Legislation.

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FOR UNDOCUMENTED ALIENS

Program Description and Accomplishments

Section 1011 of the Medicare Modernization Act (P.L. 108-173) (MMA) makes funding available to pay eligible providers for furnishing emergency health services to undocumented and certain other aliens.

The Secretary must directly pay hospitals, certain physicians, and ambulance providers, including Indian Health Service and Tribal organizations, for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act Emergency Medical Treatment and Labor Act[1] and related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa.

Budget Request

Section 1011 of the MMA appropriated $250 million per year for FY 2005 through FY 2008. Two-thirds of these funds ($167 million) have been allotted to all 50 States and the District of Columbia, based on their relative percentages of the total number of undocumented aliens. The remaining one-third ($83 million) have been allotted to the six States with the largest number of undocumented alien apprehensions. Funds appropriated shall remain available until expended.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

[1] 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.

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.

CMS awarded start-up grants in FY 2006 to 15 individual PACE providers. This grant program also provides technical assistance, outreach, and education to State agencies and provider organizations interested in serving rural areas. Additionally, CMS will make available cost outlier protection to awardees for recognized outlier costs equal to 80 percent of costs that exceed $50,000 for an eligible outlier participant. Total cost outlier protection cannot exceed $100,000 for the12-month period used to calculate the payment.

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. Awardees must provide quarterly status reports to CMS on their progress towards the goal of obtaining a PACE 3-way agreement. Grant funding will revert to the US Treasury for those awardees not executing a 3-way agreement by the September 30, 2008 deadline.

As of July 2007, CMS had received six awardees' PACE provider applications from the States. CMS is in the process of reviewing these applications. The remaining nine awardees are either in the process of developing and finalizing their applications for submission to the States or have submitted their applications to the States for review and approval. Once approved by the States, the applications are forwarded to CMS for review and approval.

Budget Request

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. 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.

No new funding is requested beyond what Congress has already provided in authorizing legislation.

DRUG SURVEYS AND REPORTS

Program Description and Accomplishments

Section 6001(e) of the DRA requires the Secretary to contract with a vendor to conduct a survey of retail prices for covered outpatient prescription drugs. The vendor must 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[2] list. In addition, the provision requires the Secretary to provide information on retail survey prices to States on at least a monthly basis.

Budget Request

The DRA appropriated $5 million dollars for each of fiscal years 2006 through 2010 to carry out this requirement. CMS will provide the overall leadership for the survey.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

EXPANSION OF STATE LONG-TERM CARE (LTC) PARTNERSHIP PROGRAM

Program Description and Accomplishments

The Partnership for Long-Term Care (LTC), enacted under section 6021 of the DRA, establishes 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 long-term care 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. The DRA established authority for all States to implement LTC partnerships. As of January 24, 2008, CMS has approved 16 Medicaid state plan amendments implementing the DRA provision related to the LTC partnership. In addition, the DRA authorized and appropriated $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.

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[2] 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.

The National Clearinghouse for Long-Term Care Information:

- Educates consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program,
- Provides contact information for obtaining State-specific information on long-term care 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 long-term care needs; and
- Maintains a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

The LTC Clearinghouse will be 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 two major components of the National Clearinghouse for Long-Term Care Information are the "Own Your Future" Long-Term Care 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 has expanded to 16 state-specific campaigns within three phases of the campaign. The 16 states that have participated to date are: Arkansas, Georgia, Idaho, Kansas, Maryland, Michigan, Missouri, Nebraska, Nevada, New Jersey, Rhode Island, South Dakota, Tennessee, Texas, Virginia, and Washington. The next phase, targeting approximately 3.3. million households with individuals between the ages of 45 to 65, will commence in March 2008 and consist of four parts: 1) direct mail supported by the State Governor, 2) a state-specific insert with local planning resources and information, 3) a Governor's press conference to launch the campaign, and 4) a follow-up postcard to remind individuals who have not yet requested the Long-Term Care Planning Kit to submit a request. There have been two states, Ohio and Pennsylvania, selected for Phase IV and are expected to be announced in January 2008.
- Website: The National Clearinghouse for Long-Term Care Information website (located at www.longterm.gov) was launched in the fall of 2006. The website supports the "Own Your Future" campaign and contains educational information regarding long-term care 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.

The States that have opted to operate Partnership for Long Term Care programs since the passage of Deficit Reduction Act of 2005 are:

Colorado	Nevada
Florida	North Dakota
Georgia	Ohio
Idaho	Oklahoma
Kansas	Oregon
Minnesota	Pennsylvania
Missouri	South Dakota
Nebraska	Virginia

Arizona, Michigan, New Jersey, and Texas are pending.

Budget Request

The DRA authorized and appropriated $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 funding needed for the website to enhance consumer access to long-term care information activity is approximately $110,000 for each of fiscal years 2006 through 2010.

- The funding needed for the consumer education campaign to increase awareness of the need to plan for long-term care campaign model is approximately $2.89 million for each of fiscal years 2006 through 2010.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

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, which provides a State option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver, and adds a new subsection 1903(y) authorizing Federal grant funds for States to use for the establishment of alternate non-emergency service providers, or networks of such providers.

States may not use funds as the State's share of the Medicaid program costs or to supplement Disproportionate Share Hospital payments. Grant applicants are limited to the 51 State Medicaid Agencies and the Medicaid Agencies in the Federal Territories.

Budget Request

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, FY 2007, FY 2008 and FY 2009) and expects to make all awards by September 30, 2008.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

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." Further, States may elect to add additional criteria to carve out or target a specific sub-population to receive home and community-based services under this demonstration.

This program will assess the cost effectiveness of the provision of home and community-based services and evaluate whether the youths in this demonstration maintain and/or improve their functional level. The ten participating States must submit a 5-year, web-based 1915(c) demonstration waiver as the grant implementation plan. CMS will review and approve each State's demonstration waiver application prior to allowing States to access funds for Federal reimbursement of services under this grant.

The table below shows the total grant awards funded in FY 2007 by individual States and the FY 2008-2011 projected grant awards by States for the Alternatives to Psychiatric Residential Treatment Facilities Demonstration.

Budget Request

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 made awards totaling $21 million in FY 2007 to ten States. 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.

The DRA provides $37 million for FY 2008. CMS will award these funds as supplemental grants to the 10 States based on the funding requested in the PRTF 1915 (c) demonstration waiver application submissions.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grants

State	2007 Awards	FY2008-11 Request	5 Yr. Request
MS	$784,726	$50,843,203	$51,627,929
FL	$2,104,693	$7,184,610	$9,289,303
MD	$3,374,487	$19,602,975	$22,977,462
SC	$741,584	$19,957,556	$20,699,140
GA	$1,189,509	$17,460,753	$18,650,262
AK	$555,805	$7,096,201	$7,652,006
IN	$3,817,063	$17,361,105	$21,178,168
MT	$360,482	$4,643,464	$5,003,946
KS	$4,899,534	$11,784,163	$16,683,697
VA	$3,172,117	$12,052,509	$15,224,626
Total	**$21,000,000**	**$167,986,539**	**$188,986,539**

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 will support 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.
- Promote a strategic approach to implement a system that provides person centered services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions.

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 period for as long as the person needs community services and is Medicaid eligible.

The table on the following page shows awards that were made in FY 2007 and the beginning of FY 2008. The FY 2008 amount only reflects awards made through early January 2008. The remaining FY 2008 awards will be made when State Operational Protocols are approved. All Operational Protocols will be approved by May 2008.

Budget Request

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 that participate 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 their regular FMAP rate by the number of percentage points equal to 50 percent of the difference between their State share and 100 percent. The provision appropriated $250 million for the portion of FY 2007 that began on January 1, 2007, and ended on September 30, 2007. Of the $1.75 billion total, up to $2.4 million of the amount appropriated over the FY 2007 and FY 2008 period can be used to carry out technical assistance and quality assurance activities and is made available through FY 2011. 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.

In 2007, CMS awarded $1,435,709,479 in grants to 31 States. With these funds, States propose to transition 37,731 individuals out of institutional settings over the five-year demonstration period. Additionally, CMS awarded both evaluation and quality assurance contracts.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

Money Follows the Person Rebalancing Demonstration Grants

State	*5 Year Commitment*	*FY2007 Award Amount*	*FY2007 Sup. Award*	*FY2008 Award Amount*	*Remaining Committed Funds*
AR	$20,923,775	$139,519			$20,784,256
CA	$130,387,500	$90,000			$130,297,500
CT	$24,207,383	$1,313,823			$22,893,560
DE	$5,372,007	$132,537			$5,239,470
DC	$26,377,620	$2,546,569			$23,831,051
GA	$34,091,671	$480,193			$33,611,478
HI	$10,263,736	$231,250			$10,032,486

IL	$55,703,078	$6,879,166			$48,823,912
IN	$21,047,402	$860,514			$20,186,888
IA	$50,965,815	$307,933			$50,657,882
KS	$36,787,453	$102,483			$36,684,970
KY	$49,831,580	$4,973,118			$44,858,462
LA	$30,963,664	$524,000			$30,439,664
MD	$67,155,856	$1,000,000			$66,155,856
MI	$67,834,348	$2,034,732			$65,799,616
MO	$17,692,006	$3,398,225			$14,293,781
NE	$27,538,984	$202,500			$27,336,484
NH	$11,406,499	$297,671	$2,925,523		$8,183,305
NJ	$30,300,000	$230,000			$30,070,000
NY	$82,636,864	$192,981			$82,443,883
NC	$16,897,391	$16,055			$16,881,336
ND	$8,945,209	$18,089			$8,927,120
OH	$100,645,125	$2,079,488			$98,565,637
OK	$41,805,358	$3,526,428			$38,278,930
OR	$114,727,864	$80,785			$114,647,079
PA	$98,196,439	$130,609			$98,065,830
SC	$5,768,496	$34,789			$5,733,707
TX	$142,700,353	$143,401	$0	$7,407,946	$135,149,006
VA	$28,626,136	$13,793			$28,612,343
WA	$19,626,869	$108,500			$19,518,369
WI	$56,282,998	$8,020,388			$48,262,610
Total	**$1,435,709,479**	**$40,109,539**	**$2,925,523**	**$7,407,946**	**$1,385,266,471**

QUALIFIED HIGH RISK POOLS

Program Description

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

In FY 2006, section 6202 of the DRA and State High Risk Pool Funding Extension Act of 2006 extended the funding of grants under section 2745 of the Public Health Service Act by authorizing and appropriating $15 million for seed grants to assist States to create and initially fund qualified high risk pools and $75 million for grants to help fund operational losses and bonus grants for supplemental consumer benefits to the existing qualified State high risk pools. CMS awarded grants to 36 States in FY 2006 and to five States in FY 2007. The table on the following pages lists the States and award amounts granted for establishing and/or operating high-risk pools under P.L. 107-210 since 2006.

The Consolidated Appropriations Act, 2008 (P.L. 110-161) has appropriated $49 million for State high-risk health insurance pools for FY 2008. These funds are administered in Program Management.

Budget Request

The Budget is requesting additional funding for FY 2009 and FY 2010 as stated in the proposed legislation section at the end of this chapter.

Grants to States Operating High-Risk Pools

State	2006 Seed	2006 Operational losses	2006 Bonus Grants	2007 Seed	Total	Description of Use of Grant Funds
Alabama		$1,442,972			$1,442,972	To offset insurance losses and reduce premiums for plan enrollees
Alaska		$790,482	$895,640		$1,686,122	To fund claims and offset assessments – Bonus Grant increased benefits
Arkansas		$1,253,047	$55,900		$1,308,947	Bonus Grant – Disease Management
California	$150,000				$150,000	Seed grant for feasibility study
Colorado		$1,658,396	$1,478,373		$3,136,769	Bonus Grant – Disease Management

Connecticut	$1,147,452	$700,000		$1,847,452	To offset a portion of the assessment of pool's members and plan losses. Bonus Grant – Premium reduction
District of Columbia			$150,000	$150,000	Seed grant for feasibility study
Idaho	$960,424			$960,424	To offset operational losses
Illinois	$2,939,767	$1,250,000		$4,189,767	To reduce monthly premiums - Bonus Grant – Premium reduction
Indiana	$1,926,155	$942,000		$2,868,155	Bonus Grant – Disease Management and Low Income Premium Subsidy
Iowa	$994,341			$994,341	To offset insurance losses
Florida			$150,000	$150,000	Seed grant for feasibility study
Georgia			$150,000	$150,000	Seed grant for feasibility study
Kansas	$1,031,608	$295,000		$1,326,608	To make generic drugs more affordable for enrollees; to support case management services for enrollees; Website development; outreach; coverage for preventive services and flu shots for adult and children enrollees; compensation of executive director Bonus Grant – Disease Management
Kansas	$1,031,609	$295,001		$1,326,610	To make generic drugs more affordable for enrollees; to support case management services for enrollees; Website development; outreach; coverage for preventive services and flu shots for adult and children enrollees; compensation of executive director Bonus Grant – Disease Management
Louisiana	$1,354,951	$992,713		$2,347,664	Offset operational losses and implement a disease management and enrollment outreach program
Maryland	$1,797,813	$1,200,000		$2,997,813	Operational 7/2003, Bonus Grant – Low Income Premium Subsidy

Massachusetts		$414,569			$414,569	To fund a comprehensive demographic survey of the Minnesota Comprehensive Health Association (MCHA) population for use in planning a premium subsidy program; to fund MCHA's Board of Directors Strategic Planning Process; to develop and implement a premium subsidy program for eligible MCHA enrollees; to expend any remaining funds not used by the end of the project period to fund overall MCHA plan losses, Bonus Grants – Low Income Premium Subsidy
Minnesota		$3,664,879	$2,000,000		$5,664,879	To offset operational losses
Mississippi		$1,392,593	$449,202		$1,841,795	To offset insurance losses, provide benefits to enrollees, consideration of implementation of a disease management program
Missouri		$1,409,440	$1,000,000		$2,409,440	Bonus Grant – Low Income Premium Subsidy
Montana		$1,074,800	$729,875		$1,804,675	Applied to plan losses, Bonus Grant – Disease Management and Premium Subsidy
Nebraska		$867,573			$867,573	Bonus Grant- Disease Management
New Hampshire		$1,273,440	$934,097		$2,207,537	Bonus Grant- Disease Management
New Mexico		$826,355	$782,644		$1,608,999	Bonus Grant- Pool Expansion
New York	$150,000	$1,121,553	$950,000		$2,221,553	Bonus Grant: Funding Methodology Study
North Carolina	$150,000			$850,000	$1,000,000	FY06: Seed grant for feasibility Study. FY07: Creation and Implementation of new HRP
North Dakota					$0	To offset operational losses
Ohio					$0	Seed grant for feasibility study
Oklahoma		$1,388,788	$1,000,000		$2,388,788	To pay claims, Bonus Grant – Disease Management and Premium Subsidy
Oregon		$2,375,581	$1,500,000		$3,875,581	Bonus Grant- Reduction in Cost Sharing
Rhode Island				$150,000	$150,000	Seed grant for feasibility study
South Carolina		$1,278,624	$700,000		$1,978,624	Bonus Grant- Premium Reduction

South Dakota		$785,577	$312,851		$1,098,428	Operational, Bonus Grant – Premium Reduction
Tennessee	$1,000,000				$1,000,000	Creation and Implementation of new HRP
Texas		$7,237,175	$2,000,000		$9,237,175	Bonus Grant – Premium Reduction
Utah		$1,162,603	$1,250,000		$2,412,603	To pay claims, Bonus Grant – Low Income Premium Subsidy
Vermont	$1,000,000				$1,000,000	Creation and Implementation of new HRP
Washington		$1,575,759	$856,705		$2,432,464	Bonus Grant – Premium Reduction
West Virginia					$0	Creation and Implementation of new HRP
Wisconsin		$2,672,935	$1,750,000		$4,422,935	Bonus Grant – Low Income Premium Subsidy
Wyoming		$773,843			$773,843	To offset operational losses
Total	**$2,450,000**	**$49,625,104**	**$24,320,001**	**$1,450,000**	**$77,845,105**	

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.

The statute provides a preference to States that design programs that target providers that treat significant numbers of Medicaid beneficiaries, and also earmarks 25 percent of funds for States with population increases of 5 percent or greater based on December 2005 U.S. Census data.

Note: The following States were determined to have 5 percent population growth:

- Arizona
- California
- Colorado
- Delaware
- Florida
- Georgia
- Nevada
- New Hampshire
- North Carolina
- Texas
- Utah
- Virginia

- Idaho
- Maryland
- Washington

Section 6081(a)(4)(B) of the DRA stipulates that Census Bureau data is to be used to calculate this 5 percent increase by comparing State specific populations as of July 1, 2004 with the population as of April 1, 2000. CMS' reference for this date was the Annual Estimates of the Population for the United States and for Puerto Rico: April 1, 2000, to July 1, 2005 (NST-EST 2005-01), Population Division U.S. Census Bureau; Release Date: December 22, 2005.

There is no requirement for State matching funds in order to receive payments for transformation grants.

Budget Request

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 $98,059,694. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $51,940,306. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

There is no new budget authority for FY 2009. The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

Section 6034 of the DRA requires the Secretary to promote Medicaid integrity by contracting with eligible entities to carry out certain specified activities including reviews, audits, identification of overpayments, and education. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste and abuse beginning in FY 2006. A recent CMIP was published in August which covers FYs 2007 to 2011. Building upon the accomplishments of the first several years, activities in FY 2009 will include hiring the remaining Medicaid integrity staff, procuring Medicaid integrity contractors to audit providers of Medicaid services, conducting oversight reviews, and providing technical support and assistance to State Medicaid integrity programs. To assure the implementation and success of the plan CMS is measuring the percentage return on investment (ROI) of the Medicaid integrity program. For FY 2008 and FY 2009, CMS set ROI targets at greater than 100 percent. To calculate the ROI, the numerator will be the annual total Federal dollars of identified overpayments in accordance with the relevant Medicaid overpayment statutory and regulatory provisions. The denominator will include the annual Federal funding of the Medicaid integrity contractors.

Budget Request

Section 6034 of the DRA authorized and appropriated permanent authority for the Medicaid Integrity Program beginning in FY 2006 with an initial funding level of $5 million as well as $50 million each in FY 2007 and FY 2008. New budget authority for FY 2009 is $75 million.

The Budget requests no funding beyond what Congress has already provided in authorizing legislation.

IMPACT OF PROPOSED LEGISLATION

Funding for Operation of State High-Risk Health Insurance Pools Reauthorization

Health insurance high-risk pools are special programs created by State legislatures to provide a safety net for the "medically uninsurable" population. High-risk pools provide private insurance to those with pre-existing conditions that cannot get health insurance in the private market. Congress appropriated $90 million for FY 2006 for grants to: partially cover losses incurred by States in connection with the operation of the pools, provide supplemental consumer benefits, and fund the start-up costs for new State high risk pools. Although appropriations for operational losses and supplemental consumer benefits bonus grants are authorized for FY 2007-2010, no funds are actually appropriated for FY 2007 or subsequent years. The Consolidated Appropriations Act, 2008 (P.L. 110-161) directed CMS to provide $49 million for State high risk health insurance pools for FY 2008, which will be administered in Program Management.

To help States offer health insurance options to hard-to-insure populations, the President's FY 2009 Budget proposes $75 million in both FY 2009 and FY 2010 as authorized by the State High-Risk Pool Funding Extension Act of 2006 (P.L. 109-172).

Five-year budget impact: $150 million

Outreach Grants to Enroll Children in Medicaid and SCHIP

The FY 2009 President's Budget proposes to include annual grants to States, localities, community-based organizations to reach children eligible but not enrolled in SCHIP or Medicaid.

Five-year budget impact: $350 million

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
			Actual	Target	Actual	Target	Actual		
Long-Term Objective: Accountability through Reporting in the Medicaid Infrastructure Grant Program									
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.	N/A	N/A	Annual Report	Goal met	Annual Report	Goal met	Annual Report	Annual Report

Clinical Laboratory Improvement Amendments of 1988

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA…………………	$44,653,000	$43,000,000	$43,000,000	$0
FTEs……………...	58	78	92	+14

Authorizing Legislation………………..Public Health Service Act, Title XIII, Section 353

FY 2009 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 for health purposes. 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 19,830 laboratories during the FY 2008-2009 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. 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, 195,561 laboratories are registered with the CLIA program. Approximately 159,640 or 81.6 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 107,119, or 54.7 percent, of the laboratories registered under the CLIA program. Approximately 87,689 or 81.9 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 2007-2008 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 2009 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 2008-2009 cycle include surveys of 19,830 non-accredited laboratories, State validation surveys of 850 accredited laboratories, and approximately 1,388 follow-up surveys and complaint investigations.

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective: Improve Cytology Laboratory Testing									
CLIA1	Percent of pathologists receiving a passing score in gynecologic cytology proficiency testing	N/A	88% (CY 2005)	N/A	N/A	Promulgate appropriate regulatory changes to address issues based on formal recommendations from the Secretary of HHS' Clinical Laboratory Improvement Advisory Committee and analysis of 2005 and 2006 data.	Goal partially met.	93%	93%

Quality Improvement Organizations

	FY 2007 Apportionment	FY 2008 Apportionment	FY 2009 Apportionment	FY 2009 +/- FY 2008
BA..	$172,473,000	$445,048,000	$547,000,000	+$101,952,000

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

FY 2009 Authorization…………………………………………………………Active

Allocation Method……………………………………………………………Contracts

* The FY 2008 direct contracts activity includes an estimated $6.5 million to be carried forward from the 8th SOW.

Program Description

Under the Quality Improvement Organization (QIO) program, CMS maintains contracts with independent community-based organizations (one contract in each State, Washington D.C., Puerto Rico, and the U.S.Virgin Islands) 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. In addition, through the Quality Improvement Organizations and other State and local partners, CMS collaborates with health care providers and suppliers to promote improved health status, including quality improvement in nursing homes.

CMS monitors several key performance measures reflecting efforts to ensure beneficiaries receive the high-quality care they need and depend on. These measures include a focus on influenza/ pneumococcal immunizations, mammography, diabetes blood testing, and surgical site infection. While these measures are part of Medicare benefits, the focus of the QIOs helps bolster them. Overall, the QIO program has been able to improve the quality of care for our beneficiaries. Improved quality of care is a cornerstone of value driven health care. These efforts, among others, are included in the 9th Scope of Work, scheduled to begin August 2008.

One of our key measures supported by the 8th SOW is an effort to increase the rate of influenza immunizations in nursing homes and to increase the national rate of pneumococcal immunization. Recent data show that we exceeded our FY 2006 nursing home influenza target of 74 percent at 78.4 percent, and achieved our national pneumococcal target of 69 percent at 69.6 percent. We attribute this positive trend to the September 2006 requirement for Minimum Data Set immunization assessments of nursing home residents and publication of facility-specific nursing home immunization rates on Nursing Home Compare undoubtedly contributed to the increase in both immunization rates. FY 2007 results will be available at the end of calendar year 2008.

We increased our influenza targets for FY 2008 and FY 2009 to 79 percent, and expect that the focus on attaining the goal in the long-term care population, an emphasis on

preventive services and recent changes to the immunization reimbursement methodology will result in higher immunization rates. CMS will continue to explore additional opportunities to improve adult influenza and pneumococcal immunization rates as this effort continues to be supported in the 9th SOW.

The QIO responsibilities are specifically defined in the portion of the contract called the Statement of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the QIOs perform. Funding patterns tend to vary substantially from year to year as a result of staggered 3 year contract start dates. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

Budget Request

FY 2009 will be the second year of the upcoming 9th Statement of Work. CMS has allocated $1,128,400,000 for QIO direct and support contracts in the 9th SOW. The funding for these contracts will be obligated at different times during the three year SOW. The 9th SOW begins in fiscal year 2008 on August 1, 2008; 19 QIO's will be awarded contracts on that date; 17 QIO's will be awarded contracts during November 2008 (technically in FY 2009). 17 other QIO contracts will be issued later in calendar year 2009.

CMS management of the 9th SOW QIO program will include active monitoring and reporting of QIO activities, including semi-annual reports that will be provided to OMB consistent with the management agreement. QIO contract management in the 8th SOW was characterized by: Almost identical contracts for all States; contract language targeted toward the achievement of "minimum standards" of performance; lack of serious consequences to the contractor for underperformance; one "baseline" performance measurement at the beginning of the contract, one remeasurement at the end of the contract (three years later), and little regular monitoring of results in between; and a tendency toward "automatic non-competitive renewal" of each QIO contract at the end of each cycle. The 9th SOW is significantly different than any previous QIO contract. It will hold all QIOs to specific predefined performance targets; continued work/funding for each quality improvement effort (Patient Safety, Patient Pathways, and Prevention) will be predicated on meeting 18 month performance targets. QIOs that meet their 18 month targets will be measured again at 28 months.

The four 9th SOW themes are: Beneficiary Protection, Prevention, Patient Pathways, and Patient Safety. Beneficiary Protection activities will emphasize mandatory review activity and quality improvement. Mandatory review includes utilization review, quality of care review (including beneficiary complaints), review of beneficiary appeals of certain provider notices, and reviews of potential anti-dumping cases. Emphasizing quality improvement, Beneficiary Protection in the 9th SOW will engage in more active evaluation of program activities and will benefit from more highly advanced reporting and tracking systems. During the 9th SOW CMS estimates that QIOs will review 211,000 cases. This includes an estimated 25-percent increase in beneficiary complaints (3,300 cases) resulting from increased outreach to beneficiaries concerning their appeal and complaint rights under the QIO program.

Prevention efforts will emphasize evidence-based and cost-effective care proven to prevent and/or slow the progression of disease. Prevention work will impact health care

programs, products, polices, practices, community norms, and linkages and will produce 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 Patient Pathways theme will reduce the unnecessary rehospitalizations of Medicare beneficiaries that both harm patients and drain the trust funds. Collaborations among QIOs, community coalitions, and professional groups, utilizing chartered value exchanges, publication of performance, and value-based purchasing will achieve what none of the parties alone could accomplish.

Patient safety efforts will 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 will be 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 will, by definition, increase the value of health care services as it produces higher quality care for Medicare beneficiaries. QIO activities for the Patient Safety theme will 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.

Another key performance measure supported by the QIOs is to increase the percentage of Medicare patients who receive preventative antibiotics within recommended timeframes prior to surgery is part of the Surgical Care Improvement Partnership (SCIP), and intended to reduce morbidity, mortality and health care costs. The success of this effort is demonstrated by the increase in the percentage of patients who received preventive antibiotics within the recommended timeframe from 60 percent in FY 2002 to 83 percent in FY 2006. QIOs in most States sponsored collaborative learning sessions that targeted this and other SCIP measures during the 8th Scope of Work, and the Institute for Healthcare Improvement included quality improvement interventions related to surgical antimicrobial prophylaxis in the Million Lives campaign. In addition, the National SCIP Steering Committee supported broad scale participation in the SCIP by promotion and recruitment of member organizations and through many different organizational newsletters and communications. FY 2007 results will be available in June 2008. Our FY 2008 and 2009 targets of 85 percent and 87 percent, respectively, will be achieved through continued emphasis of the performance measure of SCIP in the QIO 8th and 9th Scopes of Work, and we will use the performance measure for continued accountability through public reporting and eventual value-based purchasing.

Outcomes and Outputs

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective: Protect the Health of Medicare Beneficiaries									
QIO 1.1	Increase nursing home sub-population influenza immunization	Trend 73.0%	Trend 73.7%	74%	78.4%	74%	Dec-08	79%	79%
QIO 1.2	Increase pneumococcal Immunization	67.4% (Goal met)	68.4%	69%	69.6%	69%	Dec-08	71%	71%
QIO 4	Increase percentage of timely antibiotic administration	68.2%	77.5%	75.4%	83.1%	82.0%	Jun-08	85.0%	87.0%
Long-Term Objective: Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older									
QIO 2	Increase biennial mammography rates in women age 65 years and older	51.3%	52.1%	52.5%	52.7% (Goal met)	52.5%	Aug-08	53.0%	53.0%
Long-Term Objective: Improve the Care of Diabetic Beneficiaries									
QIO 3.1	Increase hemoglobin A1c testing rate	N/A	Trend 84.3%	N/A	Trend 85.2%	85.0%	Sep-08	85.5%	86%
QIO 3.2	Increase cholesterol (LDL) testing rate	N/A	Trend 78.1%	N/A	79.5%	80.0%	Sep-08	80.0%	80.5%

Achieving Error Rate Efficiencies

Beginning with the 9th SOW, CMS will transfer the inpatient Hospital Payment Monitoring Program (HPMP) activity currently performed by the QIO to Medicare's Comprehensive Error Rate Testing (CERT) contractor, fiscal intermediaries (FIs) and Medicare Administrative Contractors (MACs) funded under the Medicare Integrity Program (MIP). These MIP contractors have demonstrated that they can be more effective handling this workload than the QIO's HPMP program. Part of the efficiencies is achieved by using a different mix of staff to perform the same work that was performed primarily by physicians. Under the 8th SOW, the QIOs spent approximately $59 million over a three-year period. We believe the MIP CERT contractor; FIs and MACs can perform this same workload for approximately $35 million, roughly $24 million less than the QIO during a comparable three-year period. This funding would be absorbed within the MIP baseline.

CMS Program Management
Budget Authority by Object

	2008 Estimate	2009 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)..	$384,244,000	$390,890,000	$6,646,000
Other than full-time permanent (11.3)......................	$12,827,000	$13,701,000	$874,000
Other personnel compensation (11.5)......................	$6,397,000	$6,159,000	($238,000)
Military personnel (11.7)...	$7,743,000	$8,104,000	$361,000
Special personnel services payments (11.8)............	$0	$0	$0
Subtotal personnel compenstion.......................	**$411,211,000**	**$418,854,000**	**$7,643,000**
Civilian benefits (12.1)...	$93,691,000	$99,534,000	$5,843,000
Military benefits (12.2)..	$3,989,000	$3,814,000	($175,000)
Benefits to former personnel (13.0)...........................	$0	$0	$0
Total Pay Costs..	**$508,891,000**	**$522,202,000**	**$13,311,000**
Travel and transportation of persons (21.0)................	$8,000,000	$7,000,000	($1,000,000)
Transportation of things (22.0)....................................	$0	$0	$0
Rental payments to GSA (23.1)...................................	$25,564,000	$26,746,000	$1,182,000
Communication, utilities, and misc. charges (23.3)......	$2,241,000	$2,297,000	$56,000
Printing and reproduction (24.0)..................................	$2,543,000	$2,703,000	$160,000
Other Contractual Services:			
Advisory and assistance services (25.1)..................	$0	$0	$0
Other services (25.2)..	$107,062,000	$112,652,000	$5,590,000
Purchase of goods and services from government accounts (25.3)..................................	$2,687,000	$2,687,000	$0
Operation and maintenance of facilities (25.4)..........	$0	$0	$0
Research and Development Contracts (25.5)...........	$0	$0	$0
Medical care (25.6)...	$2,535,092,000	$2,612,857,000	$77,765,000
Operation and maintenance of equipment (25.7)......	$0	$0	$0
Subsistence and support of persons (25.8)..............	$0	$0	$0
Subtotal Other Contractual Services.................	**$2,644,841,000**	**$2,728,196,000**	**$83,355,000**
Supplies and materials (26.0)......................................	$800,000	$800,000	$0
Equipment (31.0)..	$100,000	$100,000	$0
Land and Structures (32.0)	$9,800,000	$9,800,000	$0
Investments and Loans (33.0).....................................	$0	$0	$0
Grants, subsidies, and contributions (41.0).................	$63,872,000	$7,500,000	($56,372,000)
Interest and dividends (43.0).......................................	$0	$0	$0
Refunds (44.0)..	$0	$0	$0
Total Non-Pay Costs..	**$2,757,761,000**	**$2,785,142,000**	**$27,381,000**
Total Budget Authority by Object Class..................	**$3,266,652,000**	**$3,307,344,000**	**$40,692,000**

CMS Program Management
Salaries and Expenses

	2008 Estimate	2009 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)..	$384,244,000	$390,890,000	$6,646,000
Other than full-time permanent (11.3).......................	$12,827,000	$13,701,000	$874,000
Other personnel compensation (11.5).......................	$6,397,000	$6,159,000	($238,000)
Military personnel (11.7)...	$7,743,000	$8,104,000	$361,000
Special personnel services payments (11.8).............	$0	$0	$0
Subtotal personnel compenstion........................	**$411,211,000**	**$418,854,000**	**$7,643,000**
Civilian benefits (12.1)..	$93,691,000	$99,534,000	$5,843,000
Military benefits (12.2)...	$3,989,000	$3,814,000	($175,000)
Benefits to former personnel (13.0)............................	$0	$0	$0
Total Pay Costs...	**$508,891,000**	**$522,202,000**	**$13,311,000**
Travel and transportation of persons (21.0).................	$8,000,000	$7,000,000	($1,000,000)
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)......	$2,241,000	$2,297,000	$56,000
Printing and reproduction (24.0)..................................	$2,543,000	$2,703,000	$160,000
Other Contractual Services:			
Advisory and assistance services (25.1)...................	$0	$0	$0
Other services (25.2)..	$107,062,000	$112,652,000	$5,590,000
Purchase of goods and services from government accounts (25.3)..................................	$2,687,000	$2,687,000	$0
Operation and maintenance of facilities (25.4)..........	$0	$0	$0
Research and Development Contracts (25.5)...........	$0	$0	$0
Medical care (25.6)..	$2,535,092,000	$2,612,857,000	$77,765,000
Operation and maintenance of equipment (25.7)......	$0	$0	$0
Subsistence and support of persons (25.8)...............	$0	$0	$0
Subtotal Other Contractual Services..................	**$2,644,841,000**	**$2,728,196,000**	**$83,355,000**
Supplies and materials (26.0)......................................	$800,000	$800,000	$0
Total Non-Pay Costs..	**$2,658,425,000**	**$2,740,996,000**	**$82,571,000**
Total Salary and Expense...	**$3,167,316,000**	**$3,263,198,000**	**$95,882,000**
Direct FTE..	**4,222**	**4,148**	**(74)**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2007 Actual	2008 Estimate	2009 Estimate
Office of the Administrator...	23	23	22
Center for Beneficiary Choices......................................	286	280	276
Center for Medicaid and State Operations.....................	347	340	335
Center for Medicare Management.................................	436	427	421
Office of the Actuary..	79	77	76
Office of Acquisition & Grants Management...................	110	108	106
Office of Beneficiary Information Services......................	51	50	49
Office of Clinical Standards and Quality.........................	194	190	187
Office of E-Health Standards and Services....................	15	15	14
Office of External Affairs..	192	188	186
Office of Equal Opportunity and Civil Rights...................	19	19	18
Office of Financial Management....................................	359	352	347
Office of Information Services.......................................	382	374	369
Office of Legislation...	42	41	41
Office of Operations Management.................................	196	192	189
Office of Policy...	10	10	10
Office of Research, Development and Information.........	132	129	128
Office of Strategic Operations and Regulatory Affairs.....	144	141	139
Consortia..	1,388	1,360	1,341
CMS Program Management FTE Total.......................	**4,405**	**4,317**	**4,257**

Average GS Grade

2004..	13.4
2005..	13.3
2006..	13.4
2007..	13.4
2008..	13.4

CMS Program Management
Detail of Positions

	2007 Actual	2008 Estimate	2009 Estimate
Subtotal, ES	61	61	61
Total - ES Salary	$9,492,000	$9,874,000	$10,200,000
GS-15..	420	411	405
GS-14..	591	578	570
GS-13..	2,055	2,010	1,981
GS-12..	823	805	793
GS-11..	108	106	104
GS-10..	1	1	1
GS-9..	193	189	186
GS-8..	20	19	19
GS-7..	158	155	152
GS-6..	26	25	25
GS-5..	28	27	27
GS-4..	7	7	7
GS-3..	1	1	1
GS-2..	0	0	0
GS-1..	2	2	2
Subtotal	4,434	4,336	4,273
Total - GS Salary	$383,418,000	$397,620,000	$406,154,000
Average ES salary...............................	$155,607	$161,869	$167,213
Average GS grade................................	13.4	13.4	13.4
Average GS salary...............................	$86,472	$91,702	$95,051

CMS Program Management
Programs Proposed for Elimination

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

Information Technology

Funds Source	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
Medicare Operations 1/…………	$580,720,000	$569,215,000	$765,648,000	$196,433,000
Federal Administration………….	23,383,000	21,366,000	21,376,000	10,000
Survey & Certification…………....	2,522,000	3,416,000	3,440,000	24,000
Research…………………………	-	4,649,000	5,349,000	700,000
Revitalization Plan………………	23,963,000	-	-	-
Subtotal, Program Management Appropriation….	**$630,588,000**	**$598,646,000**	**$795,813,000**	**$197,167,000**
Coordination of Benefits (COB) User Fee 2/………………………	-	-	38,000,000	38,000,000
CLIA User Fees………………….	2,700,000	2,040,000	2,040,000	--
Health Care Fraud & Abuse Account (HCFAC) 3/…………….	45,718,000	31,229,000	31,229,000	--
Quality Improvement Organizations (QIOs) 3/………...	38,844,000	76,827,000	65,757,000	-11,070,000
Total, CMS IT Portfolio………..	**$ 715,150,000**	**$708,742,000**	**$932,839,000**	**$224,097,000**

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 $89.9 M of the FY 2009 estimate.
2/ The FY 2009 estimate assumes an increase in the Part D coordination of benefits user fees collected. $38 million will be used to fund Part D systems costs.
3/ 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.

Program Description and Accomplishments

As shown in the table above, funding for CMS' information technology (IT) investments is spread across several budget resources, including the program management appropriation, user fees, and the HCFAC and QIO programs. IT activities support various programs that CMS oversees, including Medicare, Medicaid, SCHIP, 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 CMS's Exhibit 53 and Exhibit 300s, which can be viewed at www.hhs.gov/exhibit300.

CMS Program Management Appropriation

CMS' information technology investments support a broad range of basic operational needs as well as ongoing support of provisions of legislation. The CMS request also supports the President's Management Agenda initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process. Below, 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.

Investment portfolios and activities include:

- *Beneficiary Enrollment, Plan Payment, and 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). 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.

- *Modernization* 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 notable investments proposed in CMS' FY 2009 request include:

  - *ICD-10 and Version 5010*- ICD-10 is the biggest change in healthcare standard coding systems in over 20 years. Each year that Medicare continues to use the ICD-9 code set, the more likely it becomes that claims could be paid

inaccurately, increasing costs and placing the Medicare trust fund 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, implementing ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code. CMS is requesting funding to begin implementing this new revision in FY 2009. 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.

- *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.

- *MA and Part D Systems Recompetes* – many contracts for CMS systems will be recompeted in FY 2009. This funding covers the anticipated costs should a new contractor be selected.

Lastly, the CMS request includes activities to support the President's Management Agenda e-Gov initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

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 2009 request supports the continued automated implementation of the Quality Indicator Survey (QIS).

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.

HCFAC

IT funding from the MIP budget within HCFAC 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. Another potential source of IT funding is HCFAC "wedge" money. CMS and other HHS operating divisions compete for these dollars, which are subject to annual negotiation and allocated by the Secretary of HHS.

QIO

Lastly, 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.

Budget Request

CMS Program Management Appropriation – the total FY 2009 request for program management IT is $795.8 million, $197.2 million more than the FY 2008 enacted level. The majority of this increase, $89.9 million, reflects the movement of all of the enterprise data center costs to Medicare Operations IT. Previously, all data center costs were included in the non-IT claims processing line. The program management request includes:

- *Medicare Operations* - $765.6 million, a $196.4 million increase, mainly due to the movement of the $89.9 million in EDC costs to IT.
- *Federal Administration* - $21.4 million, a slight increase.
- *Survey and Certification* - $3.4 million, a slight increase.
- *Research* - $5.3 million, a $0.7 million increase.

Additional Sources of IT Funding for CMS Programs

In FY 2009, a portion of the Part D coordination of benefits (COB) user fee will be used to fund Part D systems costs. The FY 2009 request proposes collection of $38 million in COB user fees for this purpose. In addition, a portion of the user fees collected under the Clinical Laboratory Improvement Amendments of 1988 pays for information systems that support the CLIA program.

Lastly, the FY 2009 estimate includes $31.2 million for HCFAC IT and $65.8 million for QIO IT. 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 are subject to change.

Unified Financial Management System

Unified Financial Management System Operations and Maintenance

UFMS has now been fully deployed. The Program Support Center, through the Service and Supply Fund, manages the ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes Consolidated Reporting and continued maintenance of the Global Interfaces. CMS will use $979,000 for these costs in FY 2009.

FY 2009 HHS Enterprise Information Technology Fund-PMA e-Gov Initiatives

The **CMS** will contribute **$6,973,000** of its FY 2009 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These 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. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, **$1,492,597** is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2009. This amount supports the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	**FY 2009 Allocation**
Business Gateway	$43,748
E-Authentication	$0
E-Rulemaking	$0
E-Travel	$0
Grants.Gov	$17,395
Integrated Acquisition	$0
Geospatial LOB	$0
Federal Health Architecture LoB	$1,039,280
Human Resources LoB	$9,848
Grants Management LoB	$1,822
Financial Management LoB	$28,840
Budget Formulation & Execution LoB	$19,179
IT Infrastructure LoB	$0
Integrated Acquisition – Loans and Grants	$7,486
Disaster Assistance Improvement Plan	$325,000
TOTAL	$1,492,597

Business Gateway: Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS' participation in this initiative provides HHS with an effective communication means to provide its regulations, policies, and forms applicable to the business community in a business-facing, single access point.

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments,

education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2007, HHS posted over 1,000 packages and received 108,436 application submissions – more than doubling 52,088 received in FY 2007 with NIH substantially increasing its applications submissions from 47,254 to 89,439 submissions.

Integrated Acquisition Environment for Loans and Grants: Managed by GSA, all agencies participating in the posting and/or awarding of Loans and Grants are required by the Federal Funding Accountability and Transparency Act (FFATA) to disclose award information on a publicly accessible website. Cross-government cooperation with the Office of Management and Budget's Integrated Acquisition Environment initiative in determining unique identifiers for Loans & Grants transactions furthers the agency in complying with the Transparency Act, which enhances transparency of federal program performance information, funding, and Loans & Grants solicitation.

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. The DAIP program office, during its first year of operation, will quantify and report on the benefits and cost savings or cost reductions for each member agency.

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-Geospatial One-Stop: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

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.

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-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. An HHS agency, 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 and has applied to be a GMLOB consortia lead. 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-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.

Significant Items of Interest to Congress
FY 2008 House Appropriations Committee Report Language
(House Report 110-231)

Item

Therapy Management Program Models -- The Committee encourages CMS to conduct a demonstration project to identify effective therapy management program models for low-income Medicare Part D enrollees living with HIV/AIDS. The demonstration project would emphasize evidence-based prospective medication management, technological innovation, and outcome reporting. Recent medical studies show that patients receiving medication therapy management services for HIV dramatically improve their clinical status and demonstrate significant cost reductions in their overall health care. (p. 186)

Action taken or to be taken

The final rule for the Medicare prescription drug benefit made clear that medication therapy management programs (MTMP) is one component of the Part D program that we may wish to explore further in the future. CMS has been contacted by representatives of several management companies and advocacy organizations that are interested in pursuing demonstrations to test best practice models of MTMPs under Part D. CMS is conducting an examination of MTMPs.

Item

Low Vision Rehabilitation -- The Committee commends CMS on its work to implement the low-vision rehabilitation services demonstration. The Committee encourages CMS to update the design and consider expanding the number of sites in the five-year demonstration. (p. 186)

Action taken or to be taken

CMS has revised some coverage limitations within the Low Vision Rehabilitation Demonstration. Beginning in April 2008, eligible beneficiaries will be able to receive up to 12 hours of rehabilitation services in each calendar year of the demonstration (up from a 9-hour lifetime limit). This represents a 400-percent overall increase in rehabilitation services covered under the demonstration. In addition, CMS has expanded the geographic area covered by the demonstration for two existing sites. Vision rehabilitation services are now being provided in the Greater New York City Metropolitan Area and the Greater Atlanta Metropolitan Area. This increases the area of coverage to include New York City's five boroughs (Manhattan, Brooklyn, Bronx, Queens, and Richmond), as well as Westchester, Putnam, Duchess, Orange, Sullivan, Nassau, Suffolk, and Ulster counties. The Greater Atlanta Metropolitan area is now extended to include an additional 477 zip codes, or a total of 31 counties. CMS will reevaluate the progress of the demonstration following these expansions of geography and hours of covered services to see if services are more widely used. We will consider further geographic expansion, if warranted, at a future time.

Item

Long Term Care -- The Committee is 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 stating its intention to inform all target households through its initial mailings that "Medicare generally does not pay" for long term care. The Committee also encourages the Department to use other efficient communication methods, in addition to the Internet and direct mail, to clarify widely held misperceptions about Medicare and long term care. This policy would allow individuals to better prepare for their potential long-term care needs without impoverishing themselves to qualify for Medicaid where they have limited choices beyond institutional care. (p. 187-188)

Action taken or to be taken

CMS recognizes that many Americans do not have an adequate understanding on the costs of long-term care or have misconceptions regarding the role of Medicare and long-term care. As part of a public awareness and education campaign, CMS is implementing 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: the "Own Your Future" Long-Term Care Awareness Campaign and a national website.

Campaign update: To date, 16 states have participated in the "Own Your Future" Campaign in three phases. The states include: Arkansas, Idaho, Nevada, New Jersey, Virginia, Kansas, Maryland, Rhode Island, Washington, Georgia, Michigan, Missouri, Nebraska, South Dakota, Tennessee and Texas. The next phase, targeting approximately 3.3 million households with individuals between the ages of 45 to 65, will commence in March 2008 and consist of four parts: 1) direct mail supported by State Governor, 2) state-specific insert with local planning resources and information, 3) a Governor's press conference to launch the campaign, and 4) a follow-up postcard to remind individuals who have not yet requested the Long-Term Care Planning Kit to do so. CMS will be working with the Governors' staffs in the upcoming campaigns to insert a statement about Medicare not paying for long-term care in the initial letter that Governors send to the target households in their states. CMS is revising the direct mail campaign materials. While already in the planning kit, CMS is rewriting the tri-fold brochure that is included in the initial mailing to households to insert the "Medicare generally does not pay" language.

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 misconceptions about Medicare and long-term care. Some examples are as follows:

CMS issued a national press release earlier this year to: improve the public awareness of Medicare's limited role in covering and paying for long-term care, encourage people to start the planning process, and announce which states had been selected for the fourth phase of the Campaign.

CMS is working with the Administration on Aging and the 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. One of the revisions that will be made to the manual this year is the insertion of clearer language about Medicare's coverage of long-term care to clarify any misconceptions.

CMS plans to provide a presentation on Medicare and long-term care awareness to the Caregiver Coalition Network on a future quarterly conference call. This in-depth presentation will highlight the website. CMS will ask caregiver coalitions to provide feedback on the usefulness of the website and any improvements they may want to suggest that may be helpful to caregivers using the website.

CMS plans to present on Medicare and long-term care awareness to the CMS Caregiver Workgroup. CMS will leverage the networks of the Caregiver Workgroup to share Medicare and long-term care awareness information to the caregiver community through its meetings, newsletters, websites, list serves, and other information channels.

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

Item

One-on-one Counseling for Dual Eligibles with Mental Disabilities -- The Committee commends CMS for its initial community-based activities for a Medicare education and outreach campaign directed towards dual eligible persons. The Committee is aware, however, that there is considerable evidence that low-income dual eligible persons with mental disabilities continue to need

direct help with Part D enrollment. The Committee urges CMS to increase the share of funds for one-on-one pharmaceutical benefits counseling that are provided for counseling of dual eligible persons through community-based organizations and safety net community mental health centers. (p. 188)

Action taken or to be taken

Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) (P.L. 101-508, codified at 42 USC 1395 b-4) authorizes CMS to make grants to States to fund State Health Insurance Assistance Programs (SHIPs). In the FY 2007 grant year, CMS took several steps to direct and equip SHIPs to provide one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities. In FY 2008, CMS will take the following steps.

- In FY 2008, CMS will continue to require that SHIPs submit program budgets that demonstrate that at least 5 percent of Federal SHIP funding will be directed toward one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities.

- In FY 2008, CMS expects SHIPs to build upon the activities begun in 2007 and to continue to foster local partnership efforts, including relationships with the mental health community, and to engage in outreach to better reach, inform, and assist beneficiaries with disabilities.

- In 2008, CMS plans to provide training at the 2008 SHIP Directors' Annual Conference on providing one-on-one counseling and outreach to pharmaceutical services to beneficiaries with mental disabilities. The training will provide the opportunity to share "best practices" from SHIPs, the mental health community and other partners.

- As part of the 2007 grant report process, CMS required SHIPs to describe their progress on efforts to enhance one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities as part of the mid-year reports required of all SHIPs. From these reports, counseling and outreach practices implemented by SHIPs will be shared in FY 2008 among the SHIP network via the SHIPTalk website and during training at the 2008 SHIP Directors' Annual Conference.

- In 2008, CMS will require SHIPs to continue to build capacity to serve the needs of dual eligible beneficiaries with mental disabilities. Mid-tern narrative reports will again be a requirement of the Terms and Conditions of the SHIP grant.

- During FY 2007, SHIPs have reported on the development of coalitions and training with their State and county community mental health agencies. In some instances, referral systems have been developed between the state or local SHIP and the community health network. SHIPs have provided

counseling and training on Medicare benefits, while community mental health providers have provided sensitivity training and referral networks for SHIPs. In 2008, SHIPs will continue their work with CMS Regional Offices to expand their mental health networks, using the SHIP-Technical Assistance Program (TAP) pilot project developed by CMS' Medicare Ombudsman as a model for network expansion.

- CMS will expand the network of help available to SHIP Directors to include major disability organizations such as the Centers on Independent Living (NCIL) and National Spinal Cord Injury Association as they often encounter the target population and could work proactively with SHIPs. NCIL has chapters across the county and staff in those chapters to provide hands-on help to constituents.

- CMS will continue to provide technical assistance to national disability organizations with a mental health component in their structure. CMS will provide these organizations and component members with information and access to the SHIP-TAP materials, helping them to understand the role of CMS' Ombudsman, and linking CMS Regional Offices to the SHIPs to proactively serve beneficiaries with mental illness.

- CMS will expand the network of support for SHIPs to engage mental health coalitions such as the National Coalition on Mental Health and Aging. CMS is working with these organizations to distribute mental health information through their newsletters.

- CMS will leverage faith-based programs to reach out and serve people with disabilities, including those with mental illness. CMS is exploring ways to combine outreach efforts that will have a national impact. Examples of national faith-based partners include Catholic Charities and Lutheran Services of America.

- CMS will leverage the networks of its national partners that provide direct services to homebound beneficiaries, many of whom struggle with depression and anxiety. CMS staff will share SHIP-TAP training and contact resources with these providers of service. Examples of partners are the Visiting Nurses Association of American, the Occupational Therapy Association of America and the Physical Therapy Association of America.

Item

Coverage for Type 1 Diabetes Patients -- Biomedical research progress is enabling increasing numbers of type I diabetes patients to live with this disease for more than fifty years. Recent advances in continuous glucose monitoring technology have the potential to revolutionize the way diabetes is managed on a daily basis, and the Committee is aware that more research is underway to validate this technology in a variety of patient populations under "real world"

conditions. While research is underway, the Committee urges CMS not to make premature coverage decisions for this durable medical equipment or take actions that would delay the adoption of these technologies. (p. 188)

Action taken or to be taken
CMS has taken the following actions regarding continuous glucose monitoring:

- On August 30, 2006, CMS held a public meeting of the Medicare Coverage Advisory Committee (MCAC, since renamed the Medicare Evidence Development and Coverage Advisory Committee (MedCAC)) on "Glycemic Control" to consider evidence for the use of continuous glucose monitors and other monitoring strategies. The MCAC identified data deficiencies and areas for future research. The transcript of the MCAC meeting can be found at: http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=36.

- Also, CMS commissioned through the Agency for Healthcare Research and Quality (AHRQ) a Technology Assessment (TA) titled "Applicability of the Evidence Regarding Intensive Glycemic Control and Self-Monitored Blood Glucose to Medicare Patients with Type 2 Diabetes," which was presented at the MCAC meeting on Glycemic Control. On September 10, 2006, a final version of the Technology Assessment was issued and made available to the public.

CMS maintains discussions about continuous glucose monitoring practices and technologies with interested stakeholders.

Item
Critical Care Workforce Shortages -- The Committee believes that the growing gap between the size of the nation's aging baby boom population and the number of pulmonary/critical care physicians poses challenges to the future delivery of high quality, efficient care under Medicare and Medicaid. The Committee urges CMS to review HRSA's May 2006 Report to Congress, "The Critical Care Workforce: A Study of Supply and Demand for Critical Care Physicians", and to consult with relevant critical care societies to develop recommendations and pulmonary/critical care-based models to be tested to alleviate the impact of the critical care workforce shortage on Medicare and Medicaid beneficiaries. (p. 189)

Action taken or to be taken
CMS will review the relevant Health Resources and Services Administration (HRSA) report and other existing literature on the topic. This information would then used for the purpose of addressing any recommendations that might be appropriate.

Item
Intravenous Immune Globulin -- The Committee notes ongoing concern

regarding Medicare beneficiary access to the lifesaving biologic therapy intravenous immune globulin (IVIG). The Committee encourages CMS to continue to work with members of the IVIG community to address these challenges, and commends CMS for establishing separate Medicare codes for each brand of IVIG introduced in the market after October 1, 2003. (p. 189)

Action taken or to be taken
CMS has met with IVIG manufacturers and industry groups and continues to monitor changes in the IVIG marketplace. CMS notes that implementation of separate pricing in July 2007 appears to have contributed to price stabilization. Recent data indicates a slight price increase for both powdered and liquid IVIG. CMS has learned that one IVIG manufacturer plans to reduce production of one IVIG product in 2008. CMS will meet with this manufacturer to understand the basis behind the production decrease and will closely monitor pricing. CMS notes that it continued the additional pre-administration services fee for the administration of IVIG in 2008.

Significant Items of Interest to Congress
FY 2008 Senate Appropriations Committee Report Language
(Senate Report 110-107)

Item

Coverage for Type 1 Diabetes Patient --Advances in medicine have enabled increasing numbers of Type 1 diabetes patients to live with this disease for more than 50 years. Recent advances in continuous glucose monitoring technology have the potential to revolutionize the way diabetes is managed on a daily basis. While research is underway, the Committee urges CMS not to make premature coverage decisions for this durable medical equipment nor take actions that would delay the private adoption of these technologies. (p. 179)

Action taken or to be taken

CMS has taken the following actions regarding continuous glucose monitoring:

- On August 30, 2006, CMS held a public meeting of the Medicare Coverage Advisory Committee (MCAC, since renamed the Medicare Evidence Development and Coverage Advisory Committee (MedCAC)) on "Glycemic Control" to consider evidence for the use of continuous glucose monitors and other monitoring strategies. The MCAC identified data deficiencies and areas for future research. The transcript of the MCAC meeting can be found at: http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=36.

- Also, CMS commissioned through the Agency for Healthcare Research and Quality (AHRQ) a Technology Assessment (TA) titled "Applicability of the Evidence Regarding Intensive Glycemic Control and Self-Monitored Blood Glucose to Medicare Patients with Type 2 Diabetes," which was presented at the MCAC meeting on Glycemic Control. On September 10, 2006, a final version of the Technology Assessment was issued and made available to the public.

CMS maintains discussions about continuous glucose monitoring practices and technologies with interested stakeholders.

Item

Long Term Acute Care Hospitals -- In early 2007 CMS promulgated new regulations for long term acute care hospitals [LTACHs]. The Committee is concerned that the CMS guidelines once again set arbitrary quota limits for the number of patients which an LTACH can accept from any one hospital. Patients who need access to LTACHS are among the most vulnerable of the sick. This Committee has previously stated that the decision as to which patients should go into a LTACH should be made by physicians based on well-defined patient and hospital admissions criteria -- not on arbitrary quotas. The Medicare Payment

Advisory Commission [MEDPAC] in its March 22, 2007 letter to CMS warned that arbitrary criteria increase the risk of unintended consequences. The Committee expects that CMS will work closely with providers and others in an expedited timetable to develop and promulgate realistic and workable admissibility criteria which will allow for the reasonable and measured expansion of the LTACH system. (p. 179-180)

Action taken or to be taken
With respect to patient criteria, CMS has engaged Research Triangle Institute (RTI) to study the issue of the feasibility of developing such criteria for Long Term Care Hospitals (LTCHs).

Item
Access to Recreational Therapy -- The Committee is aware of concerns that Medicare beneficiaries have inconsistent access to recreational therapy [RT] services in various inpatient settings due to a lack of clarity in CMS regulations. These settings are inpatient rehabilitation facilities [IRFs], skilled nursing facilities [SNFs] and inpatient psychiatric hospitals [IPFs]. CMS has not adequately communicated policies to these inpatient providers through revisions to its regulations or the Medicare Benefits Policy Manual [MBPM]. This lack of clarity is creating confusion among Medicare providers and contractors and resulting in inconsistent access to recreational therapy for Medicare beneficiaries in need of these services. The Committee encourages CMS to issue revised regulations or publish policy guidance in the MBPM that clarifies policies related to recreational therapies. (p. 180)

Action taken or to be taken
CMS has responded to inquiries from the recreational therapy industry and their trade associations on this issue in order to clarify our existing policies. The inquiries suggest that there is confusion between Medicare's "coverage" of these services and the effect of including a covered service within the bundled institutional payment made under a prospective payment system (PPS).

A facility may choose to provide recreational therapy as a Medicare-covered therapy treatment. The bundled PPS payment methodology for IRF, IPF, and SNF settings, along with our "outcome-oriented" facility standards--which focus on the presence of desired patient outcomes rather than on the specific process used to achieve the outcome--combine to make the facility and the attending physician (rather than the Medicare program) responsible for determining which of the various types of Medicare-covered therapy treatments is appropriate and medically necessary in a given instance. Under this approach, the facility, acting in concert with the attending physician, selects from among the covered therapeutic treatments the particular ones it determines will be the most effective in achieving the desired patient care outcomes.

CMS has developed a report to explain that another potential means of improving

access to recreational therapy in institutional settings involves its inclusion in the patient care planning process. Finally, the report advises that we revise the language in a provision to eliminate the problematic wording that had created confusion in this area.

CMS will continue to educate the provider community and others by sharing our "Report on Medicare Coverage of Recreational Therapy Services in Certain Institutional Settings."

Item

Power Mobility Devices -- The Committee is aware of the significant Medicare reductions (in excess of 25 percent on average) to the Power Mobility Device [PMD] fee schedule amounts, which became effective November 15, 2006. The Committee strongly encourages CMS not to alter further the PMD fee schedule in effect November 15, 2006 during fiscal year 2008. The Committee further encourages CMS to validate any subsequent alterations in a report based on claims data under current PMD fee schedule amounts. The Committee is concerned that the Medicare Modernization Act provision requiring mandatory provider accreditations has not been fully implemented. Such a requirement will reduce fraud and abuse and ensure beneficiary access only to quality providers and equipment. The Committee believes that the provision of medically necessary PMDs can save Medicare money through cost-avoidance associated with expensive institutional care or hospitalization resulting from falls by the growing elderly population. (p. 180)

Action taken or to be taken

CMS has no plans to revise the fee schedule amounts for the codes implemented on November 15, 2006, for PMDs during FY 2008, unless we determine that there may have been a miscalculation of the fee schedule amounts for one or more of these codes.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) required that the Secretary of the Department of Health and Human Services establish and implement quality standards for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). All DMEPOS suppliers will have to meet the quality standards in order to bill the Medicare Part B program for DMEPOS furnished to Medicare beneficiaries, including walkers, wheelchairs and hospital beds. Those suppliers who are participating in the DMEPOS competitive bidding program are required to be accredited.

In December 2007, CMS announced the deadlines for when DMEPOS suppliers must be accredited. Existing DMEPOS suppliers enrolled in the Medicare program (prior to January 1, 2008) are required to obtain and submit an approved accreditation to the National Supplier Clearinghouse (NSC) by September 30, 2009. New DMEPOS suppliers who do not have a completed enrollment application with the NSC between December 1, 2007 and February

29, 2008 will need to obtain and submit an approved accreditation to the NSC by January 1, 2009. The NSC will revoke a DMEPOS supplier's billing privileges if the DMEPOS supplier does not obtain and submit supporting documentation that the DMEPOS supplier has been accredited.

DMEPOS suppliers submitting an enrollment application to the NSC on or after March 1, 2008 must be accredited prior to submitting the application. The NSC will not approve any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt or in response to a developmental request. The NSC may reject the enrollment application unless the DMEPOS supplier provides supporting documentation that demonstrates that the supplier has an approved accreditation.

Item
Erythropoiesis Stimulating Agents -- The Committee is aware that the Centers for Medicare and Medicaid Services [CMS] has proposed a national coverage decision memorandum for the use of Erythropoiesis Stimulating Agents [ESAs] in Cancer and Related Neoplastic Conditions. Recent concerns have been raised by both CMS and the Food and Drug Administration about the use of ESAs in treating anemia that results from chemotherapy. These concerns may be valid for patients treated with ESAs to high hemoglobin targets (above 12g/dL), but, as the FDA noted, they do not apply to all individuals treated for chemotherapy-induced anemia or bone marrow failure diseases, eg. myelodysplasia. The Committee is concerned that evidence from some studies is being broadly and inappropriately extrapolated, resulting in proposals that are not evidence-based or scientifically rigorous. The committee requests that CMS delay finalizing the Proposed Decision Memo for Erythropoiesis Stimulating Agents [ESAs] for non-renal disease indications (CAG-00383N) until after the FDA has completed its current review of ESA labeling. (p. 180-181)

Action taken or to be taken
On July 30, 2007, CMS published a national coverage determination (NCD) for the use of ESAs in cancer and related neoplastic conditions. The NCD was initiated by CMS in response to the Blacked Boxed Warning on the use of ESAs issued by the Food and Drug Administration (FDA), which focused on the serious and life-threatening risks associated with the use of these drugs. CMS determined through its NCD process, which included a review of all relevant scientific evidence and over 2,600 public comments, that there is sufficient evidence to conclude that ESA treatment is not reasonable and necessary for beneficiaries with certain clinical conditions, either because of a deleterious effect of the ESA on their underlying disease or because the underlying disease increases their risk of adverse effects related to ESA use. However, CMS did not make any national coverage determination on the use of ESAs in myelodysplasia therefore local Medicare contractors may continue to make reasonable and necessary determinations for uses of ESAs that are not determined by the NCD. In addition, CMS has determined that ESA treatment for anemia secondary to

myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is only reasonable and necessary under certain dosing conditions.

Since the issuance of the NCD, some stakeholders have claimed that the NCD is inconsistent with FDA approved labeling, the NCD restrictions may deny patients important therapeutic options to combat cancer, and the NCD compromises quality of care. For the NCD, CMS reviewed over 800 individual publications and found that the evidence does not support the contentions made by some members of the medical community regarding the impact on patient care.

Additionally, the FDA, in a response to a letter from Congressmen Stark and Waxman, stated that the FDA believed that the ESA approved labeling and the CMS NCD are generally consistent in their recommendations regarding the use of ESAs in patients with cancer undergoing chemotherapy. The NCD has also received support from many members of the patient advocate community including the National Breast Cancer Coalition and a number of consumer groups. In a December 21, 2007 letter from the American Cancer Society, American Cancer Society Cancer Action Network (ACS CAN), C3: Colorectal Cancer Coalition, Lung Cancer Alliance, Marti Nelson Cancer Foundation, and the Ovarian Cancer National Alliance to Amgen, Johnson & Johnson, and FDA, they expressed ongoing concern about additional safety signals seen in trials of ESAs in cancer patients.

CMS does not believe that it is in the best interests of Medicare beneficiaries to delay implementation of the current NCD in light of these mounting safety concerns.

Item

Healthy Start Grow Smart **-** The Committee recommends continuing the Healthy Start, Grow Smart program, which disseminates educational brochures to low-income pregnant women and new mothers. The prenatal brochure provides information on prenatal care and highlights the link between maternal behaviors and development of the unborn child. The remaining brochures are distributed at birth and at key developmental points during the first two years of life. The publications offer vital health and safety information for new parents and focuses on infant brain development and skills these children need to be successful in school. (p. 181)

Action taken or to be taken

CMS has distributed more than 60 million "Healthy Start, Grow Smart" brochures to low-income pregnant women, parents and caregivers since the program began in FY 2003. The series is available in four languages: English, Spanish, Chinese and Vietnamese.

Beginning in FY 2008, CMS enhanced the program by distributing a prenatal

issue for low-income expectant mothers providing information on prenatal care and highlighting the link between healthy (e.g., exercising) or unhealthy (e.g., smoking) behaviors and development of the unborn child. CMS is currently revising the original 13-issue Healthy Start, Grow Smart series (covering newborn through age12-months) to include additional areas of emphasis on childhood obesity, dental care, and immunization. An additional tool is being developed that will help parents with recording and tracking vital information for their children including health, immunization, and birth records. These products will be available for distribution in FY 2009.

Item
Allied Health Professions Training in Rural Areas --The Committee commends CMS for supporting rural health interdisciplinary training initiatives. The Committee strongly supports demonstration projects to develop interdisciplinary, collaborative and culturally appropriate family medicine residency, nursing and allied health professions training in rural areas. These projects have the potential to reduce health disparities and to improve access to culturally appropriate health care for underserved populations. The Committee urges CMS to consider waivers of population density requirements for demonstration projects in rural and/or isolated areas. (p. 181)

Action taken or to be taken
CMS will take into account population density concerns for any demonstration projects of allied health training. CMS will consider whether to develop such a demonstration in the future, with consideration of overall agency research priorities and availability of resources.

Item
Waiver Authority -- The Committee encourages CMS to use existing waiver authority under the Public Health Service Act to issue waivers of the governance requirements for Federally Qualified Health Centers [FQHC] look-alike centers to nurse practice arrangements commonly referred to as nurse-managed health centers. (p. 181)

Action taken or to be taken
The Health Resources and Services Administration (HRSA) will respond to this issue in their FY 2009 Congressional Justification.

Item
Nurse Practitioners and Managed Care Organizations -- The Committee recognizes that nurse practitioners and nurse-managed health centers are an important part of the Nation's healthcare safety-net serving vulnerable and underserved populations. Vulnerable populations are populations comprised of a high percentage of uninsured patients that lack access to adequate primary care services. The Committee understands that States have the primary role regarding the scope of practice for nurse practitioners and other health

practitioners. The Committee is pleased that CMS has taken some steps to ensure that these providers do not face provider-based discrimination when applying for admission to the primary care provider networks of managed care organizations [MCO] operating around the Nation. The Committee is, however, concerned that a large percentage of MCOs have established policies which unfairly exclude nurse practitioners as a class of providers from their provider panels. The Committee encourages CMS to develop written guidance informing MCOs that Federal regulations allow and encourage nurse practitioners to be part of an MCO's panel of providers. The Committee also encourages CMS to conduct a survey of MCOs to determine the extent to which nurse practitioners are part of their panel of providers and if not, the reasons for that. (p. 181-182)

Action taken or to be taken
As the committee points out, States have the primary role regarding the scope of practice for nurse practitioners and other health practitioners. CMS does not have a statutory or regulatory role in this process beyond requiring that mandatory services be available in managed care setting (or out of network, if not otherwise available) and enforcing the prohibition on provider discrimination in section 1932 (b)(7) of the Social Security Act and 42 CFR 438.12.

Also, Regulations at 42 CFR 438.214 require States to establish a uniform credentialing and re-credentialing process that each MCO must follow. Such a process would have to meet State laws on provider qualifications as well as comply with the Federal prohibition on provider discrimination. In addition, we believe that the trend in primary care is for increased use of nurse practitioners for a variety of reasons including, fewer medical school graduates in family care, pediatrics and other areas of primary care, and the savings that can be achieved through the use of a nurse practitioner as a substitute for physician services. Consequently a letter to all States as suggested by the Committee is unnecessary at this time.

Further, a survey of the more than 300 Medicaid MCOs to determine the extent to which nurse practitioners are part of their panel of providers would be major information collection burden and would provide little useful information, since any changes to increase nurse practitioner participation would need to be made at the State rather than the Federal level. This is a state professional practice issue over which CMS has little control.

Item
Nurse Practitioners and Home Health Care-- Since January 1, 1998, nurse practitioners have been providing reimbursable care to patients as part B providers. Despite their ability to provide and bill for services rendered in all of these areas, they are still unable to order or certify home health care for patients. CMS has referenced the sections 1861(r) of the Social Security Act's definition of physician, which does not include nurse practitioner. The Committee encourages CMS to expand its interpretation of the word “physician” in Part A,

section 1814, of the Medicare law to enable nurse practitioners to certify and order hospice and home health care. (p. 182)

Action taken or to be taken
Section 1814(a) of the Act lays out the statutory conditions of and limitations on payment for services. Paragraph (2)(C) requires that a plan for furnishing home health services be established and periodically reviewed by a physician. The law also requires that home health services be furnished while the beneficiary is under the care of a physician. The Medicare statute contains separate definitions of NPs, CNSs and physicians, whereby NPs and CNSs are not defined as physicians. Current law does not provide the flexibility to allow non physician practitioners to certify for home health services.

In addition, Section 1814(a)(7) requires both an attending physician and a hospice physician certification of terminal illness for eligibility for Medicare hospice. This section of the statute specifies that the attending physician cannot be a nurse practitioner. The hospice physician is described in Section 1861(dd)(3)(B) as a physician as defined in Section 1861(r). Thus, current law does not provide the flexibility to allow non physician practitioners to certify eligibility for the Medicare hospice benefit.

Item
Support of Programs with Highest Evidentiary Standards -- The Committee encourages the Secretary to work across the Department to direct its resources toward programs with the highest evidentiary standards, such as randomized trials. For example, the Committee is aware of extensive evidence that Nurse-Family Partnership, an early home visitation program for first-time low-income mothers, prevents child abuse and childhood injury, helps develop positive parent-child relationships, and helps the brain development of the children served. The Committee requests that the Secretary apply the high evidentiary standards to programs across the Department, and to support agencies within the Department, such as Health Resources and Services Administration [HRSA] and Administration for Children and Families [ACF], adopting evidence-based programs. (p. 182)

Action taken or to be taken
Studies supported by CMS employ randomized designs whenever feasible. In addition, to the extent that such trials exist, CMS incorporates the results of randomized trials in our reviews of the literature.

CMS will hold a federal workshop in which scientists from 14 of the NIH Institutes and the CDC in April 2008. This group will work together to provide further input into our research priority list and refine the final product. The Medicare Evidence Development & Coverage Advisory Committee (MedCAC) will be reconvened soon after to evaluate the final research priority list. CMS will disseminate this list to the research community.

Item
Telehealth Services -- This Committee has supported demonstration projects that have assessed the efficacy of using interactive video technology as a means for providing intensive behavioral health services to individuals with serious emotional and behavioral challenges, such as autism and other at-risk populations. Such projects have assessed the effectiveness of the medium in providing a range of services such as behavior analysis, case management, medical services, psychiatric services, support to education and training. However, the Committee has observed that one of the most serious obstacles to the integration of telemedicine into health practices is the absence of consistent, comprehensive reimbursement policies. Medicare authorizes only partial reimbursement. Medicaid policies set at state levels vary widely and are inconsistent from State to State. The Committee believes that telehealth technology is a way to provide intensive behavioral health therapy services in a cost effective manner. Further, since the 1999 Supreme Court Olmstead decision, the Committee has been dedicating resources towards States to move individuals out of institutions into community-based settings. The Committee recognizes the potential benefits that telehealth technologies can have in supporting the independence, productivity and integration into the community of persons with developmental disabilities.

The Committee urges CMS this year to provide it with a comprehensive survey on a State-by-State basis of telehealth services provided under Medicaid. It further requests that CMS meet with an appropriate array of telehealth specialists including those who have been involved in the demonstration projects supported by this Committee to survey and assess best practices and professional criteria standards and make recommendations to the Committee concerning national standards for telehealth reimbursement which advances and encourages this technology. (p. 182-183)

Action taken or to be taken
A comprehensive State-by-State survey of Medicaid coverage and reimbursement for telemedicine services has not been completed by CMS for several years. However, in the coming year, CMS plans to do such a survey and also to update its current website which provides policy guidance with regard to Medicaid coverage, reimbursement and coding of telemedicine.

We expect that the States' survey will obtain information on the standards used by States to provide telemedicine under the Medicaid programs, and based on the results of the survey, we will consider the need for national guidance to State Medicaid agencies on the provision of these services.

Item
Medication Management Programs -- The Committee is aware that many low-income Medicare part D enrollees living with HIV/AIDS have benefited from

effective medication management programs. In its fiscal year 2008 budget justification, CMS noted that it was considering demonstration authority as a way to test best practice models of medication therapy management programs. The Committee strongly encourages CMS to develop such demonstrations in fiscal year 2008. (p. 183)

Action taken or to be taken
The final rule for the Medicare prescription drug benefit made clear that medication therapy management programs (MTMP) is one component of the Part D program that we may wish to explore further in the future. CMS has been contacted by representatives of several management companies and advocacy organizations that are interested in pursuing demonstrations to test best practice models of MTMPs under Part D. CMS is conducting an examination of MTMPs.

Item
Long Term Care -- The Committee is 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 stating its intention to inform all target households through its initial mailings that "Medicare generally does not pay" for long-term care. The Committee also encourages the Department to use other communication methods, in addition to the Internet and direct mail, to clarify widely held misperceptions about Medicare and long-term care. This policy would allow individuals to better prepare for their potential long-term care needs without impoverishing themselves to qualify for Medicaid. (p. 183)

Action taken or to be taken
CMS recognizes that many Americans do not have an adequate understanding on 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 is implementing 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: the "Own Your Future" Long-Term Care Awareness Campaign and a national website.

Campaign update: To date, 16 states have participated in the "Own Your Future" Campaign in three phases. The states include: Arkansas, Idaho, Nevada, New Jersey, Virginia, Kansas, Maryland, Rhode Island, Washington, Georgia, Michigan, Missouri, Nebraska, South Dakota, Tennessee and Texas. The next phase, targeting approximately 3.3 million households with individuals between the ages of 45 to 65, will commence in March 2008 and consist of four parts: 1) direct mail supported by State Governor, 2) state-specific insert with local

planning resources and information, 3) a Governor's press conference to launch the campaign, and 4) a follow-up postcard to remind individuals who have not yet requested the Long-Term Care Planning Kit to do so. We will be working with the Governors' staffs in the upcoming campaigns to insert a statement about Medicare not paying for long-term care in the initial letter that Governors send to the target households in their states. We are revising the direct mail campaign materials. While already in the planning kit, we are rewriting the tri-fold brochure that is included in the initial mailing to households to insert the "Medicare generally does not pay" language.

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 issued a national press release earlier this year to: improve the public awareness of Medicare's limited role in covering and paying for long-term care, encourage people to start the planning process, and announce which states had been selected for the fourth phase of the Campaign.

CMS is working with the Administration on Aging and the 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. One of the revisions that will be made to the manual this year is the insertion of clearer language about Medicare's coverage of long-term care to clarify any misperceptions.

CMS plans to provide a presentation on Medicare and long-term care awareness to the Caregiver Coalition Network on a future quarterly conference call. This in-depth presentation will highlight the website. We will ask caregiver coalitions to provide feedback on the usefulness of the website and any improvements they may want to suggest that may be helpful to caregivers using the website.

CMS plans to present on Medicare and long-term care awareness to the CMS Caregiver Workgroup. CMS will leverage the networks of the Caregiver Workgroup to share Medicare and long-term care awareness information to the

caregiver community through its meetings, newsletters, websites, list serves, and other information channels.

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

Significant Items of Interest to Congress
FY 2008 Joint Explanatory Statement Report Language
Accompanying the Consolidated Appropriations Act

Item

GAO Report on State Efforts on Health Care and Access - The Government Accountability Office is requested to submit a report to Congress by November 30, 2008: (1) assessing State efforts to reexamine health care delivery and expand access; and (2) providing recommendations regarding the potential role of Congress in supporting State-based efforts. The Senate proposed a similar report in section 228 of H.R. 3043, as passed by the Senate. The House had no similar provision. (p. 84)

Action taken or to be taken

CMS facilitates state efforts to improve health care delivery and expand access by providing technical assistance to States, reviewing and processing State Plan Amendments for titles XIX and XXI, as well as facilitating improvements and expansions through State demonstration and waiver programs. During CY 2008, CMS will work with GAO and States to assist GAO's efforts to gather information on State efforts to reexamine health care delivery and expand access, and to assist GAO's formulation of recommendations regarding the potential role of Congress in supporting State-based efforts.

Item

Worker's Compensation Set-Asides - The Secretary of HHS is directed to submit a report to the Appropriations Committees of the House of Representatives and the Senate no later than 30 days after enactment of this Act on workers' compensation set-asides under the Medicare secondary payer set-aside provisions under title XVIII of the Social Security Act. The Senate proposed a similar report in section 240 of H.R. 3043, as passed by the Senate. The House had no similar provision. (p. 84)

Action taken or to be taken

CMS will send the information requested to the Appropriations Committees.

Item

Clinical Trials - The Secretary of HHS is directed to maintain "deemed status" coverage under the Medicare program for clinical trials that are Federally funded or reviewed, as provided for by the Executive Memorandum of June, 2000. The Senate expressed a similar view in section 241 of H.R. 3043, as passed by the Senate. The House had no similar provision. (p. 84)

Action taken or to be taken

CMS issued a revised clinical trial policy in July 2007 which maintained the deeming process established in the 2000 policy without change. In October 2007, CMS announced that it was not changing the July 2007 policy in order to

consider legislative changes made in the Food and Drug Administration Amendments Act of 2007. No further NCDs on this topic have been initiated at this time.

Item

***Medicare & You* Handbook Changes -** CMS is directed to include in the next publication of "Medicare & You" information regarding: (1) the importance of writing and updating advance directives and living wills; and (2) access to laboratory findings and medical records and encouraging patients to be more proactive in asking for copies of these important pieces of health information. (p. 84)

Action taken or to be taken

Each October, the *Medicare & You* handbook is bulk mailed to all beneficiary households. CMS plans to incorporate information regarding: (1) the importance of writing and updating advance directives and living wills; and (2) access to laboratory findings and medical records, in the 2009 version that will be mailed out in October 2008.

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Centers for Medicare & Medicaid Services

Resource Summary

	Budget Authority ($ in Millions)			
	FY 2007 CR	FY 2008 Appropriation	FY 2009 PB	FY 2009+/- FY 2008
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

Program Summary

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. CMS helps to achieve the goals of the National Drug Control Strategy through support of screening and brief intervention services for those at risk for substance abuse.

Budget

CMS has added two new optional Healthcare Common Procedure Coding System (HCPCS) codes for alcohol and drug screening and brief intervention (SBI) that became effective on January 1, 2007. It is anticipated that States may begin to implement the use of these codes during FY 2008. The costs of the SBI services to be tracked by the optional HCPCS codes are funded through the Grants to States for Medicaid appropriation. As such, a separate funding request would be duplicative and is unnecessary. The amount of spending that would be captured by the use of these codes is dependent on the number of States which opt to use them. CMS' Office of the Actuary has estimated that if only 4 or 5 States used the codes, that identified Medicaid

expenditures would be $75 million annually. If as many as 20 States participated, identified expenditures would grow to $265 million.

State's implementing these SBI reporting codes are responsible for determining their own reimbursement cost schedule. These actuarial cost estimates assume:

- A 10 percent effective participation rate for FY 2008 and FY 2009;
- An average cost of $21.00 per each screening of a beneficiary;
- An average cost of $61.50 per each brief intervention; and
- A 15 percent probability that a given screening will lead to an intervention.

Grants to States for Medicaid Appropriation

Total FY 2009 Budget Authority Request: $216.6 billion
(This initiative to capture spending for the interventions does not affect the amount of the FY 2009 request for the Medicaid appropriation.)

Screening and Brief Intervention

(This initiative to capture spending for the interventions does not affect the amount of the FY 2009 request for the Medicaid appropriation.)

CMS has provided States the ability to report on early intervention and treatment for substance abuse. On January 1, 2007, two new Healthcare Common Procedure Coding System (HCPCS) codes were introduced to facilitate the reporting of Medicaid costs for alcohol and drug screening and brief intervention (SBI). 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. The cost for a screening is dependent on where and how it is carried out. The screening, a preventative service, is generally accomplished using a brief questionnaire concerning a patient's alcohol or drug use. It can be carried out in various settings, most likely a physician's office or a hospital emergency room. Based on data provided to CMS, the average cost of a screening a beneficiary is $21.00.

The second code, H0050, covers a brief intervention that generally occurs right after the screening. The brief intervention 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. The cost of the intervention depends on both the amount of time involved and the treatment. Based on data provided to CMS, the average cost of an intervention is $61.50.

These codes, 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.